Bundle Health Board 25 July 2024

1 PRELIMINARY MATTERS

2 09:30 – 24/139 Welcome and apologies for absence (Verbal) – Chair

3 09:31 – 24/140 Declarations of Interest relating to the agenda (Verbal) – Chair

4 09:32 – 24/141 Unconfirmed minutes of Health Board meetings held on 10.7.24 (ExtraOrdinary), 30.06.24 and 11.04.24 (ExtraOrdinary) – Chair

- 24.141a Health Board ExtraOrdinary minutes 10.7.24 public draft v0.2
- 24.141b Health Board minutes 30.5.24 v.04 draft public session
- 24.141c Health Board Minutes 11.04.24 public session draft V0.3

5 09:37 – 24/142 Matters arising and action log – Chair

- 24.142 Action log HB_Public session

6 09:42 – 24/143 Staff Story – Dementia Support Activities Co-ordinator Story – Executive Director of Nursing and Midwifery

- 24.143 Staff Story – Dementia Support Worker – July 2024 revPW

7 10:02 – 24/144 Report of the Chair – Chair

- 24.144 Chair report July 2024 v1.0

8 10:12 – 24/145 Report of the Chief Executive – Chief Executive

- 24.145 Chief Executive report July 2024 v1.0

9 10:22 – 24/146 Report of the Vice Chair – Vice Chair

- 24.146 Vice-Chair Report July 2024 revPW

10 STRATEGIC

11 10:32 – 24/147 Health Board Response to the Royal College of Psychiatrists' Invited Review Services Report –Lead for Mental Health & Learning Disabilities / Executive Director of Nursing and Midwifery

- 24.147 Health Board response to RCPsych Mental Health review July TAO v18724
- 24.147a Copy of RCPsych Response Plan 2024 V.19xlsx

12 10:47 – 24/148 All Ages Mental Health Digital Solution Outline Business Case – Chief Digital and Information Officer

- 24.148a All Ages Mental Health Digital Solution revPW
- 24.148b MH Draft Case Final Draft v0.3

13 11:02 – Comfort Break

14 11:12 – 24/149 North Wales Vascular Network – update report – Chief Executive

- 24.149 Vascular Update_Health Board_July 2024-incl appendix vFinal

15 11:29 – 24/150 Digital Augmentation Contract – Chief Digital and Information Officer

- 24.150 Digital Augmentation Contract July 2024 v1.0 revPW

16 QUALITY, GOVERNANCE AND ASSURANCE

17 11:44 – 24/151 Integrated Concerns Policy – Executive Director of Nursing and Midwifery / Acting Executive Director Therapies and Health Sciences

- 24.151a Integrated Concerns Policy – July 2024 revPW
- 24.151bi Appendix (Slides) new Integrated Concerns Policy – July 2024
- 24.151b Integrated Concerns Policy – July 2024 revPW
- 24.151c Appendix (IC Hub Decision Tree) for new Integrated Concerns Policy – July 2024
- 24.151d Appendix (Implementation Plan) for new Integrated Concerns Policy – July 2024 revPW

18 11:59 – 24/152 2024/25 Annual Delivery Plan Quarter 1 – Executive Director Transformation and Planning

- 24.152 Annual Delivery Plan 24-25 plan v2.2

19 12:14 – 24/153 2023/24 Annual plan closure report – Executive Director Transformation and Planning

- 24.153 23_24 ADP_SpecialMeasures Closure Report v2

20 12:19 – 24/154 Integrated Performance Report – Interim Executive Director of Finance

- 24.154a Integrated Performance Report July 2024 revPW
- 24.154b Integrated Performance Report – HB – July 24 v2

21 12:36 – Lunch

22 12:56 – 24/155 Quality Report – Executive Medical Director/Executive Director for Nursing and Midwifery

24.155 Improving Quality Report – July 2024 revPW2

23 13:13 – 24/156 Finance Update Q1 – Interim Executive Director of Finance

24.156a Finance Report month 3 revPW

24.156b Finance Report month 3 2024 revPW

24 13:30 – 24/157 Corporate Governance Report – Director of Corporate Governance

24.157a Corporate Governance Report – July 2024 1.1

24.157b App 1 – Health Board CoB V0.02 revPW

24.157bii App 1a – Board Development Programme rev PW

24.157c App 2 – Remuneration Committee ToR V1.02

24.157di App3 All Wales AC and Section12 Board Report – July 2024 Board meeting

24.157dii App3 Appendix 1 FV – Approved Clinicians Data – July 2024 Board report

24.157diii App3 Appendix 2 FV – All Wales Section 12(2) Doctors Data – July 2024 Board Report

25 13:40 – 24/158 Corporate Risk Register Q1– Director of Corporate Governance

24.158a Risk Report and Corporate Risk Register July 24 v1 PWrev

24.158b Appendix 1 RM01 – Risk Management Framework

24.158c Appendix 2 Corporate Risk Register June PW v2

27 13:50 – 24/159 Committee and Advisory Group Chair Reports

Audit Committee 9.7.24
Finance, Performance and Information Governance Committee 25.6.24
Planning, Population Health and Partnership Committee 18.6.24
People and Culture Committee 13.6.24
Remuneration Committee June/July 2024
Charitable Funds Committee 14.5.24 The Board is asked to ratify the 2024-27 Charity Strategy, which was approved by the Charitable Funds Committee on 15/04/24, subject to the approval of the Health Board. (24/159.6 Appendix 1)
Stakeholder Reference Group 3.6.24
Health Professional Forum 7.6.24

24.159.1 Chair Report Audit Committee 9.7.2024 v1.0 revPW

24.159.2 Chair Report PFIGC 25.6.24 v1.0 revPW

24.159.3 Chair report PPHPC 18.06.24 V1.01 revPW

24.159.4 Chair report PCC 13.06.24 V1.01 revPW

24.159.5 Chair report Rem Com_JuneJuly 2024 V1.0revPW

24.159.6a Chair report CFC 1.7.24_15.4.24 v1.0 revPW

24.159.6b Appendix 1 Awyr Las Strategic Plan (2024-28)

24.159.7 Chair report_SRG 3.6.24_1.0pwrev

24.159.8 Chair report_HPF 7.6.24 v1.0 revpw

28 13:55 – CLOSING BUSINESS

29 24/160 Review of meeting effectiveness (Verbal) – Chair

30 24/161 Any other business (Verbal) – Chair

31 24/162 Date of next meeting – Chair

26th September 2024 Health Board, Venue Cymru
25th September 2024 Annual General Meeting – Venue TBA

32 14:00 – Resolution to exclude the Press and Public

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

Betsi Cadwaladr University Health Board (BCUHB)
Draft minutes of the Health Board meeting held in public
on 10th July 2024 livestreamed via Zoom

Board Members present	
Name	**Title**
Dyfed Edwards	Chair
Karen Balmer	Independent Member / Chair Audit Committee
Clare Budden	Independent Member
Russell Caldicott (RC)	Interim Executive Director of Finance
Gareth Evans	Acting Executive Director of Therapies and Health Sciences
Urtha Felda	Independent Member
Chris Field	Independent Member
Dyfed Jones	Independent Member
Prof Mike Larvin	Independent Member
Dr Jane Moore	Acting Executive Director of Public Health
Mike Parry	Associate Member – Chair Stakeholder Reference Group (SRG) (part meeting)
Fôn Roberts	Associate Member – representing Social Services Directors
Carol Shillabeer	Chief Executive (part meeting)
Rhian Watcyn Jones	Independent Member
Jane Wild	Associate Member – Chair Healthcare Professionals Forum (HPF)
Angela Wood	Executive Director of Nursing and Midwifery
In Attendance	
Jason Brannan	Deputy Director of People
Matt Edwards	Audit Wales
Dave Harries	Head of Internal Audit
Andrea Hughes	Interim Director Finance – Operational Finance
Michelle Phoenix	Audit Wales
Dylan Roberts	Chief Digital and Information Officer
Helen Stevens-Jones	Director of Partnerships, Engagement & Communications
Simon Weaver	Head of Financial Control
Pam Wenger (PW)	Director of Corporate Governance
Diane Davies	Corporate Governance Manager - for minutes

Agenda Item	**Action**
OPENING BUSINESS	
24/132 Welcome and apologies for absence Apologies for absence were received from Gareth Williams, Vice-Chair, Billy Nicholls and Dr Caroline Turner, Independent Members, Dr Nick Lyons, Executive Medical Director and Chris Stockport, Executive Director Planning & Transformation.	

24/133 Declarations of Interest None were received	
24/133.1 Chair Audit Committee address **24/133.1.1** The Chair of the Audit Committee advised that the Audit Committee had met the previous day (9th July) to consider the financial statements, the audit report on the accounts (ISA 260), Head of Counter Fraud Annual Report, Head of Internal Audit Opinion and the Annual Report (including the Performance Report, Accountability (and Annual Governance Statement). The Chair and Chief Executive were in attendance at the meeting. **24/133.1.2** The Audit Committee Chair advised the Audit Committee recommended to the Board the approval of the 2023-24 Annual Accounts following consideration of Audit Wales findings on their review of the Financial Statements. In addition, the Audit Committee recommended to the Board the approval of the Annual Report 2023-24 for onward submission to Welsh Government (WG), following the incorporation of the accounts subject to Board approval. **24/133.1.3** The Audit Committee had recognised the work of the teams during the year and noted, in particular, some of the challenges in relation the Remuneration Report, as the regularity issue disappointingly related to the appointment of a previous Interim Executive Director of Finance which had rolled into the 2023/24 year. The Team was working closely with Audit Wales to address the issues going forward. **24/133.1.4** The Internal Audit Opinion was received which provided 'limited assurance' on systems of internal control and, whilst disappointing, was acknowledged as the health board anticipated. Work to improve the systems of internal control would be a key priority for the Executive Team in 2024/25. The Annual Report and Annual Governance Statement was received and recommended to the Board to approve as part of the Annual Report. **24/133.1.5** The Audit Committee Chair acknowledged the volume of work undertaken and the positive collaboration that had taken place in year with Internal Audit and Audit Wales. She commended delivery of the accounts on time and to a high standard. She was pleased to invite the Board to receive the 2023/24 reports for consideration and approval of the annual report and accounts for onward submission.	
24/134 BCUHB Annual Accounts 2023-24 financial statements **24/134.1** The Interim Executive Director of Finance presented the financial statements highlighting the positive achievement of £24m deficit delivered against the original planned £33m deficit, which had also enabled the £76.4m additional Welsh Government (WG) allocation to be incorporated into the baseline as recurrent funding into future years also. He reported that the qualification issued was due to failure to deliver a break even position and an	

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irregularity regarding the remuneration of a previous interim director. This was due to decisions taken in the previous financial year and had now been finalised. **24/134.2** He emphasised the positive auditors' opinion of the accounts as unqualified, this represented an important step for BCUHB demonstrating that processes of financial control and delivery could be relied upon. He thanked BCU staff, his Finance Team and Audit Wales colleagues for their contributions in achieving the position, against a condensed timeline in comparison to previous years' submission deadlines. **24/134.3** The Chair and Board Members echoed their thanks to those who had enabled a more effective and robust system of financial control to be put in place and deliver quality improvements to the documentation provided. The Chair requested that the Interim Executive Director of Finance extend the Board's thanks to all involved throughout the year, as the Board was now in a better position to deliver the best for the people BCUHB serves.	RC
24/135 ISA 260 Audit of Financial Statements Audit Wales **24/135.1** Mr Matt Edwards, Audit Wales acknowledged the comments that had been made previously regarding the Audit Committee's discussions. He commended the achievement of delivering the accounts to the timetable outlined (the first time since 2021). It was reflective of the improvements which had been made and welcomed working in a very collaborative environment. He advised the Senedd would be provided with a more detailed report on the qualification matters, being a breach of BCUHB's first financial duty to achieve financial balance over a 3 year period and the irregularity previously mentioned along with advice that the organisation had not met the second financial duty to prepare a 3 year Integrated Plan. **24/135.2** Mr Edwards advised that whilst there had been significant changes in Board membership during the year, more robust governance arrangements needed to be embedded around remuneration reporting to ensure accuracy, he acknowledged this was a priority for the newly appointed Director of Governance who would be working with Audit Wales to achieve the necessary improvements. It was **noted** that the Chief Executive had given assurance at the Audit Committee meeting that remuneration reporting would be improved throughout the year. **24/135.3** The Chief Executive joined the meeting commenting that whilst financial and governance processes had improved there was more work to do to improve the effectiveness of the organisation. There would be an opportunity to share more at the Annual General Meeting scheduled in September. **24/135.4** The Chair was keen to keen to work together with Audit Wales into the future whilst continuing on the improvement journey, he was grateful to receive the feedback provided which would enable the Health Board to focus on the issues and achieve better outcomes.	

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24/136 Head of Internal Audit's (IA) Opinion **24/136.1** The Director of Corporate Governance presented the report acknowledging the Team's support. A limited assurance opinion had been provided and it was **noted** that strengthening internal systems of control would be a key priority for the Executive Team during the year with progress monitored through the Audit Committee. **24/136.2** The Head of Internal Audit advised the report had been drawn together based on internal audit public services standards issued by WG and the IA Team's independent role had been respected which included freedom of access to the Accountable Officer, Audit Committee Chair and Health Board Chair if required. He acknowledged the positive collaborative work undertaken with Audit Wales. *The Associate Member SRG joined the meeting*	
24/137 Annual Report 2023-24 **24/137.1** The Director of Corporate Governance emphasised the technical nature of the documentation based on HM Treasury guidance. She explained the 3 stages of the documentation which in combination would provide the finalised Annual Report 2023/24 for submission to Audit Wales and Welsh Government. **24/137.2** The Director of Corporate Governance advised that following discussion at the Audit Committee the previous day, a subsequent meeting had taken place with Audit Wales to **agree** the approach in response to a number of queries that had been raised. She undertook to share a brief schedule of amendments (eg typographical errors and further explanations) with the Audit Committee Chair and Chair and ensure these were incorporated to the finalised document prior to submission. **24/137.3** Special thanks were provided to the Corporate Governance and Engagement Teams working together to compile the report. **24/137.4** The Director of Corporate Governance highlighted the inclusion of standing order breaches within the documentation which related to late paper submissions and were now subject to strengthened processes. She drew attention to the difficult and challenging year that BCUHB had moved through including establishing many new Board members, responding to critical reports and being placed in Special Measures however, recent reports had demonstrated significant improvements and stability eg Audit Wales' Structured Assessment and Board Effectiveness Review. She concluded that the reports prepared were a true and fair view of governance over the year and was pleased to endorse adoption of the recommendations provided. **24/137.5** The Chief Executive acknowledged the work undertaken and recognised that this was a milestone for the organisation which was actively being monitored through Special Measures reporting at Board and Committee meetings. There had also been a notable change in approach to openness and	PW

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transparency during the year. She acknowledged the participation and contribution of external stakeholders to the work of the Board. **24/137.6** The Chief Executive stated that the reports signified the Board was in a more stable position, with significant improvements in corporate and financial governance however there was more to do in operational performance and delivery of services to patients as well as improving quality which were heavily reflected in the 2024/25 Annual Plan. **24/137.7** As a true and fair opinion of BCUHB's position on 2023/24, the Chair and Chief Executive welcomed the significance of the assessment. However, whilst progress had been made on processes and procedures it was now time to deliver on quality and performance for all patients within the Health and Wellbeing system. **24/137.8** The Chair stated the ambition to report on significant improvements following the challenging year ahead and sought support to work in transformative ways for the benefit of the patients BCUHB served. **It was resolved that** the Board • **RECEIVED** the Annual Report 2023-24, Part 1 and 2 and Annual Governance Statement • **APPROVED** the Annual Report 2023-24 (including the audited financial accounts) in readiness for submission to Audit Wales and Welsh Government; and • **APPROVED** the Letter of Representation for signing by the Chair and Chief Executive, on behalf of the Board	
24/138 Date of next meeting 25 July 2024, Optic Centre, St Asaph The Chair and Chief Executive welcomed members of the public to attend the Annual General Meeting and also the Community Engagement event taking place the next day in Llandudno.	

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Betsi Cadwaladr University Health Board (BCUHB)
Draft minutes of the Health Board meeting held in public
on 30 May 2024 at Venue Cymru, Llandudno

Board Members present	
Name	**Title**
Dyfed Edwards	Chair
Clare Budden	Independent Member
Russell Caldicott (RC)	Interim Executive Director of Finance
Urtha Felda	Independent Member
Chris Field	Independent Member
Dyfed Jones	Independent Member
Prof Mike Larvin	Independent Member
Dr Nick Lyons (NL)	Executive Medical Director
Dr Jane Moore	Acting Executive Director of Public Health
Mike Parry	Associate Member – Chair Stakeholder Reference Group (SRG)
Carol Shillabeer (CS)	Chief Executive
Dr Caroline Turner	Independent Member
Rhian Watcyn Jones	Independent Member
Gareth Williams	Vice-Chair
Jane Wild	Associate Member – Chair Healthcare Professionals Forum (HPF)
Angela Wood (AW)	Executive Director of Nursing and Midwifery
In Attendance	
Jason Brannan	Deputy Director of People
Phil Dickerty	Invited member of the public (for item 24/94)
Andrew Doughton	Audit Wales (part meeting)
David Graves	Invited member of the public (for item 24/94)
Gordon Hughes	Llais (for item 24/94)
Sue Irlam	Llais (for item 24/94)
Leon Marsh	Head of Patient Experience (part meeting)
Teresa Owen	Mental Health & Learning Disabilities (MH&LD) and Welsh Language Lead (part meeting)
Michele Phoenix	Audit Wales (part meeting)
Dylan Roberts	Chief Digital and Information Officer
Geoff Ryall Harvey	Chief Officer – Llais (for item 24/94)
Helen Stevens-Jones (HSJ)	Director of Partnerships, Engagement & Communications
Paolo Tardivel	Director Transformation and Improvement (part meeting)
Jane Trowman	Acting Assistant Director Care Homes support & Continuing Health Care (CHC) Commissioning (for item 24/107)
Pam Wenger (PW)	Director Corporate Governance
Iain Wilkie	MH&LD Director
Diane Davies (DD)	Corporate Governance Manager - for minutes

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Observing
Members of the public, BCUHB staff and media

Agenda Item	Action
OPENING BUSINESS	
24/91 Welcome, Introductions and apologies for absence Apologies for absence were received from Karen Balmer, Independent Member, Billy Nicholls, Independent Member, Fôn Roberts, Associate Member – representing Directors of Social Services, Dr Chris Stockport, Executive Director of Planning and Transformation, and Gareth Evans, Acting Executive Director of Therapies & Health Science. Pam Wenger, newly appointed Director of Corporate Governance was welcomed to her first full meeting of the Health Board in post.	
24/91.1 Declarations of Interest on current agenda Clare Budden, Independent Member declared an interest in agenda item 24/107 due to her substantive role outside of the Health Board relating to housing as Chief Executive of Clwyd Alyn. She agreed to absent herself from the meeting whilst the item was discussed.	
24/92 Draft minutes of the previous meeting held on 28.3.24 and matters arising **24/92.1** The draft minutes of meeting held on 28.3.24 were **approved** as a true and accurate record *subject to the inclusion of Chris Field who was in attendance at the meeting and an amendment to Jane Wild's title.* **24/92.2** In response to the Vice-Chair's question, it was not anticipated that the Junior Doctors decision in NHS England to continue industrial action would affect the reported suspension of industrial action within NHS Wales.	DD
24/93 Action Log Members **received** the action log, **noted** the progress provided and agreed the closure of the items as indicated.	
24/94 Mental Health: Royal College of Psychiatrists' Invited Review Services Report **24/94.1** The Chair welcomed receiving the report commissioned by Welsh Government which focussed on four reports including the Holden Report (2013), first Ockenden Report (2014), the Health and Social care Advisory Service (HASCAS) report (2018) and the second Ockenden Report (2018). He also welcomed family members present of affected patients who had been invited to address the Board Members. He was grateful for the support provided to them by Llais officers (previously the Community Health Council) in North Wales.	

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24/94.2 The Chief Executive acknowledged the report, written by experts in the field, which set out that poor care had been provided to patients 10 years ago and it was the key issue being discussed at the outset of the meeting to ensure that due attention was brought to Mental Health and Learning Disability services patients and families as well as those affected by dementia whilst accessing all areas of healthcare provided within BCUHB. Whilst there had been progress made, there remained much work to do, and it would be important to also ensure that peers and families were listened to and involved in the improvements going forward. She stated publicly her apologies, on behalf of the Health Board, to all those affected and renewed the current Board Members' commitment to work with, and listen to, staff, carers and family members to make the necessary improvements in future care provision.

24/94.4 In inviting the family members and Llais officers to address the Board Members the Chair emphasised the importance of listening and recognising the pain and suffering that they had endured.

24/94.5 The Llais Chief Officer read a statement explaining how the Tawel Fan Families Group had formed following the closure of the ward in December 2013. He stated the families felt let down that 51 of the 84 recommendations arising from the Holden, Ockenden 1&2 and HASCAS review reports had not been implemented or embedded into practice. He called for one of the findings of the HASCAS report to be publicly corrected in regard to 'no institutional abuse' as the Nursing and Midwifery Council had recently struck off a nurse for their abusive and aggressive actions on the Tawel Fan ward at that time. The Llais Chief Officer recommended setting up an independent oversight group to closely monitor progress of the relevant recommendations in order that the Tawel Fan Families Group might receive some assurance that this would never affect any other patients or their families again.

24/94.6 Mr Philip Dickerty read out a statement on behalf of the Tawel Fan Families Group which reflected the very personal and painful experiences of listening to and seeing the poor care that their family members had endured. The Group was very disheartened by the failure to learn from the original and subsequent reports and very concerned that, without implementation, this could lead to similar experiences in the future.

24/94.7 Mr David Graves, whose family member was a patient on the ward, spoke of his personal experiences and deep concern regarding accountability and governance failings. He felt it was time to consider the introduction of a new national NHS Wales regulator similar to the Care Quality Commission in England. He also sought apologies for misleading statements regarding implementation. Mr Graves wished it to be known that he had admiration for the late Dr Peter Higson, a previous Chair of the Health Board.

24/94.8 The Vice-Chair gave his personal commitment that these experiences would be focussed upon and that he would direct the Board to ensure the report remained a priority to action. In relating his personal experiences with staff working in these areas recently, he emphasised there were many committed and compassionate staff. However, work needed to be implemented on new organisational structures with stability to ensure staff were well supported and

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avoided stress. The Vice-Chair also shared insight into complaints management issues, listening holistically to patients and their families, financial challenges with estate condition and networking. He was very committed to making the future better than the past. **24/94.9** The Executive Director of Nursing and Midwifery gave a sincere apology to all those affected and welcomed the Review as an opportunity to ensure the issues were actioned. She shared process improvements which were already being implemented in complaints management with sharing learning across the organisation, increased pace and complaint staff support. The Executive Director of Nursing and Midwifery also shared the introduction of a Dementia Steering Group and recent appointment of a Dementia Lead. She was keen to fulfil a substantive appointment to the post of Mental Health Director of Nursing to share her high standards of leadership and vision within MH&LD. **24/94.10** The Chair of the Quality, Safety and Experience (QSE) Committee gave her commitment that there would be a collective responsibility to ensure that the action plan formed in response to the Review would be implemented and followed through at pace. It was important that the quality of care received by the citizens of North Wales was at the heart of the organisation. Independent Member Dyfed Jones thanked the families and reinforced the commitment to ensure that these experiences were never repeated. **24/94.11** The Chair thanked the families for their dignity having gone through so much self sacrifice in seeking not revenge, but action to ensure that these experiences were never repeated. He emphasised the gratitude and appreciation of the Board Members which must transform and shape BCUHB into an organisation to be proud of in supporting our Health Board family, patients and communities. He invited the Chief Executive to outline the way forward with certainty. **24/94.12** The Chief Executive advised that the Health Board would enter into discussions with Llais and people with experience of the issues reported on. It would also be necessary to embed trust and faith in the evidence to provide assurances. An action plan would be developed that demonstrated progress with clarity, and be monitored at the Health Board meetings at six monthly intervals, whilst being appropriately monitored through the QSE Committee in between. **It was resolved that** the Board: • **Received** the report of the Royal College of Psychiatrists and the key findings of the review. • **Received** the views of families with experience of care, their feedback on the report and consideration of the best way forward. • **Noted** that an earlier meeting had taken place with Llais representatives and families with experience of the services previously provided. The Health Board was grateful to those whom accepted the invitation to speak at the Board meeting on behalf of families and their personal experiences • **Extended a sincere apology** to people who were let down by the Health Board.	PW

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• **Agreed** to draw up a formal response to the findings of the Review with consideration of the views of families and other stakeholders, including Llais. • **Agreed** to present the formal response at the July Health Board meeting.	PW/CS
24/95 Patient Story - Community Stroke Prevention Team **24/95.1** The Executive Director of Nursing and Midwifery introduced the video presentation of an insight into the work of the Community Stroke Prevention Team and the powerful positive story of a patient's experience in the diagnosis of previously unknown conditions. She stated she had great pride in the Team and their work. **24/95.2** IM Clare Budden reflected on her substantive role within Housing Associations and the very practical benefit this service provided for many people closer to their home. In response to IM Dyfed Jones, the Executive Director of Nursing and Midwifery advised that GPs were aware of the service. **It was resolved that** the Board: • **Noted** the report and supporting video presentation	
24/96 Citizen Experience Report **24/96.1** The Director of Partnerships, Engagement & Communications presented the report which provided a summary of the themes from the Health Board's involvement with citizens during the past three months. She highlighted continuing themes of citizen conern with waiting times, access and communication and also that engagement events within communities would continue throughout the year. She also advised that families were now involved with ongoing discussion to improve vascular services. **24/96.2** The Head of Patient Experience reflected on the fundamental challenge of effectively capturing and providing robust evidence of experiences. He stated that patient experience was working well within Forums and there was a clear commitment to listen within Committees. **24/96.3** IM Rhian Watcyn Jones expressed concern with continuing themes of not robustly sharing learning and the need for clarity on accountability and ownership. She stressed the importance of transparency in ths area. In response to this and a number of other IM questions relating to response times, involvement within shaping services and frustration on access, the Head of Patient Experience undertook to improve publicity on learning from all lessons, provide the Board Members with data requested on Emergency Department access and Opthalmology access. He provided examples of service user involvement. **24/96.4** IM Chris Field was pleased to note the positive aspects of staff recognition and appreciation set out in the report.	AW (LM)

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24/96.5 The Chair was pleased to see this second report developing, requesting that the Director of Partnerships, Engagement and Communication and her team explore more opportunities for the Board Members to understand the voice of the Citizen through this ongoing regular report. **It was resolved that** the Board: • **Noted** the report	
24/97 Chair's Report The Chair presented his report of many of the activities undertaken since the previous meeting. He highlighted the pre-habilitation unit visit at Wrexham Maelor hospital and the positive impacts that were ensuing from this service for patients. He emphasised that, as the Health Board moved into a new phase of Special Measures, it was clear that the Cabinet Secretary's expectation was to see performance improvements being progressed and delivery of the plans outlined. He acknowledged the considerable challenge ahead. It was also important to recognise work within community services and the positive opportunities provided. **It was resolved that** the Board: • **Noted** the report	
24/98 Chief Executive's Report **24/98.1** The Chief Executive presented her report of many of the activities undertaken since the previous meeting. She highlighted the Special Measures appendices to her report provided within the papers which also included the management responses to the Contract and Procurement Independent Reviews. The Vice-Chair was pleased to note that much change management was reported to have already been undertaken in regard to the procurement review. It was **noted** that a stocktake of all the Independent Reviews would be undertaken in due course and that with the receipt of the de-escalation framework these areas would be incorporated within the Board's focus on overall improved performance. **24/98.2** The Chief Executive drew attention to the establishment of a new Corporate Governance Directorate under the newly appointed leadership of Pam Wenger, acknowledging the difficulties that this team had experienced in recent times. The report also included updates on the Infected Blood Inquiry and Corporate Parenting Charter. She added her apologies in regard to the Blood Inquiry, which echoed those of the Government, for those who had been affected. The Board Members noted the Emergency Medical Retrieval Service decision of the Joint Commissioning Committee to accept recommendation 4 (regarding withdrawal of a base at Caernarfon), which the Board had not supported. The Health Board would continue to endevour to influence this outcome.	

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24/98.3 The Chief Executive reported that a strategic item on Vascular Surgery would be considered by the Board in July 2024, and she was planning to extend invitations to meet with families of experience. **It was resolved that** the Board: • **Noted** the report and • **Agreed** to sign the Corporate Parenting Charter	PW/CS
24/99 Vice-Chair's Report The Vice-Chair drew attention to the many visits he had undertaken, passionately stating that if the Health Board put in place an effective structure then improvements could be delivered, as there were very many good and committed staff working across the organisation. **It was resolved that** the Board: • **Noted** the report	
STRATEGIC OBJECTIVE 4 - IMPROVING QUALITY, OUTCOMES AND EXPERIENCE	
24/100 Planned Care Fund – 2024/25 utilisation **24/100.1** The Executive Medical Director introduced the report which set out how the Health Board would support the recovery of long waiting patients within elective care through the £34m Welsh Government (WG) 2024/25 ringfenced allocation which was now recurrently within the organisation's baselines. He emphasised the sobering numbers of patients waiting which included us, our families and communities. There would also be a need to address the patients' journey during this time with effective communication, especially in regard to managing deteriorating conditions, highlighting innovative work progressing in this area. He advised that regular Executive meetings would be taking place to drive forward improvements and report to Welsh Government (WG) on the challenging targets set out. He emphasised that quality, highest standards and good governance would also be factored into this. **24/100.2** The Interim Executive Director of Finance acknowledged the generous ringfenced allocation which would be provided by WG on a very welcomed recurrent basis, it would allow BCUHB to plan more effectively and demonstrated WG's commitment to support effective improvements in this area. He highlighted the demand and capacity modelling work, as set out within the paper, to succeed in providing the sustainable services for long waiting patients, as far as possible within BCUHB provided services however, premium cost external services would also be engaged in the short term. Robust governance and effective monitoring would be key, as well as having confidence that BCU's financial resources were clearly understood and robust data metrics in place. **24/100.3** Independent Members raised a number of points including variation of practices across different areas within the organisaton, the cost of the support team, collaboration required across the Health Board, understanding patient	

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flexibility to travel further for quicker access and the need to provide patients with an understanding of their progress along the list whilst waiting.

24/100.4 The Vice-Chair welcomed the additional funding provided at the cost of other public services during this period of austerity, recognising the Health Board had a responsibility and important obligation to ensure that consistency of delivery would be achieved. He questioned opening up a discussion with the Cabinet Secretary in regard to utilisation of funding to also address areas of Mental Health services whose metrics were not included within the ring fence. The Vice-Chair emphasised his preference for utilising BCU staffing instead of external services where possible to ensure greater grip.

24/100.5 In regard to governance, the Director of Corporate Governance advised that the Performance, Finance and Information Governance Committee (PFIGC) and QSE Committee would shortly be provided with clarity on their role in monitoring appropriate performance levels and risk in a timely manner.

24/100.6 In response to Primary Care involvement, the Chair emphasised that patient care, especially in regard to potential deterioration whilst waiting for appointments was a very important area that needed to be worked on. The Chief Executive undertook to share further information on patient pathways and the Executive Medical Director stated the importance of communicating the need to provide referrals of the highest standards. The Treat in Turn model was also discussed, including examples of very difficult decisions that would need to be undertaken by clinicians. CS

24/100.7 A discussion ensued on the timeliness of reporting to the Board and confidence in the ability to meet the performance targets set out. The Chief Executive expressed mixed confidence as the delivery plan was currently ambitious but not water tight and there were similar issues facing Health Boards across the country. She felt that the work outlined in Theatre Optimisation and implementing follow up appointment process improvements would be extremely important to succeeding with performance improvements for patients. The Interim Executive Director of Finance concurred and emphasised the need to ensure that the methodology took into account whether agreed actions might create additional pressures elsewhere in the healthcare system. Also highlighted were the complexities of bringing together some specialty service provision on a pan BCU basis, albeit that some services had managed this successfully. In regard to the vacancy of Chief Operating Officer and concerns regarding potential gaps in oversight of Integrated Healthcare Communities, it was noted that recruitment was being progressed.

24/100.8 Many Board members felt that a robust, timely monitoring system needed to be in position that ensured Board members were provided with updates each month. **It was agreed** that a group would be formed to undertake this and provide monthly reports to the Performance, Finance and Information Governance (PFIG) Committee, chaired by the Board Vice-Chair. RC/NL

It was resolved that the Board**:**

- **Noted** the opportunity to improve performance through in house enhanced productivity, endorsing implementation of 'treat in turn' and the

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plans articulated for use of Planned Care resources detailed within table 8, with; (a) Green schemes to commence as described (b) Orange schemes supported once approved by Executive (c) Schemes highlighted yellow whilst supported requiring separate business cases for Health Board prior to securing WG approval (owing to value). • **Noted** that the report also references consideration being given to how resources are utilised to develop robust demand and capacity models (to include opportunity for efficiency). With revised performance trajectories to be submitted by the end of May 2024, performance assessed moving forwards against these revised trajectories and Welsh Government targeted levels of performance. • **Agreed** monthly, timely monitoring reports to be developed for Board Members	
STRATEGIC ITEMS	
ITEMS FOR APPROVAL/RATIFICATION/DECISION	
24/101 No item	
24/102 Annual Audit report 2023 and Structured Assessment - Director of Corporate Governance **24/102.1** The Director of Corporate Governance introduced these annual reporting items which provided the Board members with key findings from the audit work undertaken at Betsi Cadwaladr University Health Board by Audit Wales during 2023 and examined the Health Board's arrangements that supported good governance and the efficient, effective and economic use of resources. **24/102.2** Michele Phoenix, Audit Wales, presented the Annual Audit report and drew attention to the key findings which included a number of qualified opinions and the reasoning advised. **24/102.3** Andrew Doughton, Audit Wales presented the Structured Assessment reflecting on the tangible progress in Board effectiveness that had made since the very challenging and difficult transition position 14 months previously, recognising that governance arrangements were continuing to be strengthened however, there remained some historic recommendations outstanding which needed to be addressed. The service pressures and sustainability of planned care resources was recognised including outpatients. He drew attention to the work required to address workforce planning, particularly in ensuring alignment with an effective organisational clinical strategy. He stated that all Audit Wales reports were scrutinised at BCU's Audit Committee and he extended his thanks for the candidness and engagement shown by BCU staff in cooperating with the work undertaken. **24/102.4** Discussion ensued on the technically complex work that had been undertaken, particularly in regard to finances. It was noted that BCU's Finance department had been strengthened and was cohesive. The Vice-Chair agreed that there was more to do on providing solutions on improving productivity. The	

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Chief Executive indicated that she would give consideration as to how the Financial Control action plan monitored by the Audit Committee might be shared more widely. She was pleased to state that a strengthened systematic approach to governance would be led by the newly appointed, highly experienced, Director of Corporate Governance which would provide greater confidence and assurance within the Board on following up recommendations and transparency in this area. **24/102.5** The Chief Executive concluded that the report was an accurate reflection of the position, with challenging undertakings to address regarding governance and a recognition that accounting had moved forward significantly. She reflected on the importance of **how** changes were made, stating that the Annual Delivery Plan articulated some of these. **It was resolved that** the Board • **Received** and **supported** the annual audit report; • **Received** and **supported** the structured assessment report; • **Agreed** that the executive team would address the improvement opportunities as outlined within the management response to the structured assessment provided; • **Agreed** that the Audit Committee would continue to scrutinise the delivery of the recommendations.	CS
24/103 Annual Delivery Plan - Executive Director of Transformation and Planning **24/103.1** The Director of Transformation and Improvement joined the meeting to present the report which provided an overview of the end of year delivery position of the 2023/24 Annual Delivery Plan and the latest status of the 2024/25 plan development. He drew attention to the 67% completion rate of 2023/24 actions that had been achieved during the period, which centred upon stabilisation. Whilst many of those outstanding had been significantly progressed, they had not met target and would therefore also be tracked alongside BCU's integrated annual plan 2024/25 as provided within the papers. It was noted that additional actions recently received from WG would also be integrated into the plan via an appropriate change control process. **24/103.2** The Board Members raised concern regarding lack of focus in primary care and that improvements were necessary in regard to commissioning and also contracting with the third sector. **24/103.3** Clarity was sought on the action plan, the Vice-Chair emphasised the need for improved communication between the ambulance service and availability at Minor Injury Units to potentially alleviate pressure at Emergency Departments. **24/103.4** The Director of Transformation and Improvement stated that the team would work to provide assurances of impacts achieved by the actions in future	

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monitoring. He advised that the non-achievements within Cancer highlighted by IM Prof Larvin had been due to staffing issues. **24/103.5** The Chief Digital and Information Officer made the point that as the organisation was within the first quarter there were opportunities to amend priorities as the year unfolded, he also undertook to liaise with the Director of Transformation and Improvement to further update the digital actions. **24/103.6** The Chief Executive reflected on dealing with a very high intensity year dealing with Special Measures, she reflected that some of the actions BCU had set out were too much of a stretch in some areas and delays had also been experienced that had been beyond the organisation's control. However, pinch points had become better understood eg within Primary Care which needed to be addressed. The next year would be focussed on capability and having an effective annual delivery plan alongside BCU's own 3 year plan to provide better longer term vision **It was resolved that** the Board • **Received** the report; and • **Noted** the overall progress made along with the challenges highlighted.	
24/104 Integrated Quality Management System (QMS) Framework **24/104.1** The Executive Medical Director presented this item, outlining the Board's intent to introduce a quality management system across the organisation to ensure consistency of high level quality experiences moving forward. This new way of working had drawn upon the experiences of a wide range of other organisations and been discussed at recent Board Development sessions. Particular attention was drawn to the area of quality planning which would provide opportunities to do things very differently from the outset and also the intention to be a self-improving organisation, learning from past experiences. He stated that Vascular and Urology service developments were currently following this approach for consistency of their improvement journey. **24/104.2** The Chair of the Planning, Population Health and Partnerships (PPHP) Committee suggested that future reporting of any items previously discussed at a Committee should state this within the reporting template and include an opportunity for the appropriate Committee Chair's feedback to be voiced, as this was an example of an item discussed previously at PPHPC. Comments were also made regarding the importance of dialogue with citizens and the theme of ensuring coproduction which had been prevalent during the meeting. **24/104.3** The Chief Executive assured that there were some individual QMSs in place across the organisation where services were required to report to standards eg ISO regulations and these needed to be recognised within the report. She stated the need to also include user involvement and use of insights from external reports. A demonstration for Board members would be organised and it was **noted** that the QSE Committee would be delegated to monitor the implementation on behalf of the Board. **It was resolved that the Board**	PW NL

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• **Approved** the report in support of the approach to implementation of a Quality Management System for the Health Board	
24/105 Research and Development Annual Report 2023/24 **24/105.1** The Executive Medical Director was proud to introduce the inspiring work being undertaken within the Health Board which also drove quality of care and improved the recruitment and retention of staff. A presentation was provided which included very positive patient and clinician experiences of clinical trials. The Executive Medical Director drew out many potential encouraging opportunities in this field including income generation, quality improvements within primary care and growing opportunities with the University through development of the new North Wales Medical School. He took on board the Vice-Chair's request to reference BCU's performance against the annual NHS Framework Review's 10 pillar WG structured reporting in future iterations. Board members welcomed the positive news and would welcome opportunities to raise the profile of the work being undertaken, especially in potentially improving recruitment. **24/105.2** The Executive Medical Director acknowledged the encouraging comments regarding improving outcomes. He stated that there were opportunities to develop commercialisation of some programmes. The Interim Executive Director Public Health was also pleased to highlight Public Health's activities and collaborations within this area. **It was resolved that** the Board **Noted** • the contents of the Annual Report; • the potential to further develop opportunities to collaborate with both commercial and non-commercial partners; and • the opportunity to work closely with Universities and, in particular the North Wales Medical School	NL
24/106 Nurse Staffing Levels (NSL) assurance report – **24/106.1** The Executive Director of Nursing and Midwifery presented this item which provided assurance to the Board that the requirements of the Nurse Staffing Act were being satisfied. She stated the triennial report approved at the previous Board meeting, had been submitted WG and feedback was awaited. It was noted that appropriate discussions with Human Resources and Finance were being taken forward to ensure deliverability of appropriate staffing skills to meet the plans and she was pleased to highlight the increase in staffing (including international recruitment) and decrease in vacancies that had taken place. **24/106.2** In response to questions relating to Healthcare Acquired Pressure Ulcer (HAPU) issues within the report, the Executive Director of Nursing and Midwifery gave assurance that deep dive activity had taken place and members of the QSE Committee would shortly be receiving an update on the improvement plan. Assurance was provided that QSE Committee undertook delegated	

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responsibility on reporting in this area, and future reports to the Board would include reference to this activity.
 	
It was resolved that the Board
 	
• **Received** the report to gain assurance that
  • Betsi Cadwaladr University Health Board (BCUHB) was meeting its statutory "duty to calculate and take steps to maintain nurse staffing levels" in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016; and
  • BCUHB was meeting its statutory duty to provide an Annual Presentation to the Board detailing calculated nurse staffing levels
• **Noted** that a financial assessment arising from the organisations statutory duty to calculate nurse staffing levels had been submitted via the IMTP scheme for consideration within the financial planning cycle for 2024/25	

Clare Budden left the meeting for this item and Jane Trowman joined to support discussion of the item. **24/107 Funded Nursing Care Interim Annual Fee Rate 2024/ 2025** The Executive Director of Nursing and Midwifery presented the item, advising that as a national rate had not yet been agreed, WG was encouraging Health Board's to utilise the interim rate agreements so that care providers were not unduly penalised. In response to the Vice-Chair, the Interim Executive Director of Finance confirmed that any further WG agreed uplift would also include retrospective allocation. **It was resolved that the Board** **Approved** • a proposed interim FNC rate for NHS contributions of £213.18 per resident per week with effect from the 1st April 2024 pending finalisation of the National FNC rate for 2024/25; and • that, once the settlement of the A4C pay award for 2024/25 and the principles of the IUM are applied to form a final National FNC rate, IF the final national FNC rate is greater than the proposed interim rate, the difference between the interim rate and the final rate should be retrospectively applied and backdated to the 1st April 2024. *Clare Budden rejoined the meeting and Jane Trowman left the meeting.*	
24/108 Corporate Governance Report The Director of Corporate Governance reported that the annual Board workplan, and consequent Committee workplans, would be worked on to align with the agreed delivery plan. Board items going forward would be of increased strategic focus. Following a discussion in relation to the application of the common seal, it was noted that the process was being addressed to provide the Board with more timely information.	

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It was resolved that the Board **Noted** • the contents of the report • the affixing of the common seal • the matters considered in the Private Board meeting on 30th March 2024 • the briefings from the Joint Commissioning Meeting held in April 2024; and **Agreed** the proposal to circulate minutes of the Joint Commissioning meetings to members outside of the Board meetings as these were available to the public on their website	
24/109 Update of Approved Clinicians (All Wales) and Section 12(2) Doctors (All Wales) registers with effect from 5th March 2024 to 5th May 2024 **It was resolved that** the Board • **Noted** the contents and • **Ratified** previous Chair's Action's undertaken to grant approval or reapproval for Approved Clinicians and Section 12(2) Doctors across Wales.	
24/110 Corporate Risk Register and Board Assurance Framework **24/110.1** The Director of Corporate Governance acknowledged the work undertaken however, there was further work to be done in order to ensure strategic alignment with all the Board's objectives. She advised that Risk and Board assurance were a priority area, especially in ensuring that there was alignment within the Board and Committee cycles of business that were being developed. Work would be undertaken with Executive colleagues to make the necessary improvements. **24/110.2** A discussion ensued on clarity regarding the Board's 10 year strategy, in relation to the disconnect between the risk and BAF rating for Emergency Care the Director of Corporate Governance highlighted this as an example of an area which would require further discussion within the Executive Team. **24/110.3** The Digital and Estates risks were highlighted as of particular concern. The Director of Corporate Governance gave assurance that the improved robustness of processes to be introduced would also pay attention to the timeliness of updates in response to concerns raised by IM Clare Budden. In response to various other questions raised, the Chief Executive stated that the Director of Corporate Governance would take these forward in discussions with Executive colleagues to make improvements to the documentation and facilitate further discussion at a Board Development session. **It was resolved that** the Board • **Noted** the report; • **Received** assurance in relation to the management of risk as outlined in the Board Assurance Framework and Corporate Risk Register; • **Endorsed changes** highlighted around the Board Assurance Framework and realignment to the Health Board's objectives.	PW

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24/111 Improving Quality Report **24/111.1** The Executive Director Nursing and Midwifery drew attention to the HAPU data which had been discussed earlier in the meeting, overdue reporting of incidents which were being supported and monitored, coroner's concerns on learning from investigations and robust reporting – particularly sighting the Electronic Health Record outline business case which was being presented to WG which would support the prevention of Future Death notices. Unscheduled Care would be a focussed item on the next Board agenda. **24/111.2** The development of an integrated policy on concerns and complaints processing was explained. **24/111.3** The Chair emphasised that the Board's drive to improve would need to be underpinned by the quality agenda. The QSE Chair was pleased to understand that the QSE Committee would be receiving improved data on quality as the reporting was developed. IM Chris Field raised processing and timeliness questions, examples of these were provided and it was advised that inquest reports were provided to the QSE Committee. The Executive Medical Director undertook to discuss length of claims with him outside the meeting. **24/111.4** The Executive Director of Nursing and Midwifery explained that a portal was under development for launch in June to address evidence capture and provide an effective targeted cascade system. Governance arrangements were also being worked through with the newly appointed Director of Corporate Governance to strengthen processes and provide greater clarity. She undertook to liaise with the Associate Board member SRG to address some concerns he had raised regarding staff accommodation. **24/111.5** The Chief Executive expressed her commitment to ensuring that complaints were clearly understood and dealt with in an appropriate and timely manner, drawing attention to the fact they were also an indicator of potential areas of concern to the Board. **24/111.6** The Chair emphasised the need to ensure that complaints were dealt with in a timely manner to avoid further distress as highlighted through the Coroner's concerns. It was resolved that the Board • **Noted** the report	NL AW
24/112 Integrated Performance Report 2023/24 Month 12 **24/112.1** The Interim Executive Director of Finance presented the report which, whilst showing some trajectory improvement, was not in alignment with other Health Board's in Wales and these would be modified moving forward. **24/112.2** The Executive Director Nursing and Midwifery highlighted clinical coding staffing, training and retention issues. The Deputy People Director highlighted lowered sickness absence levels commensurate with the time of	

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year, improved retention levels of nursing staff, agency staffing improvements and greater grip in establishment controls. **24/112.3** The Interim Executive Director Finance undertook to include trajectory reporting in regard to complaints in response to the previous item's discussion noting an expectation of reduction by October 2024. **24/112.4** A discussion ensued on clinical coding recruitment and potential pay enhancements to improve retention, noting that Executive team would receive a position report in July. The Chief Digital and Information Officer emphasised the potential adverse impact on the organisation in regard to not having timely data or ability to promptly monitor clinician activity. **24/112.5** The Chief Executive was concerned with the timing of the report, the next report would provide further information on Urgent Care. She was pleased to note that access to adult mental health services was continuing to improve. It was also noted that pharmacy prescribing and audiology were performing well. **24/112.6** The Vice-Chair questioned Delayed Transfers of Care (DTOC) comparisons with other Health Boards. In response to IM Clare Budden's question regarding understanding the impact of strikes on Outpatient waits and elective surgery, the Executive Medical Director undertook to share with all Board members outside the meeting an analysis which had been undertaken. **It was resolved that** the Board • **Noted** the report	RC CS NL
24/113 2023-24 Financial Outturn 2023/24 report **24/113.1** The Interim Executive Director of Finance reported that the full year, draft unaudited financial position of the Health Board was a deficit of £24.3m, with the in-month position reporting a surplus of £11.4m. The end of year financial position would be subject to the closure and submission of the final accounts for 2023/24 and subsequent audit by Audit Wales. The Health Board had delivered an £8.7m surplus against the planned forecast deficit of £33.0m. As the Health Board had made significant progress towards delivering the £20m deficit control total, WG had agreed for the Health Board to include the conditionally recurrent funding of £74.6m as recurrent funding in the underlying position reported in the Month 12 Monthly Monitoring Return to WG, to support sustainability of current services moving into the 2024/25 financial year. Key drivers remained as capacity in regard to delayed transfers of care, increased continuing health care fees, increasing mental health out of area placements. Of positive note was delivering all the savings targets. The Capital Resource Limit was attained. **24/113.2** There was a challenging financial year to be faced which had commenced with the need to understand and address the increased provision of MH out of area placements. Savings plans to address the £44m target were currently being worked through. It was noted that the Planned Care ring fenced funding must only be utilised for this provision.	

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24/113.3 The Vice-Chair complimented the Finance Team on the outturn, given the pressures faced. IM Clare Budden was pleased to understand the positive early feedback being received from Audit Wales. **24/113.4** The Chief Executive stated that the levels of financial controls introduced could not be sustained going forward however, the Value and Sustainability workstreams would aid improvements. The Chair thanked the Finance Team, led by the Interim Executive Director of Finance, however he emphasised the cultural financial message which needed to be understood amongst staff regarding everyone's financial responsibilities. **It was resolved that** the Board **received and scrutinised** the report	
FOR INFORMATION	
24/114 Committee and Advisory Group Chair Reports The Associate Board member SRG advised that he had recruited representatives of other organisations to strengthen the membership. It was agreed that the Director of Partnerships, Engagement and Communication would liaise with him to consider further items for discussion. **It was resolved** that the Board **Noted** the reports of the following Committees' and Advisory Groups' Chairs 1. Audit Committee 2. Performance, Finance and Information Governance Committee 3. Quality, Safety and Experience Committee 4. Planning, Population Health and Partnership Committee 5. People and Culture Committee 6. Mental Health Legislation Committee 7. Remuneration Committee 8. Local Partnership Forum	HSJ
OTHER MATTERS	
24/115 Review of meeting effectiveness • The importance of allocating appropriate time for items • The Transformation and Improvement resource and service provision was requested to be included as a development session • The Director of Corporate Governance's comments on moving the agenda towards strategic items was welcomed • Difficulties in listening were noted as the microphones did not amplify the sound within the room, but were used for the purpose of livestreaming only. This would be explored by the technical support team.	PW DD
24/116 Any other business There was no additional business to be discussed.	

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24/117 Date of next meeting 12:00 10 July 2024 livestreamed only Health Board meeting to consider the final accounts 9.30 25 July 2024 Health Board meeting at the Optic Centre, St Asaph and livestreamed	
Resolution to Exclude the Press and Public "Those 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."	

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Betsi Cadwaladr University Health Board (BCUHB)
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on 11 April 2024 Via Zoom

Board Members Present	
Name	Title
Dyfed Edwards	Chair
Karen Balmer	Independent Member
Jason Brannan	Deputy Director of People
Russell Caldicott	Interim Executive Director of Finance
Chris Field	Independent Member
Urtha Felda	Independent Member
Dyfed Jones	Independent Member
Prof Mike Larvin	Independent Member
Dr Nick Lyons	Executive Medical Director/Deputy Chief Executive
Dr Jane Moore	Acting Executive Director of Public Health
Mike Parry	Associate Member – Chair Stakeholder Reference Group
Fôn Roberts	Associate Member – representing Directors of Social Services
Carol Shillabeer	Chief Executive
Dr Caroline Turner	Independent Member
Gareth Williams	Vice Chair
Angela Wood	Executive Director of Nursing and Midwifery
In Attendance	
Pam Wenger	Director of Corporate Governance
Georgina Roberts	Associate Workforce Director
Helen Stevens-Jones	Director of Partnerships, Engagement & Communications
Philippa Peake-Jones	Head of Corporate Affairs
Organisations / Individuals observing the meeting	
Geoff Ryall Harvey	Llais - North Wales

Agenda Item	**Action**
OPENING BUSINESS	
HB24/74 Welcome, introductions and apologies for absence The Chair welcomed everyone to the meeting. Apologies were noted from Chris Stockport, Clare Budden, Rhian Watcyn Jones, Billy Nichols, Gareth Evans and Dylan Roberts.	
HB24/75 Declarations of Interest on current agenda There were no declarations of interest made in respect of items on the agenda.	

HB24/76 Emergency Medical Retrieval and Transfer Service (EMRTS) Review

HB24/76.1 The Chair introduced the one agenda item noting that the Board would discuss the Emergency Medical Retrieval and Transfer Service (EMRTS) review that had been led by the Chief Ambulance Commissioner on behalf of the NHS Wales Joint Commissioning Committee (JCC) Director of Commissioning, Ambulance and 111.

HB24/76.2 The Chief Executive gave a presentation on the background to the review, the purpose of the review, the engagement scope and purpose and the engagement process and the responses. The engagement conclusion was highlighted and the next steps identified.

HB24/76.3 The Chair invited Geoff Ryall Harvey from Llais to update attendees with regards to engagement. Mr Harvey advised that the role of Llais, in service change, was to ensure that the voice of communities was heard by decision makers and that Llais and Community Health Councils, before the formation of Llais, had been involved in the discussions with EMRTS and the Air Ambulance Charity since August 2022. It was noted that Llais had not approved the proposals shared at the meeting in August 2022 and advised that the changes suggested should follow NHS guidance for engagement and had offered to support this, despite this offer being accepted this was not followed up and CHC were not involved in the engagement.

HB24/76.4 Mr Harvey advised that Llais had attended many of the engagement events that had taken place and that those events had been more information giving exercises. It was noted that feedback had been shared with EMRTS and a letter, included in the agenda bundle, had been sent to the Chief Ambulance Services Commissioner relating to the feelings of rural communities on the proposed changes, noting that a lot of the charity's money was received from the rural communities. The Board were advised that Llais felt that more work was needed and no decision, including in principle, should be taken until the work of the task and finish group concludes in September 2024 and that the service changes were not likely to change until 2026.

HB24/76.5 The Board held a full and informative discussion on engagement, lack of detail around some of the numbers quoted, night flying, understanding around land vehicles and their impact and the concerns of rural communities. Some Independent Members felt that if a decision had to be made at the meeting, then based on the numbers presented, the result was better for the population of North Wales as a whole. Overall, it was agreed that due to the lack of detail presented in recommendation four an agreement could not be reached.

It was resolved that the Board:

- **noted** concerns around process

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• **discussed** the lack of detail in recommendation 4, as currently presented, as it did not set out how the unmet needs for the population of North Wales would be addressed and suggested that further work was required to explore the different options alongside recommendation 4 to maximise the unmet needs and maintain confidence in the service • **noted** that any implementation would take effect from 2026 and recognised that there was a case for change • **agreed** that they would support the work of the task and finish group which is due to conclude in September 2024 • **noted** that any future recommendations need would need to include evidence to look at the best possible option The meeting ended at 14:30	

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

Health Board

Table of actions log – arising from meetings held in public

18.7.24

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
Open actions						
24/96.3	Executive Director Nursing & Midwifery (Head of Patient Experience)	Arrange for Head of Patient Experience to improve publicity on learning from all lessons	12.9.24	The Head of Patient Experience is working with the Comms Teams to identify the best way to share learning. The target date will be September 2024.	In progress	
24/102.4	Chief Executive / Director of Corporate Governance	Consider how the Financial Control action plan monitored by the Audit Committee might be shared more widely.	18.7.24			
24/104.2	Director of Corporate Governance	Consider how items previously discussed at a Committee could state this explicity within the reporting template to Board and facilitate the opportunity for the appropriate Committee Chair to comment at Board.	18.10.24	In progress, a revised set of templates are being developed which will included the governance route. It is anticipated that these will be in place in the next quarter following consideration by the Chair and Committee Chairs	In progress	

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
24/104.3	Executive Medical Director / Director of Corporate Governance	Arrange a demonstration of the developing Quality Management System for Board members	31.8.24	Due to the absence of the Executive Medical Director this has not been completed. Discussions to take place with the Director of Nursing and Midwifery and the Chair of the Quality and Safety Committee.	In progress	
24/112.5	Chief Executive / Director of Corporate Governance	Provide a report on Urgent Care to the next meeting	18.7.24 12.9.24	To be considered at the Board in September as agreed with the Chair	In progress	
24/115	Director of Corporate Governance	Explore improving clarity of sound issues within the room at hybrid meetings	30.8.24	Ongoing discussion taking place to factor in audio solution for hybrid meetings that wake place in person with live streaming and provision of simultaneous translation.	In progress	
Actions suggested for closure						
HB24/52.3	Interim Executive Director Finance	Provide trajectories regarding backlogs of overdue complaints within Integrated Performance Reports from May.	16.5.24	RC 21.5.24 An improvement trajectory has been agreed, targeted improvement to be attained by 14th October 2024. Performance Report for July 2024 Health Board will reflect these revised trajectories. Remain open until completion at July Board	Completed in July IP report Suggest to be closed	

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
				15.7.24		
24/92	Director of Corporate Governance (DD)	Amend draft minutes of the previous meeting held on 28.3.24	10.6.24	Amendments made and approved version published on website	Suggest to be closed	
24/94	Chief Executive / Director of Corporate Governance	Present the formal response to Royal College of Psychiatrists' Invited Review Services Report at the July Health Board meeting	18.7.24	Agenda item 25.7.24 Health Board	Suggest to be closed	
24/112.3	Interim Executive Director Finance	Arrange to include trajectory reporting in regard to complaints in response to the Quality report discussion noting an expectation of reduction by October 2024	18.7.24	Included within the IQPR	Suggest to be closed	
24/100.8	Interim Executive Director of Finance	Planned Care Fund discussion item - Form a group to undertake monitoring and provide monthly reports to the Performance, Finance and Information Governance (PFIG) Committee members, chaired by the Board Vice-Chair.	30.6.24	Planned Care Escalation meeting formed and Planned Care Board to review performance monthly (reporting performance within the IQPR to PFIG.	Suggest to be closed	
24/98.3	Chief Executive /	Present strategic item on Vascular Surgery to July	18.7.24	Agenda item 25.7.24 Health Board	Suggest to be closed	

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
	Director of Corporate Governance	2024 Health Board meeting.				
24/100.6	Chief Executive	Share further information on patient pathways with Board Members for information – in regard to the Planned Care Fund discussion item	18.7.24	Addressed within Private session Board paper 25.7.24	Suggest action to be closed	
24/114	Director Partnerships, Engagement and Communication	Director of Partnerships, Engagement and Communication would liaise with SRG Chair to consider further items for discussion.	30.6.24	15.7.24 Discussions have taken place on the SRG supporting the urgent and emergency care major change programme. SRG workshop will focus on an approach in September.	Suggest to be closed	
24/134.3	Interim Executive Director Finance	The Chair requested that the Interim Director of Finance extend the Board's thanks to all involved throughout the year.	18.7.24	This has been communicated throughout the leadership forums of the Health Board and directly to the local teams reporting to the Interim Executive Director of Finance. In addition, a communication has been uploaded to BCUHB's intranet and shared throughout the Health Board	Suggest to be closed	

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
24/111.4	Executive Director Nursing & Midwifery (EDON)	Liaise with the Associate Board member SRG to address some concerns raised regarding staff accommodation.	18.7.24	EDON liaised with Associate Board member SRG, update received from MHLD and meeting held with Interim Executive Director of Finance (EDOF) and Director of Governance. Interim EDOF to review accommodation options for the team.	Suggest to be closed	
HB24/94	Director of Corporate Governance	Update Cycles of business on action plan to address Royal College of Psychiatrists' Invited Review Services Report : Health Board COB : 6 monthly intervals QSE COB – Monitoring frequency TBA	18.7.24	Completed, included within the updated cycles of business as developed for the Board and Committee.	Suggest to be closed	
24/96.3	Executive Director Nursing & Midwifery	Arrange to provide Board Members with data requested on Emergency Department access and Opthalmology access.	30.6.24	Circulated briefing to Board Members via email 17.7.24	Suggest to close	
24/110.3	Director of Corporate Governance	Facilitate further discussion on BAF and CRR at a future Board Development session.	18.7.24	Complete. Session held in June 2024.	Suggest to be closed	

Ref	Lead Executive / Member	Agreed action	Original Timescale	Update (date)	Action status	RAG status
24/111.3	Executive Medical Director	Discuss length of claims with IM Chris Field outside the meeting	18.7.24	Complete. Director of Corporate Governance met with Chris Field and an approach to dealing with claims is in progress and will be presented to the board in September	Suggest to be closed	
24/115	Director of Corporate Governance	Schedule Transformation and Improvement resource and service provision as a Board Development item	18.7.24	Included in the Board Development Plan	Suggest to be closed	
24/105.1	Executive Medical Director	Arrange to reference BCU's performance against the annual NHS Framework Review's 10 pillar WG structured reporting in future iterations of the R&D Annual report	31.12.24	To be included in future annual reports, action escalated to the Deputy Medical Director for discussion with the Author.	Suggest to be closed	
24/112.6	Executive Medical Director	Share with Board members the analysis of industrial action on Outpatient waits and elective surgery.	18.7.24	Circulated briefing to Board Members via email 18.7.24	Suggest to close	

RAG	
Action Closed	
Action ongoing	
Action Outstanding	

Teitl adroddiad: ***Report title:***	Dementia Support Activities Co-ordinator Story
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	25th July 2024
Crynodeb Gweithredol: ***Executive Summary:***	A staff story is presented to Board to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.
Argymhellion: ***Recommendations:***	Board is asked to **note** this report.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

In line with best practice, a patient or carer story is presented to Board to bring the voice of the people we serve directly into the meeting, but 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.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan	BAF21-10 - Listening and Learning

gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: I am willing for my story to be shared with: [√] Level 1 – Any Health and Social Care Professionals within BCUHB [√] Level 2 – Researchers for Service Evaluation and improvement beyond BCUHB [√] Level 3 – Meetings and Conferences with anyone present including public and journalists [√] Level 4 – Anyone including Online, Internet, Social Media and CIVICA ***List of Appendices:*** Appendix A- Staff Story Summary Dementia support story version 2.mp4	

Betsi Cadwaladr University Health Board

Dementia Support Activities Co-ordinator Story

An audio-visual story will be played at the meeting.

Overview of Patient Story

The storyteller describes her role as a Dementia Support Activity Co-ordinator, at Mold Community Hospital. The storyteller shares her experience of delivering activities to support dementia patient's wellbeing and recovery.

Key Messages

- Dementia Support Workers provide a daily connection to a person living with dementia.
- The role is dedicated to support the social and psychological wellbeing of patients.
- Activities may include arts and crafts, games, music, and reminiscence pieces of work.

Summary of Learning and Improvement

There are currently 35 hospital-based Dementia Support Workers (also known as Activity Coordinators or Dementia Care Enablers) putting patients first across the Health Board in the Integrated Health Communities (IHC) and Mental Health Learning Disability (MHLD) Service. Covering acute and community settings, this incredible team work tirelessly to enable patients with dementia to receive optimum person-centred care recognising them as unique individuals.

Dementia Support Workers are a valuable resource in the day to day lives of a person living with dementia, especially during hospital admissions. As Dementia Support Workers do not usually provide day-to-day care that Health Care Support Workers do, their role is dedicated to support the social and psychological wellbeing of patients. They provide a daily connection to a person living with dementia which can include:

- A helping hand with communication between the patient and staff.
- A reassuring presence during times of agitation.
- Promoting engagement in meaningful activity which can give a sense of self.
- An opportunity for an individual to reminisce and discuss who they are, their interests, their family.
- Someone who offers stimulation on a physical, mental and emotional level.
- Promoting the importance of routines which are important to the individual and help facilitate rehabilitation.
- Providing elements/periods of fun activities to engage, lift mood, and promote movement and function.

Dementia Support Workers offer activities to distract, calm and soothe the patient, and help make their hospital stay more comfortable as well as prevent deconditioning. This may include arts and crafts, games, music, and reminiscence pieces of work.

All Dementia Support Workers use 'This is Me' biographical tool to identify patient's individual preferences and aspirations and tailor care around these including meaningful engagement e.g. maintaining a passion they have or trying out a new activity such as painting. Patients are helped to maintain their identity which often blurs with dementia. De-stigmatizing and inclusivity are promoted by facilitating group activities with non-dementia patients.

Dementia Support Workers co-produced a Handbook of Activities, available on SharePoint to help staff by exchanging ideas on how to keep patients active and supported by person-centred care and tailored activities. Dementia Support Workers also help to coordinate schemes such as the Butterfly Scheme and John's Campaign. They also ensure the John's Campaign is followed, welcoming families at meal-times, to help with personal caregiving or for social activities.

Since December 2021, Dementia Support Workers attend a monthly network meeting run by the Consultant Nurse for Dementia which identified evidence that this team was not well understood across BCUHB. An independent evaluation was commissioned of the role. A report was published by Bangor University in November 2022, and an improvement plan made up of the study recommendations has led to significant improvements for the team. At each meeting a standing agenda item asks about their wellbeing because they recognise compassion starts with themselves. They also continually learn from a topic speaker per month e.g. diversity, LGBGTQ+ and micro-aggressions, helping them understand how easily patients can be excluded.

Dementia Support Workers have been trained in assessment of how dementia-appropriate our hospital environments are, and make necessary changes to prevent exclusion. Continual learning helps keep team members fully-prepared and updated for their roles so they can have informed, honest and open conversations with staff and families who may find caring for someone with dementia difficult. Feedback from families suggests they feel very reassured when a Dementia Support Worker is available to support their relative, and have their individuality recognised. Promoting dignity, equality and respect are key elements of the Dementia Support Workers role along with valuing every patient to ensure they feel accepted, validated and celebrated.

The Health Board has a Dementia Delivery and Transformation Group that drives Dementia Hospital Charter work. It is one of five regional task groups made up of Health Board staff and external stakeholders. West IHC, have set up a Hospital Dementia Care Group. This group is a sub-group of the Dementia Delivery and Transformation Group. All IHC West dementia activity will be reported through this group. Consultant Nurse for Dementia is working with other IHC's to replicate this model.

The Patient and Carer Experience Team will share this feedback and will continue to work with all services to promote the patient experience initiatives outlined above. The Patient and Carer Experience Team extend their gratitude and appreciation to the storyteller for sharing her experience.

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

Teitl yr adroddiad: ***Report title:***	Chair's Report
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	July 25, 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides information on key issues within the organisation and external work with Government and other partners • Meetings with Elected Representatives • Appointments • Details of visits and meetings
Argymhellion: ***Recommendations:***	That the Board discusses and notes the content of the report
Arweinydd Gweithredol: ***Executive Lead:***	Chair
Awdur yr Adroddiad: ***Report Author:***	Chair

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Ar gyfer sicrwydd *For Assurance* ☐

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Meetings cover a range of strategic priorities.

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no specific implications arising from this report.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable at this stage.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable at this stage.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The issues raised impact across a range of risks.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no specific implications arising from this report.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no specific implications arising from this report.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risgiau Corfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The issues raised impact across a range of risks.
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential Committee (where relevant)***	Not applicable.
Next Steps: ***Implementation of recommendations*** Not applicable to this report.	

Report of Chair to Betsi Cadwaladr University Health Board
July 25, 2024

Some of the work I have undertaken since my report to the May Board is summarised below.

Board and Committees

We have recently established an Integrated Governance Committee which is a further development in the governance of the Health Board. This is a meeting of Chairs of our Committees and provides an opportunity for oversight of the work and to ensure issues that are cross-cutting can be identified. We are also in the process of establishing Board Champions who will be able to give particular support and focus to specific areas of our work. These roles will develop over a period and I'm sure will help us progress further as an organisation.
Our Board Development programme is an opportunity for us to work and develop as a team and we have arranged additional Board Briefing sessions in order to look in detail at specific areas of our activity.

Developing the Organisation

As a Board, we will continue with the now quarterly Special Measures Forums with the Cabinet Secretary focusing on specific areas of improvement. The Cabinet Secretary has now introduced monthly meetings with all Health Board Chairs looking at performance both locally and nationally. My monthly meetings with the Cabinet Secretary reviewing specific areas of activity also continue. As I have previously mentioned, the clear expectation from government is to ensure that our performance as a Health Board improves. We know that we face challenges but we also have an opportunity to work in new ways that will produce different results. I am keen to ensure that we have a One Health Board approach to improvement and that we can support and learn from each other. Innovation and efficient use of resources can be at the heart of this work and there are excellent examples of this approach in some areas.

Engaging with others

We have continued with our Board engagement events across our region, the most recent being in Llandudno Junction. These events are undoubtedly an excellent opportunity for us to listen and learn from people in their local communities. Many tell us of the excellent care they receive when accessing the health system, though often they tell us that they have been waiting too long for treatment. A further theme that is developing is people telling us about those community initiatives that support their health and well-being. We are often unsighted about such activity, though we do support certain groups also. I think we can work closer with community and third sector groups in order to promote a comprehensive health and well-being agenda. Whilst we rightly concentrate on addressing major issues around long waits for treatment and access to health care, we also need to work at community level to help shape a healthy and prosperous future for the next generation.

Below is a summary of some of my meetings and visits for the period up to 19 July, 2024

Date	Meeting / Visit
20 May 2024	Mental Health Support Group, Abergele
21 May 2024	Audit Committee
21 May 2024	50+ Action Group, Connahs Quay
22 May 2024	NHS Chairs with Cabinet Secretary
22 May 2024	Long Service Awards, Bangor
23 May 2024	Executive Director Mental Health, Learning Disabilities (MHLD) & Allied Health Professionals interviews, Wrexham
29 May 2024	Executive Recruitment shortlisting
29 May 2024	Board Development, Llandudno
30 May 2024	Board meeting, Llandudno
3 June 2024	Stakeholder Reference Group
4 June 2024	Leadership conference, Llangollen
4 June 2024	Ruthin Hospital League of Friends
6 June 2024	Integrated Governance Committee
6 June 2024	Quality, Safety and Experience Committee
11 June 2024	Remuneration Committee
11 June 2024	Director of Environment interviews
12 June 2024	Bwyd Da Môn, Llangefni
13 June 2024	People and Culture Committee
13 June 2024	100 Stories Project, Wrexham University
26 June 2024	Monthly meeting with Cabinet Secretary for Health and Social Services
26 June 2024	Quarterly Independent Members meeting
26 June 2024	Informal Board to Board with Digital Health and Care Wales
27 June 2024	Board Development, Llandudno
1 July 2024	Darren Hughes, Welsh NHS Confederation
3 July 2024	Small Business Research Initiative (SBRI) Family Communications Project End Celebration, Ysbyty Glan Clwyd
4 July 2024	SBRI Family Communications Project End Celebration, Ysbyty Gwynedd
5 July 2024	Bore Paned 50 Abersoch a'r Cylch
8 July 2024	Simon Jones, Chair Digital Health and Care Wales
9 July 2024	Extraordinary Audit Committee
10 July 2024	Extraordinary Board meeting
11 July 2024	Board Engagement event, Llandudno Junction
11 July 2024	Public Bodies Chairs meeting with Welsh Government
12 July 2024	Regional Partnership Board
12 July 2024	Meeting re planning process
15 July 2024	Audit Committee
16 July 2024	Ros Alstead, MHLD Advisor
17 July 2024	Mental Health Support Group, Abergele
18 July 2024	All Wales Chairs and Chief Executives meeting with Cabinet Secretary
18 July 2024	Audit Committee
19 July 2024	Project SEARCH Graduation Ceremony, Deeside

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

Teitl adroddiad: ***Report title:***	Chief Executive Report
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report has been developed to provide an overview of key activity, progress and issues by the Chief Executive. It covers the period end of May to 12th July 2024. Some of the content is further expanded in other reports on the Board agenda. The report outlines some of the key engagement activities undertaken both within the health board and more broadly with partners and the public.
Argymhellion: ***Recommendations:***	The Board is asked to **DISCUSS** and **NOTE** the report.
Arweinydd Gweithredol: ***Executive Lead:***	Chief Executive
Awdur yr Adroddiad: ***Report Author:***	Chief Executive

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Relates to all objectives
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No recommendation results in a financial decision or implication
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No recommendation results in a workforce decision or implication
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** There are a range of actions to address relating to the content of the report. ***Implementation of recommendations*** Recommendations are to discuss and note.	
Rhestr o Atodiadau:	

CHIEF EXECUTIVE REPORT

1. INTRODUCTION

This report has been developed to provide an overview of key activity, progress and issues by the Chief Executive as well as important matters to draw attention to which may or may not be subject of other more detailed reports. It covers the period end of May 2024 to 12th July 2024.

There are a number of key items on the main agenda of the Board, noting that the format of the report has been modified to reflect strategic Objectives of the Health Board Annual Plan. Whilst the detailed reports will be presented, specific emphasis is given to the following:

2. OBJECTIVE 1 - BUILDING AN EFFECTIVE ORGANISATION

2.1 Oversight and Escalation Arrangements

In line with the NHS oversight and escalation framework, escalation levels are considered at least twice a year. This includes an assessment of each health organisation against the six escalation domains, and discussions with partners around the current issues, concerns and progress since the last review.

Welsh Government has written to the Health Board on the 12th July, 2024 confirming that following a recent meeting, there has been no change to the escalation status for the Health Board, Level 5 Special Measures. The progress related to organisational stability and improved governance processes was noted, including the substantive appointment of the Chief Executive, Chair, Vice Chair and a full complement of Independent Members.

Welsh Government reported that although there is no change to the escalation status, a number of issues that are consistent with the WG Special Measures Framework concerns were discussed including:

- The ability of the health board to deliver your plan within the previously set target control total and to ensure that the plan is appropriately de-risked to ensure the required savings are delivered in year.
- Lack of improvement across planned care, cancer and urgent and emergency care, the recently submitted trajectories were considered and it was noted that these fall considerably below expected levels.
- Lack of stability and capacity of the executive team and the need to strengthen leadership and management capacity to secure and support change.
- Lack of clinical services plan to support staff in new ways of working.
- Continued concern around quality and safety, investigations and learning from incidents.
- A number of fragile clinical services.
- A real need to implement changes to the organisational structure.
- Primary and community care sustainability.

Welsh Government will continue to hold quarterly Special Measures Assurance Board meetings to monitor progress against the agreed special measures framework and de-escalation criteria.

2.2 Corporate Performance Reviews

The Health Board approved the Integrated Performance Framework in September 2023 which included the commitment to ensure strong governance and accountability arrangements, introducing the Corporate Directorate Performance reviews. The first round of reviews were held in June. These Performance Reviews, chaired by the Chief Executive, will take place twice a year

and are an opportunity for the Corporate Directorates to outline their achievements and plans for the year, including the confidence of delivery in terms of the Annual Plan Delivery Plan, Financial Performance and action plans to address audit recommendations. These Reviews will refine over time and have been an important development in the strengthening of the performance and accountability arrangements for the Health Board.

2.3 Executive Appointments

The appointment process for the Director of Performance and Commissioning has concluded with a conditional offer made to the successful candidate. The Remuneration Committee has had oversight of the appointment.

A number of other Executive Director posts and interim positions are currently out to advert, a further update will be provided via the Remuneration Committee.

3. STRATEGIC OBJECTIVE 2 - DEVELOPING STRATEGY AND LONG-LASTING CHANGE

3.1 Mental Health Electronic Patient Record

The Board received an update at the last meeting on the outcome of the Invited Review from the Royal College of Psychiatrists. A further update is covered on the agenda today. One of the key priorities for the health board is the accelerated procurement and implementation of a tactical Mental Health specific Electronic Health Record starting in 2024. The Performance, Finance and Information Governance Committee considered the business case at the meeting in June, the full business case is on the agenda for consideration by the Board today.

3.2 Electronic Prescribing

Boots is the second pharmacy supplier to have its electronic prescription technology approved by Digital Health and Care Wales for use in its community pharmacies across Wales. This follows a successful pilot in their Llanfairfechan site, carried out in partnership with the adjacent Plas Menai Surgery.

3.3 Digital Infrastructure

The Health Board has installed a new security and network operations centre (SNOC) to provide improved protection against cyber-attacks such as the one that recently impacted multiple hospitals in London. The SNOC monitors the Health Board's IT infrastructure in over 250 locations across North Wales, collecting and analysing data on the network's performance, security and availability, improving the ability to detect, diagnose and resolve any issues that arise.

4. STRATEGIC OBJECTIVE 3 - CREATING COMPASSIONATE CULTURE, LEADERSHIP AND ENGAGEMENT

4.1 Leadership Conference

Following the first Leadership Conference in February 2024, June 2024 saw around 500 colleagues from a variety of roles and disciplines gather at Llangollen Pavilion.

A range of interesting speakers and activities were on the agenda:

1. **Avoidable Employee Harm -** Health Education and Improvement Wales' (HEIW) Assistant Director of Organisational Development, Wellness and Inclusion Rhiannon Windsor and

Aneurin Bevan University Health Board's Head of Programmes for Employee Wellbeing Andrew Cooper addressed the Main Hall to outline the national approach to fostering cultures of compassionate leadership and share Aneurin Bevan's new approach to addressing the avoidable employee harm caused by investigations and thinking differently to develop a just and learning culture.

2. **Leading Organisational Culture Change, NWP** - North Wales Police Chief Constable Amanda Blakeman and colleagues from Senseia who have undertaken a culture improvement programme across the force and their 'takeaways' from this process;
3. **Compassionate Leadership** - A specially-recorded Professor Michael West (Professor of Work and Organisational Psychology at Lancaster University) video on culture methodology and the importance of kindness and empathy for a happy workforce; and
4. **Engagement on Values & Behaviours to inform revision of organisational approach -** BCUHB's Head of Improvement Julie Ward-Jones and Christopher Shirley, Professional Development Lead – Resus Services and Ffion Pursglove, Specialist Nurse for Medicines Management shared their expertise on human factors.

4.2 Staff Recognition

The 2024 Long Service Awards across the organisation have been held. Staff were congratulated for their years of loyal service within the NHS. It provided an excellent opportunity for Executives including the Chief Executive the opportunity to thank colleagues for their commitment.

Wrexham Maelor-based Consultant Anaesthetist Anna Williams and Rakesh Kumar, a Clinical Specialist Physiotherapist at the Hergest Unit, at Ysbyty Gwynedd, are both among the recipients in this year's King's Birthday Honours List. Anna was awarded a British Empire Medal for services to Environmentally Sustainable Healthcare at Wrexham Maelor Hospital while Rakesh was awarded an MBE for his valuable services to Black, Asian and Minority Ethnic (BAME) communities.

Three Health Board teams have been shortlisted for this year's prestigious NHS Wales Awards.

- The Welsh Language Team have been shortlisted for their work promoting bilingual services on hospital wards.
- Consultant Orthopaedic Surgeons, Mr Edwin Jesudason from Ysbyty Gwynedd and Mr Preetham Kodumuri from Wrexham Maelor Hospital have been shortlisted for their work to relocate minor day case surgeries to a dedicated outpatient area in the hospitals.
- A joint initiative between the Health Board, Public Health Wales and the charity Hepatitis C Trust has been chosen for their work to develop rapid screening and treatment for Hepatitis C for all individuals arriving into HMP Berwyn in Wrexham.

One of our nurses has recently returned from a week in Guatemala volunteering with a charity that provides cleft lip and palate surgery. Kirstin Clark, a Diabetes Specialist Nurse in Ysbyty Glan Clwyd has been volunteering for the Love Without Boundaries charity since 2007 and this was her third trip to support their work.

Last month Happy Valley star James Norton read a book on CBeebies Bedtime Story written by Dr Rose Stewart, a Clinical Psychologist based in Wrexham, to help young children understand diabetes. James, who has type 1 diabetes, read 'How to Manage a Mammoth' during Diabetes Awareness Week. The book encourages families to think of diabetes as an animal, something that will not go away but which they can learn to accept and control.

4.3 General Election – new Members of Parliament

Following on from the General Election of the 8 MPs representing North Wales we have 6 new MPs (listed below). We look forward to working positively with the elected members and look forward to meeting with them all at the end of the month.

Mark Tami (Lab)	Alyn and Deeside
Claire Hughes (Lab)	Bangor Aberconwy – new MP 2024
Becky Gittins (Lab)	Clwyd East – new MP 2024
Gill German (Lab)	Clwyd North – new MP 2024
Liz Saville-Roberts (PC)	Dwyfor Meirionnydd
Andrew Ranger (Lab)	Wrexham – new MP 2024
Llinos Medi (PC)	Ynys Môn – new MP 2024
Steve Witherden (Lab)	Montgomeryshire and Glyndwr - new MP 2024

4.4 Equality, Diversity and Inclusion

4.4.1 Windrush Day

In 2019, the Welsh Government launched a scheme to mark Windrush Day on the 22nd of June. Each year, community groups and organisations have been welcome to apply for funding to hold events, activities, and celebrations for those who came to the UK as part of the Empire Windrush generations.

The Equality team placed a bid for this year's grant for two activities. The first to purchase 40 children's books telling the story of the Windrush for different age groups and for these books to be shared across the Health Board on children's wards, waiting areas etc, to share with our younger patients to read or have read to them. The second activity is working with our local North Wales Regional Equality Network to arrange a hybrid event of Afternoon Tea with a local Windrush Elder who will share their experiences of what it was like to leave their home country, travel on the Empire Windrush and arrive in the UK and their experiences of moving and working in the UK as part of the Windrush Generation.

4.4.2 Supporting Deaf and BSL using Community

Bangor University has been awarded a £1m 3-year research grant from the UKRI to work with the Deaf British Sign Language-using Communities in Wales to tackle health inequalities. Ceri Harris has been identified as a co-investigator on this 3-year project, creating a funding stream for her commitment to the project.

The funding is being used to pilot Sign Live in the health board and provide 24/7 BSL interpretation service via Video Relay Interpretation and Video Interpretation. BSL users can use their smartphones or computers to contact the health board via a standard telephone. Following the pilot, the service is intended to be rolled out across the health board. In addition, the funding will cover the costs training for 20 external stakeholders to enable them to be able to undertake inclusive access reports for health board sites.

Alongside this work the Equality team has been working closely with the Patient Experience and Communication and Engagement team and held a listening event with the Deaf and BSL community in partnership with the Centre for Sight, Sound and Sign on the 17th June. This will be followed up with a further meeting in six months where we can feedback the changes, we have made in the health board following their comments, stories and suggestions.

5. STRATEGIC OBJECTIVE 4 - IMPROVING QUALITY, OUTCOMES AND EXPERIENCE

5.1 Maggie's Cancer Support Centre

Work has commended on the construction cancer support centre Maggie's in North Wales, on 11 July 2024. Located in the grounds of Glan Clwyd Hospital in Bodelwyddan, Denbighshire, the centre's expert staff will support people living with cancer, as well as family and friends, from across the whole region - including Bangor and Wrexham.

5.2 Mobile Renal Dialysis

A North Wales renal patient is set to embark on her first holiday in 15 years after receiving a mobile dialysis machine that she can easily transport in the back of her car. Ceri Ann Granton, from Brynsiencyn on Anglesey, is the first patient in Wales to use this type of machine that grants her the kind of freedom not experienced in years. The technology means that the home therapy team can monitor Ceri's dialysis remotely and offer assistance, if needed.

5.3 Learning Disability Week

To celebrate this year's Learning Disability Week, The Health Liaison Team for Learning Disabilities held a number of events across our three district hospitals. The theme of this year's campaign, led by Mencap, is 'Do you see me?', is about challenging the barriers people with a learning disability face, which is all about individuals being seen, heard and valued.

Raising of the Paul Ridd flags in all Integrated Health Sites took place:

- Ysbyty Gwynedd – Flag raising was supported by a range of team members, Wynne Roberts (chaplain), Sean Gallagher, Head of Nursing for learning disabilities in attendance and our supported interns.
- Ysbyty Glan Clwyd – Flag raised by Anna Macaulay (Mayor of Towyn and Kinmel Bay), with Nichaela Jones (head of operations and service delivery for learning disabilities), learning disability health check champions and supported interns.
- Ysbyty Maelor – Flag raised by Laura Andrews (senior improvement manager NHS executive), with Sean Gallagher Head of Nursing for learning disabilities attending.

6 STRATEGIC OBJECTIVE 5 - ESTABLISHING AN EFFECTIVE ENVIRONMENT FOR LEARNING

6.1 Pharmacy Degree at Bangor University

A new Pharmacy undergraduate degree at Bangor University has been given the go-ahead, with students set to begin their studies in September 2025. The four-year Master of Pharmacy (MPharm) undergraduate degree programme is the primary route that students take to become pharmacists.

As Bangor University continues to grow and develop its new Professional North Wales Medical School, the offering of Pharmacy alongside Medicine and Allied Health programmes is part of the University's strategy to ensure that there are opportunities for local applicants to enter these important fields and that graduates fulfil the workforce needs of North Wales and beyond.

The recent developments follow a successful visit by the General Pharmaceutical Council (GPhC) as part of the required accreditation process. This positive outcome enables the University to begin the process of recruiting students to the MPharm pharmacy degree for a September 2025 start whilst continuing to work towards accreditation of the programme with the GPhC. The programme will be provisionally accredited until the accreditation process is complete.

Bangor University provides significant experiential teaching through partners including the Betsi Cadwaladr University Health Board (BCUHB), community pharmacies, GP practices and Health Education and Improvement Wales (HEIW). In partnership with BCUHB, Bangor University intends be the foremost provider of quality pharmacy education in North Wales.

6.2 Meetings with Families

Following a number of Prevention of Future Deaths notices, families have been invited to meet with the CEO to discuss their experience and influence improvement. This aligns with the Health Board's approach to be a learning organisation and also an opportunity for personal apologies and commitments to be made by the CEO and wider HB.

6.3 Public Interest Reports

A Public Interest Report (PIR) was published on 10 July which identified failings to a patient with learning disabilities admitted to an acute hospital in July 2022. A further two PIRs are due to be published: the first relates to April to February 2023 and concerns urological care and delays and is expected to be published in July 2024, and the second relates to care between January 2021 and January 2022 covering discharge and follow up care with no publication date set. The reports when published will be presented to the Quality, Safety and Experience (QSE) Committee.

6.3 Moondance Cancer Awards

The Chief Executive attended the Moondance Cancer Awards in June. The awards celebrate and spotlight brilliant people across NHS Wales and its partners who deliver, lead and innovate cancer services. The BCUHB Cellular Pathology – New Ways of Working team were shortlisted in the Innovation & Improvement – Cancer Workforce category. It was fantastic opportunity to showcase and celebrate the work the team are doing.

7. CONCLUSION

The report intends to give an overview of key activities undertaken by the Chief Executive as well as important matters to draw attention to which may or may not be subject of other more detailed reports. Feedback on the report is welcome.

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

Teitl yr adroddiad: ***Report title:***	Vice Chair's Report
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides information on key areas of engagement undertaken since being appointed as Vice Chair
Argymhellion: ***Recommendations:***	That the Board discusses and notes the content of the report
Arweinydd Gweithredol: ***Executive Lead:***	Vice Chair
Awdur yr Adroddiad: ***Report Author:***	Vice Chair

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Ar gyfer sicrwydd *For Assurance* ☐

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Meetings cover a range of strategic priorities.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no specific implications arising from this report.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not applicable at this stage.

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable at this stage.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The issues raised impact across a range of risks.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no specific implications arising from this report.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no specific implications arising from this report.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risgiau Corfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The issues raised impact across a range of risks.
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential Committee (where relevant)***	Not applicable.
Next Steps: ***Implementation of recommendations*** Not applicable to this report.	

Report of the Vice-Chair to the Betsi Cadwaladr University Health Board, 30 May 2024

Partly due to having been away for three weeks in July, I seem to have done less since our last meeting in May than in previous periods.

Mental Health

In terms of **Mental Health and Learning Disabilities (MHLD),** there has obviously been a fair amount of work arising out of the Royal College of Psychiatrists report, including continued media interest and the development by the staff of the plan in response to it.

We had a very positive first meeting with the new Minister for Mental Health and Early Years, Jayne Bryant MS who visited North Wales on 20 June. As well as the formal quarterly meeting, she visited the Ablett Unit, Llys Dyfrig (Older People's Community Mental Health Team (CMHT)) and the Memory Assessment Service in Llandudno. The Minister showed a genuine interest and emphasised that she sees it as a common endeavour to improve the reputation of our services.

For myself, continuing my programme of visits.

- I visited Hergest for a second time to discuss recent developments
- I spent a fascinating few hours with Professor Peter Lepping and the Liaison Psychiatry Team who support colleagues in the Maelor with patients admitted for physical health issues but who also display signs of poor mental health. It was a privilege to see the sensitivity with which Peter and his colleagues deal with distressed patients, and interesting to hear of his view that the Liaison service felt less isolated in Welsh Heath Boards because of the opportunity to work with colleagues in MHLD.
- I dropped in at GISDA in Caernarfon which delivers an iCAN service targeted at young people in Arfon.

I have also been undertaking a series of visits to local authorities to meet Cabinet members for Social Care (and in some cases also those dealing with Children's Services). I have now met five of the six Councils (my meeting with Cllr Ellen Heaton of Denbighshire was postponed because of illness):

- Cllr Penny Andow and Cllr. Elizabeth Roberts of Conwy Council
- Cllr Christine Jones and Neil Ayling of Flintshire Council
- Cllr Dilwyn Morgan and Cllr Elin Walker Jones of Gwynedd Council
- Cllr John Pritchard and Alwyn Jones of Wrexham CBC
- Cllr Alun Roberts of Ynys Môn Council

I have been pleasantly surprised by how positive these meetings have been, while of course recognising the considerable pressure both on our services and on social care.

Meanwhile, the qualitative survey through the Regional Partnership Board (RPB) with Directors of Social Services and CMHT leads about relationships between local authorities and MHLD has gone 'live' and most responses have been received. The Together for Mental Health Partnership will have an initial discussion at our meeting on 19 July.

Internally, I continued my regular meetings with Teresa Owen and with Ros Alstead, our external advisor.

I have managed to step up my interaction with **Children and Adolescents' Mental Health Services (CAMHS)** over the last couple of months:

- I joined one of the regular meetings of the CAMHS Strategic Improvement and Development Group which is steering the delivery of the recently agreed improvement plan.
- I visited the CAMHS Team in Caernarfon where I sat in on a Multi-Disciplinary Team (MDT) meeting which gave a real insight into the challenging cases dealt with by the service and the close and supportive relationships between different disciplines within the team.
- I received a briefing on the Early Intervention Work being undertaken by the CAMHS team, much of which is inspirational.
- I had a useful meeting with Louise Bell, Assistant Director of CAMHS to resolve some issues relating to the ring-fenced budget for mental health.

Primary and Community Care

In terms of Primary and Community Care, I have continued to build my knowledge of the large range of services which we deliver. In particular:

- I visited West End Medical Centre, one of our largest managed practices which has been subject to constant criticism from Darren Millar MS.
- I have been undertaking a series of visits to independent community pharmacies (Fferyllfa Llyn in Llanbedrog and Llanberis; and Caerwys Pharmacy), with Adam Mackridge, our Head of Community Pharmacy to discuss the very positive developments in respect of pharmacy independent prescribing – where we are well ahead of the field.
- I spent an interesting afternoon with my opposite number in the Welsh Ambulance Service Trust (WAST), Ceri Jackson and senior managers in North Wales learning about their aim of moving away from being a conveyance service to a much greater emphasis on managing incidents on the ground. I think there is considerable mileage in working closely with WAST about the potential of Minor Injury Units (MIUs) as an alternative to taking patients to Emergency Departments (ED)s, but this will depend on developing a more consistent offer across our MIUs. I also spent some time listening in on calls being received by the 111 service.
- I took part in a celebration of the 20 years of the Health Team in Caia Park, learning about their excellent work in promoting healthy lifestyles across the most deprived parts of Wrexham.

Meeting with the Cabinet Secretary

I also participated in one of the monthly meetings between Health Board Chairs and the Cabinet Secretary due to the Chair being on holiday. This certainly gave me a good insight into the extent of the challenge facing all Health Boards in meeting the (justified) aspirations of the Welsh Government in terms of delivery.

Gareth S. Williams *July 2024*
Vice-Chair

Teitl adroddiad: ***Report title:***	**The Health Board Response to the Royal College of Psychiatrists' Invited Review Services Report**
Adrodd i: ***Report to:***	Health Board - Public
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	The following report details the Health Board response, approach and proposed governance arrangements by which the Health Board will deliver against the ten themes identified in the Royal College of Psychiatrists (RCPsych) Invited Review Service (IRS) report. The report was considered at the Health Board meeting on **30th May 2024**, with a request to draw up a formal response to the findings of the review. An integral part of this recommendation focused on incorporating the views of families and other stakeholders, including Llais following their feedback on the provision of care provided to their relatives, during the May meetings (both in the Health Board meeting and in the Earlier Families meeting. The four key themes and actions were: • For the Board to draw on best practice from elsewhere in the UK and internationally and to bring this to North Wales. • For the Board to take some time to consider the Independent Review Service findings, rather than move too swiftly to an 'action plan' • For people 'outside' the Board to help provide the Board with advice and on overview of how services are being developed and delivered • For the Board to pull out some of the elements of the further work required within the report and progress as soon as possible'. A further meeting with the families and Llais colleagues was held on the 17th July 2024, when Health Board colleagues shared their outline approach to the response, with a focus on sustainable improvements in safe and reliable care, and gained valuable feedback from the families to shape the next steps. This discussion and feedback has informed this paper to the Board. The core report (Section one) details the key Health Board building blocks/ /foundations which will support the overall improvement to support safe and reliable care across all its services. These are described under the following headings: • Developing the **Strategy** and Vision of the Health Board (HB)

	• The **Operating Model** refresh • Introduction of a **Quality Management System: a framework for improvement (24/25)** • The new **Integrated Concerns Policy**. • Strengthening **Organisational Development** in BCUHB**: Culture, Leadership and Engagement** • Progressing an **Electronic Health Record** (EHR) for Mental Health Services • Service User and Carer **engagement** • Embedding the HB **Risk Management Framework** • **Dementia Activity** across the Health Board, and in partnership The second section of the report describes the high level governance arrangements to oversee the response plan delivery. The third section describes some of the positive progress being made in a number of the specific themed areas highlighted by the Royal College Review. No actions have been' signed off' at this stage, given the need for the scrutiny/independent expert advisory group to be established. Some highlights are detailed below: • A service and carer engagement strategy 'task and finish group' has been established with broad representation from across the Mental Health and Learning Disabilities (MHLD) Division, and with people with lived experience of services. This group has been formed to specifically develop a Mental Health and learning Disability Divisional Strategy for Service User Involvement and Engagement. It aims to build on good experience from across Wales and further afield, and 'Co-Production Lab Wales' is to offer support. • The HB teams are examining real time-feedback feedback mechanisms to improve patient and user centred care. • A physical health strategy has been developed within the division, and a physical health lead identified. A steering group will progress the comprehensive physical health policy for MHLD. The Health Board is working with Public Health Wales to develop a Physical Health webpage, while support from Health Education Improvement Wales (HEIW), is enabling a new health promotion and prevention approach to be trialled in Denbighshire Community Mental Health teams. A Physical health suite is now established on the Heddfan site. • During 2024, three additional Quality and practice Development nurses have been recruited to the Mental Health and Learning disabilities Division.

	• A HB draft learning outcomes framework (which was also linked to the Special Measures Outcome work) has been developed. • E-roster management is in place across the HB. Given the staffing challenges in the MHLD division, the topic of E-Rostering is a standing agenda item at key divisional meetings. • Links with HEIW have been strengthened. A Careers booklet is in the pipeline related to mental health carers. • The Dementia Consultant Nurse post (for the MHLD division) is progressing well with plans for the interviews to be held in September 2024. • The HB ward accreditation programme position has improved in the MHLD division. Three wards are aiming for Gold status within the next year. • The HB has delivered two Leadership Conferences during 2024 – with over 700 colleagues attending. The report also provides an update on the progress against the areas rated as Amber or Red within the RCPsych report. Finally, Appendix 1 provides the detail on the specific actions in the detailed response plan.
Argymhellion: ***Recommendations:***	The Board is asked to: • **Consider** the Health Board response to the Royal College of Psychiatrists Invited Review Services Report entitled 'Moving Forward Together'. • **Endorse** the outlined approach and proposed governance arrangements.
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive
Awdur yr Adroddiad: ***Report Author:***	• Teresa Owen, Lead for Mental Health and Learning Disabilities and Welsh Language. • Iain Wilkie, Divisional Director, Mental Health and Learning Disabilities Division. • Carole Evanson, Director of Operations, Mental Health and Learning Disabilities Division.

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd:	Arwyddocaol	Derbyniol	Rhannol	Dim Sicrwydd

Assurance level:	*Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	*Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	*Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1: Building an effective organisation 3: Compassionate culture, leadership and engagement 4: Improving quality, outcomes and Experience 5: Effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Strategic Priority P18: Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None to note at this stage
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	None to note at this stage

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been prepared following the recommendation from the Health Board meeting on 30th May 202 to draw up a formal response to the findings of the review.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR 24-04 Failure to Embed Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion
Next Steps:

To establish the recommended governance framework, which will include an 'Expert Advisory Group', independently chaired with family representatives, Llais colleagues and other stakeholders included as group members.

Continue to strengthen the patient and carer experience work and to ensure this influences future service developments.

To commence monitoring of the implementation of the RCPsych Response plan, focussing on the ten themes identified.

To provide a regular updates on progress to the Health Board of the RCPsych Response plan with regular oversight through the Quality, Safety and Experience Committee, and also to the Health Board - every six months.

List of Appendices:

Appendix 1: Royal College of Psychiatrists' - Response Plan

The BCUHB Response to the Royal College of Psychiatrists' Invited Review Services Review

Prepared for the BCUHB Health Board meeting

25 July 24

Introduction

The Royal College of Psychiatry (RCPsych) undertook a review of how the Health Board implemented the findings from four previous reports and the extent to which these have been maintained and integrated into '*business as usual*' practices. The scope of the review covered the recommendations made in the following reports:

- Ockenden 1 (2014)
- Ockenden 2 (2018)
- HASCAS (2018)
- Holden (2013)

The Review Team grouped their findings into ten themes hoping this would be helpful to the Health Board in setting priorities for service development and quality improvement.

Listed below are the ten themes:

- ✓ Theme one: Patient and user centred care
- ✓ Theme two: Legislation and clinical guidelines
- ✓ Theme three: Governance
- ✓ Theme four: Staffing
- ✓ Theme five: Management structure
- ✓ Theme six: Clinical services organisation
- ✓ Theme seven: Training and development
- ✓ Theme eight: Leadership and staff engagement
- ✓ Theme nine: Resources
- ✓ Theme ten: Physical environment

The Health Board met with the families in preparation for the May 2024 Board meeting, and formally discussed the Report at its Board Meeting on the 30 May 2024. The papers are available on the Health Board website.

Both family and Llais representatives spoke at the meeting and highlighted their wish to see the completion of the actions. They expressed their disappointment that not all families with experience had been involved in feeding into the review, however the focus on looking ahead and making positive progress across mental health, older adults and dementia services in particular was welcomed.

When the report was considered at the Health Board meeting on 30th May 2024, a request was made to draw up a formal response to the findings of the review. An integral part of this request focused on incorporating the views of families and other stakeholders, including Llais following their feedback on the provision of care provided to their relatives,

during the May meetings (both in the Health Board meeting and in the earlier families meeting).

The four key themes and actions were:

- For the Board to draw on best practice from elsewhere in the UK and internationally and to bring this to North wales.
- For the Board to take some time to consider the Independent Review Service findings, rather than move too swiftly to an 'action plan'
- For people 'outside' the Board to help provide the Board with advice and on overview of how services are being developed and delivered
- For the Board to pull out some of the elements of the further work required within the report and progress 'soon as possible'.

During the Health Board discussion, a number of key themes were discussed including:
- Accountability
- Clarity on the purpose of wards/units
- Standard setting – knowing what good looks like
- Culture
- Leadership
- Standardisation
- Openness and transparency
- Ambition, with a clear ask that the Health Board should set its bar high.

The Health Board met again with the families and Llais representatives on the 17th July 2024. The Health Board colleagues shared their outline approach to the response, with a focus on delivering sustainable improvements in safe and reliable care across the Health Board. The families again emphasised the need for a focus on patient centred care, sustainable actions, with clear evidence gathered through a clear and transparent process. During the discussion, the Board members present re-stated their commitment to strengthen the work with patients, carers and families (past and present) in its work, and to work collaboratively as the work on the response progresses.

The feedback was most valuable, and has informed this report to Board.

This report is written in three sections with Appendix 1 as a key reference document:

- **Section 1**: The Health Board system-wide approach going forward.
- **Section 2**: The governance arrangements to oversee/monitor the implementation of the response plan.
- **Section 3**: Examples of positive progress underway across the Health Board and in the Mental Health and Learning Disabilities (MHLD) Division – aligned to the ten themes. Also an update on progress in some of the RED and AMBER rated action (as rated by the RCPsych)
- Finally, **Appendix 1** contains the detailed actions which are required to close off the outstanding recommendations. The work is system wide with both system-wide actions and specific Mental Health and Learning Disability (MHLD) Division actions. The delivery actions have been aligned to the ten themes as outlined by the Royal College of Psychiatry. Support has been provided by the Transformation team to ensure actions are described appropriately for scrutiny and sign off in due course

Section 1: Key System-Wide Actions across the Health Board

The Health Board acknowledges the need to take a system wide approach, and the need to take key strategic actions to improve services. The '*One Year On: BCUHB's Special measures Delivery over the Last Year*' document (published March 2024), details the Board ambition in the closing statement *'...to be known as an organisation with a compassionate culture, with visible leadership and engagement with staff, partners and our communities to be a Health Board they trust and can be proud of… We must learn from the past, from our previous experiences and are committed to ongoing and continuous improvement'*.

The Board has recognised that many aspects of the way in which the Health Board has operated over recent years have been unsatisfactory, with systemic failings in terms of processes such as dealing with concerns and complaints and listening to and engaging with partners and service users, and their families and carers. These shortcomings were at the root of the decision by the Welsh Government to place the Health Board in Special Measures.

As a result, the Health Board is engaged in a wide-ranging and ambitious change programme which is aimed above all at securing long-term change in the culture of the organisation, with a focus on transparency, a willingness to learn from its own experience and from good practice elsewhere, and an unwavering commitment to quality. All of the elements of this programme are relevant to MHLD, as they are to all parts of the HB.'

This change programme focuses on the core building blocks/foundations for system wide improvement. These actions align with the Health Board Three Year Plan 24/27 and the Annual Delivery Plan 24/25. Many of these key 'change programme' elements are highly relevant to ensure progress aligns to the RCP recommendations, in addition to the detailed response plan activity.

Key building blocks are detailed below:

- Developing the **Strategy** and Vision of the Health Board (HB)
- The **Operating Model** refresh
- Introduction of a **Quality Management System: a framework for improvement (24/25)**
- The new **Integrated Concerns Policy**.
- Strengthening **Organisational Development** in BCUHB**: Culture, Leadership and Engagement**
- Progressing an **Electronic Health Record** (EHR) for Mental Health Services
- Service User and Carer **engagement**
- Embedding the HB **Risk Management Framework**
- **Dementia Activity** across the Health Board, and in partnership

Developing the Strategy and Vision for the Health Board

The Health Board has agreed that the strategy be reviewed and refreshed to meet the current and future needs of the organisation. This is detailed in the Annual Delivery Plan, and developing the new strategy is proposed as a major change programme for the Health Board in 24/25, with significant transformation support in place to ensure the strategy is fit for purpose for the coming years and changing needs across the population of North Wales.

As part of this development, the current Health Board Clinical Services plan will be reviewed and reshaped. A major requirement will be to ensure that the new document meets both the physical and mental health/wellbeing needs of the population in North Wales. As a practical step in this direction, the MHLD division have reviewed the Terms of Reference for its Acute Care Pathway group to ensure it aligns to the intended outcomes of patients admitted to inpatient services, with a focus on how risk and safety is managed during the admission, particularly in reference to home based and other treatment modalities. There is a renewed focus on an outcomes and value approach.

The HB Operating Model refresh

The 'Operating Model' of the Health Board relates to how the Health Board works and a robust operating model should help ensure a cohesive organisation. In the 24/25 annual delivery plan, this is an area of focus and review, under the 'Building an effective organisation section' (Item 1C).

Much of the Health Board went through fairly recent operating model changes, however not all divisions/services had the opportunity to complete their work. The Mental Health and Learning Disability Division operational model is due a refresh, and this is key for stability. Under the new Board leadership, there is significant work underway to achieve an optimal operational model which is fully inclusive of all services/divisions. This work will be supported further as the substantive Executive level vacancies are filled.

Key agreed actions to progress this work include completing the system-wide stock take in the Health Board drawing on the work of the Internal Audit Team; understanding benefits and issues; assessing the business partnering model currently in place; reviewing and revising the clinical leadership model and, monitoring the effectiveness of the Integrated Performance Framework.

Introduction of a Quality Management System: a framework for improvement (24/25)

A Duty of Quality Act applies to NHS bodies in Wales, and came into effect in April 2023. It has two overarching aims:

- To improve the quality of healthcare services
- To improve outcomes for people in Wales.

It requires Health Boards in Wales to establish effective quality management systems that focus on learning and driven forward by Health Boards.

The guidance makes clear that the four aspects of Quality Control, Quality Planning, Quality Improvement and Quality Assurance must work together to form the quality management system (QMS). Central to the QMS model is the commitment to being a learning, self-improving, intelligence led organisation that serves the people of North Wales.

Clinical leads from across the Health Board supported the development of the Health Boards new QMS system, and input and engagement from across the corporate teams, the Executives and the Health Board members was significant. The approach was shared by the Executive Medical Director at the Health Board Public Meeting in May 2024, and the QMS is seen as a catalyst for further change

and improvement, helping to build a more effective integrated organisation. The approach is new to the Health Board, and new to health services in Wales in general. The principle of co-production is built into the work as the local implementation rolls out.

Integrated Concerns Policy

A new policy is being developed by the Executive Director of Nursing and Midwifery to ensure incidents, complaints and mortality reviews across the Health Board are addressed as per the NHS Wales requirements.

The policy is enhanced given the focus on the five key principle of person centredness; fairness; candour; timeliness, effectiveness and proportionality; and an outcome and improvement focus.

The Health Board Executive Quality Delivery Group (EQDG) will be the lead management group with responsibility for ensuring this policy is implemented. The policy references the importance of listening to complainants fully, and the important role of the Patient Advice and Liaison Service (PALS), who can provide confidential advice and support.

The policy also is clear on record keeping arrangements in relation to incidents, complaints and mortality reviews. This Policy is due to be approved by the Board in its July 2024 meeting. In essence this policy ensures that the Health Board not only acts, investigates and reports in a robust manner – the Health Board also 'learns' as a system.

Strengthening Organisational Development in BCUHB: Culture, Leadership and Engagement

Significant evidence is now in place that having the right culture in Healthcare organisations leads to improved care and positive staff experience. Similarly, evidence also indicates the important contribution that effective leadership and leaders have on shaping and developing culture; also how culture and leadership are a pre-requisite for the engagement of staff in their work and their organisation.

This arena of work was a key part of the Special Measures Response Plan in 23/24, and the work is now being progressed in 24/25, with oversight via the People and Culture committee. Papers are available on the Board website. All Board members have been asked to actively participate in the work, with support from the Organisational Development team. Key elements being focused upon, aligned to the annual delivery plan 24/25, include:

- An examination of the pervasive culture in the HB
- Revisiting the values of the organisation, and working in partnership to test and reshape as necessary
- The development of a behaviours framework
- An active dialogue and exploration of the leadership approach the HB wishes to adopt
- An agreed comprehensive leadership development programme

Developing an Electronic Health Record (EHR) for Mental Health Services

The Health Board acknowledges that Mental Health and Learning Disability services require change and modernisation. A critical aspect of this modernisation agenda is the need for a comprehensive electronic health record.

Numerous Health Board reviews (former and current), Health Inspectorate Wales (HIW) reports, and Coronial reports all identify the limitations of the current record keeping approach, and the risks of patient harm, maintaining service delivery and delivering on the Health Board strategic and operational objectives.

An Outline Business Case has been developed jointly by the Digital, Data and Technology (DDaT) and MHLD teams. The 'Case' has been shared with the Performance, Finance and information Governance (PFIG) committee on the 25 June 2024, and has now been submitted to Welsh Government colleagues. The Health Board understands that that this 'Case' will be reviewed at the Welsh Government Investment Panel on the 25 July 2024. The Case will be formally discussed at the Health Board meeting in July 2024.

Service User and Carer engagement

Service User and carer engagement and lived experience is vital in shaping existing and future person centred services. Lived experience should be considered across a spectrum of participation from people and their significant others and families being fully involved in their own care and support, or that of a relative, right through to advising providers and commissioners on service design and strategy. This outcome can only be achieved by putting lived experience at the heart of provision across the whole Health Board.

In terms of MHLD services, a Service user and carer engagement strategy task and finish group has been established with broad representation from across the MHLD division and with people with lived and living experience of services. The Group has been formed to specifically develop a Divisional Strategy for Service User Involvement and Engagement. This group acknowledges fully the need for people with lived and living experience of services be at the heart of the planning, delivery and evaluation of services as equal partners in the care that they receive.

This work aims to build on current good practice in involving service users across services to date and also utilise good practice that exists across Wales and further afield.

Embedding the HB Risk Management Framework

In September 2023, the HB approved its new Risk Management Framework 2023-2025, given the explicit commitment to ensuring a robust infrastructure to manage risk ensuring an integrated approach, and where risks crystallise, to evidence improvements. The HB 'risk framework' statement states *'…the HB will encourage staff to work in a collaborative partnership with each other and service users and carers to minimise risk to the greatest extent possible and promote patient well-being as a duty of care to the population'.*

The framework also articulates clearly the risk architecture within the HB, and the governance approach to risk and Board escalation, including the roles and responsibilities of the Board, committees etc.

Dementia Activity across the Health Board, and in partnership

Improvement in Older Persons and Dementia care was a consistent theme throughout the RCPsych report. The Health Board works in partnership to ensure this work is progressing across North Wales. The five key areas of the Regional Dementia work plan are listed below:

1. Dementia Action Plan (DAP) Schemes
2. NWRPB Dementia Strategy Action Plan
3. All Wales Dementia Care Pathway Standards (AWDCPS)
4. Memory Support Pathway (MSP) Improvement
5. Dementia Friendly Communities

In March 2024, a Community Engagement Listening Campaign Celebratory event was held on the 14th of March 2024. This brought partners across North Wales from the Health Board, local authorities, the third sector, Bangor University and blue light services together, for partners to present and share learning, projects and programmes that have the potential to open new ways of working and developing original ways to support people with dementia and their carers.

The Health Board has established a Dementia Pathway Design Group focusing on Dementia Standards and the Hospital Charter. Recent positive examples of work include the Dementia Connector work, and the development of a comprehensive Charter communication and engagement plan. The Health Board has also refreshed its dementia awareness website and includes self-study tools and dementia training resources.

Dementia support workers are now in place in the Health Board, while within the MHLD Division, there is an increased focus on dementia training and compliance with a Level 3, 2 day training established. This training is called ‘Finding the Light’.

Section 2: Governance and Oversight going forward:

Establishing a governance framework that enables transparent and accountable progress with full assurance provided to all involved is required to take forward this work. Following discussions, the following approach is recommended.

- Establishment of an Expert Advisory Group, independently chaired with family and user representatives, and Llais included as group members. Initial membership to be agreed in advance of the Quality, Safety and Experience Committee in August 2024.

- Establishment of a Health Board RCPsych Action Delivery Group (an internal management group) which reports into the Executive Team.

- Regular monitoring and oversight of response plan progress/delivery via the Quality, Safety and Experience Committee.

- Terms of Reference to be collaboratively developed and agreed for all groups, supported by the Office of the Director of Corporate Governance.

To further support the process an agreed procedure for providing progressive and sustained evidence of actions is required. A draft Evidence Submission form has been developed for use by the proposed Delivery Group. Further consideration of this template/form can be discussed as the HB Governance approach is finalised.

The governance approach should be approved at the next Quality, Safety and Experience (QSE) Committee. Regular Chairs Assurance reports, will be utilised to support the Expert Advisory Group and BCUHB QSE.

All the processes will need to enable a robust oversight to check, challenge and quality assure evidence submitted by each of the delivery groups and ensure that the evidence threshold has been obtained to meet the expectations of all involved.

A repository for the evidence will be established with support from the transformation and planning team - with access provided to corporate colleagues to enable the Expert Advisory Group to function effectively and to support the critical oversight of the progress through the Quality, Safety and Experience Committee oversight mechanism.

Section 3: Examples of positive progress underway

The following list are examples of work progressing across the Health Board – aligned to the ten themes. No actions will be assigned to a closure status without the expert Advisory Group scrutiny and the oversight of the Quality, Safety and Experience Committee.

Theme	Example/Progress Update
Patient and user centred care (**With QSE approval in August required, there is a proposal to change the wording of this theme to reflect the important role of families and carers)**	• A service and carer engagement strategy 'task and finish group' has been established with broad representation from across the division, and with people with lived experience of services. This group has been formed to specifically develop a Mental Health and learning Disability Divisional Strategy for Service User Involvement and Engagement. It aims to build on good experience from across Wales and further afield, and 'Co-Production Lab Wales' is to offer support. • The HB Teams are examining real time-feedback feedback mechanisms to improve patient and user centred care. • Service walk-abouts have been arranged in the MHLD Division - providing opportunities for increased visibility and direct engagement with senior leadership team members for staff. • BCUHB are participating in national discussions to assess patient feedback measures and metrics with WG and other colleagues. • The Patient Experience Team (PALS), together with Caniad, are due to undertake a review of the current approach to recommend stronger alignment of the MHLD Division to corporate Patient Carer Experience processes. To realise

	this, the Patient and Carer Experience Group and representatives of the Patient Carer Experience Team have set up a Task and Finish Group to review and develop a Patient Carer Involvement and Engagement Strategy for the Division. • Tablet-based feedback is being used positively across the Patient Experience Team, capturing stories and experiences in the "moment". To support this activity, all areas across the MHLD Division are mapped to CIVICA.
Legislation and clinical guidelines	• The Division has developed a Physical Health Care Strategy, which focuses on six areas - Governance, Health Promotion and Disease Prevention, Training, Physical Health Care in Services, Information Technology and the development of a Liaison Physician. • A Physical Health Implementation Group was established to implement the strategy, which reports into the Clinical Effectiveness Group and the MHLD Service Quality Delivery Group. A Physical Health Lead has been identified and a steering group is progressing the production of a comprehensive MHLD Physical Health Policy aligned to this strategy. This will ensure that processes are in place to aid physical health monitoring by staff who are appropriately trained to do so. • The Physical Health Implementation Group has worked in conjunction with Public Health Wales to develop a Physical Health Webpage to be a resource for practitioners. • A pilot project, with the support of Health Education Improvement Wales (HEIW) funding, has also recently agreed a focus on Health Promotional and Prevention in Denbighshire Community Mental Health Teams (CMHTs). The team will comprise of Allied Health Professionals including access to an Occupational Therapist and Dietitian. • In the last six months, the MHLD Division has recruited three additional Quality and Practice Development Nurses in addition to the one WTE previously recruited to in 2021. • A Physical Health Suite has been developed in the Heddfan Unit to aid all aspects of Physical Health Care Monitoring. • The Division has also joined POMH-UK (Prescribing Observatory for Mental Health) and carried out a comprehensive audit in 2021. The audit is due to be repeated over the next 12 months.
Governance	• The Health Board approved its Quality Management System (QMS) at the Board meeting in May 2024, with work underway to develop the support for services to embed this across the organisation over 2024-25 led by the Executive Director of Nursing. • The Health Board is due to approve its new Integrated Concerns Policy at the Board meeting in July 2024. This new policy will provide enhanced clarity and an integrated approach to managing incidents, complaints and mortality reviews with implementation planned from September.

	• In September 2023, Welsh Government launched "Connecting Care: Digital Transformation for All Ages Mental Health and Learning Disabilities Services". On behalf of Welsh Government, Digital Health Care Wales (DHCW) has been working with Health Boards and Local Authorities across Wales to ensure they have all the information needed to define to market leaders the content and function required in a digital system. BCUHB have been fully supporting this work stream and have fostered good relationships with the national teams. BCUHB MHLD services are recognised as one of the least digitally supported services in Wales. Due to this the HB had approval to develop an outline business case. The cases are not in competition with each other but are being developed mutually in order to maximise the opportunity to bring digital solutions to North Wales. • A HB draft learning outcomes framework (which was also linked to the Special Measures Outcome work) has been developed.
Staffing	• E-roster management is in place across the HB. Given the staffing challenges in the mental health and Learning disabilities division – the topic of E-rostering is a standing agenda item at key divisional meetings. • Links with HEIW have been strengthened. A Careers booklet is in the pipeline related to mental health carers. • The Wellness, Work and Us service continues to provide support and intervention to MHLD staff at times of need. Annual Reports are available on the service activity. • MHLD divisional recruitment and retention continues to be a focus, and the various innovative measures implemented has resulted in a downward trend in the vacancy rate the last six months. The HB is using various social media platforms to showcase the Division and have attended various recruitment events to support with raising awareness of the various career opportunities available across all the services pan North Wales. Current activity includes progressing the development of a HCA career pathway to enable the MHLD Division to "Grow our own" nurses for the future.
Management structure	• Progress will be aligned to the implementation of the Operating Model. For MHLD, a communication and engagement plan has been developed to ensure all key partners and stakeholders are regularly updated.
Clinical Services Organisation	• Audit activity has been strengthen across the HB and MHLD division. During November 2023, as part of the HSE Notice of Contravention (NOC) Improvement Plan, a series of peer review audits took place on Care and Treatment Plans. The audit highlighted a high level of compliance with the four main themes, namely:

	Has a Part B Risk Formulation been completed? **Divisional compliance at 98.7%.** Has and Inpatient Care and Treatment Plan been completed? **Divisional compliance at 94.5%.** Is the patient in an appropriate bed? **Divisional compliance at 99.2%.** Is the current version of the Therapeutic, Engagement and Observation Monitoring Form being completed? **Divisional compliance at 98.2%** In addition, the Mental Health Measure Team also undertake audits on Care and Treatment Plans. The outcome of the audits are fed into local and Divisional Operational Leadership Meeting to review and monitor progress with any recommendations. These Mental Health Measure Audits have occurred on an annual basis, but in the future will be undertaken on a six monthly basis. • The MHLD Acute Care Pathway work has been reviewed to ensure it aligns to the intended outcomes of patients admitted to inpatient services, with a focus on how risk and safety is managed during the admission, particularly in reference to home based and other treatment modalities.
Training and Development	• As of 30th June 2024, overall, divisional compliance for Level 1 Mandatory Training competencies is 93%, overall compliance for Level 2 competencies is 88%, and overall compliance for 'Other' competencies is 82%. The target level of all Mandatory Training compliance is 85%. Detailed analysis of all competency levels is reported into the Service Quality Delivery Group (SQDG) to monitor and review any areas below the required compliance target. • In addition to the above, the Ward Accreditation Programme details a number of KPI's in which all staff working on MHLD Wards are expected to achieve. The Divisional position for Ward Accreditation has improved with no flagged wards, 23% (n5) at silver status, 73% at bronze status and three wards aiming for Gold status within the next year.
Leadership and Staff engagement	• The Health Board has delivered two Leadership Conferences during 2024 as part of its focus on improving culture, leadership and engagement. So far around 700 colleagues have attended from all levels of seniority, including managers from the MHLD Division, and from a variety of roles and disciplines at a North Wales venue with a range of internal and external speakers and activities on the agenda. • The Health Board has developed a suite of learning programmes for current and aspiring leaders across the organisation, and this includes a programme of coaching and mentoring to practically embed and maximise potential. • An intranet based staff engagement toolkit has recently been launched, full of resources to support all staff across the

	organisation who are looking to develop areas of staff engagement within teams. • A 12 month MHLD Walkabout Schedule has been developed, (which recently commenced in June 2024) to further increase the visibility of the Senior Leadership Team across the Division. This Walkabout schedule includes Drop in Sessions for patients, carers and their families to meet with members of the senior team to give a chance to share their views and provide feedback about experiences of using Mental Health Services.
Resources	• A demand and capacity gap analysis has commenced for therapies staff including development Occupational Therapy, Physiotherapy, Dietetics, Speech and Language Therapy, and Art therapy. This work is being led by the Assistant Director of Health Science. • In terms of the role of pharmacy there have been a number of developments within MHLD Community Mental Health Teams (CMHT's) to optimise the pharmaceutical element of care. The HB has successfully introduced the EMIS software, prescribing module across the Community Teams, enabling safer, effective and timely prescribing.
Physical environment	• Key strategic planning for estates for MH&LD has begun with an outline list of priorities that will support both delivery of immediate objectives and shape our longer term estates planning. This includes the: -delivery of Ablett unit project- ongoing -delivery of Plas Gororau project- complete -delivery of Roslin project -complete review of all estates utilised by MHLD services. This work will link to the HB estates strategy. • Resource has this year been focused on the emerging requirements that have been identified following a Notice of Contravention (NoC) issued in 2023/24. The senior leadership team has led on a scheme of Ligature Risk Reduction improvements to address issues identified through the NoC and also to use the learning to identify any further issues across the division. This work is ongoing and as reviews are completed, will continue to add to the existing capital and revenue estates requirements.

In addition, the following tables provide a brief note on some of the positive progress underway aligned to the specific actions rated as Red and Amber by the RCPsych review.

RED ACTIONS	**Progress to date**
Shared Log-in's	Working in partnership with Digital. Data and Technology colleagues – a solution has been implemented.
Assessment of the performance ability of operational, clinical and managerial roles	The review of the MHLD operating model (taking into account the RCPsych findings is progressing and will feed into the H operational model work.

The Consultant nurse (dementia).	One post holder is in place in the HB. Approval now in place for the recruitment of the additional Consultant Nurse (dementia). Interview slots are being planned for September 2024.
High level of interim posts	The HB has significantly reduced its agency and interim staff usage (this is recorded in other HB papers). The MHLD division has developed Terms of Reference to assist with the progression of interim posts – currently at divisional governance sign of stage.
Lack of external networking	Opportunities being sought with MHLD for engagement with external partners. Engagement with HEIW is helpful as staff development and leadership opportunities explored.
Conflicting models of care	Discussions have commenced supported by the Clinical Advisory group mechanism in MHLD with the aim of agreeing the approach and embedding a consistent model. The MDT working is a key feature of MHLD work, and work is underway to review and optimise the position.

AMBER ACTIONS	**Progress to date**
Overhaul of concerns/complaints/ SUI reporting structure	The recent RCPsych review and the National Collaborative Commissioning Unit (NCCU) recognised the comprehensive governance systems around 'Putting Things Right' (PTR) in MHLD, while highlighting the need to focus on learning form PTR. The MHLD Division is progressing this work by being an early adopter of the Learning Organisational Framework.
Ward to Board communication	An MHLD communication and engagement Plan has been developed and is progressing through governance sign off.
Supporting the Deteriorating Patient and Physical Health Assessments	A physical health Group has been stablished in the MHLD division. A DRAFT policy is being considered and will require consultation and sign off as per processes. Joint working between the Integrated Health Communities and MHLD colleagues has led to an increases in the training on 'deteriorating patients'
Clinical Policy Reviews	The monthly position is reported to the MHLD service quality delivery group.
Effective working with third sector, carers, partners an stakeholders	The Patient and Carer experience meeting terms of Reference have been reviewed. CIVICA has been mapped across the MHLD division.
Prescribing and monitoring of antipsychotic medication	Regular audits on the use of antipsychotic drugs for older people are undertaken and reported to the Clinical Effectiveness Group. (Evidence of improvement)

Closing Statement

Alongside the mainly HB wide change programme/ strategic actions detailed in Section 1, **Appendix 1** provides the detailed responses to the recommendations.

By listening better to patients, families, carers and staff groups, and through the opportunity of an independently Chaired Expert Advisory Group, with robust Health Board Committee and Board oversight – the Board is committed to make significant progress in the service delivery areas highlighted in the various reviews scrutinised by the Royal College of Psychiatry. Thanks are extended via this report to the families who helped with this consideration so far. Further discussions will take place with Llais in formaulting the detail of the approach.

The HB is committed to making good progress on this work at a steady pace, with clear evidence that actions are completed, and real focus on moving forward collaboratively with patients and users, and families – to deliver safe and reliable care to the people of North Wales.

Royal College of Psychiatrists' Invited Review Services Report

Introduction

The Royal College of Psychiatrists' Invited Review Service (IRS), supported by the Royal College of Nursing Wales, was commissioned by the Welsh Government in 2023 to provide an external assessment of the extent to which recommendations from previous reports have been implemented and embedded into the delivery of services.

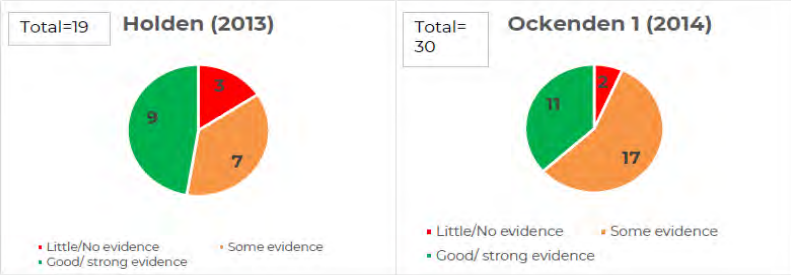
Over the past ten years several reports and reviews have been carried out across the health board, however this review focuses on the recommendations made in four reports; the Holden report from 2013, the first Ockendon report from 2014, the health and social care advisory service (HASCAS) report from 2018 and the second Ockenden report, also from 2018. There was a total of eighty-four recommendations from these four reports, covering all aspects of mental health care within BCU health board.

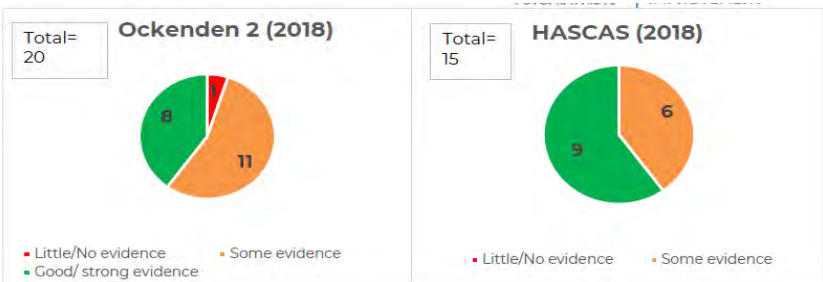
When the review team completed a thematic analysis across the reports, there were a total of 66 recommendations

37 were rated green (44%), 41 recommendations were rated amber (49%) and **6 were rated red (7%).**

Looking at the separate recommendations across each report the following were noted:

- First Ockenden report - 17 recommendations were amber, 11 green and 2 red
- Holden Report - 7 recommendations amber, 9 green and 3 red
- HASCAS report - 6 recommendations amber and 9 were green
- Second Ockenden report - 11 were amber, 8 green and 1 red.





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

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS | CCQI COLLEGE CENTRE FOR QUALITY IMPROVEMENT

Royal College of Psychiatrists' Invited Review Services Report
Mental Health and Learning Disability services in Betsi Cadwaladr University Health Board
May 2023 - December 2023
Commissioned by the Welsh Government

RESPONSE PLAN SUMMARY

Action Status	Completed	In progress and due within deadline	In progress, but not to deadline	Overdue and no recent progress	Total number of actions
Theme 1	0	6	0	0	6
Theme 2	0	7	0	0	7
Theme 3	0	8	0	0	8
Theme 4	0	2	0	0	2
Theme 5	0	2	0	0	2
Theme 6	0	3	0	0	3
Theme 7	0	3	0	0	3
Theme 8	0	3	0	0	3
Theme 9	0	2	0	0	2
Theme 10	0	2	0	0	2
Total	0	38	0	0	38

Total number of actions due to commence within timeframe.	41

Total number of RCPsych actions included in the plan	**79**

Royal College of Psychiatrists' Invited Review Services Report

RESPONSE PLAN

Theme one - RCPsych Feedback: Patient and user centred care	Theme one outcome:
The review team did not think that the health board was structured in a way that best meet the needs of older people. They did not see enough evidence of true partnership working and were concerned that the lack of electronic records made continuity of care difficult. There was some evidence of good partnership working and innovative practice, particularly in the regional secure unit.	Improved older adult and dementia care through a skilled workforce, improved communication, engagement and partnership working both strategically and operationally with service user, families, carer and wider stakeholder and partners.

Aim - Delivering safe and reliable patient centred care

	Agreed MH&LD Action	Target Date	Action Lead	Update	Action Status
1.1	Progress the recruitment of the MH&LD Nurse Consultant Dementia.	31/08/2024	Assistant Director of Nursing	EC approval obtained 5/6/24. Awaiting Welsh Translation of JD. Proposed interview date 30/7/24.	In progress and due within deadline
1.2	Achieve Finding the light in Dementia Care training compliance across the MH&LD Division to 85% for Tiers 1 (Informed/Foundation), Tier 2 (Skilled/Intermediate) and Tier 3 (Influencers/Advanced).	31/10/2024	Training, Development and Wellbeing Lead		
1.3	Strengthen partnership working through Together for Mental Health, including raising awareness of iCAN hubs by ICAN teams attending CMHTs to present activity locally on a regular basis to develop closer working relationships. (The Corporate Planning team will provide support to identify and enable opportunities that further support partnership working such as Third Sector, Local Authorities and other system partnership areas)	31/12/2024	Head of Integrated Strategy and Development		
1.4	Strengthen data capture of real time patient feedback and experience through the MH&LD Patient Carer Experience group incorporating the revised Service User and Carer Engagement Strategy to ensure embedded patient and carer centred care. (HB is committed to becoming an Intelligence Led and a Learning organisation, priorities outlined in the Three Year Plan will enable us to better understand patient needs, supporting proactive decision making and supporting better health an well-being outcomes)	31/12/2024	Head of Integrated Strategy and Development		
1.5	Re-establish local regular bi-monthly engagement with Head of Operations and Llais	31/10/2024	Head of Operations and Service Delivery		
1.6	Strengthen the model of patient and carer engagement.	31/12/2024	Assistant Director of Nursing	Currently underway in MH&LD PCE and dovetails with a BCUHB Engagement Group led by Helen Stevenson-Jones developing a BCU model.	In progress and due within deadline
1.7	Review Local Authority partnership working model in Community Mental Health Teams.	31/12/2024	Director of Operations		
	Agreed BCUHB Corporate actions	**Target Date**	**Action Lead**	**Update**	Action Status

1.8	Strengthen data gathering and consistent reporting aligned to Dementia Care until fully assured that BCHUB are in a position to provide reliable and accurate data to Welsh Government	31/12/2024	BCUHB Dementia Improvement Manager	Memory Assessment Service Improvement Group established to progress 4 work streams.	In progress and due within deadline
1.9	Improve Finding the light in Dementia Care training compliance across BCUHB for Tiers 1 (Informed/Foundation), Tier 2 (Skilled/Intermediate) and Tier 3 (Influencers/Advanced).	31/12/2024	BCUHB Consultant Nurse Dementia		
1.10	Ongoing engagement with Tawel Fan families.	31/12/2024	Director Of Partnerships, Communications and Engagement		
1.11	Ongoing engagement from Llais Wales, Patient Advice & Liaison Service, Canaid and wider partners and stakeholders aligned to patients and carer co-working.	31/12/2024	Director Of Partnerships, Communications and Engagement		
1.12	Involve Local Authority colleagues in the creation of our operational and strategic plans	31/12/2024	Director Of Partnerships, Communications and Engagement		
1.13	DoLS Application audit specific to MHLD to audit Quality, Compliance and Outcomes in line with DoLS Legislation. To influence Safeguarding Training developments to target the required learning outcomes evidenced by recognised themes.	30/09/2024	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	Registered on the 08.03.2024 (Within the period of 2024-2025)	In progress and due within deadline
1.14	Develop Data Incidents tool to support identification of incidents and those resulting in Harm involving patients with Dementia.	31/03/2025	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	The Safeguarding Dementia Lead and Safeguarding Data Analyst, in collaboration with the Dementia Nurse Consultant submitted a development Datix request. Approved by the BCUHB Quality Systems group in February and submitted to the Once For Wales Team. It is currently being reviewed within the Incident Work stream.	In progress and due within deadline
1.15	Develop supporting materials to support the application of MCA and DoLS.	31/05/2025	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	Easy read MCA/DoLS/Best Interest materials have been developed to provide staff working in various settings including those in isolated units with easily accessible information in an easily read format. These documents will be ratified, implemented and evaluated following the Safeguarding Reporting Framework.	In progress and due within deadline

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Theme two - RCPsych Feedback: Legislation and clinical guidelines	Theme two outcome:
The review team noted that in general, there were comprehensive training packages and regular audits in place. However, the review team did not find strong evidence of how wider learning was spread throughout the health board.	Improved processes in place for sharing and embedding wider learning from incidents and audit activity which informs training, clinical practice and appropriate action to reduce incidents and risks.

Aim - Delivering safe and reliable patient centred care

Agreed Action		Target Date	Action Lead	Update	Action Status
2.1	Ensure regular wider learning across the Health Board aligned to falls data captured from Datix.	31/10/2024	Assistant Director of Nursing		
2.2	Increase attendance at current tool box talks by consideration of establishing MH&LD Divisional Learning Forums developed across all teams. Monitor, review and report into monthly SQDG. 1. Therapeutic Engagement and Observation 2. Nurse in Charge 3. End of Life	31/10/2024	Governance Project Lead	Current MH&LD Divisional tool box attendance General Policies 554 staff attended TEO 602 staff attended End of life not yet commenced.	In progress and due within deadline
2.3	Increase RRAILS deteriorating training compliance across the Division from current level to 85% compliance. Monitor and review at MH&LD Training and Development Group meeting.	31/12/2024	Training, Development and Wellbeing Lead	Current MH&LD Divisional attendance 86 staff.	In progress and due within deadline
2.4	Progress the consultation, approval and implementation of the Physical Health Strategy.	31/03/2025	Medical Director	MH&LD Physical Health Strategy due to go out for consultation and a Divisional Implementation Plan is currently being developed.	In progress and due within deadline
2.5	Continue with the projected policy review, as provided as part of the NCCU Action plan.	31/03/2025	Head of Governance	MH&LD Policy Position paper presented at monthly Divisional Tier 1 Service Quality Delivery Group meetings.	In progress and due within deadline
2.6	Continue with annual audit of antipsychotic medication prescribing and subject it to audit and review at the medicines management committee.	30/09/2024	Deputy Medical Director (Chair of CEG)	MH&LD annual audit programme plan currently being developed by the Clinical Effectiveness Group and the Medicine Management Group.	In progress and due within deadline
2.7	Consider and agree use of tool for monitoring antipsychotic medication in inpatient settings	31/03/2025	Medical Director	MMG and Acute Care Pathway group to take forward considering CQST tool in the first instance.	

	in inpatient settings.				
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
2.8	BCUHB support to progress MH&LD being an early adopter of the Learning Organisation Framework (LOF).	31/03/2025	Senior Organisational Development Manager	Paper presented in OLM and DSLT to agree next steps of MH&LD early adoption of LOF	In progress and due within deadline
2.9	DoLS Audit to evidence learning and understanding of Safeguarding /MCA/DoLS Training. To inform Training packages and the development of training material as a result of the identification of training needs - Themes/Trends.	30/06/2024	Director of Safeguarding and Public Protection/Head of Safeguarding Adults	Registered DoLS audit specific to MHLD. A 7 minute briefing will be co produced with the findings and the actions taken and shared through IHC/MH&LD Safeguarding Forums/Case Supervision.	In progress and due within deadline

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RESPONSE PLAN

Theme three - RCPsych Feedback: Governance	Theme three outcome:
The review team was particularly concerned about the lack of an electronic records. The team was shown evidence of the 'putting things right' system and of safety huddles but staff reported that there was a lot of duplication and repetition in the various meetings. In addition, some patients the review team spoke to were not satisfied with how complaints had been addressed, and there were a number of overdue complaints. It was not clear that learning was spread throughout the board or reached staff all staff in clinical areas. The large number of posts being held on a temporary or interim basis was also a particular concern for the team.	For our patients to receive seamless care co-ordination through a fit for purpose, fully adopted Electronic Patient Record System in addition to an effective MH&LD Governance Framework from ward to board.

Aim - Optimal Service Delivery

Agreed Action		Target Date	Action Lead	Update	Action Status
3.1	Progress the Electronic Patient records business case for national procurement of an optimum system to replace WCCIS. This includes preparedness for significant changes to clinical and operational practice across BCU. Complete the procurement exercise during 2024 aiming for a digital patient solution to be operational in 2025.(Identified as priority area in the Health Boards Three Year Plan - 2024/27, and identified as priorityt area for DDaT)	31/12/2025	Head of Planning and Performance	Business Case for Electronic Patient Records developed, approved through Division due governance. Ongoing meetings held with Welsh Government to agree next steps.	In progress and due within deadline
3.2	Audit on call medical staff to ensure they have their own personal login for Paragon.	30/09/2024	Head of Operations and Service Delivery, SCS		
3.3	Progress the development of the MH&LD specific Ward Accreditation process. (Carried over from the NCCU Action Plan)	31/03/2025	Practice Development Nurse	Review and development of ward accreditation process more specific to MH&LD undertaken. Pilot of the newly developed Ward Accreditation process undertaken in the Ablett Unit during January to test suitable alignment with MH&LD. Ongoing account development, consultation and building of the software. Testing period to be agreed Q4 24/25.	In progress and due within deadline
3.4	Aligned to the outcome of the review of the MH&LD Operating Model commence socialisation and engagement of the proposal.	30/09/2024	MH&LD Director	Ensure support from WOD colleagues.	

3.5	Establish a Health Board Oversight Group to ensure delivery of the Response plan including the approach for evidence submission to discharge actions.	31/07/2024	TBC		
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
3.6	Ensure that a mechanism is developed for consistently sharing of all learning from Serious Untoward Investigations within MH&LD and the wider Health Board.	31/03/2025	Head of Governance	Paper presented in OLM and DSLT to agree next steps of MH&LD early adoption of LOF	In progress and due within deadline
3.7	Develop monthly Putting Things Right learning portal, as part of the development of the Learning Organisational Framework to enable Divisional wide and Health Board access to lessons are learnt.	31/03/2025	Head of Governance		
3.8	Support with engagement events aligned to the MH&LD Operating Model to ensure all staff, partners and wider stakeholder are kept updated on progress with implementation.	30/09/2024	Director Of Partnerships, Communications and Engagement	Once wider review is finalised and in conjunction with 3.4	
3.9	Support from Digital, Data Technology and Procurement colleagues to progress the implementation of Mental Health electronic patient records and change process.(Identified as priority area in the Health Boards Three Year Plan - 2024/27, and identified as prioritytyt area for DDaT)	31/12/2025	Chief Digital And Information Officer		
3.10	The development of an Integrated Complaints/Incidents/Mortality Review Management Framework. To implement an Integrated Framework aligning the Patient Safety and Experience Departments ensuring a consistent 5 step approach to the management of Complaints, Incidents and Mortality Reviews further streamlining the process and improving the process for staff and patients.	31/07/2024	Deputy Director of Quality	Paper to be submitted to Board in July following completion of task and finish group	In progress and due within deadline
3.11	Implementation of an agreed training plan for the Corporate and Operational teams in relation to Complaints Management and PALS.	01/12/2024	Head of Patient & Carer Experience	This action will commence once the Integrated Complaints/Incidents/Mortality Review Management Framework has been approved by Board in July 2024.	In progress and due within deadline
3.12	A further enhanced improved Complaints performance improvement trajectory (Linear Model) to support the achievement of the performance target for complaints closures by the 14th of October2024 for compliance of 75% of complaints responded to within less than 30 working days in line with PTR guidance.	14/10/2024	Head of Patient & Carer Experience	All IHC and Specialist Services are on Track to be compliant with the 75% target of overdue complaints with exception of the Central IHC who will be 61.34% compliant by the 14th Oct,2024 with current closure rate	In progress and due within deadline
3.13	Implementation of the Telephony System to support an improved single point of contact for the public to raise concerns/enquiries.	01/07/2024	Head of Patient & Carer Experience	Final IT system checks being undertaken before the system goes live on 1st July 2024.	In progress and due within deadline

3.14	Commence a formal campaign to promote how to raise concerns.	31/10/2024	Lead Complaint Manager and Patient & Carer Experience Lead		In progress and due within deadline

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RESPONSE PLAN

Theme four - RCPsych Feedback: Staffing	Theme four outcome:
A consultant nurse with specific responsibility for dementia within the directorate had not been appointed. The review team was concerned about the lack of psychological input and multidisciplinary working in the Hergest unit. There were ongoing difficulties in ensuring adequate staffing levels, however there had been many initiatives in recruitment and retention and the Streamliners programme was well received.	To have in place a fully appointed substantive divisional structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to have the right staff, with the right skills at the right time to meet the mental health needs of the population of North Wales currently and in the future.

Aim - Optimal Service Delivery

Agreed Action		Target Date	Action Lead	Update	Action Status
4.1	Recruit to the position of MH&LD Director of Nursing post.	30/11/2024	MH&LD Director	EC approval obtained 6/6/24, awaiting REMCOM approval.	In progress and due within deadline
4.2	Recruit dedicated Consultant Psychiatrist for the Hergest Unit.	31/12/2024	Medical Director		
4.3	Continue to progress the recruitment and retention activities aligned to the MH&LD Recruitment and Retention plan, with quarterly reporting through due governance with any agreed area of focus as determined by the Divisional Service, People and Culture Group.	30/09/2024	MH&LD Operational Business Lead	Weekly MH&LD Recruitment and Retention meetings held, with reporting into MH&LD Service, People and Culture Group meetings	In progress and due within deadline
4.4	Increase awareness and attendance of MH&LD staff at Dementia Essentials study days.	31/03/2025	Director of Nursing	Full day training on Person centred care, dementia friendly environments, EoLC/palliative care, antipsychotics use, patient positioning and deconditioning prevention.	
4.5	Review cover arrangements when Dementia Support Workers are vacant or on sick leave to ensure continuity of service provision.	30/09/2024	Director of Nursing		
4.6	To progress the Business Case for substansive funding for the MH&LD Wellness, Work and Us Service	01/10/2024	Director of Operations		

4.7	Consider the recruitment of dedicated dementia practice educator for MH&LD to support Dementia activity	31/03/2025	Director of Nursing		
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
4.8	Raise awareness and attendance of Health Board staff at Dementia Essentials study days.	31/03/2025	BCUHB Consultant Nurse Dementia		

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Theme five - RCPsych Feedback: Management structure	Theme five outcome:
The large number of interim posts was a particular concern to the review team, who were not clear that there was full multidisciplinary input at a senior management level and did not think that the older adults mental health services were adequately represented within the management structures.	To have in place a fully appointed substantive management structure, with an effective and efficient recruitment and retention plan focusing on attraction strategies to enable the Division to have stable leadership to support meeting the mental health needs of the population of North Wales currently and in the future.

Aim - Optimal Service Delivery

Agreed Action		Target Date	Action Lead	Update	Action Status
5.1	Continue to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model and in line with the wider Operating Model review	31/03/2025	MH&LD Director	Terms of Reference to progress all Divisional interim post has been developed and is currently progressing through due divisional governance for sign off.	In progress and due within deadline
5.2	Ensure that older adults mental health services are represented in the Directorate management structure.	31/03/2025	Medical Director		
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
5.3	Support to progress recruitment of interim posts to substantive posts aligned to the MH&LD Operating Model.	31/03/2025	Associate Director For People - Pan		In progress and due within deadline

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Theme six - RCPsych Feedback: Clinical services organisation	Theme six outcome:
It continued to be difficult to fulfil a substantive post in old age and adult psychiatry especially in the western sector and there was a lack of evidence of multidisciplinary working in the inpatient unit in Bangor. There was also a lack of access to psychological and occupational therapies there. The review team was concerned that the consultant nurse for dementia had not been appointed and the practice development nurses did not focus specifically on dementia care. There was no clear agreed model of clinical care throughout the health board.	All patients will have access to multi disciplinary support based on need to improve patient outcomes and patient experience.

Aim - Valuing learning, training and strengthening planning

Agreed Action		Target Date	Action Lead	Update	Action Status
6.1	Ensure robust multi-disciplinary ward rounds occur at the agreed frequency as determined within the Terms of Reference	30/09/2024	Medical Director	MDT ToR''s reviewed aligned to HIW Discharge Action Plan.	In progress and due within deadline
6.2	Develop dementia contribution within Practise Development Nurse role.	31/03/2025	MH&LD Consultant Nurse Dementia	To progress with support from BCUHB Consultant Nurse Dementia until MH&LD Consultant Nurse Dementia appointed	
6.3	Consider extending regional pilot of applied behaviourists working with patients with complex needs.	31/03/2025	MH&LD Consultant Nurse Dementia	To progress with support from BCUHB Consultant Nurse Dementia until MH&LD Consultant Nurse Dementia appointed	
6.4	Continue monthly Consultant Nurse Dementia led network meeting with all MHLD Activity Coordinators.	31/03/2025	MH&LD Consultant Nurse Dementia	To progress with support from BCUHB Consultant Nurse Dementia until MH&LD Consultant Nurse Dementia appointed	
6.5	Ensure all Centre and East Memory Assessment units attain MSNAP accreditation.	31/03/2025	MH&LD Consultant Nurse Dementia	West are currently accredited	In progress and due within deadline
6.6	Progress the pilot scheme for in reach workers in care homes, and expand to enable consistency of service provision.	31/03/2025	MH&LD Consultant Nurse Dementia	To progress with support from BCUHB Consultant Nurse Dementia until MH&LD Consultant Nurse Dementia appointed	
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
6.8	Continue monthly Consultant Nurse Dementia led network meeting with all Health Board Dementia Support Worker/Activity Coordinators.	31/03/2025	BCUHB Consultant Nurse Dementia		In progress and due within deadline

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RESPONSE PLAN

Theme seven - RCPsych Feedback: Training and development	Theme seven outcome:
The review team was concerned that there was little engagement with external networks. As noted earlier, further progress needed to be made in recruiting practice development and consultant nursing staff in the field of dementia care. The review team was pleased to see the board supporting healthcare assistants to train as nursing staff.	To ensure a skilled and developing workforce through the completion of identified training and learning opportunities including a programme of regular Divisional Learning Events with external speakers to enable an increase in networking with other organisations both within Wales and nationally.

Aim - Valuing learning, training and strengthening planning

	Agreed Action	Target Date	Action Lead	Update	Action Status
7.1	Strengthen external networking opportunities of ward staff across the range of Divisional services to enable sharing of best practise.	31/12/2024	Director of Nursing		
7.2	Implement an agreed HCA career pathway to "Grow your own" MH&LD nurses for the future in collaboration with Health Board, aligned to the annual plan reference working with educational providers of Higher and Further Education to enhance students experience	30/11/2024	Assistant Director of Nursing	MH&LD Recruitment and Retention group developing a paper for approval through Divisional governance.	In progress and due within deadline
7.3	Develop Divisional Learning Events rolling programme plan to include key external speakers to aid staff development. Link in with WOD colleagues regarding future themes from leadership events or topical themes within the Health Board	30/11/2024	Governance Project Lead	Next Division Learning Event planned for September 2024, focus on Wellbeing.	In progress and due within deadline
	Agreed BCUHB Corporate actions	**Target Date**	**Action Lead**	**Update**	Action Status
7.4	Review of DSW/Activity Coordinator JD to reduce variation in roles.	31/03/2025	BCUHB Consultant Nurse Dementia		In progress and due within deadline

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RESPONSE PLAN

Theme eight - RCPsych Feedback: Leadership and staff engagement	Theme eight outcome:
Overall, there was evidence of improved engagement with staff, but this was not completely consistent throughout the health board.	To ensure our MH&LD staff receive a clear and consistent level of information appropriate to their needs, underpinned by a communication and engagement strategy and action plan. This will support a culture of openness and honesty with the ability to challenge safely.

Aim - Delivering safe and reliable patient centred care

Agreed Action		Target Date	Action Lead	Update	Action Status
8.1	Implement the MH&LD Communication and Engagement Plan. (Form part of the Health Board overall Citizen Engagement Commitments, ensuring that plans and priorities are informed by what matters to citizens)	31/10/2024	Head of Integrated Strategy and Development	Draft MH&LD Communication and Engagement Plan currently progressing through due governance	In progress and due within deadline
8.2	Capture the themes and feedback from the bi-monthly "Ask Divisional Senior Leadership Team" virtual sessions to develop a "You said, we did, we are going to do" staff engagement. Report updates into Tier 1 Divisional meeting including DSLT and Service, People and Culture Group meeting and include summaries in the MH&LD Staff Briefing.	31/10/2024	Director of Operations	12 month DSLT Walkabout schedule commenced 17/6/24.	In progress and due within deadline
8.3	Agree the 12 month Divisional Senior Leadership Team Walkabout schedule for 24/25, incorporating all lessons learnt from current arrangements.	31/01/2025	Director of Operations		In progress and due within deadline
8.4	Creating a culture within the MH&LD service that is consistently compassionate and high performing.	31/03/2025	MH&LD Director		
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
8.5	Support with the implementation of the MH&LD Communication and Engagement Plan.	31/10/2024	Director Of Partnerships, Communications and Engagement		
8.6	Analysis staff survey findings, capture themes and agree actions and how we will strengthen communication and engagement with staff to improve and learn from good	31/10/2024	Director Of Partnerships, Communications and Engagement		

	practice.		Engagement		
8.7	Support the creation of a culture within the MH&LD service that is consistently compassionate and high performing.	31/03/2025	Associate Director For People - Pan		

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RESPONSE PLAN

Theme nine - RCPsych Feedback: Resources	Theme nine outcome:
The review team was concerned about the lack of access to psychological therapies for inpatients especially in the western sector, concluded that there needs to be more development of multidisciplinary working there and that the role of pharmacy needed to be further developed.	For our inpatients to be able to access multi-disciplinary support to improving their health which includes psychological therapies .

Aim - Fit for purpose resources and enablers

Agreed Action		Target Date	Action Lead	Update	Action Status
9.1	Review the role of pharmacy to consider further developing across the Division.	31/03/2025	Consultant Mental Health Pharmacist		
Agreed BCUHB Corporate actions		**Target Date**	**Action Lead**	**Update**	Action Status
9.2	Review the demand and capacity arrangements for therapeutic options available to all inpatient units to identify any gaps and agree next steps.	30/07/2024	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences has commenced the development of a gap analysis document aligned to an action from the HIW Discharge Action plan. Progress has been ongoing for the last 3 months.	In progress and due within deadline
9.3	For any identified gaps in therapeutic provision across inpatients units develop a business care where relevant for therapeutic staffing by accessing WG Improvement Funds.	31/10/2024	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences		In progress and due within deadline
9.4	Ensure this is regularly reviewed with a clear escalation procedure if further equipment/facilities are needed to ensure swift resolution.	31/03/2025	Assistant Director of Allied Health Professionals (AHPs) and Health Sciences		In progress and due within deadline
9.5	Dedicated resource from the Health Board Transformation and Improvement team to support with development of the action plan and for the transformation/improvement activity required.	31/12/2025	Director Of Transformation & Improvement		In progress and due within deadline

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RESPONSE PLAN

Theme ten - RCPsych Feedback: Physical environment	Theme ten outcome:
The review team recommend that urgent attention is given to ensuring that all remedial works necessary to ensure patient safety are completed, and this particularly applies to ligature risks. There was no clear timeline to ensure that the recommendations made by Health Improvement Wales and the National Collaborating Commissioning Unit (NCCU) in recent inspections were carried out.	A MH&LD Capital and Estates Strategy which will ensure that we have short, medium and long term plans so estates and all patient environments remain fits for purpose currently and in the future.

Aim - Fit for purpose resources and enablers

	Agreed Action	Target Date	Action Lead	Update	Action Status
10.1	Strengthen escalation of any outstanding remedial environmental estates works from local area Estates meeting through to the MH&LD Capital and Estates meeting.	30/07/2024	Head of Operations and Service Delivery	Controlled memo circulated May 2024.	In progress and due within deadline
10.2	Progress Environmental Ligature Risk Assessment Audit, report outcome through Tier 1 meeting to progress actions to completion.	30/09/2024	Governance Project Lead	Audit methodology approved at NCCU meeting.	In progress and due within deadline
10.3	Provide six monthly update on progress of NCCU Action plan.	31/08/2024	Director of Operations	NCCU Inpatient Safety Group continue to meet fortnightly, current position of NCCU Action plan is 73% completed.	In progress and due within deadline
	Agreed BCUHB Corporate actions	**Target Date**	**Action Lead**	**Update**	Action Status
10.4	Support progressing necessary actions for any outstanding remedial environmental MH&LD estates works escalted to the Divisional Estates and Capital Group or the Divsional Ligature Risk Reduction Group using a Tripartate approach within their area of expertise to enable safe environments to be maintained.	31/03/2025	BCHUB Estate Operations Manager		
10.5	Support progressing necessary Divisional Capital Estates works as part of the annual plan to ensure all works are captured.	31/03/2025	BCHUB Head of Capital Development		In progress and due within deadline
10.6	Support from Health and Safety aligned to ensuring an appropriate physical environment for patient including the ligature tripartite risk assessments.	31/03/2025	BCHUB Assistant Director Of Occupational Health, Safety And Security Corporate Office	Encompassed in MHLD 0056 and in the H&S Three Year Strategy, which had an action to complete tripartite inspection for all inpatient units, which is completed and now extended to the MH&LD outpatient setting, partially completed.	In progress and due within deadline
10.7	Support from Health and Safety to continue to provide advice, support and lead on the Ligature Environmental Risk Assessment training for staff.	31/03/2025	BCHUB Assistant Director Of Occupational Health, Safety And Security Corporate Office	On going training undertaken, latest attendance figures. H & S colleagues noted commitment to training dates 1 per month for the remainder of 2024, all programmed with SN delivering and other Advisors able to step in if required. To consult with MH&LD and Corporate Nursing on plans going in to 2025 e.g. spreading out among our trainers or converting to a training video/slide deck on ESR. Guidance and risk assessment template for non-	In progress and due within deadline
10.8	Support from Health and Safety to continue to undertake ad-hoc health and safety inpatient inspections.	31/03/2025	BCHUB Assistant Director Of Occupational Health, Safety And Security Corporate Office	Part of usual Advisor duties as needed as per Policy HS01 under competent advice and inspection, all local H & S advisors trained to the same standard, regard this action as completed.	In progress and due within deadline

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

Teitl adroddiad: ***Report title:***	All Ages Mental Health Digital Solution
Adrodd i: ***Report to:***	Health Board meeting
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	Presentation of the Outline Business Case (OBC) for All Ages Mental Health Digital Solution. All Ages Mental Health and Learning Disability (MH&LD) Services in BCUHB require significant change and modernisation. It is imperative that this change is acted upon now or BCUHB will continue to contribute to preventable deaths, having a major negative impact on patients, their families, friends and communities.
Argymhellion: ***Recommendations:***	The Health Board is asked **to approve** the All Ages Mental Health Digital Solution Business Case.
Arweinydd Gweithredol: ***Executive Lead:***	Dylan Roberts, Chief Digital and Information Officer Teresa Owen, Interim Exec Director Mental Health
Awdur yr Adroddiad: ***Report Author:***	Andrea Williams, Assistant Director – Digital Delivery, Strategy and Engagement

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	There are a large number of strategic objectives that this programme will support the delivery of. These include: - A Healthier Wales: Our plan for Health and Social Care (2021) - Well-being of Future Generations (Wales) Act 2015 - National Clinical Framework (2021) - Digital and data strategy for health and social care in Wales (2023)

	- Together for Mental Health Strategy and Action Plan for Wales 2012 (Refresh due *2024)* - Strategic Programme for Mental Health – Mental Health outcomes and measures
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The MH&LD service has specific responsibility to deliver on the requirements of the Mental Health Act, Mental Capacity Act and the Mental Health Measure (Wales) which the All Ages Mental Health Digital Solution will support: Mental Health Act Mental Capacity Act Mental Health Measure This Business Case responds to the Mental Health Improvements required under Special Measures, Health Inspectorate Wales (HIW) Inspections, other external reviews, including the Royal College of Psychiatrists report 2023, and the following Coroners Regulation 28 notices: Prevention of future deaths report - Courts and Tribunals Judiciary 08/06/2023 (Ref:2023-0185) Prevention of future deaths report - Courts and Tribunals Judiciary 14/09/2023 (Ref: 2023-0333) Prevention of future deaths report - Courts and Tribunals Judiciary 08/09/2023 (Ref: 2023-0322)
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	It has been identified that an Integrated EqIA is required. This will be completed alongside this business case and a draft will be provided with the Full Business Case and so will be approved prior to the start of the implementation process. A wider EqIA has been developed for the Digital Roadmap which this programme is part of.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	It has been identified that a SEIA is required. This will be completed alongside this business case and a draft will be provided with the Full Business Case and so will be approved prior to the start of the implementation process. A wider SEIA has been developed for the Digital Roadmap which this programme is part of.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper,***	**BAF SP13** - There is a risk of failing to meet the Health Board's strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled projects and change. **CRR 24-07** - There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm. **CRR24-17** There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber-attack.

including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The financial appraisal over a 7-year period, for the preferred option is as follows: Total 7-year Project Cost (£18,515m including £393k cost savings subject to further validation). This is highlighted in the table below:

		Programme				BAU		
		Year 1* 24/25 **£'000**	Year 2 25/26 **£'000**	Year 3 26/27 **£'000**	Year 4 27/28 **£'000**	Year 5 28/29 **£'000**	Year 6 29/30 **£'000**	Year 7 30/31 **£'000**
WG Funding Required	Revenue	658	3,322	3,282	3,571	0	0	0
	Capital	0	575	575	0	0	0	0
BCUHB Contribution**	Revenue	545	974	974	974	941	941	941
	Capital	0	0	0	0	0	0	558
Total Savings				25	50	106	106	106
Total Project Cost	Revenue	1,203	4,296	4,231	4,495	835	835	835
	Capital	0	575	575	0	0	0	558

*Year 1 is for 6 months only

**Includes current staffing from the non-recurrent transformation fund

The Welsh Government are not expected to pay for any further costs when the Project goes into business as usual (Year 5), this becomes a cost pressure of £835k per annum for the Health Board.

It is recognised that further work is required to be undertaken to make the project cost neutral from year 5 onwards as the project goes into business as usual. There is a commitment from the service, supported by Digital, Data and Technology (DDaT) that this will be delivered, and budgets will be aligned at that time. A benefits lead has just been appointed within DDaT to drive this work forward collaboratively, this will involve the validation of the already stated benefits and the identification of further cash releasing and non-cash releasing savings.

At the Outline Business Case (OBC) stage the costs are only estimates and it is expected, due to the procurement approach that the supplier costs will be less than stated.

The further cash releasing and non-cash releasing savings and the actual costs will be presented in the Full Business Case. (FBC)

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	In addition to the existing staff (funded from the non-recurrent transformation reserves that has been subject to RIGA) the equivalent of an additional 20 WTE (the majority of whom are from the MH&LD service) have been identified to support this change. Some of these posts may be backfilled from existing posts within the service.

Workforce implications as a result of implementing the recommendations	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The OBC has been developed jointly by All Ages MH&LD and DDaT Requirements gathering has been undertaken across All Ages MH&LD and a wide range of staff have engaged. Work previously done as part of Connected Care Programme has been incorporated where it can be for future National Fit. Early feedback has been provided by Welsh Government and appropriate amendments made. The OBC has been shared with Judith Paget, CEO of NHS Executive, Ciara Rogers, Director of Mental Health and Mike Emery, Director of Digital – Welsh Government. Welsh Government support the imperative for BCUHB to invest in a Mental Health EPR and the associated clinical and business change. They commit to work with the Health Board to address the funding requirements as a priority. This case will be reviewed at the Welsh Government investment panel on 25 July, prior to a recommendation being made to the Cabinet Secretary for Health and Social Care. The Outline Business Case was presented to the Performance, Finance and Information Governance (PFIG) Committee on the 25th June 2024 and it was agreed that the Business Case was required to be cost neutral and clarification on this was to be provided within the Board report, this has been completed and can be found in the financial implications section. (Please note: the action minutes from PFIG have not been agreed at the time of writing)
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Risks are covered above.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	

Camau Nesaf:
Gweithredu argymhellion
 	
Next Steps:
- If approved:
  o Continue to work with the Welsh Government to secure funding
  o Development of the Full Business Case strengthening the benefits

Rhestr o Atodiadau: Appendix A – MH Draft Case Final Draft v.03 (Appendix B – Business Case Appendices available to Board Members on request)

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

All Ages Mental Health Digital Solution

Business Case

'Finding a Mental Health Digital Solution for people of all ages in North Wales, transforming the way we provide care to save lives...'

Division / Area / Department	**Mental Health, Learning Disabilities, Child and Adolescent Mental Health and Digital and Data and Technology**
Development or Scheme Title	**All Ages Mental Health & Learning Disability Digital Solution**
Author/s	All Ages Mental Health Project Team
Executive Sponsor	Teresa Owen/Dylan Roberts
Version	**V0.3 Final Draft**
Date	**03/06/2024**

Version Review and History

Version	Date	Reviewers/Contributor	Description
0.1	23/05/24	MH Steering Group members	Final Draft 0.1
0.2	29/05/24	MH Steering Group members	Further Amendments 0.2 - sent to Lauren and Dylan for review
0.3	30/05/24	MH Steering Group members	Outstanding actions from previous version comments 0.3

Document Approvals

Version	Date	Name	Role
V0.3	03/06/2024	Andrea Williams	Assistant Director – Digital Delivery and Strategy
V0.3	03/06/2024	Anita Pierce	Senior Responsible Officer
V0.3	03/06/2024	Dylan Roberts	Chief Digital & Information Officer
V0.3	03/06/2024	Teresa Owen	Executive Lead
V0.3	05/06/2024	Executive Team	Various
V0.3	10/06/2024	Mental Health Project Board	Various
V0.3	11/06/2024	Welsh Government	
V0.3	20/06/2024	Children and Adolescent Mental Health Service (CAMHS) Senior Management Team	
V0.3	21/06/24	MH&LD Divisional Senior Leadership Team (DSLT)	
V0.3	25/06/24	Performance, Finance & Information Governance Committee	
	25/07/24	Health Board	

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Patient Story - Bryn

It was to be a fresh start. Bryn decided to move closer to his mother. He had several admissions over the years and involvement with Mental Health teams for his schizophrenia, including support from forensic and substance misuse services. Bryn had a good relationship with his care coordinator (CCO) Alys.

However, on the break-up of his relationship with his girlfriend, Bryn took an overdose in May 2022. Due to failing liver function his treatment was changed from depot antipsychotic to oral medication and his liver function started to improve.

He remained well.

Following inpatient treatment and discharge he decided he wanted to live closer to his family who lived in another county. It did mean that the Mental Health team who supported him and his CCO Alys would no longer be involved in his care. Bryn was however reassured that the Mental Health team in the new area would provide similar services and a new care coordinator would be appointed.

Alys contacted the new team and planned for transfer, sharing the Care and Treatment plan, risk assessment and Mental Health Measure paperwork, which were sent over by secure email to a specified email address. The case was discussed the next day in the new team referral meeting and a request was made to receive the paper files which include historical records, which would enable the team to decide on allocation of the patient to service. After handing over the case file to the admin staff for transfer to the new Mental Health service, Alys closed Bryn's case on her SharePoint list.

Each Community Mental Health Team (CMHT) has a standalone SharePoint list, and cases could not be transferred between SharePoint systems. They must be 'opened' in the new SharePoint and 'closed' on the old one manually.

The paper files were received a week later in the new team and were not addressed to any specific individual. Reception staff and filing administrator were not alerted about the request for case notes. On arrival, the case notes were stored in the records filing area.

Three months later in March 2023 Bryn contacted Alys and left a voice mail about his Personal Independence Payments (PIP) being stopped. She attempted to call him back, but the call went to voicemail. She advised him to check for payments in the following days as there may have been a delay, as was the situation in previous years.

A week later Bryn ended his life. He was never opened to the new team

There is no assured workflow to alert and track activity plans, there is no closed loop to confirm receipt or handover of requested information, no means of prioritising patients when they move teams or areas or joined up working or risk stratification of patient lists.

The lack of effective hand-over, visibility of the patient record across sites due to fragmented, siloed systems and continued reliance on paper to share information and inability to schedule automated alerts and notifications contributed to this person's death.

Bryn's death was reviewed by the coroner who undertook a detailed review of his case. Through a Regulation 28 notification to prevent future deaths the coroner communicated concerns to Ministers.

Staff Story – Nia

It was a dream to be promoted to a Band 3 Team secretary in the mental health team for Nia. She felt valued and enjoyed a sense of achievement.

She commenced work full time managing paper-based case files, sharing information, organising records, uploading information onto various databases and transferring files between locations covering a large geographical area.

As time went on, she felt increased pressure to keep abreast of her commitments, juggling various case files and records for the team and using several databases to add similar information repeatedly and she started making mistakes including mislocating files. This led to a strained relationship with her manager and Nia went off sick from work. She did not want to burden her colleagues with her own work, but she felt there was no resolution to what she felt were unsurmountable problems with handling such large volumes of case files and information. Her mental wellbeing deteriorated, and she had thoughts of suicide. She was actively supported by the "Wellness Work and Us" project and helped back to return to work. Nia reflected that, the geographical area and the volume of case files she must work with, as well as complexity of maintaining paper files will likely cause future difficulties for her and will seek support.

These are just some of several stories that illustrates the need to move to a digital solution to ensure such experiences and failings in sharing information, handovers and alerting are not repeated.

1. Executive Summary

The executive summary will summarise each section of the case.

1.1 Introduction

All Ages Mental Health and Learning Disability (MH&LD) Services in BCUHB require significant change and modernisation in workflows, consistency in clinical delivery, process and practice that can only be enabled by a Mental Health Electronic Patient Record system.

This is our business case to procure, deploy and undertake the change underpinned by an enabling digital solution for MH&LD services for all ages in North Wales, delivering against our ambition of ensuring that our services are efficient, safe, timely and accessible for people who deliver and rely on, as well as use these services.

This will be a transformational change in the way we present and share health care records and will make a significant difference to the quality and safety of care as well as the patient and carer experience. It recognises that digital transformation is, an enabler and this case is far more than simply introducing information technology but also about embracing a culture of continuous improvement, safety and quality, transformation and innovation.

We recognise that a new system will require standardisation of our process and practice across the Health Board, adopting best practice and targeting unwarranted variation through standardised workflows. We will improve data capture, support increasing analytics across our services which will enable us to better report on performance, track productivity gains and benefits, be transparent in our ways of working and ensure consistent delivery of key statutes such as the Mental Health Act and the Mental Health Measure.

It is also about enabling the best of our workforce through standardised workflows and careful resource management to deliver systematic high quality coordinated care. This is also about re-writing the relationship with the people of North Wales by enabling systems to support engagement, communication and involvement and ultimately improve patients and carers experience and outcomes.

We acknowledge we are behind in the use of digital technologies, and a mental health electronic health record is a standard component of a modern health system architecture, it is considered a "must have" system.

It is imperative that this change is acted upon now or BCUHB will continue to contribute to preventable deaths, having a major negative impact on patients like Bryn, their families, friends and communities.

This OBC (Outline Business Case) has followed the Green Book (2018) guide following the 5-case model, the five cases summarised below have been developed to secure investment to enable the significant change required to improve the services.

1.2 Strategic Case

MH&LD is a large and complex service, spread over 200 locations across North Wales with over 2,300 staff, supporting 33 speciality services for the population of North Wales and some cross border residents. The BCUHB are the least digitally enabled across NHS (National Health Service) Wales and has no digital provision in core and crucial services, and where present, it is disparate.

The service is currently reliant on paper records and this lack of digital enablement has been identified as:

- a contributory factor to patient deaths by the H.M Coroner within regulation 28 reports
- an issue for resolution in numerous Health Inspectorate Wales (HIW) reports and external reviews
- contributing to variation in clinical decision-making putting patients at risk and delivering unwarranted variation
- contributing to poor staff retention/recruitment and poor job satisfaction

14 risks have been identified with the following being the highest, mitigation actions are provided in the case.

Risk Score – 25

- Management of legacy and current case load paper records are not resolved before a digital system is implemented

Risk Score – 20

- National funding may not be available to purchase a suitable system/fund implementation
- Local funding may not be available to purchase a suitable system/fund implementation

The project strategically aligns to the National and Local Strategies including the Ministerial Priorities and without this project BCUHB will fail to be able to deliver some of these strategies and priorities.

1.3 Economic Case

The outcome of the economic appraisal indicates that the Preferred Option is Option 3 - Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed"

Net Present Value (NPV) identifies that Option 3, provides better value for money as shown in the table below:

Net Present Value (NPV)	
Option 3 - Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed"	**Option 4** - National system procurement of "Best of Breed" under the Connecting Care Programme
£8,398,000	**£10,235,000**

<u>Summary of the benefits</u>

- Avoidance of deaths, quality and safety of care through clinical teams having access to the patient's record and alerted of any significant issues in a timely manner.
- Ability to deliver on regulatory compliance requirements.
- Increased productivity through seamless handovers, easy recording of information and automated workflows.
- Recruitment and retention of staff improvements as there is an electronic system which is the norm in other organisations.

Cost avoidance of expensive DHCW (Digital Health and Care Wales) Service Level Agreement costs. Specific, measurable, realistic and achievable measures will be developed as part of the procurement and change process.

1.4 Commercial Case

The Commercial Case provides the overview of the Procurement Strategy and the BCUHB approach to delivering this in collaboration with NHS Wales Shared Services Partnership (NWSSP).

Four procurement options have been identified that BCUHB are able to use. This assessment incorporated the work undertaken nationally by Perago and InForm for DHCW.

The London Procurement Partnership (LPP) Framework – Further Competition, has been selected as the recommended procurement route. Further market engagement will be undertaken assess the suitability of products and services and the estimated contract start date is expected to be 1st April 2025.

The recommended evaluation criteria used will be 70% Technical/Quality and 30% Commercial.

1.5 Financial Case

The Financial Case reflects the scale and complexity of the project, especially in relation to the amount of change required to move from paper (plus various systems) to digital.

The financial appraisal over a **7-year period**, for the preferred option is as follows:

Total 7-year Project Cost (£18,515m including £393k cost savings subject to further validation). This is highlighted in the table below:

		Programme				BAU		
		Year 1* 24/25 **£'000**	Year 2 25/26 **£'000**	Year 3 26/27 **£'000**	Year 4 27/28 **£'000**	Year 5 28/29 **£'000**	Year 6 29/30 **£'000**	Year 7 30/31 **£'000**
WG Funding Required	Revenue	658	3,322	3,282	3,571	0	0	0
	Capital	0	575	575	0	0	0	0
BCUHB Contribution**	Revenue	545	974	974	974	941	941	941
	Capital	0	0	0	0	0	0	558
Total Savings				25	50	106	106	106
Total Project Cost	Revenue	1,203	4,296	4,231	4,495	835	835	835
	Capital	0	575	575	0	0	0	558

*Year 1 is for 6 months only

**Includes current staffing from the non-recurrent transformation fund

The Welsh Government are not expected to pay for any further costs when the Project goes into business as usual (Year 5), this becomes a cost pressure of £835k per annum for the Health Board.

All identified costs and any further potential cash-releasing savings from year 5 onwards will be revisited in the Full Business Case once preferred solution and scope is clear.

It is recognised that further work is required to be undertaken to make the project cost neutral from year 5 onwards as the project goes into business as usual. There is a commitment from the service, supported by Digital, Data and Technology (DDaT) that this will be delivered, and budgets will be aligned at that time.

1.6 Management Case

The Health Board is mature in relation to digital project delivery, and this case clearly sets out how the project will be managed through recognised best practices. This will ensure that the project is deliverable and will deliver what it is setting out to achieve. The level of change is large and complex with a delivery approach of being clinically led and digitally enabled, with users needing to be seconded over to the programme and therefore backfilled as part of delivery. It is expected that the people and process changes will be more significant than the technology implementation.

There will be strong senior leadership and sponsorship of this project from the Executive Team coupled with clinical SRO.

A range of external specialists may be required including change management, technology assurance, clinical safety, DHCW, NWSSP and the NHS Executive.

It is expected that total project implementation through to benefits realisation, including procurement will be 3.5 years (6 months for procurement)

A Change Management Strategy will be developed collaboratively with end users, this approach is important due to the level of change and the involvement of end users.

1.7 Approval Route and Timescales

Date	Approval
5th June 2024	Executive Team
10th June 2024	Mental Health Project Board
20th June 2024	Children and Adolescent Mental Health Service (CAMHS) Senior Management Team
21st June 2024	MH&LD Divisional Senior Leadership Team (DSLT)
25th June 2024	Performance, Finance & Information Governance Committee
25th July 2024	Health Board
TBC	Welsh Government

End of Executive Summary

2. The Strategic Case

Part A: The **Strategic Context**

2.1 Organisational Overview

BCUHB was created on the 1st of October 2009, following the dissolution of two North Wales NHS Trusts and six Local Health Boards. It is the largest health organisation in Wales, providing a full range of primary, community, mental health and acute hospital services to more than 700,000 people across the six counties of North Wales (Ynys Mon, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham), with the more densely populated areas in the region situated around an urban strip roughly following the northern coast/A55 and English border.

The Health Board employs over 19,000 staff and has a budget of approximately £1.87 billion. It is responsible for the operation of three district general hospitals (Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd near Rhyl, and Wrexham Maelor Hospital) as well as 19 other acute and community hospitals, and a network of over 90 health centres, clinics, community health team bases and mental health units. It also coordinates the work of 121 GP practices and NHS services provided by North Wales' community dentists, opticians, and pharmacies. The Health Board boundaries encompass around a third of the landmass of Wales and include 23% of the Welsh population.

Much of our acute hospital, primary and community services are managed within three Integrated Health Communities (IHCs) – West, Central and East which include CAMHS services. Adult Mental Health and Learning Disabilities, Women's health, Cancer Services, diagnostic and therapy services are managed as Pan North Wales specialty services.

We provide general and specialist services to patients in North Powys and to English border patients and conversely some North Wales residents' access healthcare services and support outside of the area. Service provision outside North Wales is typically for specialist healthcare such as cardiac surgery and neurosurgery, from providers located in the northwest of England.

Addressing the needs of the population of North Wales to improve lifelong health and well-being and tackle inequalities is the overarching aim of the Health Board.

2.2 Current National Overview for Mental Health, Community and Social Care Systems - Connecting Care

The Welsh Community Care Information Solution (WCCIS) programme is a DHCW responsibility and was established in 2015. The aim of the programme was to support the delivery and implementation of a national digital solution for Social Care, Mental Health &

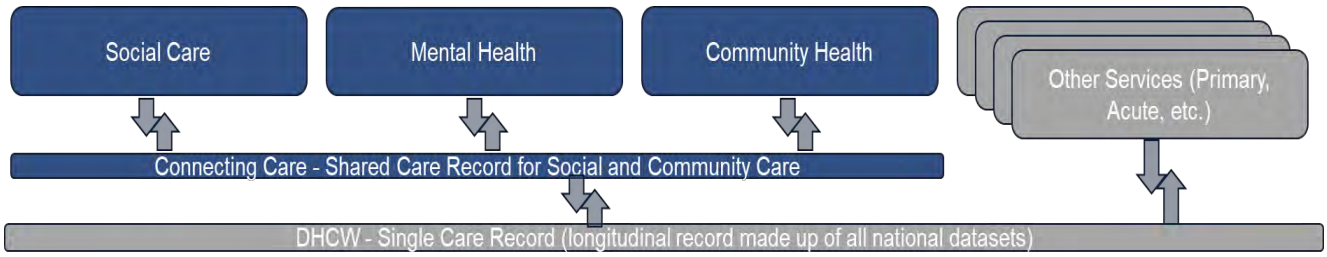
Learning Disability services and Community Health Care Services with a focus on integration across these services within the community. As part of this programme, WCCIS' procured Care Director product was identified as the single digital solution for all services including MH&LD within BCUHB. Adult and Childrens MH&LD services have engaged with the programme from the onset.

The original intent was for BCUHB to have digital mental health services by 2018, but delays with development pushed back this date numerous times. Due to the length of delays nationally, the Auditor General for Wales undertook an audit in October 2020. The following year a strategic review of the WCCIS Programme was commissioned by the WCCIS Leadership Board and WG. At this point, the WCCIS solution had not been implemented in BCUHB and Mental Health services continued to rely on paper and manual processes to manage their patients.

In 2023 WG made the decision that the WCCIS programme would cease, and the National Programme Team outlined recommendations for a way forward, supported by Welsh Government.

The new programme to deliver systems previously outlined under the WCCIS programme is known as 'Connecting Care'. The connecting Care Programme sets out to deliver the following objectives:

- Provide a Shared Care Record for citizens' data to support improved care
- Procure and implement 'Best Fit' solutions for Social Care and Health organisations at pace
- Adopt national data standards and standardised digital processes to support the provision of improved care



An all-Wales business case is currently being drafted by the National Connecting Care Team for all systems within the programme. An outline business case was submitted to Welsh Government in August 2023 which was approved and the case to secure funding was due to have been submitted on 1st March 2024. However, this has been subject to delay, and it is now anticipated to be submitted in June 2024.

There is significant risk associated with the Social Care work stream of the Connecting Care programme and therefore it has been identified as a priority in the national programme. The risk is due to the number of organisations (currently 18) that need to procure new system(s) in order to move from their existing platforms which are approaching obsolescence.

Throughout the last nine years, the promise of a national solution has prevented BCUHB from pursuing an alternative, forcing continued reliance on paper and manual processes which have contributed to causing harm to patients.

Due to the critical urgency and harm being caused, BCUHB has taken ownership of the issue and developed this business case to deliver what is required at a rapid pace, whilst still meeting the vision of Connecting Care and being able to connect into and contribute to the development of the shared care record.

2.3 Services Overview

2.3.1 Adult Mental Health & Learning Disabilities

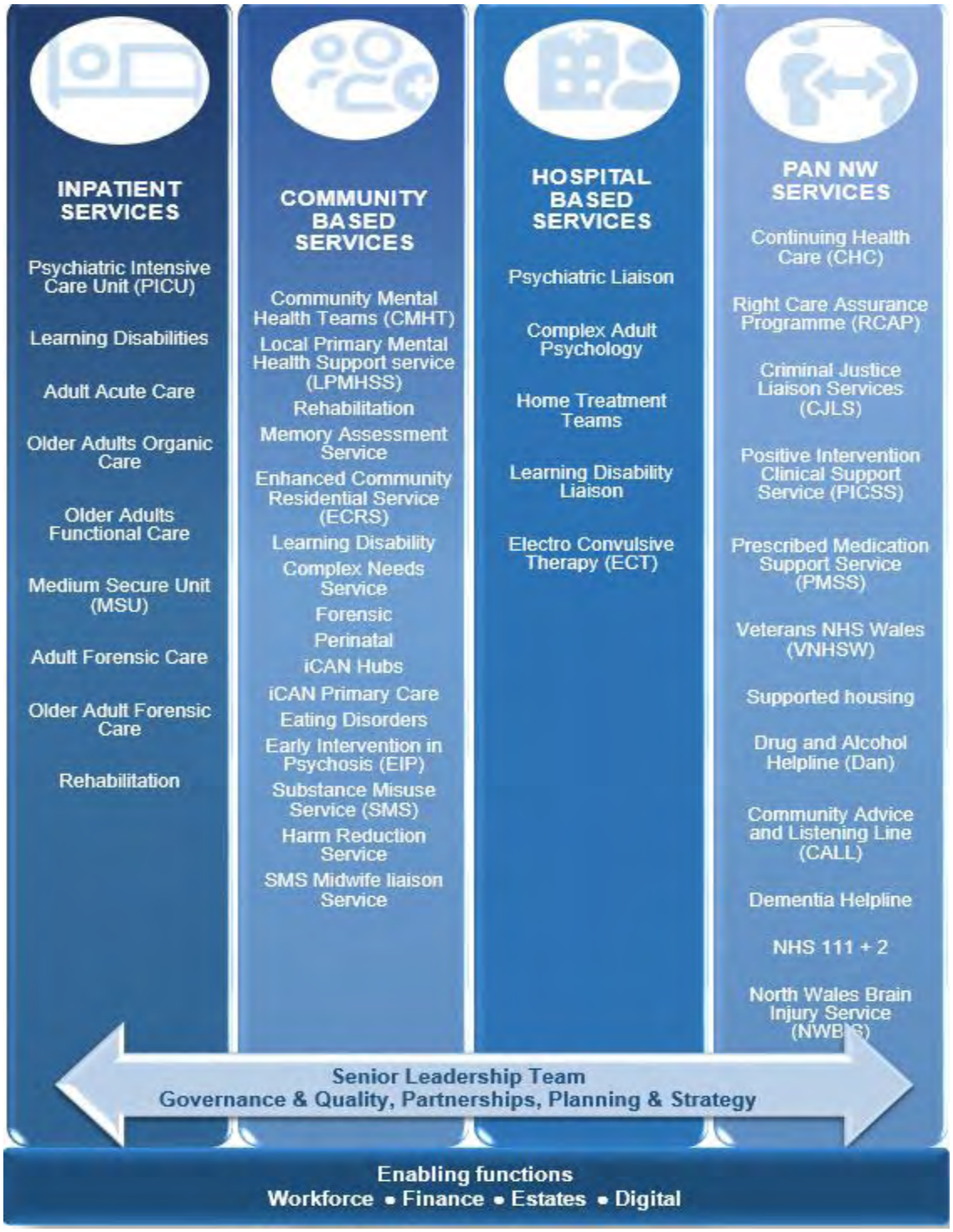
Adult Mental Health and Learning Disabilities provide and commission Mental Health and Learning Disability treatment, support and advice services to citizens aged 18 and over across the six Local Authority areas of North Wales and to the citizens of north Powys. They also host the national helplines for Wales; Community Advice & Listening Line (CALL), Dementia Helpline and Drug and alcohol Network (DAN).

The service operates from several acute, community and partner sites across North Wales, delivering inpatient and outpatient services, as well as providing telephony and online services. All of this is delivered with a workforce establishment of 2,048 employees that is bolstered by our partnership working, our commissioned services and our dedicated volunteers.

The range of services is broad and complex and in recent years has grown due to investment in services including Eating Disorders, Perinatal and Early intervention in Psychosis. The range of services broadly fit into our service area categories of Mental Health, Learning Disabilities and Substance Misuse Services. These areas although distinct, do have cross cutting themes and dependencies and each has a range of 33 specialty areas within them. The services and speciality areas are shown in Image 2.

This highlights that the service is highly specialist and complex with significant dependencies between the services, and that an electronic patient record is essential to enable visibility across geographies wherever they may present.

Image 2: Mental Health 18 Years and over services



2.3.2 Child and Adolescent Mental Health Service (CAMHS)

Children's Mental Health Services including CAMHS, Learning Disability and Neurodevelopment Services provide and commission services to children and young people from birth to the age of 18 across the 6 local authorities and Tier 4 specialist services for the citizens of North Powys.

The service operates across multiple community sites, inpatient settings and partner sites across the region including into education settings. Both face to face and virtual consultations are offered. This is delivered by a wide multi-disciplinary team across the region including over 300 staff from a wide variety of clinical disciplines supported by wider services including third sector and externally commissioned providers.

The range of services provided is broad and complex and has significantly grown with additional investment into the service, particularly around Crisis Care, Eating Disorders and Early Help. The service provides an integrated model of care to support delivery of care across the 4 tiers of services as indicated in image 3. Providing support for children who experience emotional, behavioural, and other psychological difficulties, including support for their families.

CAMHS is like the over 18 services as they are also highly specialised, have dependencies between the Tiers and the need to become digitally enabled, particularly considering safeguarding reviews over recent years highlighting the lack of digital systems.

Image 3 - CAMHS Services

Further information in relation to the service challenges and drivers are included in Section 2.4 Current Position, Business Strategy and Aims.

2.4 Current Position, Business Strategy and Aims

2.4.1 Current Position

2.4.1.1 Profile of Mental Health and Wellbeing in North Wales

North Wales has a population of just over 688,000 residents with the overall population of BCUHB predicted to increase to 718,830 by 2043 (Office of National Statistics (ONS)). The most significant population change within this period, will be seen in the number of residents aged 65 years and over which is predicted to increase by just over 28%; the number of children and young people aged 15 years and under is set to decline by just over 5%.

Our 2022 Population needs assessment demonstrates that:

- 93,800 adults in North Wales are estimated to have a Common Mental Disorder
- 9290 children aged 5 – 16 are estimated to have a mental health problem
- 3,630 adults (16+ years) are registered as having a learning disability a rate of 516 per 100,000 which is higher than the all-Wales rate of 487.
- 770 children (0 – 15 years) are registered as having a learning disability a rate of 618 per 100,000 which is higher than the all-Wales rate of 416. - Wales and North Wales figures do not include Anglesey
- In 2017 we had 11,200 people living with dementia in North Wales. Due to the ageing profile of North Wales this is set to rise, with predictions of an increase on the 2017 figures of 64% by 2035
- During the period 2017-2021, the BCUHB suicide rate was the same as the Wales rate (12.2 per 100,000 persons aged 10 years and over, rates ranged from 10.7 per 100,000 in Conwy to 13.8 per 100,000 in Gwynedd (Public Health Wales, 2022). There are further factors that need to be considered in understanding how the risk of experiencing poor mental health and wellbeing may differ amongst different groups in the population (BCUHB Public Health Team, 2021).

2.4.1.2 Special Measures

On 27 February 2023, the Minister for Health and Social Services took a decision to invoke the NHS Escalation and Intervention Arrangements (2014) which sets out the process for acting on serious concerns and raised the escalation level of BCU to special measures. This decision was taken due to serious concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management.

The response, which is our approach to addressing the concerns raised, was approved at the BCUHB Health Board meeting on 25 May 2023. It covers our five core outcomes:

- Be a well-functioning Board
- Have a clear, deliverable plan for 2023/24
- Have stronger leadership and engagement

- Have improved access, outcomes, and experience for citizens
- Be a learning, self-improving organisation

The Health Board prioritised actions to address identified areas for improvement through Special Measures within the annual plan for 2023/24 and now within the 3 Year Plan 2024 - 2027. (**Appendix: A**)

In November 2023, the following milestone was added to the Special Measure plan in relation to the lack of digital provision for all age MH&LD services:

3. Stronger leadership and engagement			
Exec Lead	**Milestone**	**Due Date**	**Why is it important to track**
C1-3.10: Implement plans for integrated electronic healthcare record			
Dylan Roberts	3.10.9 Case developed for best of breed Mental Health system in conjunction with DHCW and WG to help address the lack of electronic health care records.	29/02/2024	There are significant record keeping issues in Mental Health which have repeatedly featured in Regulation 28 notices from the coroner.

A draft case was developed by BCUHB but was not finalised due to the delay in the development of the national Connecting Care Business Case. The timeline for the national business case was aligned to the BCU plan and the slippage has caused significant challenges.

Further milestones have been added to the 2024/25 Special Measures plan in relation to the lack of digital provision for all age MH&LD services to mitigate the impact of the delayed national business case and decreasing confidence:

Category	**Lead Exec**	**Milestones by Quarter**
Digital	Dylan Roberts	**Q1**: Finalise Mental Health Business Case Prepare Mental Health Procurement readiness
		Q3: Mental Health system procurement (subject to funding)

A key driver for the inclusion of these actions within the Special Measures plan is the acknowledgement of findings within formal reviews by Health Inspectorate Wales, Royal College of Psychiatry, as well as independent investigations, and regulation 28 reports to prevent future deaths by the H.M Coroners, that the lack of digital records was a significant factor to failings in Mental Health services. The lack of an electronic health record system has been escalated through a number of routes including special measures, Strategic Programme for Mental Health Meetings with NHS Executive, Coroners reports and Chief Information Officer escalations.

2.4.1.3 Key Service Drivers

All age MH&LD services within BCUHB are the least digitally enabled in Wales. The service has no digital provision in core and crucial services, and where present, is disparate.

Therefore, the service is reliant on paper records and the lack of digital enablement has been identified as:

- a contributory factor to patient death by the H.M Coroner within regulation 28 reports
- an issue for resolution in numerous Health Inspectorate Wales (HIW) reports and external reviews
- contributing to variation in clinical decision-making putting patients at risk

(i) Coroners Regulation 28 notices:

H.M. Coroner's in England and Wales have a duty to write a Regulation 28 (Reg.28) report when they identify causes for concern that, if addressed, could prevent future deaths. It is also called a Prevention of Future Deaths report (PFD).

The MH&LD services have received several such reports since 2018 with most of them submitted in 2023. Six of these reports identify non-electronic systems as contributing to patient deaths and 3 regulation 28 reports were specifically related to concerns about the lack of electronic records.

The following Prevention of Future Death reports specifically highlight concerns around the ability to share information digitally:

Prevention of future deaths report - Courts and Tribunals Judiciary 08/06/2023 (Ref: 2023-0185)
Prevention of future deaths report - Courts and Tribunals Judiciary 14/09/2023 (Ref: 2023-0333)
Prevention of future deaths report - Courts and Tribunals Judiciary 08/09/2023 (Ref: 2023-0322)

"*Patient notes for mental health are still not electronic; they are paper based. I have issued several Prevention of Future Death Reports specifically relating to this. There has been considerable delay in actioning this and yet there is still not anticipated timescale for this to occur. As such, deaths will continue to occur or may occur into the future with the risk that notes are paper based only. The risk relates to only one department or individual having access to them at once when there is wider support for the patient*," - Coroner's Concerns, 5c. 14th September 2023. (Link as above)

The Minister for Health and Social Services directly responded to the H.M Coroner with a clear outline of the plans:

"We *recognise the need for investing in developments to digital shared care systems and services to improve data sharing between settings and organisations across NHS and Social Care sectors……Initiatives are now being developed to join up clinical systems and data across all care sectors as part of a new Digital Health and Care Record ecosystem in Wales. This extends to replacing the incumbent Welsh Community Care Information System (WCCIS)*

with a new national digital service to achieve greater integrated care across social services and community Health".
The above extract is taken from the WG Minister's response Letter - dated 18 October 2023. (**Appendix: B**)

Due to exacerbating situation and continued delays of the National Programme to deliver an approvable business case to Welsh Government, the need for this case to be developed quickly is necessary.

A summary analysis of these serious investigation reports for these incidents identifies the following:

Activity	Implication
Storage of patient files	Paper case-records are stored in the Community Mental Health team's premises. These services are closed and locked overnight which means that out-of-hour (OOH) services such as Emergency departments, Psychiatric Liaison, Inpatient services and s136 and Emergency duty team assessments have no information to formulate their risk assessments, nor have sight of any recent escalation of risks or concerns.
Referrals	Urgent referrals are stored in the case-records and not available or visible for wider OOH services which means that there is no visibility of the update on patient's situation or the risks of potential harms.
Filing	Misfiling of letter and information, and lost paper records remains a continuing safety risk.
Transfer between teams and services	The receiving team is unable to comprehensively act on the request until paper files are also transferred for visibility of assessments, plans and risks, delaying crucial interventions and communications. Periods of joint working leads to further risks in recording contacts and care plans increasing risk of additional sets of case files being generated.
Care planning	Delays in specialist multi-disciplinary teams and specialist opinions due to needing to transfer paper files back and forth also delays care planning for the patient adversely affecting patient related outcomes. All teams/individuals providing care do not have visibility of the contemporaneous care record as the paper case file is in one part of the service and not the other and therefore affects the quality of care provided.

Discharge arrangements	Discharge processes have no reliable means of ensuring completed actions and follow through and contributes significantly to missed opportunities for care and support at the most critical times in a person's life.
Post-incident processes	Post-incident processes for investigation such as Putting Things right (PTR) and any rapid learning requirements are also hampered by the need to move the case files to different parts of the systems to compile reports or lessons learnt. This delay in identifying contributory causes does not enable the system to rectify and mitigate ongoing issues or concerns in a timely manner.

(ii) Health Inspectorate Wales (HIW) and other external reviews:

There have been several reviews, annual reports and safety reports which recognise the need to review the patient health care records with a view to implementing an electronic health record to support care and treatment planning.

There has been concerns raised about documentation gaps in therapeutic observations, risk assessments, lack of consistency and quality in record keeping and case files being left unattended. Recommendations to increased vigilance and actions to improve record keeping do not adequately address the core issue of requiring an electronic health record that supports good record keeping governance.

The HIW Discharge Planning Action plan recommendation 19 states:
The Health Board (BCUHB) must provide assurances on electronic patient care records to be in place to allow for essential information to be shared electronically between inpatients and community services.

https://www.hiw.org.uk/betsi-cadwaladr-university-health-board-summary-2018-19
WG48836 (hiw.org.uk)
Reviewing Mental Health Discharge Arrangements | Healthcare Inspectorate Wales (hiw.org.uk)
BCHB Safety Review (nhs.wales)

(iii) Variation in Clinical Decision Making:

Paper based clinical records are not fit for purpose for a Mental Health service that operates across numerous teams across the geography of North Wales.

It propagates variation in recording as well as decision making at the clinical interface.
Real time monitoring of patient journey and ability to deliver proactive targeted care is affected with paper records as the information is not available at the time it is required.

Paper records contribute to poor coordination of care and therefore a fragmented approach and missed opportunities.
Patient experience is therefore poor with barriers to accessing right care, in a timely manner at a point where they need it most.
The governance around data capture, security, sharing information, policy application and variations in practice is variable with paper records.

(iv) Performance Targets and Key Performance indicators:

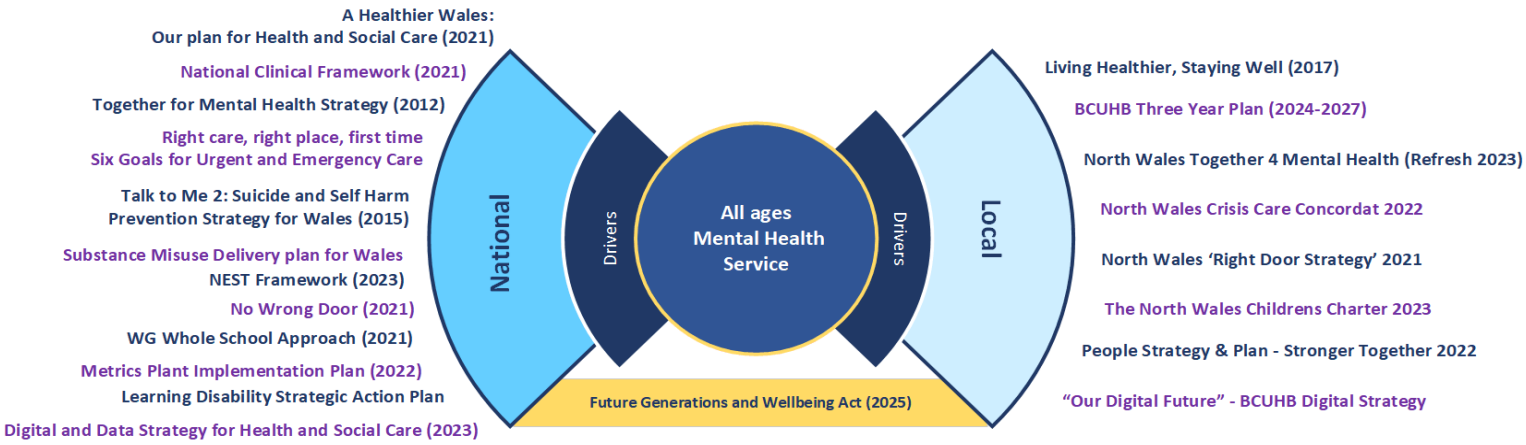
The nationwide mental health services have seen a surge in referrals post pandemic and serial analysis and trend reporting locally continues to evidence that BCUHB are currently not meeting the relevant objectives. Without digitising BCU will not achieve its targets.

Mental Health - Part 1				
Objective	**Measure**	**Baseline**		
Recover waiting time performance to performance framework standards for all age LPMHSS assessment and intervention and specialist CAMHS. (Target : 80%)	LPMHSS assessments undertaken within 28 days of referrals - under 18 years	150	68.5%	Apr-24
	LPMHSS assessments undertaken within 28 days of referrals - 18 years and over	632	78.3%	Apr-24
	Therapeutic interventions started within 28 days following an LPMHSS assessment - under 18 years	28	30.4%	Apr-24
	Therapeutic interventions started within 28 days following an LPMHSS assessment - 18 years and over	238	76.5%	Apr-24

Mental Health - Part 2				
Objective	**Measure**	**Baseline**		
Part 2 of the Measure places duties on Local Health Boards and Local Authorities in Wales to work together to ensure that people of all ages within secondary mental health services have a care co-ordinator and a care and treatment plan that is reviewed at least yearly.	Total number of patients with a valid CTP - AMH	2940	85.6%	Apr-24
	Total number of new referrals under Part 2 - AMH	51		
	Total number of patients with a valid CTP - OPMH	1015	91.1%	Apr-24
	Total number of new referrals under Part 2 - OPMH	73		

2.5 National Strategies

Mental Health, Learning Disabilities and Children and Adolescent Mental Health services work within a complex strategic environment nationally and regionally (local) due to the large number of strategies and plans that must be considered when planning and delivering the services. The following diagram summarises the current strategic landscape:



MH&LD services must work towards to compliance with key national and statutory requirements.

National Strategic Drivers for MH&LD Digital Solution		
Title	Link	Link to all age MH&LD Digital system
A Healthier Wales: Our plan for Health and Social Care (2021)	A healthier Wales: long term plan for health and social care | GOV.WALES	Recognising Digital as a key enabler of Transformational change, via investment in digital solutions: digitally empowered & skilled workforce
Well-being of Future Generations (Wales) Act 2015	Well-being of Future Generations (Wales) Act 2015 (legislation.gov.uk)	Act clearly stipulates the Seven well-being goals public bodies, e.g., Health Boards must work to achieve, emphasising – Health, equality, cohesiveness - Milestone to improve mental wellbeing.
National Clinical Framework (2021)	National clinical framework: a learning health and care system | GOV.WALES	Recognition of complexity underpinning Healthcare - emphasis on integrated digital systems to deliver seamless, safe, efficient Healthcare outcomes.
Digital and data strategy for health and social care in Wales (2023)	Digital and data strategy for health and social care in Wales [HTML] | GOV.WALES	WG update on 'A Healthier Wales' & National Clinical Framework – Aim to improve modern Healthcare services delivered through technology and use of data. Vision for Healthcare Professionals, e.g., MH&LD all ages services to collaborate effectively through secure, connected digital means
Together for Mental Health Strategy and Action Plan for Wales 2012 (Refresh due *2024)*	Together for mental health: our mental health strategy | GOV.WALES	Welsh Government 10-year cross-governmental Strategy, underpinned by six high level outcomes to improve Mental Health and Well-being across all Ages. Recognition: complexity, challenges, multi-faceted causes and effects of poor Mental Health. To deliver outcomes Minister asked NHS Executive and National Collaborative Commissioning Unit to support development National Mental Health dataset and to collect this data Key requirement is a Mental Health Digital Solution.

		The new draft strategy (currently out for consultation) states the need for supporting the MH&LD system as a whole to include: • Better use of technology to support access to services, but that this should not replace access to experienced and skilled professionals and off-line resources and alternative channels, as this will always be needed, particularly for those that are digitally excluded. • Digital services that can improve care planning and the recording of care, as well as support the sharing of patient information safely. Enabling an increased offer of remote support, access to resources which overcomes geographical or logistical barriers for those in need of mental health support. Therefore, these are the resulting actions that have been outlined: • Develop a digital and data plan for mental health. This will align work in DHCW, Health Technology Wales and TEC Cymru to improve digital and data service provision in mental health. It will be based on the principle of parity with physical health and will deliver on key areas including electronic records, data sharing, use of digital across services and improved mental health data • Support the digitalisation of the Mental Health Act – including the communication of statutory forms and other documents electronically.
Strategic Programme for Mental Health – Mental Health outcomes and measures technical group	Strategic Programme for Mental Health	A Technical Group led by NHS Wales Executive (formerly the Delivery Unit) and Welsh Government. This group, as part of the strategic Programme for Mental Health will support developing and standardising a Mental Health Core Dataset to cover Mental Health Services for people of all ages. As set out in Welsh Government's 'Together for Mental Health' Strategy, the dataset "will provide consistent definitions to facilitate benchmarking of service capacity, quality, and delivery and to inform investment and cost comparisons. It will also facilitate the monitoring of the implementation and delivery of this Strategy and its key outcomes." This group will also fulfil the data objective of the Connecting Care programme The requirement for a Mental Health Core Dataset is also a recommendation (24) within the Welsh Parliament Health and Social Committee report '*Connecting the dots: tackling mental health inequalities in Wales'* published in December 2022. (**Appendix: C**)
Legal responsibilities	Mental Health Act Mental Capacity Act Mental Health Measure	The MH&LD service has specific responsibility to deliver on the requirements of the Mental Health Act, Mental Capacity Act and the Mental Health Measure (Wales)

2.6 Local Strategies

Local Strategic Drivers for MH&LD Digital Solution		
BCUHB Three Year Plan 2024-27 BCUHB Three Year Plan 2024-27	**BCUHB Three Year Plan 2024-27**	Strategic Objectives – in relation to NHS Planning framework, Ministerial Prioritises & 'Special Measures' – focused upon a 'twin-track approach' of planning ahead alongside improving the 'here and now' of 2024-25, to ensure consistent, sustainable progress. Key actions focused on areas leading to greatest improvement – Objective 4 – Improving quality, outcomes & experience – 4I – Adult Mental Health, Learning Disability, CAMHS and ND.
Living Healthier, Staying Well (2017)	Living Healthier, Staying Well	10-Year Strategic vision with 6 main aims to improve Health, Well-being and Healthcare. Recognition Key enabler is investment in digital systems and ways of working for all ages MH&LD services
BCUHB – Our Digital Future – Digital Roadmap for Health in North Wales 2021-24	Digital Strategy - Betsi Cadwaladr University Health Board (nhs.wales)	Digital Strategic vision setting out 'transforming the Patient experience, safety and outcomes through digital ways of working'. (Currently drafting – Roadmap for 2025/28).
CAMHS – Programme Plan 2023/26	Child and Adolescent Mental Health Services (CAMHS) Programme Plan (sharepoint.com)	Strategic Plan emphasising Ministerial Priorities for Mental Health services across all Ages, plans to expand Tier 0/1 support, improve services across CAMHS, drive improvements in quality and safety, reducing variation and delivering better, more equitable outcomes, access, experience.
MH&LD Annual Plan 2024-25	202311 MHLD Annual Plan 202425 - V0.3 4.docx (sharepoint.com)	MH&LD Annual plan and 3-year forward look, coproduced division-wide to include a range of perspectives. Emphasis on the 'very best services' delivered by experienced, dedicated and compassionate workforce.
Digitally Enabled Clinical Models and Pathways		MH&LD services have an overarching strategic objective within BCUHB operational and transformational plans to build capacity and capability through working with colleagues across the organisation, to develop a sustainable electronic infrastructure and appropriate systems to support clinical models and pathways.
Divisional Improvement Plan (DIP)		MH&LD also have a responsibility to deliver actions within Special Measures and Divisional Improvement Plan (DIP). The DIP is the response to recommendations and actions from reviews, HIW reports and Regulation 28s.
Vacancy Rates/Recruitment		the MH&LD service have a vacancy rate of just under 20% and a vacancy rate of 27% in CAMHS, resulting in many services delivering without sufficient staff causing operational pressures Many new starters who leave cite the lack of Digital systems as a key factor.

Other national and local Strategic Drivers can be found in **Appendix: D**

Part B: The Case for Change

2.7 Project Aims

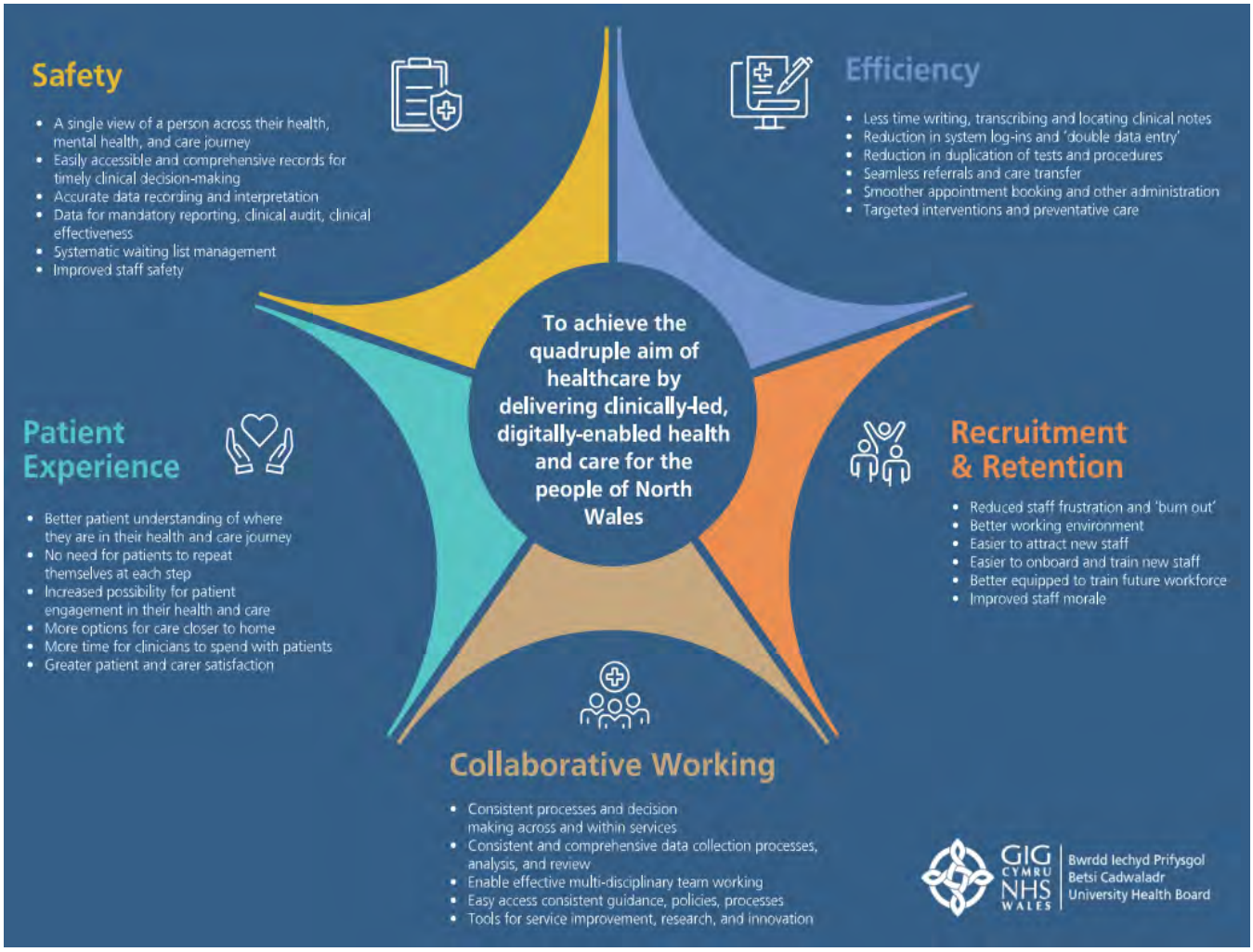
The key aims of this project are:

- To transform all age MH&LD services, through staff having a single view of the patient record and automated workflow resulting in increased time to care with improvements in quality, safety and clinical decision-making contributing to an improved patient experience and saving lives and avoiding deaths.
- To procure and implement an all-age MH&LD Electronic Healthcare Record System to enable the service transformation.

2.8 Investment Objectives

Investment Objectives set out the outcomes we are trying to achieve by reflecting on our existing arrangements and business needs.

The Investment Objectives have been developed based on our BCUHB "North Star" which has been developed as part of a wider piece of strategic work on the development of an Electronic Healthcare Record. This was developed through stakeholder engagement, coupled with existing national and local strategies and is representative of our existing arrangements (our pain points) across all services within scope of this project.



In addition to the key areas within the "North Star" the Services have identified a further area in relation to quality that is specific to their services, this has been included in the investment objectives below.

Investment Objective	Existing arrangement	Business Need
1. To improve clinical quality and safety, including reducing clinical risk and mortality.	• Prevention of Future Death / Regulation 28 Reports point to the lack of joined up digital systems as contributory factor. • Digital and data do not support a contemporaneous view of a person across their mental health journey; there are too many risks / opportunities for care to fall through the gaps. • There is a risk that Paper-based records are not available or not sufficiently comprehensive for timely clinical decision-making, including risk assessment. • Hand-written notes are difficult to read and interpret, which creates risk. • Data for mandatory reporting, clinical audit and clinical effectiveness constrained by current disparate clinical systems and manual processes.	**To make services safe:** It is a requirement under Regulation 28 to take action to reduce the likelihood of harm occurring. It has also been highlighted in BCUHB Special Measures, Health Inspectorate Wales (HIW) reports and external reviews, that improvement is needed. A digital system will reduce the likelihood of harm to patients reoccurring. **To make services timely:** Delays in accessing care records in real time prevents timely interventions, increases waiting times and contributes to patient risk. **To make services effective:**

Investment Objective	Existing arrangement	Business Need
		Because of the disparate digital and manual systems currently in place, the required information is not always available to clinicians at the right place at the right time to support assessments and care planning leading to risk **To make services efficient:** A solution which provides a contemporaneous view of data to all staff involved in a patient's mental health care would improve the availability of data for targeted provision of care. **To make services equitable:** A digital solution would enable standardised models of care, reduce unwarranted variation in care provided to all people in need. It would enable timely reporting and actions **To make services patient-centred:** A digital solution would enable patients to tell their story once, receive interventions and care plans and improve engagement.
2. To support evidence-based, consistent clinical decision-making, ways of working and agreed best practice.	• No data / systems to drive consistent decision making across the division. • Lack of digital consistency encourages hugely disparate data collection processes. • Variation in clinical decision-making puts patients at risk.	**To make services safe:** A digital solution would enable best practice and evidence-based decision making through consistent adoption of guidance **To make services timely:** A digital solution would monitor and enable time scales to assessments and intervention **To make services effective:** A digital solution would enable standardised care delivery as to reduce variation, gap analysis, benchmarking exercises and therefore support data-driven decision making **To make services efficient:** A digital solution would enable clinical decision support tools and monitor unwarranted variations in practice **To make services equitable:** A digital solution would enable consistent comparability of activity and decisions making across areas enabling reconcilable data collection and analysis **To make services patient-centred:** A digital solution will provide quality assurance of processes and serve to improve patients' confidence

Investment Objective	Existing arrangement	Business Need
3. To improve clinical and operational efficiency and accountability across and within BCU services.	• No holistic view of the patient across the service, teams, specialties, organisation, across the ages (CAMHS to Adults) and with partner organisations (e.g. Local Authorities). • Paper-based solutions and disparate systems results in significant duplication of effort. • Lack of availability of patient's notes in the out of hour's periods for crucial legal assessments, e.g. Section 136 assessments. • Significant amounts of time wasted trying to locate patients' records. • Processes are either still manual (e.g., test requests done by phone) or done in word/excel (e.g., waiting list management, appointment booking). • Significant time spent entering data, transferring records (by foot, by vehicle), locating records, storing records across the Health Board.	**To make services safe:** A digital solution enables all operations and workflows to be streamlined. All decisions and activity are visible. **To make services timely:** A digital solution will provide ease of access of contemporaneous records and ensured visibility to all workers providing care and supports timely actions. This will have an impact on ED waiting lists, GP and primary care and community activity and will assist in activity related to police and WAST services. **To make services effective:** Opportunity to improve and standardise processes, pathways and practice within and across teams. **To make services efficient:** A digital solution could reduce the administrative burden and duplication of tasks. Opportunity to reduce amount of paper records, storage facilities and transportation required and therefore contribute positively to our BCUHB carbon footprint. **To make services equitable:** A digital solution will enable analysis of gaps in service provision – ensures all operations and workflows are aligned across region **To make services patient-centred:** A digital solution will enable co-production in developing care plans, track their care plans and exchange secure messages and appointments enhancing their experience.
4. To enable personalised direct and self-care, prevention, and targeted early intervention for the people of North Wales.	• Long waiting lists and time between appointments with limited to no communication to enable people to understand where they are in the clinical pathway. • Lack of digitally enabled patient services, e.g., digital prescribing, booking. • Expectation that people will travel for care rather than utilising digital solution to enable care closer to home. • Lack of access to patient-centred digital tools and digitally enabled interventions (e.g., virtual wards) limits ability for	**To make services safe:** A digital solution would provide opportunities for personalised care to be accessed even when a person is placed on a waiting list **To make services timely:** A digital solution would enable key information to be shared automatically at the point of acceptance for a service **To make services effective:** A digital solution would ensure preventative strategies could be harness

Investment Objective	Existing arrangement	Business Need
	people to take responsibility for their own health and care and limits ability for earlier intervention. • Lack of access to data limit's ability to do population health management, targeted interventions. • Repetition of basic information and clinical assessment • Patients currently get lost on waiting lists	right across the spectrum from primary/secondary and tertiary care presentations. **To make services efficient:** A digital solution would enable consistent messaging and opportunities for self-help, and supports early intervention **To make services equitable:** A digital solution would improve access at the right time and 'no wrong door' principles and use of telehealth widely **To make services patient-centred:** A digital solution would enable care closer to home at the right time and opportunities to connect using a range of modalities to communicate. It will empower them. It is envisaged that patient's may have access to agreed information relating to their care via the NHS App as part of the forward programme.
~~5.~~ **To provide a user-friendly digital environment; intuitive and accessible at the point of care.**	• Reluctance to enter data due to lack of user-friendly systems, processes. • Users must log into multiple systems. • Repeated inputting of similar data and information into various databases. • Very few systems work on mobile. • Lack of technical infrastructure (broadband, equipment) and supporting equipment (printers). • Inability to demonstrate and compare activity and performance	**To make services safe:** A digital solution would be user friendly and fit for purpose and prevent staff from working with missing information. **To make services timely:** A digital solution would ensure any actions are reliably tracked and followed through to completion in a timely manner. Agile solutions, mobile working could ensure rapid response and communications **To make services effective:** That administrative burden for clinicians is reduced and increase capacity to delivering care. **To make services efficient:** A digital solution would streamline workflows, standardising activity and expectations and enabling comparable performance data to drive up quality **To make services equitable:** A digital solution would enable optimisation of resource allocation, identifying gaps and redirecting resource thus enhancing equity of care provision and targeting the Inverse-Care Law. **To make services patient-centred:**

Investment Objective	Existing arrangement	Business Need
		A digital solution provides assurance in developing person centred care and risk management that allows multidisciplinary input keeping the patient firmly at the centre of the process.
6. To invest in a digitally enabled workforce supported by fit-for-purpose tools.	• Lack of IT systems and user-friendly digital solutions make working in BCUHB unattractive. • Cannot compete with other health systems where workforce is digitally enabled. • Recognised low levels of 'digital maturity.'	**To make services safe:** A digitally enabled system would enable care pathways to become learning pathways **To make services timely:** A digital system would allow analytics to drive a culture of continuous improvements **To make services effective:** This would enable recruitment and retention of staff and provide enhanced job satisfaction. **To make services efficient:** Investing in user friendly and fit for purpose digital systems that have been proven elsewhere, along with the ability to support continued professional development, would allow us to change the culture we are working in and encourage and future proof. **To make services equitable:** A digital system helps adopt and evidence value base health care principles to deliver services. That BCUHB MH&LD services are not left behind in a technologically advanced society **To make services patient-centred:** A digitally enabled system would enable patient related (PROMS) and patient experience outcome measures (PREMS) to be consistently utilised to inform improvements

Investment Objective	Existing arrangement	Business Need
7. To underpin collaboration across BCU and other health and care partners through effective interoperability.	• Digital and data does not support a holistic view of a person across their mental health journey. • Systems do not talk to each other. • Data does not flow in and out of GP systems. • Social care and community care unable to share single view of patient. • Tertiary and specialist services are delivered in England or other parts of Wales with no way to share records. • Some services are delivered within BCU for other organisations in Wales/England • Limitations in data collection, access to digital systems means no way to establish if providing an equitable service.	**To make services safe:** A digitally enabled service would be able to collaborate with other agencies and other departments in BCUHB ensuring that information critical to patient safety is shared across borders. **To make services timely:** A digitally enabled service would be able to evidence timely patient flow through the various parts of the system **To make services effective:** A digitally enabled system would support effective conversations between agencies and departments **To make services efficient:** Will enable efficiency in data sharing, information flow leveraging productivity gains through staff activation **To make services equitable:** That access to information and subsequent decision ownership is consistently recorded **To make services patient-centred:** That patients are assured that relevant agencies and organisations are having the important conversations on their behalf.
8. To ensure configure ability and responsiveness to business change, improvement, research, and innovation.	• Business transformation focussed on processes that do not rely on digital solutions. • Lack of data / information to support improvement, innovation, transformation. • Research and innovation hindered by access to quality data.	**To make services safe:** Will enable information to be captured consistently without duplication of records and can be pulled through to populate relevant areas of the system so the record is able to demonstrate veracity. **To make services timely:** On hand back-office capabilities and configurability would enhance the timeliness of iterative approaches to plan service developments **To make services effective:** Will enable responsiveness to need to change Contribute to provision of Continued Professional Development – ability to support newly qualified and student clinicians and build further relationships with universities and research bodies to collaborate as part of the learning process. **To make services efficient**

Investment Objective	Existing arrangement	Business Need
		Will be able to demonstrate evidence for much needed improvements, Demand and capacity analysis Comprehensively respond to NHS benchmarking exercises **To make services equitable:** To demonstrate digitally service gaps and understand impact of any solutions Reduce variation in data collected and interpreted across the BCUHB regions. **To make services patient-centred:** Contribute to collation of public health data and prioritise what matters to individuals
9. To implement cyber safe and sustainable technology that meets the required standards	• Pressures on ICT workloads with unsuitable and ageing IT systems linked to the BCU Network • Security issues associated with paper records transport and maintenance (Datix reports associated with Patient data breaches) • Increased work and guidance required from IG and Cyber Security teams	**To make services safe:** To replace ageing IT systems and enhance security Procurement IT systems to meet modern security standards of data security and trust – Suppliers - Cyber Essentials and Essentials Plus Carry out supplier Due Diligence to protect all BCU Sensitive information (Patient, staff, corporate **To make services timely**Integration: The use of open health standards for data interoperability such as Fast Healthcare Interoperability Resources (FHIR) is the global industry standard for passing healthcare data between systems. **To make services effective**There is a need to ensure all age MH&LD Digital Solution is underpinned by the DDAT user led design principle. **To make services efficient**Working with MH&LD services /teams, not to or for them, in the co-design of the products and services, with a focus on delivering quantifiable outcomes, addressing the clearly defined problem. 'Mobile first' approach - web and app-based products with responsive design optimized for mobile devices. **To make services equitable**Use of Application Programming Interface (API) for exchanging Electronic Health Records (EHR), either DHCW APIs or APIs created using DHCW specifications Digital, Data and Technology Design Principles (cloud.microsoft)

Investment Objective	Existing arrangement	Business Need
		To make services patient-centred Ease for Patient's privacy, opt-in/out choices & compliance

2.9 Business Needs – current and future

To support the effective delivery of care to our service users and support and enable our staff in all aspects of their role, it is essential to provide services in ways that meet service user needs. This requires several accessible formats that records and uses the right information, for the right people at the right time. This is not just a priority for MH&LD services but is a requirement for BCUHB and of all Public Services under a number of Welsh Government policies and legislative requirements.

The importance of the role of data is evident in the Well-being of Future Generations (Wales) Act 2015 legislation where it outlines the requirement to use data to understand our population, demography, diversity, protected characteristics, evidence capacity and capability, identify social, economic, environmental, and cultural interdependencies. **(Appendix: G**)

How we capture the data to fulfil these requirements and effectively run our services is a challenge for MH&LD. Our services have disparate digital provision, which is outdated, ineffective and is not interoperable with other systems (see **Appendix: H** Current systems usage per MH services). In many instances, we have no digital provision at all and are reliant on paper-based processes. This disparate position is due to a legacy of inherited systems from the health organisations that preceded BCUHB and a lack of significant investment and development since. Our digital infrastructure, systems, and the data within them are not equitable to other areas of BCUHB and our MH&LD services are the least digitally developed across Wales. The risks that we carry due to lack of appropriate digital support is significant and these risks and issues have featured in several formal reviews into MH&LD services, Healthcare Inspectorate Wales (HIW) reports and Coroner Regulation 28 Reports (Prevention of Future Death Reports (PFD)).

As referenced in section 2.8 (Investment Objectives), our business needs are summarised below, and further details are provided in 4.5 Outline Based Specification

- Ability for all staff involved in a patient's mental health care to access a holistic and contemporaneous view of data, including clinical risk. This is required across ages (CAMHS to Adults), teams, services, organisations, and borders. This will ensure the right information is available to care givers at the right place and at the right time to reduce risk of patient harm which has been highlighted in a number of reviews.

- A solution is required to drive standardisation and simplification of processes and reporting.
- A fit for purpose digital solution that enables collation of required data and the ability to comprehensively respond to requests and benchmarking exercises.
- A fit for purpose digital solution that supports recruitment, retention, and continual professional development.
- Eventually, through the Shared Care Record, the ability for patients to access agreed information relating to their care via the NHS App to support.

2.10 Scope and Service Requirements

2.10.1 In scope

Services

The services currently considered within scope of the project are listed below:

Acute and Community Mental Health	
Local Primary Mental Health Support Services (LPMHSS)	Secondary Community Care (Adult)
Older Persons Mental Health community teams	Learning Disability
Drug & Alcohol	Prescribed Medication & Counselling support services
Memory Assessment service	Forensic Community
Specialist Adult Eating Disorder	North Wales Brain Injury Service
Rehabilitation	MH&LD therapies including ICan primary care Services
Early Intervention in Psychosis	Perinatal Mental Health
Adult inpatients	Older persons inpatients
Medium secure	Rehabilitation
Liaison Psychiatry	Home Treatment team
Electroconvulsive Therapy (ECT)	Integrated Autism Service
Core CAMHS	
Family Therapy	Psychological Interventions
Children Looked After	Eating Disorders
Transition	Specialist Eating Disorder for CAMHS (SPEED)
Criminal Youth Justice Service	Bwthyn Y Ddol
Multisystemic Therapy (MST)	
Learning disability and neurodevelopment	
Early Intervention	
Early Years	Early Intervention Community
Family Wellbeing Practitioners	Schools In Reach
LIFT	
Planned Care	

Child Health Psychology	
Acute CAMHS	
	FACTS (Forensic CAMHS)
Intensive Community Support Team (KITE)	North Wales Adolescent Service (NWAS)

As part of the procurement exercise, each system will need to be assessed against the requirements for each of these services. However, the "off the shelf" system will be expected to meet the needs of all these services and that BCUHB services also need to be standardised against this proven practice.

Other areas in scope:

- The digitisation of live patient records (The assumption made is at least 1 years' worth of records and this is to be discussed), including the migration of patient care plans and risk assessments from shared drives. Due to the variation and complexity of the current paper patient records processes across services, the size and scope of this work is yet to be determined. Data migration for the services currently utilising WPAS
- Collaborate with key partners where joint working exists that the Health Board are involved in and undertake an assessment of feasibility.
- Meeting Mental Health Act and Measure Requirements
- Mental Capacity Acts/ Deprivation of Liberty Safeguards
- National Strategic Programme for Mental Health including Mental Health Outcomes and Measurement work

2.10.2 Out of scope

The following elements are considered out of scope of the project currently:

- Connecting Care objectives other than MHLD that sit within and will be delivered through the national Connecting Care Programme
- HMP Berwyn (use their own system – SystmOne)
- Archiving of legacy paper records
- Digitising of legacy paper records
- Externally commissioned services – NHS and Non-NHS Services
- Continuing Health Care (use their own specialist system – Broadcare)

NB. All of the requirements above are important to progress the work of BCUHB around quality, safety and productivity but have had to be de-prioritised at this time in lieu of delivering the Mental Health imperative first.

2.11 Main Benefits and Risks

2.11.1 Benefits

Anticipated Benefits are detailed below. These are explored further in the Economic Case.

There are 10 high level benefits identified.

Ref.	Benefit	Benefit Category	Link to Investment Objectives
Ben1	Improved quality and safety of care (staff having the right information at the right time, standardising ways of working, legible records, improved ICP, automated data collection, resource allocation, alerts, warnings, tracking)	Qualitative – non-financial	1, 3, 7
Ben2	Improved regulatory compliance, performance and reporting	Qualitative – non-financial	2, 8
Ben3	Improved efficiency, increasing time to care - less time assessing and more time intervening (Includes travel, standardisation)	Quantifiable – Non-cash Releasing and Cash Releasing	3, 5
Ben4	Improved patient, carer, and family experience	Qualitative – non-financial	1, 2, 3, 4, 7, 9
Ben5	Improved staff experience and retention	Qualitative – non-financial	5, 6
Ben6	Reducing our Carbon Footprint by reducing in paper use, storage and travel (Net Zero Target)	Quantifiable – Cash Releasing Benefit	3
Ben7	Reduction in preventable mortality and morbidity (Risk Adjusted Mortality Indicator)	Quantifiable – Cost Avoidance Quantifiable – Societal Benefit	1
Ben8	Reduction in litigation	Quantifiable – Cost Avoidance	1
Ben9	Reduction in Putting Things Right Procedures, investigations	Quantifiable – Cost Avoidance	1, 4, 7
Ben10	No annual increase in the DHCW SLA	Quantifiable – Cost Avoidance	3

2.11.2 Risks

The following risks have been identified, please note that some of these are option dependent and further detail is provided in the Economic Case:

Ref	Description of Risk	Likelihood of Risk (1-5)	Impact	Impact Severity (1-5)	Overall Risk Score	Mitigation Measures
R1	The reputation of the Health Board will further decrease because it has not delivered an improvement in its all-age MH&LD Services as set out within its 3-year plan	3	BCUHB will remain in Special Measures. Loss of trust in the WG. Loss of trust with the people of North Wales.	5	15	• BCUHB to develop their own Business case to request funding from Welsh Government to allow improvement at a faster pace
R2	DHCW unable to provide a fit for purpose solution within the required timescales	4	Further delays to a BCUHB all age MH&LD digital solution implementation.	4	16	• BCUHB to develop their own Business case to request funding from Welsh Government to allow improvement at a faster pace
R3	DHCW do not have capacity to deliver the whole Connecting Care Programme concurrently and Mental Health is not	4	Further delays to a BCUHB Mental Health digital solution implementation.	4	16	• BCUHB to develop their own Business case to request funding from Welsh Government to allow improvement at a faster pace

	prioritised (Option 4 related)					
R4	DHCW do not have capacity to support any work outside the Connecting Care Programme i.e., Integration, API's	3	Could result in delays to anticipated functionality such as integration with other systems	4	12	• Work with DHCW to schedule them in their plan • Monitor the requests through engagement meetings
R5	There may be local delays to recruitment (e.g., delays in approval etc.)	3	Further delays to a BCUHB all age MH&LD digital solution implementation.	4	12	• Prepare all job descriptions and impact assessments in advance and taking any new roles through job evaluation as soon as possible • Early escalation for Exec intervention
R6	National funding may not be available to purchase a suitable system/fund implementation	4	BCUHB may need to fund a system locally. The services remain on paper and clinical risk remains (if local funding is also not available)	5	20	• Document funding options in the Business Case for consideration • BCUHB to make a decision on local funding
R7	Local funding may not be available to purchase a suitable system/fund implementation	4	BCUHB will be reliant on national funding which may cause further delays The services remain on paper and clinical risk remains (if national	5	20	• Document funding options in the Business Case for consideration • BCUHB to make a decision on local funding

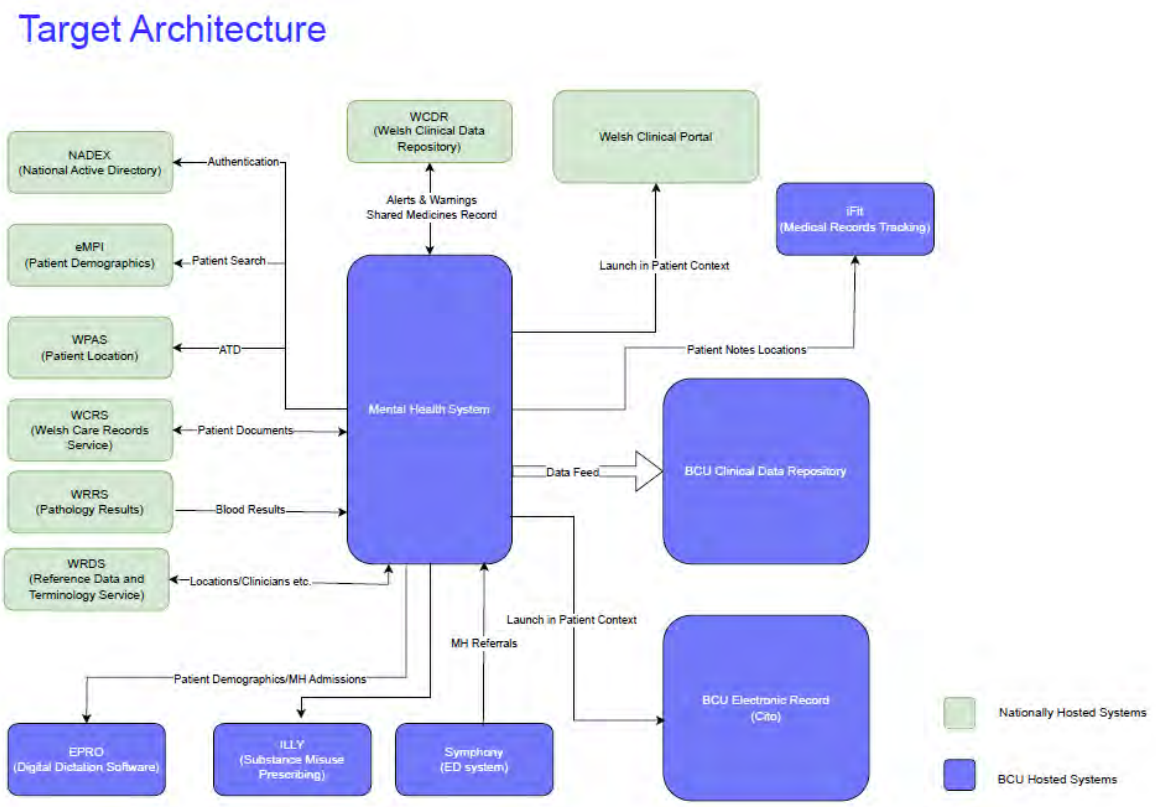
			funding is also not available)			
R8	A suitable commercial off the shelf MH&LD product may not be available to cover the areas defined as in scope	3	Will result in a contract not being awarded and the need for further procurement, meaning further delays to a BCUHB all age MH&LD digital solution implementation. BCUHB may be required to accept a system that provides less capabilities than what it requires	5	15	• Undertake robust pre-market engagement • Prioritise scope and requirements as to further define the Minimum Viable Product (MVP)
R9	The supplier post-contract award is unable to deliver a fit for purpose solution	3	Will result in further procurement and further delays to a BCUHB all age MH&LD solution implementation.	5	15	• Undertake robust pre-market engagement • Undertake a robust procurement exercise with evaluation involving an MDT • Strong specification and requirements
R10	Management of legacy and current case load paper records are not	5	May result in the lack of available clinical information, key to safe patient care and dual	5	25	• Invite Health Records lead to Mental Health Project Board • Undertake an options appraisal with the aim of reducing the clinical risk

	resolved before a digital system is implemented		processes being in place to manage patient records. Poor staff experience. Clinical risk remains high.			• Initial pump prime funding and to re-align the services and staff to this new way of working
R11	Staff digital skills may not be adequate to manage the change from manual processes to digital	3	System will not be fully adopted, and benefits not realised. Staff have a poor experience and disengage and do not use the system.	4	12	• Digital skill development is integrated into the change plan • Digital assessments are undertaken • Appropriate support provided • Use end user design so staff are involved from the beginning
R12	Staff from the services do not have the capacity to engage with the Project	4	May result in the failure to derive the full benefits of implementation and a failure to embed the change. Delay in project implementation.	4	16	• Some staff are backfilled within the Business Case • Provide additional resources to support, including external resources • Undertake operational readiness assessments
R13	There is a risk that requests for additional Category 5e structured cabling installations will be seriously delayed due to the need for correct	4	Will result in delayed deployment of Wi-Fi access points to Mental Health locations	4	16	• Continued engagement with Estates to ensure data cabling for Wi-Fi Access Points are installed in a planned and timely way. • Assisting with investigation for enabling new ways of working to potentially mitigate the lack of Wi-Fi.

	management of external contractors whilst on HB site, in particular the management and control of asbestos, the management of fire stopping, and Construction Design Management.					

2.12 Digital and IT

2.12.1 National Target Architecture Alignment



The following technical standards and requirements are mandated in the national framework technical authority of requirements schedule, which where applicable will see the all-age MH&LD system able to integrate with both local and national systems.

- Adheres to the DSCN (Data Standard Change Notice) 2022/76 medicines and interoperability standards:
  - **HL7® FHIR (Fast Healthcare Interoperability Resources).**
  - **SNOMED CT UK Edition.** Enables identification of allergies, intolerances, and indications
  - With use of nationally agreed **Application Programming Interface (API)** or **other integration methods** for exchanging electronic health records (EHR). See integration non-functional requirements (**See Appendix: W**)
  - Implementation digital transfer of WP10 outpatient prescriptions is dependent on the delivery of the **Electronic Prescription Service** programme within the DMTP.
  - Follows the principles of Open Standards and Open Architecture.
  - Covers the architecture domains for Open Architecture & Integrations, Digital Products & Software Engineering.

Cloud Statement

The health board makes use of both Private Cloud (BCU Cloud Services) and Public Cloud in

the delivery of its services. The approach to all new business and clinical systems is that preference is placed on Software as a Service (SaaS) delivery first, followed by local or on premise delivery should there be reasons that prohibit the former – these may include complex integrations, lack of SaaS provision by the service provider or the SaaS provision does not provide assurance in relation to resilience, Information Governance or cyber security. This aligns with the All-Wales Infrastructure Programme (AWIP) Cloud Strategy.

2.12.3 Current Standards and Policies for Technology

Technical Requirements and specification
The IT technical requirements are documented as part of the ICT Solutions Specification, to ensure compatibility and compliance with local and national infrastructure. These standards will be used as part of the procurement criteria and include core infrastructure architecture, end user devices, cyber security, and regulatory compliance.

Data Migration
The data migration approach will become clear once the functionality of the new system is clarified and will ultimately be decided by the Project Board. The assumption is that all data will be migrated to the new solution. A detailed Data Migration Strategy will be agreed with the successful supplier during project initiation.

There may be some data that is not migrated to the new system but will still need to be accessed. The option for doing this can be explored in more detail with the chosen supplier.

2.12.4 Current Gaps in ICT provision and digital maturity

Core ICT Infrastructure aligns with the All-Wales Infrastructure Programme (AWIP) documents and strategies. External verification has been undertaken that shows that the infrastructure is both resilient and scalable, and responsive to changes in demand both from a network and datacentre perspective. The ICT Essential Services Programme (ESP) ensures continued investment in core infrastructure and devices. This is however constrained by the reduced levels of capital investment available to ICT through the discretionary scheme.

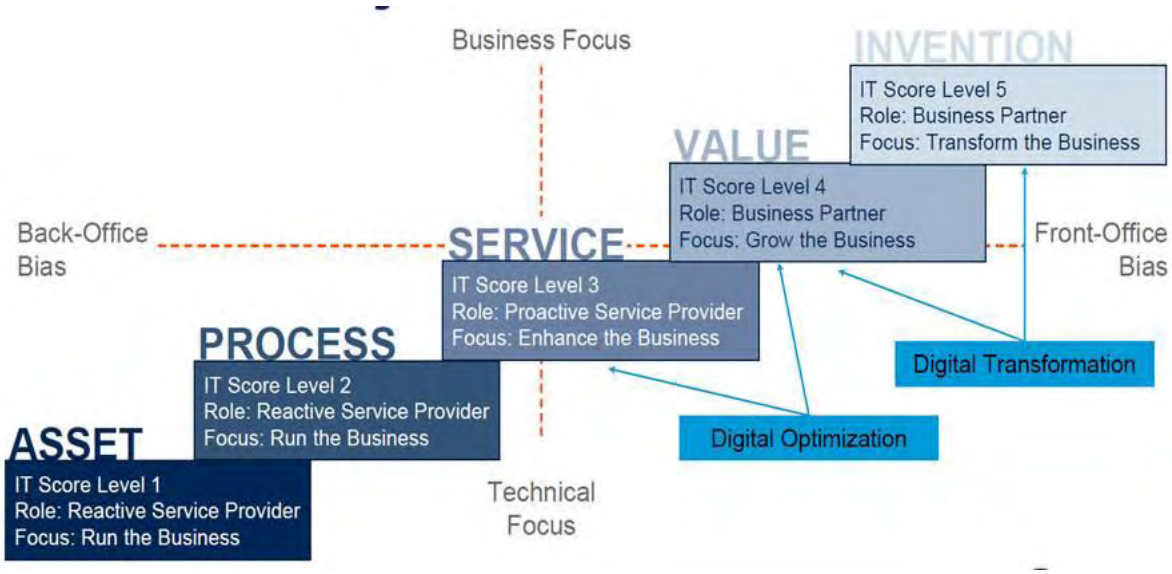
There is however a recognised gap in the deployment of Wi-Fi access points which is being addressed and is caused by additional asbestos checks delaying the installation of data cabling.

Gartner IT Score (DDaT Self-Assessment)
The starting point in 2022 was an IT Score 0, which is below the entry level and that of a reactive service provider working to good IT disciplines and standards. The service and its operating model achieved a move to IT Score Level 2 (Process) in 2023. There is a good digital portfolio, programme and project management approach whereby all new requirements for work must come through DDaT, there are some standards and design principles in place to guide the effective delivery of DDaT services and the ICT element of the service has now attained Platinum Level from the British Computer Society (BCS) for demonstrating

commitment to staff development and upholding standards in practice. With external help and support, these achievements have been made possible with the existing team and capabilities.

The move to Level 3 will be dependent upon bringing in key skills, capabilities and functions **that are now being developed in the Health Board**.
These are:

- Architecture function
- Business Relationship Management
- Software engineering function
- Service design and clinical change function (Office of the CCIO)



EMRAM Assessment

In delivering on our Digital Strategy, BCUHB have been assessed against an international standard of digital maturity. The Electronic Medical Record Adoption Model (EMRAM) is an eight-stage model that measures clinical outcomes, patient engagement and clinician use of EHR technology within acute care; there is no equivalent assessment available for other care sectors. This assessment was undertaken to highlight the gaps and to establish a starting position that is familiar and recognisable to all those supplying the data. Following completion of an online survey (self-assessment) the Health Board invited the Healthcare Information and Management Systems Society (HIMSS) to conduct an EMRAM onsite gap assessment which was completed on the 10th of February 2023. Although some criteria within higher levels were achieved, HIMSS concluded that BCUHB is only compliant with the EMRAM Stage 1 requirements: the lowest possible assessment.
Further information is available in **Appendix: I**

2.13 Strategic Case Conclusions

This is a strategic priority investment for BCUHB as this Case identifies the significant challenges and risks that the services are carrying that are impacting on patient care and staff experience that need addressing urgently.

It also highlights that BCUHB knows what needs to be changed through the work undertaken on the "North Star," the Investment Objectives and a robust digital assessment that has been undertaken by the service.

The initial benefits identified are mainly

Ben1	Improved quality and safety of care (staff having the right information at the right time, standardising ways of working, legible records, improved ICP, automated data collection, resource allocation, alerts, warnings, tracking)
Ben2	Improved regulatory compliance, performance and reporting
Ben3	Improved efficiency, increasing time to care - less time assessing and more time intervening (Includes travel, standardisation)
Ben4	Improved patient, carer, and family experience
Ben5	Improved staff experience and retention
Ben6	Reducing our Carbon Footprint by reducing in paper use, storage and travel (Net Zero Target)
Ben7	Reduction in preventable mortality and morbidity (Risk Adjusted Mortality Indicator)
Ben8	Reduction in litigation
Ben9	Reduction in Putting Things Right Procedures, investigations
Ben10	No annual increase in the DHCW SLA

The project strategically aligns to the National and Local Strategies including the Ministerial Priorities and without this project BCUHB will fail to be able to deliver some of these strategies and priorities.

BCUHB must improve its digital maturity, all standards and requirements are known and will be used, and we will work collaboratively with DHCW.

The continued lack of a single view of the patient in all ages MH&LD across North Wales will continue to impact on the quality of care. BCUHB will continue to contribute to preventable deaths causing distress to families, friends, and communities.

3. The Economic Case

3.1 Introduction

The purpose of the Economic Case is to undertake an appraisal of the options as to ensure that the Health Board delivers Value for Money (VfM). The case appraises the societal, environmental, economic costs, benefits, and risks for the short-listed options as to identify the preferred option.

The Health Board project multi-disciplinary team identified and appraised a "long list" of options and then undertook a further detailed appraisal of the "short list" of options as to enable the full appraisal. The Investment Objectives identified in the Strategic Case and the following Critical Success Factors are used alongside an assessment of the advantages and disadvantages of each long-list option.

3.2 Long List Options

The following table shows the extensive list of options that were developed as part of the option development and scoring workshop held with a multi-disciplinary team.

	Option
Option 1	Do Nothing
Option 2	Utilise existing digital systems – (Do the minimum)
Option 3	Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed" (Intermediate)
Option 4	National system procurement of "Best of Breed" under the Connecting Care Programme (Intermediate)
Option 5	Health Board builds its own bespoke system (Intermediate+)
Option 6	Health Board Procures a Technical Partner to develop a bespoke system (Maximum)

3.3 Critical Success Factors

Key Critical Success Factors (CSFs) have been identified as the attributes essential for successful delivery of the project, against which the initial assessment of the options for the delivery of the project will be appraised.

	Critical Success Factor	Description
CSF 1	Strategic fit and business needs	How well the option meets the strategic context, programme scope and objectives, related business needs and service requirements
CSF 2	Potential value for money	How well the option optimises social value (social, economic, and environmental), in terms of the potential costs, benefits and risks

CSF 3	Supplier capacity and capability	How well suppliers can meet the requirements and timescales of the Health Board
CSF 4	Potential affordability	How well the option can be financed from available funds and aligns with sourcing constraints
CSF 5	Potential achievability	How well the option is likely to be delivered given an organisation's ability to respond to the changes required and matches the level of available skills required for successful delivery, this also includes technical complexity
CSF 6	Timescale to Deliver	How quickly the procurement and implementation can be delivered
CSF 7	Staff Experience	Meets key usability and design principles and has a positive impact on user experience
CSF 8	Adoption	How well Mental Health Services adapt and change to standardise practice and adopt the basic capabilities of new systems out of the box.

The Critical Success Factors 1-5 are the standard Green Book Factors, additional Critical Success Factors 6, 7 and 8 have been added, the reasons for their addition are:

- CSF 6 – Timescale - reflects the urgency of improvement within the Health Board due to being in special measures.
- CSF 7 – User Experience – to ensure that the end user is considered as previously in some national and local implementations this has not been considered.
- CSF 8 – Adoption – to ensure the Services' ability to adapt and cultural change is considered.

3.4 Shortlisting Assessment

An option development and scoring workshop was undertaken to assess each of the longlisted options (OP) using the 9 Investment Objectives (IO) and the 8 Critical Success Factors (CSF).

The scoring use was:

- Does not meet the objective/factor = 0
- Fully meets the objective/factor = 1

The "Do nothing" option will be automatically shortlisted as a comparison can be undertaken.

		Op1	Op2	Op3	Op4	Op5	Op6
		Do Nothing	Utilising existing digital systems	Procure COTS 'Best of Breed'	National Connecting Care – Procure 'Best of Breed'	BCUHB build bespoke system	BCUHB procure Technical Partner to build bespoke system
Investment Objectives							
IO1	To improve clinical quality and safety, including reducing clinical risk and mortality.	0	0	1	1	1	1
IO2	To support evidence-based, consistent clinical decision-making, ways of working and agreed best practice.	0	0	1	1	1	1
IO3	To improve clinical and operational efficiency and accountability across and within BCU services.	0	0	1	1	1	1
IO4	To enable personalised direct and self-care, prevention, and targeted early intervention for the people of North Wales.	0	0	1	1	1	1
IO5	To provide a user-friendly digital environment; intuitive and accessible at the point of care.	0	0	1	1	1	1
IO6	To invest in a digitally enabled workforce supported by fit-for-purpose tools.	0	0	1	1	1	1
IO7	To underpin collaboration across BCU and other health and care partners through effective interoperability.	0	0	1	1	1	1
IO8	To ensure configure ability and responsiveness to business change, improvement, research, and innovation.	0	0	1	0	1	1
IO9	To implement cyber safe and sustainable technology that meets the required standards	0	0	1	1	1	1
	Investment Objectives (Total)	**0**	**0**	**9**	**8**	**9**	**9**

Critical Success Factors							
CSF 1	Strategic fit and business needs	0	0	1	1	1	1
CSF 2	Potential value for money	0	1	1	1	0	0
CSF 3	Supplier capacity and capability	0	1	1	1	0	0
CSF 4	Potential affordability	1	1	1	1	0	0
CSF 5	Potential achievability	1	1	1	1	0	0
CSF 6	Timescale to Deliver	1	1	1	0	0	0
CSF 7	User Experience	0	0	1	1	1	1
CSF 8	Adoption	0	0	1	1	1	1
	Critical Success Factors (Total)	**3**	**5**	**8**	**7**	**3**	**3**
	Total Scores	**3**	**5**	**17**	**15**	**12**	**12**

A high-level review of the shortlisting assessment is as follows:

	Option	Assessment	Justification
Option 1	Do Nothing	Discounted but will be used for comparison	Does not meet the strategic or business needs of the organisation
Option 2	Utilise existing digital systems – (Do the minimum)	Discounted	Does not meet the strategic or business and clinical needs of the organisation and needs of patients
Option 3	Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed" (Intermediate)	Preferred	Meets all the Investment objectives and critical success factors
Option 4	National system procurement of "Best of Breed" under the Connecting Care Programme	Possible	Meets most of the Investment objectives and critical success factors. Some concern regarding configurability and timescales to deliver. Affordability could also be an issue.
Option 5	Health Board builds its own bespoke system	Discounted	Will take too long, not affordable, limited capability and not the best value for money
Option 6	Health Board Procures a Technical Partner to develop a bespoke system	Discounted	Will take too long, not affordable, limited capability and not the best value for money

3.5. Detailed Longlist Option Assessment

To ensure robustness of the shortlisting a further detailed assessment of the advantages and disadvantages has also been undertaken.

	Option	Description	Detail
Option 1	Do Nothing	All services in scope continue to use paper records.	**Advantages** • None **Disadvantages** • Continued clinical risks and impact on quality of care (including variation) • Health Board remains in special measures • Continued Reg 28's related to patient records • Increased litigation

			• No digital service transformation • Continued poor staff experience • Unable to undertake national reporting • No intelligence use of data to improve performance or monitor equality of care
Option 2	Utilise existing digital systems – (Do the minimum)	Use national and local systems such as WPAS, CITO etc.	**Advantages** • Some staff already use some of the systems • No procurement required • Low cost • Some level of reporting may be possible • Knowledge of the systems
			Disadvantages • Could cause the same level of continued clinical risks and reduced care due the patient data and pathways still being fragmented across numerous systems • Health Board remains in special measures • Continued Reg 28's related to patient records • Increased litigation • Continued poor staff experience • Cannot be developed to meet user needs • Unable to undertake full national reporting • No intelligence use of date to improve performance or monitor equality of care • May not be suitable for all services
Option 3	Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed" (Intermediate)	Go to the market and buy a solution that does not need much development and can integrate in the future through the national programme	**Advantages** • Reduced clinical risks and should improve quality of care (including variation) as the Patient information will be in the right place at the right time • Supports the Health Board get out of Special Measures • Reduced number of Reg 28's related to patient records • Reduced litigation • Digital service transformation • Improved staff experience • National reporting can be undertaken • Intelligence use of date to improve performance and monitor equality of care • Solutions are currently deployed for MH Services in England so they can work

			• The Health Board has choice over the supplier • Some local configurations can be done • They are standard solutions so should meet the technical requirements • No national overheads being paid for annually through the SLA with DHCW • Supplier market is known • Shorter implementation timelines compared to custom-developed solutions • Suppliers already working in MH&LD have a proven track record, reducing the risk. • Access to supplier support reduces risk. • "Off the shelf" aligns with National Policy
			Disadvantages • The need for significant business change to standardise against best practice. • Will have to be procured by the Health Board • Additional work will be required in relation to paper to digital records i.e. to digitise live records • Dependence on a single supplier for support and updates, which can be problematic if the supplier's service levels decline or if costs increase.
Option 4	National system procurement of "Best of Breed" under the Connecting Care Programme	Work collaboratively across Wales to have one system in Wales, integrating all connecting care systems and national systems with	**Advantages** • Reduced clinical risks and should improve quality of care (including variation) as the Patient information will be in the right place at the right time • Supports the Health Board get out of Special Measures • Reduced number of Reg 28's related to patient records • Reduced litigation • Integration and information sharing with other organisations who agree to be part of the programme • Support from the Connecting Care programme team • Opportunity to accelerate and be first to get a Best of Breed MH&LD system through the National Programme • Digital service transformation

			• Improved staff experience • National reporting can be undertaken • Intelligence use of data to improve performance and monitor equality of care • Part of the all-Wales approach • The Health Board does not have to run its own procurement and is supported by DHCW (procurement and delivery) • Supplier market is known • Availability of national-level technical support and resources for troubleshooting and system maintenance.
			Disadvantages • Must go with the collaboratively procured national solution so Health Board does not have full supplier choice • Requirements will be nationally agreed so may not meet the Health Boards needs • Unsure if local configuration can take place as procurement strategy and business case have not been released by DHCW • Unknown deliver timescales and part of a larger national programme where Mental Health may not be a priority due to challenges and size of social care transition required • Project resources are a one size fits all for each Health Board, but BCUHB is the largest in Wales which is usually not reflected in national business cases • DHCW SLA paying for national level overheads. Due to its size the Health Board usually pay around 20% of all DHCW costs per project • It is expected that this option would take longer to deliver than Option 3 but quicker than Options 4 & 5 • Additional work will be required in relation to paper to digital records i.e. to digitise live records • Increased dependency on national decision-making processes, which may not always align with local priorities or timelines.

Option 5	Health Board builds its own bespoke system	Full end to end development of a system by the Health Board that fully integrates with appropriate national and local systems	**Advantages** • Reduced clinical risks and should improve quality of care (including variation) as the Patient information will be in the right place at the right time • Supports the Health Board get out of Special Measures • Reduced number of Reg 28's related to patient records • Reduced litigation • Digital service transformation • Improved staff experience • Fully bespoke system designed with the end users • National reporting can be undertaken • Intelligence use of data to improve performance and monitor equality of care • Improves the developing technical capabilities within the Health Board
			Disadvantages • The Health Board does not understand the optimal clinical and business model that needs to be moved to and will be the base requirement for digitisation. • Will have to develop the technical capabilities such as development, integration and product management capabilities which may take time due to recruitment and availability of these specialist roles • Interoperability can be complex and support of DHCW will be required • It is expected that this option would take longer to deliver than Option 3 & 4 & 6 • This Option is likely to be more expensive than Options 3&4 • Additional work will be required in relation to paper to digital records i.e. to digitise live records • Fully delivery risk on the Health Board
Option 6	Health Board Procures a Technical Partner to develop a bespoke system	Full end to end development of a system by a technical partner that	**Advantages** • Reduced clinical risks and should improve quality of care (including variation) as the Patient information will be in the right place at the right time

		fully integrates with appropriate national and local partner systems	• Supports the Health Board get out of Special Measures • Reduced number of Reg 28's related to patient records • Reduced litigation • Digital service transformation • Improved staff experience • Fully bespoke system designed by the end users • National reporting can be undertaken • Intelligence use of data to improve performance and monitor equality of care • Improves the developing technical capabilities within the Health Board • Most expensive Option
			Disadvantages • Will have to develop some technical capabilities such as development, integration and product management capabilities which may take time due to recruitment and availability of these specialist roles • Interoperability can be complex and support of DHCW will be required • It is expected that this option would take longer to deliver than Option 3 & 4 • This Option is likely to be more expensive than any of the other options • The supplier market is unknown • Additional work will be required in relation to paper to digital records i.e. to digitise live records

3.6 Economic Evaluation

The Economic Appraisal has been carried out which uses Costs and Benefits discounted across the lifetime of the investment. This excludes VAT, Capital Charges and NHS-derived income.

3.6.1 Benefit Evaluation

Benefits work to-date within the Health Board has been done as a multi-disciplinary team and by using existing best practice. Some benefits have been identified by Service Design work carried out by DHCW in Cwm Taf Morgannwg UHB. These need to be validated against BCU.

Nationally, metrics have been developed for the Connecting Care Programme by MH&LD Group from workshops lead by the National Programme Team.

Please note that the quantifiable benefits are based on MH&LD and not all services within the scope of the project as further benefits work will be required to be undertaken.

It is expected that both shortlisted options 3&4 will provide the same benefits but Option 1 – Do nothing will result in dis-benefits, the dis-benefits have not been calculated.

The benefits identified are either quantifiable or qualitative with the following four benefit categories used:

Quantifiable

1. Cash Releasing Benefits (which also support the Affordability in the Financial Case);
2. Non-Cash Releasing Benefits (which have a perceived £ "value" to the Health Board or wider public sector but do not translate directly to financial savings, this also includes cost avoidance);
3. Societal Benefits (which have a £ value to society); and

Qualitative

4. Non-financial Benefits (Non-monetised)

3.6.1.1 Identified Benefits

There are 10 high level benefits identified.

Ref.	Benefit	Benefit Category
Option 3 & Option 4 Benefits		
Ben1	Improved quality and safety of care	Qualitative – non-financial
Ben2	Improved regulatory compliance, performance and reporting	Qualitative – non-financial
Ben3	Improved efficiency, increasing time to care - less time assessing and more time intervening (Includes travel, standardisation)	Quantifiable – Non-cash Releasing and Cash Releasing
Ben4	Improved patient, carer, and family experience	Qualitative – non-financial
Ben5	Improved staff experience and retention	Qualitative – non-financial
Ben6	Reducing our Carbon Footprint by reducing in paper use, storage, and travel (Net Zero Target)	Quantifiable – Cash Releasing Benefit
Ben7	Reduction in preventable mortality and morbidity (Risk Adjusted Mortality Indicator) In relation to societal benefits, the average economic cost of suicide is £1,458,136 per person, 135 people on average are affected by someone who takes their own life (Samaritans, 2022). It is worth stating but not possible to use due to the multiple factors related to suicide.	Quantifiable – Cost Avoidance Quantifiable – Societal Benefit
Ben8	Reduction in litigation (Cost Avoidance for NHS Wales not the Health Board)	Quantifiable – Cost Avoidance

Ben 9	Reduction in Putting Things Right Procedures, investigations	Quantifiable – Cost Avoidance
Option 3 Benefit Only		
Ben10	No annual increase in the DHCW SLA (£1.25m - based on an estimate of £250k per year (WNCR) for 5 years with no increases.)	Quantifiable – Cost Avoidance

3.6.1.2 Benefit Estimations

The following are how the quantifiable cash releasing benefits will be calculated, based on the work of Inform Consultants. **These are indicative and need to be validated as part of the service design work in BCUHB and system selection process.**

Ref.	Benefit	Beneficiary	Metric	Baseline	Target	Saving per annum	Timeline / Ambition
Ben3	Improved productivity, increasing time to care - less time assessing and more time intervening (Includes travel, standardisation)	MH&LD Staff	Based on entering new referrals into a system that has integration to demographics service so that patients' data does not need to be entered from scratch. There is an additional saving for data capture that extends beyond the nursing referral	Time and motion study to be undertaken to verify the national Service Design work carried out by DHCW in Cwm Taf Morgannwg UHB.	17mins per referral	£6056.28 Realistically if we realise 25% of efficiency savings as a budget reduction. Further staffing efficiencies across the service are to be explored before any cash-releasing costs are quantified.	Year 5 onwards
		MH&LD Staff	This metric has been calculated based on improvements in the way that office duty staff are able to process and complete patient related enquiries.		67mins per working day	TBC	Year 5 onwards Further staffing efficiencies across the service are to be explored before any cash-releasing costs are quantified.

		MH&LD Staff	For all staff managing a personal caseload. This metric is calculated based on being able to access and update digital care treatment plans for each client by using a mobile application.		34mins per client	TBC	Year 5 onwards Further staffing efficiencies across the service are to be explored before any cash-releasing costs are quantified.
		MH&LD Staff	An average of 8.1 miles per person, per day (travel back to base) can be saved with the introduction of a mobile app supporting access to case load data for front-line staff working in the community. For this staff group, a reduction factor is applied to take 10% of working days as this does not apply to every day that they work Due to the wide geography of the Health Board this could be higher.		8.1 miles per 10% of working days	TBC	Further efficiencies across the service are to be explored before any cash-releasing costs are quantified.

		MH&LD Staff	15 minutes saving was identified when using national forms, specifically "CPA recovery assessment' and 'Initial assessment', documents which are completed as part of the nursing assessment for every patient.		15mins per referral	TBC	Year 5 onwards Further staffing efficiencies across the service are to be explored before any cash-releasing costs are quantified.
Ben6	Reducing our Carbon Footprint by reducing in paper use, storage, and travel (Net Zero Target)	MH&LD	Swansea Bay health board expected that there would be a significant reduction in paper, printing and postage costs, and associated record storage, as a result of staff using a digital system. This benefit will be larger within the BCU Health Board as there is a significant issue in relation to records management and storage and printing.	Calculate number of patients, number of paper in file per month	32% total costs for printing, postage, storage	£40k p.a. Storage £60k p.a. Consumables, printer servicing & postage reduction These are indicative and need to be validated as part of the service design work in BCUHB and system selection process	Year 3 – 25% Year 4 – 50% Year 5 – 100% onwards

3.6.1.3 Benefit Summary

At this stage the main benefits have been identified as efficiency benefits resulting in more time to care, standardising how we work will enable data and information to be captured in the same way which will be used to improve reporting and monitoring service performance.

Benefit 1 - Improved quality and safety of care is expected to yield significant non-cash releasing benefits.

Further work is required to be undertaken as to assess the validity of the benefits estimations within the Health Board. This will be done using the Benefits Management Framework working collaboratively with all services. This work will be undertaken prior to the FBC submission.

Suicide has a significant impact on not only the economy but families, friends and communities.

The Benefits Evaluation provides evidence to support Option 3 - Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed" based on the system which is a best fit for BCU which is based on good practice with minimal configuration required.

3.6.2 Risks Evaluation

The risk identification and assessment work to-date within the Health Board has been done as part of initial discovery as a multi-disciplinary team and by using existing best practice.

The following are considered the high-level risks for this project, split down by Options:

- Option 3 - Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed"
- Option 4 - National system procurement of "Best of Breed" under the Connecting Care Programme

The assessment below identifies if there is a financial risk of the Option to the Health Board as to enable the financial calculation of the risk of the Options.

	Risk Descriptor	Option 3	Option 4	Risk Owner
R1	The reputation of the Health Board will further decrease because it has not delivered an improvement in its all-age MH&LD Services as set out within its 3-year plan	X	X	BCUHB
R2	DHCW unable to provide a fit for purpose solution within the required timescales	X	√	DHCW
R3	DHCW do not have capacity to deliver the whole Connecting Care Programme concurrently and Mental Health is not prioritised (Option 4 related)	X	√	DHCW
R4	DHCW do not have capacity to support any work outside the Connecting Care Programme i.e. Integration, API's	√	X	DHCW

R5	There may be local delays to recruitment (e.g. delays in approval etc.)	√	X	BCUHB
R6	National funding may not be available to purchase a suitable system/fund implementation	√	√	WG/BCUHB
R7	Local funding may not be available to purchase a suitable system/fund implementation	√	√	BCUHB
R8	A suitable commercial off the shelf MH&LD product may not be available to cover the areas defined as in scope	√	√	BCUHB
R9	The supplier post-contract award is unable to deliver a fit for purpose solution	√	√	BCUHB
R10	Management of legacy and current case load paper records are not resolved before a digital system is implemented	√	√	BCUHB
R11	Staff digital skills may not be adequate to manage the change from manual processes to digital	X	X	BCUHB
R12	Staff from the service do not have the capacity to engage with the Project	X	X	BCUHB
R13	There is a risk that requests for additional Category 5e structured cabling installations will be seriously delayed due to the need for correct management of external contractors whilst on HB site, in particular the management and control of asbestos, the management of fire stopping, and Construction Design Management	√	√	BCUHB

The scoring of these risks can be found in Section 3.5.2.1 – in the Strategic Case

3.6.2.1 Risk Scores and Costs

The only risk costs that can be calculated at this stage are the implementation delay risks, R2, R3, R4 and R5 as only the Health Boards costs are known.

The risk assessment has highlighted that R2, R3 (Option 4 related risks) are higher than R4 and R5 (Option 3) risks as highlighted below due to the scale and complexity of what DHCW have to deliver at a national level.

Ref	Description of Risk	Likelihood of Risk (1-5)	What are the impacts if the risk actually happens?	Impact Severity (1-5)	Risk Score (Likelihood X Impact) and Grading	Mitigation Measures
R2	DHCW unable to provide a fit for purpose solution within the required timescales	4	Further delays to a BCUHB all ages MH&LD digital solution implementation	4	16	BCUHB to develop their own Business case to request funding from Welsh Government to allow improvement at a faster pace
R3	DHCW do not have capacity to deliver the whole Connecting Care Programme concurrently and Mental Health is not prioritised	4	Further delays to a BCUHB all ages MH&LD digital solution implementation	4	16	BCUHB to develop their own Business case to request funding from Welsh Government to allow improvement at a faster pace
R4	DHCW do not have capacity to support any work outside the Connecting Care Programme i.e. Integration, API's	3	Could result in delays to anticipated functionality such as integration with other systems	4	12	Work with DHCW to schedule them in their plan Monitor the requests through engagement meetings
R5	There may be local delays to recruitment (e.g. delays in approval etc.)	3	Further delays to a BCUHB all ages MH&LD digital solution implementation	4	12	Prepare all job descriptions and impact assessments in advance and taking any new roles through job evaluation as soon as possible Early escalation for Exec intervention

The financial cost of delays on implementation will cost the Health Board **£232,497** per month (excluding shifts/travel and optimism bias) resulting in Option 4 being a higher risk to the Health Board based on the above risk assessment.

3.6.2.2 Risk Summary

The risk evaluation that has been undertaken highlights that there are greater financial risks to the Health Board in relation to Option 4, so Option 3 would be the preferred option in related to financial risks.

3.7 Costs

3.7.1 Implementation Costs

Implementation costs have been identified to deliver the two shortlisted options:

- Option 3 - Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed"
- Option 4 - National system procurement of "Best of Breed" under the Connecting Care Programme

Full implementation costs can be found in the Financial Case.

3.7.2 Cost Assumptions

Costs have been estimated over a 10-year period in line with the Health Boards standard practice, this includes the 7-year period of the contract (5 years plus 2).

A generic optimism bias of 20% has been applied to all the implementation costs at this stage. Costs exclude VAT and depreciation

3.7.3 Capital & Revenue Costs

The detailed capital and revenue costs can be found in the Financial Case, the following provides a high-level overview:

		Programme				BAU		
		Year 1* 24/25 **£'000**	Year 2 25/26 **£'000**	Year 3 26/27 **£'000**	Year 4 27/28 **£'000**	Year 5 28/29 **£'000**	Year 6 29/30 **£'000**	Year 7 30/31 **£'000**
WG Funding Required	Revenue	658	3,322	3,282	3,571	0	0	0
	Capital	0	575	575	0	0	0	0
BCUHB Contribution**	Revenue	545	974	974	974	941	941	941
	Capital	0	0	0	0	0	0	558
Total Savings				25	50	106	106	106
Total Project Cost	Revenue	1,203	4,296	4,231	4,495	835	835	835
	Capital	0	575	575	0	0	0	558

*Year 1 is for 6 months only

**Includes current staffing from the non-recurrent transformation fund

Note: This does not include funding for the Shared Care Record, DHCW are developing a separate case for this.

3.7.4 Net Present Cost/Value Findings and Analysis

This NPV highlights that Option 3 provides a lower Net Value Cost so would provide better value for money.

3.7.4.1 NPV Option 3

Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed".

NPV @ 3.5% p.a.

YEAR :	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	TOTAL
CAPITAL COSTS (£ 000s):											
Capital	0	575	575	0	0	0	558	558	0	0	2,266
A. Total Capital Costs (Annual)	0	575	575	0	0	0	558	558	0	0	2,266
B. Total Capital Costs (Cumulative)	0	575	1,150	1,150	1,150	1,150	1,708	2,266	2,266	2,266	
REVENUE COSTS (£ 000s):											
Initial Non-Recurrent Costs	0	685	530	500	0	0	0	0	0	0	1,715
Staff Costs	1,203	3,016	2,972	2,972	218	218	218	218	218	218	11,468
Supplier Costs	0	187	381	724	724	724	724	724	724	724	5,634
Consolidation and Optimisation	0	408	399	399	0	0	0	0	0	0	1,207
Implementation Optimism Bias	0	0	0	0	0	0	0	0	0	0	0
Capital Charges (Depreciation)	0	0	0	0	0	0	0	0	0	0	0
C. Total Revenue Costs (Annual)	1,203	4,296	4,282	4,595	941	941	941	941	941	941	20,024
D. Total Revenue Costs (Cumulative)	1,203	5,499	9,781	14,376	15,317	16,258	17,200	18,141	19,082	20,024	
E. Total Costs (Annual) (=A+C)	1,203	4,872	4,857	4,595	941	941	1,499	1,499	941	941	22,290
F. Total Costs (Cumulative) (=B+D)	1,203	6,075	10,932	15,526	16,467	17,409	18,908	20,407	21,349	22,290	
BENEFITS (£ 000s):											
Welsh Government Funding Revenue	658	3,322	3,307	3,620	0	0	0	0	0	0	10,907
Welsh Government Funding Capital Charges	0	0	0	0	0	0	0	0	0	0	0
Welsh Government Funding Capital	0	575	575	0	0	0	0	0	0	0	1,150
G. Total Benefits (Annual)	658	3,897	3,882	3,620	0	0	0	0	0	0	12,058
H. Total Benefits (Cumulative)	658	4,555	8,438	12,058	12,058	12,058	12,058	12,058	12,058	12,058	
NET UNDISCOUNTED COST* (=E-G)	545	974	974	974	941	941	1,499	1,499	941	941	10,232
DISCOUNT FACTOR @ 3.5% p.a.	0.966	0.934	0.902	0.871	0.842	0.814	0.786	0.759	0.734	0.709	
NET PRESENT COST* (Annual)	527	910	879	849	793	766	1,178	1,139	691	667	8,398
NET PRESENT COST* (Cumulative)	527	1,436	2,315	3,164	3,957	4,723	5,901	7,040	7,730	8,398	
TOTAL NET PRESENT VALUE (NPV) =	8,398										

* A minus sign in these rows denotes a Net Present Value rather than a Net Present Cost.

Option 3 produces a Net Present Cost of £8,398,000

3.7.4.2 NPV Option 4

National system procurement of "Best of Breed" under the Connecting Care Programme

NPV @ 3.5% p.a.											
YEAR :	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	TOTAL
CAPITAL COSTS (£ 000s):											
Capital	0	575	575	0	0	0	558	558	0	0	2,266
A. Total Capital Costs (Annual)	0	575	575	0	0	0	558	558	0	0	2,266
B. Total Capital Costs (Cumulative)	0	575	1,150	1,150	1,150	1,150	1,708	2,266	2,266	2,266	
REVENUE COSTS (£ 000s):											
Initial Non-Recurrent Costs	0	685	530	500	0	0	0	0	0	0	1,715
Staff Costs	1,203	3,016	2,972	2,972	218	218	218	218	218	218	11,468
Supplier Costs	0	187	381	724	724	724	724	724	724	724	5,634
Consolidation and Optimisation	0	408	399	399	0	0	0	0	0	0	1,207
Implementation Optimism Bias	0	0	0	0	0	0	0	0	0	0	0
Capital Charges (Depreciation)	0	0	0	0	0	0	0	0	0	0	0
DHCW SLA	0	250	250	250	250	250	250	250	250	250	2,250
C. Total Revenue Costs (Annual)	1,203	4,546	4,532	4,845	1,191	1,191	1,191	1,191	1,191	1,191	22,274
D. Total Revenue Costs (Cumulative)	1,203	5,749	10,281	15,126	16,317	17,508	18,700	19,891	21,082	22,274	
E. Total Costs (Annual) (=A+C)	1,203	5,122	5,107	4,845	1,191	1,191	1,749	1,749	1,191	1,191	24,540
F. Total Costs (Cumulative) (=B+D)	1,203	6,325	11,432	16,276	17,467	18,659	20,408	22,157	23,349	24,540	
BENEFITS (£ 000s):											
Welsh Government Funding Revenue	658	3,322	3,307	3,620	0	0	0	0	0	0	10,907
Welsh Government Funding Capital Charges	0	0	0	0	0	0	0	0	0	0	0
Welsh Government Funding Capital	0	575	575	0	0	0	0	0	0	0	1,150
G. Total Benefits (Annual)	658	3,897	3,882	3,620	0	0	0	0	0	0	12,058
H. Total Benefits (Cumulative)	658	4,555	8,438	12,058	12,058	12,058	12,058	12,058	12,058	12,058	
NET UNDISCOUNTED COST* (=E-G)	545	1,224	1,224	1,224	1,191	1,191	1,749	1,749	1,191	1,191	12,482
DISCOUNT FACTOR @ 3.5% p.a.	0.966	0.934	0.902	0.871	0.842	0.814	0.786	0.759	0.734	0.709	
NET PRESENT COST* (Annual)	527	1,143	1,104	1,067	1,003	969	1,375	1,328	874	845	10,235
NET PRESENT COST* (Cumulative)	527	1,670	2,774	3,841	4,844	5,813	7,188	8,517	9,391	10,235	
TOTAL NET PRESENT VALUE (NPV) =	10,235										

* A minus sign in these rows denotes a Net Present Value rather than a Net Present Cost.

Option 4 produced a Net Present Cost of £10,235,000.

3.8 Sensitivity Analysis

As part of the Full Business Case, a sensitivity analysis will need to be undertaken on the options as to test their robustness in relation to changing values and different scenarios for costs and the delivery of benefits. Further information in relation to supplier costs are required to do this.

3.9 The Preferred Option

The outcome of the economic appraisal indicates that the Preferred Option is Option 3 - Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed"

The reasoning behind this can be found in the Economic Case Conclusions.

3.10 Economic Case Conclusions

The Economic Case provides a clear understanding of the Benefits, Risks, Critical Success Factors (CSF) and how these have been used with the Investment Objectives to reduce the long list to the short-list.

The Preferred Option has been identified through using a standard process for appraisal and through working collaboratively as an MDT.

The reasoning for the preferred option is based on the following:

The estimated increased DHCW SLA costs of 1.25M over 5 years for Option 4, Option 3 will not incur these costs, these costs will also increase year on year.

Option 3 has a lower risk of implementation delays as BCUHB won't be fully reliant on DHCW and won't be impacted by other Health Board implementations and provides more control over system choice and procurement route.

There is potential to integrate to the other Connecting Care Programme Solutions in the future.

This option also allows BCUHB to deliver what is required in relation to datasets and reporting that is currently being done nationally by the Mental Health Team.

The NPV identifies that Option 3, provides better value for money.

4 The Commercial Case

The Commercial Case outlines the procurement approach for the preferred option identified in the Economic Case.

This section sets out commercial factors for the preferred way forward including:

- Context
- Procurement Strategy
- Framework Suppliers
- Charging Mechanism
- Contract Length
- Outline Based Specification
- Commercial Risks
- Special Advisors
- Accountancy Treatment
- Commercial Case at FBC

4.1 Procurement Strategy

In line with Welsh procurement, our approach to procurement will be to:

- Embed The Well-being of Future Generations Act into all our activities.
- Meet ministerial priorities and deliver effective public services.
- Support the delivery of key policy areas such as decarbonisation, social partnership and fair work including promoting ethical employment in supply chains.
- Be accountable and compliant with procedural, legal and international obligations.
- Commit to the principles of the Wales Procurement Policy Statement
- Focus on achieving best value for money for the Welsh pound.
- Streamline and simplify bidding for potential suppliers.

We will work within the financial regulations of BCUHB and ensure our approach to procurement is in line with BCUHB procurement and adheres to the guidance in the All-Wales

Infrastructure Programme and NHS Wales Standing Financial Instructions Page 65 of 121 (SFIs).

The Procurement Strategy is summarised below.

4.1.1 Procurement Options and Recommended Route

A variety of procurement routes have been assessed as to identify the recommended procurement option as to provide successful delivery, value for money and getting the best deal for the Health Board.

Procurement Option	Pros	Cons
1. Welsh Open procedure – single supplier with drawdown for each of Mental Health and Community Health (can be same supplier)	• Working for once for Wales • Better value for money at an all-Wales level • Can draw down when we are ready • BCUHB can be the contracting authority • Terms and conditions can be negotiated • Recommended National Option	• This would not deliver the preferred option • Not Mental Health only • Expected to take more time than doing a standalone procurement • No choice of supplier • Contract length driven nationally
2. Open Procedure	• Any supplier can participate • Choice of supplier through a structured competitive procedure • BCUHB will be the contracting authority	• Full Invitation to Tender (ITT) would be required • The Health Board would need to develop its own contract terms and conditions, and operational schedules • Refrained by Public Contract Regulations 2015 on timings for certain aspects of the procurement, so will take longer • It is a limited supplier market, so provide limited value
3. London Procurement Partnership (LPP) Framework – Further Competition	• Full ITT not needed as pre-qualification has already been undertaken and providers meeting the selection criteria have been awarded to the Framework Agreement. • The Framework Agreement Standard Terms and Conditions are set out and agreed with the providers	• Further pre-market engagement will be required so this will increase the timeline • The current Framework Agreement expires on 31st March 2025

	• The Health Board can amend or refine the Call-Off Terms and Conditions specific to its contract • Pre-qualified providers in an extremely limited market • Assurance that requirements can be met through the Framework selection process • Further pre-market engagement will be required but this is an opportunity to assess if the supplier can meet the requirements early on and increase market knowledge and inform the specification development • Choice of supplier through a structured competitive procedure • BCUHB will be the contracting authority • Increased assurance if other Health Boards wanted to award direct as "fast followers"	
4. London Procurement Partnership (LPP) Framework – Direct Award	• Full ITT not needed as pre-qualification has already been undertaken • Pre-qualified providers in an extremely limited market • Quickest procurement route • Choice of supplier through the supplier matrix selection process • BCUHB will be the contracting authority	• The Health Board should use the Framework Agreement Standard Terms and Conditions • No market competition • A direct award is only compliant if the Health Board's requirement is specifically covered in the Framework's "catalogue." In other words, the contracting authority can directly call off based on any product that has a fixed list price as of the CDS Catalogue • The current Framework Agreement expires on 31st March 2025

The Health Board values working collaboratively but due to the scale of the current risks within the services, the pace to deliver the change is a crucial factor so based on these and the need to ensure value for money the Health Board's procurement route will be the NHS

London Procurement Partnership (LPP) Clinical Digital Solutions (CDS) Framework using a further competition approach to secure a commercial off the shelf (COTS) solution with a standards-based technology architecture for Mental Health only. Clinical and Digital Information Systems Contract Details NHS London Procurement Partnership (lpp.nhs.uk). This is due to be replaced by the CDHS (Clinical Digital Health Systems) Framework and this will be used once it has gone live.

The CDS Framework Agreement covers a wide range of clinical digital solutions, the Electronic Health and Care Record being one of these solutions so can meet the requirements.

As this is a Framework Agreement, the Invitation to Tender (ITT) has already been undertaken so the Health Board can enter a call off contract from this framework by completing a further competition. There is no charge to the Health Board for using this framework.

NHS Shared Service Partnership (NWSPP) has confirmed that the Health Board being a National Health Service (NHS) body is entitled to use the LPP – CDS Framework as the Health Board meets the Access Requirements.

The LPP Framework Agreement has pre-agreed Standard Terms and Conditions, but the Health Board will be able to amend or refine the call off agreement Terms and Conditions specific to its requirement in the Operational Schedules issued as part of the further competition.

This LPP Procurement Route has been investigated by Perago on behalf of DHCW and further market engagement work has been undertaken by InForm who identified this route as one of two viable options, the other option being Option 1 as above. This route is also considered viable by NHS Wales Shared Services Partnership. The Perago Report can be found in **Appendix: J**– Perago Report, January 2024

The Perago report also recommended further market engagement and in response DHCW arranged a Mental Health supplier demonstration day on 10 April 2024 to assist with the identification of the appropriate method to market by understanding the preferred product.

The suppliers who responded to this request for information (RFI) exercise and provided demonstrations, are detailed below:

- TPP (SystmOne)
- Civica (Paris)
- Access (RIO)
- Epic

Due to the recommended procurement option and that Perago identified some concerns in relation to the market capacity and capability in relation to COTS, the Health Board have identified the need for even further pre-market engagement as to gain assurances regarding suppliers capacity and capabilities and to increase their supplier knowledge as to enable a robust supplier decision as a result these are included within the procurement timeline.

In summary, the recommended procurement route of using the London Procurement Partnership (LPP) Framework – Further Competition is appropriate and will enable the Health Board to:

- Deliver its preferred option of procuring a system independently
- Provide the best value for money
- Have the choice of supplier from a suitable range of suppliers
- Use a validated and quick route to market
- Be the contracting authority
- Have a commercially and deliverable route to market

4.1.2 Procurement Timetable

The following table provides the provisional timescales and are subject to change due to their dependency on OBC and FBC approvals.

No.	Action	Deadline
Pre-procurement		
1.	Signed Framework Access Agreement	01/06/24 (Complete)
2.	Pre-market Engagement (3 Weeks) (EOI to be sent out 05/06/24 (10 days)	28/06/24
3.	Procurement Document Preparation	26/07/24
4.	Approval to Commence (Project Board)	12/08/24
Procurement and Recommendation		
5.	Welsh Government Approval to Commence	31/08/24
6.	Invitation to Tender – Request for Proposal (RFP)	16/09/24
7.	Tender bid submission deadline (30days)	15/10/24
8.	Evaluation of tenders (4 weeks)	15/11/24
9.	Contract Award recommendation report (7 days)	27/11/24
Full Business Case Approvals		
10.	Full Business Case Completion (2 Weeks)	09/12/24
11.	Project Board Approval	09/12/24
12.	Performance, Finance, and Information Governance Committee (PFIG) Approval	23/12/24
13.	Health Board	30/01/25
14.	Welsh Government	30/01/25

15.	Award/Regret Letters standstill (10 Days)	10/02/25
16.	Contract Award (7 Days)	17/02/25
17.	Completion of the operational schedules with supplier (2 weeks)	03/03/25
18.	Contract Execution/Start	01/04/25

4.1.3 Procurement Management

The Procurement will be managed by NHS Shared Services Partnership, supported by the SRO (or delegated officer) and a Programme Manager from Digital, Data and Technology with a wider multi-disciplinary team undertaking the tender evaluations.

4.1.4 Evaluation Criteria

The framework uses the most economically advantageous tender (MEAT), using Technical/Quality and Commercial as the evaluation criteria, these must be used but the Health Board, under the framework can decide on the weightings and can include sub-criteria if they are clearly stated to all suppliers upfront in the further competition tender documents.

The following evaluation criteria and weightings will be used:

Criteria	Comprising	Weighting
Technical/Quality	Clinical (40%) Technical (30%) Social Value (10%) Service Management (10%), Risk Transfer (10%) Sub Criteria 100% = 70 Technical/Quality	**70%**
Commercial	Best and Final Offer	**30%**
Total		**100%**

With the necessity to incorporate Social Value and the importance of the right system to enable the transformation required the Health Board have prioritised Technical/Quality over cost on a 70/30 basis.

4.2 Framework Suppliers

The London Procurement Partnership have a suitable Framework Agreement, Clinical Digital System (CDS). This framework provides a Supplier Matrix which consists of twenty suppliers awarded to the appropriate Lot, “Electronic Health and Care Record Solutions”. However, as these are not all Mental Health specific and there is no filtering methodology to provide the required differentiation, all twenty suppliers will be sent the Expression of Interest (EOI). This

ensures that the good procurement principles of equal treatment, transparency and no discrimination are observed in the process to identify suitable suppliers, resulting in an early indicator of which companies may bid after the Expression of Interest (EOI) stage.

The details of all these suppliers are provided in **Appendix: K** – Framework Suppliers

4.3 Charging Mechanism

Awaiting Schedules from the Framework

4.4 Contract Length

It is proposed that the contract will be awarded for an initial term of five (5) years, with an option to extend this term by further period/s to be no more than a total of an additional four (4) years in duration that will be split into two (2) x two years (2), resulting in the contract being five + two +two. This is considered the most appropriate in terms of length of investment, supplier lock in and possible future national alignment.

All proposed extensions would need to be scoped and agreed utilising the appropriate governance processes.

4.5 Outline Based Specification

The system requirements are split between functional (end-user needs and processes) and non-functional (operational capabilities).

4.5.1 Functional Requirements

The development of the system requirements for BCUHB end-users, started by using the baseline requirements from the National Program Team's Connecting Care program, which are specifically tailored for MH&LD for all ages.

The requirements underwent a three-stage validation process:

1) initial walk-throughs with clinicians and the National Data Design team,
2) detailed reviews by 'Care Champions' and 'Cascades,' and
3) Regional engagement for prioritisation and gap analysis.

Locally, between April and June 2024, BCUHB MH&LD for all age's representatives provided user scenarios to map against these requirements, which were then validated locally by BCUHB representatives, ensuring alignment with national standards while addressing local needs.

This thorough validation, involving over 60 staff members and employing various validation methods, resulted in a robust and inclusive set of system requirements for BCUHB's MH&LD all ages services.

The requirements for the BCUHB system are organised into High-Level Use Cases and a catalogue of Level 2 Requirements, structured around patient and clinician journeys, and designed to be solution agnostic.

The approval process involves internal reviews by local Subject Matter Experts (SMEs), followed by review meetings to finalise requirements, and sign-off by Directors of Digital and the Project Board.

The validated Functional Requirements are:

- Single view of the patient;
- Support interoperability, integration, and open API's
- Integration and interoperability with new Social Care solutions.
- Effective and efficient Clinical workflow;
- Fully integrated applications;
- Intelligent worklists/scheduling capability;
- Multi-Disciplinary Team solution;
- Clinical Decision Support;
- Full audit trails (Including NIIAS functionality/interface);
- Structured reporting capability;
- Business Intelligence / Data Analytics and Predictive Modelling;
- Capacity in the agreement to support business change and growth;
- Product innovation and technical development incorporated over its lifetime of the contract;
- Data portability to support Freedom of Information and Subject Access Requests;
- Mobile Accessibility;
- User Experience (UX) and User Interface (UI) Design;
- Compliance with National Standards (including All Wales Mental Health Response and Access targets, Mental Health Act, All Wales Mental Health Measure, Patient Outcomes & Experience (PROMS/PREMS), Improvement Cymru (Memory Service), All Wales Mental Health Core Dataset, Outcome Measures, Psychiatric Consensus, Standards aligning with Psychology reporting and specific acute care pathway standards, NICE guidance, 1000 lives framework, ICD codes, READ codes, SMS Treatment Outcome Profile (TOPS), LD Consensus, Healthy Equality Framework)
- Ability to support bidirectional data sync
- Configurability in line with All Ages Safeguarding and Looked After Children ("LAC") National and Local reporting needs
- Interoperability with national and local solutions*
- Interoperability and integration with local push interfaces*

*The FBC will include a full and detailed understanding of the Integration and Interoperability work required against the preferred Solution.

4.5.2 Non-Functional Requirements

The national non-functional requirements are being validated by specialist leads in BCUHB, including Cyber Security, Information Governance, Infrastructure and Service Support.

These non-functional requirements will meet the required national technical standards. The BCU Integration non-functional requirements can be found in **Appendix: W**.

4.6 Commercial Risks

The following are considered the key commercial risks, the wider project risks are included in the Strategic Case:

	Commercial Risk	Mitigation / Mitigating Actions
a.	Limited or poor response to the further competition resulting in the contract not being awarded	Mitigated by Soft Market testing, followed by use of the Alternative Framework or Approach if Plan A is not suitable.
b.	Delays in the procurement timelines impacting the contract award date due to the multiple approval processes. It is estimated that if key approvals are missed it could result in a 3-to-4-month delay. Any delay within this procurement phase will cost BCUHB due to pre-procurement resource invested	Mitigated by ensuring all key stakeholders understand the situation as imperative, that they are informed on the approval processes and held to account for delivering what is required and by when
c.	Suppliers not agreeing to any proposed changes to the Operational Schedules.	Mitigated by Management within the tender process
d.	Supplier unable to meet the needs of BCUHB due to:	
	The technical complexity and the required national system integrations	Mitigated by ensuring the must have requirements of a basic Mental Health system for BCUHB are primary, and national system integrations are secondary
	Service size, complexity, and scale of standardisation and change	Mitigated by having the necessary time and space afforded to users and teams despite the negative impact on operational services and the "air cover" from Welsh Government

	Existing management of paper records	Mitigated by having a risk-based approach to this issue where through the leadership of the SRO Clinicians accept the risk of not having access to historical records.
e.	The solution is not affordable once all supplier costs have been confirmed	Mitigated by using a framework with costs included
f.	No partnership—approach in the BCUHB and Supplier Relationship	Mitigated up front through supplier engagement and soft market testing
g.	Timing considerations and demands on supplier capacity to submit tenders if BCUHB run the further competition at the same time as other Health Boards or the national procurement is advertised.	Mitigated by inviting and including ABH and CTM to all supplier sessions and sharing our requirements with them
h.	The preferred Framework Agreement as detailed in section 4.2 expires 31st March 2025 which would present time pressure for BCUHB.	NWSSP – Procurement Services have discussed the framework expiration date with London Procurement Partnership and understand that a new Framework Agreement is due to go live in June 2024 with a slightly modified offering. BCUHB's requirement will be covered by the new Framework Agreement and would remove any time constraints. Therefore, the "new" Framework Agreement will provide the optimal solution.

4.7 Special Advisors

Specialist advisors (in addition to the expertise within the services and project team) have been identified as follows:

Commercial	NWSSP
Legal	NWSPP
Finance	Andrea Hughes, BCUHB

4.8 Stakeholders

There has been extensive stakeholder engagement Pan BCUHB with a broad spectrum of medical, operational and corporate staff which has been driven with strong clinical input to help meet the needs of the services.

Local Primary Mental Health Support Services (LPMHSS)	Secondary Care Community Mental Health Teams (Adult & Older Persons)	Inpatient Services
Home Treatment Teams	North Wales Brain Injury Services (NWBIS)	CAMHS
Older Persons Mental Health (OPMH)	Psych Liaison	Early Intervention Psychosis Service (EIPS)
Pharmacy	Therapy Services	Forensic medium secure
Specialist Adult Eating Disorders Service (SAEDS)	Rehabilitation	Perinatal Mental Health
Forensic Community	Learning Disabilities	Prescribed Medication & Counselling support services
Drug & Alcohol	Medical Staff	Nursing Staff
Digital, Data & Technology Staff	Procurement Staff	Finance Staff
Administration Staff	Planning & Performance Staff	Clinical Directors
Service Management Staff	Corporate Communication Staff	Change Management Staff
Digital Insight & Intelligence Staff	Reporting & Analysis Staff	Pharmacy Staff

4.9 Accountancy Treatment

It is envisaged that the assets underpinning delivery of the service will be recorded on the balance sheet of the Health Board.

4.10 Personnel Implications

It is anticipated that the TUPE – Transfer of Undertakings (Protection of Employment) Regulations 1981 – will not apply to this investment as outlined above. The contract will not involve the transfer of staff from the Health Board to the appointed contractor.

4.11 Commercial Case Conclusions

The Commercial Case provides assurance that the Procurement Strategy is robust and provides the best rote to market for BCUHB.

Four procurement options have been identified and assessed; all have been confirmed that BCUHB is entitled to use them. The assessment has integrated the work undertaken nationally by Perago and InForm for Digital Health Care Wales (DHWC).

The London Procurement Partnership (LPP) Framework – Further Competition has been selected as the recommended procurement route based on the following reasons:

- Deliver its preferred option of procuring a system independently
- Provide the best value for money
- Have the “choice” of supplier from a suitable range of suppliers
- Use a validated and quick route to market
- Be the contracting authority

- Have a commercially and deliverable route to market

It is important for BCUHB to procure the right solution, so further market engagement will be undertaken.

The Health Board values working collaboratively but due to the scale of the current risks within the services, the pace to deliver the change is a crucial factor.

It is planned that procurement will start once approval to commence has been gained and will be finalised by the end of March 2025 with the contract start being the 1st April 2025 but this timescale is subject to both BCUHB and Welsh Government approval timelines.

The main commercial risks include delays in the timeline impacting on the contract award date; suppliers not being able to provide the capabilities BCUHB requires; the solution is not affordable. The CDS Framework ends March 2025 but it's replacement CDHS will be used.

It is anticipated, for the procurement only services provided by NWSSP (Commercial and Legal) will be required and internal financial expertise.

Further details are required from the Framework as to enable the charging mechanism to be finalised, this will be updated once it is received.

The Outline Based Specification has been developed and shows the high level functional and non-functional requirements, these have been developed collaboratively on a national and BCUHB level engaging a wide range of staff and services.

Prior to the FBC, the following will be produced:

- The full requirements (functional and non-functional) need to be finalised and undergo quality assurance; this will be gained from working with all the Health Boards through the National Connecting Care Programme. (Due to be completed by the end of June 24)
- Full Procurement Strategy (End June 2024)

5 The Financial Case

The Financial Case demonstrates the financial impact of the investment on BCUHB and the affordability and funding considerations relating to the preferred option.

The following financial appraisal methodology has been used:

- The financial model adopted for the proposed investment aims to cover:
    - Financial assumptions,
    - Proposed funding source/structure,
    - Input schedules such as cash-releasing benefits and risks,
    - Projected impact on cash-flow, income and expenditure and balance sheet.

The financial information below is for the preferred Option 3 - Procure a Commercial Off the Shelf (COTS) Solution – "Best of Breed".

5.1 Revenue and Capital Costs

To deliver transformation for Mental Health and CAMHS All Ages, a hybrid mix of skills across the divisions will be required. The estimated resources have been identified based on a collaborative assessment, previous implementation resources and the indicative plan. These are an essential part of revenue costs to ensure the change is delivered and embedded as to deliver the benefits. The additional revenue costs include the supplier costs, in this case these are licenses.

The revenue costs are subject to variances including supplier support, service requirements, roll-out approach, training, data migration, integration, hosting, and the wider impact to the service.

The resources and roles to support the implementation are a combination of staff to be recruited by the Health Board and staff that will be prioritised to deliver the project at a cost to BCUHB. These are set out in the Resources document **Appendix: P** Resource Costs
There may be occasions where specialist skills will be required where alternative resourcing may be required for example, if we are unable to backfill/recruit or specialist change capacity. These will be funded from within the total project budget.

Suitable end-user devices are included within the capital costs, these are essential for successful project implementation. Infrastructure works i.e., Wi-Fi etc. will also be required and these have already been assessed and will come under BCUHB current capital programme of works.

The overall estimated capital and revenue costs (project and recurring) for implementation, resources, additional hardware, and annual service charges are shown in the 7- and 10-year profile in the ROI table below.

The tables set out a full ten-year profile in line with the Health Board's financial practices. Years 1-7 are highlighted as this is Welsh Governments expectation for a minimum contract term. Welsh Government have suggested a minimum of 7 years life, our 10-year profile therefore encompasses as does our recommended contract length.

Revenue is broken down into one off project costs and recurring costs for a period of 10 years to show the long-term costs, this includes the 7-year period of the contract (5 Years plus 2). Capital includes indicative costs of new hardware needed through the life of the project.

Full details including Net present costs can be found in **Appendix: N**.

A full and detailed roadmap of the implementation will be completed as part of the FBC. An outline project timeline is provided in Section 6.2 and key descriptions of activities are included in **Appendix: O**.

The overall 7- & 10-year cost profile is as follows:

7&10 Year Profile for ROI

	Programme				BAU				BAU			
	Year											
	1	2	3	4	5	6	7	7 YR TOTAL	8	9	10	10 YR TOTAL
All costs excl. of VAT	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Costs												
Non Recurrent Costs		685	530	500	-	-	-	**1,715**	-	-	-	**1,715**
Staff Costs	1,203	3,016	2,972	2,972	218	218	218	**10,815**	218	218	218	**11,468**
Supplier Costs	-	187	381	724	724	724	724	**3,463**	724	724	724	**5,634**
Optimism Bias	-	408	399	399	-	-	-	**1,207**	-	-	-	**1,207**
Capital Charges (Depreciation)	-	-	-	-	-	-	-	**-**	-	-	-	**0**
Capital	-	575	575	-	-	-	558	**1,708**	558	-	-	**2,266**
TOTAL COST	**1,203**	**4,872**	**4,857**	**4,595**	**941**	**941**	**1,499**	**18,908**	**1,499**	**941**	**941**	**22,290**
Capital	-	575	575	-	-	-	558	**1,708**	558	-	-	**2,266**
Revenue	1,203	4,296	4,282	4,595	941	941	941	**17,200**	941	941	941	**20,024**
Revenue 10% tolerance								**-**				**0**
TOTAL COST	**1,203**	**4,872**	**4,857**	**4,595**	**941**	**941**	**1,499**	**18,908**	**1,499**	**941**	**941**	**22,290**
WG Funding Revenue	658	3322	3307	3620	-	-	-	**10907**	-	-	-	**10907**
Depreciation Capital Charges	-	-	-	-	-	-	-	**0**	-	-	-	**0**
WG Funding Capital	-	575	575	-	-	-	-	**1150**	-	-	-	**1150**
TOTAL FUNDING	**658**	**3,897**	**3,882**	**3,620**	**-**	**-**	**-**	**12,058**	**-**	**-**	**-**	**12,058**

Savings												
Medical Staff								**0**				**0**
Nursing Staff								**0**				**0**
Admin Staff					6	6	6	**18**	6	6	6	**36**
Storage			10	20	40	40	40	**150**	40	40	40	**270**
Reduction in Consumables			15	30	60	60	60	**225**	60	60	60	**405**
Other								**0**				**0**
TOTAL SAVINGS	**-**	**-**	**25**	**50**	**106**	**106**	**106**	**393**	**106**	**106**	**106**	**711**
TOTAL WG FUNDING AND SAVINGS	**658**	**3,897**	**3,907**	**3,670**	**106**	**106**	**106**	**12,451**	**106**	**106**	**106**	**12,769**
Capital	-	575	575	-	-	-	-	**1150**	-	-	-	**1150**
Revenue	658	3,322	3,332	3,670	106	106	106	**11300**	106	106	106	**11619**
TOTAL SAVING	**658**	**3,897**	**3,907**	**3,670**	**106**	**106**	**106**	**12,451**	**106**	**106**	**106**	**12,769**
Revenue impact each year	545	974	949	924	835	835	835		835	835	835	
Cumulative Revenue Implications												
Costs	1,203	6,075	10,932	15,526	16,467	17,409	18,908		20,407	21,349	22,290	
Savings	658	3,980	7,312	10,982	11,088	11,194	11,300		11,407	11,513	11,619	
CUMULATIVE NET POSITION	**545**	**2,095**	**3,619**	**4,544**	**5,379**	**6,214**	**7,608**		**9,001**	**9,836**	**10,671**	

5.2 Financial Assumptions

- Inflationary Supplier increases are not included.
- Existing system cost benefits have not been taken into account.
- Digitisation of paper records for active patients has not been fully assessed. Costs may therefore change and there may be some additional costs.
- It is important to note that supplier costs are indicative at OBC stage and are likely to be subject to significant change during procurement and clarification of health board requirements, supplier capacity and capability.
- Infrastructure costs have been estimated by technical colleagues from within the Digital Data and Technology Service. Hardware will be purchased with 5-year warranty and is expected to be replaced. Infrastructure costs therefore include the cost of refresh in Year 8.
- Costs for the purchase of local devices are included.
- Within the financial appraisal there is a calculation included for optimism bias, i.e. 20% on all costs (but taken out for year 1 – pre-implementation).
- Resources that will make up the temporary organisation formed to prepare for a MH&LD and CAMHS solution. This will typically include resources to complete the implementation itself, covering project management, business analysis, design, testers, business change, trainers, clinical specialists, and communications.
- The duration to implement the solution will be approx. 36 months subject to detailed planning post procurement exercise.
- Pre-implementation teams in place to assess readiness for procurement costs.
- A period of post go-live before areas are handed over to operational Business as Usual.
- Integration for the solution with National platforms will be provided free of charge by DHCW.
- Licence costs based on the number of users in MH&LD and CAHMS has been costed across Implementation years. Year 1 of roll-out up to 500 users, Year 2 up to 1500 users and Year 3 up to the total number of 2850 users.
- The supplier costs are outline costs only, based on the G-Cloud 13 framework. **Appendix: Q**.
- Note that any staff cost savings reflected are not directed towards a reduction in staff numbers but as an overall reduction due to the benefits and process efficiencies from the shift away from a paper-based system. Further staffing efficiencies across the service are to be explored before any additional cash-releasing costs are quantified.

5.3 Affordability and Source of Funding

The following summarises the financial requirements required from the Welsh Government and BCUHB:

		Programme				BAU		
		Year 1* 24/25 **£'000**	Year 2 25/26 **£'000**	Year 3 26/27 **£'000**	Year 4 27/28 **£'000**	Year 5 28/29 **£'000**	Year 6 29/30 **£'000**	Year 7 30/31 **£'000**
WG Funding Required	Revenue	658	3,322	3,282	3,571	0	0	0
	Capital	0	575	575	0	0	0	0
BCUHB Contribution**	Revenue	545	974	974	974	941	941	941
	Capital	0	0	0	0	0	0	558
Total Savings				25	50	106	106	106
Total Project Cost	Revenue	1,203	4,296	4,231	4,495	835	835	835
	Capital	0	575	575	0	0	0	558

*Year 1 is for 6 months only

**Includes current staffing from the non-recurrent transformation fund

In determining affordability for the chosen system, it is presumed therefore that:

- Welsh Government will support funding of capital and revenue costs in years 1, 2, 3 and 4.
- BCU Health Board will also fund an element of capital and revenue costs from year 1 onwards.
- Business as usual will need to be funded by the Health Board from Year 5 as a cost pressure of £835k per annum, as set out in **Appendix: M**
- If the funding is not provided or is insufficient, BCUHB will review in line with the Contingency Arrangements in Section 6.10.

The Welsh Government funding is not expected to cover:

- Extended periods of post go-live support for Service areas.
- Resources deemed necessary for the ongoing operation of an all-age MH&LD Solution (except during the readiness period – for example upskilling of resources that will become business as usual).
- Integration with local applications unless otherwise agreed in writing by the Welsh government. This is expected to be provided by DHCW.

For a longer term view the financial appraisal table below, shows a break-down of costs against the preferred option across 7- and 10-year periods as needed for Welsh Government and BCUHB:

7&10 Year Profile for ROI		Year											
All costs excl. of VAT		1	2	3	4	5	6	7	7 YR TOTAL	8	9	10	10 YR TOTAL
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Costs													
WG FUNDED	Capital	-	575	575	-	-	-	-	1,150	-	-	-	1,150
	Revenue	658	3,322	3,282	3,570	-	-	-	10,832	-	-	-	10,832
BCUHB FUNDED	Capital	-	-	-	-	-	-	558	558	558	-	-	1,116
	Revenue	545	974	974	974	835	835	835	5,974	835	835	835	8,480
TOTAL COSTS	Capital	-	575	575	-	-	-	558	1,708	558	-	-	2,266
	Revenue	1,203	4,296	4,257	4,545	835	835	835	16,807	835	835	835	19,313
TOTAL SAVINGS		-	-	25	50	106	106	106	393	106	106	106	711
		1,203	4,872	4,832	4,545	835	835	1,393	18,515	1,393	835	835	21,579

5.4 Financial Case Conclusions

The Economic case identified the preferred option as shortlisted option 3 - Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed".

The financial appraisal over a **7-year period**, for the preferred option is as follows:

Total 7-year Project Cost (£18,515m including £393k cost savings subject to further validation)
Break-down

- Capital - £1.150m (funding to be sought from WG)
- Revenue - £10.832m (funding to be sought from WG)

- Capital - £558,000 (funding to be sought from BCUHB)
- Revenue - £5,974m (funding to be sought from BCUHB) includes £3.468m from the non-recurrent transformation fund. Further staffing efficiencies across the service are to be explored before any additional cash-releasing costs are quantified.

A full breakdown of resources is available in **Appendix: P**

All identified costs and any further potential cash-releasing savings from year 5 onwards will be revisited in the Full Business Case once preferred solution and scope is clear.

6 The Management Case

This Management Case sets out at a high-level the "achievability" of the project and provides assurance that the Health Board can deliver both the digital and service transformation changes required.

6.1 Project Management and Governance

6.1.1 Digital Portfolio Management

All Health Board digital change projects sit under an established Digital Portfolio structure that monitors and controls the implementation of all national and local projects. This is based on Axelos best practice for Managing of Portfolios (MoP).

Portfolio Management, led by a PMO Manager provides an additional layer of assurance in relation to:

- Strategic alignment with the Health Board priorities – doing the right projects
- Demand Management
- Prioritisation and impact assessments
- Standard ways of setting up, managing, and closing projects
- Management of resources, finance, capacity planning, risk management and resource planning
- Quality management
- Stakeholder engagement
- Monitoring, reporting and Health Board escalation
- Visibility of the portfolio
- To raise delivery standards - support to staff to continually develop and improve (part of Centre of Excellence)

Portfolio management provides the benefit to the Health Board of having a high-level overview of all the projects which allows greater flexibility in planning, delivery and the ability to flex across projects.

6.1.2 Project Management Arrangements

The project management arrangements are aligned with BCUHB corporate approach that is underpinned by the principles of Axelos PRINCE2 and PRINCE2Agile. PRINCE2 Methodology has a prescribed structure of governance and reporting mechanisms, which can be tailored to the magnitude, scope, and complexity of individual projects to enable successful, and efficient project delivery. Agile approaches will be used to support delivery and in relation end user design and experience.

The Project Manager will use these principles to ensure that the project is properly led, planned, resourced, monitored and controlled for its entire lifecycle. The project also requires a project assurance role, as set out in the roles and responsibility section of this document.

Whilst this project is being project managed by the Digital, Data & Technology Team, strong clinical leadership, ownership, and engagement is required to make the project successful.

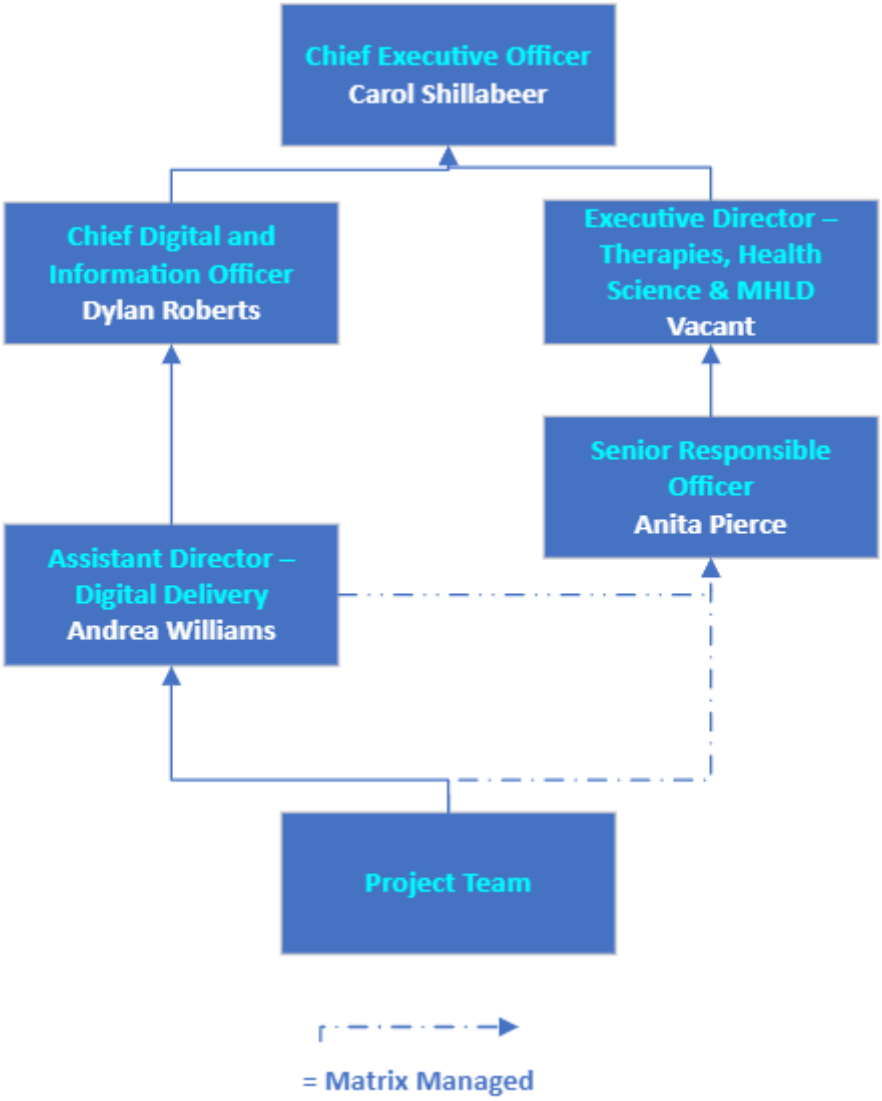
The project team will work closely with the relevant clinical and operational stakeholders to ensure that the implementation meets the agreed business need and service transformation. Detailed Roles and responsibilities are included in the Project Management Framework.

The role of the Senior Responsible Officer is key to successful implementation of this project and will be undertaken by Dr Anita Pierce, Deputy Medical Director/Consultant Psychiatrist, MH&LD. If this post becomes vacant for any reason this will be escalated to the Medical Director, Dr Alberto Salmoiraghi.

6.1.3 Management Structure, Project Management Team and Budget

6.1.3.1 Management Structure

The following details the high-level management structure showing that the project has significant senior leadership. The project governance structure is included in Section 6.1.4



6.1.3.2 Project Team and Budget

There is one multi-disciplinary Project Team (post-procurement) consisting of the following resources, these have been identified due to the scale, complexity and the skills required to deliver this project, a large amount of change resources have been included due to the complex change required.

Role	WTE	Type
MH&LD Consultant Psychiatrists / Clinical Directors	1.6	Senior Leadership/Change (inc SRO)
DDaT Information Skills Trainer	1	Change
MH&LD Head of Planning & Performance	0.4	Change & Senior User
DDaT Business Change Manager (inc Communication)	1	Change
DDaT Information Skills Trainer	1	Change
MH&LD / CAHMS Service Product Manager	1	Change
MH&LD Senior Administrator	1	Change
CAHMS Business Support Manager	2	Change & Senior User
MH&LD Clinical Operations Manager	3	Clinical Change & Senior User
MH&LD Senior Psychiatrists	1.5	Clinical Change & Senior User
MH&LD Nurse Specialist/ Specialist Practitioner	3	Clinical Change & Senior User
MH&LD Nurse Specialist/ Specialist Practitioner	1	Clinical Change & Senior User
Clinical Governance Lead	1	Operational
DDaT Assistant Director of DDSE	0.2	Project
DDaT Programme Manager	0.4	Project
DDaT Project Manager	1	Project
DDaT Assistant Project Manager	1	Project
DDaT Senior Project Support Officer	1	Project
DDaT Project Administrator	0.5	Project
DDaT Solutions / Product Specialist	1	Project
DDaT Assistant Solution / Product Specialist	1	Project
DDaT Information Analyst	1	Project
DDaT Information Analyst	1	Project
DDaT Information Developer	1	Project
DDaT Integration Lead	0.5	Technology
DDaT ICT Systems Engineer	1	Technology
DDaT ICT Technician	1	Technology
DDaT Floorwalkers	2	Technology
DDaT Voice and Data engineers	1	Technology
DDaT ICT Technician	1	Technology
DDaT ICT Helpdesk Analyst	2	Technology

Please note that benefits resources will be provided by the Digital PMO and have not been included in the above costs.
The roles and responsibilities of some of the above staff are as follows:

Name	Role	Responsibilities
Dr Anita Pierce	Senior Responsible Officer (Consultant Psychiatrist)	• Provide strategic and clinical leadership to the Project Board and Project Team. • Ensure alignment with the organisation's overall strategy and goals. • Clearly articulate the business vision and expected benefits of the project. • Communicate the strategic importance of the project to stakeholders, Implement the communications strategy; act as an ambassador to gain buy-in and commitment, promotion of the project, publicity, or other dissemination of information about the project. • Act as the primary interface between the project and the organisation. • Chair Project Board meetings. • Ensure that the project remains viable and aligned with business objectives, delivering a product that will achieve the forecasted benefits. • Approve stage plans, key deliverables, and any necessary changes and escalations. • Authorisation of gateways • Development and review of the Business Case. • Receive regular reports from the Project Manager. • Provide updates to the organisation's leadership on project progress. • Ensure decisions are made promptly to avoid project delays. • Approve or reject changes, considering their impact on the project. • Ensure changes align with organisational goals. • Take responsibility for high-level risk and issue management and ensure that risks and issues are being monitored and mitigated as effectively as possible. • Make strategic decisions on risk tolerance and risk response. • Provide guidance on resolving conflicts within the Project Board and national stakeholders. • Ensure the project offers value for money. • Monitor expenditure and progress, including escalation of financial matters where required. • Participate in gateway reviews and project prioritisations. • Formal project closure

		• Post-stage / project review; ensure benefits have been realised, including lessons learnt review. • Share expertise with other SRO's.
Dylan Roberts Andrea Williams Jamie Slater	Project Assurance	• Monitor all aspects of the project's performance and products independently of the Project Manager • Translate and interpret for the Programme, using technical, policy and other experience and advises a course of action if required • Check the performance and products independent of the Project Manager • Ensure organisational standards and policies are followed
Angela Wilson	Project Manager	• Define the project governance (controls) • Plan the overall project, allocating work packages, monitoring and reporting progress. Identify and obtain support and advice when required • Monitor overall progress and use of resources, initiating corrective action where necessary • Manage the project budget and prepare reports in collaboration with the finance member • Manage risks and issues taking corrective measures • Lead the Project Team • Act as a link between the Project Board and the service • Deliver the required product to the required capability and quality, within the constraints of costs and time • Deliver the outcome that is capable of achieving the benefits defined in the Project Initiation Document • Oversee the communications plan, including to build and sustain effective communication with other project stakeholders • Maintain awareness of and manage potential interdependencies with other projects • Adopt and apply appropriate technical and quality strategies and standards • Oversee handover to business as usual, including follow-up actions • Other activities as delegated by the SRO and Project Board
Lynda Jackson Nicola Lodge	Project Support	• Assist the Project Manager with relevant tasks • Report to the Project Board on project activities • Support the SRO to deliver their responsibilities • Bring to the Project Board's specific attention any significant matters, ensuring appropriate escalation • Highlight any concerns (Risk, Issues, conflict etc.) to Project Board, producing project documentation, communicating key messages, and providing awareness • Adhering to governance arrangements (Including DPIA, compliance with Cyber Security Welsh Health Circular etc.) • Lead on/participate in work packages

		• Assist in go live and post go live activities
Gethin Evans and identified change leads from the service	Business Change Manager	• Translate, identifies and reconciles key stakeholder interest in the project • Identify key areas for change to bring benefit to the organisation • Lead on the transition to change and benefits realisation • Engage with all stakeholders involved with the change and escalating any resistance to change as appropriate • Identify, assesses, and prioritises risk associated within the Project • Lead on the production of product descriptions, ensuring the products are fit for purpose and signed off before work is significantly progressed • Manage risks and issues and escalates where needed • Involvement in production of training documentation ensuring training materials suit the audience • Participate in testing during User Acceptance phase to ensure product is meeting deliverables
Vicky Jones Chris Lindop Renee Evans Jessica Jones Kathryn Thomas Key service reps	Senior Users	• Ensure change is effectively managed, pro-active and policies standardised, system adopted and time allocation to staff to do this • Achieve the results required by the Senior Users within the cost and time parameters. • Authority to commit or acquire the required resources. • Promote and maintain focus on the desired project outcome and ensure the product(s) provides the expected benefits • Ensure users are able to meet implementation timescales and resources are available when needed • Understand how the product works in the day-to-day operations of the area • Assist the Business Change Manager with transforming the project vision into a working model • Assist with issue resolution when needed • Ensure products are signed off once completed • Accountable for their own part of user assurance • Assist in go live and post go live activities
Jessica Arthur supported by Assistant Solution Specialist Claire Penlington and	Solution Specialist	• Contribute to assigned Work Packages • Provide knowledge from previous implementations including training and current ways of working • Co-ordinate staff to undertake UAT activity as per timeframes within the project plan • Sign off the completion of testing against the relevant acceptance criteria • Responsible for monitoring the performance of the system

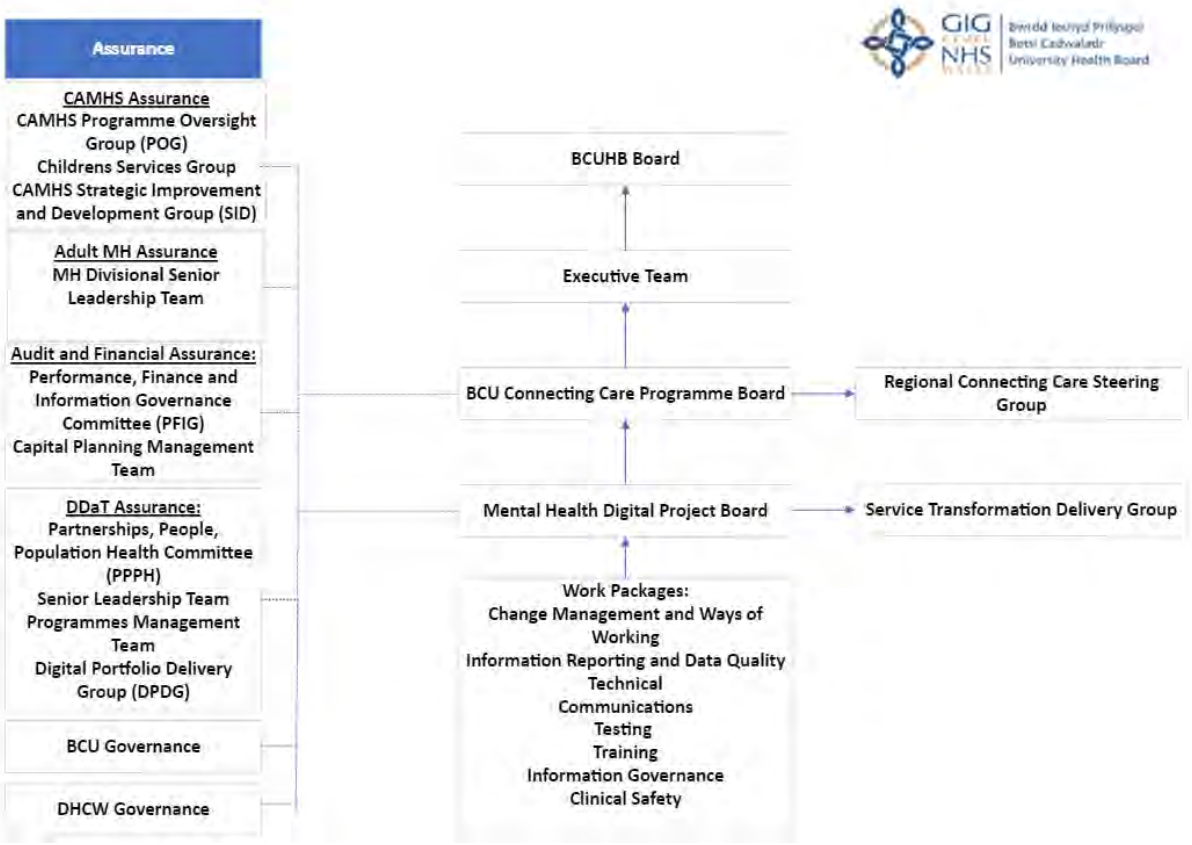
Information Skills Trainers Sion Pritchard & Tina Hayward		• Responsible for defining the longer-term development strategy, to ensure that developed software will continue to meet constantly changing user and stakeholder needs • Assist in go live and post go live activities
John Thomas Paul Graver	ICT Specialists	• Provides technical advice and support to the project

Standard roles and responsibilities for all project (including SRO), technology and some change staff are documented, further work will be required to document some of the clinical change, operational roles and the product manager.

The monthly budget required for this team is **£232,497**, (Excluding shift allowance/travel and optimism bias) please note that many of these roles are provided by BCUHB, full details can be found in the Financial Case.

6.1.4 Project Governance

Project governance is critical as to monitor and control the delivery, implementation and closure of the project, the indicative governance structure is provided below and will be finalised during the project start up and documented in the Project Initiation Document (PID) and Project Board Terms of Reference.

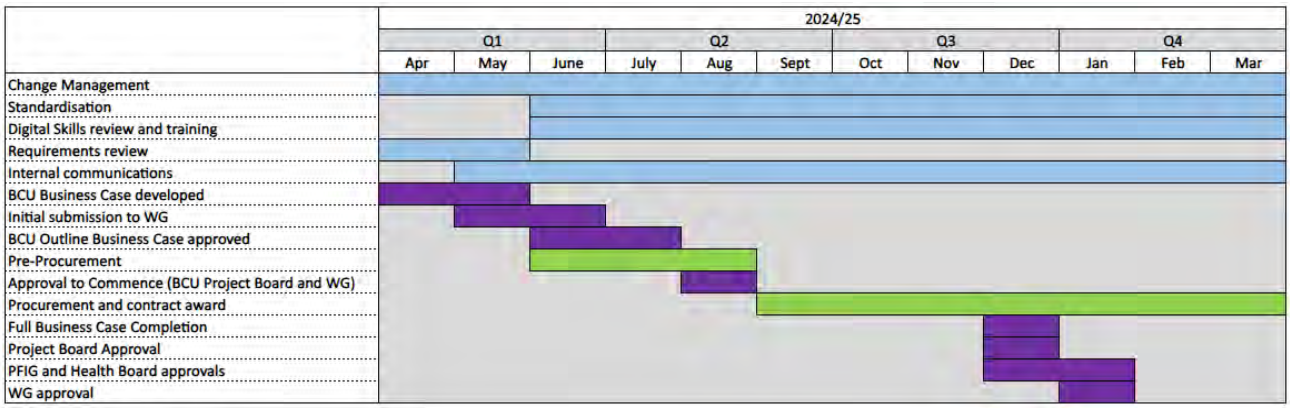


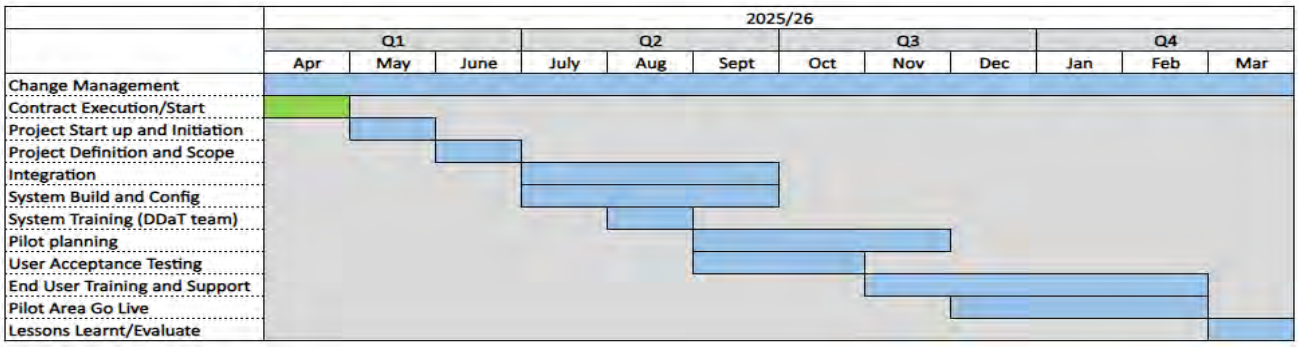
The indicative project governance diagram above will link into the DHCW - National Connecting Care Governance and Programmes Structure (**Appendix: R**) and the Regional Connecting Care Steering Group as to ensure national and regional alignment.

6.2 Indicative Project Timelines

The project, including procurement is expected to be undertaken within 3.5 years. 6 months for procurement in Financial Year (FY) 2024/25 and 3 years for full implementation during FYs 2025/26, 2026/27 and 2027/28. Business as Usual from FY 2028/29 onwards.

The below is the indicative timeline for the project lifecycle up to the end of the first pilot. This is indicative due to the scale and complexity of the change and detailed planning needs to be undertaken with the chosen supplier and the services and lessons learnt need to be integrated. The two considerations are “Big Bang” or a “Phased” both these approaches must be assessed in relation to the clinical risk and speed of benefits realisation.





Key:

	BCU tasks
	Approvals
	Procurement

Prioritisation of services will be decided clinically via the Service Transformation Delivery Group (STDG). At this point it is anticipated that the pilot will include Local Primary Mental Health Support Services (LPMHSS) which is the 'front door' to the service.

A post-project evaluation will be conducted 12 months after the formal project closure and this will be led by the Programme Manager,

6.3 Use of specialist advisers

The project is likely to require additional assistance and expertise in change management, financial, legal, technical, clinical and procurement throughout the project lifecycle.

Change Management will play a significant part in the successful delivery of this project, this is a large and complex project that will require backfill of certain roles as to enable our staff within the services to lead the change. Some of these may be highly specialist clinical roles.

In addition, specialist change capabilities and an increase in capacity may be required, the Health Board are currently working on a resources approach as to be able to augment our projects and services utilising a preferred partner model. This route will be used to gain the specialist change skills as and when needed.

DHCW support will be required in relation to the interoperability of the solution with the national systems.

The Mental Health Project Team are working with DHCW throughout the project and will be supported by NWSSP Procurement colleagues with regards to the procurement exercise.

Clinical safety is crucial in this project, currently BCUHB have no Digital Clinical Safety Officers so specialist resources will need to be bought in.

A specialist advisor from the NHS Executive in relation to the standardised Mental Health Core Datasets that will cover Mental Health Services for people of all ages, they have not been approved nationally. (This includes Referral to Treatment (RTT))

6.4 Digital and Technical Compliance

BCUHB will ensure that suppliers commit and adhere to all relevant functional and interoperability standards including the Technology Code of Practice (below). This adherence includes:

- Compliance with the Digital Service Standards for Wales including meeting at minimum the AA standard for accessibility
- Compliance as appropriate with standards and design principles set by the DHCW Technical Design Authority, Welsh Technical Standards Board and Welsh Information Standard Board for integration and interoperability
- The ability to share data in line with the Professional Records Standard Body's (PRSB) Core Information Standard
- Compliance with NHS national contract provisions for technology-enabled delivery (for example, clinical correspondence and electronic discharge summaries)
- Ensure clinical systems and tools meet clinical safety standards as set out by the Digital Technology and Assessment Criteria (DTAC) and DCB0129 and DCB0160
- The Digital Service Standards for Wales (Please see **Appendix: S** – Digital Service Standards) which includes an assessment of how this project will meet these Standards. Digital Service Standards for Wales | Centre for Digital Public Services (gov.wales)
- Compliance with the BCU ICT Solutions Specification (**Appendix: T**).

6.5 Engagement, Change and Contract Management Arrangements

6.5.1 Engagement

There has been significant engagement across Mental Health Services to determine the current state of working, technology environment, the business need and satisfaction with current systems.

A year-long engagement exercise was carried out in readiness for the WCCIS programme: See MH&LD Digital Enablement Phase 1 paper **Appendix: E**). The Digital survey (**Appendix: F**) was designed to inform, shape, and compliment site visits, giving the opportunity for staff completing the survey to raise any specific issues or ideas.

Engagement extended beyond BCUHB to ensure we had comprehensive service user and partner organisation input. In 2022, MH&LD held four Together for Mental Health workshops to support the collaboration and co-design of the North Wales Together for Mental Health Interim Strategy 2023-24. Representation from health, social care, public, private and third sector and service users and carers were present at these sessions, and the senior digital project lead was also in attendance to hear the discussion and consider how digital plays a part in the issues raised and in the strategic priorities that were agreed.

Direct engagement by the Mental Health Digital system project Senior Responsible Officer, Dr Anita Pierce, is ongoing with frontline teams (discussing digital news), via scheduled presentations to the Strategic Transformation Delivery Group, which is chaired by the MH&LD Medical Director, and via the set-up of a specific LPMHSS (the identified Phase 1 pilot area) Digital user group.

To facilitate an all-age approach, colleagues from CAMHS were also approached for consideration.

CAMHS provide essential assessment, care and treatment of C&YP, and their families/carers, who are experiencing serious mental health problems. BCUHB CAMHS are delivered by multi-disciplinary teams, including psychiatrists, psychologists, nurses, social workers, youth workers, child and adolescent practitioners, psychological therapists allied health professions and others. They also have an important role in supporting the mental health capability of the wider network of children's services across partner agencies.

The CAMHS 3 Year Improvement Programme sets out how Integrated Health Communities (IHCs) within BCUHB, supported by the CAMHS Programme Management Office, will deliver key areas of improvement and re-design to move us towards achieving our vision.
These priorities apply as much to resetting core service activity, stabilising our current workforce and consolidation as they do to implementing new ways of working.

A further survey is planned to be shared with staff to capture their hopes and fears prior to the introduction of the planned digital system.

6.5.2 Change Management

The level of this complex change will not be underestimated as it will see a shift from outdated paper processes to digital across a diverse range of services within locations across the wide geography of North Wales.

Due to the level of change, staff will need a variety of support models to support them through the change and end user engagement and design will be at the core of the change strategy.

This is a clinically (all disciplines) led and digitally enabled project so it is important that the change is clinically led, this will result in the need to provide clinical roles and backfill for key leads and specialities in the services.

The digital skills of some of the staff are likely to need some development, these skills are essential for the service change and staff will be supported throughout their change journey.

The change, in the short term could lead to a drop in performance, this is a difficult time during implementation and on-site support will be provided to minimise the service disruption and to ensure staff are suitably supported.

The change management strategy will be developed with a focus on the different levels of where change is needed, these are: organisation, team and individual. This will enable a systematic approach to planning, initiating, controlling, and effecting change.

The change management strategy will use best practice from the NHS Change Toolkit, incorporating the PROSCI ADKAR methodology which are both best practice and promotes the use of end user design and engagement which is a priority for this project. Operational Readiness Assessments (ORA) will be undertaken for each part of the project lifecycle and will align to projects gates.

Change management, aligned with strong leadership and project management are crucial to the success of the transformation required. A high-level draft plan to provide examples of some of the change approaches that can be found in **Appendix: U** – High level draft change plan.

Due to the significant change needed in relation to people and process within this project specific resources to manage the change have been included in this business case and BCUHB recognises that training will be required in change management, and this will be arranged and financially supported by the Health Board.

6.5.3 Contract Management

Contract management will be undertaken by the Health Board as the Contracting Authority and DDaT uses the Chartered Institute of Procurement and Supply (CIPS) Contract Management Cycle as this is recognised as an approach of best practice and supports the maximisation of value and the minimisation of risk. This is an end-to-end plan from Pre-award to Renewal or Transition. Contract management can be split into two stages – Stage 1- Pre-award and Stage 2 – Post-award. Stage 1 is covered by the Commercial Case so the remaining post-award will be covered within this case which covers contract management and maintenance.

A strong supplier relationship is essential for project success and can be the make or break of a project, key areas of the Contract Management Plan (CMP) will be developed collaboratively with the supplier. Please see **Appendix: V** – Contract Management Plan Template.

The Contract Manager will be Jamie Slater - Programme Manager and this role will then be transferred to the system owner once the project is closed.

6.6 Benefits Management

Benefits Management arrangements use the APMG, Managing Benefits which have been used to develop the DDaT Benefits Realisation Framework, will be used, and all benefits will be documented on MS Project for the Web.

The Benefits Lead for this project is Gethin Evans, Change Lead for Connecting Care.

The Health Board are currently further developing capabilities in this area.

The following benefits cycle will be used:

Phase	Objectives and tasks within stage
Phase 1: Identify and Quantify	• The identification of benefits - Primarily via benefits discovery workshops, benefits mapping, and customer insight. • Quantification of benefits - Here the focus is on forecasting/estimating the scale of benefits anticipated and addressing the main problems faced in developing reliable benefits forecasts and the solutions.
Phase 2: Value and Appraise	• Options analysis - to compare the various options or alternative ways of achieving the desired outcomes and benefits; • Investment appraisal - to assess whether the benefits justify the cost required; • Portfolio prioritisation - to rank potential investments in priority order where resources are limited;
Phase 3: Plan	• Forecasted benefits are validated • Benefits are prioritised • Pre-transition activity is managed • Appropriate benefits measures are selected
Phase 4: Realise	• Ensuring that project outputs/deliverables/products are fit for purpose and can be integrated into business operations; • Tracking and reporting benefits realisation at an initiative level; • Going beyond processes and practices to consider the softer side of business change.
Phase 5: Review	• The benefits to be realised are achievable and continue to represent value for money; • Appropriate arrangements have been made for benefits monitoring, management, and evaluation; • Benefits realisation is being effectively managed; • Lessons are learnt for both the current initiative and as a basis for more effective benefits management practices.

Best practice and lessons learned throughout the course of the project will be captured in a Lesson Learnt Log and formally shared in the Project Closure Report and added to the DDaT Portfolio Lessons Learnt Register. Lessons learnt will be undertaken collaboratively with all key stakeholders through an interactive workshop.

As most benefits will be realised after project closure, the Senior Responsible Officer is responsible for ensuring post-project benefit reviews are undertaken, this role is to be confirmed in the Project Closure Report.

The Benefits Framework is available on request.

6.7 Risk management arrangements

Arrangements for managing and mitigating risks during the delivery of the project are aligned with the *Corporate Risk Management Strategy*. This ensures there is a proactive approach and process in place to identify, assess and control risks that emerge during the lifecycle of the project. This is supported within the governance arrangements by underpinning the risk management of the Project, with a decision-making framework for effective evaluation of risks and issues.

All risks are captured, analysed, and assessed within a local risk register on SharePoint. Risks identified for escalation will be included on the Digital, Data and Technology (DDaT) Risk Register (DATIX). The risk register will capture a risk reference, risk type, date identified, date last updated, and description of risk, likelihood, impact, risk owner, mitigation, and RAG status.

The risks register will be updated and reviewed continuously to ensure that risks are properly managed and mitigated to ensure successful delivery of the project. This ensures a proactive approach and robust process are in place to identify, assess and control risks that emerge during the lifecycle of the project.

All risks are scored using the Health Boards matrix:

	Likelihood				
Consequence	**1 - Rare**	**2 - Unlikely**	**3 - Possible**	**4 - Likely**	**5 - Almost Certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

Score

	1 to 3	Low risk
	4 to 6	Moderate risk
	8 to 12	High risk
	15 to 25	Extreme risk

6.8 Quality Assurance

The project's direction and management, in line with the DDaT Project Management Framework, will use three levels of assurance depending on the circumstances. Level 1 & 2 provide a range of options that the Project Board can use depending on where the project is at, the assurance activities highlighted with a * have to be undertaken as standard practice. The Project Board will be required to agree the others as and when the need arises.

For Level 3, BCUHB will be part of a national wider plan of assurance.

All levels of assurance will be used as tools to improve delivery.

Level 1 – Internal to DDaT

- Internal Gate Reviews*
- Health Check*
- Deep Dives – if tolerances are being exceeded*
- Risk Potential Assessment (RPA) – a structured self-assessment if there are multiple issues affecting the project
- Peer Project Review (Full or Partial) OR
- Assistant Director/Head/CCIO Review

Level 2 – Internal to BCUHB

- Programme/Project Board Effectiveness*
- Project Assurance Review (Full or Partial) *
- Internal Audits

Level 3 – External to BCUHB

- Project Assurance Review - nationally commissioned or undertaken by DHCW or Welsh Government (as part of a Gateway Review)
- External Audit

6.9 Post-Project Evaluation

The following post-project evaluations will be undertaken and shared nationally with DHWC and other Health Boards:

1. Project Closure
2. Post Project Evaluation Strategy (PPES)
    a. Project Implementation Review (PIR)
    b. Project Evaluation Review (PER)

Currently, the PRINCE2 best practice framework is used for Post-Project Evaluation, however this approach will be reviewed to incorporate guidance within the Magenta Book.

6.9.1 Project Closure

As soon as possible after go-live, a Project Closure Evaluation will be undertaken as part of the formal closing a project process within the project lifecycle. This ensures that the system is accepted by the service as meeting their needs and measures project success against the objectives set out in the Project Initiation Document (PID) whilst also providing assurance that any outstanding actions, issues and risks will be operationally managed as business as usual (BAU).

Best practice and lessons learned throughout the course of the project will be captured in a Lesson Learnt Log and formally shared in the Project Closure Report and added to the DDaT Lessons Learnt Register. Lessons learnt will be undertaken collaboratively with all key stakeholders. The Project Closure Report Template on Microsoft Project for the Web is to be used.

6.9.2 Post Project Evaluation Strategy (PPES)

The purpose of the post-project evaluation strategy is to provide a structured approach for improving project delivery through lessons learned and evaluations.

There are two key review processes, the Project Implementation Review (PIR) and the Post Evaluation Review (PER).

The Project Implementation Review (PIR)

A Project Implementation Review will be conducted 12 months after the system goes live. This review will focus on the realisation of project benefits, the operational performance of the system, and additional lessons learned.

This will enhance project delivery practices by identifying and addressing issues during the project delivery phase via gateway reviews, gathering feedback from project team members and stakeholders, documenting lessons learned and best practices and implementing correcting actions to improve ongoing project performance.

Post Evaluation Review (PER)

- Conduct a review after project completion
- Compare actual outcomes with initial objectives and expected benefits
- Assess adherence to required quality standards
- Evaluate how well the system is running
- Measure stakeholder satisfaction
- Assess effective resource utilisation
- Ensure completion of deliverables on time and within budget
- Identify factors contributing to success and shortfalls
- Document findings and recommendations for future projects

Information for this evaluation will be gathered from the Lessons Learned log, formally documented in the Project Closure Report and added to the DDaT Lessons Learned Register. This process will be collaborative involving all key stakeholders.

As most benefits will be realised post-project, the Senior Responsible Officer (SRO) will ensure post-project benefit reviews are conducted.

6.10 Equalities Impact Assessment and (EQIA) and Data Protection Impact Assessment (DPIA)

The Equality Impact Assessment and Social-Economic Assessment are statutory requirements for Public Sector organisations in Wales and is fulfilled by completing an Integrated Equality Assessment within BCUHB. This will assess the impact on equality to those with protected characteristics due to changes with policies, procedures and practices brought about by the implementation of an all-age MH&LD solution. The Integrated Equality Assessment will be completed alongside this business case and will be approved prior to the start of the implementation process.

The DPIA will be completed alongside this business case and outcomes from the procurement evaluation, particularly the highest scorer's responses to relevant criteria shall be included in the final DPIA document. This also includes how the system supplier will meet all obligations under UK GDPR and the Data Protection Act (2018) as well as the Welsh Government Security Circular. The DPIA will be submitted to the Information Governance team in due course, but prior to the chosen system supplier contract being signed.

6.11 Contingency Arrangements and Plans

It is expected that contingency will be required in the following areas and are related to the risks and their probability of happening.

Risk/Issue	Plan
Insufficient national funding	Health Board to assess financial position and if funding can be prioritised
Insufficient Health Board funding	Reduce the scope of the project with the focus on the higher risk, interdependent services
Any cost-saving benefits not being realised	Monitor the benefits plan, significant savings have not been identified as focus is on more time to care
Service change leads not being able to be released from duties due to staffing levels	Backfill has been added into the Financial Case or backfill is not possible due to recruitment and current staffing levels so the low intensity services will be used to support the high intensity services i.e. reduction in routine activity. Decanting service managers.

Delays in recruitment and not able to recruit to the capacity and capabilities required to deliver the projects	Covered within 20% Optimism Bias and agency costs
Additional deployment costs	Dependant on amount covered within 20% Optimism Bias for revenue but if Capital, the Health Board Capital budget would be required to be prioritised
Additional staffing on-costs i.e., national salary increases	Covered within 20% Optimism Bias or provided by the Welsh Government

6.12 Assumptions, Constraints and Dependencies

6.12.1 Assumptions

Several Assumptions have been made about the project:

- The project will deliver a fit for purpose all ages MH&LD solution that will meet the project objectives and agreed requirements of BCUHB
- Subject matter experts, internal and external (including supplier) can be released as and when required to participate throughout the lifecycle of the programme where required
- Supplier and solution capability and reliability
- Service process and procedures will change as a result of the new solution
- Sufficient funding will be available by Welsh Government & BCUHB for the project to meet its objectives, and to deliver the transformation at pace in line with the Minister's request
- Local training needs will be identified
- Resources will be made available by the Health Board to support the adoption of a new all ages MH&LD solution
- Staff will embrace the change
- During go-live and a period after, service performance is likely to decrease, and reporting will be impacting
- Parallel running for an agreed period
- Historical records (non-live records) paper or digital, within disparate systems may not be digitised/migrated
- Any business-as-usual costs associated with the local all ages MH&LD solution will be funded by the Health Board
- Floor walkers from other projects will be required for pre-go lives and go-lives
- 24/7 support will be required for some services

6.12.2 Constraints

Constraints to be considered as part of the project:

- Funding to enable delivery – system, implementation, and business as usual
- Sufficient resources to support the project (staff capacity)

- Level of digital skills of the workforce
- Technology Infrastructure
- Technical outputs delivered as part of the project will need to conform to national data standards for Mental Health, and interoperability standards
- Suitability of suppliers on the framework
- Key dependencies delivered by the national programme such as applicable Application Program Interfaces (APIs)
- Alignment of National Mental Health Datasets with procurement timescales. The National Information Management team have been commissioned by the National Mental Health Outcomes board to define the data and reporting requirements in relation to Mental Health Services. The outcome of this work will be considered as part of the requirements
- Some buildings in the estate cannot be altered to allow installation of Wi-Fi and networking due to asbestos and other safety concerns.

6.12.3 Dependencies

This project is not being delivered in isolation and will be dependent on a number of points listed below:

- Availability of Welsh Government and BCUHB funding to procure a solution
- Availability and capacity of required staff and skillset to deliver the project
- Availability and capacity of third-party resource (DHCW/supplier) to deliver elements of the project
- A suitable solution is identified
- Suitable infrastructure investment (Wireless network connectivity including data cabling and Wi-Fi access points)
- Suitable capital funding is available for end user devices
- Publication of national APIs and interoperability standards by the National programme to support an all-age MH&LD implementation.

6.13 The Management Case Conclusions

The Health Board is mature in relation to digital project delivery and this case clearly sets out how the project will be managed through recognised best practices as to ensure that the project is deliverable and that will deliver what it is setting out to achieve. These areas of best practice include:

- Portfolio - Management of Portfolios
- Project Management – PRINCE2 and PRINCE2Agile
- Change Management – NHS Change Toolkit
- Benefits Management – APMG – Managing Benefits and Value
- Contract Management – CIPS Contract Management
- Risk Management – Corporate Risk Management
- Quality Assurance – BCUHB Project Best Practice

The level of change is large and complex with a delivery approach of being clinically led and digitally enabled, these are reflected in the costs within the Financial Case. It is expected that the process and people changes will be more significant than the technology implementation.

There will be strong senior leadership with direct management through Executive Directors to the Chief Executive with the SRO matrix managing the Project Team.

Strong governance will be provided that mirrors the clinically led approach with clearly defined roles and responsibilities and BCUHB will work nationally and regionally to ensure strategic and operational alignment.

A range of specialist advisors may be required these include change management, clinical safety, DHCW, NWSSP and the NHS Executive.

A detailed plan is required but this cannot be provided until the contract has been awarded and further work is required to assess the clinical and benefit risks of the implementation approaches.

The digital and technical compliances have been assessed, and they can be delivered.

A Change Management Strategy that is developed collaboratively with end users' needs to be developed, this is so important due to the level of change.

The integrated Equality Impact Assessment and Socio-economic Assessment will be finalised with the supplier within 3 months of contract award. This will also be the same for the Data Protection Impact Assessment and the Cyber Assessment as supplier input is required.

To be provided in the FBC:

- Draft implementation plan (Further refined) (will be required to be finalised with the supplier)
- Change Management Strategy
- Outline Impact Assessments (will be required to be finalised with the supplier)

7. Conclusions and Recommendation

We need significant change and this OBC clearly sets out why we need to change, what we need to change, how we can change and by when whilst also providing assurance that we can deliver what is needed to improve services, save lives and avoid deaths.

The OBC has been developed collaboratively, we are stronger together and this sets the future direction for how we will work to make this happen.

The findings within this case, through the economic appraisal, risks and benefits clearly define the preferred option to be **Option 3 - Procure a Commercial off the Shelf (COTS) Solution – "Best of Breed"**

The recommendation is for the Health Board and the Welsh Government to approve this OBC and provide the required funding.

8.0 Declarations

✓	The above information has been reviewed to ensure it is accurate and represents a true and fair view of the service to be provided, the benefits and the costs
✓	Where third parties have provided information, this is in writing/e-mail format, and they have confirmed it is correct to the best of their knowledge
✓	Where the OBC has an impact on another Area / Division / Department the impact has been agreed with that Area / Division / Department in writing and the relevant Managers have signed below to confirm

Title	Name	Signature	Date
Interim Finance Director	Russell Caldicott		
Chief Digital & Information Officer	Dylan Roberts		
Senior Responsible Officer	Dr Anita Pierce		

9. Appendices

Separate document due to size (Appendices List v0.3)

Teitl adroddiad: ***Report title:***	North Wales Vascular Network
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides a progress report on the improvements being undertaken in Vascular services in North Wales. A vascular network on a 'hub and spoke' model was implemented in North Wales in April 2019 after extensive external review, consultation and Board discussion. A modern hybrid theatre was opened on the YGC site in April 2019 following recruitment of consultants. Pathways began to be put in place to deliver care as close to peoples' homes as possible. Concerns about the quality of care however, led to an external service reviewed and in March 2022, to Healthcare Inspectorate Wales (HIW) identifying the service as a Service Requiring Significant Improvement. HIW undertook an inspection of the service in November 2022 and the report was published in June 2023 which resulted in the HIW designation being deescalated. The Health Board commissioned an externally chaired Vascular Quality Panel in 2022 which reported in 2023. A number of service improvements have taken place and close working with the families of a number of patients whose cases were reviewed by that panel resulting in meetings with families from September – October 2023. As part of the Special Measures intervention, the Welsh Government requested a further external assessment of the vascular service at BCUHB. The review was undertaken in May 2023. Improvement work, enabled by additional, targeted fundings for this services followed. This improvement work will be continue to be driven by a Programme Board approach, and underpinned by effective delivery groups, which will help to maintain and develop strong clinical engagement and leadership of key areas of work. Welsh Government recognises the significant work undertaken to date in order to strengthen and improve quality and safety within the network, and acknowledges the network's commitment to ongoing improvement. This service remains within the Level 5 (Special Measures) Framework, and Welsh Government has outlined a number of key areas, which if implemented successfully, will support the service's de-escalation.

Argymhellion: ***Recommendations:***	▪ To discuss the Vascular Service Progress Report, specifically the level of progress made and the current status of the service following external assessment ▪ To endorse the proposal for a further peer review in 12 months to ensure continued improvement, reporting through regularly to the Quality, safety and Experience Committee.
Arweinydd Gweithredol: ***Executive Lead:***	Paper to be presented by Carol Shillabeer, CEO with support from other Executive Directors on behalf of Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad: ***Report Author:***	Dr Jo Flannery, Vascular Network Manager

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	▪ SO4: Improving quality, outcomes and experience
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Incidents of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards or safety legislation
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	None for this paper
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	**CRR24-12:** Areas of clinical concern (note – further work is underway to separate this risk into the specific clinical service areas)

Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	A financial support case has been developed to enable the ongoing improvement work of the Network, and to support the Network to address to recommendations outlined within the external reviews.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The ongoing improvement work of the vascular network is dependent upon the recruitment of a number of key posts, as outlined within the vascular business case
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been shared with the IHC Director, and Interim IHC Medical Director, who have influenced the report
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**BAF21-02:** Recovering access to timely care pathways
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A for this paper
Next Steps: ▪ To continue to implement the improvement actions ▪ To provide further progress report to the Quality, Safety and Experience Committee	
List of Appendices: **Appendix 1:** Chronology of events	

Vascular Services – Progress Report

Introduction and purpose

The purpose of this report is to provide the Health Board with an overview of the progress being made in relation to vascular services improvement in North Wales. The report provides background and chronology of concerns raised through a number of external reviews, together with the work undertaken by the organisation to address those concerns, to strengthen and stabilise the service, and take steps for the medium to longer term.

The report crucially outlines the current position with regards vascular improvement, and provides details of current and future improvement priorities.

2010 – 2023: Vascular service development

The information provided below is intended to provide a short history of the North Wales vascular service, including the decision to centralise, independent and external reviews, special measures. A timeline of key events, by way of background, can be found at **Appendix 1**.

The decision to centralise

Betsi Cadwaladr University Health Board (BCUHB) vascular services were reconfigured into a hub and spoke model in 2019, with the centralisation of arterial and endovascular surgical services at Ysbyty Glan Clwyd (YGC). The decision to reconfigure resulted from increasing concerns, raised from 2010, regarding the quality and sustainability of the three standalone vascular services delivered in the Health Board's three acute hospitals. At the same time, there was increasing UK-wide focus on the move to regional vascular services via development of networks.

By 2012, a proposal to centralise the service on the Ysbyty Glan Clwyd site had been developed by existing vascular consultants, and an interim model was developed which would see the service being temporarily based in Wrexham Maelor Hospital (WHM) and Ysbyty Gwynedd (YG) whilst plans for a new, modern hybrid vascular theatre in YGC were developed. This plan was formally approved by the Board on 18th January 2013, with the Community Health Council being supportive of the proposal, as were the Royal College of Surgeons in their report published in 2014[1].

The Business Case for the new hybrid theatre was approved in 2017 and recruitment of senior medical staff commenced, with a view to full implementation in 2019. Capital works commenced in late 2017. This service re-design was completed in line with written guidance issued by the Vascular Society of Great Britain and Ireland[2].

The Board confirmed that the service would "go live" on 10th April 2019 in its meeting in March 2019 and that the pathway issues highlighted by Healthcare Inspectorate Wales (HIW) were being addressed.[3]

[1] Royal College of Surgeons England (2014) "Report on Vascular Surgical Services BCUHB"
[2] Vascular Society of Great Britain and Ireland (2018) 'The Provision of Services for Patients with Vascular Disease"
[3] HIW Report (2019)

Emerging concerns – Royal College of Surgeons of England report

Shortly after opening, a number of service concerns were highlighted in a Community Health Council (CHC) report[4], including a particular focus on the continuity of services in Ysbyty Gwynedd.

In July 2020, with ongoing concerns relating to quality and patient experience, the Board commissioned the Royal College of Surgeons of England (RCSE) to undertake an 'Invited Service Review' of the reconfigured vascular service.

The review commenced in January 2021, with the report being received by the Health Board in March 2021, and took the form of a review of the service and an examination of forty-four clinical records of patients treated by the vascular service. The first stage of the report was produced in March 2021. The second stage of the report, dealing with the note review, was published in January 2022, and set out key findings and recommendations, covered later.

The Vascular Steering Group (VSG) was established in October 2021, chaired by the Executive Medical Director. Patient and CHC representation at the Steering Group was established from the outset. The purpose of this group was to:

- oversee the implementation of a number of improvement actions
- bring a number of plans together into a single improvement plan
- provide a greater focus on going incidents and quality review of the service.

HIW designation – vascular as a 'service requiring significant improvement'

In March 2022, following the occurrence of two 'Never Events' in the vascular service, Healthcare Inspectorate Wales (HIW) identified the service to be a 'Service Requiring Significant Improvement'. The two Never Events were subsequently downgraded and in one of the cases the initial concerns were challenged by the independent external reviewer who recognised good practice in BCUHB.

HIW undertook a repeat inspection of the service in November 2022 and the report, published in June 2023, resulted in the HIW designation being de-escalated.

Vascular Quality Review Panel (VQRP)

In the review referenced above, published in January 2022, the Royal College of Surgeons of England were not able to provide assurance from the notes reviewed in relation to the quality of care (in cases that dated from 2014-2020) and recommended that an external review should be commissioned.

The RCSE recommended that the Health Board review should use additional knowledge not available to the RCSE, as well as the data within the clinical records to determine if the records contain the expected information recorded for the patient's episodes of care. The RCSE also recommended that the Health Board review should scrutinise whether the necessary appropriate follow-up and aftercare plans were in place for patients.

In order to provide assurance on the quality of this review an external chair was appointed to a Vascular Quality Review Panel (VQRP), with independent clinical advice from a vascular nurse and a vascular consultant. Recommendations from the VQP report were presented to the Board from June 2022 onwards, before publication of the final report in January 2023.

[4] CHC Report

The Vascular Quality Review Panel final report was received by BCUHB and published on the 30th January 2023. Whilst HIW highlighted improvement within the scope of their inspections, resulting in HIW de-escalation, the VQRP identified additional gaps in the service when completing the clinical records review recommended by the RCSE. In total, the report highlighted twenty-seven recommendations for improvement, with seven overall themes:

- Clinical pathway effectiveness
- Clinical governance including, consent and decision-making
- Accountability, professional practice and person-centred care
- Team working, including the multi-disciplinary team
- Complex pain management and palliative care
- Education and learning
- Discharge and necessary and appropriate follow-up and aftercare plans

Escalations from the Vascular Quality Review Panel led to a number of important service changes, including dual consultant operating, and the establishment of the external MDT with Liverpool and Stoke hospitals.

Patients and families whose cases were being reviewed by the Panel were contacted and a Vascular Patient helpline was established. Where meetings were requested with families, these took place, and continued to take place, some through the redress procedures.

Learning and Sustainability

During this period, the Board considered learning that should arise from the events of 2014-2021, and the Board Secretary commissioned a report from the Good Governance Institute[5]. In addition a sustainability assessment for vascular services took place[6], received in March 2023.

The assessment outlined the needs for further scrutiny of the plans for vascular surgical expansion, including reviews of the processes around surgery, e.g., (Cardio Pulmonary Exercise Test) CPET, Pre-operative Assessment Clinic (POAC) etc. Furthermore, it was recommended that Health Board wide reviews of the acute care physician backup for surgery model, diabetic foot service, diabetology should be widened.

Special Measures

On 27th February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of BCUHB to Special Measures.

As part of the Special Measures Intervention, Welsh Government requested a further, two-part external assessment of the Vascular Service at BCUHB. It was agreed with the Health Board that Part one of this Assurance Assessment would be a supportive piece of work undertaken in collaboration with the Health Board. The purpose of the Assurance Assessment was to review the quality of the vascular service and other related services that are involved in the pathways of care, to assess the extent to which recommendations from various reviews and reports have been implemented (see below). Part two of the assurance assessment was to review 40 case notes from vascular patients who

[5] Good Governance Institute (2022) 'Vascular Services Learning Review'
[6] Kendall Bluck (2023) 'High Level Vascular Service Review'

had received care more recently (between August 2022 and August 2023) than those in the earlier notes review.

Where are we now?

The most recent external assessment is the two-part assurance assessment requested as part of special measures:

Assurance Assessment – Part 1

Welsh Government, working with the Health Board as part of the Special Measures intervention, commissioned an assurance assessment of the quality of vascular services and other related services that are involved in the pathways of care, to assess the extent to which recommendations from the various reviews and reports have been implemented sustainably.

The assessment, published in October 2023, highlighted an overall improvement in the quality and safety of the vascular service, and noted the following key points:

- The Vascular Quality Plan (VQP) adequately brings together recommendations and escalations from the Royal College of Surgeons (RCSE) and Healthcare Inspectorate Wales (HIW) reviews, with good progress made.
- Vascular services have improved from the previous RCSE reviews and now provide a better service – clinicians work more collaboratively, with patient management being Multi-Disciplinary Team (MDT) driven.
- The Health Board's submission to the National Vascular Registry (NVR) is within the acceptable range for surgical outcomes, although angioplasty data needs to be improved.
- The Vascular Service is constrained by capacity issues (hub beds, CPET) and nurse/ therapist vacancies. However, the Vascular Team have clear aspirations to continue to improve and be allocated to support the training of senior vascular trainees going forward.
- The Vascular Transformation Team have been pivotal in bringing about the positive changes in the service, but it is important that operational, nursing and therapy teams are more involved, which will help promote a culture of change across the entirety of the service and embed the changes made to date.
- There are several areas, including pathway implementation, and spoke site working, which require further work to ensure sufficient improvement
- There are a number of areas within the VQP action plan that are still to be adequately tackled – for example, capacity for administrative support, access to critical care beds, imaging requesting, and nursing input.

Assurance Assessment – Part 2

Welsh Government then commissioned a review of 40 case notes from vascular patients between August 2022 and August 2023. The purpose of this case note review was to support the Part 1 assessment by analysing the extent to which recommendations from various previous reviews and reports has been implemented and are operationally in place. This report was shared with the Health Board in March 2024.

The review made the following key points:

a. The findings of the Panel were that 38 out of 40 of a number of different vascular procedures undertaken during the time period of 1 August 2022 to 31 July 2023 were considered to be acceptable. Taking into account the recent time period, contrasted against the earlier clinical notes review covering more historic periods, it was considered by the Panel that this demonstrated an ongoing positive trajectory of improvement within BCUHB vascular practice.

b. It is important to recognise that this progress forward was underpinned by many examples of good work happening across the Health Board. Several patients and their families highlighted that they were pleased and appreciative of the care that they had received, and information within the report sets out many examples where patients and their families identify good practice, compassionate care and express thanks to staff across all sites and different specialties. It was also clear from local vascular team representation on the Panel, that there was a strong desire to deliver optimal care to patients and their families.

c. The report identified areas where it was considered that further improvements could be made to strengthen the service. It is important to note that these areas are not solely associated with the direct practice of the vascular service and include other related services and practice involved in the delivery of multi-professional pathways of care.

A total of 10 recommendations for further improvement were identified from part one, and 17 recommendations from part two, which have all been incorporated within the latest version of the Revised Vascular Integrated Improvement Plan (R-VIIP).

Revised Vascular Integrated Improvement Plan (R-VIIP)

Using the publication of the WG Vascular Services Assurance Assessment Report as a framework, a 'stocktake' of progress against the current Improvement Plan has been undertaken to create a Revised Integrated Improvement Plan (R-VIIP) that reflects those legacy priorities identified during previous service reviews, as well as any new improvement recommendations issued as part of the Assurance Assessment.

The R-VIIP has been developed in partnership with the Transformation and Improvement Team, and has been designed to follow evidence-based improvement methodology, and to reflect the Health Board's commitment to demonstrating the measurable outcomes and benefits of any improvement work.

National Vascular Registry data on activity, performance and outcomes

The National Vascular Registry produces an annual benchmark report, analysing submitted data on emergency and elective procedures for patients with peripheral arterial disease, patients who have had an open abdominal aneurysm (AAA) repair, and patients who have undergone carotid endarterectomy (CEA), in NHS hospitals across England, Scotland, Wales and Northern Ireland.

The most recent annual report, published in November 2023[7] highlighted improvements in practice across BCUHB's vascular network, since the previous year.

[7] National Vascular Registry (2023) 'State of the Nations Report 2023'

Key areas of improvement include:

	BCUHB 2021	BCUHB 2022	All Wales 2022
AAA – median time from assessment to procedure (days)	100 days	74 days	131 days
AAA – % patients receiving surgery within 8 weeks of assessment	26%	39%	16%
CEA – patients receiving surgery within 7 days of referral	31%	50%	62%
CEA – median delay from index symptoms to surgery (days)	14 days	13 days	14 days
Amputation – median delay from vascular assessment to amputation (days) for non-elective admissions	15 days	12 days	8 days
Amputation – median inpatient length of stay (days)	30 days	29 days	24 days

Performance has reduced in five areas, including:

	BCUHB 2021	BCUHB 2022	All Wales 2022
CEA – patients referred within 7 days of symptoms	75%	68%	58%
CEA – median inpatient length of stay (days)	2 days	4 days	3 days
Arterial bypass – median inpatient length of stay (days)	8 days	13 days	10 days
Lower Limb revascularisation – waiting time	8 days	10 days	6 days
Lower Limb revascularisation - % treated within 5 days	36%	17%	45%

Actions to improve performance in the above 5 areas are included within the Revised Vascular Integrated Improvement Plan (R-VIIP). Performance against the improvement actions will be routinely monitored during Clinical Governance meetings. A watching brief will be maintained for those areas where performance is currently on track, in order to ensure progress is maintaineds.

Work is currently underway within the Network to map performance against the range of national KPIs that have been identified by NHS England and endorsed by the Vascular Society. Designed to function as an annual audit tool, this will enable the Network to map progress against an additional suite of key performance indicators, understand where performance sits with regards national targets, and develop a clear plan of action to improve performance in those areas of need. This will assist the Quality, Safety and Experience Committee in overseeing the performance and level of assurance related to the service.

Open Abdominal Aortic Aneurysm repairs

In recent years the number of open abdominal aortic aneurysm (AAA) repairs undertaken in the UK has sharply declined. There are a number of reasons for this including the increase in the use of Endovascular Aneurysm Repairs (EVAR) techniques for established aneurysms instead and due to lifestyle factors such as reduced levels of smoking resulting in less aneurysms to be treated.

Open AAA procedures are complex procedures requiring specialised pre-operative, peri-operative and post-operative care. Across the UK, this is leading to debate about further increasing the catchment areas for vascular services in order to ensure that clinical teams see sufficient patients to maintain specialist experience.

This has been discussed by the Executive Team, and plans have been agreed to further develop the health board pathway, concentrating open aneurysm surgery to a smaller number of surgeons. This will enable higher case numbers per surgeon supporting maintenance of aneurysm surgery skills. In addition an aneurysm MDT is being developed to similarly maintain expert clinical skills amongst other professionals caring for aneurysm patients. Alongside, proactive audit is in place to monitor aneurysm outcomes, with immediate escalation of adverse events.

Workforce

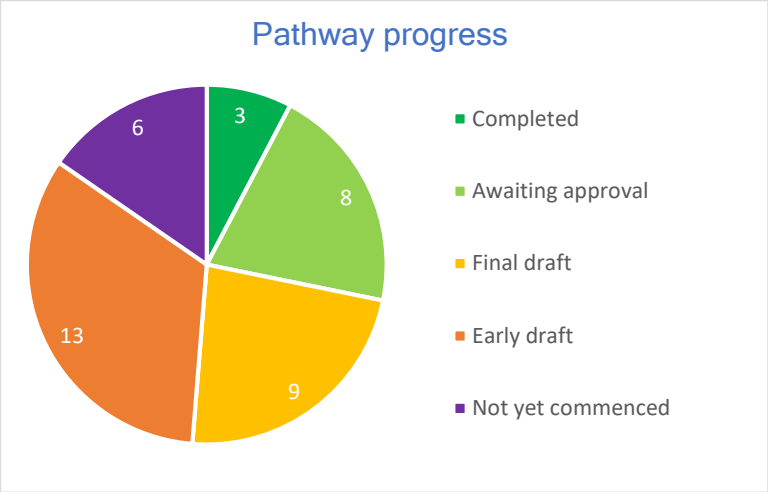
The North Wales Vascular Network covers a population of c700,000, served by nine consultant surgeons (including 2 consultant vacancies within the service).

- ***Surgical Trainee Training***

Looking ahead it is important that the Network takes all necessary steps to ensure it is able to attract and retain a highly-skilled and motivated vascular workforce. Work is currently underway in order to determine whether the vascular service will be in a position to accept speciality trainees from 2025. The Network is working closely with the Director of Medical and Dental Education to develop a clear plan to ensure network readiness.

Pathways

A key area of improvement work has been the development and documentation of robust and standardised clinical pathways, across the network. The figure below outlines current progress against the 39 identified pathways/ Standing Operational Procedures (SOP's) required for development.



The development of the vascular clinical pathways has been supported by the Transformation and Improvement team over recent months.

The pathways largely seek to support the consistent adherence to best practice, where necessary. The current focus has been upon agreeing the pathway elements that sit within secondary care settings.

Continuous Improvement Programme in 2024

A 'business case' approach was followed in order to draw down funding to support vascular improvement work. This process brought together and streamlined a number of business cases, with the intention of further progressing the recommendations identified within the external service reviews outlined above, as well as further building the staffing model to continue to broaden the multidisciplinary team approach that was developing and continue to evolve the service. The funding allocation was signed-off by the Executive team in March 2024.

The Priorities outlined below have been identified as the most pressing for immediate investment to enable the provision of services in line with advancing national standards, and provide capacity for long-term resilience within the service.

- Priority 1: Vascular Beds
- Priority 2: Vascular Medical Workforce
- Priority 3: Cardio Pulmonary Exercise Test (CPET)
- Priority 4: Endovascular Aneurysm Repair (EVAR) developments
- Priority 5: Renal Vascular Access
- Priority 6: Vascular inpatient Therapies and Diabetic Foot Pathway
- Priority 7: Vascular Radiology
- Priority 8: Governance & Admin Support within the vascular network

In line with the best practice from other services elsewhere, it is proposed that a peer review of the service is scheduled for approximately 12 month's time.

Strategic planning and development

Developing a clear plan with defined deliverables has been a key priority for the Network. Drawing on the range of improvement recommendations and existing service improvement priorities, it has been possible to develop a clear approach for the coming 12-18 months.

The service is keen to strengthen its strategic planning arrangements, and is closely aligned with the Health Board planning cycle and approach. Work will commence later in this year, to develop a forward plan for the service, which will be informed by activity and outcome data, driven by patient, carer and workforce experience and feedback, and will sit within the wider, emerging, Health Board Clinical Services Plan. This medium-term plan will inform the development of annual delivery plans, which will be underpinned by clear resourcing plans.

Central to the services long-term ambition will be the range of prevention and early intervention for good vascular health within the North Wales population. This will be achieved by strengthening the networks relationship with key partners, including public health and primary care, as well as the Welsh Abdominal Aortic Aneurysm Screening Programme (WAAASP).

Consultation and engagement

The service is committed to ensuring that patient, carer and staff experience and feedback drives service improvement. A communications and engagement plan has been developed in order to set out the approach to communication and engagement, which includes the following 6 core components:

- Communicating with the vascular workforce in order to build a positive culture of communication and collaboration across hub and spoke sites

- Communicating with partners and key stakeholders in order to strengthen the delivery of positive outcomes

- Engaging with patients, their family members/ carers with regards their experiences of care, and using that lived experience to support continuous service improvement

- Engaging the workforce across the three sites, in order to improve job satisfaction, staff well-being, recruitment and retention
- Work with patients, family members/ carers and staff to agree a number of outcome measures that can help measure the success of the vascular service, according to what matters to them
- Strengthening information and advice provided to patients and their family members/ carers in order to support clinical care and treatment

This work is being overseen by the Vascular Programme Board, and the Vascular Steering Group (VSG).

Conclusion

The journey of developing a single hub and spoke North Wales Vascular Service, has been long and complex. Whilst initiated due to concerns regarding sustainability and safety, the development of the service has not been straightforward and the health board over several years has needed to implement rapid and sustained improvement to build confidence in the services provided.

Progress has been made and several sources of external assessment support that conclusion. There is however, further work to continue to make improvements to outcomes and experience as well as sustainability. All of these improvements will be tracked with clear and objective evidence of progress. This increased stability of the service enables the health board and specifically this service to focus more upon proactive, continued future development. Strategic changes in this speciality will continue across the UK and internationally, the health board will through Clinical services Planning and wider strategy work, consider these further over the coming months.

Recommendations

1. To discuss the Vascular Service Progress Report, specifically the level of progress made and the current status of the service following external assessment

2. To endorse the proposal for a further peer review in 12 months to ensure continued improvement, reporting through regularly to the Quality, Safety and Experience Committee.

Appendix 1: Chronology of events

2010

INITIAL CONCERNS

Vascular services at each acute hospital. However, concerns about quality and sustainability of three standalone services:

- Poor recording of outcomes
- Differing approaches to surgery across sites
- Increasing UK-wide focus on moving to regional networks

In 2012, consultants proposed a more centralised model for vascular services, leading to the implementation of an interim model based in WMH and YG whilst plans to create a modern vascular theatre in YGC were developed.

Proposal approved at Board in January 2013. Business case for new hybrid vascular theatre approved in 2017.

2019

NETWORK RECONFIGURATION

BCUHB vascular services **reconfigured into a hub and spoke model with centralisation of arterial and endovascular surgical services at YGC.**

Concerns arising from implementation included:

- Unclear governance and reporting lines
- WMH and YG beds not identified, and medical cover for spoke sites not finalised
- A number of pathways agreed but not fully established
- Recruitment of senior medical staff at pace (which created issues), and less pace on other staff groups and grades

Health Board decision to commission the Royal College of Surgeons of England (RCSE) to undertake a review of the reconfigured vascular service
Part 1: published March 21
Part 2: published January 22

2021

RCSE (PART 1)

RCSE Part 1 report published, covering 2019-21 period.

- Lack of clarity regarding responsibilities and leadership
- Vascular services managed closely by secondary care MD with lack of clarity of Executive scope
- Turnover of network managers

Action plans commenced

2022

TARGETED INTERVENTION

RCSE Part 2 report published. This reviewed vascular case notes from 2014-20, and recommended further detailed review of the relevant clinical records.

HIW designated service as one Requiring Significant Improvement, leading to vascular services in BCUHB being placed in 'Targeted Intervention' (May 22).

The **Vascular Quality Panel (VQP)** was established in response, with external chair and external vascular clinicians. Changes included:

- The appointment of a clinical lead
- Dual consultant operating, initially 24/7, and later daytime only
- MDTs established with Liverpool and Stoke

These improvements resulted in National Vascular Registry (NVR) data being quality assured.

This, and an improved HIW site visit in Nov 22 resulted in HIW **de-escalating** vascular from being a service 'Requiring Significant Improvement' in Jun 23

2023

SPECIAL MEASURES

Feb 23 – BCUHB escalated into 'Special Measures'.

Four historic vascular cases referred by BCUHB to HM Coroner following Vascular Quality Panel review.

Vascular Assurance Assessment requested by WG as part of Special Measures
Oct 23 – part 1 report received

- Clinicians working more collaboratively and patient care is MDT driven
- NVR data showing acceptable range for surgical outcomes
- Recognition of continual improvement approach, including need to further develop 'learning from incidents' reviews

2024

EMBEDDING OF CONTINUAL IMPROVEMENT

Apr 24 – Vascular Assurance Assessment part 2

- 38 of 40 notes reviews "acceptable"
- Ongoing widening of the MDT to include other related services
- Ongoing development of pathways of care
- Recognition of a consistent focus upon continual improvement methodology

Report title:	**Proposal to acquire technical and business change partners to augment and enhance our Digital, Data and Technology (DDAT) application development and business change resources**
Report to:	Health Board
Date of Meeting:	25th July 2024
Executive Summary:	This paper proposes an approach to procure external partners to augment and enhance the Health Board's DDAT (Digital, Data and Technology) team to give them the capabilities necessary to deliver priority projects **with a combined spend that may now exceed £1m.** This approach was approved by the Executive Team based on an initial budget of £500K being available. Work has commenced to replace and re-engineer some critical, legacy applications with this available budget. Additional requirements and available funds have now been approved through business cases e.g. £660K for the Therapy Manager system replacement. Advice provided by the North Wales Shares Services Partnership (NWSSP) Procurement Team noted that the Health Board set an initial contract limit of £500K and based on the expectations of additional work and to be transparent with the supplier market, a range was specified from the initial £500K through to £2m a year, subject to available budget allocations. As available budgets and possible spend (£500K + £660K = £1,160,000 limit) now exceeds £1m, there is now a requirement for Board approval. The proposal was shared with digital colleagues from Welsh Government, and they are supportive of the approach, with the expectation that the cumulative spend could reach a maximum of £2m a year, based on need. An augmentation contract is where third party suppliers with expertise, work with the Health Board team to jointly develop and deliver solutions whilst transferring knowledge and skill to enable the Health Board to become self-sustaining. This procurement has been undertaken via the Government approved G-Cloud13 framework to acquire 'Resource Augmentation' contracts with two/three external partners on a 'zero contract' basis. The duration of these contracts will be for three years, with a one-year extension option. Every piece of work will be subject to a separate business justification or case, orders, and functional requirements. However, the capabilities, skills, tools and methods applied to deliver against those requirements will be the same.
Recommendations:	• That the Health Board **notes** the conclusions of this report and recognises the immediate need to strengthen and grow its limited internal software application development, business change capability and capacity with the assistance of expert third-party partners.

	• That the Health Board **agrees** with the award of augmentation contracts up to the maximum value of £2m, subject to approved business cases, whilst recognising that the contract value spend limit is to be £1,160,000 based on available budgets and approvals to date. • That the Health Board **agrees** to delegate future approvals above the £1,160,000 to the Executive Team. • That the Health Board **agrees** that the Planning, Population Health and Partnerships Committee will receive regular updates on the contracts, to ensure appropriate governance and oversight.
Executive Lead:	Dylan Roberts, Chief Digital and Information Officer
Report Author:	Dylan Roberts, Chief Digital and Information Officer Sion Jones, Assistant Director: Chief Technology Officer

Purpose of report:	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

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

***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 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:**

G-Cloud 13 is a Crown Commercial Service, pre-procured framework that is considered by NHS Wales Shared Services Partnership Procurement Team as fit for our requirements and therefore a high level of assurance is provided on the procurement route and method, which is prescriptive for this framework. This is a no commitment, 'zero based contract', where orders can be placed up to the limit for the defined set of skills and capabilities required, against a clear rate card. The G-Cloud framework is used extensively in this way across the public sector, for digital services.

Link to Strategic Objective(s):	The delivery of the following objectives in the Annual Plan are dependent on this contract being a success: 1. The Health Board will work with stakeholders across the Organisation and Wales to develop and secure agreement for investment in an Electronic Healthcare Record (EHR) transformation. Due to the safety concerns in Mental Health, the Health Board will commence the accelerated

	procurement and implementation of a tactical, mental health specific EHR, starting in 2024. 2. The Health Board will work to optimise the use of current systems and capabilities to deliver the most value for patients and clinicians, mitigating the risks associated with duplication of systems and processes. 3. The Organisation will continue to modernise the running and delivery of Digital, Data and Technology. This will bring in the minimum capabilities and skills necessary to improve DDaT maturity against industry benchmarks. 4. Essential Services Programme. The Health Board will upgrade infrastructure technology to prevent major IT failures and protect against cyber-attack. SE Learning Organisation.
Regulatory and legal implications:	The ineffective management of digital systems and, as a result, the applications and services across the Health Board, could lead to major service disruptions and data loss, which can have regulatory as well as legal and reputational implications.
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	Although an EqIA has been completed in the development of the overall Digital Roadmap, EqIAs will be required for the projects that these resources will support.
In accordance with WP68, has an SEIA identified as necessary been undertaken?	A Socio-Economic Impact Assessment (SEIA) was undertaken for the Digital Strategy 2021 and has not been identified as necessary for the preparation of this report. The potential of digital enabling the delivery of the “triple aim” of improving patient experience, population health and per capital cost of health care would have a positive socio-economic impact in terms of social and digital inclusion, raising education levels and the potential to improve the health tech economy. Therefore, it is suggested that an SEIA would be completed when the current strategy is revised.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF SP13: There is a risk of failing to meet the Health Board’s strategic and operational objectives caused by having inadequate arrangements for the identification,

	commissioning and delivery of Digital, Data and Technology enabled projects and change. CRR 24-17 There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber-attack. CRR 24-07 There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling which could lead to deaths and harm. .
Financial implications as a result of implementing the recommendations	The proposals identified in this report will, subject to funding, support the reduction and rationalisation of differing systems and contracts where they are in place and mitigate risks of major, costly failures. The right expertise contributing to delivering effective digitally enabled change should result in better benefits realisation. However, initial cost to support development, workflow changes and training, will be required. NB. Any spend against this contract will be on a case-by-case basis.
Workforce implications as a result of implementing the recommendations	These contracts will mean that internal staff will work jointly with external service provider expertise to deliver the outcomes needed. Skills transfer is important in this regard.
Feedback, response, and follow up summary following consultation	The current state of DDAT and the plans for the transformation of the operating model have been developed through consultation with the Executive Team, the Transformation and Improvement Team, DDAT Teams, Integrated Healthcare Communities (IHC) Teams and Clinical Informatic Leads. Stakeholders recognise the current gaps in the provision of DDAT services and the need for modernisation. They are equally cognisant of the impact of doing nothing and are supportive of proposals to positively move forward. Welsh Government officials, through the Office of the Chief Digital and Innovation Officer, have reviewed this proposal, agree with its need and that the financial levels set, are reasonable.

Links to BAF risks: (or links to the Corporate Risk Register)	See above
Reason for submission of report to confidential board (where relevant)	Could be prejudicial to future procurements. and the market.
Next Steps: Work to continue with the augmentation partner to address the systems issues to a limit of £1,160,000 with further extensions been subject to approved business cases and available funds.	
List of Appendices:	

1. Introduction / Background

BCUHB operates a significant estate of circa 428 IT applications that underpin and support all of the Health Board's clinical and business activity. Of these 428 applications, 116 are currently 'at risk' and are insufficiently supported for various reasons e.g., out of contract with the supplier or in-house developers have left the Organisation. Therefore, measures must be taken to re-establish sustainable control over these applications. This paper articulates the strategy and approach for addressing this critical matter. Much of this problem could be mitigated in the long term through Welsh Government approval and support for the Electronic Healthcare Record Programme. However, in lieu of decisions on that and due to the immediacy of some risks and issues, and a lack of recruitment by the Health Board to some key roles this work and approach is necessary.

This work directly contributes to the following Annual Plan objectives.

1. The Health Board will work to optimise the use of current systems and capabilities to deliver the most value for patients and clinicians, mitigating the risks associated with duplication of systems and processes.

2. The Organisation will continue to modernise the running and delivery of Digital, Data and Technology. This will bring in the necessary capabilities and skills to improve DDaT maturity against industry benchmarks.

The right expertise in-house is also essential if and when we progress towards an Electronic Healthcare Record system, with due regards to data migration, integration and safe transition.

2. Proposal

The options that have been evaluated :

- The Health Board can retire some of the applications and, if necessary, replace/consolidate/reuse their functionality with functionality available (with some adaption) in other applications. This exercise has already begun and requires external assistance.
- The Health Board can acquire replacement applications from other providers, including Digital Health & Care Wales (DHCW).

- The Health Board can redevelop some of the applications in a future-proofed way. This will require external assistance to augment limited, internal resources and will transfer skills/knowledge to the Health Board.

Each option has associated costs, benefits, and risks. The strategy and approach will be to execute a combination of all these options. If applications can be retired, consolidated or reused, then this is the most cost-effective option. However, in many cases, it will be necessary to acquire alternative solutions or rebuild them. The choice will depend on a cost, risk, and benefit assessment. However, in some instances it will make the most sense to redevelop the application internally; the challenge here is the limited IT development and business change capacity and capability of the Health Board. Any redevelopments must be to modern standards, to a consistent methodology, using the same tools, focus on reuse and deliver as sustainable as possible solutions.

The Health Board's Digital, Data and Technology (DDAT) Service is already in the process of building a stronger internal capability to develop, enhance and integrate its IT/digital application estate, where this approach makes the most sense and yields the greatest benefit. These applications currently consist of those provided by Digital Health and Care Wales (DHCW), commercial suppliers and those developed internally. Moving forward, the Health Board will also be looking to develop and integrate additional applications that will primarily be used by the Health Board but may also be utilised by other health and care organisations across Wales and possibly beyond.

Presently, the capability and capacity to develop these applications and provide the requisite business change is limited. The 'future proof' approach is to develop these applications in a 'cloud native' way using 'microservices' (reusable cloud components). This is in line with application development strategies across the world and aligns with the Welsh National Health & Care Development Strategy. What this means is applications will be built in a way that takes advantage of the abundance of readily available micro services (some of them free of charge) or built on cloud platforms like those provided by Google, Microsoft or Amazon. An example of such a micro-service might be a 'patient validation' service. These services increasingly adopt 'open standards' and 'open-source program code', which mean they can be used without being restricted or tied to hardware/software vendors. This approach gives greater independence, less vendor lock in, lower costs and will also provide an opportunity to share and trade the software assets developed.

This augmentation partnership will take two forms:

1. A technical partner that understands and has considerable experience in developing public service, cloud native, solutions, using these kinds of cloud platforms and micro-services. Over time, their knowledge and skills will be transferred to our own developers and architects so that our dependency on the partner reduces and our capability commensurately grows. This partner would typically provide the following resources:
   - Cloud and data architects.
   - Cloud and application development strategy specialists with a knowledge of building and using reusable micro-services that are 'cloud compatible'.
   - Agile development teams, including agile team leads e.g., scrum masters. These development teams will also provide expertise in health & care 'open' development standards e.g., FHIR and HL7 and 'open' languages/tools e.g., Node-JS, as well as developing best practices.
   - UI (user interface) and UX (user experience) specialists.
   - Establish a "product based" approach.

- For all of the resources above, these experts will be capable of training and mentoring BCUHB architects and application development specialists in these new skill-sets.
- Assist DDAT with recruitment of relevant resources.
- Assist DDAT with solution options appraisals, as it won't always be the case that building an application internally is the best option.
- Assist with application migrations and integrations.

Continuity with a partner is important as it relates to our development, understanding of the peculiarities of our digital and technology environments, security and risks, standardised approaches and use of shared tools.

2. A business change partner(s) who can work with our clinical and non-clinical staff to understand problems and challenges in our current working practices and processes and can help change these, as well as augment our project delivery and portfolio management resources if required. This will often be alongside new technical developments i.e. working with the technical partner cited above, as well as our own technical people. More specifically, they will conduct or provide services:
   - Business analysis ('as is' / 'to be') and requirements specifications.
   - Business re-engineering and process change.
   - End user engagement and training.
   - Full life cycle support business case and portfolio prioritisation, through project planning and delivery, service transition, adoption and ROI tracking, across Waterfall, Agile and Hybrid methodologies.
   - Project and portfolio management as a service (PPMaaS).
   - Agile development environments.
   - Training and mentoring BCUHB staff in these new skill-sets.
   - Assist BCUHB with recruitment of relevant resources.

It is prudent to keep these partners separate in order to ensure impartiality, objectivity and healthy challenge and therefore we will look to acquire two partners to help with these two, separate (but related) objectives. These partners must be acquired in the most effective and efficient way, using existing procurement frameworks, thus reducing the effort, time and cost involved.

3. Conclusions

- To augment our own limited resources and help deliver the new clinical applications required, together with the associated 'business and people' implications and changes. It is proposed that two or possibly three, separate contracts are established, as articulated above.

- It is proposed that the contracts are 'zero based' and therefore there will be no obligation to spend anything if there isn't clear justification to use the external resources proposed (on a 'case by case' basis). However, there is a backlog of work to be undertaken and our internal resources need to be re-skilled. This backlog now includes the clinically critical 'Therapy Management' System, which is in urgent need of being redeveloped on the basis that it is no longer supported.

- It is proposed that an upper limit of £2M per annum be set by the Board, with approved budgets allocated against these contracts currently set at £1,160,000, based on the addition of the Therapy Manager requirement.

- The use of the G-Cloud-13 procurement framework, which involves a longlisting exercise, shortlisting exercise and an award on the basis of 'best price', allows for an award on a 3 year + 1 year basis (optional). This should hopefully give the Health Board sufficient time to reduce the application development backlog, using new methods that are aligned to national strategies and best practices. The arrangement will also prepare the Organisation for the required business and people change implications of introducing new applications.

- It is also important to note that the ambition associated with this approach is to reduce our dependency on the external partners, over time. In the early stages, it might be 80% partner effort and 20% internal effort. Three to four years on, it is envisaged this would switch to 80% internal effort and 20% partner effort. This is dependent of course on recruitment/expansion and retention.

4. Recommendation

Members of the Board are asked to:

- **NOTE** the report and **SUPPORT** the need to strengthen and grow our limited internal application development, business change capability and capacity, recognising the assistance of expert third-party partners, is required.

- **AGREE** that the continuation of procurement activities via the Government approved G-Cloud13 framework, to acquire 'Resource Augmentation' contracts with two/three external partners on a 'zero contract' basis, is approved based on spend possibly exceeding £1m per annum. The duration of these contracts will be for three years with a one-year extension option.

- **AGREE** that the PPHP committee will monitor progress against the procurements and provide assurance to the Board in terms of the appropriate governance and oversight of delivery of the contracts.

5. Budgetary / Financial Implications

As the proposed contracts will be 'zero based', there will no obligation to spend anything unless there is a need, detailing justification to do so. The initial allocations are £500K based on available DDaT budget and £660K based on the Therapy Manager business case, which totals £1,160,000. Future initiatives will be undertaken on a 'case by case' basis and funding (Capital & Revenue) will be justified and stated in individual business cases. Going forwards these will be signed off by Executive Management Team as required.

6. Risk Management

Because of the 'zero based' nature of the contracts. the risk is intrinsically low. Contracts awarded will be issued based on milestone payments, with agreed deliverables and agreed quality criteria. Payment milestones and values will be realistic and limited by mutual agreement. The nature of the developments (using open standards and opensource code) will mean that in extreme cases and, if necessary, other parties could be engaged to complete any work started. The risk of this eventuality is low. It is also the case that as internal skills and knowledge develop, there will be less reliance on 3rd parties.

Teitl adroddiad: ***Report title:***	Integrated Concerns Policy
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	The Health Board has been working on a new policy to provide an integrated framework for Incidents, Complaints and Mortality Reviews – the attached policy is submitted to the Board for approval alongside the implementation plan.
Argymhellion: ***Recommendations:***	The Board is asked to **approve** the attached policy.
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery • Gareth Evans, Acting Executive Director of Therapies and Health Sciences
Awdur yr Adroddiad: ***Report Author:***	Working group reporting to the Responsible Director

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

The new policy has been developed as a result of the lack of assurance in the processes for Incidents, Complaints and Mortality Reviews. The assurance the Board can take in this area is expected to increase as this new process is implemented.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress

	Arrangements) (Wales) (Amendment) Regulations 2023 requires a framework to be in place that complies with the Putting Things Right framework. The Duty of Candour Procedure (Wales) Regulations 2023 requires a framework to be in place that complies with the statutory guidance. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Integrated Concerns Policy 2. Implementation Plan 3. Decision Support Tree for the Integrated Concerns Hub	

Integrated Concerns Policy

INTRODUCTION

The Board will be aware of concern it holds regarding the approach to Incidents, Complaints and Mortality Reviews across the Health Board. These concerns have come from the Board's own assurance but also from external stakeholders such as His Majesty's Senior Coroners who have raised concerns about the governance of investigations. Additionally, assurance activity such as Internal Audit have identified concerns over aspects of the processes. The Chief Executive commissioned a programme of work to review investigations open to the Coroner, and this project has identified a significant volume of learning from reviewing 262 cases.

Collectively, the case for change is overwhelming and the Chief Executive commissioned a further programme of work to develop a new Integrated Policy covering Incidents, Complaints and Mortality Reviews. The Executive Director of Nursing and Midwifery and Acting Executive Director of Therapies and Health Sciences have overseen this work supported by a working group consisting of representatives from the various quality teams involved in the process, and taking into account the learning from the above issues and engagement activity with internal and external stakeholders over the past several months.

A new Integrated Concerns Policy is attached to this paper for approval.

Also attached is the implementation plan for the policy alongside the decision support tree which shows the Board one significant change in approach, which is the early integrated triangulation of concerns across corporate teams to ensure a unified approach to Incidents, Complaints and Mortality Reviews. The Board is asked to note the implementation work is dynamic and moving at pace: the implementation plan therefore reflects the position at the time of Board paper drafting and the Executive Director of Nursing and Midwifery is ensuring close personal oversight of implementation to ensure effective delivery

BACKGROUND

As outlined above there is significant case for change to the existing approach arising from:

- The Board's own assurance and that of the Quality, Safety and Experience Committee;
- Concerns from His Majesty's Senior Coroners who have raised concerns about the governance of investigations through a high number of Prevention of Future Death Notices over the last year;
- Feedback from the Ombudsman in Public Interest Reports regarding complaint handling;
- Internal Audit activity including an audit of Lessons Learned;
- The Learning from Investigations Project which reviewed 262 cases open to the Coroners.

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations, commonly known as the Putting Things Right (PTR) Regulations, require a process to be in place that complies with the Putting Things Right framework. The attached policy has been

developed to ensure compliance with those requirements. However, Welsh Government are currently developing updated regulations and guidance which might mean this policy will require review over the next year: where possible the policy has been aligned to the expected new requirements.

The Duty of Candour Procedure (Wales) Regulations 2023 require a process to be in place that complies with the statutory guidance regarding being open and honest with patients when harm has occurred. The attached policy has been developed to ensure compliance with those requirements.

DEVELOPMENT

The Chief Executive commissioned this work, and the Executive Director of Nursing and Midwifery and Acting Executive Director of Therapies and Health Sciences have overseen this work.

They have been supported by a working group consisting of representatives from the various quality teams involved in the process. The work has also taken into account the learning from the various reviews, reports and projects above issues as well as engagement activity with internal and external stakeholders over the past several months.

The new policy will deliver changes in a number of areas, and the aim (subject to Board approval) is to begin implementation from 01 September 2024. An implementation plan is in place supported by the working group and overseen by the Executive Director of Nursing and Midwifery. It is expected that full embedding of the new policy across the Health Board will take several months.

Of note, the Welsh Government are currently developing updated PTR Regulations and Guidance which might mean this policy will require review over the next year: the Health Board has been engaged in the development process, and where possible the policy has been aligned to the expected new requirements to avoid disruption but the Health Board awaits the full regulations and guidance to be published.

RECOMMENDATION

The Board is asked to approve the new Integrated Concerns Policy.

Integrated Concerns Policy

New policy for approval – July 2024

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

What are we trying to solve?

- Incidents are not always being recognised i.e. ME concerns are not always being acted upon.
- Silo approach to the same issue across different processes (i.e. complaint, incident, mortality not triangulated or aligned).
- Limited/inconsistent investigation skills, limited training offer and limited investigator capacity.
- Patient, family and staff engagement is poor.
- Investigations are not prioritised/targeted.
- Quality and timeliness of investigations is inconsistent and often below standard.
- Investigations are driven by harm or external triggers, rather than driven by the opportunity for learning and improvement.
- Learning is narrow focused and poorly shared.
- Improvement actions are not being tracked and evaluated/evidenced.
- Performance monitoring is limited and poor.
- Confidence in the processes by WG, regulators, stakeholders is extremely low.

The aim

- To create a single, aligned policy that sets out the standards and framework to recognise, respond, learn and improve from incidents, complaints and mortality reviews (along with a supporting toolkit) which ensures:
    - Incidents, complaints and deaths are promptly identified, recorded and initially reviewed;
    - Reviews are completed in a timely way for every incident, complaint and death;
    - Incidents, complaints and mortality reviews are triangulated to ensure alignment;
    - Where necessary, further in-depth investigations are carried out in a timely and thorough way;
    - Patients, families & staff are enabled & empowered to be active contributors to, & participants in, the process;
    - Learning is identified, shared and acted upon;
    - Improvement actions are tracked to completion with evidence.

The proposal

Stage 1 – Identification, triage & acknowledgment

- Timely identification of a complaint, incident or mortality and recording on Datix
- Immediate actions to make safe and inform all relevant people
- Triangulation to ensure the *investigate once, investigate well* approach is taken with oversight from the Integrated Concerns Hub
- Decision made on Duty of Candour and type of review/investigation and timescales/deadlines (i.e. 30 or 60 working days)

Stage 2 - Candour and Review or Investigation

- Learning Review commenced by the service or Learning Investigation commenced if determined by IC Hub
- Learning Investigator appointed by IC Hub for Learning Investigations and service to conduct Rapid Review within 72 Hours
- Duty of Candour enacted and patient/family/staff support put in place

Stage 3 – Identification of learning and improvement

- Learning and Improvement Plan developed
- Where appropriate, linked to thematic improvement plan

Stage 4 – Approval and cascade

- Learning Review approved locally and if a complaint or incident where the Duty of Candour applies or review due at inquest, submitted for corporate approval
- Learning Investigation approved locally and submitted for corporate approval and clinical executive director approval
- Findings shared with patient/family and feedback to staff involved
- Report submitted to the Coroner (if applicable)

Stage 5 - Delivery of Improvements

- Datix updated with the outcomes and actions
- Learning and Improvement Plan delivered (with monitoring of progress)
- Learning shared across other services
- Ongoing assessment for thematic learning and identification of system wide improvement opportunities

Stage 1

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- Triangulation to ensure the *investigate once, investigate well* approach is taken with oversight from the Integrated Concerns Hub
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Stage 2

Stage 2 – Duty of Candour and Investigation

- Learning Review commenced by the service or Learning Investigation commenced if determined by IC Hub
- Learning Investigator appointed by IC Hub for Learning Investigations and service to conduct Rapid Review within 72 Hours
- Duty of Candour enacted and patient/family/staff support put in place

Stage 3

Stage 3 – Identification of learning and improvement

- Learning and Improvement Plan developed
- Where appropriate, linked to thematic improvement plan

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- Learning shared across other services
- Ongoing assessment for thematic learning and identification of system wide improvement opportunities

Integrated Concerns Hub

- The Integrated Concerns Hub (referred to as the IC Hub) is a virtual hub which ensures on a (working) daily basis the correct triage and processing of incidents, complaints and mortality reviews.

- There will be a particular focus on ensuring those matters which require a Learning Investigation and external reporting are identified, triangulated and acted upon with clear deadlines.

- The Hub is a collaboration of the Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team and each Head of Service will work on a rota to be "Hub Co-ordinator" for a week.

Clinical and Corporate Directors leadership responsibility

Clinical and Corporate Directors and their senior leadership teams are responsible for ensuring local arrangements exist to ensure incidents, complaints and mortality are identified and acted upon in accordance with the policy and any supporting procedures and guidelines. this includes:

- establishing a weekly an Incident, Complaint and Mortality Operational Panel to ensure this policy is applied (these may be formerly known as a PTR Panel);
- ensuring their staff are supported throughout the process and that a culture of candour and learning is created and embedded (including compliance with the Duty of Candour);
- ensuring learning is identified, cascaded and acted upon to ensure a culture of continuous learning and improvement.

Implementation plan

An Implementation Plan is being developed and delivered. This will include:

- Standard Operating Procedure for the IC Hub and Flowcharts
- IC Hub roster and role/responsibility clarification
- Development of a training programme; policy and investigator training
- Development of a investigator network; log and register
- Development of templates: rapid review, investigation report, complaints letters, etc;
- Develop new monitoring and assurance reports; dashboard
- Develop new meeting terms of reference and templates
- Agree performance indicators for services and corporate functions.

The above is being underpinned by recovery plans already underway for backlog positions i.e. complaints.

Once the policy is approved at Board in July 2024, implementation will begin throughout August in terms of raising awareness with services, with a launch of the new process from 01 September 2024 with embedding over the following 3 months.

PTR01
V0.7
DRAFT

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

Integrated Concerns Policy

Author:	Working group reporting to the Responsible Director				
Responsible Director:	Executive Director of Nursing and Midwifery				
Approved by:	Health Board				
Date approved:	25 July 2024				
Date activated (live):	01 September 2024				
Documents to be read alongside this document:	• Putting Things Right Guidance • Duty of Candour Guidance • NHS Wales Patient Safety Incident Framework • NHS Wales Mortality Review Framework • NHS Wales Learning from Events Framework • NHS Wales Social Media Policy • BCUHB Legal Services Policy • BCUHB Health and Safety Policy • BCUHB Maternal Death/Perinatal Mortality Policy • BCUHB Unreasonable Behaviour Procedure • BCUHB Safeguarding Policies including the Procedural Response to the Unexpected Deaths in Childhood (PRUDIC)				
Date of next review:	01 September 2025				
Date EqIA completed:	01 July 2024				
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Previously reviewed:	N/A				
Changes made yes/no:	N/A				

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

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PRINCIPLES

Betsi Cadwaladr University Health Board is committed to working in partnership with the community it serves and the people who work for us, with a view to listening and learning as we make making continuous improvements in everything we do.

There is a standard framework to handling incidents and complaints across NHS Wales, which complies with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as the 'Putting things Right' Regulations ('PTR').

Within the Health Board, our approach is enhanced around the following key principles which guide how we approach all incidents, complaints and mortality reviews:

1. **Person-centred:** The patient, carers, families and our staff will be at the centre of the process. Time will be taken to understand all their needs. The focus will be on what matters to them to listen, respond, learn and improve together.

2. **Fair:** Patients, carers, families and our staff will be treated fairly and with dignity and respect throughout the complaint. No person shall suffer for having raised an incident or complaint. All staff will be treated within the principles of a just and learning culture.

3. **Candour:** Reviews, investigations and responses will be open and honest. Where issues are identified these will be clearly stated, meaningful apologies given and information provided on what will be done to put things right and improve for the future.

4. **Timely, effective and proportionate:** Reviews, investigations and responses will be dealt with promptly, or where more detailed action is needed this will be clearly communicated. People will be kept informed throughout the process. Reviews, investigations and responses will be thorough, proportionate, coordinated and of a high standard.

5. **Outcome and improvement focused:** The primary aim of the process is to put things right based on what matters to the patient, carer, family and staff. Reviews, investigations and responses will be used to drive improvement in the quality of services.

The above principles guide the way incidents, complaints and mortality reviews will be handled within the Health Board. The principles will help ensure when an incidents, complaints or mortality is identified the Health Board listens, acts, investigates, reports and learns.

POLICY

1. INTRODUCTION

1.1 The Health Board is committed to the prompt identification, review, learning and improvement from adverse events which affect our patients, carers, staff, infrastructure and community.

1.2 Additionally, the Putting Things Right (PTR) Regulations and guidance sets out how NHS bodies should effectively handle concerns according to the requirements of the NHS (concerns, complaints, and redress arrangements) Regulations Wales (2011).

1.3 This policy therefore sets out the arrangements for identifying, responding, learning and improving from incidents, complaints and mortality to ensure we meet our own commitment and our legal obligations.

1.4 The Health Board supports the principles of a just culture. It endorses the decision support tool developed by partners across the UK and will use this tool when deciding is professional or managerial action is needed based on a review or investigation undertaken under this policy.

1.5 This policy sets out a standard 5 step approach for responding to any incident, complaint or mortality. Its aim is to provide a consistent, integrated and triangulated approach to ensure candour and learning. The policy is supported by a number of Appendices and Technical Appendices (which provide specific technical or statutory guidance).

1.6 The policy should be considered alongside the Legal Services Policy which provides the framework for litigation claims, inquests and redress.

2. SCOPE

2.1 This policy applies to all clinical and corporate services within the Health Board and all staff. The term ‘staff’ is used throughout this document and includes employees, bank, agency, locums, students, etc.

2.2 The Health Board is committed to ensuring any member of staff can raise an incident without fear, but it does acknowledge that staff may on occasion feel that they need to raise concerns through the raising concerns process which may in some cases mean anonymously. A separate policy and process exists for this which can be access on the Speak out Safely site on BetsiNet.

3. ROLES AND RESPONSIBILITIES

3.1 The **Executive Director of Nursing and Midwifery** is the lead executive officer for this policy. They perform the duties of Responsible Officer for the PTR Regulations and Duty of Candour Regulations. The Executive Director of Nursing and Midwifery has delegated authority from the Board and Chief Executive to ensure all services within the Health Board comply with this policy.

3.2 The **Executive Medical Director** is the lead executive officer for learning from deaths. In that role they will ensure robust mortality review and learning arrangements however for clarity this policy provides the overall framework for all incidents, complaints and mortality.

3.3 The **Chair of the Quality, Safety and Experience Committee** is the lead Independent Board Member for quality. They are the lead independent member for the PTR Regulations and Duty of Candour Regulations. Their role is to ensure the Board has a framework to seek and receive assurance on quality including on the implementation of this policy.

3.4 The **Deputy Executive Director(s) of Nursing** and **Deputy Executive Medical Director(s)** are the lead operational officers for this policy. They perform the duties of Senior Investigating Officer for the PTR Regulations. They have a responsibility to support the lead executive officer with ensuring all services within the Health Board comply with this policy and will also ensure the corporate services they manage (the Patient Safety Team, Patient and Carer Experience Team including Complaints and PALS, and Clinical Effectiveness Team including Mortality Review Team) provide the necessary guidelines, support and oversight to ensure this policy is delivered.

3.5 The **Executive Quality Delivery Group (EQDG)** is the lead management group with responsibility for ensuring this policy is implemented. The EQDG is supported a follows:

- The Patient Safety Group will provide oversight of the organisations arrangements for the reporting and management of incidents and subsequent learning and improvement;
- The Patient and Carer Experience Group will provide oversight of the organisations arrangements for the reporting and management of complaints and subsequent learning and improvement;
- The Clinical Effectiveness Group (and Learning from Mortality Forum which reports to it) will provide oversight of the organisations arrangements for the reporting and management of Medical Examiner (ME) Scrutiny, Mortality Reviews and subsequent learning and improvement;
- The Organisational Learning Forum will provide oversight of the organisations arrangements for learning and improvement across the quality domain;
- The Integrated Concerns Oversight Panel will meet weekly and will provide oversight at a corporate level of the implementation of this policy and the management of incidents, complaints and mortality. The panel will review the decisions made the IC Hub and will call-in for scrutiny any Rapid

Reviews (in which case, senior representatives of the division will attend to present their reviews and the learning).

3.6 The **Integrated Concerns Hub** (referred to as the IC Hub) is a virtual hub which ensures on a daily basis the correct triage and processing of incidents, complaints and mortality reviews with a particular focus ion ensuring those matters which require a Learning Investigation and external reporting are identified and acted upon. The Hub is a collaboration of the Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team and each Head of Service will work on a rota to be "Hub Leader" for a week.

3.7 The **Quality, Safety and Experience (QSE) Committee** is the lead Board committee with responsibility for seeking assurance that this policy is implemented.

3.8 **Clinical and Corporate Service Directors and their senior leadership teams** are responsible for ensuring this policy is implemented in their services with a particular responsibility for:

- ensuring local arrangements exist to ensure incidents, complaints and mortality are identified and acted upon in accordance with this policy and any supporting procedures and guidelines – this includes establishing a weekly an Integrated Concerns Operational Panel to ensure this policy is applied (these may be formerly known as a PTR Panel);
- ensuring their staff are supported throughout the process and that a culture of candour and learning is created and embedded (including compliance with the Duty of Candour);
- ensuring learning is identified, cascaded and acted upon to ensure a culture of continuous learning and improvement.

3.9 **Managers and Clinical Leaders** are responsible for ensuring this policy is implemented in their services with a particular responsibility for ensuring their staff are aware of their responsibilities under this policy and are supported throughout the process.

3.10 **All staff** have a responsibility to ensure they are familiar with this policy and ensure they comply with its requirements.

4. DEFINITIONS

4.1 A **Concern** is defined in the PTR Regulations as any complaint, claim or patient safety incident occurring from NHS funded care. Within the Health Board, this is interpreted to cover any patient safety incident, complaint or mortality review and this policy provides a single integrated framework for dealing with such issues. A concern is often used to mean complaint, but it is important to note within PTR it covers any patient safety incident, complaint or mortality review.

4.2 A **Patient Safety Incident** is "any unintended or unexpected incident, through action or inaction, which could have, or did, lead to harm for one or more people whilst in receipt of NHS-funded healthcare." This definition includes incidents of harm and or potential harm; often called near miss incidents. It is vital near

miss incidents are treated no less seriously as they provide an opportunity to learn and improve before harm occurs.

4.3 A **Complaint** is "any expression of dissatisfaction". A complaint may relate to:

- care and/or treatment, delays;
- failure to provide a service;
- inadequate standard of service;
- dissatisfaction with the organisation's policy;
- treatment by, or attitude of, a member of staff;
- the organisation's failure to follow the appropriate process including issues affecting the rights and freedoms of a data subject under the Data Protection Act;
- lack of information and clarity about treatment, appointments, and access or contact difficulties with departments/services.

A number of matters are explicitly excluded from consideration under this policy as set-out in the PTR Regulations. These include:

- Concerns notified by a primary care provider relating to a primary care provider's contract or arrangements under which they provide primary care services - these issues are dealt with through different mechanisms relating to the Regulations covering primary care;
- Concerns where a member of staff has an issue with their employment contract – these matters would be dealt with under the Health Board's workforce policies and procedures;
- Where the concern is being or has been investigated by the Public Services Ombudsman for Wales;
- Where the Health Board has not complied with the Freedom of Information (FOI) Act– such concerns would be dealt with by the Information Commissioner's Office;
- Disciplinary proceedings – these would be looked at under the Health Board's workforce policies and procedures;
- Where someone tries to re-open the same concern that they have already agreed was dealt with satisfactorily as an Early Resolution – unless the Complaints Team consider the Health Board needs to look into the issue again;
- Where the concern has already been investigated under the previous regulations, that is, complaints that were reported pre 1 April 2011 and concerns that have already been considered under the Regulations;
- Complaints in respect of which court proceedings have already been issued. If court proceedings are issued when a concern is already under investigation in accordance with the Regulations, all further investigation of the concern must stop;
- Where a concern relates to an individual patient funding treatment request, that is, requests for funding of services not usually provided by the NHS in Wales – these concerns will be dealt with under a separate all-Wales process for decision and review.

Almost anyone can raise a complaint and the Health Board will then be under a duty to consider whether it can be investigated. However, it might not always be possible to share the full details of the investigation with the person raising

the concern, for instance, if they are not the patient or not their next of kin (this is detailed in the section on consent. Complaints can therefore be raised by:

- people who are receiving or who have received services from the Health Board;
- people affected or likely to be affected by the actions, errors or decisions of the Health Board;
- staff members
- a third party acting on behalf of a person who is unable to raise a concern e.g. a young child or someone who lacks capacity to act on their own behalf because that person wants someone else to represent them;
- a third party on behalf of a person who has died.

A complaint can be notified no later than 12 months from the date on which the issue occurred, or if later, 12 months from the date the person raising the complaint realised they had an issue. To investigate a complaint after the 12-month deadline, the Health Board must consider whether the person raising the complaint had good reason not to notify the concern earlier and whether, given the time lapse, is it still possible to investigate the concern thoroughly and fairly. The discretion to consider a complaint that has been notified outside the 12 month period is subject to the provisions of PTR Regulation 15(3) which provides that a concern cannot be notified 3 or more years from the date the concern occurred or 3 or more years from the date the person became aware of the matter, which the concern is about. Or if the person who raised the complaint is a child at the time of the injury the three-year period does not begin to run until the individual reaches the age of 18. In these cases, the period will expire on the eve of the person's 21st birthday; if the person who raised the complaint lacks capacity under the Mental Capacity Act 2005, the three-year period may never begin to run, or it can start at the date of recovery.

A complaint may be withdrawn at any time by the person who notified the complaint. The withdrawal of the complaint can be made in writing; electronically; or verbally in person or by telephone. If a complaint is withdrawn verbally, the Health Board should write to the person as soon as possible to confirm their decision. However, even if the complaint has been withdrawn, if it is felt that the investigation of the complaint is still appropriate, the Health Board can continue to investigate.

The Health Board must provide a single point of contact for people to raise complaints. This is through the Complaints Team who will provide a dedicated telephone number, email address, portal address and online form.

4.4 A **Mortality Review** is a structured and systematic assessment of the care provided to patients during their final illness. The aim is to learn and share from a patient's death, to identify if there are concerns and establish if similar situations may affect other patients and to improve overall quality of care.

5. TRAINING AND GUIDANCE

5.1 The Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team will collaborate to develop standard operating procedures,

guidance notes, tools and templates to support enable consistent delivery of this policy. However, for clarity, this will be the only policy covering incidents, complaints and mortality to ensure a single, integrated framework.

5.2 The Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team will collaborate to offer an integrated training programme for staff across the organisation to support them to implement this policy. This programme will consist of three levels:

- Level 1 – This training will be targeted at all staff and covers the approach to incidents, complaints and mortality and how staff can identify, report and act on these.
- Level 2 – This training will be targeted at those responsible for undertaking Learning Reviews and is essential for those who perform this role. The training will cover the approach, methodology, process and tools to conduct a Learning Review.
- Level 3 – This training will be targeted at those responsible for undertaking Learning Investigations and is mandatory for those who perform this role. The training will cover the approach, methodology, process and tools to conduct a Learning Investigation.

Additionally, overview training of this policy and the process contained herein will be available for managers and leaders to understand their responsibility, and professional training will be available for those staff involved in the corporate teams responsible for managing this policy.

5.3 The Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team will also collaborate to develop and maintain a single intranet site on BetsiNet to provide staff with a single point of access for the supporting resources and access to training to delivery this policy. This will be known as the Learning from Integrated Concerns Portal.

6. RECORD KEEPING

6.1 All incidents, complaints and mortality reviews will be held on the respective modules of the Datix Cymru system. This is the sole management system for incidents, complaints and mortality reviews within the Health Board.

6.2 The Health Board will produce an Annual Quality Reporting, which includes an Annual Putting Things Right (PTR) Report and Annual Duty of Candour Report, as per the statutory requirements.

7. ASSURANCE AND MONITORING ARRANGEMENTS

7.1 The Executive Quality Delivery Group (EQDG) is the lead management group with responsibility for ensuring this policy is implemented. The group is supported in this by a number of sub-groups leading on particular areas of focus

including the Patient Safety Group, the Patient and Carer Experience Group, the Clinical Effectiveness Group, the Learning from Mortality Forum and the Organisational Learning Forum.

7.2 The EQDG is accountable to the Executive Team, and also reports to the Quality, Safety and Experience (QSE) Committee as the lead assurance committee of the Board for all matters of quality including ensuring this policy is implemented. The QSE Committee receives both a Quality Report and a Confidential Quality Report to provide it with assurance on the handling of, and learning from, incidents, complaints and mortality reviews.

7.3 A weekly Integrated Concerns Oversight Panel will be established to provide organisation-level oversight of both new and ongoing cases. This meeting will be chaired by a Clinical Executive Director supported by the Deputy Executive Director(s) of Nursing and Deputy Executive Medical Director(s). Clinical and corporate services will be required to attend as determined by the terms of reference.

7.4 All clinical divisions (or equivalent) will be required to establish an Integrated Concerns Operational Panel to ensure this policy is applied. The arrangements for this, including its supporting sub-structure to ward level, is a matter for the divisional directors to determine to meet local need. However, it is expected such a meeting occurs at least weekly and is chaired by a clinical divisional director.

7.5 Key performance indicators will be developed and maintained; these indicators will be incorporated within the Quality Informatics Portal/Quality Dashboard where possible. Clinical and corporate services will be required to provide assurance and exception reports, and improvement plans, to the groups mentioned in Section 7.1 as determined by their cycle of business.

8. QUALITY MANAGEMENT

8.1 The Integrated Concerns Policy is a core component of the Health Board's Quality Management System (QMS). The approach to identifying, reviewing and taking action to correct issues arising from incidents, complaints and mortality is a major part of the Quality Control and Quality Improvement domains of the QMS. However, the data that is collected will also support the Quality Assurance domain by providing intelligence on the risks and issues across the organisation, and thematic learning will support the Quality Planning domain by helping to identify areas of strategic focus of the organisation or areas for local delivery plans.

8.2 All services should ensure they use the intelligence identified from the application of this policy to inform their quality driven decision making in accordance with the Duty of Quality.

9. EQUALITY INCLUDING WELSH LANGUAGE

9.1 The Health Board is committed to equality, diversity and inclusion. This policy must be implemented with that commitment taken into account, including its commitment to the Welsh language.

10. REVIEW

10.1 As a new policy, this document will be reviewed in 1 year or sooner in the light of changes to legislation or organisational arrangements, or in light of findings from assurance and monitoring activity.

10.2 As this policy is a reserved policy for the Board, any changes or deviations will require Board approval.

PROCEDURE

The 5 step procedure at a glance:

11. STAGE 1 – IDENTIFICATION, TRIAGE AND ACKNOWLEDGMENT

11.1 Complaints

A complaint could be raised directly with the Complaints Team, Patient Advice and Liaison Service (PALS) or raised directly with any member of staff.

The first consideration is whether the issue is one of a general concern or a complaint. Examples of the type of issues that may fall within the broader category of general concerns are as follows:

- Comments concerning service delivery and patient experience;
- Subjective personal opinions on policy or service delivery;
- The sharing of information about matters of general concern;
- Anxiety or worries regarding personal care and treatment;
- Requests for information related to personal care and treatment;
- Questions about personal care and treatment.

Where such issues are raised, the appropriate course of action is to take ownership of the matter and identify how best to source the required information, guidance, advice, help, assistance, answer or response.

The temptation to default into 'complaints mode' and direct people to the complaints process without considering the substance of the concern must be avoided. It is the responsibility of all staff to listen, understand and act on any general concern, and to carefully consider the issues raised and the best course of action for resolution.

At the end of these exchanges, the person may indeed wish to pursue one or more matters as a complaint. This is perfectly fine, and if the process of answering their questions has resolved the majority of the concern, then what is left is a more manageable and focused set of issues that are readily susceptible to consideration through the complaints process. Time spent with a patient or carer addressing their concerns is time saved responding to an investigation at a later point.

The PALS Team can provide support to services with dealing with general concerns.

The second consideration is whether the complaint can be resolved by Early Resolution (ER).

In practice, Early Resolution of complaints means resolving the complaint, at the first point of contact with the person making the complaint, and within 2 working days of receipt (day 1 = the day received).

If Early Resolution seems appropriate, staff should seek the advice and support of a manager to achieve Early Resolution locally. The PALS Team or Complaints Team can also assist.

For Early Resolution to be successful, there should be clarity on:

- What exactly is the person's complaint(s)?
- What do they want to achieve by complaining (establish the expectations of the person making the complaint)?
- Can this be achieved, and if not, explain why not, and signpost to PALS or the Complains Team as appropriate as this may mean an investigation is more appropriate.

Early Resolutions may resolve the complaint by:

- Putting right the issues being raised;
- Offering an apology;
- Explaining why the issue occurred;
- Explain what will be done to stop this happening again.

All Early Resolutions must be documented on the Datix Cymru system; all staff must notify the Complaints Team of an Early Resolution and the outcome to enable this to happen as soon as possible. This enables ongoing reference, issue capture and, on resolution, actions, and learning.

If the issue cannot be resolved as general concern or Early Resolution, then **the third consideration** is to support the person to contact the Complaints Team to register a formal complaint. This must happen immediately.

The Complaints Team will discuss the formal complaint with the person concerned to both clarify the issue and understand what resolution is preferred, and will also explain the process. They will triage the complaint to ensure it is graded according to the PTR grading matrix and that the complaint is allocated to the correct service to review and respond. Where multiple services are involved, then the service with the most involvement will take a lead coordinating role on behalf of all services.

The severity grading is identified by the Complaints Team based on the information presented in the complaint:

- Grade 1 – No harm: any unexpected or unintended incident which caused no harm to the individual.
- Grade 2 – Low harm: any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons;
- Grade 3 – Moderate harm: any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons;
- Grade 4 – Severe harm: any unexpected or unintended incident which resulted in the patient sustaining permanent harm;

- Grade 5 – Catastrophic/Death: where action or inaction has contributed to the death of a person.

The triage undertaken by the Complaints Team will also determine whether the complaint should be progressed as a Learning Review or a Learning Investigation. Where a case is deemed as meeting (or potentially meeting) the criteria for a Learning Investigation under Stage 2b of this policy, the Complaints Team will liaise with the IC Hub for a decision.

The Complaints Team, as part of their triage, will search to determine if an incident report has been submitted. If it has, the complaint and incident will be linked together to ensure one review/investigation and one response to the patient, carer or family member. The Complaints Team will link the records and will notify the handler and investigator for the incident, the Patient Safety Team and local quality governance team to ensure the two matters are aligned.

All complaints must be acknowledged no later than 2 working days after the day on which it is received. This is undertaken by the Complaints Team. The acknowledgement can be in writing or via email depending on how the complaint has been received. The acknowledgement also provides an opportunity to:

- clarify the issues of concern with the person making the complaint;
- seek consent (see the Technical Appendix);
- outline the timescale in which the response is likely to be provided;
- offer information on the availability of advocacy and support service.

The Health Board has a duty to protect the health, safety and wellbeing of its staff and does not tolerate complainants who may be aggressive, threatening, or vexatious. An Unreasonable Behaviour Procedure will be developed to handle such situations.

11.2 Incidents

Where an incident has occurred, it is the responsibility of staff where the incident occurred to report this onto the Datix Cymru system. All staff can, and must, report incidents directly into the system and this can be accessed on the home page of BetsiNet. Videos, guides and training is available to support staff.

Staff should not delay reporting an incident; in all cases incidents must be reported within 24 hours of the incident being identified (and in the case of incidents involving serious harm and disruption, immediately when safe to do so).

An automated acknowledgement of receipt will be sent to the staff member when the incident report is submitted.

When an incident happens within the Health Board the first step to be taken is to ensure the immediate safety and welfare of the patient, public or staff affected.

Escalation of the incident to the appropriate manager(s) and senior manager(s) takes place at the time of the incident following local processes. It is the appropriate senior manager's responsibility to ensure escalation of the incident as appropriate to corporate services including Executives, the Safeguarding Team, the Communications Team, etc.

The initial severity grading is identified by the member of staff reporting the incident. Severity must be based on the actual harm impact of the incident as contributed to by the Health Board and is graded as:

- No harm: any unexpected or unintended incident which caused no harm to the individual.
- Low harm: any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons;
- Moderate harm: any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons;
- Severe harm: any unexpected or unintended incident which resulted in the patient sustaining permanent harm;
- Catastrophic/ Death: where action or inaction has contributed to the death of a person.

It is vital no harm and low harm incidents are treated no less seriously as they provide an opportunity to learn and improve before harm occurs.

All managers are responsible for ensuring they review any submitted incident reports within 24 hours. This immediate review is to ensure that immediate action has been taken and staff are supported. It also ensures that the severity grading is correct and allows managers to reduce or increase the grading following initial reporting.

All divisions must ensure there is also a daily review, at a divisional level, to ensure that immediate action has been taken including sharing of any immediate learning and that managers are being supported to manage the incident. This review also provides the opportunity to escalate to corporate services, divisional directors and executive directors. This daily review may be facilitated by local quality governance teams where they are in post. The daily review will identify which incidents need to be managed under Stage 2b, as a Learning Investigation rather than Stage 2a as a Learning Review.

In addition, the IC Hub will review incidents escalated from the divisional daily reviews is the function for formally confirming which incidents require a Learning Investigation under Stage 2b. When an incident is declared as requiring a Learning Investigation under Stage 2b then the Hub will determine the appropriate deadline (see below in Stage 2b).

A bulletin is sent to the Executive Directors, Corporate Deputy/Associate Directors (with a role or professional interest in quality) and Divisional Directors from the IC Hub each day summarising all Nationally Reportable Incidents and Early Warning Notifications, new Level 2b Learning Investigations and other matters such as regulatory action.

11.3 Mortality Reviews

Independent Medical Examiners (MEs) have been appointed across Wales to undertake reviews of all deaths in all health care settings, other than those that are addressed by the coronial service. After consultation with professionals and family members, they will raise any concerns or feedback with the organisation, the latter will be required to have processes in place to ensure that the concern is appropriately managed to enable the final closure of the loop.

The referrals received from the ME will be received by the Mortality Review Team and recorded on the Datix Cymru Mortality Review Module within 48 hours, which will provide an audit, assurance and learning trail as it is managed through the organisation and will be monitored consistently.

An automated acknowledgement of receipt will be sent to the ME Service.

Where an existing incident or complaint is recorded in the Datix Cymru system, the Mortality Review Team will link the records and notify the handler and investigator for the incident, the Patient Safety Team/Complaints Team and local quality governance team. This notification allows the review already underway to take into account the observations and findings of the ME.

Each new referral from the ME will screened by a weekly ME Screening Panel. The panel will be chaired by a Deputy Executive Medical Director and will consist of multi-disciplinary professionals who collectively are able to ensure all ME referrals are properly triaged and actioned. The panel should, for each case, decide one of the following actions:

- There is already an existing process underway which will effectively address the issues raised in the MEs referral (i.e. as outlined above an incident has already been raised and a Learning Review or Learning Investigation is underway).
- The case requires a Stage 2a Learning Review as detailed in this policy.
- The case requires a more in-depth investigation as per Stage 2b Learning Investigation as detailed in this policy. In this case, the Mortality Review Team will liaise with the IC Hub to raise the incident report and commence the investigation.
- The case can be closed to further review or investigation as there is no harm caused by the Health Board and no further learning.

11.4 Triangulation

The Health Board adopts the principle of *investigate once, investigate well*. This means that where an investigation is needed, it should collectively address the incident, complaint and mortality review in one integrated investigation.

The process above is designed to ensure that where an incident, complaint or mortality is recorded relating to the same issue, the respective records and linked in Datix and one investigation takes place.

However, every investigator should ensure that when they start an investigation they proactively confirm whether any incident, complaint or mortality exists and if so should take steps to ensure they *investigate once, investigate well.* This involves actively confirming no such separate process is underway rather than assuming the absence of a record on Datix is sufficient.

Where an issue affects multiple services, all are expected to cooperate together to provide one review or investigation. For a Learning Review, one service should lead (normally those with the most involvement). For a Learning Investigation, a Learning Investigator will facilitate the process.

The role of the IC Hub, bringing together the Patient Safety Team, Patient and Carer Experience Team and Clinical Effectiveness Team into one virtual collaboration, will support data sharing and triangulation and a single function for commencing Learning Investigations.

11.5 Professional and managerial processes

The Health Board supports the principles of a just culture. It endorses the decision support tool developed by partners across the UK and will use this tool when deciding is professional or managerial action is needed based on a review or investigation undertaken under this policy. The tool is available at Appendix 3. Where any manager or leader is considering professional or management action in relation to an individual they should consult this decision tree to guide their approach.

A referral to the NMC, HCPC, GDC, GPC, GMC or other professional regulator will only be made if, following a robust investigation with the support of the Workforce and Organisational Development Directorate (WOD) and oversight of the relevant clinical executive director, evidence of behaviour or conduct that warrant referral is found. A full support system will be put in place for any members of staff who are referred and staff will be informed prior to any referrals being made. It is important to emphasise that this will only be in cases where significant harm has been identified. Cases will be escalated to the appropriate clinical executive director where it is felt there are immediate practice concerns.

11.6 Safeguarding processes

Consideration of safeguarding must be made at the start, during and the end of any review or investigation. If at any point a safeguarding concern is identified then the appropriate safeguarding procedures must be followed. The Safeguarding Team can provide advice and support.

12. STAGE 2A – CANDOUR AND LEARNING REVIEW

12.1 The primary aim of a Learning Review is to undertake a proportionate review into the concern (incident, complaint or mortality) with the purposes of being open and honest with those affected, and to identify what needs to be done to put things right and areas for further improvement.

12.2 A Learning Review is not an investigation, nor is it a review intended for the purposes of litigation or workforce issues although it may be required to be disclosed for such purposes. Learning Reviews are however just as important as investigations in terms of candour and learning, it is simply a more proportionate and focussed review.

12.3 Where the incident, complaint or mortality identifies that moderate or above harm may have been caused, the Duty of Candour applies. This means that the patient or person acting for them must be verbally informed of the issue and an apology offered along with an explanation of what action will be taken next. This verbal notification must be done as soon as possible and a letter must be sent within 5 working days of this which confirms the verbal discussion. The patient or person acting for them must be given a copy of the review once it is completed. The Duty of Candour section in this policy provides details of the requirements to be followed. In some cases, it may not be apparent the Duty of Candour applies until the review is underway: the duty is therefore triggered once it is known that it does apply.

12.4 Even in cases where the Duty of Candour does not apply, the Health Board adopts the principles of openness and honesty. Patients, carers and families should be informed of any issues and informed of what reviews are taking place and the outcomes of those reviews.

12.5 Where the Learning Review is being conducted following a complaint, it is vital and mandatory that the person leading this review contacts the person complaining to understand the issue, the expected resolution, to provide details of the process including how they will be kept up to date, and to ensure the person complaining has contact details of the person reviewing to provide ongoing support (in effect acting as a single point of contact). This initial contact must be by telephone, video call or face to face.

12.6 The same level of openness and honesty must also include staff. As Learning Reviews are undertaken for the purposes of learning, the early engagement of

staff in the review process is vital in ensuring that issues are identified and improvements are made.

12.7 As a Learning Review is undertaken for less serious matters, it is permissible for the review to be undertaken by a single person which will often be a manager or leader of the relevant service. The person undertaking the review should have attended Learning Reviewer Training.

12.8 The Learning Review should be undertaken within 30 working days of the issue being identified (i.e. the incident or ME report being recorded in Datix, or the complaint being received by the Health Board). This time period must take into account the timescales for approval, which is at least 5 working days.

12.9 There is no template for the Learning Review – a number of tools are available on the Learning from Incidents, Complaints and Mortality BetsiNet site which may be used. A proportionate approach should be used – i.e. a review into a lost ID badge incident would necessarily be different to a complaint about the attitude of a staff member. However, the outcomes of the learning review must be recorded as follows:

- For incidents, the Management Review Section of Datix must be completed with the findings of the review, and if applicable the Duty of Candour Section and the Focussed Review Section (for incidents such as patient falls and pressure ulcers). If the review identifies that harm has been caused by action or inaction of the Health Board, then PTR Redress may apply and advice should be taken from the Patient Safety Team or Legal Services Department.

- For complaints, the findings of the Learning Review must documented on a Response Letter template to the person submitting the complaint. There will be different templates depending on whether the review identifies that harm has been causes by action or inaction of the Health Board. If the review identifies that harm has been caused by action or inaction of the Health Board, then it is likely an incident report will need to be raised. Where an incident report is raised from a complaint, both records must be completed fully before closure.

- For mortality reviews, the Mortality Review Section of Datix must be completed with the findings of the review. If the review identifies that harm has been caused by action or inaction of the Health Board, then it is likely an incident report will need to be raised which will trigger consideration of the Duty of Candour and PTR Redress. Where an incident report is raised from a mortality review, it is acceptable to close the Mortality Review Record in Datix and for the Incident Review Record to take precedence to avoid duplication.

12.10 It is the responsibility of the manager or leader of the service to ensure that the Learning Review is completed on time, in accordance with this policy.

12.11 A Learning Review may be stepped up to a Learning Investigation at any time if it is determined that a more detailed level of review is needed. The request to upgrade a Learning Review to a Learning Investigation should be submitted to the IC Hub.

Please refer to Sections 3, 4 and 5 in regards to the next steps.

13. STAGE 2B – CANDOUR AND LEARNING INVESTIGATION

13.1 The primary aim of a Learning Investigation is to undertake a detailed investigation into the concern (incident, complaint or mortality) with the purposes of being open and honest with those affected, and to identify what needs to be done to put things right and areas for further improvement. Unlike a Learning review, a Learning Investigation is a more thorough and considered review of the issue.

13.2 However, a Learning Investigation is equally not intended for the purposes of litigation or workforce issues although it may be required to be disclosed for such purposes.

13.3 Where the incident, complaint or mortality identified moderate or above harm may have been caused, the Duty of Candour applies. This means that the patient or person acting for them must be verbally informed of the issue and an apology offered along with an explanation of what action will be taken next. This verbal notification must be done as soon as possible and a letter must be sent within 5 working days of this which confirms the verbal discussion. The patient or person acting for them must be given a copy of the Learning Investigation once it is completed. The Duty of Candour section in this policy provides details of the requirements to be followed. In some cases, it may not be apparent the Duty of Candour applies until the review is underway: the duty is therefore triggered once it is known that it does apply.

13.4 Even in cases where the Duty of Candour does not apply, the Health Board adopts the principles of openness and honesty. Patients, carers and families should be informed of any issues and informed of what reviews are taking place and the outcomes of those reviews.

13.5 The same level of openness and honesty must also include staff. As Learning Investigations are undertaken for the purposes of learning, the early engagement of staff in the review process is vital in ensuring that issues are identified and improvements are made.

13.6 For serious cases proceeding to a Learning Investigation, a Rapid Review must be held within 72 hours of the issue being known or investigation being commissioned – serious can include no harm or low harm incidents where there is important learning. The senior manager or leader of the service is responsible for arranging this with the support of the local quality governance team. This can

be held either in person or virtually to maximise the opportunity for attendance. Those in attendance should be drawn from the clinical area within which the incident occurred, but who were not directly involved. The aim of the Rapid Review is to ensure immediate actions and support are in place, and that any immediate learning is cascaded. It is expected that a senior clinical leader from the division leads the rapid review to ensure senior support. Where an issue is particularly sensitive or serious, a clinical executive director or a deputy clinical executive director may attend. The outcome of the Rapid Review must be recorded on the correct template and uploaded to Datix (any actions must be recorded on the actions module of Datix) and a copy sent to the IC Hub. The Rapid Review meeting may also identify specific terms of reference for the Learning Investigation. Whilst a rapid review may clarify the level of harm, the focus of the review is on candour, learning and support.

13.7 As a Learning Investigation is undertaken for serious matters. The decision to commission a Learning Investigation is made by the IC Hub although the weekly Integrated Concerns Oversight Panel may also determine a Learning Investigation is needed. The decision of the panel overrules any decision by the IC Hub. The following is a list of issues that may require a Learning Investigation (this list if not exhaustive or mandatory and professional judgement must be used):

- Never Events;
- Deaths which may have been caused by, or contributed to by, actions or inactions of the Health Board and its staff;
- Grade 4 and 5 complaints;
- ME referral forms raising significant concerns;
- Serious near miss or no harm incidents with the potential for significant learning;
- Incidents or complaints with the potential for significant impact on patients or the organisation.

13.8 The IC Hub will determine a time period for the completion of the Learning Investigation. This time period must take into account the timescales for approval which is at least 10 working days. The maximum time periods (including approval time) are 60 and 90 working days.

13.9 The Learning Investigation will be led by a Learning Investigator. A central list of Learning Investigators is hosted by the Patient Safety Team and investigators act as an organisational resource. Learning Investigators are allocated by the IC Hub on a “taxi rank” system of allocation. To be a Learning Investigator, the individual must have completed the appropriate training.

13.10 A Learning Investigator leads the Learning Investigation process including drafting the report and facilitating development of the Learning and Improvement Plan. However, for clarity, they act as an independent person and do not hold accountability for the management of the investigation. The manager or leader of the service remains accountable.

13.11 A Learning Investigator must be separate from the service where the incident occurs. This generally means they do not work in, or have responsibility for, the particular service. They could work within the same division provided there is a reasonable degree of separation.

13.12 In the most serious of cases, an investigation independent to the Health Board may be commissioned. This is a decision that is reserved to a clinical executive director.

13.13 In some cases a joint investigation may be commissioned across multiple agencies. This is a decision that is reserved to a clinical executive director and terms of reference will be agreed between the respective executive officers.

13.14 As the Learning Investigator is a facilitator of the investigation process, they may not necessarily be clinical or operational expert on the issue in question. The Learning Investigator will therefore need to ensure they have access to appropriate clinical expertise which could be from within the service, another division, or where necessary from independent clinical advice.

13.15 The Learning Investigator should agree terms of reference for the investigation with the manager or leader of the service as soon as possible. The Rapid Review meeting may have already identified specific terms of reference.

13.16 The Learning Investigator should contact the patient or person acting for them to make introductions, explain the investigation process and timescales, and to determine whether the person wishes to be involved in the investigation and to what extent. This is known as a listening conversation. Where that person wishes to take an active role in the investigation, the Health Board welcomes that approach where it can be accommodated. This conversation must include any specific questions to be explores, how the person wishes to be kept up to date, how the person wishes to receive the findings at the conclusion of the process.

13.17 The Learning Investigator should use the most appropriate and suitable tools and methodology to conduct their review. There is no mandated tool or approach and they should use professional judgement and a proportionate approach to gather facts, analyse findings, and draw conclusions. For incidents involving maternal and perinatal deaths, specific national tools and processes will need to be followed as detailed in the Maternal Death Policy or Perinatal Mortality Review Tool (MPMRT) process

13.18 The Learning Investigator should use human factors and systems thinking approaches to identify effective learning and recommendations.

13.19 There is a mandatory template for the Learning Investigation. In addition to completing the template, the outcomes of the learning review must also be recorded as follows:

- For incidents, the Management Review Section of Datix must be completed with the findings of the Learning Investigation, and if applicable the Duty of Candour Section and the Focussed Review Section (for incidents such as patient falls and pressure ulcers). If the review identifies that harm has been caused by action or inaction of the Health Board, then PTR Redress may apply and advice should be taken from the Patient Safety Team or Legal Services Department.

- For complaints, the findings of the Learning Investigation must be summarised on a Response Letter template to the person submitting the complaint. There will be different templates depending on whether the review identifies that harm has been causes by action or inaction of the Health Board. If the review identifies that harm has been caused by action or inaction of the Health Board, then it is likely an incident report will need to be raised. Where an incident report is raised from a complaint, both records must be completed fully before closure.

- For mortality reviews, the Mortality Review Section of Datix must be completed with the findings of the Learning Investigation. If the review identifies that harm has been caused by action or inaction of the Health Board, then it is likely an incident report will need to be raised which will trigger consideration of the Duty of Candour and PTR Redress. Where an incident report is raised from a mortality review, it is acceptable to close the Mortality Review Record in Datix and for the Incident Review Record to take precedence to avoid duplication.

13.20 It is vital that the correct level of post review/investigation harm is recorded in Datix correctly, as this may be different to that originally identified.

13.21 It is the responsibility of the Learning Investigator and manager or leader of the service to work together in collaboration to ensure that the Learning Investigation is completed on time, in accordance with this policy.

Please refer to Sections 3, 4 and 5 in regards to the next steps.

14. STAGE 3 – IDENTIFICATION OF LEARNING AND IMPROVEMENT

14.1 Once a Learning Review or Learning Investigation is completed, the manager or leader of the service is responsible for developing a Learning and Improvement Plan.

14.2 The Learning and Improvement Plan is a mandated template and must be completed for all Learning Reviews and Learning Investigations. The plan identifies what has been learned, how that learning will be shared, and what improvement actions are needed.

14.3 Some learning and improvement actions will be local to the service and these can be agreed locally. Where learning and actions are at a divisional or

organisational level, these must be agreed with the relevant person or service to take this forward. Actions must not be agreed and allocated to a person or service without their consent. The Patient Safety Team, Complaints Team and Mortality Review Team can provide advice where a service is struggling to develop a Learning and Improvement Plan.

14.4 In some situations, there may be Learning Reviews or Learning Investigations which identify improvements needed to areas where improvement plans already exist. This will often be the case in high occurrence incidents or complaints where thematic improvement plans may be in place, such as patient falls or pressure ulcers. In these cases, if the thematic improvement plan already has actions underway, there is no need to duplicate actions in the Learning and Improvement Plan; it will be acceptable to cross reference the wider thematic learning to avoid duplication.

Please refer to Sections 4 and 5 in regards to the next steps.

15. STAGE 4 – APPROVAL AND CASCADE

15.1 There is no mandated approval process for Learning Reviews at a divisional level however divisions must establish their own arrangements (this could be a review by a senior manager or leader, a review by a panel such as a Multi-Disciplinary Falls or Pressure Ulcer Harms Panel, or a review by the Integrated Concerns Operational Panel mentioned above).

15.2 Where the Learning Review relates to a complaint *or* an incident where the Duty of Candour applies or where the review is being submitted to the Coroner, the divisionally approved Response Letter, Learning Review and Learning and Improvement Plan must be submitted to the Complaints Team or Patient Safety Team for a quality check and final approval by a Deputy Executive Director of Nursing (it is only once this approval is given that the review can be considered closed). The Complaints Tem or Patient Safety Team will then issue the documents to the patient, carer of family member (this must take account of the preferences expressed at the listening meeting i.e. the person may wish a meeting to discuss rather than receive via the post). The cover letter will be signed by the Deputy Executive Director of Nursing approving.

15.3 For Learning Investigations, the expectation is that each review is approved by the Integrated Concerns Operational Panel mentioned above or a dedicated, multi-disciplinary sub-group of this panel which must include a clinical divisional director. A single individual sign off is not acceptable.

15.4 In exceptional circumstances where the Learning Investigator and divisional sign off panel cannot agree (such as on issues of factual accuracy), the Learning Investigation will be presented directly to the Learning Investigations Approval Panel for arbitration and decision.

15.5 For Learning Investigations, the IC Hub will undertake a quality check of the completed documentation after divisional approval (this submission must

include the Learning Investigation, Learning and Improvement Plan and the appropriate cover letter).

15.6 Once a Learning Investigation submission has been quality checked by the IC Hub it will be submitted to a clinical executive director for final approval (it is only once this approval is given that the investigation can be considered closed). The Complaints Team or Patient Safety Team will then issue the documents to the patient, carer of family member, or as otherwise agreed. The cover letter will be signed by the clinical executive director approving.

15.7 The senior manager or leader of the service must ensure all affected staff are aware of the findings of the review of investigation. This could be through sharing the findings or arranging a wider learning event to feedback findings.

Please refer to Sections 5 in regards to the next steps.

16. STAGE 5 – DELIVERY OF IMPROVEMENTS

16.1 Once a Learning Review or Learning Investigation has been approved, it is the responsibility of the division to ensure Datix is updated which includes recording the Learning and Improvement Plan on the actions module of Datix.

16.2 The division is then responsible for ensuring the Learning and Improvement Plan is delivered.

16.3 During 2024, a new Learning Portal will be created to capture and cascade learning. Once this is launched the division will be responsible for ensuring information is entered into this system to enable learning to be recorded and cascaded.

16.4 The division may determine there is significant organisational learning, in which case it should arrange to present the findings at the Organisational Learning Forum (OLF). The OLF will lead identifying system wide learning and will lead on ensuring a systemic approach to learning is developed. The OLF may escalate to the Executive Quality Delivery Group issued which it feels need a system wide or systemic improvement approach.

16.5 The divisional Integrated Concerns Operational Panel must maintain oversight of the delivery of all action plans. This includes ensuring themes and trends from incidents, complaints and mortality reviews in their division are identified and inform the local clinical audit programme, local improvement programme and local risk register.

16.6 The corporate Integrated Concerns Oversight Panel will also maintain a strategic overview across the Health Board.

16.7 The Patient Safety Team, Complaints Team and Clinical Effectiveness Team will conduct rolling audits of the Datix system to ensure divisions are uploading

their Learning and Improvement Plans to Datix, which actions are being managed within date, and that evidence is being uploaded to support closure. This information will be used as part of governance and accountability processes and meetings to ensure the Health Board is delivering on its improvement commitments.

16.8 The Patient Safety Team, Complaints Team and Clinical Effectiveness Team will work together to ensure themes and trends from incidents, complaint and mortality reviews are identified and inform the corporate clinical audit programme, corporate improvement programme and corporate risk register. This would involve undertaking thematic reviews as needed.

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APPENDIX 1 – SPECIFIC REQUIREMENTS

Nationally Reportable Incidents (NRIs)

Where it is assessed or suspected that an action or inaction in the course of a patient's treatment or care, in any healthcare setting, has, or is likely to have caused or contributed to their unexpected or avoidable death, or contributed to severe harm, this should be nationally reported to the NHS Wales Executive. There are several specific areas, which automatically meet the criteria for an NRI:

- Suspected homicides where the alleged perpetrator has been under the care of the mental health service in the past 12 months;
- Inpatient suicides;
- Maternal deaths;
- Never events;
- Incidents where the number of patients affected is confirmed to be significant;
- Unusual, unexpected, or surprising incidents.

The Patient Safety Team will undertake the reporting of NRIs to the NHS Wales Executive.

RIDDOR incidents to the Health and Safety Executive

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) require employers, the self-employed and those in control of premises to report specified workplace incidents.

The Health and Safety Team will undertake the reporting of RIDDORs to the Health and Safety Executive (HSE).

Incident involving Controlled Drugs

The introduction of the Controlled Drugs (Supervision of Management and Use) (Wales) Regulations made provision to strengthen the systems for managing controlled drugs. Under the regulations, Controlled Drugs Accountable Officers (CDAO's) are required to establish and operate appropriate arrangements for ensuring the proper sharing of information in accordance with regulation 25 or 26, by their designated body with other responsible bodies regarding the management and use of controlled drugs. For a CDAO nominated or appointed by a Local Health Board, those arrangements must include establishing a network (a "local intelligence network") for sharing information regarding the management and use of controlled drugs. This network is known as the Controlled Drugs Intelligence Network (CDLIN).

Incidents involving fraud

The local counter fraud specialist will report to NHS Counter Fraud Authority incidents of fraud and corruption. They will also undertake investigations into fraud, bribery and corruption.

Incidents involving medical devices

Incidents involving suspected side effects to medicines, vaccines, e-cigarettes, medical device incidents, defective or falsified (fake) products should also be reported direct to the Medicines and Healthcare products Regulatory Agency (MHRA) to ensure safe and effective use.

This is done using the Yellow Card Reporting Site: https://yellowcard.mhra.gov.uk/

IRMER incidents to Healthcare Inspectorate Wales

Radiation incidents are reported via email to the Patient Safety Team by the Radiology Department as per the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER). The Patient Safety Team submits all radiology incident notifications to Healthcare Inspectorate Wales (HIW), copying the Quality Assurance Team.

Mental health incidents to Healthcare Inspectorate Wales

The Legal Services Department (Mental Health Act (MHA) Team) is responsible for reporting to Healthcare Inspectorate Wales (HIW) specified incidents involving detained patients under the MHA, copying the Quality Assurance Team.

Early Warning Notifications to Welsh Government

Early Warning Notifications (EWN) to Welsh Government will be undertaken by the Patient Safety Team. The Welsh Government must be informed of any incident that may be politically sensitive or have the potential for adverse media publicity as soon as possible.

Complaints raised through an elected representative

Complaints raised through an elected representative are received into the Chief Executive's or Chairman's Office and are coordinated by the Public Affairs Team. Complaints are then forwarded to the Complaints Team for progression under this procedure with responses reviewed and sent by the Chief Executive following normal approval and sign off. Some matters raised with elected representative are not complaints and are referred to as "enquiries." This could include general concerns as outlined above. These matters will be addressed by the Public Affairs Team directly with the respective division.

Complaints relating to HMP Berwyn

As with all complaints, those relating to healthcare services within HMP Berwyn are responded to within the same regulatory framework as NHS Wales. This means this policy and procedure applies. When a prisoner expresses dissatisfaction about the healthcare service they have or have not received, or about the standard or quality of service, the healthcare staff at HMP Berwyn, through Health and Wellbeing Peer Mentors and/or Service User Engagement Officers, will attempt early resolution if appropriate or possible. If early resolution is not possible then the prisoners will access 'Investigation under PTR' via the Complaints Team.

Complaints relating to primary care

If a primary care provider is a managed practice under the Health Board then any complaint is managed as per this procedure. If the primary care provider is an independent practice, it will need to be confirmed whether the matter has already been raised with the independent practice and if a formal response has already been provided. If this is the case, then the Health Board will be unable to investigate the complaint again. If the matter has not been raised previously with the independent practice, the Complaints Team working with the Primary Care Quality Governance Team will decide whether to refer the matter to the independent practice, or if the matter is serious enough for the Health Board to investigate. However, if the decision is made for the Health Board to investigate, only a factual account should be provided without any opinion on the standard of care within the response.

Incidents involving the police

Criminal incidents will, by their nature, be reported to the police. These may include assaults, actual or threatened, hate crimes, theft, vandalism, suspicious activity, or deaths. It is the responsibility of the person affected, or the manager on behalf of the Health Board, to report the incident to the police via 101, or 999 if an emergency. If necessary, the Health and Safety Team can advise and assist a member of staff or manager to report.

On the very rare occasion that the police are investigating the incident then the Patient Safety Team will work with the allocated senior police officer for the case to determine what, in terms of an investigation, the Health Board can undertake. It is important that this discussion is held with the lead police officer as soon as possible to ensure that evidence is protected and that the Health Board can ensure learning is identified. The Patient Safety Team will liaise with the police until investigation is closed.

Data protection

Complaints relating to data protection and information governance issues will be notified by the Datix system, once reported, to members of the Information Governance Team. Each complaint will benefit from a review by a member of the Information Governance Team who will assess the risk and grade the complaint according to the severity levels outlined in the appendix. This will determine whether the complaint needs to be reported to Information Commissioner and/or Welsh Government. The investigation of the complaint will then follow the same investigation process until approval whereby a member of the Information Governance Team will review the final response alongside the divisional approver.

The Information Governance Team (Data Protection Officer) is responsible for reporting incidents to the relevant national regulatory body, for example the Information Commissioner's Office.

Legal processes (claims, inquests, etc.)

Reviews and investigations under this policy are not intended for the purposes of litigation however they may be required to be disclosed for such purposes, such as reviews or investigations being provided to HM Coroners. The disclosure of such records will be undertaken by the Legal Services Department in accordance with the Legal Services Policy.

Reporting a death to the Coroner

Coroners are independent judicial officers responsible for investigating the cause of deaths. Coroners inquire into the causes and circumstance of a death under section 5 of the Coroners and Justice Act 2009; inquiries are directed solely to ascertain:

- who the deceased was;
- how, when and where the deceased came by his or her death; and,
- the particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.

The majority of deaths are not reported to the Coroner and in most cases the deceased's doctor will issue a medical certificate with the cause of death without reference to a Coroner, especially if they have been treated for an illness which caused the death. There are strict rules governing when a doctor may do this. They must know what illness caused the patient's death and must have seen and treated them for that illness within the 28 days before they died (this can include face to face or video). These rules are in place to safeguard patients and ensure that death reporting and registration is accurate. Doctors must be familiar with the requirements for completing medical certificates of the cause of death (MCCD) and only sign statements they believe to be true.

The Notification of Deaths Regulations 2019 require a doctor (who is registered with the GMC and has a licence to practise) to make a notification to the Senior Coroner in the area where the deceased's body lies, under certain circumstances. These are:

- poisoning, including by an otherwise benign substance (such as salt/sodium) and refers to either deliberate or accidental intake of poison;
- the use of a medical product, controlled drug or psychoactive substance;
- violence, trauma or injury (including those that are self-inflicted as well as assaults and accidents);
- self-harm;
- neglect, including self-neglect;
- death due to a person undergoing a treatment or procedure of a medical or similar nature;
- an injury or disease attributable to a person's employment;
- where the practitioner suspects the person's death was unnatural;
- deaths in custody or state detention;
- cause of death or identity of the deceased is unknown.

If there is no doctor available who can issue this certificate, the death must be reported to the Senior Coroner.

Where the death is suspicious, it is important to inform the police straight away. For deaths that are not suspicious, but need to be reported to the Coroner, the expectation is that this will be done as soon as reasonably practicable.

There is a common duty upon all citizens to give information which will inform a Coroner of circumstances for when an inquest should be held. It is a common law offence to obstruct a Coroner, whether by disposing of a body before a Coroner can openly inquire into the circumstances of a death or acting to prevent an inquest.

Media involvement

Some incidents, complaints or mortality may attract local or national media attention due to the individual circumstances or place where the incident occurred. Some families may approach the media as they wish to share their story or to campaign.

The Health Board Communications Team should be notified of any cases the media is covering or interested in.

Families may also post on social media, and it is important that staff do not engage with families via this method. Staff should be aware of and follow the Social Media Policy. They must not reveal confidential information about any investigation or family, including any information that could be used to reveal the identity of another person.

APPENDIX 2 – ADVOCACY

The Health Board supports and encourages the use of patient and carer advocates within all services and all staff are required to actively promote this.

Details of advocacy services are provided in the Complaints and PALS leaflets available from the Health Board web site or directly from the Patient and Carer Experience Team, Complaints Team and PALS. All services are required to display the publicity materials on accessing PALS and the complaints process.

Llais is the statutory complaints advocacy service covering the Health Board area. By law, people who wish to complain about the care and/or treatment they receive from the NHS are entitled to free, independent and confidential advocacy services to help them make their complaint.

Llais can be contacted as follows:

Wrexham Office
Units 1B&1C Wilkinson Business Park
Clywedog Road South
Wrexham LL13 9AE
Tel: 01978 356178

Bangor Office
11 Chestnut Court
Parc Menai
Bangor, Gwynedd LL57 4FH
Tel: 01248 679284

Email: northwalesenquiries@llaiscymru.org

APPENDIX 3 – JUST CULTURE

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate – most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes — **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

Yes — **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes — **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

if **No to any** — **Recommendation:** Action singling out the individual is unlikely to be appropriate: the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

if **Yes to any** — **Recommendation:** Action singling out the individual is unlikely to be appropriate: the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

Yes — **Recommendation:** Action directed at the individual may not be appropriate: follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve: individual training, performance management, competency assessments, changes to role for increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

Academy of Medical Royal Colleges, ama, BMA, Care Quality Commission, General Medical Council, Nursing & Midwifery Council, Royal College of Nursing, Royal Pharmaceutical Society, UNISON, Unite

APPENDIX 3 – PATIENT, CARER, FAMILY AND STAFF SUPPORT

Patient, Family and Carer Support

Engaging with patients, families and carers affected by an adverse event is demanding and the challenges of the role should be recognised. Service managers and leaders must consider how the support is provided as part of their response to an incident, complaint or mortality and in line with the Duty of Candour obligations. Those undertaking the role should have access to support and the sources made available and known to them.

Staff Support

It is the responsibility of all managers to ensure their staff are supported. A number of options exist for this:

- A debrief session should be arranged following an incident to help staff engage in true reflective practice to scrutinise and examine assumptions in professional work practices and seek practical solutions. It can be a mechanism whereby leaders can actively support frontline practitioners experiencing difficult situations. It is important that everyone has an opportunity to speak openly and honestly, without feeling judged. There should be no apportioning of blame.

- When addressing the events of a traumatic/stressful incident, complaint or mortality, staff require psychologically safe spaces to process, reflect, document, and review the event chronology. In the majority of cases this will be through their Line Manager as the first point of contact. In cases where this is not appropriate, a point of contact 'staff liaison' will be identified by the line manager. The Line Manager should arrange a "one-one" meeting with the individual member(s) of staff concerned to discuss the issues identified, offer support, and determine the level and type of further support required by the member of staff which may be through internal or external sources i.e., Workforce & Operational Development, Occupational Health & Wellbeing Service, Staff Wellbeing and Support Service, and/or Staff Side representatives.

- Reflection allows staff to make sense of a situation and understand how it has affected them. It allows staff to identify areas for learning and development to include in professional development objectives and supports sharing and learning from other professionals.

TECHNICAL APPENDICES

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TECHNICAL APPENDIX 1 – DUTY OF CANDOUR

Being open with service users and their representatives when things go wrong in their care is the right thing to do. The duty of candour is designed to create a safe environment that is supportive and empowering to those providing, receiving and/or experiencing NHS treatment and care.

Healthcare professionals who are subject to a professional duty of candour have to be open and honest with service users, colleagues, their employers and relevant organisations, and must take part in reviews and investigations when requested. They must support and encourage each other to be open and honest. They must also be open and honest with their regulators, raising concerns where appropriate. The fundamental principles of a duty of candour are therefore already embedded across a wide section of NHS Bodies through those professionals who work within them.

The statutory duty of candour and the professional duties of candour have the same aims – to be open and transparent with people receiving care and treatment. The strong links between the statutory and professional duties of candour will empower staff to speak openly about concerns, and seamlessly encourage learning to improve the quality-of-care provision.

The professional duty of candour relates to individual professional practice whereas the statutory organisational duty is placed on an organisation to ensure that when triggered service users have the same openness and transparency about what has occurred with their care applied by the organisation.

The statutory duty will promote a system wide culture of openness and honesty. It also places a requirement, at an organisational level for NHS Bodies, to follow a set procedure, underpinned by the Candour Procedure Regulations to evidence that a series of prescribed actions have been undertaken when the duty is triggered.

All staff involved in managing an incident, complaint, Learning Review or Learning Investigation must complete the national Duty of Candour eLearning module accessible on ESR.

Trigger for the Duty of Candour

The duty comes into effect in relation to an NHS body if both of the following conditions are met:

1. **The first condition is that a person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome.**

   'Health care' means services provided in Wales under or by virtue of the National Health Service (Wales) Act 2006 i.e. as part of any NHS service, for or in connection with the prevention, diagnosis or treatment of illness or the promotion and protection of public health.

“Illness” includes any disorder or disability of the mind and any injury or disability requiring medical or dental treatment or nursing.

The meaning of health care is deliberately widely drawn to capture all of the NHS services provided in Wales.

A service user is to be treated as having suffered an adverse outcome if the user experiences, or if the circumstances are such that the user could experience, any unexpected or unintended harm that is more than minimal. “More than minimal harm” is not defined in the Act. However, for the purposes of this procedure “more than minimal harm” is considered to constitute moderate harm, severe harm and death. This supports the existing processes for Putting Things Right processes and harm grading used in Datix.

- Moderate Harm: is any significant but not permanent harm or harm that requires a ‘moderate increase in treatment’ relating to the incident. A moderate increase in treatment is defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care.
- Severe Harm: is the permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user’s illness or underlying condition.
- Death: A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient’s illness or underlying condition

The duty may be triggered by an action taken by an NHS body during the provision of health care or by an omission to take action.

For the purpose of the duty of candour, harm includes psychological harm, and in the case of a service user who is pregnant, loss of or harm to the unborn child (section 11(7) of the Act).

2. The second condition is that the provision of the health care was or may have been a factor in the service user suffering that outcome.

The outcome must therefore relate to the provision of the care by the NHS body rather than being solely attributable to the person’s illness or underlying condition.

It need not, however, be certain that the health care caused the harm. It is sufficient that the health care may have been a factor.

To be notifiable, the harm must be unintended or unexpected. It can be as a result of either an actual intervention/treatment, or an omission in care, for example, a missed cancer diagnosis.

Medical or surgical treatment and all care interventions may of course come with inherent risks or may in itself cause a temporary increase in symptoms. Harm which is caused by the treatment itself (e.g. impairments in function as a result of surgery,) would not necessarily be notifiable. These may fall into the category of a known risk, which may have been explained to, and accepted by, the patient as part of the consenting process.

It is not the policy intention that all side effects to medication or treatment that have caused harm or yet may cause harm would necessarily trigger the duty of candour Firstly the harm threshold has to be met and the harm must be unintended or unexpected as outlined above. In essence complications associated with care that was not discussed as a risk of the health care provided may meet the trigger threshold for the duty. There are well established mechanisms for reporting and monitoring the side effects and adverse reactions of medication which will still need to be followed and learned from whether the duty is triggered or not.

It is often unclear in the initial stages whether unintended or unexpected harm has or may occurred and discussion as part of a senior review is recommended where the situation is complex.

It is important to note that the duty is triggered not only when harm is known to have occurred, but also in cases where the circumstances are such that a person could experience harm that is more than minimal in the future from an incident that has already occurred. For example, where an error in the administration of medication that was administered may cause harm that is more than minimal at a future point.

NHS Bodies will have to reach a judgment about whether the circumstances are such that the user could experience harm that is more than minimal. In the example of an error in the administration of medication, whether or not such an error may give rise to harm that is more than minimal may be dependent upon the nature of the medication that was given in error or the circumstances of the particular service user.

To put this in context for practitioners, this has been explained by the GMC in their professional duty of candour guidance as, ‘in situations where a patient ‘may yet suffer harm’ as a result of an adverse outcome.

Where a service user suffers harm whilst on a waiting list, this could potentially trigger the duty of candour. Waiting lists should be actively managed, and new clinical decisions should be taken when the known risk changes to minimise harm to the service user. The materialisation of a risk that is known to the service user and clinician, in itself, would not necessarily trigger the duty of candour.

When both of these conditions are satisfied and the duty is triggered, it is called a “notifiable adverse outcome.”

There are rare situations where it becomes clear that individual performance or actions or omissions may have breached professional codes of practice or criminal law and are not part of a wider patient safety organisational cause or action. It is imperative that the enactment of the duty of candour doesn't interfere with urgent police investigation or safeguarding multi agency strategy meetings and may be necessary that there is a consideration of a delay for the 'in-person' notification. Discussion with lead investigators prior to any further disclosure is recommended. Regulation 12 of the Candour procedure regulations allows for this.

Near miss incidents are any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care in Wales. Near miss incidents are not considered a trigger for the duty of candour procedure. The duty is designed to capture more than minimal harm that is apparent at the time of the incident or may appear later. With a near miss incident, harm (or the potential for future harm) is averted. This is often as the action that would have induced the harm was stopped from occurring or avoided.

Even though the statutory duty of candour under the Act is not triggered by a near miss, individual practitioners should familiarise themselves with the guidance on near misses provided by their professional regulatory Bodies. For example, both the Nursing and Midwifery Council and the General Medical Council provide guidance and support to practitioners on when and how to speak to service users about near miss incidents.

Duty of Candour Procedure

When and who to notify

The Act and Candour Procedure Regulations require NHS Bodies to notify on 'first becoming aware' that the duty of candour has come into effect and not to wait for the findings of any initial investigation before notification.

It is important to note that regulation 4 of the Candour Procedure Regulations requires the NHS body to notify the service user who has suffered a notifiable adverse outcome or a person who is acting on their behalf (in the Candour Procedure Regulations this person is called the "relevant person").

Notification may be made to a person who is acting lawfully on the service user's behalf, where the service user:

- has died.
- is 16 or over and lacks capacity (within the meaning of the Mental Capacity Act 2005) in relation to the matter; or
- is under 16 and not competent to make a decision in relation to their care or treatment.

The Candour Procedure Regulations also allow a service user with capacity to nominate a trusted person to act on their behalf in relation to the duty of candour, recognising that not everyone to whom the duty applies will want to engage personally with the process.

It is important to ensure that at all times the requirements of the UK General Data Protection Regulation (UK GDPR) are adhered to when accessing, processing and disclosing service user information. In cases where a representative is acting on behalf of a service user with capacity, consent for the representative to act should be obtained in writing and be kept under review throughout the process.

How to notify

Notification to the service user or person acting on their behalf should be '''inperson''' which means communication on the telephone, via audio-visual communication (such as a video call) or face to face. It is considered many service users would be surprised to receive a letter in the post advising them the duty had been triggered and may have questions/worries that will need to be answered/alleviated immediately. Leaving voice messages, is also not considered appropriate when making the '''in-person''' contact. Experience from recent stakeholder sessions also demonstrates that an '''in-person''' approach for the first contact is most appropriate.

However, NHS Bodies have a discretion as to which method of '''in-person''' communication is most appropriate. It may not be achievable in practical terms for there to be a face-to-face meeting with everyone in relation to whom the duty of candour has been triggered. The NHS body should consider each circumstance and identify the preferences of the service user/person acting on their behalf and make every effort to meet these where possible. The factors that an NHS body must consider when determining which form of '''in-person''' notification is most appropriate are:

a) severity of the harm.
b) nature and complexity of the notifiable adverse outcome.
c) personal circumstances of the service user (if known).
d) any communication already undertaken with the service user/person acting on their behalf.
e) any known preferred method of communication of the service user/person acting on their behalf. This is particularly important where the service user may require support, for example where Welsh is the first language of the service user or their family or BSL or a foreign language interpreter may be needed.

In some situations, the initial notification via the telephone or video call may suffice; in more complex cases it is likely to be more appropriate for a face-to-face meeting with the service user/person acting on their behalf to be arranged.

In person notification

The NHS body will need to determine the most appropriate person or persons to make the initial '''in-person''' notification to the service user/person acting on their behalf. The NHS body needs to consider whom is the most appropriate person or persons to make the initial '''in-person''' notification to the service user/person acting on their behalf.

Primarily, the initial contact with the service user/person acting on their behalf, is to acknowledge what has happened and offer a meaningful, personalised apology for the harm they have experienced or may yet experience and provide advice on what will happen next.

The NHS body must nominate a person with sufficient knowledge, experience, training and understanding of the duty of candour procedure to be able to assist the service user/their representative with any questions that may arise as they go through the process, this is the "nominated point of contact."

Regulation 4 of the Candour Procedure Regulations prescribes what must be covered in the initial "'in-person'" notification.

The person making the initial contact with the service user/person acting on their behalf must:

- clearly explain what information they know so far about what has happened.
- outline why the NHS body is of the view the duty of candour has been triggered.
- provide an apology.
- provide the contact details of whom is the nominated point of contact for the NHS body. The nominated point of contact is the person the service user/person acting on their behalf will contact if they have any questions about the duty of candour process.
- provide an explanation of the actions and further enquiries the NHS body will undertake to investigate the circumstances of the notifiable adverse outcome. This includes any actions the NHS body (or where services have been commissioned from an independent provider in Wales, the provider) will take under the 2011 Regulations.
- communicate to the service user/person acting on their behalf details of any services or sources of support which the NHS body reasonably thinks may be of assistance to them, taking account of their needs. Annex D sets out useful contacts for support options.
- document this in the service users care record and on Datix.

Regulation 4 also requires the person making the 'in-person' notification to provide an explanation to the service user/person acting on their behalf if the date on which the 'in-person' notification is made by the NHS body is more than 30 working days after the date on which the NHS body first became aware of the notifiable adverse outcome. This is to explain any delay in notification that could arise, for example, following a retrospective case review. The law requires that the NHS body makes the 'in-person' notification on first becoming aware of the notifiable adverse outcome and therefore it does not mean that NHS Bodies routinely have 30 working days from the date the notifiable adverse outcome occurred to make the 'in-person' notification.

It is also good practice to establish what the service user/person acting on their behalf understands about what has happened. The person making the notification on behalf of the NHS body should also demonstrate they understand the circumstances and the impact for the person affected. They should not question the extent of harm suffered by the person affected or the circumstances of the 'incident' as the service user has experienced it.

This may be the starting point for longer conversations with the service user/person acting on their behalf and it will be important for all involved that this initial contact is carried out in the true spirit of the duty, with openness, empathy and sincerity.

Things to consider – Before the 'in-person' notification takes place:

- has someone from the NHS body already been in contact with the service user/person acting on their behalf? This may be related to this incident or other aspects of their healthcare.
- what discussions or information exchange have already taken place (if any)?
- what is known about what has happened and the level of harm sustained or could be sustained?
- is the preferred method of notification known? e.g. verbal, written, electronic; it is recommended to check any previous Datix, Welsh Clinical Portal, Welsh PAS or care records.
- who will be the nominated point of contact within the NHS body following the initial notification?
- what support is available to the service user/person acting on their behalf, to assist them during the notification process and afterwards?
- ensure that communication is in a manner that the service user or the person acting on their behalf, can understand including Welsh if that is their first language.
- consider the location of the conversation if it is to be face to face or via video call to ensure privacy and confidentiality are maintained.
- it should also be recognised that a service user may have a number of questions relating to their care and the presence of a member of the clinical team may be prudent.

Written Notification

Following the 'in-person' notification, regulation 5 of the Candour Procedure Regulations requires the NHS body to take all reasonable steps to write to the service user/person acting on their behalf (unless they have indicated they do not wish to engage in the candour process) within 5 working days after the day of the 'in-person' notification. Notification in writing includes notification via email.

The aim of the written notification is to confirm in writing what has been discussed at the 'in-person' notification. This is to aid the understanding of the service user/person acting on their behalf, and also to provide the NHS body with a record of what has been discussed.

Therefore the written must include:

- a description that explains clearly what information is known so far about what has happened
- a reiteration of the verbal apology,
- the information provided in the 'in-person' notification, which for completeness is as follows:

    - the reason that the NHS body considers that the duty of candour has been triggered.
    - the name and contact details of the person at the NHS body nominated as the point of contact for the service user/person acting on their behalf in respect of the duty of candour procedure,
    - an explanation of the actions that the responsible body or the provider will take, and further enquiries that the responsible body or the provider will carry out, to investigate the circumstances of the notifiable adverse outcome, including any actions to be taken under the 2011 Regulations.
    - a reiteration of the offer of details of relevant services or support.
- where the ‘‘in-person’’ notification is made later than 30 working days after the date on which the NHS body first became aware of the notifiable adverse outcome, an explanation of the reason for the delay.
- document this on Datix Cymru.

Consideration should be given to personalising the notification letter with a handwritten signature. It has been suggested during focus sessions with members of the public that a handwritten signature has a positive impact when an apology of this nature is being conveyed.

The NHS body must take all reasonable steps to send the written notification to the service user/person acting on their behalf within 5 working days following the date of the ‘in-person’ notification.

It is important to acknowledge that delayed or poor communication makes it more likely that the service user/person acting on their behalf, will seek information in a different way, for example, by making a complaint or taking legal action. It may also mean that they will not feel that there has been openness and honesty in the process from the outset.

The apology

Making a meaningful, personalised apology is a key part of the ‘in-person’ notification process. A meaningful, personalised apology can be a practical way of maintaining or restoring trust. When conveyed with empathy, sincerity and understanding, an apology can be effective and powerful and it is crucial for everyone involved when the duty of candour is triggered, including the service user/person acting on their behalf, and the staff who care for them. The impact on everyone involved when the duty of candour is triggered cannot be underestimated. For the service user/person acting on their behalf, an apology is usually the most important action that any one individual and organisation can take, and it is important that a timely apology is given in accordance with the regulations.

People who feel that they have not been listened to or informed openly and honestly from the outset are more likely to feel that the harm they have suffered has been compounded and can lead to the loss of trust in their health care provider. This can result in feelings of anger and cause a break down in the relationship. It may also mean that escalated action is taken.

It is recognised that there may be misconceptions and misunderstanding that the provision of an apology equates to an acceptance of blame, culpability or even legal liability.

This is not the case, and it should not give rise to any such assumption or hinder or delay the offer of an apology.

"Apology" is defined within regulation 2 of the Candour Procedure Regulations as:

"apology means an expression of sorrow or regret in respect of the notifiable adverse outcome."

Regulation 13 specifically provides that an apology or any other step taken in accordance with the candour procedure does not amount to an admission of negligence or to a breach of statutory duty.

The giving of an apology acknowledges what has happened or at this stage what is known to have happened and provides assurance, the matter is being taken seriously and opportunities for learning will be taken to prevent similar circumstances from arising in the future. It is important to ensure the apology covers what is known at that point without speculating or including assumptions on what may have happened or caused the incident to occur. It is helpful to admit at this early stage that a lot may be unknown but that more detail is likely to become clearer during the investigation that follows.

We recognise that sometimes staff can find it difficult to say sorry when harm has occurred or may occur at some point in the future. They may be unclear if they can say sorry and worry that the timing for doing this will not be right, or that they will make things worse, especially as the service user/person acting on their behalf, may be understandably angry and upset. Annex E aims to provide guidance to support staff in this regard.

It is best practice to document the verbal apology in the patient care record. This means that the entire care team will know when an apology has been given and can avoid duplication.

Notification of further investigations

Regulation 6 of the Candour Procedure Regulations requires NHS Bodies to notify the service user/person acting on their behalf of the results of any further enquiries (investigations) carried out by the NHS body that may have been referred to in the 'in-person' notification. These enquiries are understood to be the investigation that is to be undertaken by the NHS body.

In practice, in the vast majority of cases once the service user/person acting on their behalf has been notified, the NHS body will undertake further enquiries and investigate the circumstances in which the duty of candour came into effect in accordance with the provisions of the 2011 Regulations. NHS Bodies will be familiar with this process as it governs the way in which incidents are currently investigated.

Communication with the service user/person acting on their behalf under the provisions of the 2011 Regulations, which includes a requirement to outline in writing the outcome of investigations, will also satisfy the requirements of regulation 6 of the Candour Procedure Regulations, so avoiding duplication in the event that the 2011 Regulations apply.

Communication with service users/persons acting on their behalf

Regulation 7 prescribes what an NHS body must do if it is unable to make contact with the service user or a person acting on their behalf to:

i. make the '''in-person''' notification (regulation 4),
ii. the written notification (regulation 5),
iii. to notify of results of further enquiries (regulation 6),

or if the service user or person acting on their behalf declines to participate in communication with the NHS body.

If the NHS body, having taken reasonable steps, is unable to make contact, the attempts to make contact must be recorded as part of the information that is required to be kept by virtue of regulation 9 (Records), see guidance on record keeping below. Ideally the information should be recorded on the incident record, which in most circumstances will be RLDatix Cymru.

If the service user/person acting on their behalf, indicates that they do not wish to communicate with, or receive information from the NHS body, this must also be clearly recorded in accordance with regulation 9 and the person's wishes respected. This should be recorded on the incident record (Datix Cymru), and also on the service user's care records.

In accordance with regulation 7(3)(b) of the Candour Regulations NHS Bodies are not required to provide information to or communicate with the service user/person acting on their behalf in these circumstances where they have indicated that they do not wish to communicate with or receive information from the NHS body. However, the investigation of the incident giving rise to the triggering of the duty must continue so that lessons can be learned, and quality improvements made.

The NHS body should inform the service user/person acting on their behalf that they can contact the NHS body should they change their mind about their involvement in the process.

The NHS body must take reasonable steps to ascertain the service user/person acting on their behalf's preferred method of communication and, where reasonably practicable, communicate with them by this method.

The NHS body must take all reasonable steps to ensure that any communication with the service user/person acting on their behalf is in a manner they can understand this is especially important where disability is present or where the service user is a vulnerable adult or child or young person.

Record Keeping

Section 4(3)(c) of the Act requires the Candour Procedure Regulations to prescribe the records that NHS Bodies must keep in relation to the discharge of the duty.

Regulation 9 of the Candour Procedure Regulations requires NHS Bodies to keep an accurate written record for each notifiable adverse outcome in respect of which the candour procedure is followed.

The written record must include every document and piece of correspondence relating to the notifiable adverse outcome, not limited to:

- the notification of the duty.
- attempts to contact the service user/person acting on their behalf.
- any decision by the service user/person acting on their behalf not to be
- contacted in relation to the duty of candour; and
- all documentation relating to the review to establish whether the duty has been triggered and the subsequent investigation of the notifiable adverse outcome, that is undertaken by the NHS body, including the response or interim report issued under regulations 24, 26 or 31 of the 2011 Regulations.

It is considered good practice to record any decision not to trigger the duty (where triggering was contemplated). It is important that accurate records are kept supporting quality assurance mechanisms needed to identify areas for learning and improvement and also to enable NHS Bodies to comply with their reporting requirements under the Act.

The Datix Cymru is used for the purposes of reporting and recording keeping.

Investigation

When notifying the service user or person acting on their behalf that the duty of candour has been triggered, an NHS body must (in accordance with regulations 4(3)(e) and 5(3)(c) of the Candour Procedure Regulations) also give an explanation of the actions and further enquiries it will take to investigate the circumstances of the notifiable adverse outcome.

In the vast majority of cases, this means following the 2011 Regulations procedure for investigating concerns. “Concerns” as defined in the 2011 Regulations includes all patient safety incidents.

However, there will be instances where, even though the duty of candour applies, an investigation under the 2011 Regulations will not be required. For instance, the 2011 Regulations do not apply to NHS Blood and Transplant, they will follow their internal procedures for investigating patient safety incidents.

In relation to an investigation under the 2011 Regulations, as is currently the case, the investigation must be proportionate, conducted openly and efficiently and the focus should be on improving quality, safety and sharing learning.

The service user/person acting on their behalf should be invited to contribute to the terms of reference of the investigation and contact should be maintained throughout the investigation, if this is what has been agreed. The preference of the service user/person acting on their behalf should be considered as not everyone will want to be involved to this extent.

The outcome of the investigation will be communicated to the service user or their representative in accordance with regulation 24 of those Regulations or, in the case of care provided by Health Boards, NHS Trusts or Welsh Special Health Authorities, in line with regulations 26 and 31 where the redress arrangements have been applied.

Consideration should be given to whether the incident should be reported to other Bodies e.g. an employer or professional regulator, the Medical Examiner Service or HM Coroner. Additionally the incident may meet the National Reportable Incident threshold or be reported to Welsh Government.

Staff involved in the treatment or care that resulted in the duty being triggered should, where appropriate, be involved in the investigation process and also be advised of the final outcome.

There have been some amendments to the 2011 Regulations to make them compatible with the duty of candour. The principal amendments are set out in regulation 14 of the Duty of Candour Procedure Regulations. Their effect is to ensure that both the duty of candour and the PTR procedures work in harmony and to ensure that there is not any duplication of processes.

Complex Arrangements

Where more than one NHS body is involved

It is often the case that a range of NHS Bodies engage in an episode of care where the duty of candour is triggered.

Although not all of the Bodies involved in the provision of an episode of care will necessarily be the ‘providing body’ in terms of the legislation (i.e. their provision of health care did not or does not have the potential to trigger the duty of candour) they may need to become involved in providing information as part of a review or providing support for the service user/person acting on their behalf. All parties must co-operate fully in an open and facilitative manner throughout the duty of candour procedure and share with each NHS body any learning identified as a result of the subsequent investigation/ review, including any actions to be taken with a view to preventing similar circumstances from arising in the future.

There may also be occasions where several NHS Bodies each are providing health care to a single service user and each trigger the duty of candour procedure for multiple ‘notifiable adverse outcomes’ in relation to a single course of treatment. Annex H has case study examples for reference.

In such circumstances, it would be best practice for the NHS Bodies to seek to communicate with the service user/person acting on their behalf to gain the

appropriate consent, in line with UK GDPR, to undertake a co-ordinated approach to notification. Otherwise, there is a risk the service user or person acting on their behalf will feel overwhelmed or confused by the process if they get multiple notifications. This is particularly important where the harm is Severe, or a death has occurred.

The aim should be to make the process as easy as possible for those involved and, in particular, for the service user or person acting on their behalf.

However, each NHS body (providing body) still has its own responsibility under the Candour Procedure Regulations and must ensure and be able to evidence that, as individual organisations, they have complied with the requirements of those Regulations.

Where there are multiple NHS Bodies involved in the duty of candour, the subsequent investigation is undertaken as detailed in regulation 17 of the 2011 Regulations. Regulation 17 deals with concerns involving more than one responsible body. It places a duty on responsible Bodies (subject to obtaining the relevant consents from the service user or person acting on their behalf) to cooperate for the purposes of coordinating the handling and investigation of concerns and the provision of a coordinated response.

If an NHS body discovers that an incident that would trigger the duty of candour procedure has occurred in a different NHS body, the NHS body that discovers the 'incident' should inform the NHS body where the 'incident' occurred so that the latter can then implement the duty of candour procedure.

The NHS body that discovers the 'incident' must also be open and transparent with the service user about what they have discovered. However, they are not required to perform the specific duty of candour procedure; this should be conducted by the responsible NHS body, i.e. the 'providing body' where the duty of candour was triggered.

Mixed care between NHS bodies and Social Care bodies

Where a service user is receiving care from an NHS body and a provider of social care (whether in a mixed model of delivery or separately), it is possible that multiple providers may have contributed to the harm that has been caused to the service user. In such cases each provider will have its own responsibilities under the duty of candour (or its equivalent for providers of social care).

The providers of both health and social care should liaise and work together to notify and investigate the incident in order to minimise any distress and to avoid multiple communications to the service user. For example it would not normally be appropriate for a family to receive two separate 'in-person' notifications about the death of a family member because of a lack of communication between providers.

However, each provider will retain their individual responsibilities under their respective duty of candour and must satisfy themselves that they have been met.

Commissioned and Hosted services

Section 11 of the Act clarifies which organisation will be responsible for complying with the duty of candour in situations where services are provided by one body on behalf of another. The position, in relation to different arrangements is set out below:

Services Commissioned by an NHS Body from Another NHS Body in Wales

An NHS body in Wales is responsible for complying with the duty of candour in relation to all care which it actually provides. Therefore, for example, where a Health Board enters into arrangements with a primary care provider for the provision of NHS services, it is the primary care provider who is subject to the duty. Similarly, if a Health Board enters into arrangements with an NHS Trust in Wales for the provision of services, the duty rests with the NHS Trust.

Services Commissioned from Non-NHS Bodies in Wales

If an NHS body enters into an arrangement for the provision of services with someone other than another NHS body, the duty to comply with the duty of candour rests with the NHS body. Therefore, for example, if a local Health Board enters into an arrangement with an independent provider for the provision of services, the duty will apply to the local Health Board. In these circumstances, it would be for the NHS body to notify the service user or person acting on their behalf for both the '''in-person''' notification in accordance with regulation 4, and the written notification in accordance with regulation 5. The provisions of the 2011 Regulations apply to persons who provide services under arrangements with an NHS body. Therefore, as is the case currently, it would be for the independent provider to investigate the circumstances of the notifiable adverse outcome and communicate the result of that investigation to the service user/person acting on their behalf. NHS Bodies should ensure that their commissioning arrangements with non NHS independent providers in Wales require the independent provider to notify them when they are of the view that the duty of candour has been triggered, so that the NHS body can comply with its obligations in relation to notification under the Act. The commissioning arrangements will also need to require the independent provider to provide sufficient information to the NHS body to enable them to comply with their reporting obligations under section 7 of the Act.

Application of the Duty of Candour to Care Commissioned Outside of Wales

The duty of candour under the Act only applies where health care is delivered in Wales as part of an NHS service. If, for example, a local Health Board enters into arrangements with an English provider, whether that provider is an NHS body or an independent provider, for the provision of health care services in England, it is the English duty of candour, under the Health and Social Care Act 2008 that may apply in relation to that care. Part 7 of the National Health Services (Concerns, Complaints and Redress arrangements) (Wales) Regulations 2011 outlines the approach to be taken in terms of services carried out by England, Scotland and Northern Ireland NHS Bodies when patient safety incidents and concerns have been raised.

Hosted services

Where healthcare is delivered by an organisation or service that is hosted by an NHS body (for example a clinical network), the Duty of Candour applies to the NHS body as the legal entity that hosts the service or organisation.

Special Considerations

Children and Young People

The duty of candour applies in respect of health care that is provided in Wales to children and young people. The welfare of children and young people, and their rights to be fully involved in decisions about their care and treatment, are essential principles to the approach to be taken when things go wrong with a child's or young person's care.

Under the UNCRC (article 12), children and young people - where they are able and wish to be - should be involved in discussions about adverse outcomes that directly affect them. This is in conjunction with the child's or young person's right to the highest attainable levels of health (article 24) and the right to receive and impart information (article 13). Honesty, transparency and openness are the guiding ethical principles to be adopted and discussions must be conducted in a sensitive manner that take age, the child or young person's experience of health care, their mental capacity and the wishes of the individual child or young person and, where appropriate, those with parental responsibility into consideration.

In discharging the duty of candour in circumstances involving health care that has been provided to a child or young person, the NHS body must notify the "relevant person" of the notifiable adverse outcome (see regulation 3 of the duty of candour regulations). This might be the child or young person themselves, unless they are:

- 16 or over and lack capacity (within the meaning of the Mental Capacity Act 2005) in relation to the matter, or
- under 16 and not competent to make a decision in relation to their care or treatment,

in which case the "relevant person" is a person legally acting on the child or young person's behalf. Where the matter concerns a child who is under the age of 16, it is important that consideration is given as to whether the child is "Gillick competent" i.e., whether the child has the requisite legal capacity and sufficient maturity and intelligence to understand the information provided and to make decisions about their own health and medical treatment.

The health care professional seeking the child or young person's consent should undertake the Gillick competency assessment if they have been adequately trained to do so. However, even where the child is "Gillick competent," or where a young person is considered to have the requisite mental capacity, children and young people should be encouraged to involve their parents or guardians in these discussions where that is advisable and beneficial.

Alternatively an advocate may be of use in this circumstance. Parents and Guardians are often best placed to understand and advise the health care team and, in many circumstances, an important source of support for the child and young person coming to terms when harm has occurred with their care. The use of appropriate language and explanation needs to be thought through carefully and, where appropriate, conducted in a timely manner and in partnership with parents or guardians. The use of appropriate professionals with experience in communicating with children can be of immense value in these circumstances.

This is important in order to mitigate against the risk of causing further harm or distress in notifying the child or young person of the notifiable adverse outcome, whilst also remaining open and honest with the child or young person about what has happened in accordance with the duty of candour, and the broader rights of children and young people to be kept fully informed.

Where a child is not considered to be “Gillick competent” then notification must be given to a person acting on the child’s behalf (e.g., their parents or legal guardian). In this circumstance, it is important to take in to account the parents’ or guardians’ views as to how a child or young person can be informed about what has happened in their care or treatment and consideration should be given as to how the health care team can support that discussion. As part of that discussion, consideration should be given as to the best interests of the child or young person in terms of the manner within which the discussion is undertaken, taking care not to cause further harm or distress.

Consideration must always be given to safeguarding principles and guidance and the need, at times, to report concerns around a child or young person’s safety discovered through these discussions where this is mandated legally or professionally. Good documentation of decision-making and the assessment of competency to understand and participate in decisions about their care is imperative. It is also important that any decisions made not to share information are regularly reviewed.

It must be recognised that children and young people are often aware of incidents and changes in their care, and it can be extremely helpful to a young person to understand why it has happened.

Often children and young people may fear unclear outcomes. These fears can be generated when issues and incidents are not discussed, and children and young people are left uncertain about why things have occurred and what the next steps are in their care. This leads to increasing anxiety, worry and mental stress.

Ensuring children and young people are afforded the opportunity to be partners in the decision-making process about their care, with their parents or guardians and their health care team is imperative, where this is appropriate and possible.

It is important to always have the child, young person and their family unit at the centre of good honest and open communication and the decisions about their care and this is especially important when unintended or unexpected harm has occurred.

Retrospective case reviews

Adverse outcomes may become known following retrospective serious case reviews, a large number of patients recalled or following a decision made by the medical examiner service or a coroner's inquest, where the cause of death attributed was not known at the time of the incident.

Additionally, further detail, not known during the initial review, may become known during the investigation of the incident. In these cases, the duty may still apply.

At the point of such a case review, and if the requisite conditions for the duty of candour have been met, the organisation therefore becomes 'aware' of the notifiable adverse outcome.

It is at this point that the DOC procedure should be initiated, if not previously initiated. In the event that the 'in-person' notification is made later than 30 working days after the responsible body first became aware of the notifiable adverse outcome, the responsible body must provide an explanation of the reason for the delay.

Adverse Outcome Incidents Which Occur Before the Duty of Candour Came into Force

The Duty of Candour legislation is not intended to operate in respect of adverse outcomes which occurred before the date that the legislation came into force. In practical terms, this means that the conditions triggering the duty of candour (i.e. the provision of health care and the harm which occurred), must have taken place after 1 April 2023.

However, we would still expect you to apologise and to be open and transparent with people about whatever has been discovered in line with the ethos of putting things right.

TECHNICAL APPENDIX 2 – PTR REDRESS

This section of the policy provides information on the Health Board's approach to meeting its obligations under the PTR Regulations, and the legal principles that inform decisions concerning the payment of financial compensation - further information is provided in the Healthcare Law Policy.

When harm is found during a review or investigation, and it is determined that this may have been caused by a breach of duty then the Health Board has a duty to consider redress.

Redress, according to PTR, comprises of an offer of compensation, an explanation, including a written report outlining the investigation, and a written apology. Compensation can take the form of financial compensation, further treatment, or both.

The provisions for financial compensation contained in the Regulations are intended to provide patients with a speedier and more accessible alternative to pursuing court based actions for settlement. The procedure provides for financial compensation for patients as one specific form of redress, subject to relevant eligibility criteria and conditions being met.

Most complaints do not allege harm, and most reviews or investigations do not find any harm has been caused, and so most response letters will not refer to an offer of redress (known as a 'Regulation 24' response letter).

If it is thought that harm has been caused following a breach of duty, then the response letter must provide the person raising the complaint with information in relation to the potential for redress. This may be an interim response (known as a 'Regulation 26' response letter) which indicates the need for further investigation to confirm that harm has been caused by the breach of duty, or a response offering financial compensation (known as a 'Regulation 33' response letter).

If the qualifying liability would attract financial compensation of greater than £25,000 then this would result in a 'Regulation 24' response which states that an offer of redress would not be made under PTR but will provide information to take this forward under civil law.

Financial compensation can only be considered if there is a proven qualifying liability in the law of tort. Investigations will therefore need to establish that the Health Board failed both in its duty of care to a patient, and that the breach of that duty has been causative of the harm that the patient experienced. Only when both of these tests are satisfied will the Health Board consider the payment of financial compensation. In reaching judgments concerning eligibility for financial compensation, the Health Board will also give due regard to the legal principles informing payments for clinical and medical negligence and the developing case law.

A legal test is used to establish whether there has been a breach of duty, known as the "Bolam" test. The Bolam test states that there will be no breach of duty if a Clinician can prove they acted in accordance with a responsible/reasonable body of medical

opinion in the circumstances. This has developed over the years, and the action/decision must withstand 'logical analysis'. If a breach of duty is identified, the Health Board will carry out further investigations to establish whether the breach of duty has caused, and/or materially contributed to any harm. The legal test for proving harm has been caused is the "but for" test i.e., "but for" the breach of duty the treatment the harm/injury would not have occurred. In some cases, despite there being a breach of duty in the care provided the outcome would have been the same in any event – so no harm caused.

There may be occasions when it is necessary to secure an independent opinion on a matter relating to a concern, with a view to resolving it. This is not done as routine, however sometimes an expert in a particular field can be commissioned to perform an external review/opinion. This also comes at a cost to the Health Board and will require senior approval for financing. This may include:

- Obtaining a second opinion to aid a patient's understanding of their own care, or to see whether there are any other issues which need to be explored in terms of the provision of care and treatment, as part of the investigation of a concern by a Responsible Body;
- In instances when an allegation of harm has been made by the patient, and where a Welsh NHS body is unable to come to a determination itself as to whether there is a qualifying liability in tort, the securing of an expert opinion to answer questions in relation to the tests relating to breach of duty of care and/or causation, as part of an investigation under Part 5 of the Regulations; and
- Where the Redress arrangements in Part 6 of the Regulations are triggered any instruction of medical experts must, in accordance with Regulation 32(1)(b), be carried out jointly by the person who notified the concern and the Welsh NHS body. Experts may be instructed to advise in relation to issues relating to causation, condition, and prognosis and/or quantum to establish whether there is a qualifying liability in respect of which an offer of Redress should be made.

If an investigation identifies possible redress, then please refer to the Legal Services Policy and the Legal Services Department Team. A weekly Redress Clinic is held to provide advice, guidance and support and the case should be tabled and reviewed at that forum.

All Regulation 33 and Regulation 24 (over £25,000) must be agreed with or drafted by the Legal Services Department.

Where the redress arrangements are engaged, legal advice without charge to the person who notified the concern will be available, should the person or his representative want it, in relation to:

- the joint instruction of clinical experts including clarification of issues arising from their reports.
- any offer of Redress made in accordance with Part 6 of the Regulations.
- any refusal to make an offer; or any settlement agreement that is proposed.

Legal advice may only be sought from a recognised firm of solicitors with known expertise in clinical negligence and who are accredited by the Law Society or from the Action against Medical Accidents (AvMA) Clinical Negligence Panel.

When an investigation identifies that redress is applicable then a ‘Learning From Events Report’ should be commenced by the service as soon as the investigation is concluded. This report is required by the Welsh Risk Pool to demonstrate that the Health Board has learnt from the issues raised.

TECHNICAL APPENDIX 3 – OMBUDSMAN

If the Health Board does not succeed in resolving a complaint, an individual may complain to the Public Services Ombudsman for Wales (PSOW).

The Ombudsman is independent of all government bodies and can look into complaints if someone believes that they personally, or the person on whose behalf they are complaining:

- have been treated unfairly or received a bad service through some failure on the part of the service provider;
- have been disadvantaged personally by a service failure or have been treated unfairly.

The Ombudsman normally expects complaints to be raised with the Health Board's attention first, in order to give the Health Board a chance to put things right.

The Ombudsman can be contacted by:

- Phone: 0300 790 0203
- Email: ask@ombudsman.wales
- The website: www.ombudsman.wales
- Writing to: Public Services Ombudsman for Wales, 1 Ffordd yr Hen Gae, Pencoed CF35 5LJ

All complaint response letters must include details of the Ombudsman's role and how they can be contacted – standard wording is agreed between the Ombudsman and the Health Board.

There are also other organisations that consider complaints. For example, the Welsh Language Commissioner's Office deals with complaints about services in Welsh.

TECHNICAL APPENDIX 4 – CONSENT

All Investigations under PTR need to comply with the Data Protection Act (DPA).

Consent is the lawful basis that allows the Health Board to access and use a patient's personal data; within PTR this is to aid a review or investigation.

For complaints raised directly, there is no need to expressly seek the patient's consent to investigate their complaint as they can be deemed to have given implied consent. However, the patient should be informed in the acknowledgement letter that their medical/clinical records may need to be reviewed so that they have the opportunity at this point to indicate if they do not want their health records accessed.

Whilst it is good practice to seek consent at the acknowledgement stage of the complaint handling process, delay or failure to provide written consent does not mean that the Health Board is unable to investigate the complaint. This is especially important in situations where issues of patient safety and/or public interest are evident.

There is a distinction to be made between the ability of the Health Board to gather evidence and review or investigate, and whether the findings can be lawfully disclosed or shared.

Disclosure or sharing of information must be carefully considered if consent is not obtained. The Health Board is under no obligation to provide a detailed response if it is felt that it is inappropriate to do so.

"PTR: processing and disclosing personal information under GDPR" (2020) provides guidance in relation to both consent and disclosure. This document is available on the intranet.

Any additional questions regarding the right to investigate complaints and disclose findings should be signposted to the Information Governance Team or the Complaints Team.

All decisions must be clearly documented on the relevant file within Datix.

Where consent is requested (i.e. someone complaining on behalf of another person), a 10 day period will be provided to supply the appropriate evidence. If no evidence is received and no further contact is made, the complaint will be closed. If there are patient safety and/or public interest issues those should still be reviewed or investigated to ensure learning.

REFERENCES

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- Duty of Candour Procedure (Wales) Regulations 2023
- Putting Things Right Guidance
- Duty of Candour Statutory Guidance
- PSOW Model Complaints Policy for Public Services Providers in Wales
- NHS Wales Patient Safety Incident Framework
- NHS Wales Mortality Review Framework
- NHS Wales Learning from Events Framework

Integrated Concerns Hub – Decision Support Tool V0.2

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Note: the stages below reflect the 5 stages of the Integrated Concerns Policy

STAGE 1 – IDENTIFICATION, TRIAGE AND ACKNOWLEDGMENT

Incidents

Complaints

Medical Examiner Forms

Relevant claims/coroner enquiries

Other relevant concerns i.e. Speak out Safely

Identify, triage and act –

- Local action to identify and act (make safe) ensuring timely recording on Datix.
- Local action to ensure Duty of Candour is enacted.
- Decision on appropriate next steps in line with policy and PTR.
- Integrated Concerns (IC) Hub to have oversight of local action and will determine which concerns need a Candour and Learning Investigation (see box below).

The Integrated Concerns Hub will operate each working day as a virtual collaboration of the Corporate Patient Safety, Complaints and Mortality functions. The Hub will be led from a rota of Corporate Heads of Service from each quality function.

A weekly Integrated Concerns Oversight Panel will meet led by a Clinical Executive to provide scrutiny, challenge and support.

Triangulation –

- IC Hub will triangulate intelligence to enable the approach of *investigate once, investigate well*.
- Where multiple records exist, the Hub will allocate a primary Datix ID (normally the Incident ID which would take precedence although the mandatory Complaint and Mortality sections of Datix will still need completing).
- IC Hub will ensure any legal cases such as a claim or inquest are linked to the primary Datix ID in Datix.

Decision on whether a Learning Investigation is needed –

- Every Incident, Complaint or ME Form will have a Learning Review within 30 working days ***or*** where decided by the IC Hub a Learning Investigation.
- Every Learning Investigation must have a 72 Hour Rapid Review.
- The IC Hub will allocate an Investigator from the central list and determine the deadline (normally 60 working days).
- The following is a list of issues that may require a Learning Investigation (this list if not exhaustive or mandatory and professional judgement must be used):
  - Never Events;
  - Deaths which may have been caused by, or contributed to by, actions or inactions of the Health Board and its staff;
  - Grade 4 and 5 complaints;
  - ME referral forms raising significant concerns;
  - Serious near miss or no harm incidents with the potential for significant learning;
  - Incidents or complaints with the potential for significant impact on patients or the organisation.

STAGE 2A – CANDOUR AND LEARNING REVIEW
or
STAGE 2B – CANDOUR AND LEARNING INVESTIGATION

New Information from the review may trigger re-assessment by the IC Hub

STAGE 3 – IDENTIFICATION OF LEARNING AND IMPROVEMENT

STAGE 4 – APPROVAL AND CASCADE

The Integrated Concerns Hub will monitor and report on deadlines and progress of Investigations and report to the Integrated Concerns Oversight Panel

STAGE 5 – DELIVERY OF IMPROVEMENTS

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New Integrated Concerns Policy - Implementation Plan

Last Update: 10/07/2024

Action	Lead	Deadline	Progress	RAG & Evidence
Finalise the new Integrated Concerns Policy for submission to the Board at its meeting on 25 July 2024	Angela Wood, Executive DoNM	12/07/24	Draft policy developed through engagement and reviewed at the Executive Team on 03/07/24	
Develop a Standard Operating Procedure for the Integrated Concerns Hub	Reena Cartmell, Director of Nursing for Quality Assurance and Learning, with: • Kath Clarke – Head of Quality Assurance • Tracey Radcliffe – Head of Patient Safety • Leon Marsh – Head of Patient and Carer Experience • Joe Shillingford – Head of Clinical Effectiveness	24/07/24		
Develop a Decision Support Tool (Decision Tree) for use by the Integrated Concerns Hub	Matthew Joyes, Deputy Director of Quality	11/07/24		

Review and finalise the relevant Letter templates to align with the new policy: acknowledgement letter, complaint response letter, investigation report cover letter, duty of candour letters, etc	Leon Marsh, Head of Patient and Carer Experience with: • Tracey Radcliffe – Head of Patient Safety	24/07/24		
Develop a new Rapid Review template to align with the new policy	Tracey Radcliffe, Head of Patient Safety	24/07/24		
Review and finalise the new integrated Investigation and Learning Report template	Tracey Radcliffe, Head of Patient Safety with: • Leon Marsh – Head of Patient and Carer Experience	24/07/24		
Develop a Terms of Reference for the new Weekly Integrated Concerns Oversight Panel (which will replace RLPs)	Chris Lynes, Deputy Executive Director of Nursing	24/07/24		
Revise the Harm Free Care Terms of Reference (and title) to align with the new policy (and change the name to better align	Chris Lynes, Deputy Executive Director of Nursing	24/07/24		
Develop am oversight and tracking report to monitor IHC/Divisional performance for incidents, complaints and mortality to align with the new policy	Mandy Jones, Deputy Executive Director of Nursing with: • Performance Team • Informatics Team	07/08/24		
Develop a central list of Learning Investigators and determine the numbers required and fair allocation from to the central resource from services	Mandy Jones, Deputy Executive Director of Nursing	07/08/24		

Develop a training programme of different levels to support delivery of the new policy	Reena Cartmell, Director of Nursing for Quality Assurance and Learning with: • Kath Clarke – Head of Quality Assurance • Tracey Radcliffe – Head of Patient Safety	07/08/24		
Develop an Integrated Concerns Portal (intranet site) on BetsiNet to provide a single place for all guidance, tools and resources	Mandy Jones, Deputy Executive Director of Nursing	24/07/24		
Rename the existing MIS section of Datix to Candour and Learning Review to ensure alignment with the new policy	• Kath Clarke, Head of Quality Assurance	07/08/24		
Develop a plan to communicate to corporate teams, divisions/IHCs and external partners of the new policy	Chris Lynes, Deputy Executive Director of Nursing	24/07/24		
Develop a risk and issues log for the project implementation	Matthew Joyes, Deputy Director of Quality	24/07/24		

Key:

	Completed
	On track and no risk of delivery
	Off track and at risk of delivery
	Overdue or serious delivery issue

Teitl adroddiad: *Report title:*	Annual Delivery Plan Q1 Update
Adrodd i: *Report to:*	Health Board
Dyddiad y Cyfarfod: *Date of Meeting:*	25th July 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this paper is to provide an overview of progress against the Quarter 1 deliverables within the 2024/25 Annual Delivery Plan. This paper represents Part A of an overall update, with elements relating to 2023/24 activity that is being carried forward covered in a Part B paper.
Argymhellion: *Recommendations:*	The Health Board is asked to: • **RECEIVE ASSURANCE** on the progress made during Q1 along with the challenges highlighted • **APPROVE** the change controls outlined within the paper
Arweinydd Gweithredol: *Executive Lead:*	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)
Awdur yr Adroddiad: *Report Author:*	Geraint Parry, Portfolio Office

Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	To support the Annual Plan and Special Measures
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Not applicable

Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP7 has an EqIA been identified as necessary and undertaken?*	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? *In accordance with WP68, has an SEIA identified as necessary been undertaken?*	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) *Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)*	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* *Financial implications as a result of implementing the recommendations*	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith *Workforce implications as a result of implementing the recommendations*	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori *Feedback, response, and follow up summary following consultation*	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) *Links to BAF risks:* *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) *Reason for submission of report to confidential board (where relevant)*	Not applicable
Camau Nesaf: *Next Steps:* Implementation of recommendations	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1: Quarter 1 2024/25 Monitoring Report Appendix 2: Change Control – Amendments to 2024/25 Annual Delivery Plan	

HEALTH BOARD 25 July 2024

Annual Delivery Plan Q1 Update

▪ Introduction

This report presents a summary of progress made during the first quarter of this year's Annual Delivery Plan, providing assurance assessments against the key commitments and highlighting where areas of challenge have emerged.

It is recommended that this report be read in conjunction with the subsequent agenda item of Integrated Performance Report as the Health Board seeks to strengthen the alignment between the change programme within the plan and the impact this has on outcomes for our population.

▪ Quarter 1 Progress

The 2024/25 Annual Delivery Plan contained 38 deliverables that were due to be completed during Quarter 1, all set within the context of the 5 previously agreed Strategic Objectives.

The following high level summary table provides an overview of progress.

Strategic Objective	Completed Deliverables	Expected to complete within 4 weeks of the end of Q1	Expected to complete beyond 4 weeks of the end of Q1	Total
1: Building an effective Organisation	5	2	1	8
2: Developing Strategy and long-lasting change	4	1	0	5
3: Creating compassionate culture, leadership and engagement	1	0	1	2
4: Improving Quality, Outcomes and Experience	10	4	4	18
5: Establishing an effective environment for learning	5	0	0	5
Overall	**25**	**7**	**6**	**38**

Table 1 – 2024/25 Annual Delivery Plan Q1 completion overview

The table shows a completion rate of 66% (25/38) against the deliverables due by the end of Q1. This completion rate marks a similar pattern to completion rates during 2023/24. However it is also worth noting that the volume of deliverables scheduled for delivery from Q2 onwards will increase significantly, and work scheduled for delivery later in the year may be dependent on progressing some of the earlier deliverables.

There are 7 deliverables that are off track against the original committed timescale but have a mitigation plan to conclude by the end of July, these are marked as Amber. These are intended for the Board to note as it is

anticipated they will be resolved in short time without the need for further intervention. Further details are included within the full breakdown in Appendix 1.

There are however 6 deliverables marked as Red, which represent overdue deliverables that do not have mitigation plans that will be bring them back on track within a short timescale. Further details on each of these can be found in Appendix 1, with a brief overview below:

- **1C.2: Business Partnering Model** - This work is interdependent with the review of the Operating Model (1C.1) which has slightly over-run. That work is due to conclude shortly, leading to an expected conclusion for Business Partnering Model by end of Q2.
- **3A.2: Leadership Development Framework** –The Framework has been approved and implementation commenced, although not concluded across all areas. Indications are that this will conclude by the end of Q2.
- **4C.2: Primary Care Same Day Offer** - A remedial action plan is in place following identification of issues, however it is expected that this will take until Q3 to take to bring back on track.
- **4E.1: Long waits in Planned Care** – Escalated monitoring arrangements are in place, however current projections point to it taking more than 4 weeks to bring back on track.
- **4J.2: Teledermoscopy –** A "soft launch" had to be deferred and is now scheduled for August, followed by iterative rollout.
- **4J.19: Plastic Surgery SLA –** Agreement has been reached on the wording of the SLA, however discussions are on-going to finalise some financial aspects.

A full breakdown of the 38 deliverables with individual assessments is included in Appendix 1.

Performance Reporting

As described in the introduction, this year will see a greater integration of tracking progress against the Annual Delivery Plan with the outcome metrics reported in the Integrated Performance Report. This is part of strengthening the implementation of the Planning and Performance Frameworks approved by Board last September, and the agenda for this meeting sees these items aligned together. In Appendix 1 references are made to charts within the Integrated Performance Report where applicable.

To support delivering a higher completion rate going forwards, examples of some of the ways the integrated Planning and Performance approaches are being matured include:

- Directorate performance reviews focussing on delivery of annual delivery plan actions and evidence of impact.
- Centrally coordinated scheduling of Executive Team meeting items necessary to meet each quarter's deliverables.
- Review of opportunities to elevate the linked organisational frameworks developed so far, into an integrated ecosystem across areas such as PADRs and objectives cascades, performance reporting, accountability arrangements, comms and engagement etc.
- Commence the re-designed annual planning cycle early, taking the right strategic direction and input from the outset.
- Constantly reviewing the current plan and performance against Welsh Government Special Measures expectations and correspondence (such as the recent letter confirming the continuation of BCU's Level 5 escalation status)

Change Control Summary

The Board will be familiar with the change control process that operated during Special Measures in 2023/24. This process has continued and has now been extended to the Annual Delivery Plan process as part of the strengthening of governance and assurance processes.

The following summary table categorises a number of change control sources which have been given interim approval by the Portfolio Office Senior Responsible Officer (SRO), Dr Stockport, and the Board is asked to give final approval to these decisions.

Number of changes	Summary and Rationale for Change
8	Amendments to wording to better clarify some existing commitments within the plan
1	Amendment of Executive Lead
3	Proposed retirement of milestone
3	Adding new deliverables from the Welsh Government priorities into this year's delivery plan

Further details regarding each of the changes summarised are included in Appendix 2.

Recommendation

The Health Board is asked to:

- **RECEIVE ASSURANCE** on the progress made during Q1 along with the challenges highlighted
- **APPROVE** the change controls outlined within the paper

Appendix 1: Quarter 1 2024/25 Monitoring Report

Key:	Completed	Off track, but with an acceptable plan to course correct and complete within 4 weeks of original completion date	Off track and unlikely to complete within 4 weeks of original completion date

Delivery Objective Ref	SRO	Delivery Objective Action	Assurance Rating	Assurance Statement
1A Board Effectiveness	Pam Wenger (BCUHB - Corporate Office)	1A.2 Progress a Board Development Programme, supporting a substantively appointed Board.		The Director of Corporate Governance has developed a new Board Development Programme with support from an external consultancy. This has identified new topics to factor into the programme, and has received support from the Health Board Chair.
		1A.3 Complete the re-establishment of a full complement of Board Committees		A full set of committees, supported by Terms of References, have now been established as part of the Cycle of Business.
1C Operating Model	Carol Shillabeer (BCUHB - Corporate Office)	1C.1 Complete the wider stock-take of the Operating Model, utilising the work of Internal Audit, feedback from external colleagues/stakeholders and feedback from colleagues internally to understand benefits and issues		An extensive exercise has been underway with good progress made during Quarter 1 with a range of activities undertaken. This will result in an "Insights Report" for the CEO in mid-July which will be shared with all stakeholders and aid the next steps. The work has not quite concluded during Q1 as originally intended, however there is a high degree of confidence of completing this phase of work early in Q2.
		1C.2 Assess the Business Partnering model across the organisation, drawing together proposals for revision where necessary		There is an interdependency between this work and the work of milestone 1C.1 around the Operating Model. This work cannot complete until 1C.1 has concluded. 1C.2 has therefore been deferred and will now be prioritised during Q2. It is worth noting that the business partnering model assessment has commenced as part of the stock take work in 1C.1.
1D Performance and Accountability Framework	Carol Shillabeer (BCUHB - Corporate Office)	1D.2 Senior leadership, and Directorate/Service Team objectives will align with the Health Board priorities for 2024-25 as laid out within the 2024-27 Health Board Plan		This action is fully complete and already becoming embedded. PADR's held with Executives and Senior leaders with personal objectives aligning with the plan and a full set of Corporate Directorate Performance Reviews have been held during Q1. Agendas for the Executive meeting are following the 5 strategic objectives and a review of Q1/launch of Q2 is scheduled for the meeting on the 17th July, with a mid-year review scheduled in October.
1E Value and Sustainability	Russell Caldicott (BCUHB - Corporate Office)	1E.1 Agree a programmed approach within the Health Board to oversee Value Based Care during 2024/25, ensuring this is configured to fully encapsulate the learning from the national Value and Sustainability Board		A series of foundational steps have been put in place during Q1 with the Integrated Performance EDG acting as the Senior Oversight group. Utilising the national approach Executive leads have been assigned to the 5 workstreams and an intelligence pack is provided outlining the opportunities. This programme of work has also been assigned as one of the top 5 priorities with Tier 2 of the Change Portfolio with additional central resource being provided to support, and over the coming weeks this will see the work developed into a fuller programmatic approach. Further schemes are also required to

				be worked up to achieve the £48m savings and ongoing monitoring will take place throughout the year. ***See Section 4, P50 onwards of IPR for financial performance.** NOTE: this priority is subject to a change control within Appendix 1 of the paper to clarify the wording
1F Legislative Improvements	Jane Moore (BCUHB - Public Health)	1F.5 Appoint to a substantive Head of Civil Contingencies, and develop a team approach across the organisation to take forward civil contingencies priorities		The post holder has been appointed and has now commenced in post, with a team approach developing within the corporate Emergency Care team. This will be expanded upon across the remainder of the year via priorities relating to emergency plans and business continuity plans.
1H Quality Management System	Nick Lyons (BCUHB - Corporate Office)	1H.1 The Health Board will continue to work with the Institute of Healthcare Improvement to inform the QMS design and to incorporate learning from other organisations		The Health Board has been working in conjunction with a range of internal and external stakeholders to design and develop a Quality Management System. This was presented to the Board in May and subsequently communicated to all staff via the Team Brief. Experience and knowledge was drawn from a range of external experts, including the Institute for HealthCare Improvement along with a visit to a Trust in East London. The implementation will continue throughout the year following testing in pilot areas. ***See Section 1, P20 onwards of IPR for Quality metrics**
2A 10 Year Strategy	Chris Stockport (BCUHB - Corporate Office)	2A.3 Collaboratively agree Health Board strategic 'Design Principles'		Work has been undertaken during Q1 to review the outcome of the 2024-27 planning process. Sessions were held with a range of stakeholders supplemented by a review at Executive Team. A Programme Initiation Document has also been completed for reviewing the 10 year strategy and this has also been the subject of discussion at an Informal Executive Session, with further sessions scheduled with Board Members and Executive Team on 24/07 and 08/08 respectively. Whilst this longer term programme of work is being developed, collaborative sessions have been held during Q1 and a set of draft organisational design principles have been agreed. These principles will guide and inform longer term work and will undergo refresh as part of future iterations of the strategy work.
		2A.4 Agree a schedule of 'what matters' conversations focused upon what has been identified above, and an understanding of successful service developments undertaken elsewhere that have helped to address similar issues		Some groundwork has been undertaken with a review of approaches from elsewhere within the UK, and through guidance from the BCU Communications Directorate. Progressing this in totality is dependent upon the work on design principles (2A.3) which has recently concluded. Following brief consultation on the design principles this work will now be brought to a conclusion.
2G Effectively Delivering Major Change	Chris Stockport (BCUHB - Corporate Office)	2G.1 Establish the highest priority major change initiatives within the Health Board and transfer them into PMO oversight, with full adoption of evidence based delivery governance and scrutiny through Board Committees. The table above		A number of papers have been taken through the Executive Team during Q1, along with an update to PPHP. This has resulted in agreement on the 4 'Major Change' programmes to be established. This is supplemented by a further list of priorities that form a second tier of programmes, which have also been agreed by the Executive Team. PMO oversight of the Programmes formation and PID development has been achieved and the process for on-going governance and reporting is being communicated.

		outlines those areas currently thought to be of greatest priority for inclusion in the major change portfolio		
2J Early identification and support of challenged services	Nick Lyons (BCUHB - Corporate Office)	2J.1 Reflection exercise to identify the common themes and flags identified from addressing the first tranche of challenged services		A reflection exercise has taken place with 7 common themes identified. The objective is therefore marked as complete however this is contingent upon supply of further evidence regarding the nature of the 7 themes and how these will be taken forward into proposals to support future learning.
		2J.2 Learn from Hywel Dda Health Board, who have already undertaken similar design work		This action is complete. A meeting with Hywel Dda has taken place where they presented on their approach and this learning is being taken forward within BCU.
3A Compassionate Leadership and OD	Jason Brannan (BCUHB - Workforce & Organisational Development)	3A.2 Approve and implement the organisation's Leadership Development Framework		The implementation plan for the Integrated Leadership Development Framework was approved by the OD Steering Group in May and has continued to progress during the quarter and is now well underway in terms of development with the Mynydd Mawr (Foundations) programme commencing on the 27th June. This is augmented by the development of the BCUHB Leadership Hub which is due to be finalised by September 2024, following by the aspiring programmes and a People Managers Forum in the coming months. Whilst good progress continues to be made, not all of the elements expected in Q1 have been delivered.
		3A.4 Support the establishment and effective working of the new People and Culture committee		The People and Culture Committee is now established and an annual plan for the committee has been developed, with three meetings held to date. *See Section 3, P45 onwards for Workforce metrics
4B Prevention	Jane Moore (BCUHB - Public Health)	4B.1 Diabetes. The intelligence and evidence suggests three main areas where BCUHB could improve health outcomes for people with diabetes and deliver more effective and sustainable services. These are: Preventing people developing diabetes, developing effective primary and community models of care for diabetes and improving the intelligence to plan and manage diabetes care. The Public Health Team will continue to lead and support colleagues across the Health Board to create an improved Diabetes care pathway in North Wales (see also Priority 4D)		Strong foundations are in place with regards to the provision of intelligence and evidence base, and a Public Health data scientist has been assigned to provide demand modelling to inform new models of care. The Data and Intelligence has begun to meet and there is an action plan for this group. Work is currently underway to agree the chair for the clinical group which is integral to moving forward the next phase of the work. This programme has also been identified as one of the top priorities within the 'tier 2' programmes and will see additional focus during Q2.

4C Primary Care and Early Intervention	Chris Stockport (BCUHB - Corporate Office)	4C.1 Continue to implement the national 'Primary Care Model' for Wales, and engage fully in the national Primary Care Programme		This action is complete and continual implementation and refinement will take place via operational structures. National workshops were held during June, with the IHC's actively engaged, and changes in the national infrastructure for implementing and monitoring the progress of the model will now be replicated within the BCUHB Primary Care governance structure. *See P36 of IPR for Primary Care Metrics
		4C.2 Develop the Primary Care 'same day' offer, to provide more equitable access to primary care as alternatives to Emergency Department attendance. This relates to in-hours primary care access and also to the provision of out-of-hours primary care, 111 and Minor Injury Units		Redistribution of leadership have identified some difficulties with the original scope. A remedial action plan is in place however this will result in some delays in delivering the milestone in an effective way. Expectations are that it will take until Q3 to fully deliver against this commitment.
		4C.6 Continue to provide sustainability support to contractors that are in difficulty		Primary Care Teams continue to work collaboratively to support practices facing sustainability issues. A GMS and Managed Practice Escalation and Sustainability process is in place and being enacted. Continued implementation and ongoing review will occur as part of business as usual arrangements.
4D Community Care and Clusters	Chris Stockport (BCUHB - Corporate Office)	4D.1 Implement the community resilience, social prescribing and early intervention programmes of care plans outlined within individual cluster plans		Engagement work undertaken with Public Health Wales to review plans and progress implementation. The Further Faster programme of work has been presented to the Regional Partnership Board, is progressing and on track. The Quarter 1 expectations have been completed in terms of commencing a range of implementation plans and work will continue throughout the year to build upon this.
4E Planned Care	Nick Lyons (BCUHB - Corporate Office)	4E.1 Focus upon delivery of the ministerial priority to reduce long waits for Planned Care by focusing additional WG support in those areas with the longest waits, by identifying variation across the Health Board and variation with GIRFT best practice		There is significant focus upon this ministerial priority with specialty based improvement plans based upon GIRFT being reviewed through a series oversight meetings, all being incorporated into the Major Change Programme approach. Significant challenges remain with particular focus ongoing regarding full implementation of 'treat in turn'. **See Section 2, P34 onwards of IPR for Planned Care Performance**
		4E.3 Do further work to validate waiting lists in order to have a more accurate position of current demand, recognising that patient requirements can change whilst on waiting lists		Narrative updates provided identify that a formal structure is now in place to validate waiting lists going forward, and that this is an ongoing process. At this stage, whilst narrative updates are indicating work is taking place in this area, the necessary assurance evidence has not been provided to complete the milestone. In the interim this milestone has been kept at amber with an expectation that this assurance could be submitted by the end of July. **See Section 2, P34 onwards of IPR for Planned Care Performance**
		4E.6 Continue work to address 'challenged' planned care services,		There is a range of work underway in this area however consistent assurance of impact across all areas is still evolving. A new governance structure has been recently put in place via a Planned Care weekly

		including in orthodontics and dermatology. Improvement plans in these areas are covered in more detail under Priority 4J		performance meeting, chaired by the CEO to reflect the organisational focus and level of concern. There is an expectation that the new escalated arrangements will yield greater pace and results in Q2. **See Section 2, P34 onwards of IPR for Planned Care Performance**
4G Urgent and Emergency Care	Gareth Evans (BCUHB - Therapies & Health Science)	4G.1 Alignment of the local 6 Goals Programme into the Health Board major change programme in order to improve change management and programme capacity and approach and to reflect the Health Board as a single organisation. In doing so, an analysis will be undertaken to identify areas where a change of approach or focus would be expected to have fresh impact		The Six Goals Programme has now been agreed by the Executive Team as one of the 4 major change programmes. A Programme Initiation Document has been prepared and presented to the Executive Team and is now proceeding, with additional central resource now being allocated to support the programme. **See Section 2, P41-45 of IPR for UEC Performance**
4I Adult Mental Health, Learning Disability, CAMHS and Neurodevelopment	Teresa Owen (BCUHB - Corporate Office)	4I.1 AMH: An improved approach to Crisis Resolution for Community Mental Health Teams		A substantial recruitment drive has seen 9 crisis resolution practitioners appointed and commenced in post. A comprehensive induction is undertaken which is supported by a detailed induction booklet. This features a 6 month development plan outlining training to be provided, all of which will lead to an improved approach to crisis resolution. **See Section 2, P34 onwards for MH Performance**
4J Currently Challenged Services	Nick Lyons (BCUHB - Corporate Office)	4J.1 Dermatology: The Health Board will maintain support for the Clinical Lead in Dermatology as part of a single Dermatology service for North Wales		Some delays have been incurred in appointing to a Specialty Doctor post that had previously been agreed. This post is seen as critical to service delivery and resulted in a reticence for Consultants to come forward for the Clinical lead post. This has now been resolved with executive approval and expressions of interest for a pan BCU clinical lead will be advertised.
		4J.2 Dermatology: The Health Board is committed to the use of 'Teledermoscopy' technology to improve efficiency within dermatology waiting times and to reduce avoidable travel for patients. Current infrastructure issues are limiting the rate at which the Health Board would like to deploy this. During the coming months the Health Board will re-assess this situation to identify any opportunity to expedite deployment		There have been delays in this area. It was agreed to proceed with a "soft launch" at the beginning of July. The soft launch will now be delayed until August with a plan towards full launch across East and Centre by November.

		4J.4 Oncology: Continue to expand SACT (Systemic Anti-Cancer Therapy) training within oncology division nursing staff, and extend the operating hours of the day unit, providing further capacity. This will include staff group ideas to further improve efficiencies and standardisation		A range of activities are underway across BCU to expand the service, all overseen by an improvement group. Some challenges exist but alternative solutions are being identified to release capacity. The service has developed a process to review, assess and monitor potential commercial trials in a timely manner with overall good progress although further work required in the next month to conclude.
		4J.18 Plastic Surgery: Complete access protocols for visiting clinicians to ensure access to appropriate Health Board systems, confirming with those clinicians that functional access is available		All protocols are reported as being in place for visiting clinicians. The objective is marked as complete contingent upon the supply of evidence that the clinicians have confirmed the functionality is fit for purpose.
		4J.19 Plastic Surgery: Agree and sign the updated Service Level Agreement (SLA) between the Health Board and partner organisations, with ongoing monitoring in accordance with the SLA		An SLA has been discussed with our partner organisation. The wording has been agreed however further discussions are required to agree the financial aspects. The next meeting is scheduled for w/c 15th July.
		4J.29 Vascular: Continue to strengthen the recording of outcomes and learning points at Morbidity and Mortality meetings		A revised and strengthened process is in place, and following an initial pilot is now embedded in core practice. The learning is captured during the meeting and further validated following the meeting. Whilst marked as complete the process will remain under review in terms of continuous improvement.
		4J.30 Vascular: Review hub and spoke vascular sites in order to identify areas of good practice as well as areas for improvement		The review has been completed with documented assessment of the current arrangements, including identification of good practice. Six core areas for improvement have been identified and the next step is to hold a workshop with clinical and operational staff to refresh the service model. This will result in a Service Level Agreement and a Memorandum of Understanding to outline roles and responsibilities across the three sites and support collaborative working.
4L Children	Carol Shillabeer (BCUHB - Corporate Office)	4L.1 Maintain ways to provide safe, needs focused care as close to home as possible		This objective is complete subject to the current position being maintained. Delivery of care is embedded throughout the region and is custom and practice. Care is tailored to the needs of the patient and this is underpinned by a Children's Charter and the emerging plans for a Youth Partnership Board, all of which ensure the voice of the child is heard in where they can access care.
5B Research, Development and Innovation	Nick Lyons (BCUHB - Corporate Office)	5B.1 Continue to increase commercial research and innovation activity		The key deliverables of this objective are reported as being in place with a robust process in place to review, assess and monitor potential commercial trials in a timely manner.

5C Academic Careers	Jason Brannan (BCUHB - Workforce & Organisational Development)	5C.1 Continue conversations with academic partners to create a proposal for how Academic career pathways might bring opportunities for all partners to grow academic practice and innovation in North Wales. In doing so the Health Board will take a broad view to offering opportunities that extend across all professional crafts (including non-clinical professionals), and with a particular attention to professional areas that are hard to recruit, retain, or where significant service change is anticipated		Initial groundwork has been undertaken during Q1 including meetings with Bangor University during early June to discuss career pathways to support students. Professor Michael Rees will be the lead for this portfolio of work which will now further progress via a working group. Iterations of this work will need to continue throughout 2024/25 in order to complete the full scope of this activity.
5D Intelligence Led	Dylan Roberts (BCUHB - Digital, Data and Technology)	5D.1 Establish a Health Board data quality and governance forum		The Data Quality and Governance Forum has now been established with a multi-disciplinary team attendance including DDaT, Performance, Finance, Workforce and Risk. Terms of Reference and outline work plan in place, along with agreement on reporting routes through to the Integrated Performance Executive Delivery Group. This group will monitor implementation of the plan during the year.
		5D.6 Identify priority areas and improve clinical engagement with data using CHKS as the chosen clinical benchmarking tool		An Analysts user group has been established following initial training. Early priorities include mortality reporting and a focus on learning from work that is already well embedded with the Heart Failure service. This will be further expanded to explore opportunities within Diabetes and Urology, and is additionally is being utilised as part of the Value and Sustainability programme. As the work evolves this group will continue to liaise with the Office of the Medical Director to identify further priority areas.
5E Learning Organisation	Angela Wood (BCUHB - Corporate Office)	5E.1 The Health Board will complete its review of how the organisation investigates and then learns from, serious incidents		The review has been completed and the Director of Nursing presented findings to the Executive Team on the 26th June. Further supplementary steps are being taken to present the findings to the Board to ensure widespread sharing of the learning. **See Section 1, P28-33 of IPR for Incident Reporting**

Appendix 2: Change Control – Amendments to 24/25 Annual Delivery Plan

Reference no: 2425-001	
Change Type	Amendment of milestone wording
Rationale for Change	In the original wording the term 'Value Based Heath Care' has been conflated with 'Value and Sustainability'. There are small but important differences between the two terms which both align with national programmes of work. The proposed change will clarify the specific focus intended for this milestone and make the distinction clearer.
Original Milestone	1E.1 Agree a programmed approach within the Health Board to oversee Value Based Care during 2024/25, ensuring this is configured to fully encapsulate the learning from the national Value and Sustainability Board
Proposed Milestone	1E.1 Agree a programmed approach within the Health Board to oversee ***Value and Sustainability*** during 2024/25, ensuring this is configured to fully encapsulate the learning from the national Value and Sustainability Board

Reference no: 2425-002	
Change Type	Amendment of milestone wording
Rationale for Change	To ensure consistent application of language and terminology
Original Milestone	1E.2 Continue to embed the principles of Value Based Care into all decision making throughout the Health Board
Proposed Milestone	1E.2 Continue to embed the principles of Value Based ***Health*** Care into all decision making throughout the Health Board

Reference no: 2425-003	
Change Type	Amendment of milestone wording
Rationale for Change	To ensure that the allocation of Value Based Health Care schemes is integrated into the Annual Planning monitoring to ensure alignment with the organisation's strategic objectives
Original Milestone	1E.3 Identify a clear and forward looking programme of work for Value Based Care within the Health Board
Proposed Milestone	1E.3 Identify a clear and forward looking programme of work ***within the Annual Planning Cycle that incorporates*** Value Based ***Health*** Care within the Health Board

Reference no: 2425-004	
Change Type	Amendment of milestone wording
Rationale for Change	To describe a key interdependency
Original Milestone	2E.1A Electronic Healthcare Record (EHR). The Health Board will work with stakeholders across BCU and Wales to develop and secure agreement for investment in an Electronic Health Care Record (EHR) transformation. Due to the safety concerns in Mental Health the Health Board will commence the accelerated procurement and implementation of a tactical Mental Health specific EHR starting in 2024.
Proposed Milestone	Electronic Healthcare Record (EHR). The Health Board will work with stakeholders across BCU and Wales to develop and secure agreement for investment in an Electronic Health Care Record (EHR) transformation. Due to the safety concerns in Mental Health the Health Board will commence ***the securing of funds and*** accelerated procurement and implementation of a tactical Mental Health specific EHR starting in 2024.

Reference no: 2425-006	
Change Type	Amendment of milestone wording
Rationale for Change	Small amendment to wording to better clarify the scope
Original Milestone	2E.2 Optimisation of current capabilities. The Health Board will work to optimise the use of current systems and capabilities to deliver the most value for patients and clinicians, mitigating the risks associated with duplication of systems and processes
Proposed Milestone	2E.2 Optimisation of current capabilities. The Health Board will ***deliver a plan*** to optimise the use of current systems and capabilities to deliver the most value for patients and clinicians, mitigating the risks associated with duplication of systems and processes

Reference no: 2425-007	
Change Type	Retire milestone
Rationale for Change	This is fully covered within milestone 2E.4
Original Milestone	2E.6c Essential Services Programme: A series of protected ICT Projects and Programmes to ensure that the core infrastructure is robust, demand responsive and kept up to date

Reference no: 2425-011	
Change Type	Amendment of milestone wording
Rationale for Change	To clarify scope of work and that further iterative improvements may still be required beyond the end of this year
Original Milestone	4I.6 Completion of anti-ligature work
Proposed new milestone	4I.6 Completion of anti-ligature work ***planned for 24/25***

Reference no: 2425-013	
Change Type	Amend the Exec Lead for CAMHS and ND on the delivery plan
Rationale for Change	To correct the current cover arrangements in the absence of the COO role, with the CEO overseeing with IHC level support
Original Milestone	Milestones 4I.8 to 4I.16

Reference no: 2425-014	
Change Type	Amendment of milestone wording.
Rationale for Change	Rewording due to change in national policy position by Welsh Energy. Results from a decision taken nationally by Welsh Energy and adopted by NWSSP following a review of NHS Wales Decarbonisation Strategic Delivery Plan.
Original Milestone	1J.6 Progress the procurement of 100% REGO-backed electricity.
Proposed Milestone	1J.6 Progress the procurement of ***Zero-Carbon*** backed electricity (currently being reviewed on an All-Wales basis).

Reference no: 2425-015	
Change Type	Amendment of milestone wording.
Rationale for Change	Rewording resulting from the awarding Re:Fit programme delivery to Vital Energi. Operational Estates have since appointed Vital Energi to support with delivering the Re:Fit programme for the Health Board, resulting in minor re-profiling of the programme.
Original Milestone	1J.4 Prepare to be able to progress low carbon heat generation for non-acute sites larger than 1,000m^2 by 2030.
Proposed Milestone	1J.4 ***Consider the feasibility*** of progressing low carbon heat generation for non-acute sites larger than 1,000m^2 by 2030.

Reference no: 2425-016	
Change Type	Addition of new milestone
Rationale for Change	This is a Welsh Government Special Measures requirement which is not currently reflected within the plan
Proposed new milestone	1G.13- Ensure a focus on consultant and speciality (SAS) doctor job planning.

Reference no: 2425-017	
Change Type	Addition of new milestone
Rationale for Change	This is a Welsh Government Special Measures requirement which is not currently reflected within the plan
Proposed new milestone	4D.7 - Commence the implementation of enhanced community service provision to support older patients in the region

Reference no: 2425-018	
Change Type	Addition of new milestone
Rationale for Change	This is a Welsh Government Special Measures requirement which is not currently reflected within the plan
Proposed new milestone	4J.28a Progress of actions from the Royal College of Surgeons of England review of urology surgical services

Teitl adroddiad: *Report title:*	Closure of 2023/24 Annual Delivery and Special Measures Plans
Adrodd i: *Report to:*	Health Board
Dyddiad y Cyfarfod: *Date of Meeting:*	25th July 2024
Crynodeb Gweithredol: *Executive Summary:*	The paper provides an update against activity from the 2023/24 financial year that had not concluded by year end, and the change control process for integrating into this year's plan. This paper represents Part B and accompanies the Part A update on Q1 2024/25, and has been separated in order to draw a delineation between the 2 years for the reader.
Argymhellion: *Recommendations:*	The Health Board is asked to: • **APPROVE** the change controls outlined within the paper
Arweinydd Gweithredol: *Executive Lead:*	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)
Awdur yr Adroddiad: *Report Author:*	Geraint Parry, Portfolio Office

Pwrpas yr adroddiad: *Purpose of report:*	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: *Link to Strategic Objective(s):*	To support the Annual Plan and Special Measures
Goblygiadau rheoleiddio a lleol: *Regulatory and legal implications:*	Not applicable

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

HEALTH BOARD 25 July 2024

Closure of 2023/24
Annual Delivery and Special Measures Plans

▪ Introduction

This report reviews the commitments made within the Annual Delivery Plan and Special Measures Plan last year that overran their original timelines and had not concluded by the end of the year.

Commencing in 2024/25 the Health Board has had a single, unitary Annual Delivery Plan that fully incorporates Special Measures.

To this point, the Health Board has continued to track in parallel the actions referenced above as overrunning from 2023/24, alongside the Q1 2024/25 Annual Delivery Plan commitments.

It is proposed that this parallel tracking now stops, and that those actions still outstanding are subsumed into the 2024/25 Annual Delivery Plan, as laid out below.

▪ Progress against outstanding milestones 2023/24 Annual Delivery Plan

In order to ensure that those 23/24 Annual Delivery Plan deliverables that are still outstanding are not monitored separately for more than a quarter, a mapping exercise has been undertaken against this year's Annual Delivery Plan. This has identified 23 deliverables which are considered to be already adequately covered by this year's plan, and a further 15 where it is proposed to add new deliverables into the plan.

The following table summarises the current position against the 60 deliverables within the 2023/24 ADP that were not completed by the end of 2023/24:

Status	Number of Milestones
Now complete	17
Not yet complete and continues to be relevant – covered by an existing 2024/25 objective	23
Not yet complete and continues to be relevant – requires new deliverable to be added to 2024/25 Delivery Plan	15
Proposal to retire deliverable due to no longer being relevant	5

▪ Progress against outstanding milestones from Special Measures Cycle 3

The Board received a Special Measures Cycle 3 closure report at its March 2024 meeting, which demonstrated a 70% completion rate against all the commitments being tracked during this cycle. The Portfolio Office has continued to monitor the 39 outstanding actions not completed in 2023/24.

The following table summarises the current position against those 39 actions.

Status	Number of Actions
Now complete	16
Not yet complete and continues to be relevant – covered by an existing 2024/25 annual delivery plan objective	12
Not yet complete and continues to be relevant – requires new deliverable to be added to 2024/25 annual delivery plan objective	11

The Portfolio Office has undertaken assurance checks against the 16 actions completed since the end of cycle 3, and this now increases the Special Measures Cycle 3 completion rate from 70% to 83%.

Proposal and Change Control Summary

It is proposed that

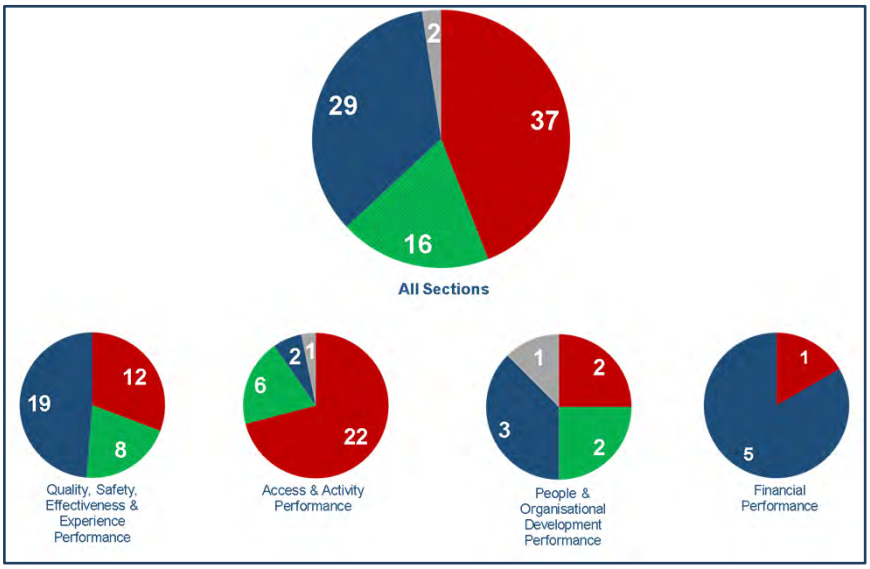
- the 23 Annual Delivery Plan objectives and 12 Special Measure Cycle 3 objectives that are not yet complete and continue to be relevant, but which are already fully covered by an objective in the 2024/25 annual plan are retired. Going forwards these would be monitored through the replacement 2024/25 annual delivery plan objective.

- The 15 Annual Delivery Plan objectives and 11 Special Measure Cycle 3 objectives that are not yet complete and continue to be relevant, but which are NOT already fully covered by an objective in the 2024/25 annual plan are added to the 2024/25 annual plan. Going forwards these would be monitored through the 2024/25 annual delivery plan objective.

Recommendation

The Health Board is asked to:

- **APPROVE** the change controls outlined within the paper

Teitl adroddiad: ***Report title:***	Integrated Performance Report, 2024/25
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 2, 2024/25 for Performance and Month 3 for Finance. The Health Board signed off the Integrated Performance Framework (IPF) 2023-2027 on the 28th September 2023, one of a trilogy of new frameworks intended to drive the strategic objectives of the Health Board. The IPF will be used in conjunction with the new Integrated Planning Framework (IPlanF) and the Risk Management Framework (RMF). The three Frameworks support the Board Assurance Framework (BAF). The Framework will align with the Quality Surveillance Strategy as it is developed. The purpose of the Framework is to integrate key performance indicators (KPIs) from: - 1. Key deliverables from the Annual Plan (IMTP) 2. NHS Wales Performance Framework (Quadruple Aims) 3. Key deliverables in response to WG, HIEW and other formal recommendations including Special Measures. The Health Board has a number of measures rated monthly and included within this report, the below graphic indicating a number of these measures are off target; 

	We also reflect the Health Board's current level of performance escalation with Welsh Government within the framework; the approach will be subject to review should escalation levels change. The Performance Directorate has been working with our partners across the organisation, oversight provided the Executive Delivery - Integrated Performance Group (IPG) in the development of locally defined metrics and these have now been included in the IPR, specifically ion the Quality and People & Organisational Development domains. Performance is RAG rated against the targets set within the NHS Wales Performance Framework, set by Welsh Government in the Special Measures Framework for BCUHB or outlined in the Ministerial Priorities. However, where appropriate, BCUHB's internal improvement trajectories as submitted and agreed by Welsh Government have also been included. Key areas of escalation are identified within the 'Escalated Performance Measures' section at the beginning of the report, the report composition articulating the following; • Within the escalation section, an initial high-level one-page summary that highlights key performance across the four quadrants, followed by escalation pages to further articulate performance within the escalated metrics. • A brief introduction to the Performance report to include a key for rag rating and Statistical Process Control (SPC) charts. • The further reporting contains all of the metrics by domain, so members can review performance against all metrics reported. The intention of the report structure is to enable members to identify key escalations from sub-committees of the Health Board, whilst enabling oversight of the current reported metrics. The key performance indicators utilised are the nationally required metrics, and local metrics that give greater insight into understanding current performance (through Executive forums & Committees). We are moving towards greater ownership by committees of the measures included within the escalation section of the report for Health Board, with areas of good practice also to be included within this section. The Performance team continue to work with the Health Board to embed the endorsed Integrated Performance Framework. These arrangements include putting in place formal and informal integrated (accountability) review structures, and escalation / de-escalation mechanisms. The Performance Directorate is working with corporate and operational colleagues to develop forward-looking recovery

	trajectories and activity plans for the Planned Care space. These will be incorporated into the IPR for HB from September 2024. The Performance Directorate is working with corporate and operational leads in developing the triangulation of Performance, Quality and Workforce intelligence at the individual metric level. This is an ambition of the Intelligence-led Organisation agenda and supported by NHS Wales Executive.
Argymhellion: ***Recommendations:***	The Health Board is asked to: Review the contents of the report and propose any actions arising from the report, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance
Awdur yr Adroddiad: ***Report Author:***	Ed Williams, Acting Director of Performance

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2024-25.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Health Board
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There remains a number of risks to the delivery of care across the healthcare system due to the legacy impact the COVID-19 Pandemic had upon planned care delivery between 2020 and 2022. Several corporate risks remained to be approved this month however the draft risks have included the rationale and evidence from the Acting Director of Performance. References to Corporate Risks have been made in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-05 Financial Sustainability 24-10 Urgent and Emergency Care 24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ indirectly impact upon the financial recovery plan of the Health Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	The delivery of the performance indicators within our IPR will directly/

Workforce implications as a result of implementing the recommendations	indirectly impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by Executive Team. The full report has been reviewed by the Acting Director of Performance, and the Executive Director of Finance
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The Acting Director of Performance continues to work with the Head of Risk Management to develop linkage from this report into the Corporate Risk Register and eventually Board Assurance Framework (BAF) once objectives have been set. Several corporate risks await approved this month however the draft risks have included the rationale and evidence from the Acting Director of Performance. References to Corporate Risks are included in the body of the report, where applicable. 24-04 Failure to Embed Learning 24-05 Financial Sustainability 24-10 Urgent and Emergency Care 24-11 Planned Care 24-12 Areas of Clinical Concern (encompasses ophthalmology and dermatology) 24-13 Timely Diagnostics
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations: Continued focus on any areas of under-performance where assurance is not of sufficient quality to believe performance is or will improve as described.

This Integrated Performance Report has been updated to reflect the NHS Wales Performance Framework for 2024-25.

Rhestr o Atodiadau:
List of Appendices: 2
1: Summary of Report
2: Integrated Performance Report in PDF

Appendix 1 **Summary of Report**

Committee: **Health Board**

Report title: **Summary of Integrated Performance Report**

Report Author: **Acting Director of Performance**

1. Introduction

The Performance Directorate continues to develop and refine the performance report for the Health Board, the key aim being to enable focus to be placed upon areas of high performance or those metrics requiring improvement, with the 'Integrated Performance Report' including a section summarising the areas requiring escalation for Board members, divided into the following four quadrants;

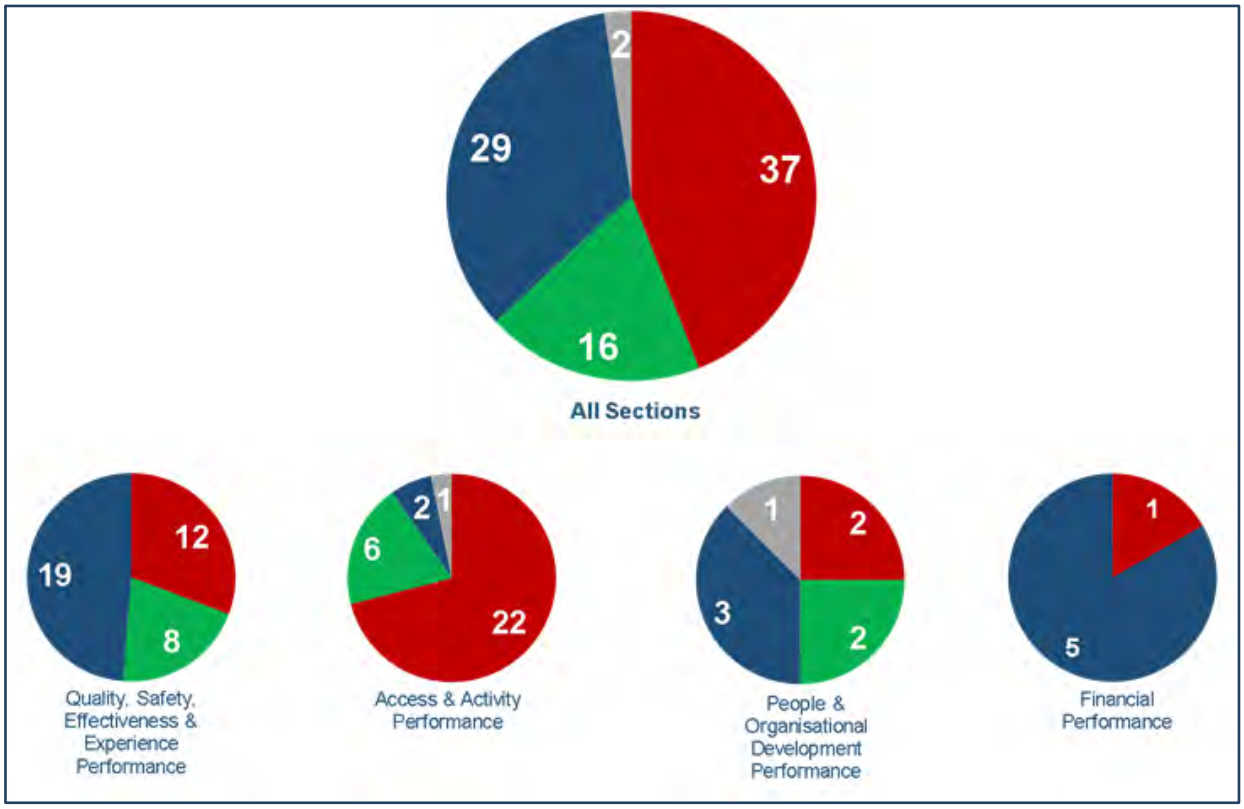
- Quality (Safety, Effectiveness & Experience) Performance
- Access & Activity Performance
- People & Organisational Development Performance
- Financial Performance

This structure enables an 'at a glance' view of the main concerns or message of the report through review of the initial one-page summary that is split into four quadrants, with the further slides contained within this escalation section articulating in more detail the current performance and actions being taken to support improvements. This should be the area of most focus in the report.

In response to the request from the Health Board on 25.01.2024, where appropriate, the Corporate Risk Register (CRR) reference number has been included in the report. This is to facilitate triangulation between the performance and risk contexts.

This report reflects performance against the NHS Wales Performance Framework for 2024-25. Furthermore, it includes several locally defined metrics within the Quality and People & Organisational Development domains.

2. Overall Summary



Of the measures (to include the NHS Wales Performance Framework) included in the report, 16 are on target and 37 are off target. It remains clear that there continues to be significant risks to delivery on a number of key metrics for which the attached report at appendix I, gives further detail within the relevant dashboards for each of the four quadrants, as articulated within the above graphic.

A prioritisation of the metrics off plan has been used to populate the escalation section of the IPR (see appendix I) to give greater focus to the metrics we are seeking to enhance in the short term. This summary report will indicate some key elements from our quality, our access and activity, our people and our finance as seen within the Health Board.

3. Key outputs from oversight of Access & Activity Performance

3.1 Quality (Safety, Effectiveness & Experience) Performance

(Corporate Risk 24-04 Failure to Embed Learning)

The key areas highlighted centre upon:-

As we continue to roll out the Integrated Performance Framework (IPR), twelve locally defined Quality (Safety, Effectiveness & Experience) performance measures have been included in this report. These are as follows:

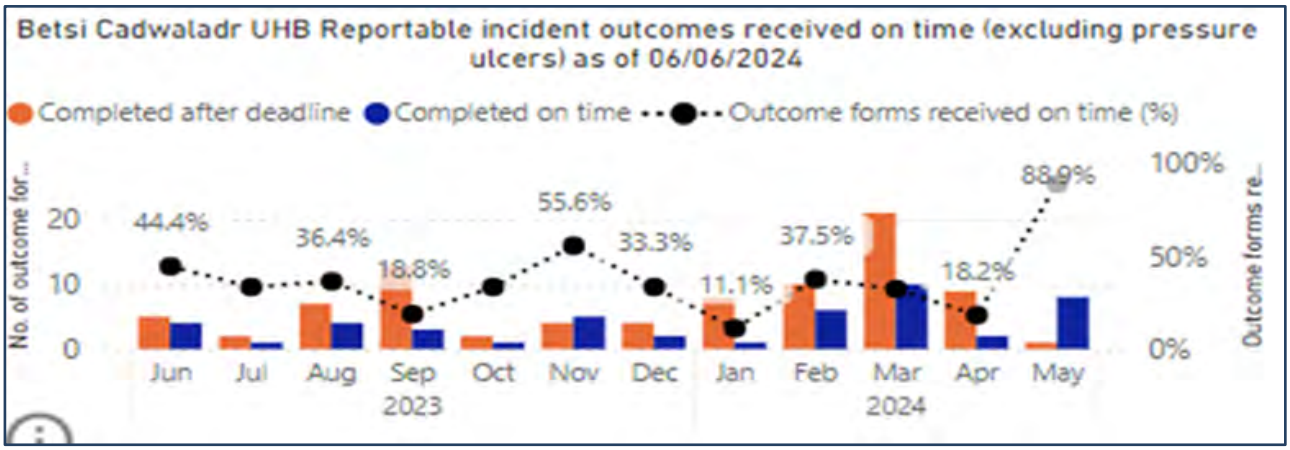
- Number of new patient safety incidents
- Number of new reported patient falls
- Number of new hospital acquired pressure ulcers (HAPU)

- Number of new reported medication incidents
- Number of new 'Putting Things Right' (PTR) complaints
- Number of new 'Early Resolution' complaints
- Number of new Patient Advice & Liaison Service (PALS) contacts*
- Number of new Ombudsman contacts
- Percentage of survey responses rating care as 'good' or 'very good'*
- Number of new Regulation 28 notices
- Number of overdue 'Learning From Event Reports (LFERs)*
- Number of Great-ix submissions

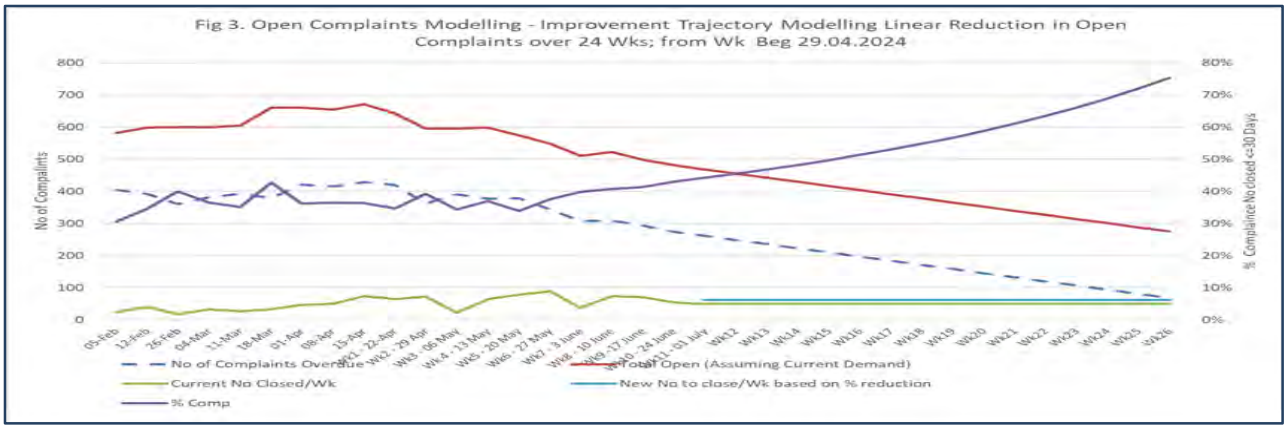
** The Performance Directorate are working with the Quality Directorate in obtaining historic data for these measures and this will be included from September 2024.*

Two new never events were reported in May 2024. A retained foreign object post procedure and the administration of the wrong medication via the wrong route. At the time of writing, these are still under review. However, we have taken initial measures in regards to seeking to prevent such events occurring again in advance of the investigation's findings.

The Integrated Performance Executive Delivery Group (IPEDG) has enacted the escalations process within the Integrated Performance Framework 2023-2027 to put performance against **National Reportable Incidents & Complaints** measures in escalation and targeted for improvement in performance against compliance with National Reportable Incidents (NRIs) and Complaints backlogs. The Integrated Health Communities (IHCs) and Divisions have submitted their plans to reduce the backlog and improve response times to the Executive Director of Nursing and Midwifery for onward, weekly monitoring of trajectories. We expect significant improvement by October 2024.



BCU HB plans for improvement target compliance with the 75% closures within 30 days rate by 14th October 2024. All Integrated Health Communities (IHC) and Regional Services are on track to be compliant with exception of the Central IHC, who will be 61.34% compliant by the 14th Oct 2024 based upon their current closure rate.



Infection rates remain above predicted trajectories. The Infection Prevention Team are ensuring learning from post infection reviews is cascaded and improvement monitored through local infection prevention groups and delivering a robust audit programme, alongside increasing awareness through promotional campaigns with a new campaign ("HABITS") being established to further engage staff, patients and public.

Clinical coding compliance remains a risk. The main cause was staff vacancies and absence experienced across the Health Board. The team continue to work with People & Organisational Development (P&OD) Directorate to address recruitment and retention issues. We have appointed to the Coding Assurance Lead role that will support development of new trainees as they progress. We have appointed five trainee coders whom commenced work in July. Work with Welsh Patient Administration System (WPAS) Operational Steering Group is ongoing to improve availability of electronic records to enable some remote working opportunities starting with theatre operation sheets.

3.2 People & Organisational Development

(Corporate Risk 24-01 People, Culture and Wellbeing)
(Corporate Risk 24-1 Leadership / Special Measures)

As we continue to roll out the Integrated Performance Framework (IPR), four locally defined People & Organisational Development performance measures have been included in this report. These are shown below:-

- 12-month rolling staff turnover rate (staff leaving the Health Board).
- Staff turnover rate for those whom have had less than 1 years' service.
- Percentage Roster compliance (rosters filled within agreed timeframe).
- Number of open disciplinary cases per 1,000 staff.

The key areas highlighted centre upon:-

Turnover rates of nursing and midwifery staff has crept up from 1.5% in February 2024 to 1.8% in May 2024. Sickness absence has remained consistent at the 5.6% to 5.7% since March 2024 (compared to a high of 6.4% in December 2023) with stress and other mental health issues continuing to be the main reason for sickness absence.

The percentage rate of agency spend as a proportion of the total pay bill remains static at around the 4.5% (4.4% April, 4.6% May).

3.3 Access & Activity Performance

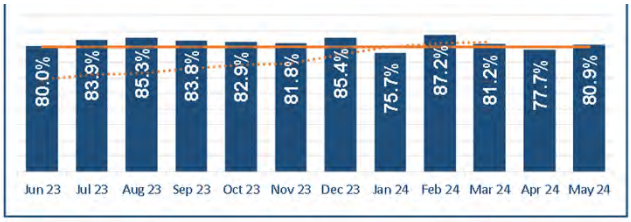
The key areas highlighted centre upon:-

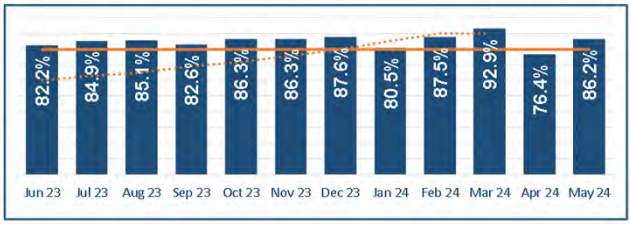
This section contains the greatest number of measures within the report, at 31, noting BCUHB is achieving the target for 6, and not achieving the target rate for 22 (c75%) of the measures. This is a very concerning picture; however, members are asked to note performance is measured on All Wales criteria that many Health Boards are finding difficult to achieve. The Health Board continues to invest significant time and energy in seeking to improve performance. Implementing additional oversight and escalation within the planned Care space (the Chief Executive Chairing a weekly oversight and escalation meeting).

3.3.1 Adult Mental Health Measures Performance

After the predicted dip in performance in April 2024, overall BCUHB performance has continued to improve or sustain performance above the 80% target rate, with East performing very well, however West, and Centre could further enhance performance within this area.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
SM: DM1 1	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)	80%	TBC	80.9%	4th of 7 (at Apr 24)
SM: DM1 2	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	TBC	86.2%	6th of 7 (at Apr 24)



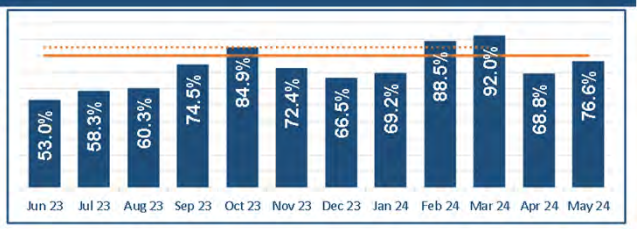


3.3.2 Children's & Adolescent Mental Health Services (CAMHS) and Neurodevelopment (both areas of escalation across Wales)

Performance against the measures remains below trajectory. After reaching a high of 92% compliance for Part 1a in March 2024, performance dipped to 68.8% in April, but has improved again in May to 76.6%. Part 1b performance continues to

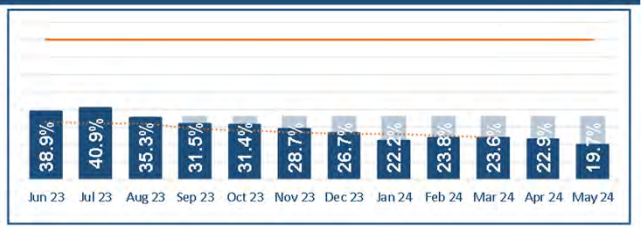
deteriorate and at 23.9% is the lowest position ever reported. At over 95%, the service continues to have good performance with regards the specialist CAMHS first appointment within 28 days measure.

CRR Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
SM: DM1 6	PFIG	Percentage of Local Primary mental health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)	80.0%	TBC	76.6%	6th of 7 (at Apr 24)
SM: DM1 5	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80.0%	TBC	23.9%	5th of 7 (at Apr 24)



Neurodevelopment waiting time compliance continues to deteriorate at 19.7% and remains a concern, with a decline in performance reflected across the national footprint.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 *SM	PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	TBC	19.7%	5th of 7 (at Apr 24)



3.3.3 Urgent & Emergency Care Performance

(Corporate Risk 24-10 Urgent and Emergency Care)

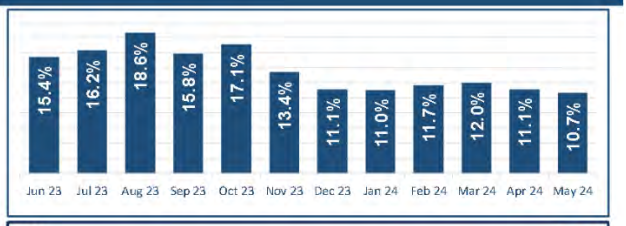
After a dip in performance through quarter 4 of 2023-24, performance has steadily improved, and for April and May 2024, was back to the 69.4% (seen in quarter 3 of 2023-24) for patients experiencing waits over 4 hours in our Emergency Departments.

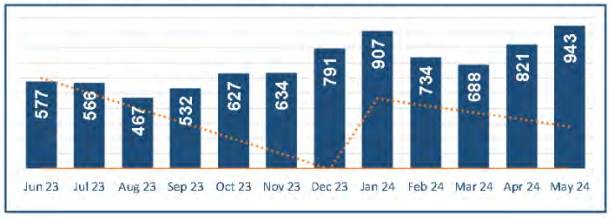
Patients experiencing waits of over 12 hours has also slightly improved at 3,060 in May 2024 compared to 3,342 in March 2024. However, this remains an area of focus for the Health Board.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	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	Equivalent month increase (2024/25 to 2023/24) to 95%	TBC	69.4%	4th of 7 (at Apr 24)
CRR: 24-10 SM: DM08	PFIG	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Equivalent month reduction (2024/25 to 2023/24) to 0	2139	3060	7th of 7 (at Apr 24)

There remains significant challenges in regards delays to getting our patients out of ambulances and into our emergency departments. The percentage of Ambulance Handovers taking place within 15 minutes is low at 10.7%, and delays of an hour or more continues to deteriorate at 2,300 patients, and delays over 4 hours has increased from 688 in March 2024 to 943 in May 2024. This evidences continued high demand and pressures being experienced within unplanned care continuing into traditionally lower intensity months.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of ambulance handovers within 15 minutes	Equivalent month increase (2024/25 to 2023/24) to 100%	TBC	10.7%	
CRR: 24-10 SM: DM06	PFIG	Number of ambulance patient handovers over 1 hour	0	TBC	2300	6th of 6 (at May 24)
CRR: 24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	280	943	





Delayed pathways of care remain a key concern for the Health Board and despite efforts to reduce assessment delays, the number of patients experiencing delays in their pathway remains at an average of 344 per month with no significant change seen since April 2023.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of Pathways of Care Delayed discharges	Decreasing trend	TBC	344	8st of 8 (at May 24)

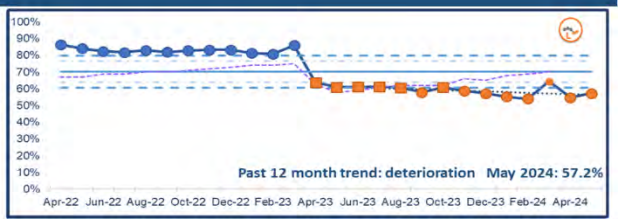
3.3.4 Planned Care Performance

(Corporate Risk 24-11 Planned Care)
(Corporate Risk 24-13 Timely Diagnostics)

Our performance against the single cancer pathway (SCP) target remains fragile, with 57.2% at the end of May 2024. Whilst this is below the Welsh Government target rate, it is consistent with our improvement trajectories thus demonstrating the grip and control we have in this sector.

Whilst, concerns remain regarding the position with dermatology and urology, the enactment of recent business cases to support (in particular Dermatology) will mitigate these risks and improve performance over the next few months.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM01	PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increasing trend (to 80%)	TBC	57.2%	4th of 6 (at Apr 24)



The number of patients waiting over 8 weeks for a diagnostic test now resides at c6,600 and a significant improvement over the 10,000, breaches reported a year ago. However, the numbers have remained static in recent months following the conclusion of contracts placed within the market. The Health Board is re-engaging the market to secure further insourcing support for this area through utilisation of Planned Care resources, the forecast impact being to reduce these waits for over 8 weeks to 3,000 patients as at 31st March 2025. It is of note this doesn't achieve the Welsh Government targeted improvements by December 2024, but is a realistic and challenging target for the service to deliver when the increase in demand is taken into consideration.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-13 SM: DM04	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	0	TBC	6619	6th of 7 (at Apr 24)

The Audiology cohort of the 14 weeks therapy waits measure have now been separated out into a measure of its own within the NHS Wales Performance

Framework for 2024-25. The number of patients experiencing waits over 14 weeks for therapy interventions has increased to 3,054 patients waiting in May 2024. Main pressures in Physiotherapy include high number of vacancies, accommodation capacity in Central and East and increased demand.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM05	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	TBC	3054	7th of 7 (at Apr 24)

The number of patients experiencing waits over 14 weeks for audiology has significantly improved, the 969 in May 2024 half that compared to the approximately 1,850, reported January 2024.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Number of patients (all ages) waiting more than 14 weeks for audiology	0	TBC	969	

The number of patients waiting over 52 weeks for a new outpatient appointment has been deteriorating since April of 2023. However, performance against this measure is an escalation for the Health board, with improvements centring upon clinics adopting Treat-in-Turn methodology and targeting patients seen in clinic at Get It Right First Time (GIRFT) numbers, with greater oversight and the setting of booking rules to deliver improved productivity combined with recruitment to the outpatient's validation and booking team improvements are targeted in the 2024/25 financial year.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM02	PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreasing trend (to 0 by Jun 25)	TBC	44286	7th of 7 (at Apr 24)

Regarding patients waiting for elective care, throughout 2023-24 there was a substantial amount of work undertaken to place focus upon longer waits. There were continuous reductions in the number of patients waiting 208 weeks down to 207 (these mainly in Dermatology, Maxillo-facial, Orthodontics); Patients waiting over 156 weeks and 104 weeks significantly reducing from commencement of the financial year at 1,621 (3,359 April 2023) and 8,720 (9,500 April 2023) respectively.

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM03	PFIG	Number of patients waiting more than 104 weeks for referral to treatment	0	TBC	9863	7th of 7 (at Apr 24)
CRR: 24-11 *SM	PFIG	Over 156 weeks all stages	N/A	TBC	1807	N/A

The number of patients waiting over 208 weeks is continuing to fall is 196 at the end of May 2024. However, since October 2023 performance has remained static and deteriorated in May 2024 (both within the number of patients experiencing waits over 104 and 156 weeks for treatment). With the targeted use of Planned Care Funds combined with 'treat in turn' methodology the Health Board is committed to having no patients waiting 156 weeks or more for treatment before the end of December 2024, and to reduce the number of patients waiting over 104 weeks.

It is of note Welsh Government are placing a great deal of emphasis on tackling extreme waits, with the Health Board seeking to have all patients waiting in excess of 150 weeks booked and (where possible) having received their operation by close of August 2024.

3.3.5 Summary

In 2024-25, the Health Board continues to face many challenges and continues to meet these challenges through (a) enhanced utilisation of in house capacity (b) validation of patients waiting for procedures (c) implementation of Treat-in-Turn methodology and (d) engagement with the commercial sector to offer short term solutions to capacity shortfalls. However, the level of delayed pathways of care continued high emergency demand continues to compound system flow pressures, medical outliers driving continued use of agency and adversely impacting upon capacity to service elective care, with potential impacts upon quality of care.

The Health Board also has key areas of challenge, centred upon:-

- Patient flow (emergency departments, and delays to discharge)
- Ambulance handover times and performance
- Delivery of planned care recovery
- Achievement of cancer standards

However, the Health Board are targeting use of Planned Care Funds, with the intention of eradication of over 156 week waits by December 2024 and improvements in 104 week waiters, also to substantially improve timely access to diagnostic tests. With further targeted interventions within outpatients (new and follow-up) seeking to improve waiting times for patients.

It is also of note that adult mental health assessment is an area performing well in relation to the 80% assessment criteria.

3.4 Financial Performance (Quarter 1 2024-25)
(Corporate Risk 24-05 Financial Sustainability)

The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with the ability to achieve financial balance and the key financial duty challenging in the current climate, despite the receipt of an uplift in funding. The plan incorporates a £48m recurrent savings requirement to achieve an outturn of a deficit totalling £19.8m. Both the savings requirement and the projected deficit are profiled equally over the financial year.

The performance against the plan is shown below, with the Health Board having a £12.8m deficit, which is £7.9m adverse to plan year to date. This is predominately due to undelivered savings, Continuing Health Care (CHC) and Adult Mental Health (AMH) out of area pressures. The projection reflects an assumption that we will deliver the full savings target in year, and that we can recover the year to date deficit and emerging cost pressures can be contained. There are significant risks to these assumptions, which need to be noted, and carefully managed.

Financial Position to date and forecast Position

	Actual Position				Forecast Position									
	Apr	May	Jun	Total YTD	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Surplus/ (deficit)	(4.3)	(4.8)	(3.7)	(12.8)	(2.3)	(2.2)	(0.7)	(0.7)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(19.8)
Planned position	(1.7)	(1.7)	(1.7)	(5.0)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(19.8)
Surplus/ (deficit) over plan	**(2.6)**	**(3.2)**	**(2.1)**	**(7.9)**	**(0.7)**	**(0.5)**	**0.9**	**1.0**	**1.4**	**1.5**	**1.5**	**1.5**	**1.4**	**(19.8)**

Savings

The graph below shows that whilst there is an increase in the value of savings schemes identified in June, there is still a significant gap of £21.5m to identify to meet the full £48m.

The Health Board has issued a 2.8% savings ask within all discretionary expenditure budgets of the Health Board, and adopted a Value & Sustainability Thematic methodology to support delivery, each theme having an Executive lead. This aligns with Welsh Government and enables the sharing of ideas and potential opportunities across Wales.

Within the Health Board the ~Integrated Performance Executive Delivery Group (IPEDG), chaired by the Chief Executive Officer (CEO), review & monitors progress of work streams.

4. Overall Summary

The Health Board continues to face challenge in attainment of the performance targeted within the national and local plans. However, it is of note that in a number of areas performance continue to improve (based on historic delivery and in year comparison) and in some instances attains national targeted levels (Adult Mental Health standards an example).

In addition, plans are developed through use of Planned Care Funds and 'treat in turn' to substantially improve elective wait times, outpatients (new & follow up) cancer and 8 week diagnostic performance.

Members are invited to review the detail contained within the performance report to assess areas of key challenge and improvement opportunity, debating delivery on a balanced scorecard.

5. Appendix

Appendix 1 – Integrated Performance Report – to May 2024 (Finance to June 2024)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Integrated Performance Report

Reporting Period: to 31.05.2024

Presented to **Health Board**

Thursday, 25th July 2024

Produced on behalf of our **Health Board** by the **Performance Directorate** and **Our Partners**

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

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

Integrated Performance Escalations Report

Produced on behalf of our **Health Board** by the
Performance Directorate in partnership with our **Integrated Performance Executive Delivery Group**

A Summary of Escalated Performance Measures

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

Quality, Safety, Effectiveness & Experience Performance

- There were 2 new **never events** reported in May 2024.
- **NRIs:** There were 22 new national reportable incidents reported in April/May 2024.
- **Complaints**: A new Concerns Response Policy is due at Board for approval.

(The 3 points above are linked to Corporate Risk 24-04 Failure to Embed Learning)

- 6 trainee **clinical coders** have been appointed with a start date of July. Coding Assurance Lead has been advertised with the intention of appointing in June.

Access & Activity Performance

- **Referral to Treatment (RTT):** Number of patients waiting over 156 weeks has increased in April/May 2024. **(Corporate Risk 24-11 Planned Care)**
- **Cancer:** Whilst performance remains below plan, use of Planned Care funds is expected to attain the Welsh Government ask of a 70% delivery by March 2025. **(Corporate Risk 24-11 Planned Care)**
- **Diagnostics waits over 8 weeks:** Improved trend with 6,619 patients currently waiting. **(Corporate Risk 24-13 Timely Diagnostics)**
- **Therapy waits over 14 weeks:** has continued to increase in numbers.
- **Pathways of Care Delays:** Despite ongoing efforts, the measures taken to reduce assessment delays have not had the desired impact.
- **Ambulance handover waits:** The number of ambulance patient handover over 4 hours is higher than any other time in the last 12 months. **(Corporate Risk 24-10 Urgent and Emergency Care)**

People & Organisational Development Performance

- **PADR** rate has improved in year but has remained under the WG target of 85%. This work feeds into the ongoing culture work and will be reported as part of the new culture dashboard under development for the organisation.
- **Sickness absence rate** remains below 6.5% in line with ongoing staff wellbeing work.
- At 1.8%, 2nd best performing in Wales as at latest benchmarking, **Turnover rate** for nursing aligned with the national and local retention work put in place with a dedicated retention lead coming on-board for the organisation funded by Health Education and Improvement Wales (HEIW).
- At 4.6%, focus continues on reduction of off-contract **agency spend.** Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

(Corporate Risk 24-01 People, Culture and Wellbeing)
(Corporate Risk 24-1 Leadership/Special Measures)

Finance

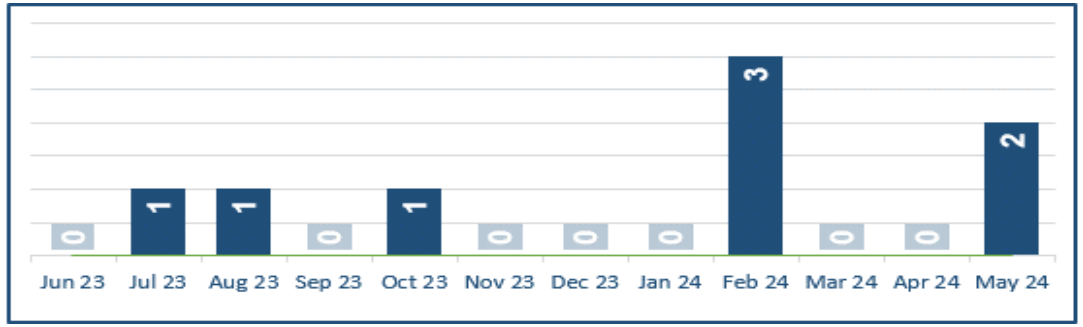
- The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year with a full year deficit of £19.8m.
- The plan incorporates a £48m recurrent savings requirement
- Both the savings requirement and the projected deficit are profiled equally across the financial year.
- At £12.8m, the year to date deficit is £7.9m over plan of £5m.
- At end of June, £26.5m of savings schemes have been identified as green
- A further £21.5m needs to be identified

(Corporate Risk 24-05 Financial Sustainability)

Our Quality: Escalated Performance Measures

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

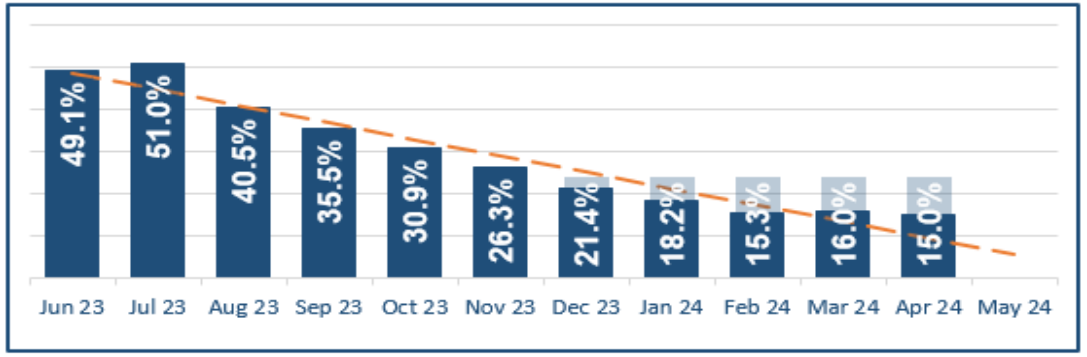
New Never Events



New Never Events - There were 2 new never events in May 2024.

- **Retained foreign object post procedure**. Fragments of guidewire left behind later identified post op by the radiographer. BCU have now implemented 'STOP' moment for all implantable procedures.
- **Administration of wrong medication by wrong route**, Oxycodone oral solution was selected and 2.5 was drawn up in an IV syringe and the prescription chart read Oxycodone and the route was sub cut. A new memo is to be collaborated using overarching learning from this case and a previous YGC case. PSN60 Has also been recirculated. **Corporate Risk 24-04 Failure to Embed Learning**

Clinical Coding Compliance

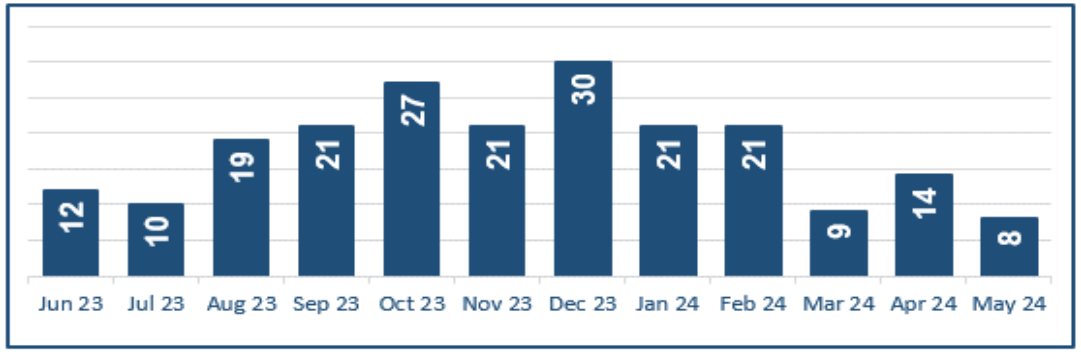


Clinical coding compliance will remain a significant risk directly attributed to staffing issues. Currently working on a delivery plan that is likely to include a proposal to work to a lower target level of coding completeness for the latter part of 2023/24 and in to 2024/25. 6 trainee clinical coders have been appointed with a start date of July. Coding Assurance Lead has been advertised with the intention of appointing in June (start date TBC). Exploring ways to maximise the use of digital systems to make more data available electronically.

Our Quality: Escalated Performance Measures cont.

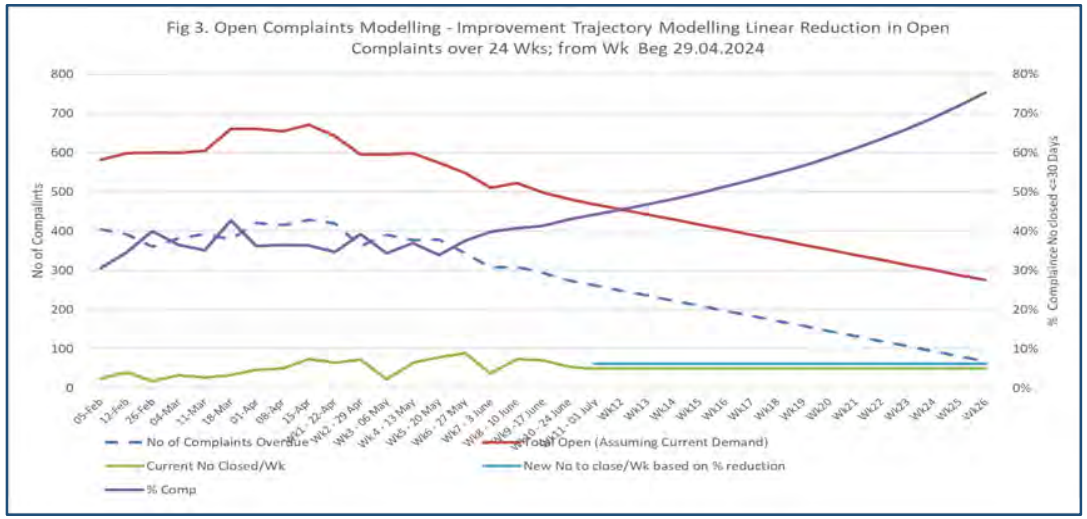
GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

New National reportable incidents (NRIs)



New National reportable incidents (NRIs) The Patient Safety Team (PST) are supporting the progression of all NRIs. Drop in clinics for staff are held weekly to help focus the outcome from the incident review with any learning which can be shared. The IHCs and Divisions have submitted their reduction plans to the Executive Director of Nursing and Midwifery for onward monitoring of trajectory. The top themes remain the same as previous months reporting, they included: Administration errors, Assessing and recognising patient/service user deterioration, Diagnostic testing – Radiology, Maternal, Medical devices, Medication prescribing error, Neonate, Patient injury, Slip, trip or fall, Struck against or by an object, Treatment or procedure issues, Unexpected death, Pressure ulcer category 3. **Corporate Risk 24-04 Failure to Embed Learning**

Overdue Complaints



Update on Complaints Corporate Risk 24-04 Failure to Embed Learning

The Chief Executive Officer (CEO) has commissioned a project to create a single, aligned policy that sets out the standards and framework to recognise, respond, learn and improve from incidents, complaints and mortality reviews (along with a supporting toolkit) which ensures:

- Incidents, complaints and deaths are promptly identified, recorded and initially reviewed;
- Reviews are completed in a timely way for every incident, complaint and death;
- Incidents, complaints and mortality reviews are triangulated to ensure alignment;
- Where necessary, further in-depth investigations are carried out in a timely and thorough way;
- Patients, families & staff are enabled & empowered to be active contributors to, & participants in, the process;
- Learning is identified, shared and acted upon;
- Improvement actions are tracked to completion with evidence;
- Full alignment to healthcare legal processes (redress, claims, inquest).

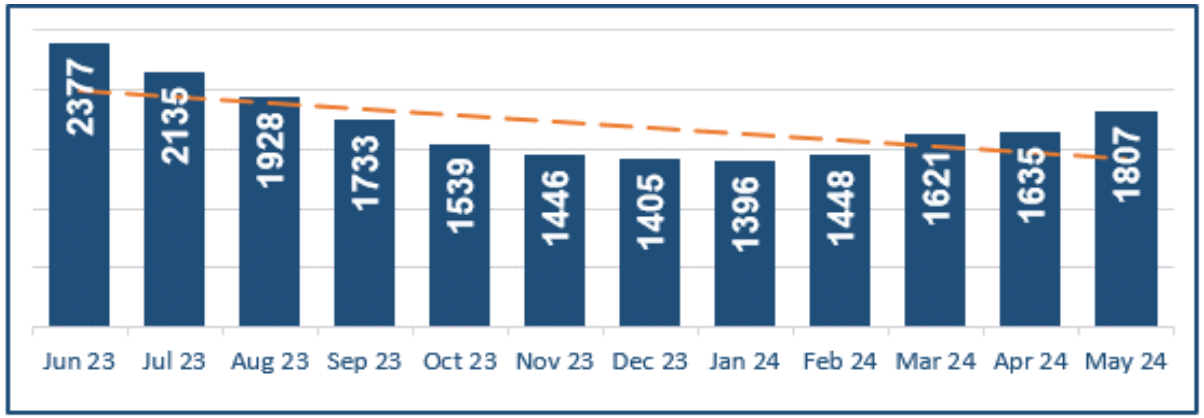
The new Concerns Response Policy will be presented at this Health Board on 25th July 2024 and will be launched with a supporting toolkit

Access & Activity: Escalated Performance Measures

Planned Care

(Corporate Risk 24-11 Planned Care & Corporate Risk 24-12 Areas of Clinical Concern

Reduction of Extreme Waits (156 Weeks and above)



The number of patients waiting over 156 weeks was reduced considerably during the 2023-24 financial year. However, since March 2024, there has a steady and consistent rise in the number of patients experiencing waits over 104 and 156 weeks for treatment.

Targeted use of Planned Care Funds combined with the work to articulate, by speciality, monthly, performance for the remainder of the financial year has been completed and key components deployed;

(a) Improved theatres use
(b) validation of lists
(c) improved treat in turn
(d) Premium working (waiting list initiatives (WLI), insourcing and outsourcing)
(e) Targeted escalation to assure all extreme waits booked by August 2024.

Suspected Cancer Pathway 62 Days Performance

Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion is at 57.2%, highlighting a 12 month deterioration trend. Although performance deteriorated in April it improved in May and is above our planned recovery trajectory of 54%.

To reduce the backlog of patients still active over day 62 additional capacity has been approved from Waiting List Initiative (WLI) funding (as at June 2024) to see and treat over 4,750 patients across 6 specialties (Breast 188, Colorectal 26, Dermatology 3,200, Endoscopy 550, Gynaecology 156, Urology 631)

Progressing insourcing process for:
Endoscopy – re-tender exercise on target for completion Sept 2024
Dermatology West – expressions of interest requested June 2024
Soft launch of teledermoscopy July 2024.

Access & Activity: Escalated Performance Measures

Planned Care

(Corporate Risk 24-11 Planned Care & Corporate Risk 24-12 Areas of Clinical Concern

Patients waiting over 8 weeks for Diagnostic tests

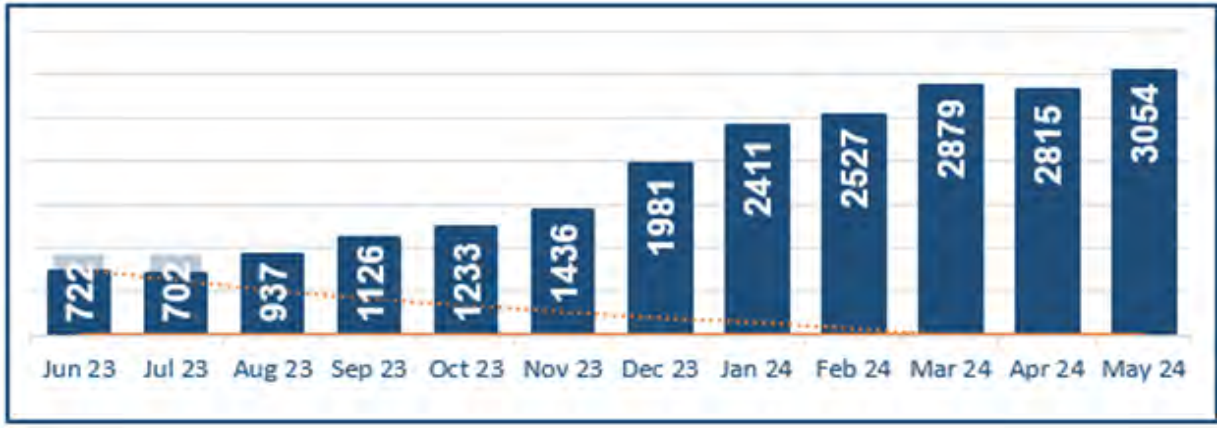
Number of pathways waiting 8 weeks for specific diagnostic has decreased by 25% in a year. With 6,619 patients currently waiting there has been a slight increase over the previous 3 months.

Position at 31.05.2024: +171 over trajectory
Key variances against plan: Endoscopy (+158) / Radiology (+191) / Others (-178)
Endoscopy: YTD GI endoscopy (+312)
Radiology: YTD GP ultrasound (+265)
Radiology Demand: YTD CT +545 (3.75%); MRI +728 (14.25%); +925 (+4.28%)

Key risk area is ultrasound, where the increases in demand in the first 2 months have not been fully matched by additional activity.

MRI and CT demand has also increased, but this is largely being met with additional activity at this time.

Patients waiting over 14 weeks for therapy (excludes Audiology)



There has been a 100% increase in the number of patients waiting over 14 weeks for therapy since November 2023. In total there are 17,264 patients on therapies waiting list, 3,054 of which are waiting 14 weeks or longer.

Nearly all the long waits experienced are in Physiotherapy at 2,979 (991 Central Integrated Health Community (IHC) and 1,988 East IHC). Dietetics service in East IHC account for 46 patients, with a further 23 in various sub specialties across BCUHB.

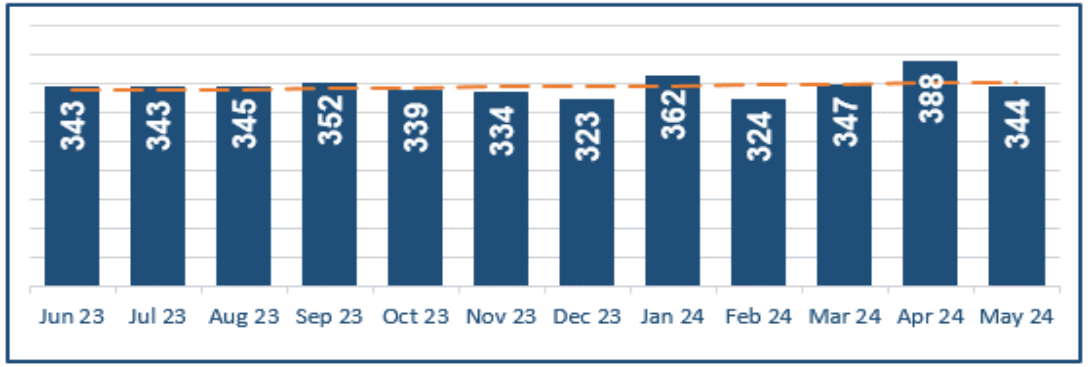
Actions

Physiotherapy – Capacity and staffing constraint impacting. Teams are using all available validation, onward referral and group and remote options as applicable. Attended workshop with Aneurin Bevan HB, using knowledge to utilise Demand and Capacity tool they have developed to support the work of the teams here.
Use of insourcing providers to support delivery of improved diagnostics trajectories utilising Planned Care Funds for 2024/25

Access & Activity: Escalated Performance Measures

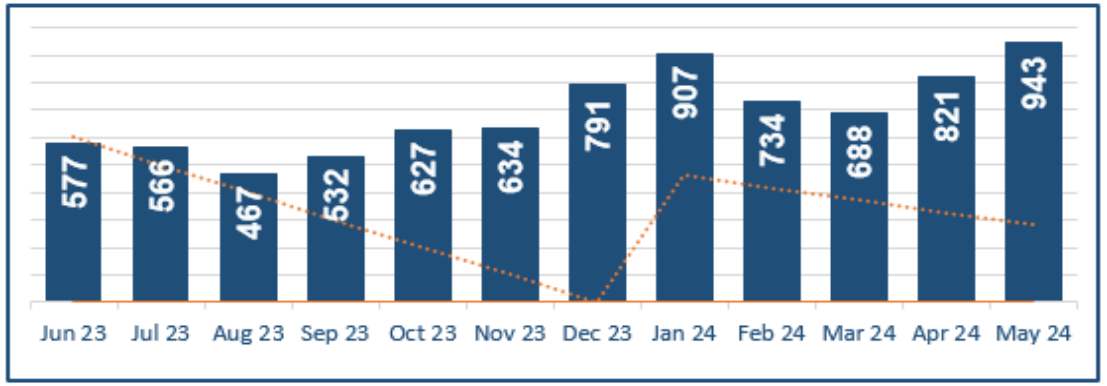
Urgent & Emergency Care

Number of Delayed Pathways of Care



Pathways of Care Delays: Despite ongoing efforts, the measures taken to reduce assessment delays have not had the desired impact and the overall position across North Wales has not improved. The average number of patients experiencing pathways of care delays per month has remained consistent over the last twelve months at approximately 340 and remains a significant concern for the Health Board. The main reason for delays are linked to high POCDs alongside increased acuity resulting in delays to clinician assessment on lower triage category of patients.

Number of Ambulance Patient Handover Delays of 4 Hours or more



The number of **ambulance patient handover over 4 hours** is reported at 943. The Health Board is currently in the process of implementing a triumvirate of senior representatives from the established UEC 6 goals programme board supported by business partners from within the organisation.

(Corporate Risk 24-10 Urgent and Emergency Care)

People & OD: Escalated Performance Measures

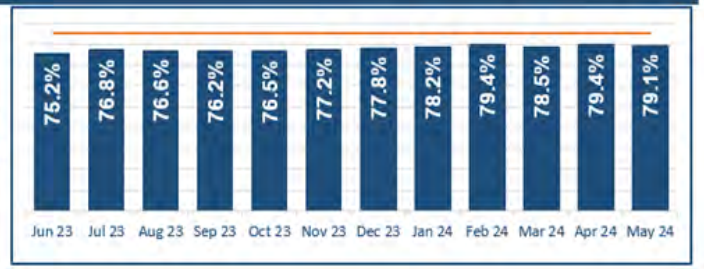
- **PADR** rate at 79.1% for May 2024, is the first dip in performance since June 2023. This work feeds into the ongoing culture work and will be reported as part of the new culture dashboard being developed for the organisation.

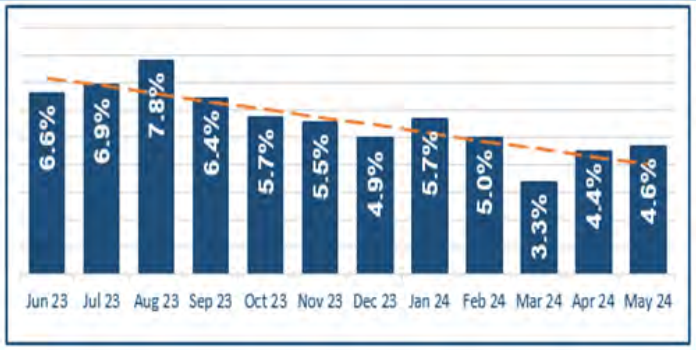
- **Sickness absence** rate stayed below the 6% mark since February 2024 in line with ongoing staff wellbeing work.

- At 1.8%, 3rd best performing in Wales as at latest benchmarking, **Turnover rate** for nursing aligned with the national and local retention work put in place with a dedicated retention lead coming on-board for the organisation funded by HEIW

- Although 1.3% higher than the end of March position, at 4.6% in May, focus on off-contract **agency reduction** demonstrating consistent improvement. Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12months(excluding doctors and dentists in training)	85%	TBC	79.1%	1st of 13 (at Mar 24)
PFIG	Percentage of sickness absence rate of staff	Decreasing trend	TBC	5.7%	7th of 13 (at Mar 24)
PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Decreasing trend against 2019/20	TBC	1.8%	2nd of 11 (at Feb 24)
PFIG	Agency spend as a percentage of total pay bill	Decreasing trend	TBC	4.6%	9th of 12 (at Mar 24)





Finance: Escalated Performance Measures

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Financial Position to date and forecast Position (Corporate Risk 24-05 Financial Sustainability)

	Actual Position				Forecast Position									
	Apr £'m	May £'m	Jun £'m	Total YTD £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Forecast year-end position £'m
Surplus/ (deficit)	(4.3)	(4.8)	(3.7)	(12.8)	(2.3)	(2.2)	(0.7)	(0.7)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(19.8)
Planned position	(1.7)	(1.7)	(1.7)	(5.0)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(19.8)
Surplus/ (deficit) over plan	**(2.6)**	**(3.2)**	**(2.1)**	**(7.9)**	**(0.7)**	**(0.5)**	**0.9**	**1.0**	**1.4**	**1.5**	**1.5**	**1.5**	**1.4**	**(19.8)**

The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with the ability to achieve financial balance and the key financial duty challenging in the current climate, despite the receipt of an uplift in funding. The plan incorporates a £48m recurrent savings requirement, but still has a full year deficit of £19.8m. Both the savings requirement and the projected deficit are profiled equally across the financial year.

The below table shows the movement in the deficit per month, and year to date deficit of £7.9m, predominantly due to the unidentified savings, CHC and MH out of area placements. The projection reflects an assumption that the full savings target will be delivered in the year, the year to date deficit can be recovered and emerging cost pressures can be contained. There are significant risks to these assumptions, which need to be noted and carefully managed.

The graph to the right shows that whilst there is an increase in the value of savings schemes identified in June, there is still a significant gap of £21.5m to be found to meet the full £48m.

The Health Board has moved to a Value and Sustainability Thematic methodology, with each theme having an Executive lead. This aligns with Welsh Government and other health boards and enables the sharing of ideas and potential opportunities across Wales.

Within the Health Board the IPEDG, which is chaired by the CEO, review and monitor the progress of each work stream.

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About the Integrated Performance Report

Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

NHS Wales Performance Framework 2023-24

The performance measures in the NHS Wales Performance Framework for 2024-2025 reflect the National Programme areas as outlined in the NHS Wales Planning Framework 2024-2027.

The 2024/25 revision now consists of 54 quantitative measures and twelve policy assurance statements where assurance is sought either quarterly or bi-annually.

The NHS Wales Quadruple Aim Outcomes are a set of four interconnected goals or aims that aim to guide and improve healthcare services in Wales. These aims were developed to enhance the quality of care, patient experience, and staff well-being within the National Health Service (NHS) in Wales.

A Healthier Wales Quadruple Aims

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

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

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

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

Our Integrated Performance Report

- **Our Quality, Safety, Effectiveness & Experience Performance**
- **Our Access & Activity Performance**
- **Our People & Organisational Development Performance**
- **Our Financial Performance**

The Integrated Performance Framework (IPF) aims to report holistically at service, directorate or organisation level the performance of the resources deployed, and the outcomes being delivered. Overall performance assessed via intelligence of performance indicators gathered across key domains including quality, safety, access & activity, people, finance and outcomes.

Key for the framework is the system review, reporting, escalation and assurance process that aligns especially to the NHS Wales Performance measures, Special Measure metrics and Ministerial priority trajectories. In the Integrated Performance Review meetings we will address key challenges and provide a robust forum for support and escalation to Executive leads and provide actions and recovery trajectories for escalated metrics.

Red, Amber & Green (RAG) Rating System

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Performance is monitored against our Annual Plan but is RAG rated against the Welsh Government targets.

Green	The latest available data point indicates that performance is at, or better than the target
Red	The latest available data point indicates that performance is worse than the target
Blue	It is inappropriate, or not possible, to rate available data against any available target
Grey	There is no / insufficient data available to rate against the target

Exception	Escalation
Referring to a deviation or departure from the normal or expected course of action, it signifies that a specific condition or event requires attention or further action to address the deviation and ensure corrective measures are taken.	When a performance matter (exception) does not meet target and hits criteria for a higher level for resolution, decision-making, or further action.
Criteria of an exception	**Criteria for escalation**
Any target failing an NHS Performance target, operational, or local target/trajectory	Any measure that fails a health submitted trajectory as part of the Ministers priorities.
Where SPC methodology reports rule 2, or rule 4 (details on next slide) even if a measure is set target.	Performance recovery failing its Remedial Action Plan (local plan to improve or maintain performance)
Any reportable commissioned metric where performance is not meeting national target	Any significant failure of quality standard e.g. never event or failing accountability conditions.

Interpreting Results of Statistical Process Control (SPC) Charts

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Variance

Common cause variation present: there is no significant change or pattern

Special cause variation present: changes or patterns appear to show improvement

Special cause variation present: concerning changes or patterns present that require investigation / action.

Special cause variation present: a upwards or downwards change or pattern is evident, which is neither positive or negative in nature.

Orange icons indicate negative occurance
Blue icons indicate a positive occurance
Grey icons indicate no significant data occurance

Assurance (*based on data presented in the SPC only)

No assurance: we would expect to sometimes achieve, and sometimes miss the target

Positive assurance: we would consistently expect to achieve the target

No assurance: we would consistently expect to miss the target

There is no profile or target, or insufficient data, thus assurance can not be ascertained

Legend

Performance	Control Line (Mean)	Upper Control Limit 3σ
Lower Control Limit 3σ	Upper Control Limit 2σ	Lower Control Limit 2σ
National Target	Internal profile	Trend

The column charts that feature within this report use the following legend:

BCU Position | Internal Profile | Trend (Rolling 12 Month) | WG Target

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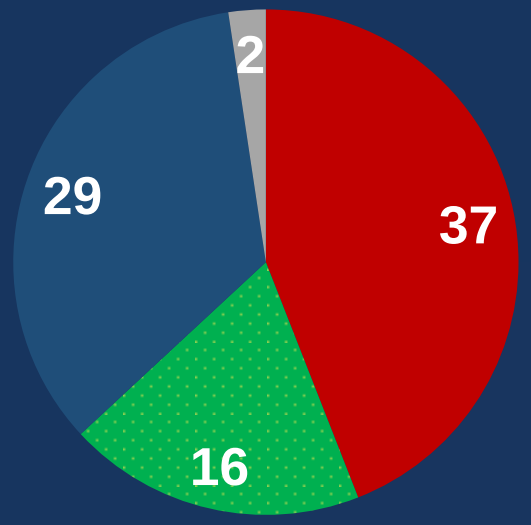
Integrated Performance Report



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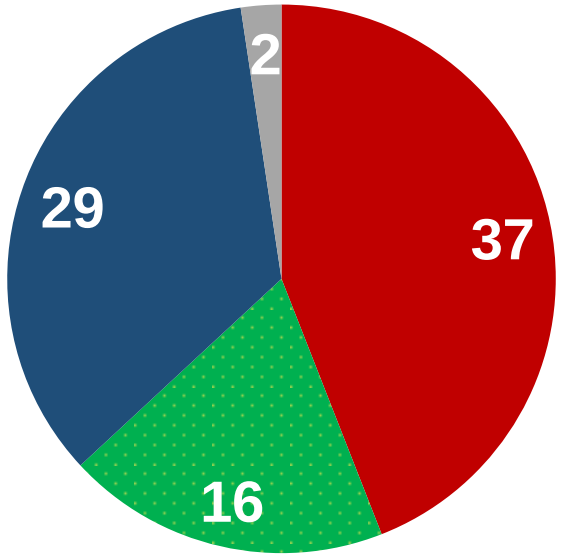
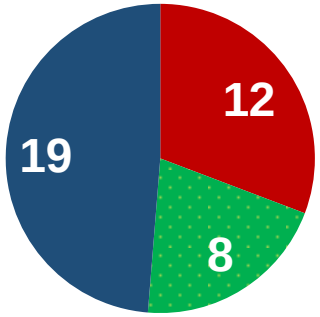
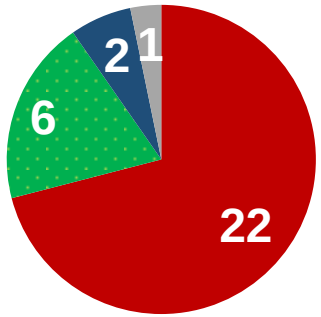
Summary of Performance to Month 12



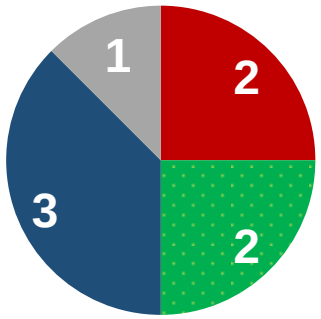
All Sections



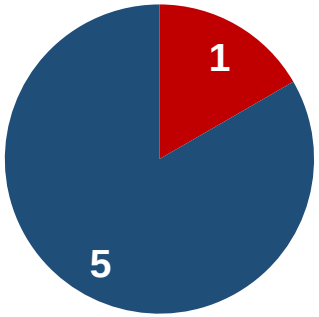
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



People & Organisational Development Performance



Financial Performance

NHS Wales Performance Dashboard- part 1

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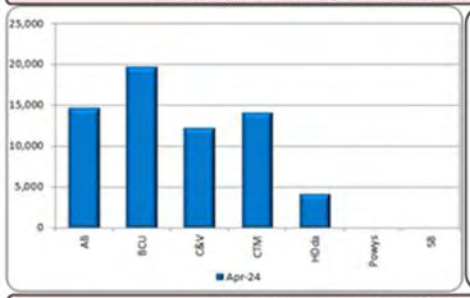
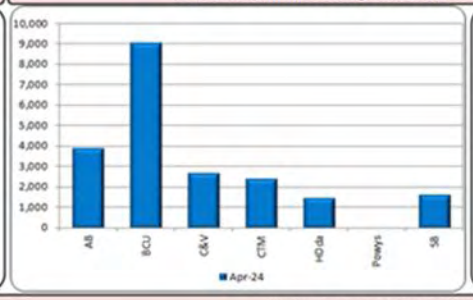
PERFORMANCE DASHBOARD

Number of patients waiting more than 52 weeks for a new outpatient appointment



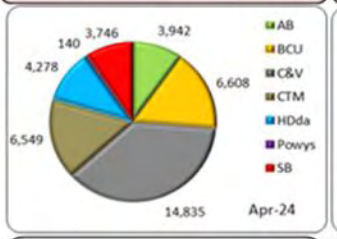
- In Apr-24, Powys and SB achieved the target of zero for the number of patients waiting over 52 weeks for a new outpatient appointment.
- At an all Wales level, the number of over 52 week new outpatient waits has increased in Apr-24, when compared to the previous month, by 4,011 to 65,111, a 6.6% increase.
- AB, BCU, C&V, CTM and HDda all saw an increase in Apr-24 compared to the previous month.
- Powys and SB had no over 52 week new outpatient waits in Apr-24, BCU had the highest number of waits at 19,720 (30.3% of the total).

Number of patients waiting more than 104 weeks for referral to treatment



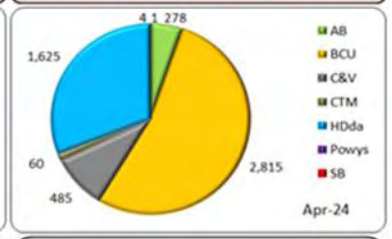
- In Apr-24, Powys achieved the target of zero for the number of patients waiting over 104 weeks for referral to treatment.
- At an all Wales level, the number of over 104 week referral to treatment waits has increased in Apr-24, when compared to the previous month, by 654 to 21,290, a 3.2% increase.
- AB, BCU, C&V, CTM and HDda all saw an increase in Apr-24 when compared to the previous month.
- Powys had no over 104 week referral to treatment waits in Apr-24, BCU had the highest number of waits at 9,081 (42.7% of the total).

Number of patients waiting more than 8 weeks for a specified diagnostic



- In Apr-24, no HB achieved the target of zero for the number of patients waiting over 8 weeks for a specified diagnostic.
- At an all Wales level, the number of over 8 week waits for specific diagnostics has increased in Apr-24, when compared to the previous month, by 193 to 40,098, a 0.5% increase.
- AB and CTM saw a reduction in Apr-24 when compared to the previous month.
- Powys had the lowest number of over 8 week waits for specific diagnostics in Apr-24 at 140, C&V had the highest at 14,835 (37.0% of the total).

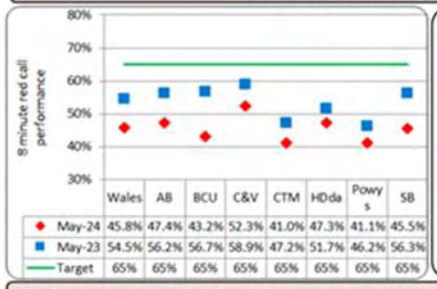
Number of patients waiting more than 14 weeks for a specified therapy



- In Apr-24 no HB achieved the target of zero for the number of patients waiting over 14 weeks for a specified therapy.
- At an all Wales level, the number of over 14 week waits for specific therapies decreased in Apr-24, when compared to the previous month, by 3,732 to 5,268, a 41.5% reduction.
- All HBs saw a reduction in Apr-24 when compared to the previous month - SB remained the same.
- SB had the lowest number of over 14 week waits for specific therapies in Apr-24 at 1, BCU had the highest at 2,815 (53.4% of the total).

Note: this measure now excludes audiology waiting times. From Apr-24 the figures also exclude weight management services which some HBs reported under dietetics hence why many have seen a reduction in numbers this month.

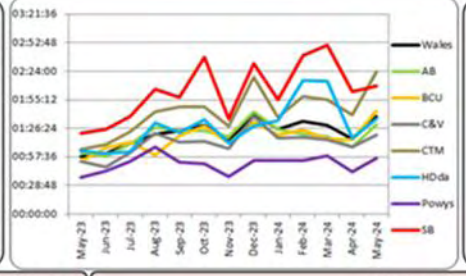
% of emergency responses to red calls arriving within 8 minutes



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
May-24	45.8%	47.4%	43.2%	52.3%	41.0%	47.3%	41.1%	45.5%
May-23	54.5%	56.2%	56.7%	58.9%	47.2%	51.7%	46.2%	56.3%
Target	65%	65%	65%	65%	65%	65%	65%	65%

- In May-24, data shows no HB achieved the 65% target for the % of emergency responses to red calls within 8 min.
- At an all Wales level, the % of emergency responses to red calls within 8 minutes has deteriorated in May-24, when compared to the previous month, by 2.3 percentage points to 45.8%.
- Over the last 12 months all HBs have seen a deterioration trend in performance. Only C&V saw an improvement in performance when compared to the previous month.
- C&V were the best performing HB in May-24 with performance at 52.3%, CTM were the lowest with performance at 41.0%.

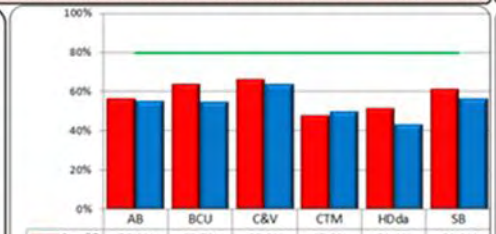
Median emergency response time to amber calls



- In Apr-24, no HB achieved the 12 month reduction trend target for median emergency response time to amber calls.
- At an all Wales level, the median amber response time is shorter in Apr-24, when compared to the previous month, by 14 mins 13 secs to 1 hr, 15 mins and 18 secs.
- Over the last 12 months all HBs have seen a deterioration trend in performance.
- All HBs saw an improvement in performance in Apr-24 when compared to the previous month.
- Powys was the best performing HB in Apr-24 with a median response time of 42 mins and 12 secs, SB had the longest median response time of 2 hrs, 3 mins and 9 secs.

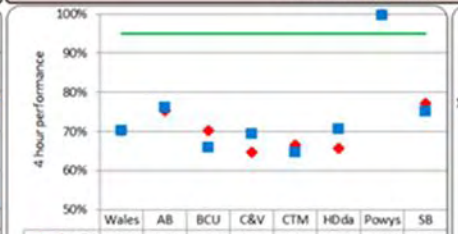
% of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route)

- In Apr-24, CTM ,HDda and SB achieved the target of a 12 month improvement trend towards a target of 80% by 31 March 2026 for the % of patients starting first definitive cancer treatment within 62 days from point of suspicion.
- At an all Wales level, the % of patients starting first definitive cancer treatment within 62 days from point of suspicion has deteriorated in Apr-24, when compared to the previous month, by 6.7 percentage points to 53.8%.
- C&V and SB saw an improvement in performance in Apr-24 when compared to the previous month.
- C&V was the best performing HB in Apr-24 was C&V with performance at 63.7%, HDda had the lowest performance at 43.0%.

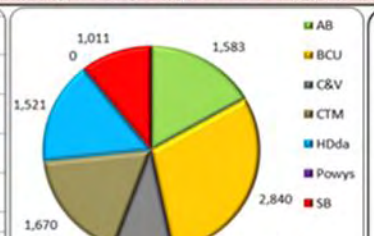


	AB	BCU	C&V	CTM	HDda	SB
Apr-23	56.1%	63.7%	66.0%	47.9%	51.4%	61.0%
Apr-24	55.0%	54.8%	63.7%	49.8%	43.0%	56.2%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

4 hour and 12 hour A&E waiting times in all major and minor emergency care facilities - from arrival until admission, transfer or discharge



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Apr-24	70%	75%	70%	65%	66%	66%	100%	77%
Apr-23	70%	76%	66%	69%	65%	71%	100%	75%
Target	95%	95%	95%	95%	95%	95%	95%	95%



- In Apr-24 BCU, CTM, Powys and SB achieved the target of an improvement compared to the same month in the previous year, towards the target of 95%, for the % of patients who spent less than 4 hours in ED.
- At an all Wales level, the % patients who spent less than 4 hours in ED. has improved in May-24, when compared to the previous month, by 2.6 percentage points to 70.3%.
- All HBs saw an improvement in performance in Apr-24 when compared to the previous month.
- SB was the best performing HB in Apr-24 (exc. Powys) at 77.3%, C&V had the lowest performance at 64.7%.
- In Apr-24 CTM, Powys and SB achieved the target of a reduction compared to the same month in the previous year, towards the target of zero for the number of patients who spent more than 12 hours in ED.
- At an all Wales level, the number of patients who spent more than 12 hours in ED has decreased in Apr-24, when compared to the previous month, by 832 to 9,472, an 8.1% reduction.
- C&V had the lowest number of patients who spent more than 12 hours in A&E (exc. Powys) at 847, BCU had the highest at 2,840 (30% of the total).

NHS Wales Performance Dashboard – part 2

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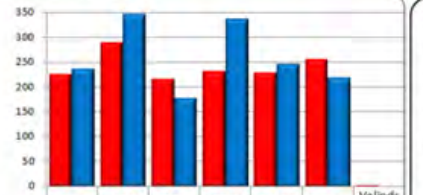
Number of Pathways of Care delayed discharges

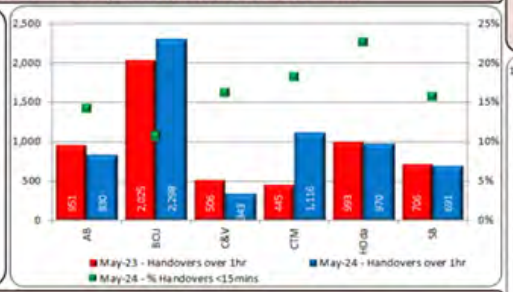
- In May-24, AB, HDda, Powys and Velindre all achieved the 12 month reduction trend target for the number of pathways of care delayed discharges.
- At all Wales level, the number of pathways of care delayed discharges has decreased in May-24, when compared to the previous month, by 114 to 1,624, a 6.6% reduction.
- All HBs, except HDda, saw an improvement in performance in May-24 when compared to the previous month.
- Powys had the lowest number of pathways of care delayed discharges in May-24 at 55, BCU had the highest at 348. Velindre had no pathways of care delayed discharges.



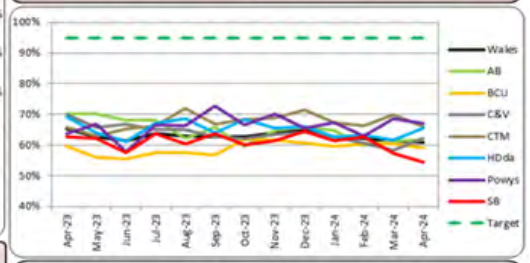
	AB	BCU	C&V	CTM	HDda	SB	Velindre
May-23	227	290	217	233	230	257	3
May-24	237	348	179	338	247	220	0

Number of ambulance patient handovers over 1 hour and % of ambulance patient handovers within 15 minutes

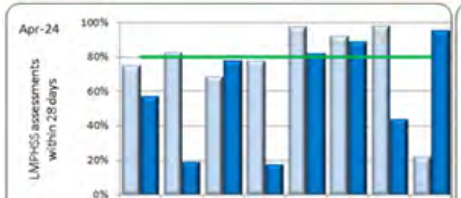
- In May-24, no HB achieved the zero target for handovers over 1 hour.
- At all Wales level, the number of over 1 hour handovers has increased in May-24, when compared to the previous month, by 123 to 6,248, a 2.0% increase.
- Over the last 12 months, AB, C&V and SB saw an improvement trend in performance.
- C&V had the lowest number of over 1 hour handovers in May-24 at 343, BCU had the highest at 2,298 (36.8% of the total).
- In May-24, no HB achieved the improvement compared to the same month in the previous year, towards the target of 100% for the % of handovers within 15 mins.
- At all Wales level, the % of handovers within 15 mins has increased in May-24, when compared to the previous month, by 0.8 percentage points to 15.6%.
- HDda had the best performance in May-24 at 22.6%, BCU had the lowest at 10.6%.
- Over the last 12 months all HBs have seen a deterioration trend in performance.



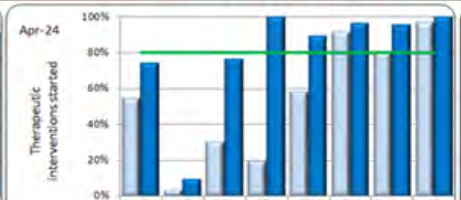
% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date



Mental Health Part 1 - % of LPMHSS assessments and therapeutic interventions within 28 days



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	75%	82%	68%	78%	97%	92%	98%	23%
>=18 years	57%	19%	78%	18%	82%	89%	44%	95%
Target	80%	80%	80%	80%	80%	80%	80%	80%



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	55%	4%	30%	20%	58%	91%	80%	97%
>=18 years	74%	10%	76%	100%	89%	97%	95%	100%
Target	80%	80%	80%	80%	80%	80%	80%	80%

<18 years

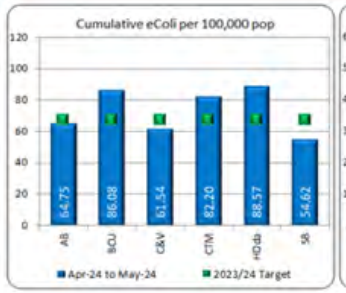
- In Apr-24, AB, CTM, HDda and Powys achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was Powys at 98.0%, SB had the lowest performance at 22.5%. Over the last 12 months, all HBs, except C&V and Powys saw an improvement trend in performance.
- In Apr-24, HDda, Powys and SB achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was SB at 96.9%, AB had the lowest performance at 3.7%. Over the last 12 months, all HBs, except BCU, saw an improvement trend in performance.

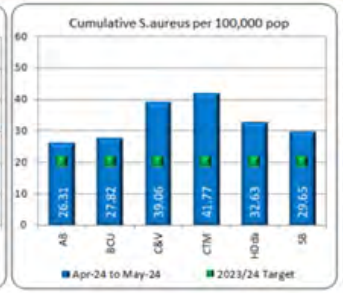
>=18 years

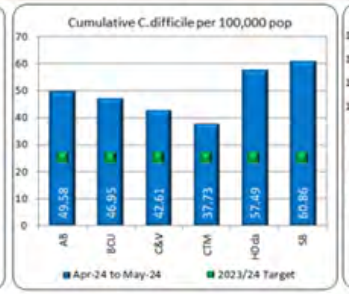
- In Apr-24, CTM, HDda and SB achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was SB at 95.2%, C&V had the lowest performance at 17.5%. Over the last 12 months, all HBs, except BCU and C&V, saw an improvement trend in performance.
- In Apr-24, all HBs, except AB and BCU, achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HBs were C&V and SB at 100%, AB had the lowest performance at 9.7%. Over the last 12 months, BCU, C&V, CTM and SB saw an improvement trend in performance.

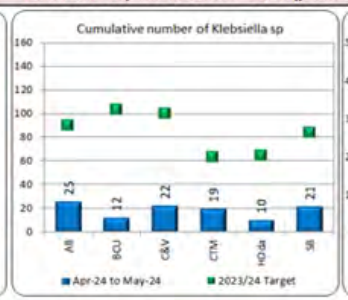
- In Apr-24, BCU, CTM and Powys achieved the target of a 12 month improvement trend towards the target of 95% for the % of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date.
- At all Wales level, the % of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date has deteriorated in Apr-24, when compared to the previous month, by 0.4 percentage points to 61.0%.
- In Apr-24, AB, C&V and HDda saw an improvement in performance compared to the previous month.
- Over the last 12 months, BCU, CTM and Powys saw an improvement trend in performance.
- Powys had the highest performance in Apr-24 at 67.2%, SB were the lowest at 54.6%.

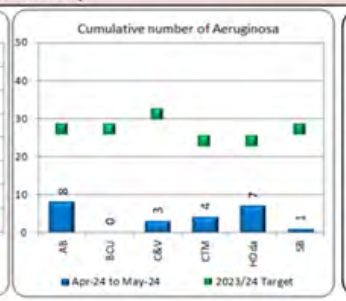
Health Care Acquired Infections - HCAIs (provisional data)











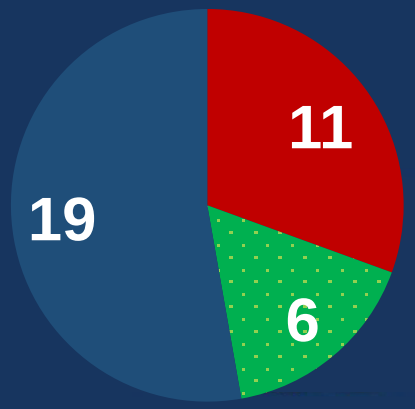
- For eColi, AB, C&V and SB are currently achieving the 2023/24 cumulative target. In the Apr-24 to May-24 period, HDda had the highest rate of eColi at 88.57 per 100,000 population compared to SB who had the lowest rate at 54.62 per 100,000 population.
- For S.aureus, none of the HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to May-24 period, CTM had the highest rate of S.aureus at 41.77 per 100,000 population compared to AB who had the lowest rate at 26.31 per 100,000 population.
- For C.difficile, none of the HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to May-24 period, SB had the highest rate of C.difficile at 60.86 per 100,000 population compared to CTM who had the lowest rate at 37.73 per 100,000 population.
- For Klebsiella, all HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to May-24 period, AB had the highest number of cases of Klebsiella at 25 compared to HDda who had the lowest number at 10.
- For Aeruginosa, all HBs are currently achieving the 2023/24 cumulative target. In the Apr-24 to May-24 period, AB had the highest number of cases of Aeruginosa at 8 compared to BCU who had no cases.

Note: Target is for achievement for Mar-24 (awaiting confirmation of the 24/25 targets).

Section 1

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

Quality, Safety, Effectiveness and Experience Performance



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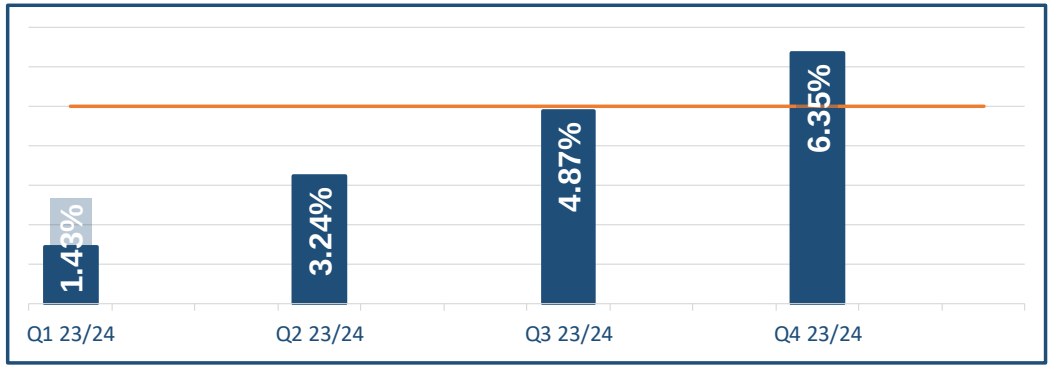
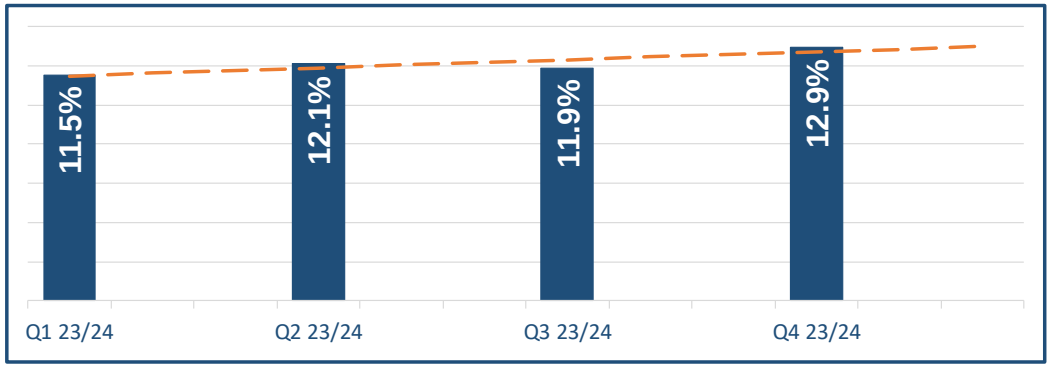
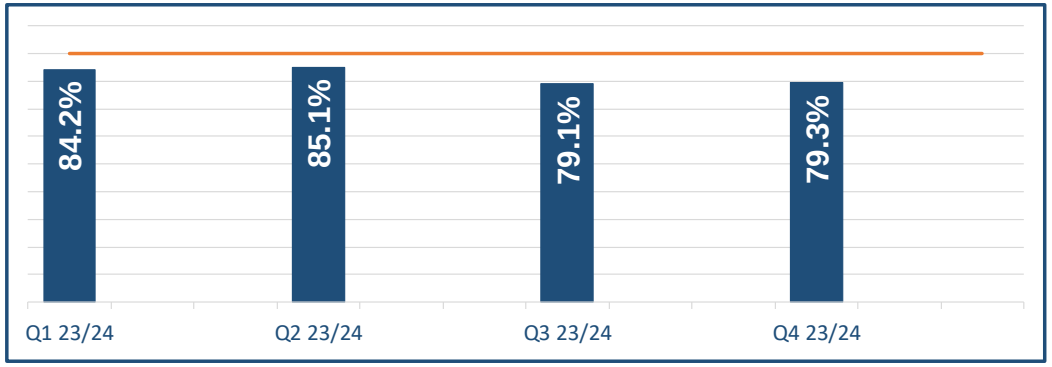
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual	TBC	6.35%	2nd of 7 (at Dec 23)
QSE	Percentage of adult smokers who made a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks	40% annual target	TBC	12.9%	
QSE	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	79.3%	5th of 7 (at Mar 24)

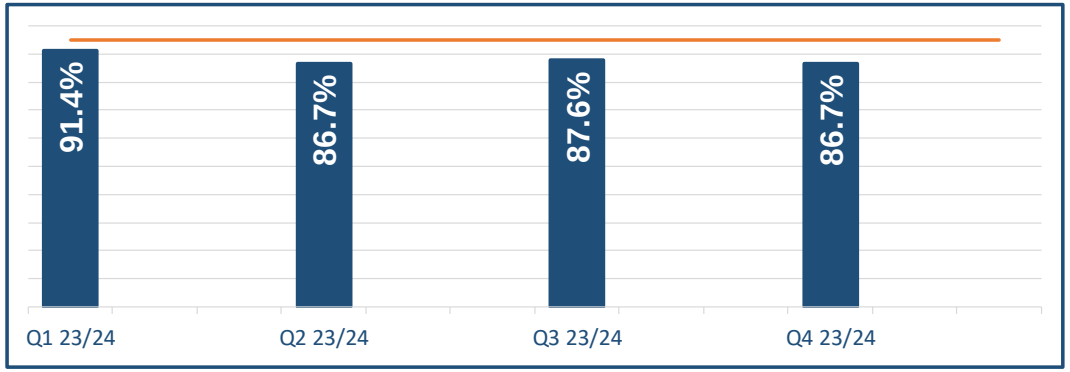


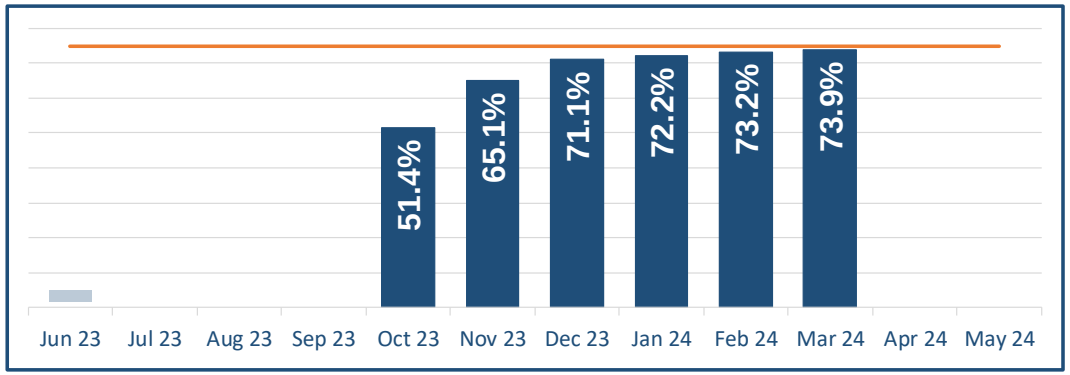


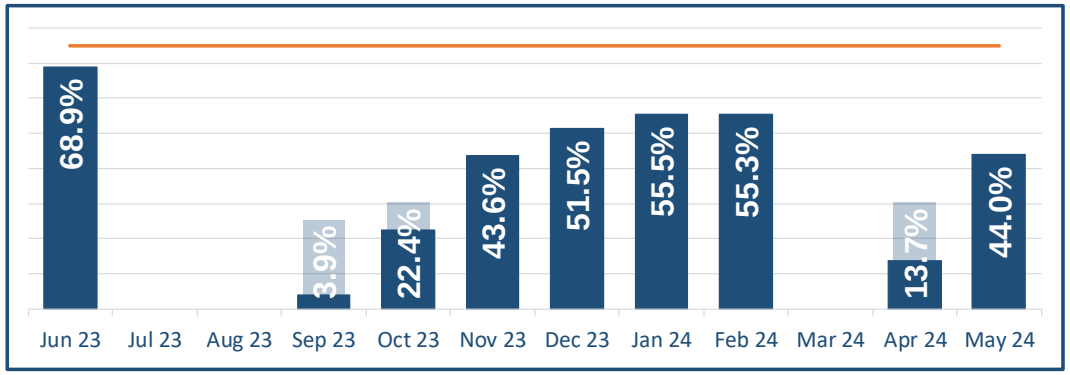


Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	95%	TBC	86.7%	2nd of 7 (at Mar 24)
QSE	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	75%	TBC	73.9%	2nd of 7 (at Mar 24)
QSE	Percentage uptake of the COVID-19 vaccination for those eligible Spring Booster 2023: Aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over Autumn Booster 2023: Age range to be confirmed	75%	TBC	44.0%	6th of 7 (at May 24)







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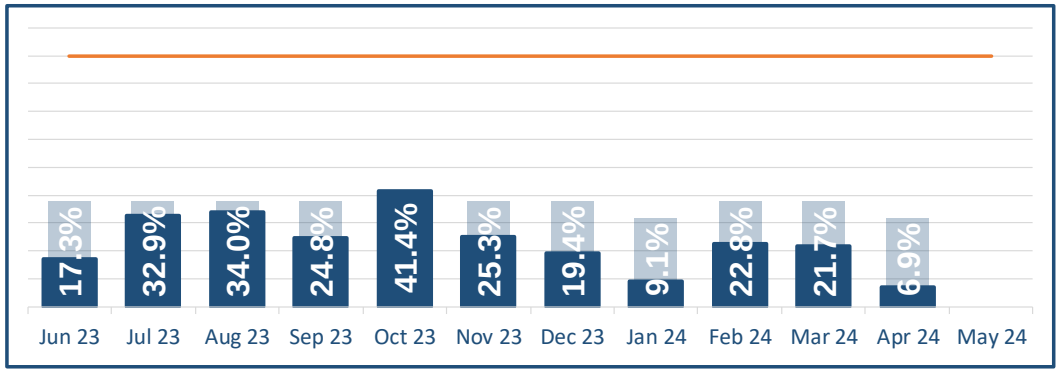
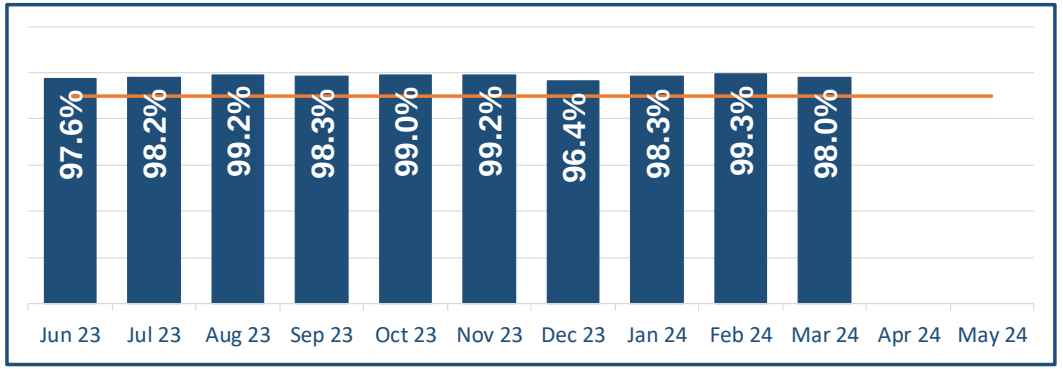
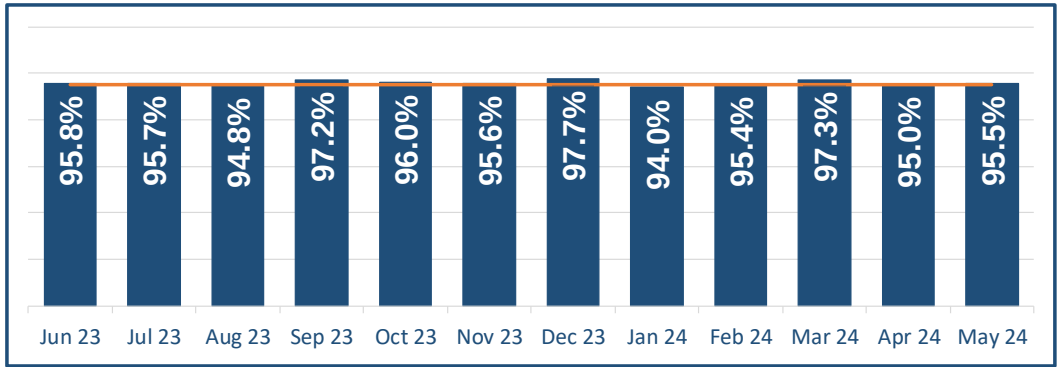
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	6.9%	4th of 7 (at Mar 24)
QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	98.0%	2nd of 7 (at Mar 24)
QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	95.5%	7th of 7 (at Apr 24)







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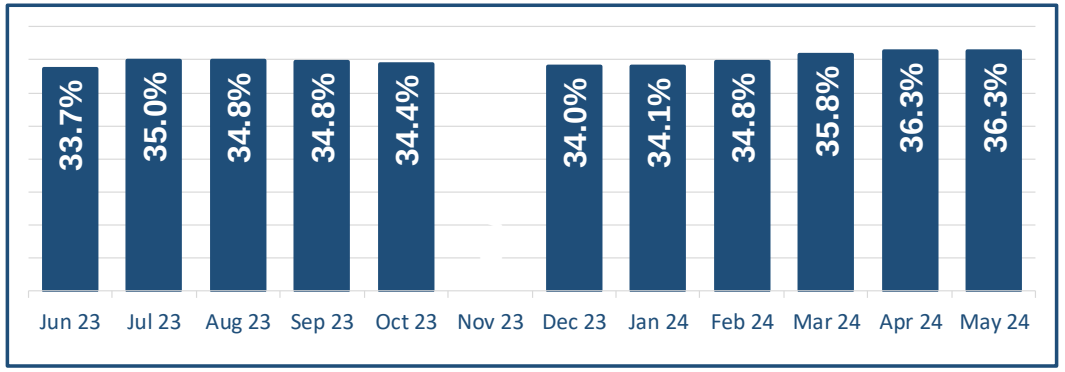
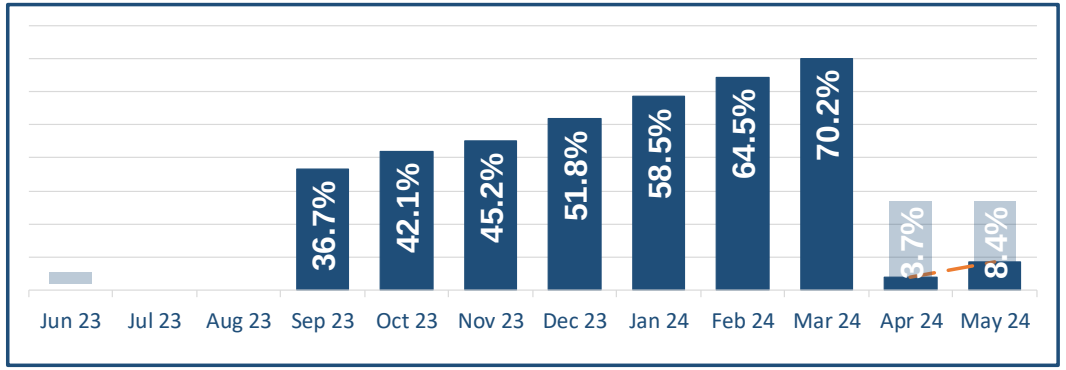
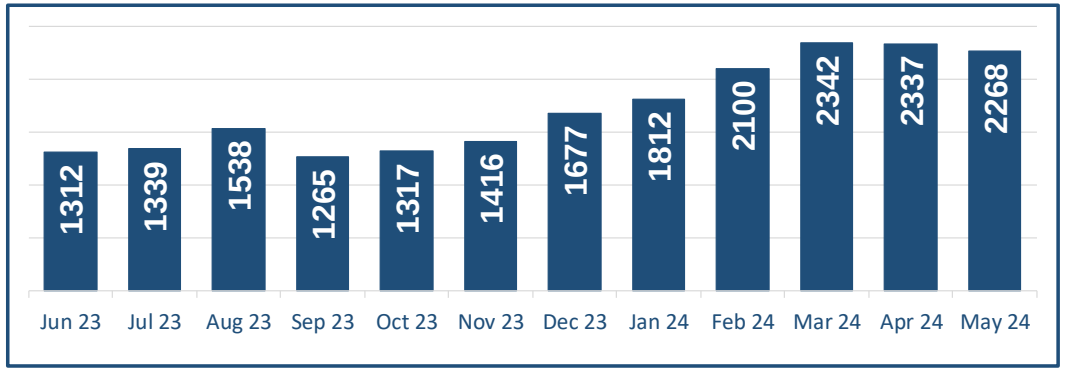
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Equivalent month increase (2024/25 to 2023/24) to 100%	TBC	36.3%	7th of 7 (at Apr 24)
PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increasing trend (to 30% (end Sept), then 100% (end Mar))	TBC	8.4%	7th of 7 (at May 24)
PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Equivalent month increase (2024/25 to 2023/24)	TBC	2268	1st of 7 (at Apr 24)



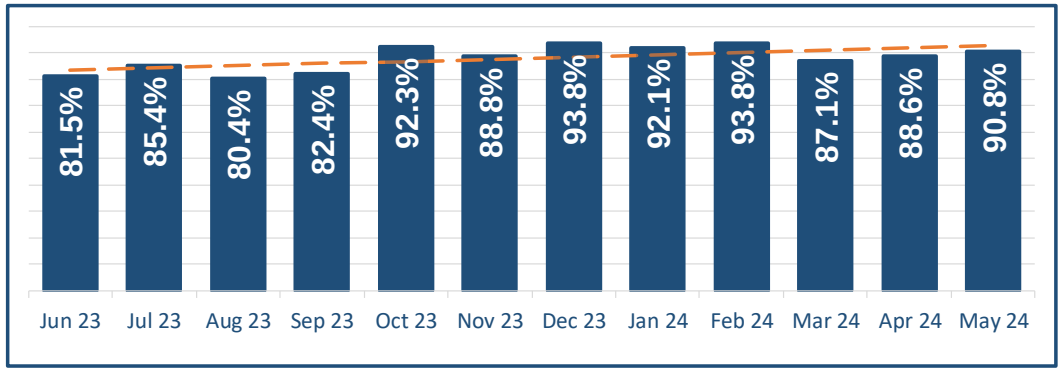


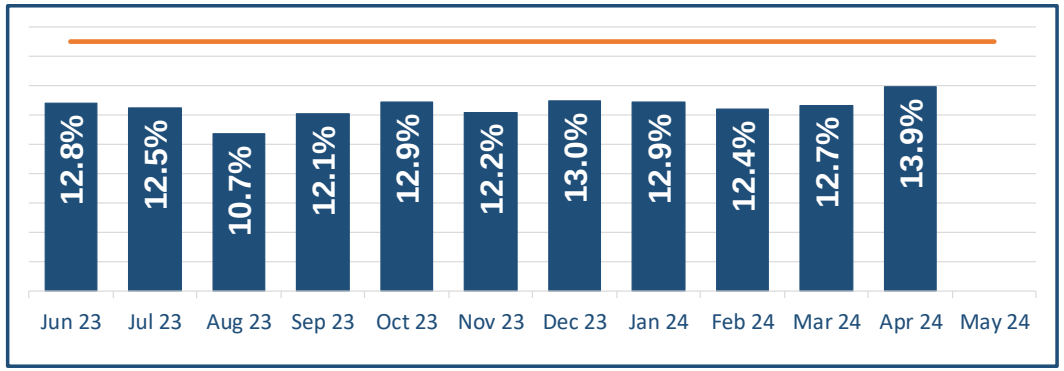


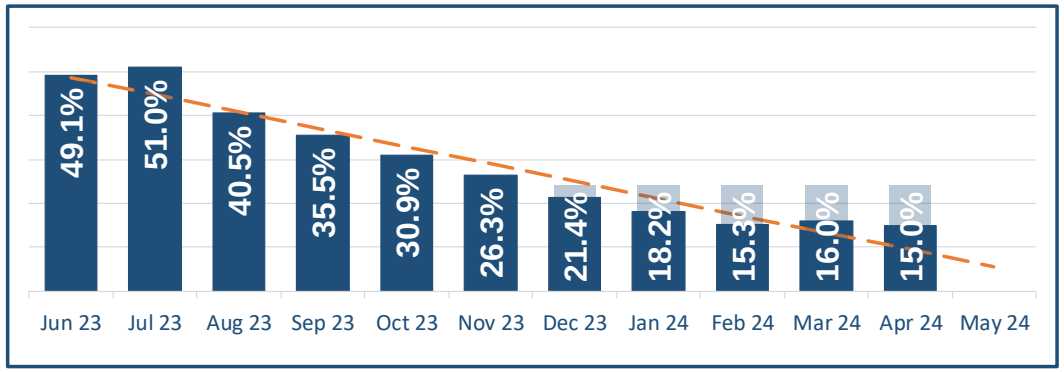
Quality: Performance

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

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	4 qtr imp. trend	TBC	90.8%	2nd of 7 (at Mar 24)
QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	13.9%	5th of 7 (at Apr 24)
QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increas-ing trend (to 95%)	TBC	15.0%	8st of 8 (at Feb 24)







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Quality: Performance

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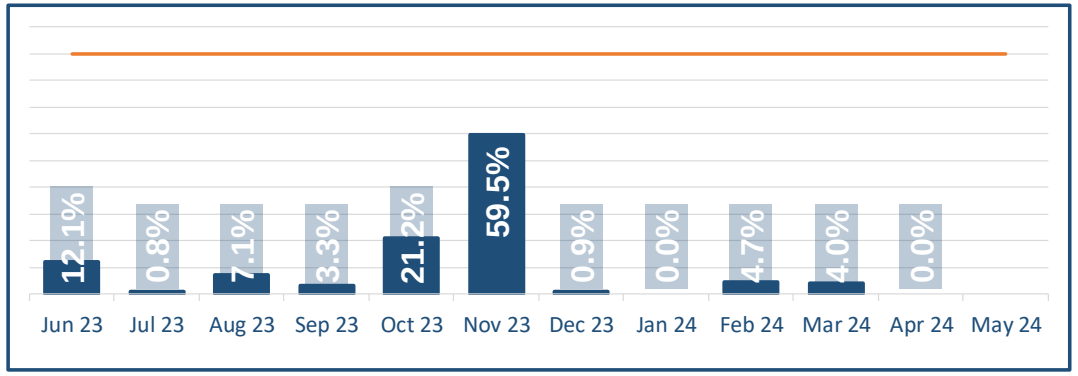
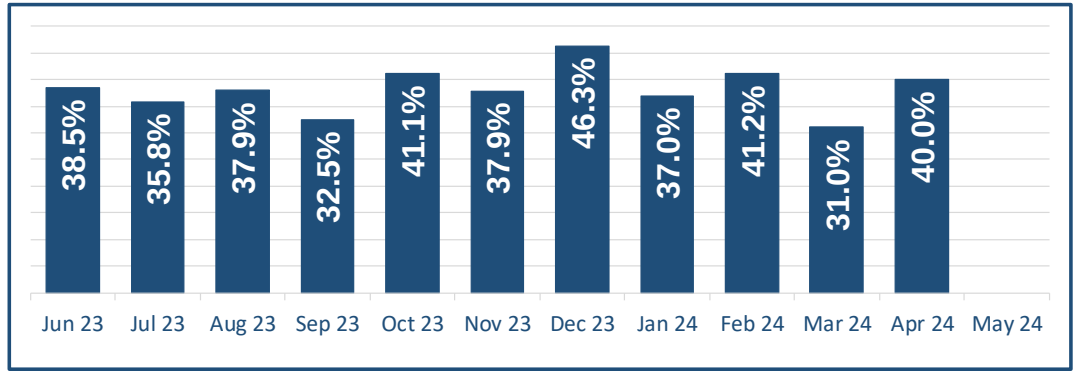
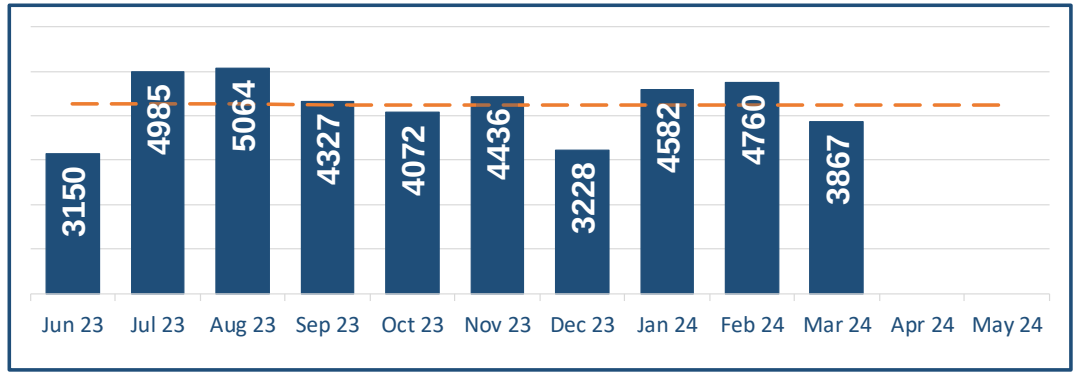
Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	90%	TBC	0.0%	7th of 8 (at Mar 24)
QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Equivalent month reduction (2024/25 to 2023/24)	TBC	40.0%	2nd of 6 (at May 24)
QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increasing trend	TBC	3867	2nd of 10 (at Mar 24)







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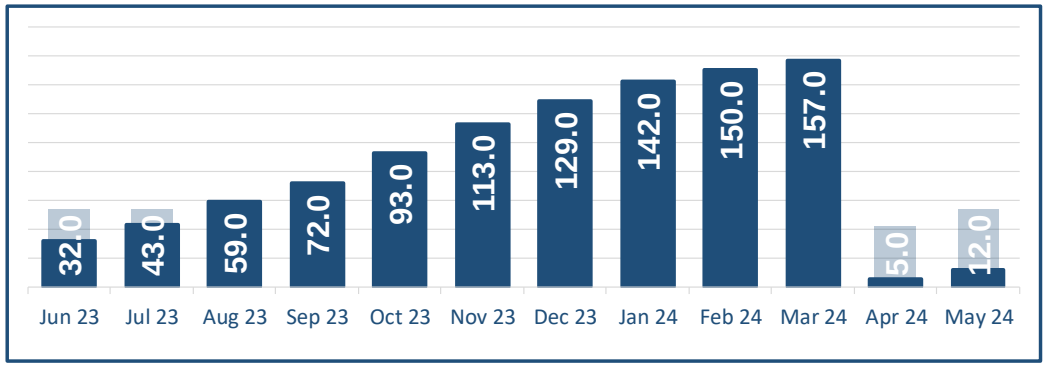
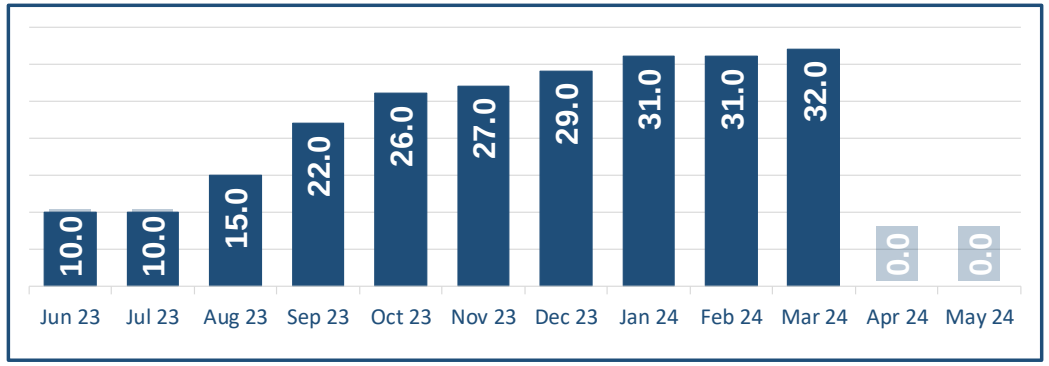
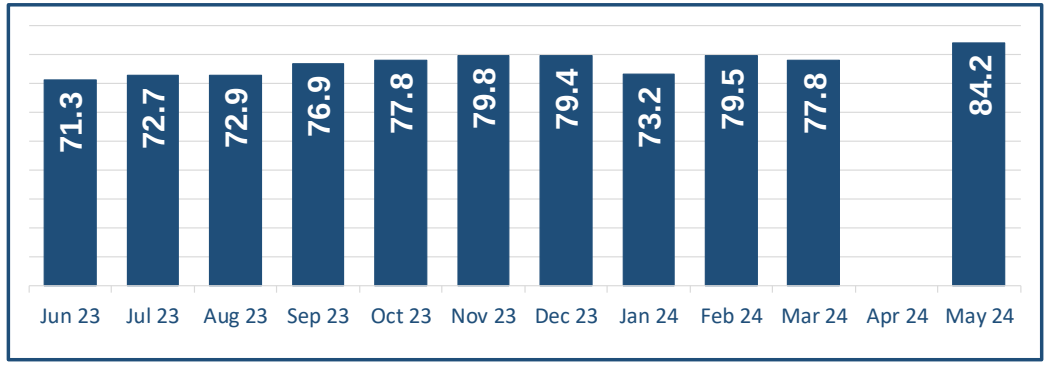
Quality: Performance

CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	Not avail-able	TBC	12	2nd of 6 (at May 24)
CRR: 24-04	QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not avail-able	TBC	0	1st of 6 (at May 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not avail-able	TBC	84.2	5th of 6 (at May 24)

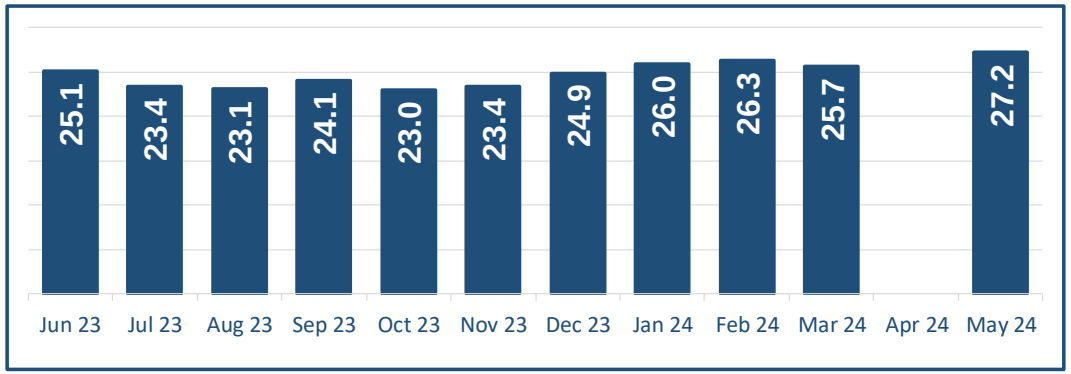


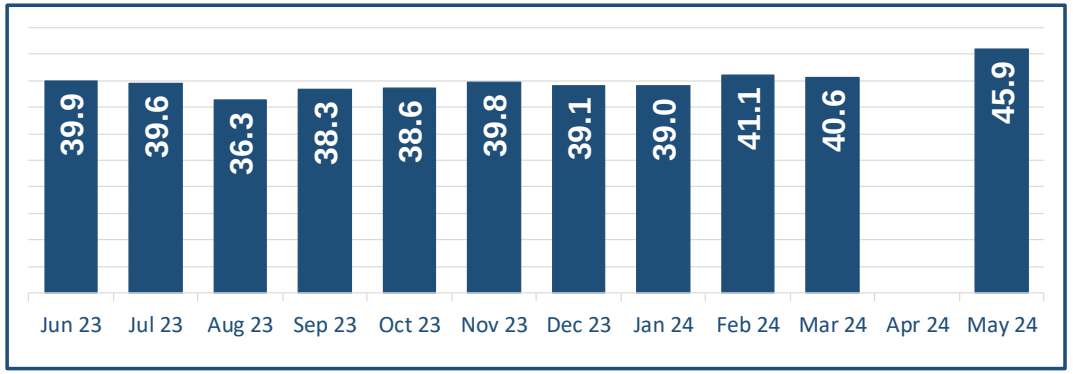


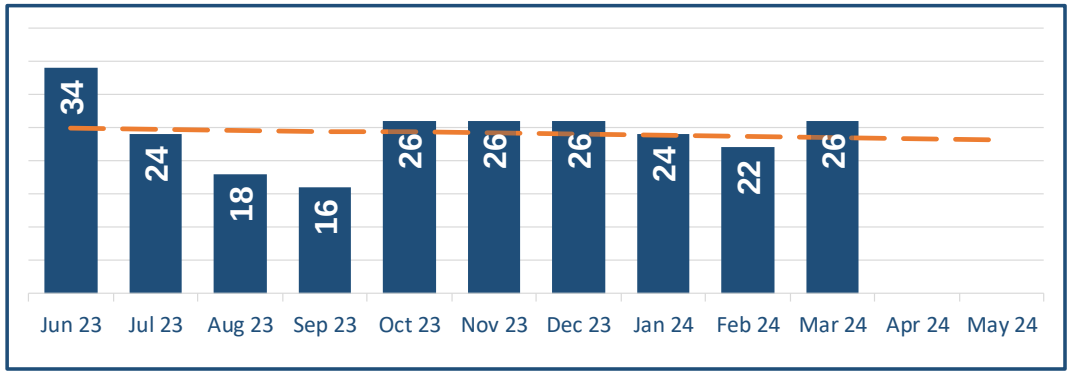


Quality: Performance

CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Not avail-able	TBC	27.2	2nd of 6 (at May 24)
CRR: 24-04	QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not avail-able	TBC	45.9	3rd of 6 (at May 24)
CRR: 24-04	QSE	Number of National reportable incidents that remain open 90 days or more	Decreas-ing trend	TBC	26	5th of 10 (at May 24)







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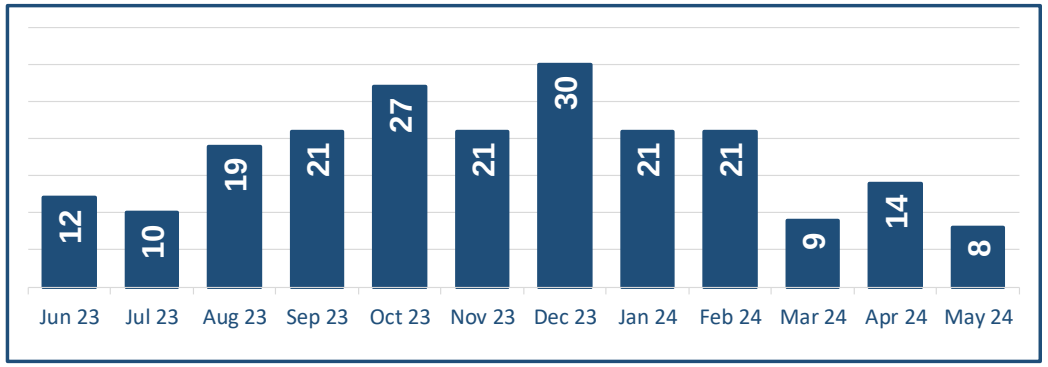
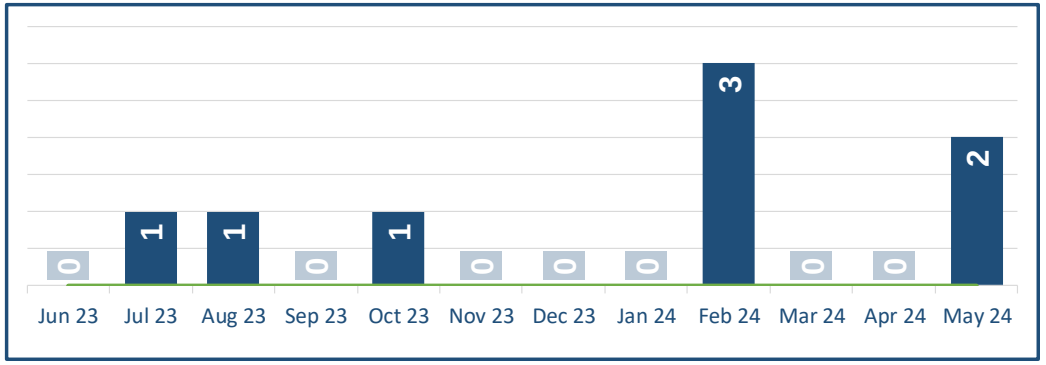
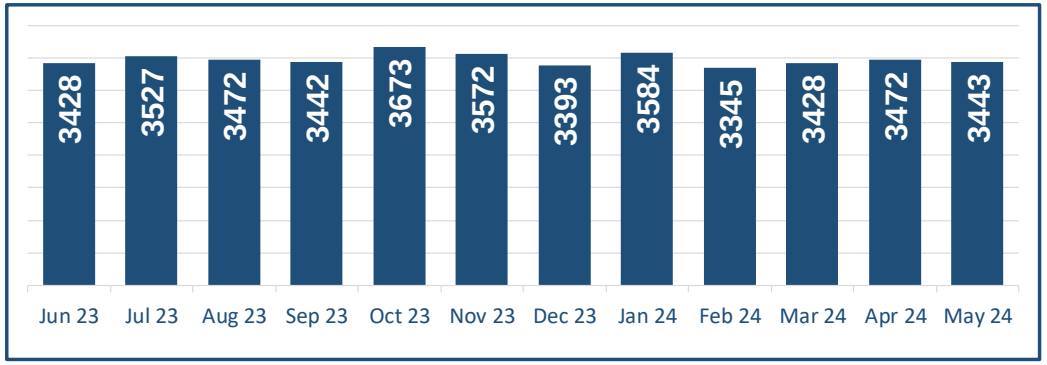
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of new National reportable incidents (NRIs)	N/A	TBC	8	
QSE	Number of new never events	0	TBC	2	
QSE	Number of new patient safety incidents	N/A	TBC	3443	







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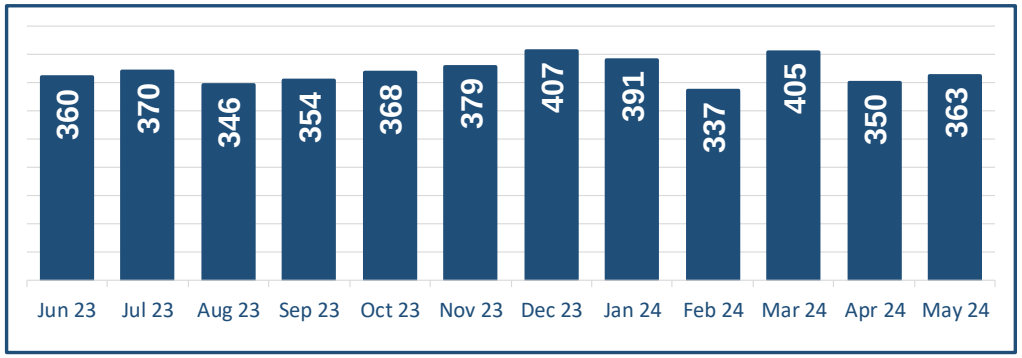
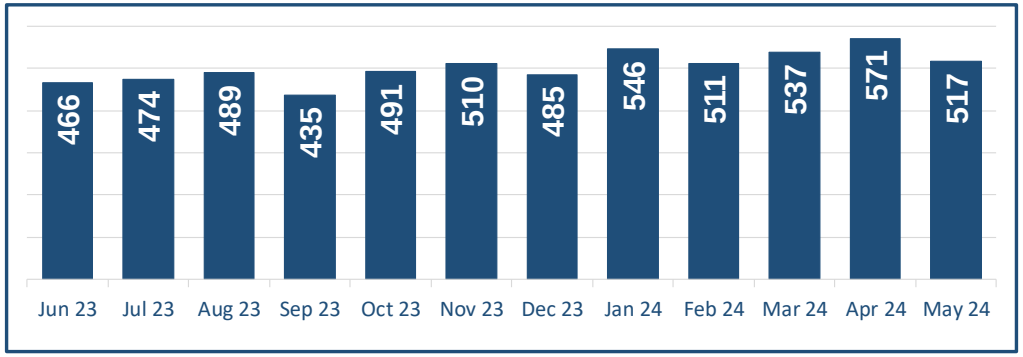
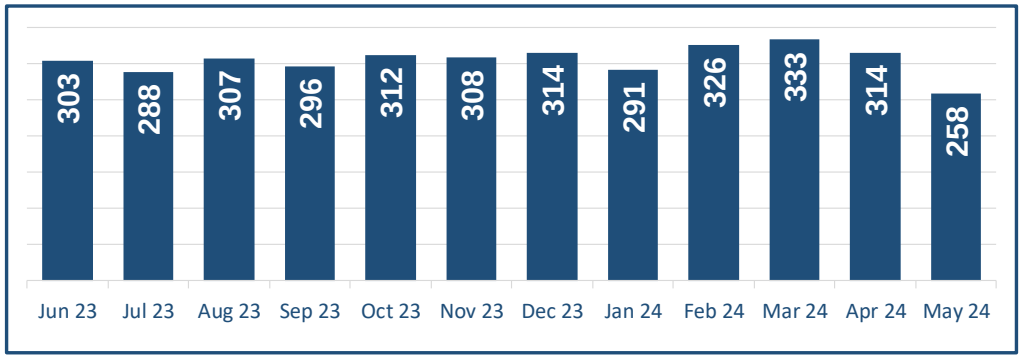
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of new reported falls	N/A	TBC	363	
QSE	Number of new reported hospital acquired pressure ulcers (HAPU) (excluding new to caseload)	N/A	TBC	517	
QSE	Number of new reported medication incidents	N/A	TBC	258	

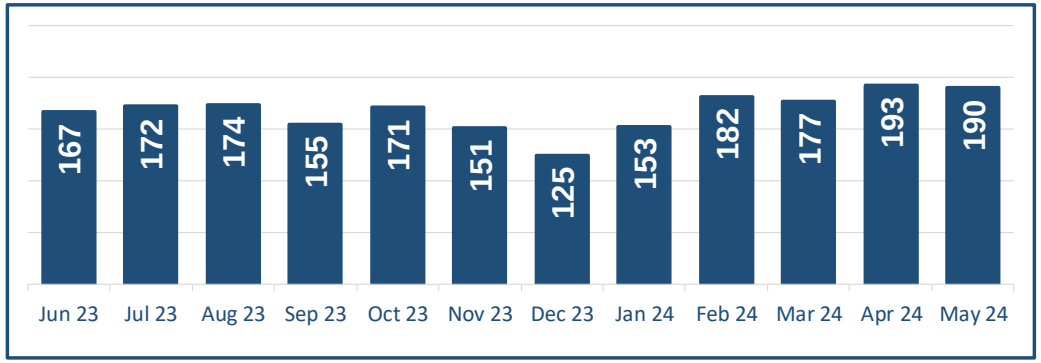


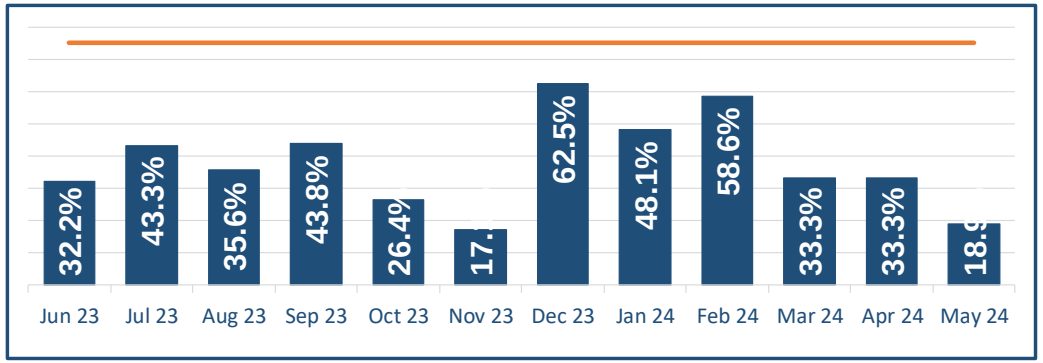


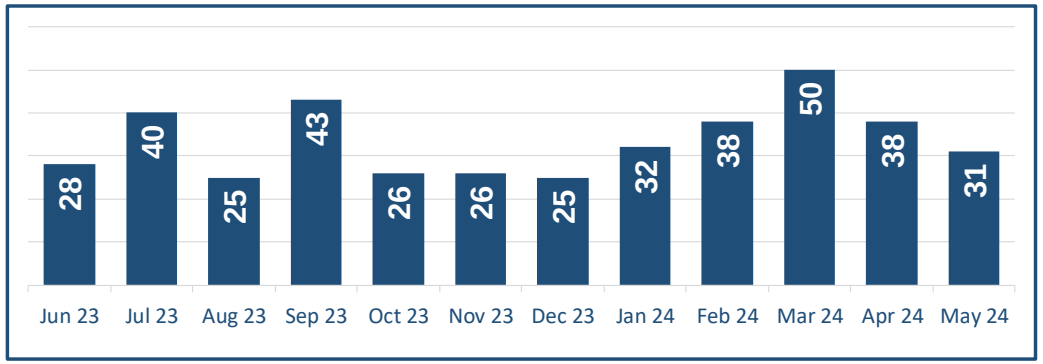


Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of new 'Putting Things Right' (PTR) complaints	N/A	TBC	190	
QSE	Of the complaints closed, the percentage that were closed within 30 days	75.0%	TBC	18.9%	
QSE	Number of new early resolutions	N/A	TBC	31	







Quality: Performance

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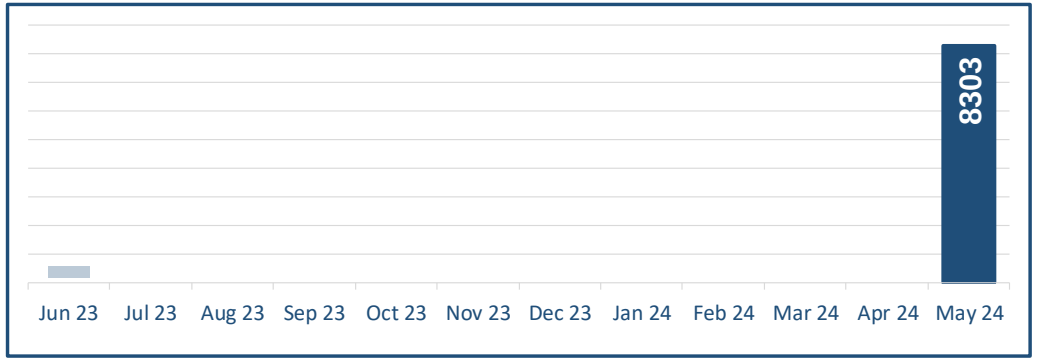
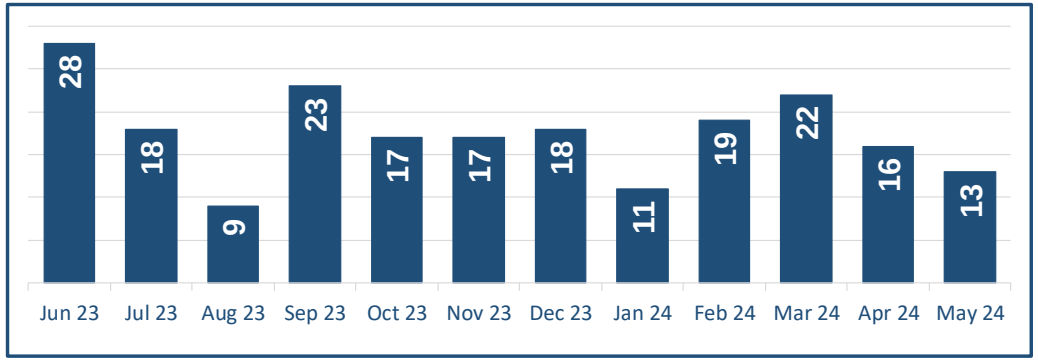
Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of new PALS (Patient Advice and Liason Service) contacts	N/A	TBC	8303	
QSE	Number of new Ombudsman contacts	N/A	TBC	13	
QSE	Percentage of survey responses rating care as good or very good	N/A	TBC	93.5%	





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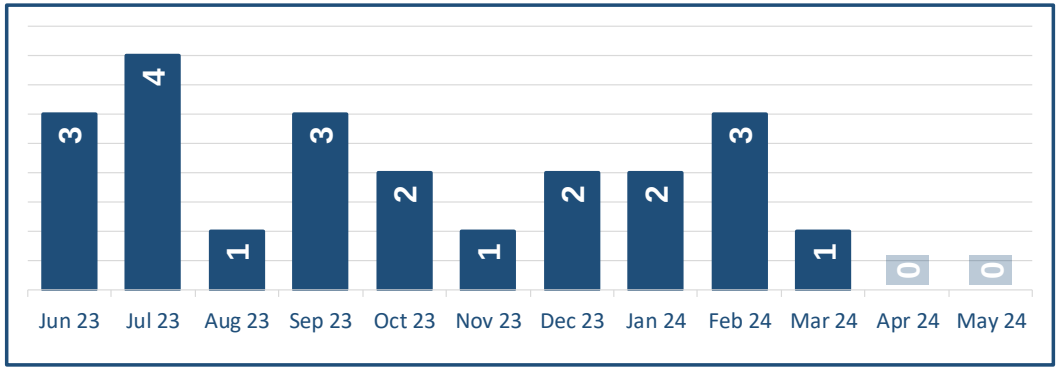
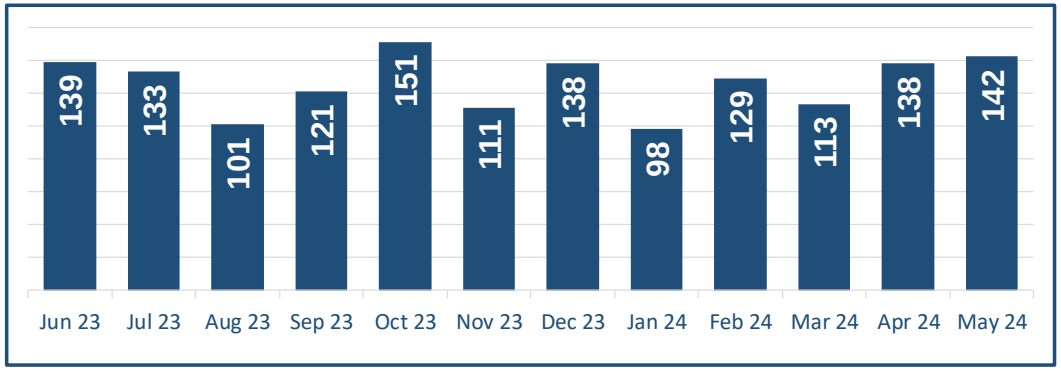
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of regulation 28 notices	N/A	TBC	0	
QSE	Number of overdue 'Learning from Event Reports' (LFERs)	N/A	TBC	32	
QSE	Number of Great-ix submissions	N/A	TBC	142	

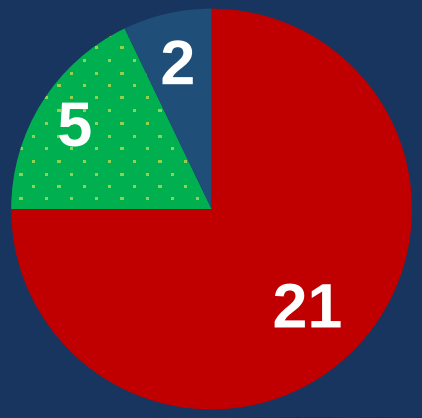




Section 2

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

Access and Activity Performance



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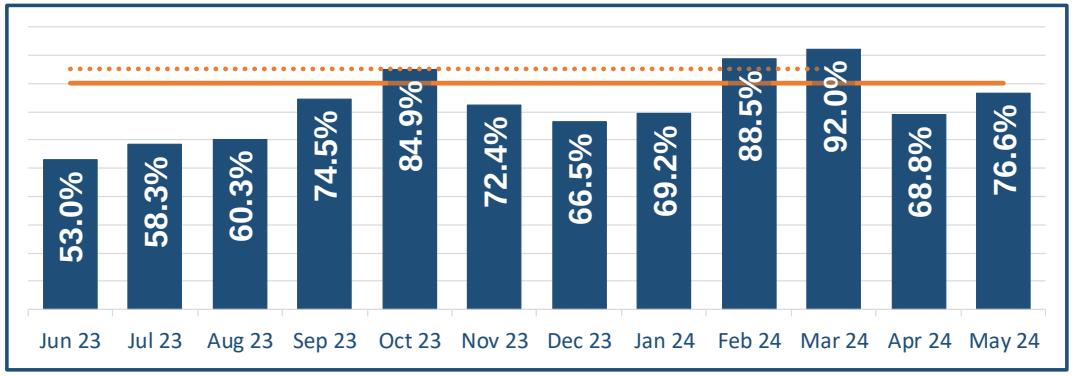
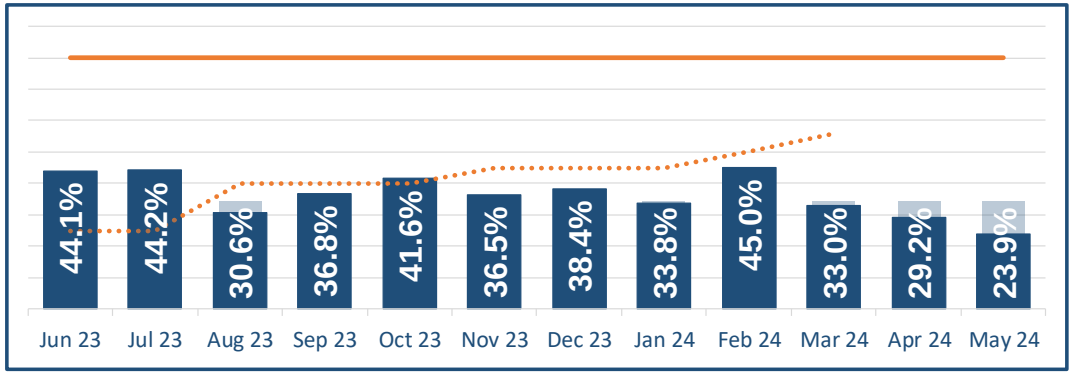
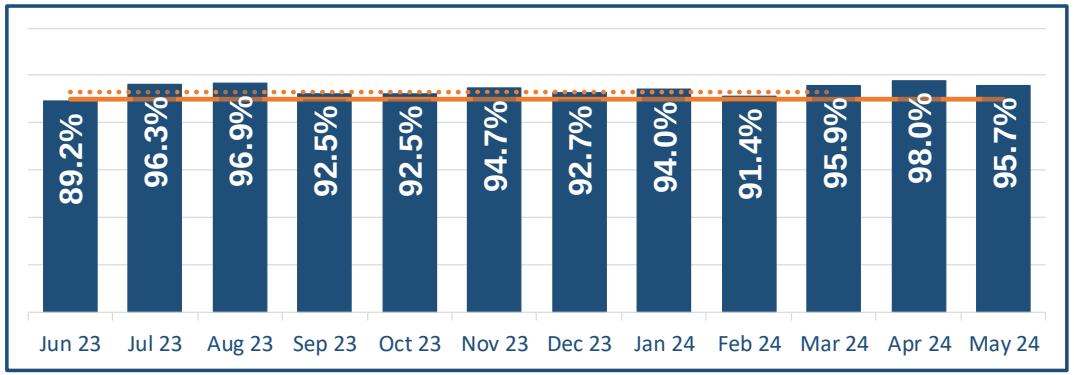
Our Access & Activity: Performance

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

CRR Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
SM: DM16	PFIG	Percentage of Local Primary mental health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged under 18 years)	80.0%	TBC	76.6%	6th of 7 (at Apr 24)
SM: DM15	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged under 18 years)	80.0%	TBC	23.9%	5th of 7 (at Apr 24)
SM: DM16	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years)	90%	TBC	95.7%	1st of 7 (at Apr 24)







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Our Access & Activity: Performance

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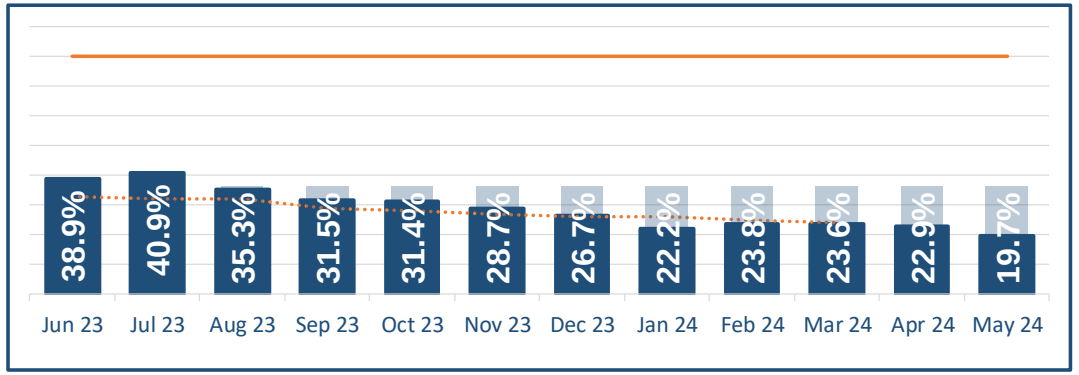
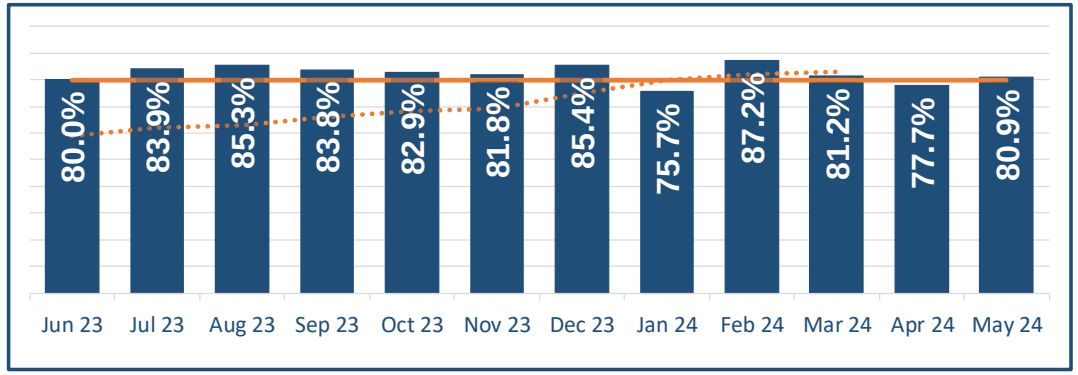
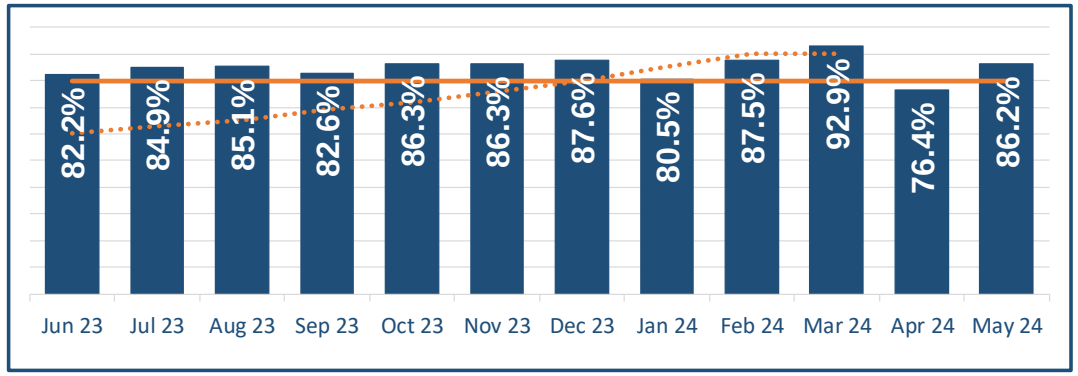
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 *SM	PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	TBC	19.7%	5th of 7 (at Apr 24)
SM: DM1 1	PFIG	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days of the date of receipt of referral (for those aged 18 years and over)	80%	TBC	80.9%	4th of 7 (at Apr 24)
SM: DM1 2	PFIG	Percentage of theraputic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those aged 18 years and over)	80%	TBC	86.2%	6th of 7 (at Apr 24)







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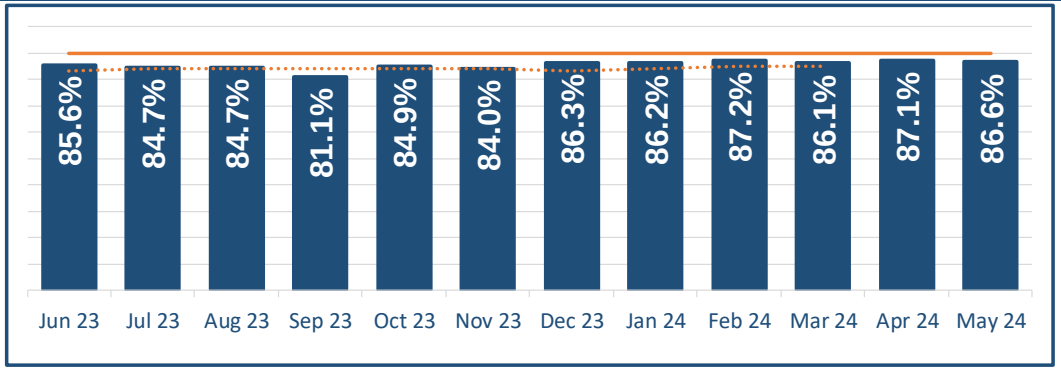
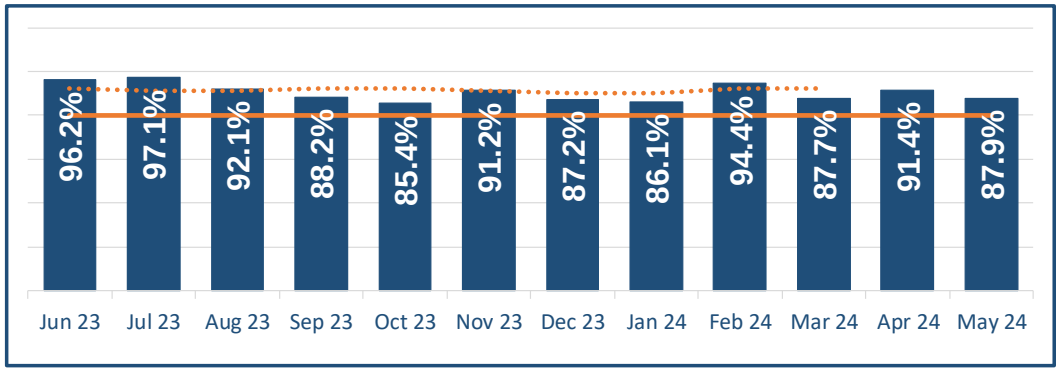
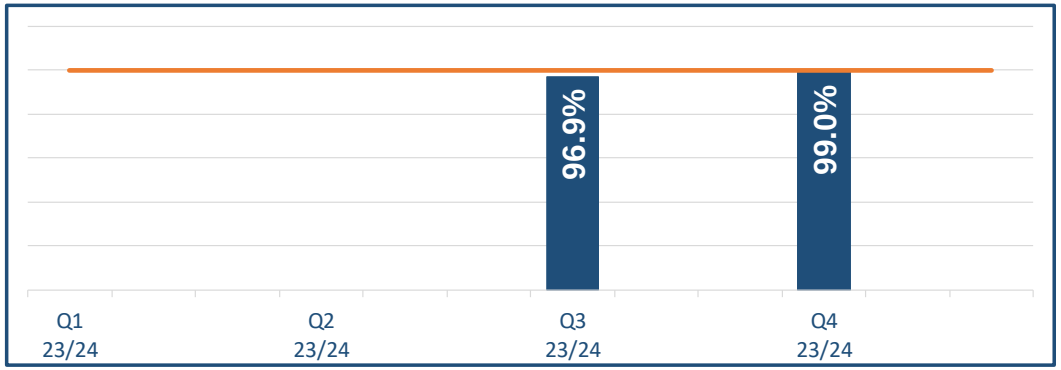
Our Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
SM: DM13	QSE	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age 18 years and over)	90%	TBC	86.6%	3rd of 7 (at Apr 24)
-	PFIG	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health BCU Level	80%	TBC	87.9%	1st of 7 (at Apr 24)
-	PFIG	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	TBC	98.96%	6th of 7 (at Mar 23)

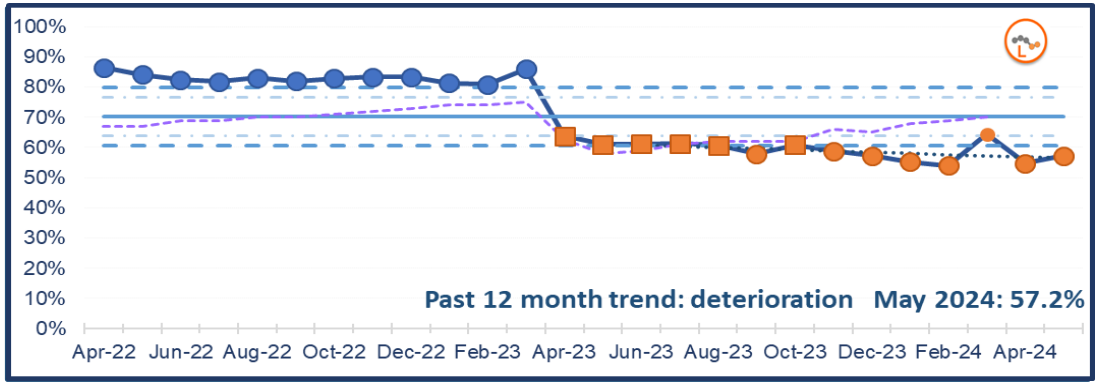


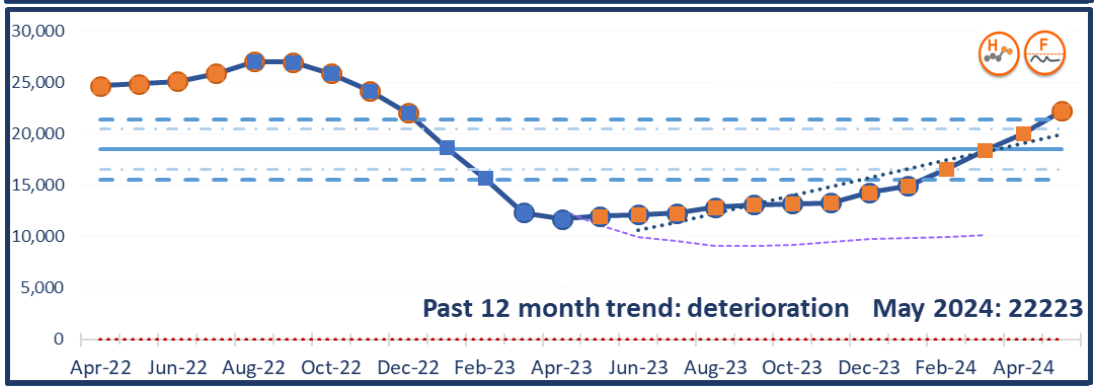


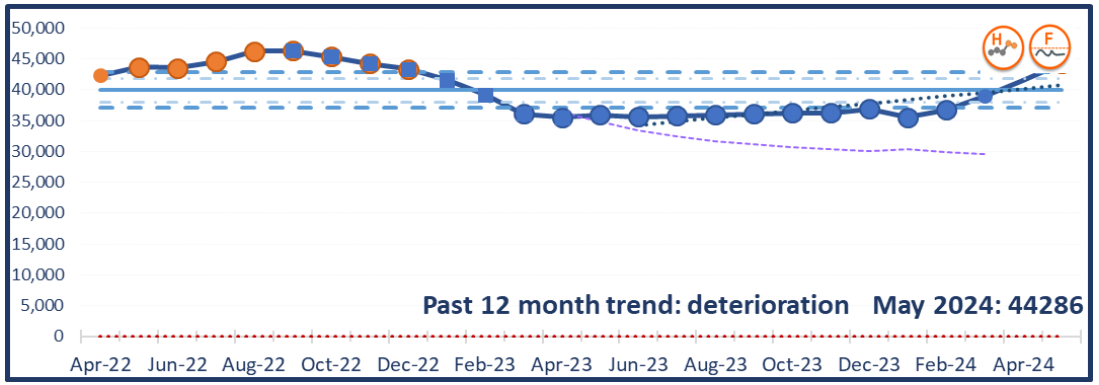


Our Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM01	PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increasing trend (to 80%)	TBC	57.2%	4th of 6 (at Apr 24)
CRR: 24-11	PFIG	Number of patients waiting over 52 weeks for a new outpatient appointment	0	TBC	22223	7th of 7 (at Apr 24)
CRR: 24-11 SM: DM02	PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreasing trend (to 0 by Jun 25)	TBC	44286	7th of 7 (at Apr 24)

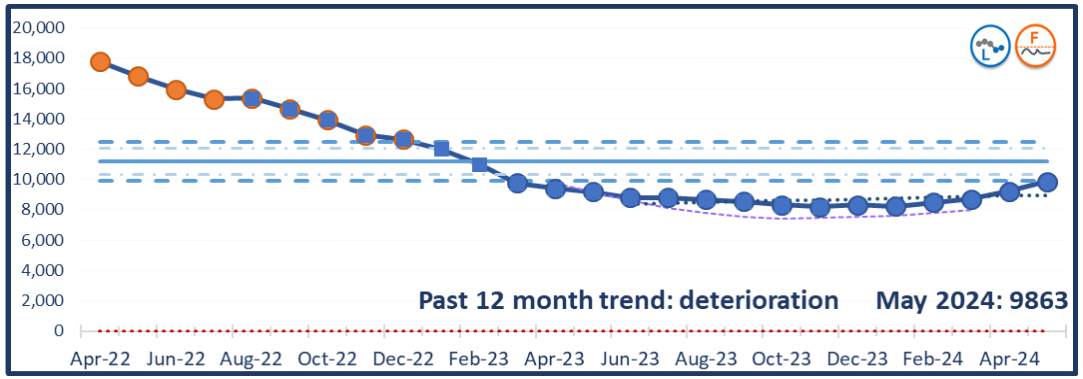


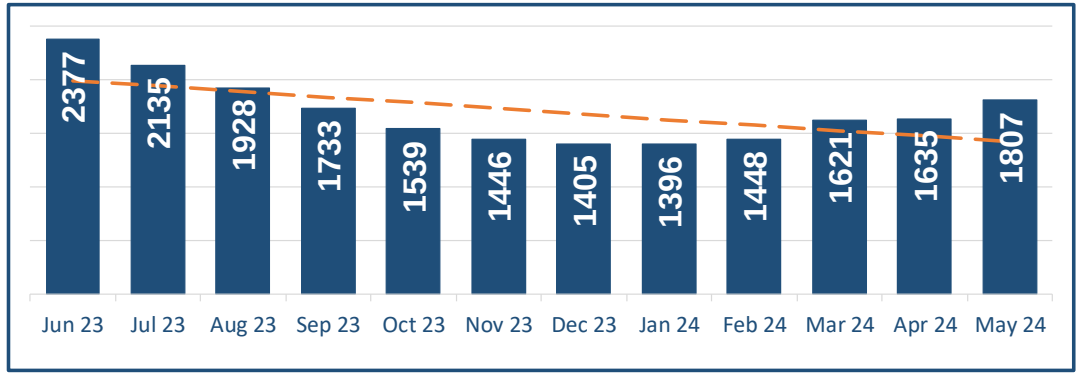


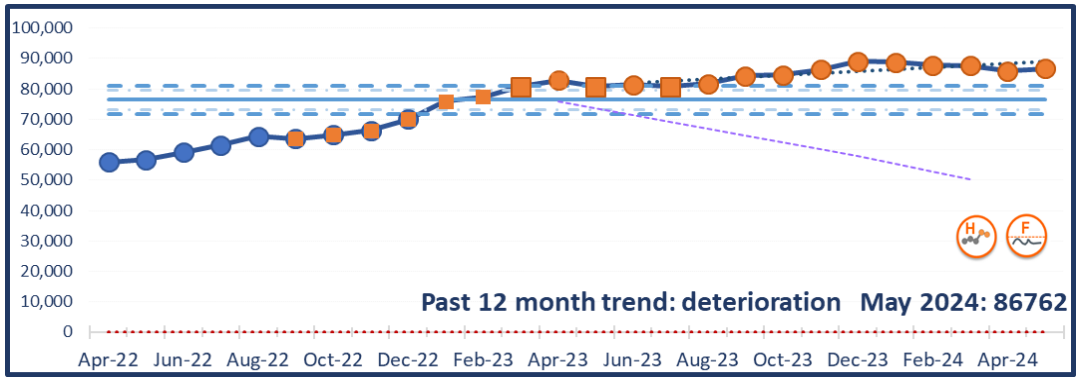


Our Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM03	PFIG	Number of patients waiting more than 104 weeks for referral to treatment	0	TBC	9863	7th of 7 (at Apr 24)
CRR: 24-11 *SM	PFIG	Over 156 weeks all stages	N/A	TBC	1807	N/A
CRR: 24-11	PFIG	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	Decreas-ing trend (to 0)	TBC	86762	7th of 7 (at Apr 24)







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Our Access & Activity: Performance

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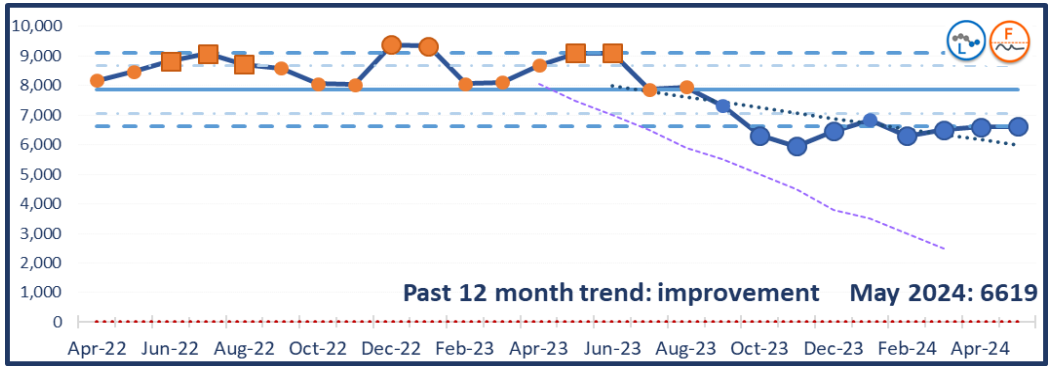
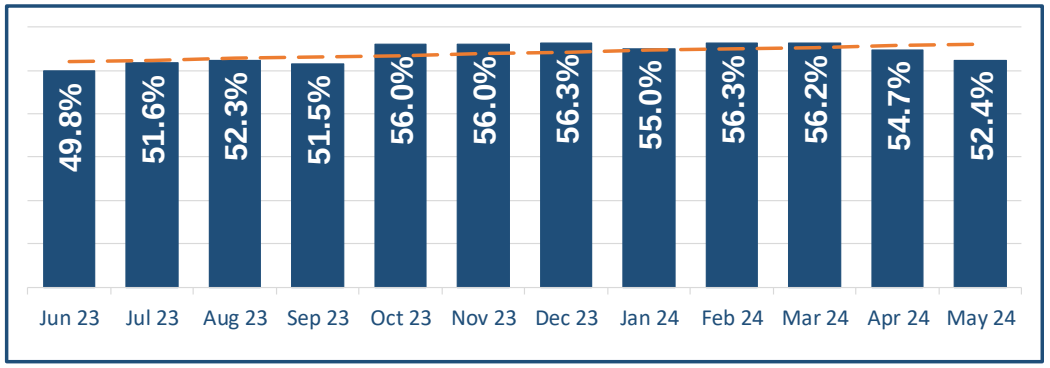
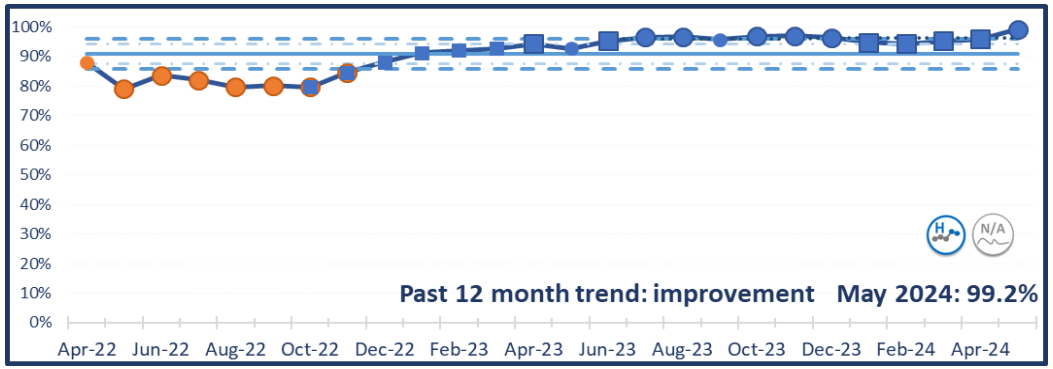
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-13 SM: DM04	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	0	TBC	6619	6th of 7 (at Apr 24)
CRR: 24-11 24-12	PFIG	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Increas-ing trend (to 95%)	TBC	52.4%	6th of 7 (at Apr 24)
CRR: 24-11	PFIG	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional (Includes: Art therapy; podiatry; dietetics; occupational therapy, physiotherapy and; speech and language therapy)	100.0%	TBC	99.2%	4th of 7 (at Apr 24)







Our Access & Activity: Performance

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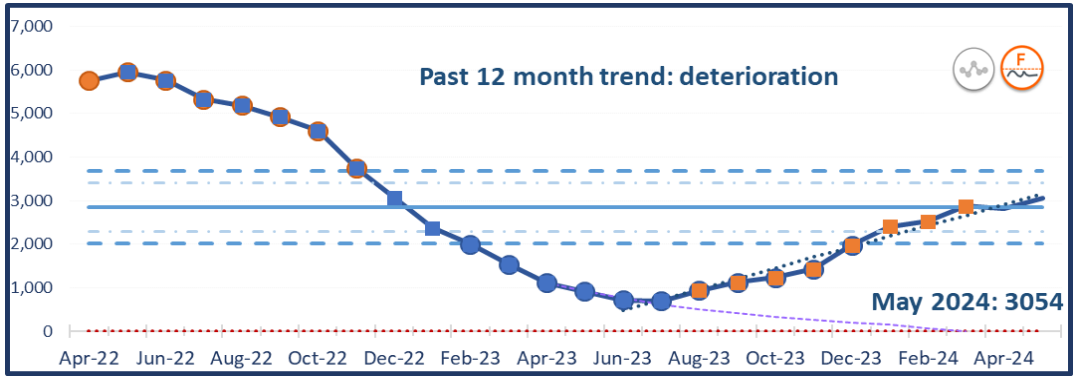
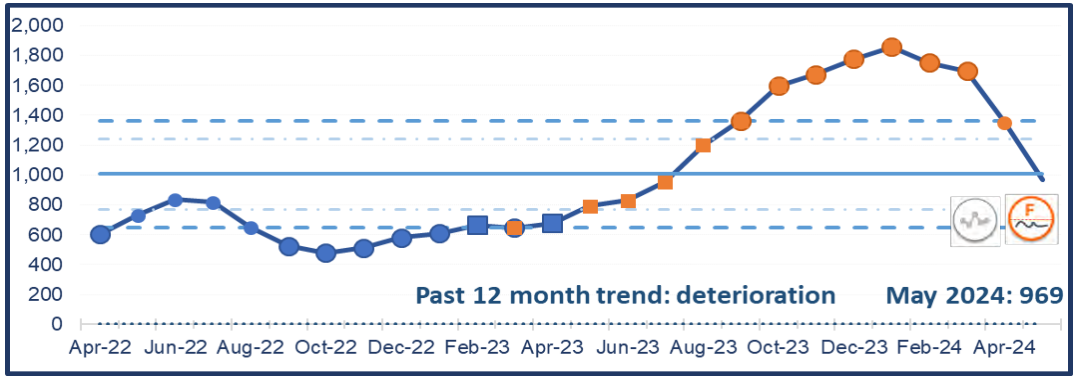
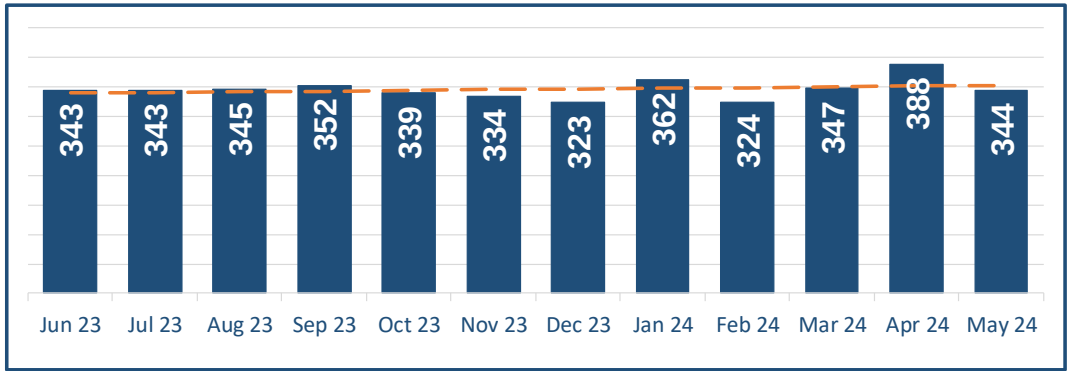
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-11 SM: DM05	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (excluding audiology)	0	TBC	3054	7th of 7 (at Apr 24)
-	PFIG	Number of patients (all ages) waiting more than 14 weeks for audiology	0	TBC	969	
-	PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	344	8st of 8 (at May 24)







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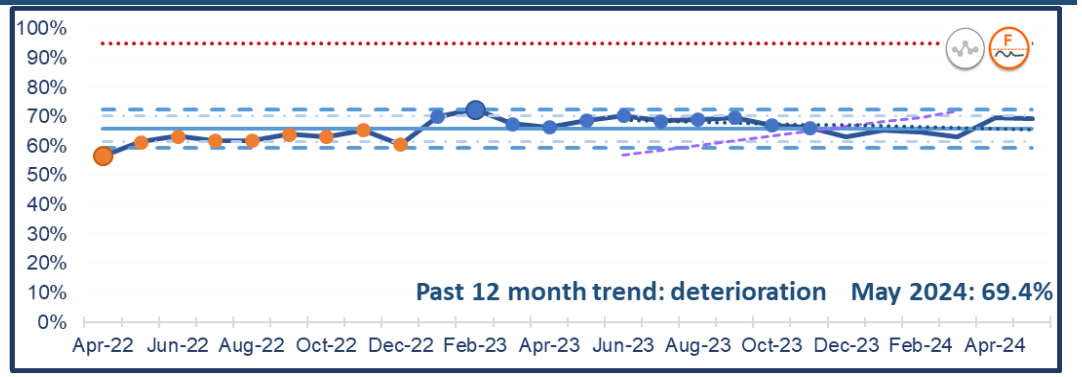
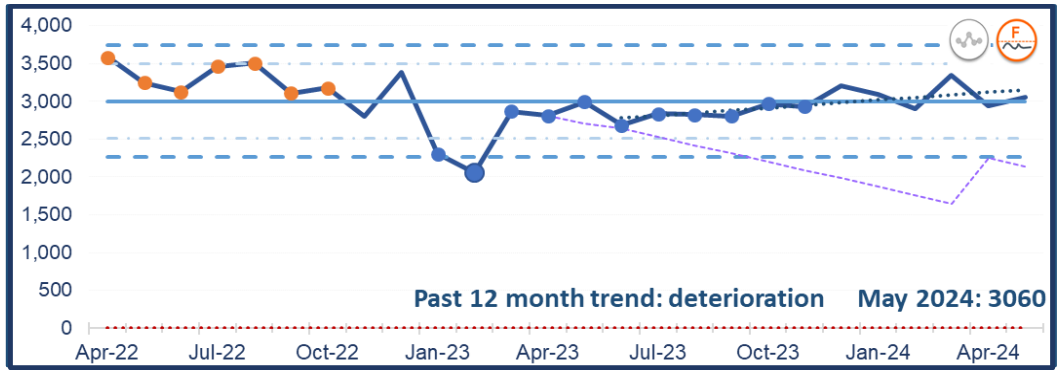
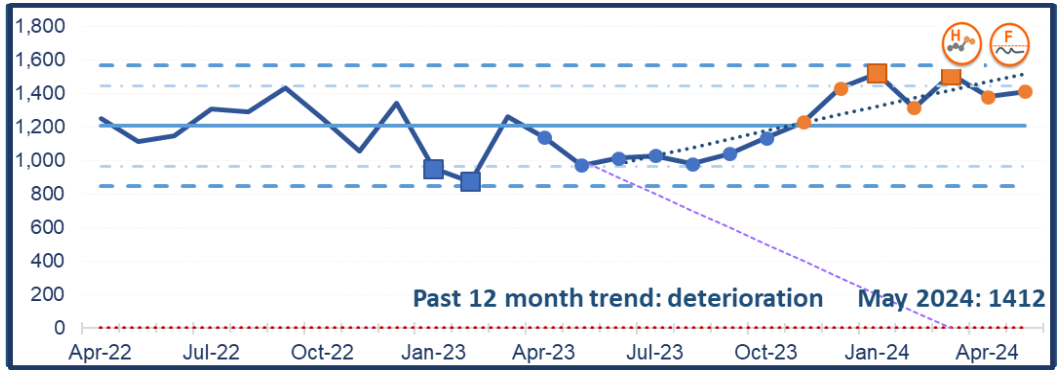
Our Access & Activity: Performance

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

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	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	**Equivalent month increase (2024/25 to 2023/24) to 95%**	TBC	**69.4%**	4th of 7 (at Apr 24)
CRR: 24-10 SM: DM08	PFIG	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	**Equivalent month reduction (2024/25 to 2023/24) to 0**	2139	**3060**	7th of 7 (at Apr 24)
-	N/A	Number of patients who spend 24 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	**N/A**	TBC	**1412**	







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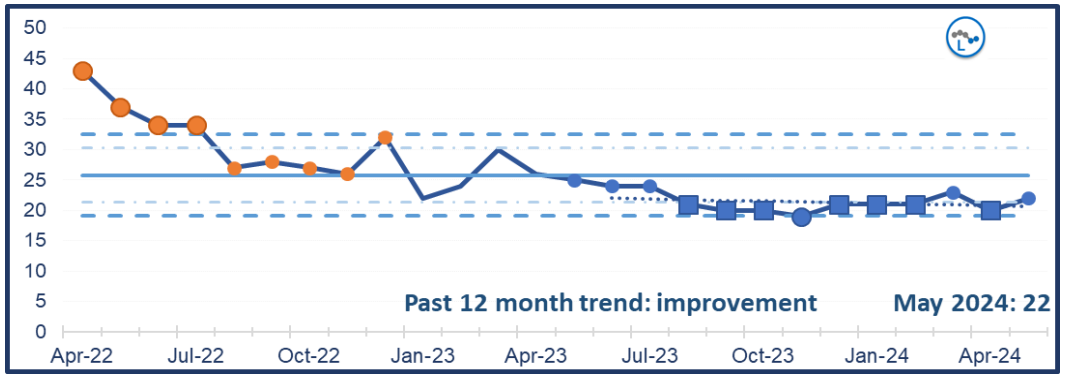
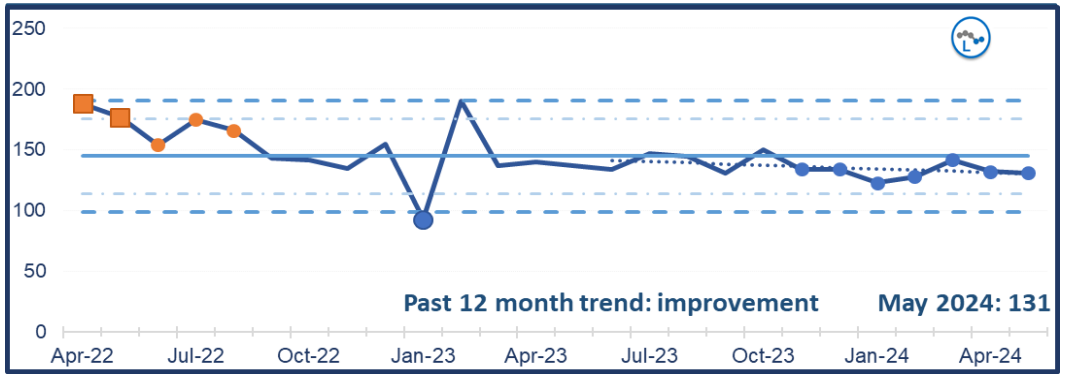
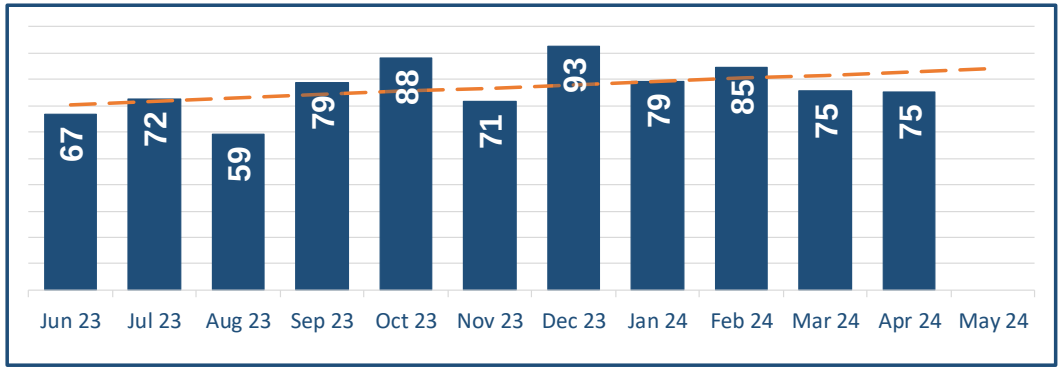
Our Access & Activity: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Median time from arrival at an emergency department to triage by a clinician	15 minutes or less	TBC	22.0	3rd of 6 (at Apr 24)
CRR: 24-10 SM: DM07	PFIG	Median time from arrival at an emergency department to assessment by a clinical decision maker	60 minutes or less	TBC	131.0	5th of 6 (at Apr 24)
CRR: 24-10	PFIG	Median emergency response time to amber calls	Decreas-ing trend	TBC	75.0	5th of 7 (at May 24)







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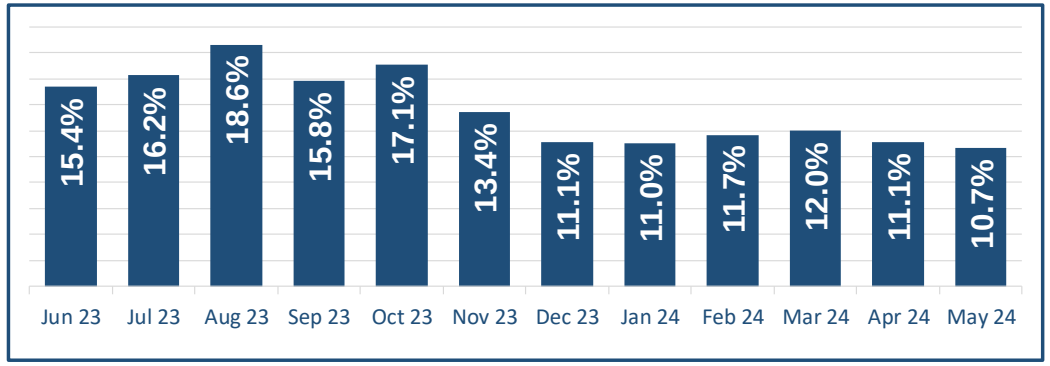
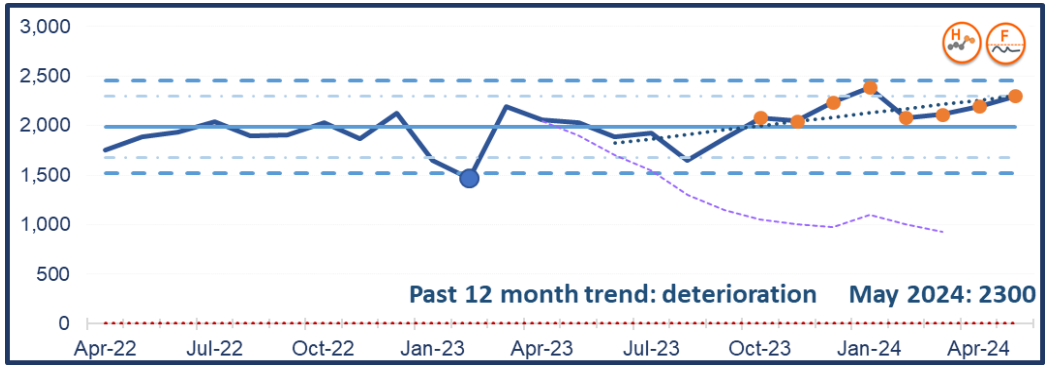
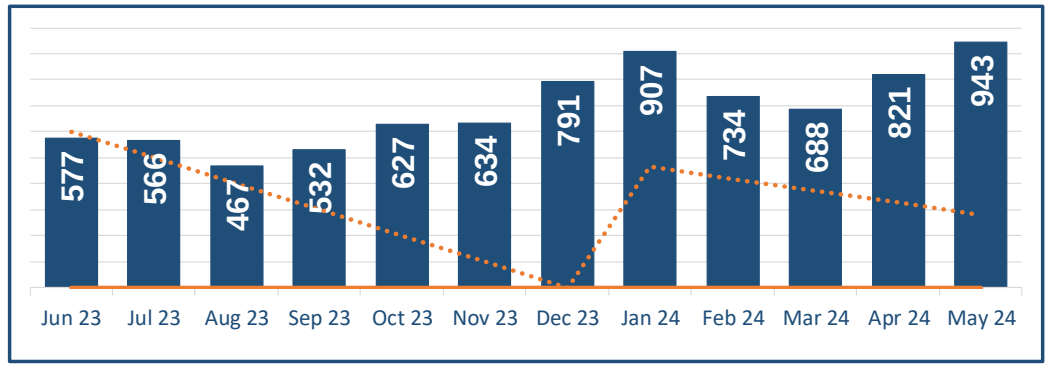
Our Access & Activity: Performance

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

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Percentage of ambulance handovers within 15 minutes	Equivalent month increase (2024/25 to 2023/24) to 100%	TBC	10.7%	
CRR: 24-10 SM: DM06	PFIG	Number of ambulance patient handovers over 1 hour	0	TBC	2300	6th of 6 (at May 24)
CRR: 24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	280	943	

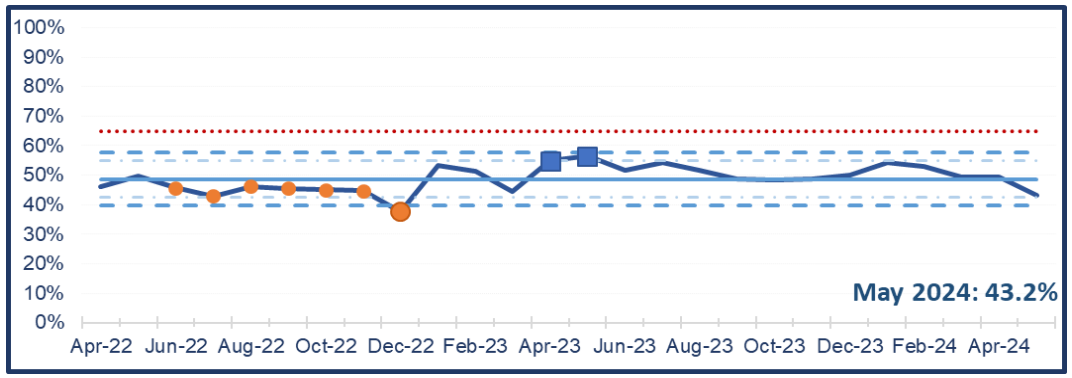






Our Access & Activity: Performance

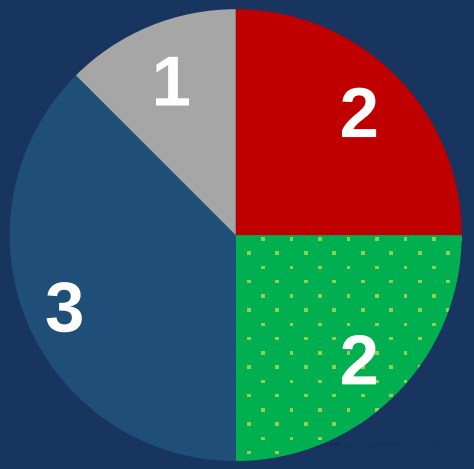
Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
CRR: 24-10	PFIG	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65.0%	TBC	43.2%	5th of 7 (at May 24)



Section 3

People and Organisational Development Performance

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

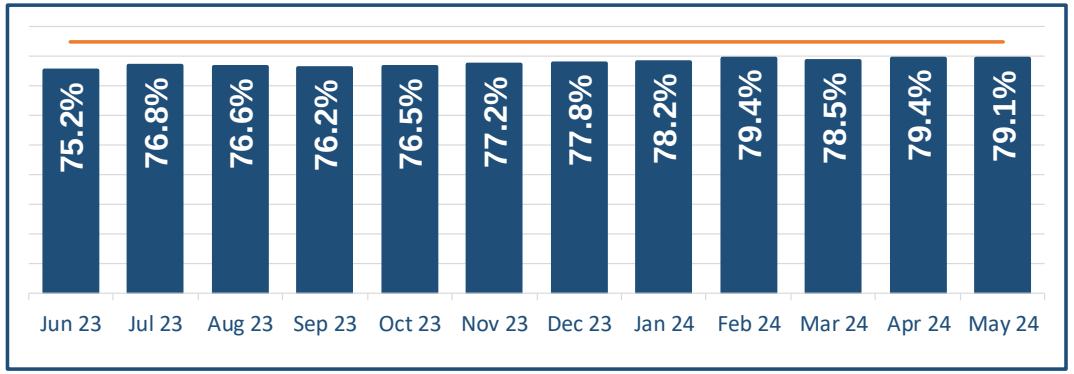


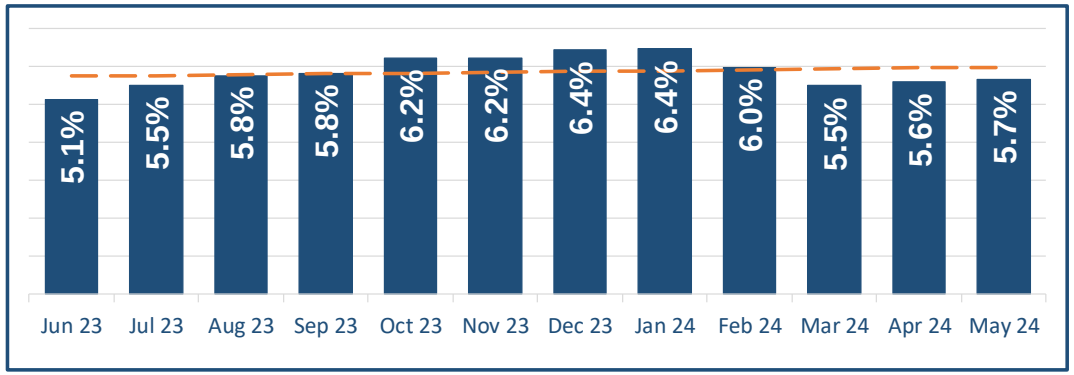
Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

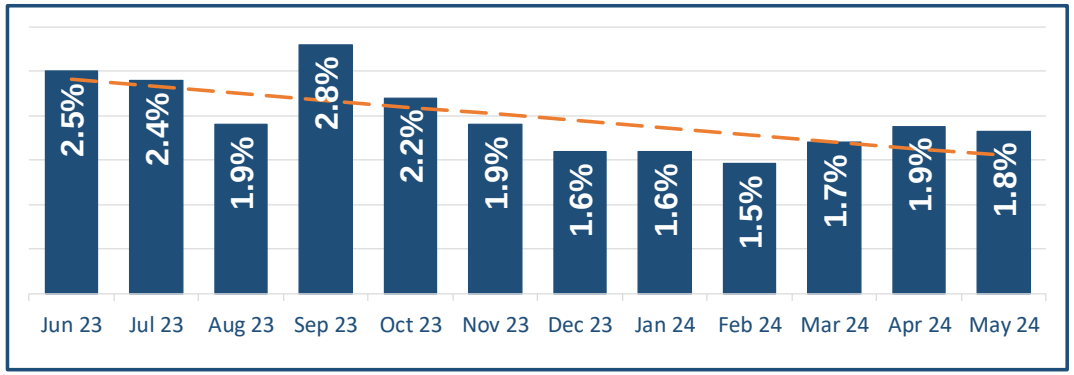
Our People: Performance

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

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12months(excluding doctors and dentists in training)	85%	TBC	79.1%	1st of 13 (at Mar 24)
-	PFIG	Percentage of sickness absence rate of staff	Decreas-ing trend	TBC	5.7%	7th of 13 (at Mar 24)
-	PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Decreas-ing trend against 2019/20	TBC	1.8%	2nd of 11 (at Feb 24)







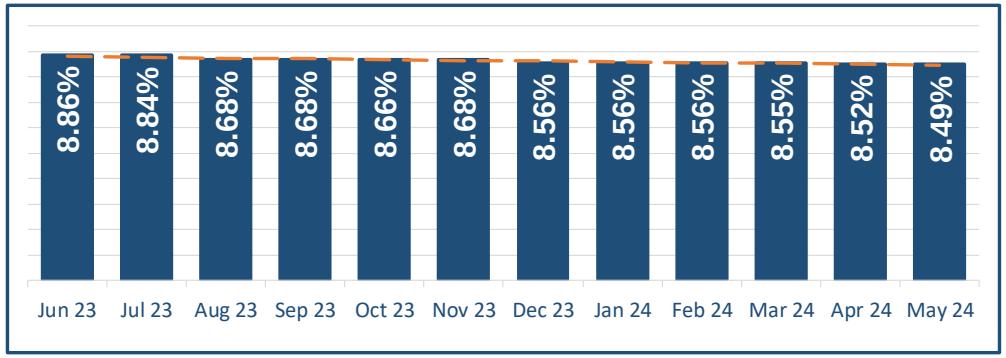
Produced on behalf of the **Health Board** by the **Performance Directorate in** partnership with our **Health Board Directors**

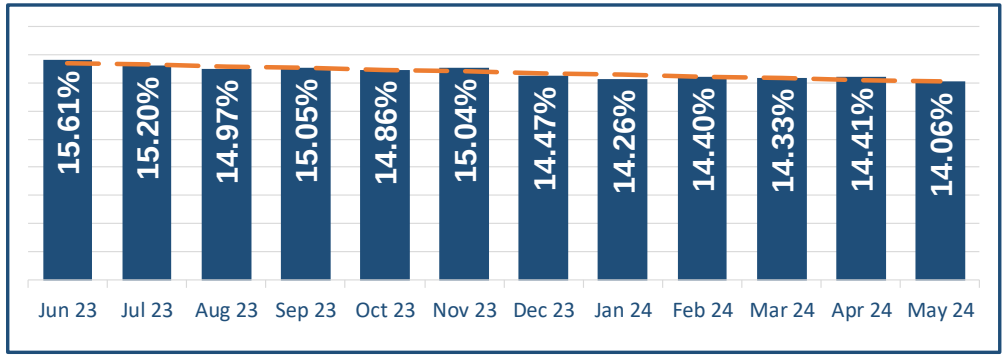
* Wales Ranking may differ as may refer to previous month

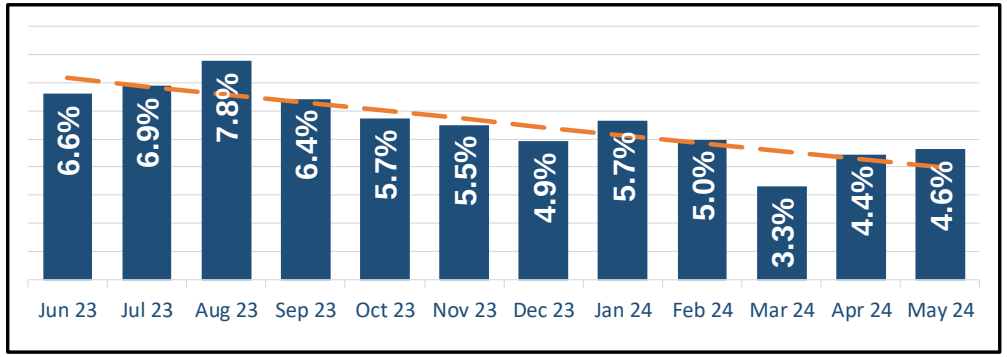
Our People: Performance

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

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
-	PFIG	12 month rolling turnover rate (External)	N/A	TBC	8.49%	N/A
-	PFIG	Staff turnover rate for those who had less than 1 year service	N/A	TBC	14.06%	
CRR: 24-05	PFIG	Agency spend as a percentage of total pay bill	Decreas-ing trend	TBC	4.6%	9th of 12 (at Mar 24)

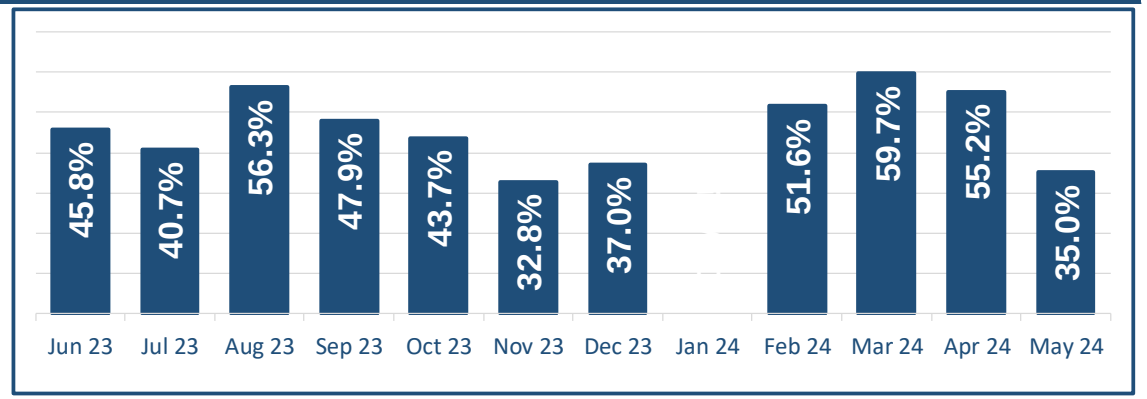


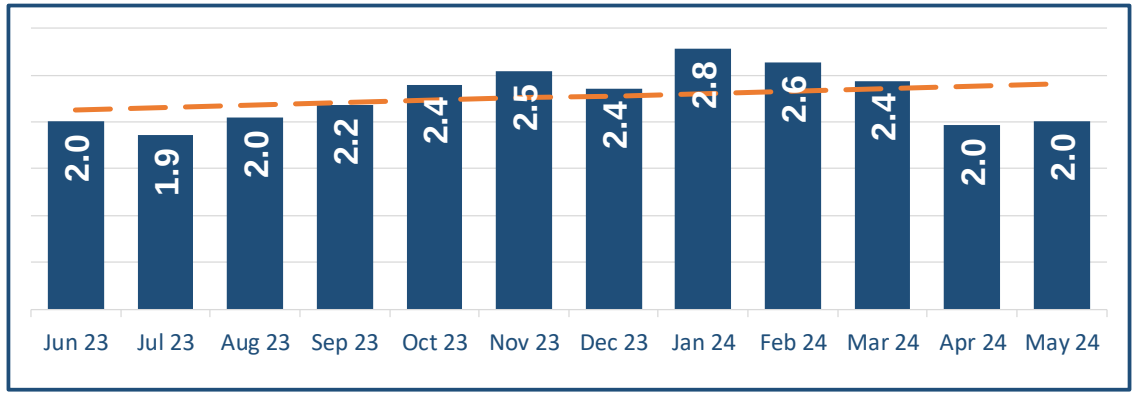




Our People: Performance

Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
-	PFIG	Roster compliance	N/A	TBC	35.0%	
-	PFIG	Open disciplinary cases per 1000 staff	N/A	TBC	2.0	

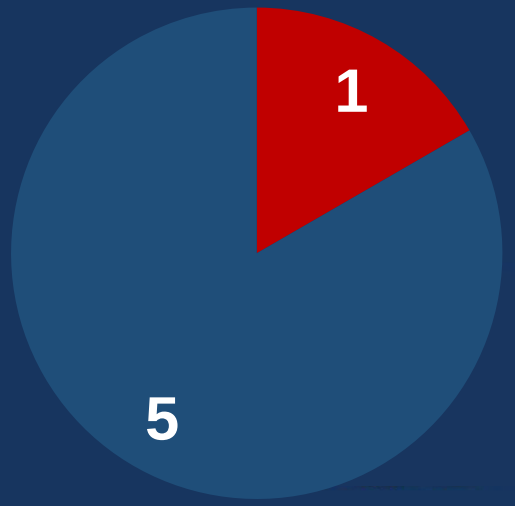




* Wales Ranking may differ as may refer to previous month

Section 4

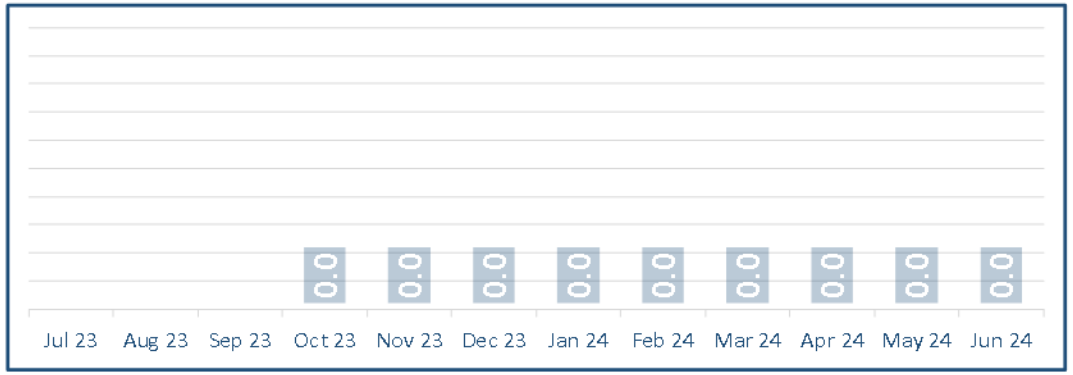
Financial Performance

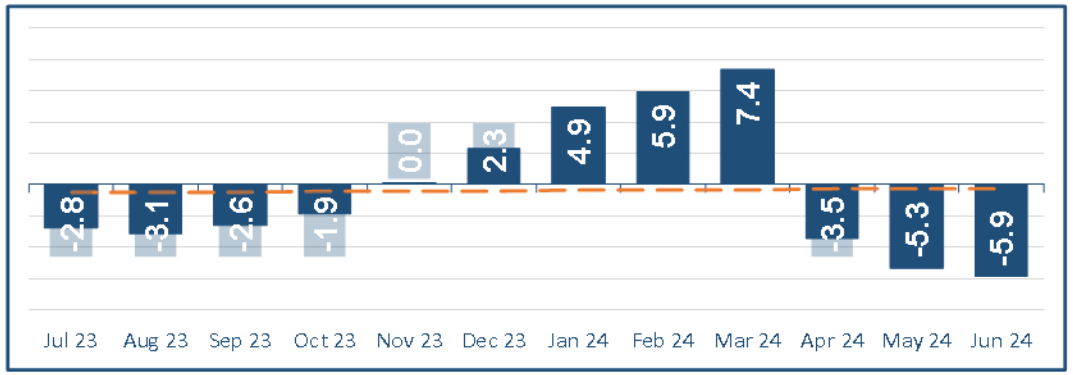


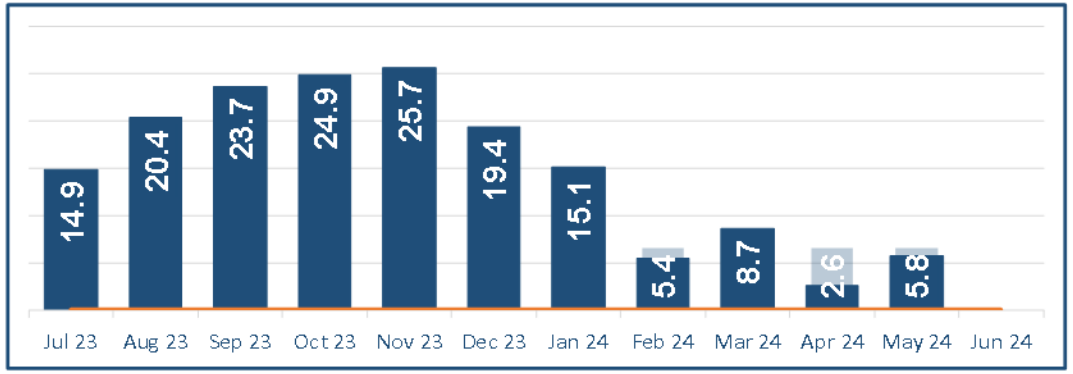
Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

Finance: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	Forecast outturn (£million)	N/A	TBC	0.0	
CRR: 24-05	PFIG	Year to date savings delivery against target (£million)	N/A	TBC	-5.9	
CRR: 24-05	PFIG	Year to date deficit against plan (£million)	N/A	TBC	5.8	

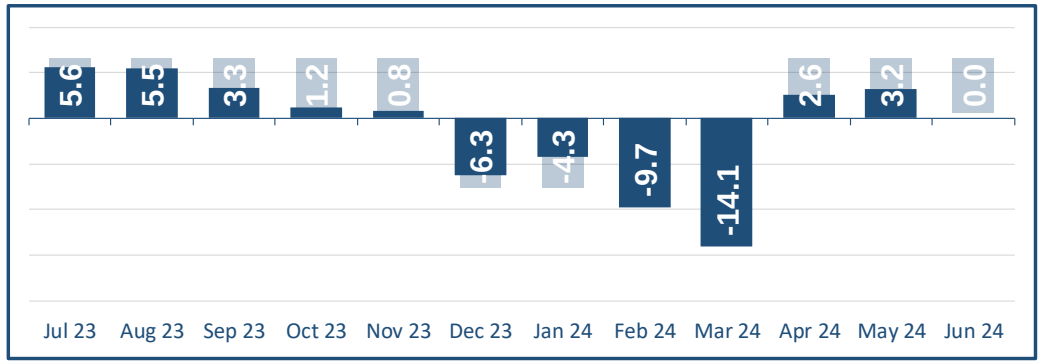


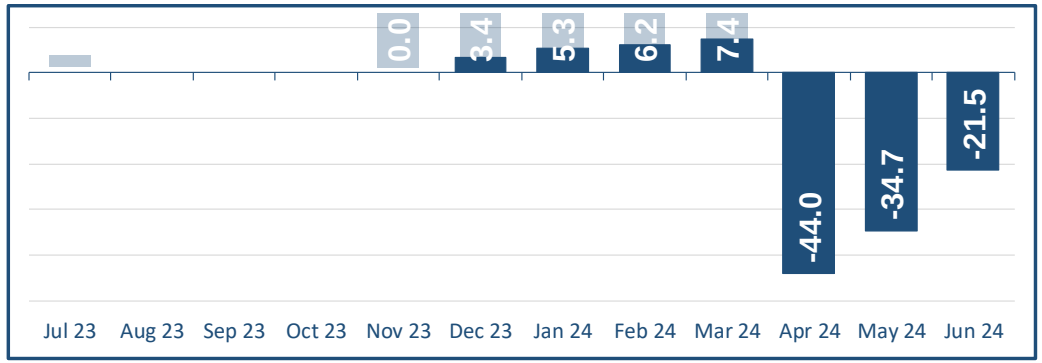


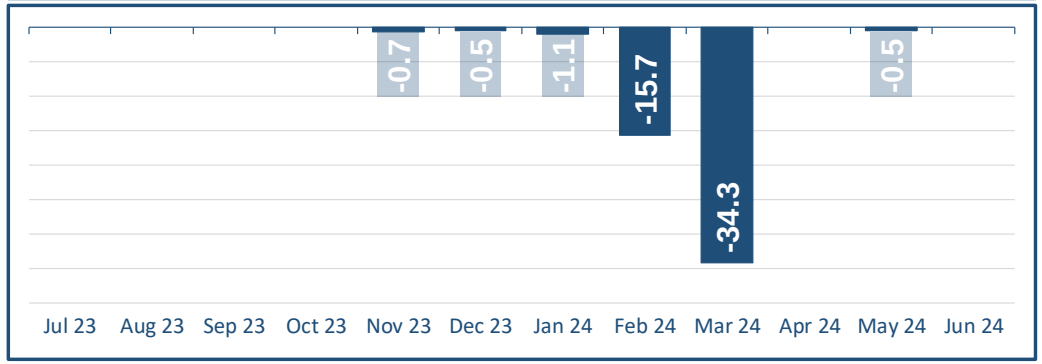


Finance: Performance

Ref	Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
CRR: 24-05	PFIG	In month variance to plan (£million)	N/A	TBC	3.2	
CRR: 24-05	PFIG	Forecast savings delivery against target (£million)	N/A	TBC	-21.5	
CRR: 24-05	PFIG	In year capital expenditure against plan (£million)	N/A	TBC	-0.5	







Finance:

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

Financial Position to date and forecast Position (Corporate Risk 24-05 Financial Sustainability)

	Actual Position				Forecast Position									
	Apr £'m	May £'m	Jun £'m	Total YTD £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Forecast year-end position £'m
Surplus/ (deficit)	(4.3)	(4.8)	(3.7)	(12.8)	(2.3)	(2.2)	(0.7)	(0.7)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(19.8)
Planned position	(1.7)	(1.7)	(1.7)	(5.0)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(1.7)	(19.8)
Surplus/ (deficit) over plan	**(2.6)**	**(3.2)**	**(2.1)**	**(7.9)**	**(0.7)**	**(0.5)**	**0.9**	**1.0**	**1.4**	**1.5**	**1.5**	**1.5**	**1.4**	**(19.8)**

The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with the ability to achieve financial balance and the key financial duty challenging in the current climate, despite the receipt of an uplift in funding. The plan incorporates a £48m recurrent savings requirement, but still has a full year deficit of £19.8m. Both the savings requirement and the projected deficit are profiled equally across the financial year.

The below table shows the movement in the deficit per month, and year to date deficit of £7.9m, predominantly due to the unidentified savings, CHC and MH out of area placements. The projection reflects an assumption that the full savings target will be delivered in the year, the year to date deficit can be recovered and emerging cost pressures can be contained. There are significant risks to these assumptions, which need to be noted and carefully managed.

The graph to the right shows that whilst there is an increase in the value of savings schemes identified in June, there is still a significant gap of £21.5m to be found to meet the full £48m.

The Health Board has moved to a Value and Sustainability Thematic methodology, with each theme having an Executive lead. This aligns with Welsh Government and other health boards and enables the sharing of ideas and potential opportunities across Wales.

Within the Health Board the IPEDG, which is chaired by the CEO, review and monitor the progress of each work stream.

Additional Information

Introduction to Integrated Performance Report (IPR)

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

What is an Integrated Performance Report (IPR)?

The Integrated Performance Report (IPR) combines the areas of Quality, Performance, People and Finance in one overarching report. It provides the reader with a balanced view of performance intelligence and assurances from across the organisation.

The Integrated Performance Framework (IPF)

The Integrated Performance Framework (IPF) for 2023-2027 was ratified by the Health Board on 28th September 2023. The Framework lays the foundations for an integrated approach to performance monitoring, intelligence, management, assurance and improvement. An integral element of the IPF is this new Integrated Performance Report and the governance structure wrapped around it.

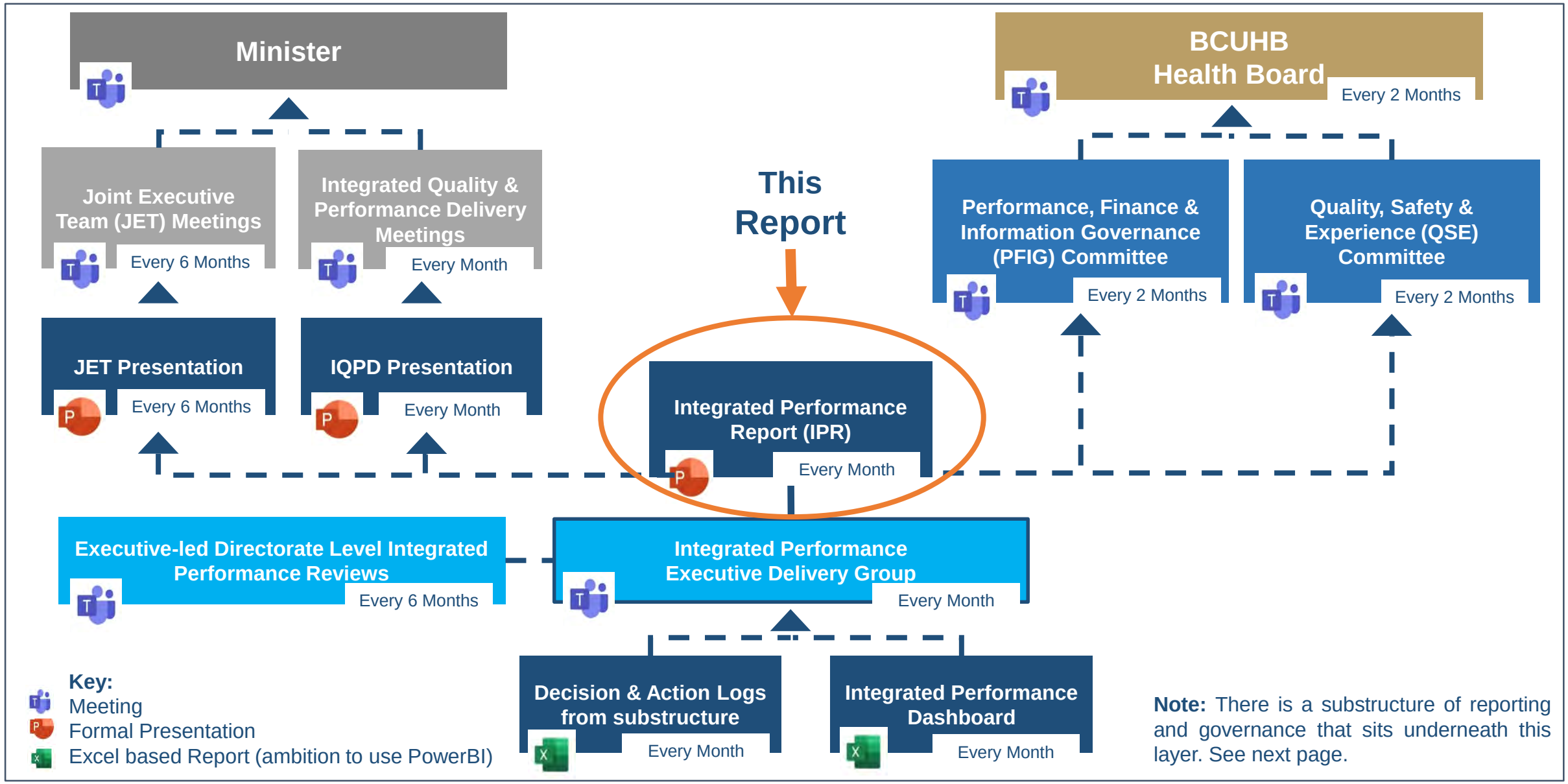
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the Health Board's strategic objectives between now and April 2027. Work has also commenced with the corporate directorates working together on the development of an integrated approach to organisational quality surveillance mechanisms. Once this initial phase is complete, we will then begin our work with the services.

Where does the IPR feature within the Performance Governance Structure

The Health Board's business rules are designed to highlight potential challenge and provide clear assurance for the Board and Public stakeholders. The IPR as a function of the IPF contains information on all metrics, including those that are consistently achieving success however, the main focus is on metrics in exception or escalation.

The IPR will be embedded as the 'single version of the truth' and used to report on performance to the Health Board, it's scrutinising committees namely Performance, Finance & Information Governance (PFIG) Committee and Quality, Safety & Experience (QSE) Committee and externally to Welsh Government. Once published for each Committee/Health Board, the report will be shared across the organisation via BetsiNet (internally), published externally on Betsi Cadwaladr University Health Board's (BCUHB) external facing website and shared in parts or as a whole on other channels such as social media via our partners in BCUHB's Communications Team.

The Integrated Performance Reporting & Governance Superstructure

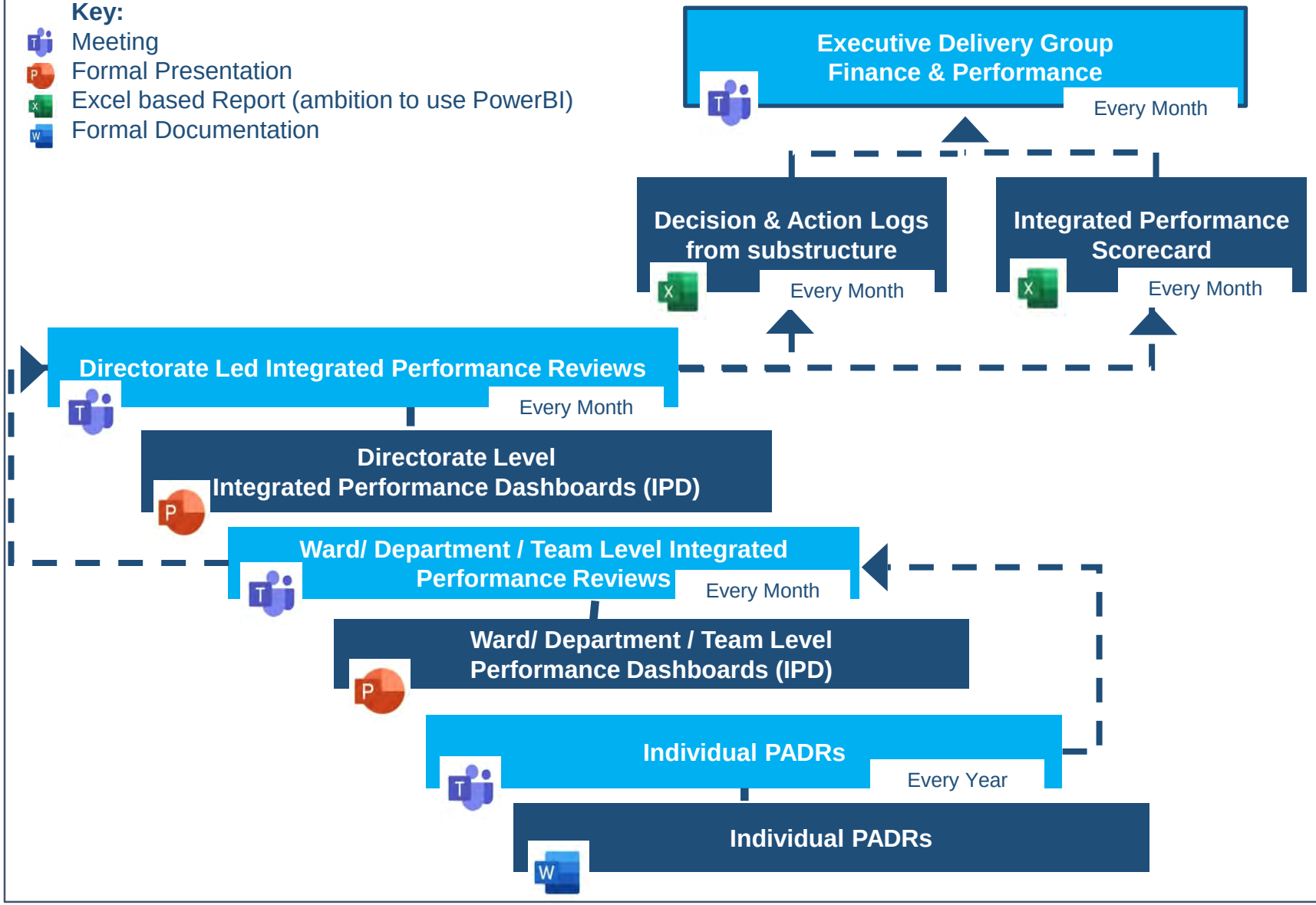


Produced on behalf of the **Health Board** by the **Performance Directorate**

The Integrated Performance Reporting & Governance Substructure

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

Key:
- Meeting
- Formal Presentation
- Excel based Report (ambition to use PowerBI)
- Formal Documentation



Note: For Directorate, please think IHC, Pan-BCU services etc. Includes Corporate Services.

Note: There is a superstructure of reporting and governance that sits above this layer. See previous page.

Performance Directorate Outputs

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

Integrated Performance Reports	Formal and comprehensive reports to the Health Board and its scrutinising committees, Integrated Quality & Performance Delivery Group (IQPD)(Welsh Government) and Joint Executive Team (JET).
Integrated Performance Scorecards	Summary scorecards for– Integrated Performance Executive Delivery Group et al
Integrated Performance Dashboards	Operational level performance dashboards with drill through capabilities. For end of month's submitted position. Ambition for production in PowerBI. – Produced by Digital, Data & Technology (DDAT) in partnership with the Performance Directorate(PI&AD)
Deep Dive Reports	Detailed Deep Dive reports used in accompaniment to Formal Reports, Scorecards and Dashboards to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary, I.e. to support escalation, de-escalation.
Ad-hoc Reports	Ad-hoc reports used outside of the formal channels and for specific queries to complement data, provide context, add intelligence and provide assurances as appropriate. Used at all levels as necessary to provide additional intelligence and assurances as required.

Common Acronyms and Abbreviations

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

Please see below a list of abbreviations commonly found within the report:

A&E	Accident and Emergency	LPMHSS	Local Primary Mental Health Support Services
AB	Aneurin Bevan Health Board	MH&LD	Mental Health and Learning Disabilities
ADHD	Attention Deficit Hyperactivity Disorder	MMR	Measles, Mumps and Rubella
ASD	Autistic Spectrum Disorder	NHS	National Health Service
BCU/BCUHB	Betsi Cadwaladr University Health Board	NR	non-recurrent
C&V	Cardiff and Vale University Health Board	PADR	Performance Appraisal and Development Review
Cmt	committee	PFIG	Performance, Finance, and Information Governance Committee
CRR	Corporate Risk Register reference	QSE	Quality, Safety, and Experience Committee
CTM	Cwm Taf Morgannwg University Health Board	R	recurrent
ENT	Ear, Nose, and Throat	SB	Swansea Bay University Health Board
GDS	General Dental Services	SM	Special Measures
GP	General Practitioner	WAST	Welsh Ambulance Services NHS Trust
HDda	Hywel Dda University Health Board	WG	Welsh Government
HEIW	Health Education and Improvement Wales	YTD	year to date
IHC	Integrated Health Community		

Our Partners

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

This report has been produced on behalf of the **Health Board** by the **Performance Directorate in** partnership with:

- Integrated Health Communities (West, Centre & East)
- Digital, Data & Technology Directorate (DDAT)
- People & Organisational Development Directorate (POD)
- Adult Mental Health & Learning Disabilities Directorate (AMH&LD)
- Children & Young Adolescent Mental Health Services Directorate (CAMHS)
- Women's Services Directorate (WS)
- Public Health
- Finance Directorate
- Office of the Medical Director (OMD)
- Quality & Patient Experience Directorate (Q&PE)
- Equal Opportunities Team
- Corporate Risk Management Team
- Corporate Communications Team

...and the following as Senior Responsible Officers for the measures within their respective Executive Portfolios.

- Executive Director of Operations
- Executive Director of Finance
- Executive Director for Public Health
- Executive Director for People & Organisational Development
- Executive Director of Therapies and Health Sciences
- Executive Director of Strategic Planning & Transformation
- Executive Director of Nursing & Midwifery
- Executive Medical Director

Benchmarking information has been sourced (as identified) from NHS Benchmarking Network, Welsh Government and CHKS

Our Integrated Performance Report
Betsi Cadwaladr University Health Board

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

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Teitl adroddiad: ***Report title:***	Improving Quality Report – July 2024
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with information and analysis on quality issues and information on the improvements underway.
Argymhellion: ***Recommendations:***	The Board is asked to **Note** this report and the progress in relation addressing quality across the Health Board.
Arweinydd Gweithredol: ***Executive Lead:***	• Angela Wood, Executive Director of Nursing and Midwifery • Dr Nick Lyons, Executive Medical Director • Gareth Evans, Acting Executive Director of Therapies and Health Sciences
Awdur yr Adroddiad: ***Report Author:***	• Patient and Carer Experience, Safeguarding and Infection Prevention and Control: Mandy Jones, Deputy Director of Nursing • Patient Safety: Chris Lynes, Deputy Director of Nursing • Clinical Effectiveness: Dr James Risley, Deputy Medical Director • Healthcare Law and Regulation: Matthew Joyes, Deputy Director of Quality

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
There is confidence in the data provided in the report however, the pace of learning and improvement remains an area of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to Special Measures and the Board Assurance Framework.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020.

	The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Board Improving Quality Report	

Board Improving Quality Report – July 2024

INTRODUCTION

For the NHS in Wales, quality is considered to be defined as continuously, reliably, and sustainably meeting the needs of the population that we serve. In achieving this, under the statutory Duty of Quality, Welsh Ministers and NHS bodies will need to ensure that health services are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**. Underpinning these domains are six enablers, which are **leadership**, **workforce**, **culture**, **information**, **learning and research** and **whole-systems approach**. These domains and enablers form the Health and Care Quality Standards for Wales introduced in April 2023 through statutory guidance.

This report provides the Health Board with a summary of key quality related assurances and improvement activities.

Detailed information relating to trends, themes, learning and improvement is provided to the Quality, Safety and Experience (QSE) Committee in specific reports, and high level quality data is provided in the Integrated Performance Report to the Board.

The report is structured, for ease, around quality governance (covering quality assurance, quality improvement and quality regulation), the three high level domains of quality: patient safety, patient experience and clinical effectiveness, and finally healthcare law.

QUALITY GOVERNANCE

Regulation

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

HIW undertook an inspection at the Emergency Department in Ysbyty Glan Clwyd from the 29th April to the 1st May 2024.

Whilst the overall inspection was positive and HIW could see evidence that the Health Board has taken further steps to improve certain areas, the immediate assurances below were required:

- Ensure that there are measures in place to ensure that risks to patient health and safety are assessed and mitigated in a timely way.
- Ensure that staff administer medication in line with prescriptions
- Ensure staff accurately record patient fluid intake and output
- Ensure that staff complete a care plan when a patient has a cannula
- Ensure that checks of resuscitation equipment are undertaken and recorded on a regular basis
- Ensure consistent monitoring and recording of visual and physiological observations

The Health Board submitted a response containing improvement actions which HIW accepted as providing assurance. The draft inspection report is now awaited.

On the 25th and 26th June 2024 HIW also undertook a planned Ionising Radiation (Medical Exposure) Regulations (IRMER) inspection at Ysbyty Gwynedd and the Bone Densitometry service at Llandudno General Hospital. Initial verbal feedback is of a positive inspection with no immediate assurances required. Inspectors reported a number of positive findings across the domains of patient experience, safe and effective care and governance and leadership with a small number of improvements required in areas such as Duty of Candour training. We await the final written report of the findings in order to respond fully and appropriately.

Care Inspectorate Wales (CIW) regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services. As the Health Board is one legal entity, it is a registered provider for multiple services which includes Enhanced Community Residential Service (MHLD) and Tuag Adref (across all three Integrated Health Communities).
The Health Board submitted its Annual Return to CIW by the deadline of 26 May 2024. This submission is required under section 10 of the Regulation and Inspection of Social Care (Wales) Act 2016. The return includes questions about regulated services operated by the Health Board (the service provider) and reflects the position as at the 31 March 2024.

Ombudsman

The Health Board currently has three draft Public Interest Reports under consideration. These reports, when finalised, will be shared via the Quality, Safety and Experience Committee papers including details of the improvement plans developed in response.

The Ombudsman measures responsiveness using a measure called Average Variance to Target (AVT). This is regularly shared with all health boards. The Health Board AVT is currently -4 (i.e. submissions are on average 4 days ahead of a deadline).

The Health Board continues to meet with the Ombudsman's Complaints Standards Authority to ensure good working practices and to facilitate awareness training for staff working within the Health Board.

Learning from Investigations Project

Following receipt by the Health Board of several Regulation 28 (Prevention of Future Deaths) Reports from His Majesty's Coroners (HMCs) across North Wales in relation to poor quality investigation reports, timeliness and lack of high quality action plans, the Chief Executive commissioned a retrospective review of all investigation reports and associated documentation, up to the end of January 2024, that had been (or would be) submitted to the Coroner.

This work commenced January 2024 and completed in mid-June, slightly ahead of schedule. In total, 278 cases were reviewed.

Details of the work has been provided to the QSE Committee, and a more detailed end of project report will be provided to the next meeting.

The new integrated policy for incidents, complaints and mortality reviews has been driven by, and informed from, the learning identified by this review project.

The review project will extend in a revised format to cover the period from February 2024, to the date the new policy comes into effect.

Learning

The Organisational Learning Forum continues to receive regular presentations identifying opportunities for organisational learning and reflection. The Assistant Director of Therapies and

Health Sciences recently took over the chair to support wider multi-professional engagement in the forum.

The Health Board has received more than 1,600 submissions through GREAT-ix in its first 10 months – GREAT-ix is the Learning from Excellence platform showcasing the wealth of innovation, improvement, kindness and empathy our whole workforce has in abundance. Any member of staff is welcome to submit a GREAT-ix to capture excellent things that happen within the Health Board. Every month the Health Board shines a light on recent submissions which showcase learning and innovation in practice.

The new Quality Learning Portal continues in development. This innovative portal will provide a single, digital organisation-wide repository for learning to be captured, analysed and cascaded.

The new Quality Informatics Portal/Quality Dashboard was launched in June 2024 on the IRIS system. This suite of dashboards will provide a single, organisation-wide resource for accessing quality information. Early usage of the portal will support data validation of feeds from the different systems and will inform future development.

Quality Management

The Quality Management System Framework was approved in May 2024 by the Board. The Executive Director of Nursing and Midwifery, as executive lead for quality, is now developing the implementation framework and plan.

PATIENT SAFETY

Nationally Reportable Incidents (NRI)

The main NRIs occurring in March /April 2024 can be themed as follows:

- Grade 3 or above healthcare acquired pressure ulcer (HAPU)
- Unexpected death of patient known to mental health services

The main themes of the learning from closed incidents were related to delayed access to services or admission, assessing and recognising patient deterioration and appropriate monitoring of follow up and/or investigations for patient care and treatment. A more detailed review of cases is included in the private section of the QSE Committee papers due to potentially identifiable patient information.

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel (led by a clinical executive or deputy) and further investigation. The learning and actions from each are recorded on the Datix Cymru incident management module. Learning forms are drafted for each investigation and are submitted nationally to the NHS Wales Executive to provide assurance of learning and actions.

The Board is aware of incidents involving oxygen cylinders and the work being done to improve staff awareness and training. Following an inquest that concluded on 10th May 2024, the Coroner issued a Prevention of Future Deaths (Regulation 28) Notice to the manufacturer expressing concerns that the CD Oxygen cylinders manufactured by them which, it is understood, supply most if not all Health Boards in Wales (under procurement processes) are unsafe for use in heightened and pressurised situations in that it is not overtly clear how the cylinders are to be operated with the confusion of the two valves. The Coroner was satisfied with the learning and actions of the Health Board.

Inpatient Falls

The Improvement Plan following the Health and Safety Executive (HSE) Notification of Contravention (NOC) is being progressed and monitored through the Strategic Falls Group. The HSE have intimated that the Health Board response to the NOC is with their legal team, and we expect to hear back on the decision in July 2024.

The third Health Board desktop review for the improvement plan was undertaken on 28th May 2024 Led by the Executive Director of Nursing and Midwifery with the aim to review progress and support against the actions within the overarching improvement plan which includes actions following HSE notice, Internal Audit review and KPI's for the National Audit of Inpatient Falls. The next meeting is scheduled for July 2024.

Selected actions identified and also discussed in the strategic inpatient falls group are specifically around agency induction, training, risk assessments and post falls management.

There has been a dip in compliance for part 1a and 1b training due to a number of staff requiring renewal at the same time. There has been an improvement in terms of overall compliance for moving and handling, but it remains below expectation, this has been escalated to Integrated Healthcare Communities (IHC)/Divisional directors to improve compliance.

Peer reviews have been monitoring quality of risk assessments and the patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings.

Healthcare Acquired Pressure Ulcers (HAPU)

As part of the Improvement Plan, there will be an implementation of a change to the Datix system Health Acquired Pressure Ulcers (HAPU) report to incorporate Tissue Viability Nurse (TVN) referrals as this has been identified as a theme within incidents. The HAPU Lead and Patient Safety Team are in the process of implementing a trial of a prompt for TVN referral/review on Datix. Thus, when an incident is reported as moderate and above, it will notify the TVN and administration team. This was progressed through the Development Request Process at the Quality Systems Group meeting in February 2024. The Once for Wales team has confirmed that it requires initial approval with All Wales Tissue Viability Nurses Forum; a request has been made for discussion at the AWTVN March meeting and the Health Board is awaiting the outcome.

Mandatory Training for pressure ulcer prevention has been approved by the Executive Director of Nursing and Midwifery and is going through the approvals process, to be rolled out across BCUHB in 2024.

Analysis of the reported data across all IHCs demonstrates increased incident reporting of HAPU – common themes still include:

- Delays in moving patients into the Emergency Departments in times of increased demand.
- Sourcing of pressure relieving mattresses.
- Correct classification of pressure Ulcers – wound photographs required as part of the TVN referral.
- Purpose T assessment completion including inconsistencies of regular skin inspection and documentation.

The HAPU lead nurse is supporting action from learning from the National Reportable Incidents outcome forms in addition to in the capture and management of themes arising through engagement and 1:1 meeting with individual leads and clinical Teams (via local Harm Meetings) to highlight, review and focus actions in line with Health Board Improvement Plan.

A HAPU Executive review is scheduled for July 2024 using the same methodology as the Falls Executive review.

Safeguarding

The Safeguarding and Public Protection Team provides oversight and organisational assurance in relation to the Health Boards' statutory duty under the Social Service and Wellbeing (Wales) Act 2014 and Wales Safeguarding Procedures 2019, the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005. The activity includes key actions and activities to ensure that the Safeguarding and Public Protection agenda remains paramount to service delivery across BCUHB. Safeguarding reports throughout the organisation in accordance with the Safeguarding Reporting Framework. This framework reinforces organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group (SGPG), and key Forums and Committees.

A review of the SGPG membership is underway to ensure safeguarding reporting and governance is in-line with the Health Boards organisational framework.

Safeguarding activity is shared weekly and monthly with respective Health Board services. Activity is then scrutinised at monthly Integrated Health Communities (IHCs) and Mental Health and Learning Disability (MHLD) Safeguarding Forums to allow for assurance and governance in relation to concerns raised and actions taken. The Safeguarding Forum is held monthly across IHCs and MHLD services. The Forum is accountable to the in full SGPG Group and ultimately to the Quality Delivery Group (QDG) and the Quality, Safety and Experience Committee. Integrated Health Communities and MHLD Nurse Directors and Medical Directors are accountable for the Safeguarding function and reporting arrangements within their areas of delegated accountability and responsibility. The purpose of the Safeguarding Forum is to ensure Safeguarding practices within the geographical area of responsibility are not only implementing the strategic safeguarding agenda set by the group and ultimately the Board, but are also actively engaged in the wider safeguarding agenda including reporting, auditing and evaluating practice.

Infection Prevention and Control

When compared to number of incidents in other Health Boards in May 2024, the Health Board were: 1st for MSSA, Pseudomonas aeruginosa & Klebsiella species bacteraemia (i.e., lowest infection rates), 3rd for C. difficile, 5th for E. coli and 6th for MRSA bacteraemia (i.e., highest infection rate). This is an improved position for C. difficile, MSSA and Klebsiella spp. since the previous month.

There has been an observed increase in the number of Norovirus and COVID-19 cases resulting in more outbreaks and ward closures. There have been no flu outbreaks reported and very few single cases.

In the Centre IHC, there has been a second CPE outbreak during the period, but this was not linked to the first outbreak reported.

PATIENT EXPERIENCE

Complaints

From the 1st of April 2024 to the 21st June 2024, 642 Complaints were received, 549 of those were managed under Putting Things Right, 93 of those were Early Resolutions with 29 re-opened complaints. During the period, 319 complains were closed.

The majority of the complaints related to Secondary Care Services. The top themes remain the same from the last report relating to: clinical treatment and assessment, poor communication,

appointments and medication. Attitude and behaviour issues are common themes across all services which is consistent with the communication issues.

There were 293 complaints overdue at the time of writing, down from 395 overdue complaints at the end of April 2024.

Each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meeting to manage the progress of complaints received. The Complaints Team are currently working to trajectories to reduce the number of overdue complaints which are under scrutiny by the Executive Team.

The closure rate within 30 working days, at the time of writing, is 41.40%.

Within the reporting period the Patient Advice Liaison Service (PALS) facilitated the resolution of 1,169 enquiries for March to April 2024. The key themes identified from PALS enquiries within this reporting period include:

- Delays in appointments/ waiting times
- Delay/lack of treatment or assessment
- Communication with family

The Patient Advice Liaison Service continue to work with Integrated Health Communities and specialist services to identify and support areas where there is an increase in the number of PALS enquiries, with the aim to encourage local resolution to concerns or enquiries.

Patient Feedback

From the 1st April 2024 to the 18th June 2024, 11,546 All Wales Real-Time Patient and Carer Feedback Survey responses were received via Civica feedback system.

- 80.84% of survey respondents said their overall experience of accessing BCUHB services was very good (85% ‘Always’ score is the All Wales benchmark).
- 84.15% of surveys respondents said they always felt listened to
- 81.06% of respondents felt they were always given the information they needed
- 80.99% of respondents were always involved in decisions about care.

From the 1st April 2024 to the 18th June 2024, 68 All Wales Emergency Department (ED) survey responses were received via Civica feedback System. Work is currently being undertaken to support the launch of SMS feedback surveys across Emergency Departments.

In preparation for the launch of the NHS Wales People’s Experience Framework, and the implementation of a new national set of Patient Related Experience Measures (PREMS) , PALS are working with IHCs and Specialist Services to ensure all wards, services and departments are mapped to Civica. All MHLD Services will be mapped to Civica by 31st July 2024. Work is being undertaken with IHCs and Specialist Services to increase inpatient feedback.

PALS will review its accessibility requirements to allow people and communities to leave their experience feedback on an ‘Always on’ basis. Exploring opportunities to encourage feedback and in their first language of choice e.g. QR code posters in waiting areas, Kiosks, SMS, and social media.

Small Business Research Initiative (SBRI) Patient Communication Project

The SBRI Patient Communication pilot funded by Welsh Government is live in Ysbyty Glan Clwyd on wards 1 and 9 and Glaslyn, Prysor and Ogwen Ward within Ysbyty Gwynedd The aim of the project is to improve communication between the families and key contacts whilst their loved one is in hospital. Staff provide written and verbal daily updates using a digital portal that supports text messaging and voice notes. The uptake of the pilot has been slightly slower than anticipated due to lack of patient/relative uptake and ward acuity has impacted on staffing ability to provide daily messages e.g. Ward 9 had a flu outbreak so had to pause.

The pilot will continue until 14 June 2024. The Patient Advice and Liaison Service are engaging with relatives to capture their experience of using this system to understand if this has helped improve communication between the wards and relatives. To date, feedback from relatives has been positive.

Patient Communication and Information

The Health Board has a duty to provide quality information, whilst adhering to statutory legislation when producing any form of patient information whether it be verbal or written.

Ongoing work continues to support the Radiology Service who are reviewing all their patient information documents, including patient letters and patient information leaflets to ensure consistent information is being given to patients across North Wales. Cancer Services have reviewed all of their patient information contained in a 'blue folder' that is given to all patients who receive a cancer diagnosis. The aim of the review was to improve the quality of information given to newly diagnosed patients and to produce information in an accessible format for all patients to access.

The Patient and Carer Experience Department is improving the way it communicates with customers by improving access to its services and the quality of information available online. To support the website improvement work 22 patients who had recently contacted PALS via the internet for support were interviewed. Patient feedback and suggested improvements made by patients will help inform website changes so access to PALS/Complaints services is more accessible and easier for the public to share compliments, provide feedback, make an enquiry and raise a formal complaint.

In May 2024, the Patient and Carer Experience Department began implementing a new single point of contact telephony system for the PALS and Complaints Team. The new telephony system will improve call handling and call waiting experiences for customers and will enable the department to monitor quality control. The telephone line will also have a survey at the end, allowing callers to provide feedback on their call experience. In line with the improvement made to the PALS website and telephony the PALS service opening hours from 1st April 2024 will change to Monday, Tuesday, Thursday and Friday 10 am – 4pm and on Wednesday 9 am – 12.30pm. The change in operating hours will enable PALS Officers to increase face to face patient experience and engagement activities, being more visible on wards and across community hospitals capturing and learning from patient and carer experiences.

CLINICAL EFFECTIVENESS

National clinical audits (Tier 1) are mandated and aimed at measuring and benchmarking the improvement of healthcare services in Wales; this year an additional 8 audits have been added. Tier 2 audits are determined by the Health Board's priorities, high-level risks or concerns, and the focus is on the main Health Board's governance priorities of risk, incidents, and complaints. Each

year the Tier 2 list is reviewed and submitted to Strategic Clinical Effectiveness Group, and subsequently the Quality Delivery Group, for discussion and agreement.

Progression of both Tier 1 and Tier 2 audits is monitored quarterly to provide accountability and to identify any assistance that may be necessary to ensure completion against agreed timelines.

The All-Wales Learning from Mortality Reviews Model Framework (second edition) and Single Process for Mortality Reviews in General Practice (second edition) have been finalised by NHS Wales Executive and Welsh Government and have been distributed to BCU Mortality Lead contacts for sharing and dissemination.

Legislation changes are now being processed; as previously reported this will encompass primary care and community deaths, and also now extends to all private care incidents being sent directly to the Health Board for consideration of mortality review.

Changes to the Mortality Datix module have been made and changes will continue to be made by way of improvement that are agreed at an All-Wales level.

HEALTHCARE LAW

Inquests

Coroners investigate all deaths where the cause is unknown, where there is reason to think the death may not be due to natural causes, or which need an inquiry for some other reason. An inquest is an inquiry held by the Coroner into the circumstances surrounding a death. The inquest does not set out who is responsible for a death. It is not the Coroner's role to determine any civil or criminal liability or to apportion blame.

A reduction in the number of Regulation 28 Prevention of Future Death (PFD) Notices has been noted. No PFDs were issued in May 2024.

At the time of writing, 1 PFD had just been issued in June 2024 relating to Coroner concerns about the lack of integrated electronic records/alerts and how this may mean urgent blood results to an Emergency Department may be missed. The Health Board has 56 days to respond and work has started to review this notice.

Two inquests concluded since the last report was written where the Coroner added a rider of Neglect. The Coroner can add a rider of neglect to a conclusion where they feel that there was a gross failure to provide medical attention, on the balance of probabilities.

The first case involved the sad death of a patient in a mental health unit in 2020. The Coroner identified issues including no recorded rationale of how staff should engage with the patient, no admissions pathway was completed, daily mental state examinations were not always done and daily room searches were not undertaken, therapeutic observations were not undertaken, visual observations were not accurately recorded and some staff on the ward had not been properly trained to work in acute settings (the ward had rapidly changed role due to the pandemic). Evidence of learning and improvement was presented and the Coroner did not issue a PFD.

The second case involved the sad death of twins in 2022. The coroner identified that monitoring at the maternity assessment unit should not have been paused and that the patient, who had not been made fully aware of the seriousness of the situation, should not have been allowed to go home. Evidence of learning and improvement was presented and the Coroner did not issue a PFD.

A bi-weekly Inquest Oversight Panel was established in autumn to provide executive support to ensuring deadlines were achieved. Improvement is being seen in the timeliness of investigation

report submissions to the Coroner, linked to the significant patient safety and complaint improvement work identified above.

A number of inquests continue to be listed which are several years following a death however these are beyond the control of the Health Board and reflect various external factors such as the long term impact of the pandemic.

Claims

The Welsh Risk Pool is part of the NHS Shared Service Partnership Legal and Risk service. It provides the means by which all Trusts and Health Authorities in Wales are able to indemnify against risk. The role of the Welsh Risk Pool is to have an integrated approach towards risk assessment, claims management, reimbursement and learning to improve. The team work with NHS colleagues across Wales to promote and facilitate opportunities to learn and support the development and implementation of improvements to enhance patient safety and outcomes.

Where claims are justified, the Health Board works for early settlement to provide support for those affected by harm and to reduce costs. All claims are managed to ensure a fair and equitable settlement.

The Health Board has a number of overdue Learning from Events Reports (LFERs) which are due to be submitted to the Welsh Risk Pool (WRP). At the time of writing, this number was 27 (all of which were with services for providing evidence of learning). There is a risk of financial penalty for delayed forms. As with other areas of overdue documents (such as incidents and complaints which both remain unacceptably high) support is being provided to divisions to facilitate completion and regularly reporting and escalation is in place.

A separate update paper is being submitted to the Board in private session regarding future high value claims.

CONCLUSION

This report provides the Health Board with a summary of key quality related assurances and improvement activities.

The key points of note are:

- The main themes of Nationally Reportable Incidents (NRIs) remain falls and healthcare acquired pressure ulcers. Improvement work for all these areas is progressing under the leadership of senior clinical staff.
- The number of overdue complaints remains high, with an impact on patients and has an impact on the closure target compliance. However, significant work is underway and improvement is being seen.
- A Regulation 28 Notices PFD has been received from the Coroner and two inquests were concluded with a rider of Neglect.
- HIW undertook an inspection at the Emergency Department in Ysbyty Glan Clwyd.
- The Health Board currently has three draft Public Interest Reports under consideration.

The Health Board will continue to submit more detailed information to the QSE Committee.

The Health Board is asked to **note** the report.

Teitl adroddiad: ***Report title:***	**2024-25 Month 3 Finance, Capital and Savings Report**
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides a briefing on the financial performance of the Health Board for the year to date position as at the end of Month 3 (June 2024). In addition, the report includes an update on delivery of the approved capital programme and savings delivery against target. <u>Finance Report</u> The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with a £48.0m recurrent savings requirement to deliver the £19.8m planned deficit for 2024/25. Both the savings requirement and the projected deficit are profiled equally across the financial year. The forecast position is to deliver a deficit of £19.8m, which is in line with the financial plan for the year. The June position is reporting an in-month deficit of £3.7m, an improvement of £1.1m from Month 2 though is £2.1m higher than the profiled Financial Plan deficit of £1.6m for Month 3. Year to date position is reporting a deficit of £12.8m. This represents a £7.9m adverse variance compared to 3/12^{ths} of the planned deficit, which is predominantly driven by the £5.9m shortfall in undelivered savings against profile and pressures in Commissioned Services and Continuing Healthcare (CHC) and in particular Mental Health placements. However, it is of note that that there was a significant increase in savings delivery in Month 3. The 2024/25 Savings Programme has been developed through an allocation of reductions against discretionary budgets, supported by a Value & Sustainability programme approach that mirrors Welsh Government modelling (CHC, Medicines Management, Workforce, Non Pay and Clinical Variation). The full year forecast value of Green Finalised Schemes totals £26.5m owing to a significant number of opportunities being converted to deliverable forecasts. In addition, the full year plan value of Red schemes totals £0.8m and the full year plan value of further pipeline opportunities totals £3.5m. The Health Board requires additional focus on mitigation of cost overruns and further savings opportunities delivery, so as to assure attainment of the 2024/25 financial plan. Attainment of the plan key to the active debate in regards to the £82m one off allocation for 2024/25 being secured within the future baselines for the Health Board (this one of allocation driving 50% of the underlying deficit).

	Capital Programme The finance report articulates performance within the Capital Programme which consists of Discretionary funding plus specific funding for Major Projects. The approved Capital Resource Limit (CRL) for 2024/25 is £44.830m and is forecast to be spent in full. Year to date expenditure is £1.7m against a year to date plan of the same value. Whilst it is normal to have a low planned level of expenditure at commencement of the financial year (allowing for delays in planning and commissioning the works) there is a focus to bring forward as much expenditure as possible to remove risk of underspends caused by delays that may occur late in the financial year. Savings Report The Health Board's financial plan has set a savings target of £48.0m to be delivered in 2024/25. The £48.0m target plan is profiled on an equal twelfth's basis. The 2024/25 Savings Programme is being developed through a Value & Sustainability thematic model which is to be delivered within five core domains (a) Workforce (b) Clinical Variation (c) Non-pay (d) Continuing Healthcare and (e) Medicines Management. Full year forecast value of Green Schemes totals £26.5m and savings delivered in Month 3 totalled £3.4m, against a £4.0m Target. Taking into account the initial savings position being low, work has progressed well on identifying further opportunities and converting them to Green schemes. As at Month 3, the Health Board has identified and finalised £26.5m savings, an increase of £13.4m from Month 2. Of these savings, £4.1m are non-recurring and £22.4m have been identified as recurring, with a full year effect of £31.6m. The full year plan value of Red schemes totals £0.8m and the full year plan value of further pipeline opportunities totals £3.5m. The identification and delivery of full year schemes that total £48m remains a key risk to attainment of the 2024/25 plan and securing of one off funds in 2024/25 into 2025/26 and beyond. Nil Accountancy Gains have been reported in Month 3.
Argymhellion: ***Recommendations:***	The Board is asked to • **receive** and scrutinise this report
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance.
Awdur yr Adroddiad:	Andrea Hughes, Finance Director (interim) Michelle Jones, Head of Financial Reporting Daniel Eyre, Head of Capital Development

Report Author:				
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒		I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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 as per the financial plan.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The financial plan and reporting, capital projects and discretionary programme assist the Health Board in meeting its' statutory and mandatory requirements.
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable. The health board continues to assess the requirement for carrying out Equality Impact Assessments and Social-Economic impact assessments on a capital project by project basis.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	BAF – Financial Stability Current risks and mitigations are shown in Appendix A, Slide 13. From a capital perspective, the Health

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Board continues to experience occasions where tenders are exceeding budget estimates due to the volatility within the construction market and general inflationary pressures. The programme is monitored monthly to ensure that financial commitments align to available funding.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Appendix A & B** **BAF risks** BAF - Financial Stability **Corporate Risk Register:** CRR24-05, Financial Plan Delivery 24/25. **Appendix C** **BAF risks** BAF 21-14 Pandemic exposure BAF 21-09, Infection prevention control BAF 21-12, Security services BAF 21-13, Health and safety BAF 21-03, Primary Care BAF 21-04, Timely access to planned care BAF 21-01, Safe and effective management of unscheduled care BAF 21-06, Safe and effective mental health service delivery 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, Noncompliance of fire safety systems 20-06, Informatics – patient records pan BCU 20-07, Informatics – capacity, resource and demand 20-11, Informatics – cyber security
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** A - 2024/25 Finance Report (Revenue, Capital and Savings) - Month 3	

Finance Report
June - Month 3 2024/25

Russell Caldicott
Interim Executive Finance Director

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

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.
Key Messages	• The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with a £48.0m recurrent savings requirement to deliver the £19.8m planned deficit for 2024/25. The savings and the projected deficit are profiled equally across the financial year. • Month 3 Year to date position is a deficit of £12.8m. This represents £7.9m adverse variance compared to 3/12ths of the planned deficit, driven by the £5.9m shortfall in undelivered savings against profile and pressures in Commissioned Services and Continuing Healthcare costs. • 2024/25 Savings Programme is being developed through allocating the targeted savings as a percentage of discretionary budgets, with a Value & Sustainability thematic model (CHC, Medicines Management, Workforce, Non Pay and Clinical Variation) efficiencies realised based on opportunity. As at Month 3, the Health Board has identified £26.5m savings, an increase of £13.4m from Month 2. Of these savings, £4.1m are non-recurring and £22.4m have been identified as recurring, with a full year effect of £31.6m. • The Health Board requires additional focus on mitigation of cost overruns and further savings opportunities delivery, so as to assure attainment of the 2024/25 financial plan. Attainment of the plan key to the active debate in regards to the £82m one off allocation for 2024/25 being secured within the future baselines for the Health Board (this one of allocation driving 50% of the underlying deficit).
Key Financial Targets	
Revenue	• In-Month a deficit of £3.7m (improvement of £1.1m from Month 2) though £2.1m higher than the profiled financial plan deficit of £1.6m for Month 3. Year to date position is reporting a deficit of £12.8m, which is £7.9m higher compared to 3/12ths of the planned deficit. • The forecast position is to deliver a deficit of £19.8m, which is in line with the financial plan for the year.
Cash	• Closing cash balance as at 30th June 2024 was £6.9m, including £4.5m cash held for revenue expenditure and £2.4m for capital projects. Current forecast 2024/25 closing cash balance of (£14.7m), made up of (£17.2m) revenue cash and £2.5m capital cash.
Savings	• The Health Board's financial plan has set a savings target of £48.0m to be delivered in 2024/25. Savings delivered in Month 3 totalled £3.4m, against a £2.9m Plan and £4.0m Target. The full year forecast value of Green Schemes totals £26.5m.
Capital	• Approved Capital Resource Limit (CRL) for 2024/25 is £44.8m and is forecast to be spent in full. Year to date expenditure is £1.7m against a year to date plan of the same value.

Key Performance Indicators

Month 3 Position

In Month Spend: £176.1m against plan of £174.0m

£2.1m adverse position (above planned deficit)

YTD Spend: £521.4m against plan of £529.3m

£7.9m adverse position (above planned deficit)

Forecast Position

Projection held at planned deficit but this is subject to savings risk and controlling cost overruns, in particular within Continuing Healthcare (CHC) at present

£19.8m deficit

Month 3 Divisional Performance

West IHC	£4.7m adverse
Central IHC	£0.6m adverse
East IHC	£0.6m adverse
Womens	£0.3m adverse
MH & LD	£5m adverse
Commissioning Contracts	£2.7m adverse
ICD Primary Care	£0.6m favourable
ICD Regional Services	£2.5m adverse
Support Functions	£0.4m favourable
Other Budgets	£20.3m favourable

Month 3 Savings

In-month delivery: £3.4m against target of £4.0m
£0.6m adverse

YTD delivery: £6.1m against a target of £12.0m
£5.9m adverse

Savings Forecast

£26.5m against target of £48.0m

£21.5m adverse

COVID-19 Impact

£2.4m YTD cost

£12.2m forecast cost
Fully funded by Welsh Government

Year to Date Income

£39.4m against budget of £38.7m

£0.7m favourable

Year to Date Pay

£260.6m against budget of £247.0m

£13.6m adverse

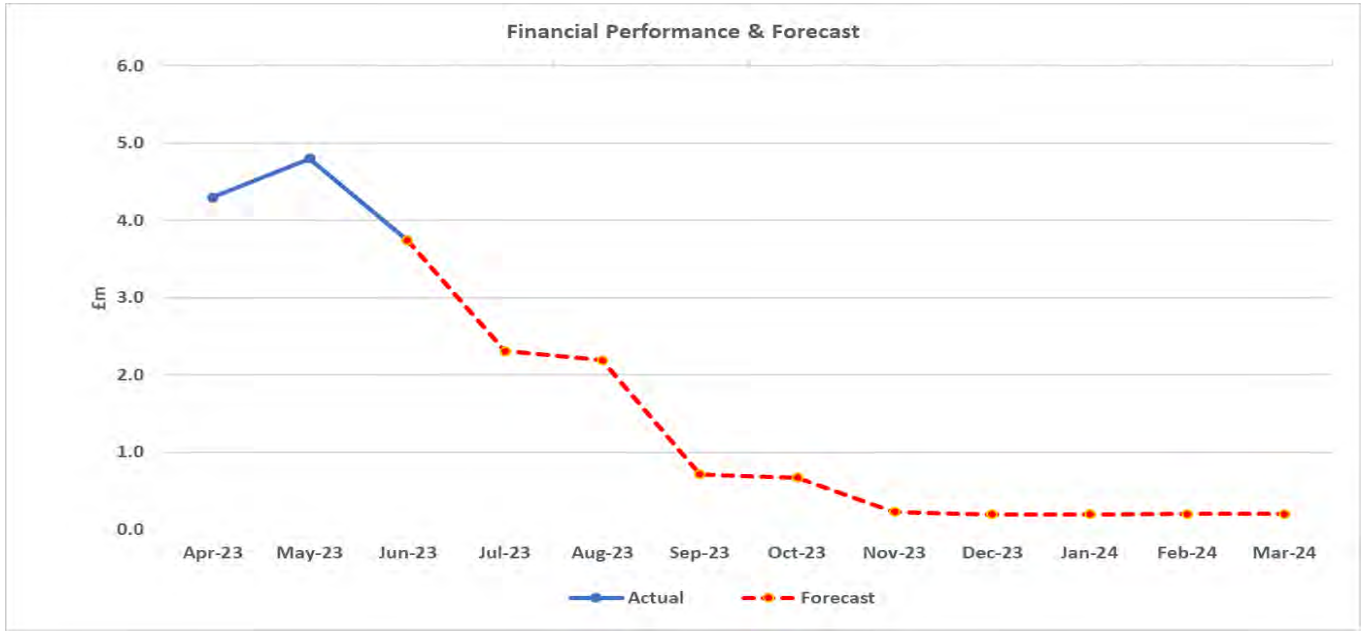
Year to Date Non-Pay

£308.0m against budget of £313.0m

£5.0m favourable

Revenue Position

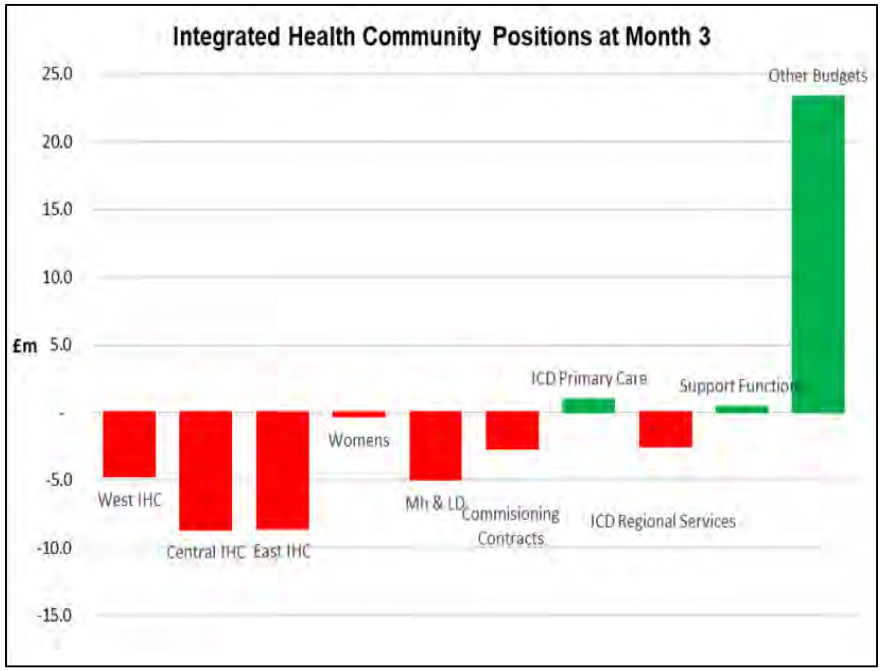
	Actual			2024/25 Cumulative against Plan				Actual Forecast
	M01	M02	M03	Budget	Actual	Variance	Variance	
	£m	£m	£m	£m	£m	£m	%	
Revenue Resource Limit	(172.4)	(171.6)	(172.4)	(516.4)	(516.4)	**0.0**	0.0%	(2,102.1)
Miscellaneous Income	(13.1)	(12.8)	(13.5)	(38.7)	(39.4)	**-0.7**	1.8%	(158.6)
Health Board Pay Expenditure	86.7	87.2	86.7	247.0	260.6	**13.6**	5.5%	1,059.7
Non-Pay Expenditure	103.1	102.0	102.9	308.1	308.0	**-0.1**	0.0%	1,220.8
Total Deficit / (Surplus)	**4.3**	**4.8**	**3.7**	**0.0**	**12.8**	**12.8**		**19.8**
Planned Deficit	**1.7**	**1.6**	**1.6**	**4.9**	**0.0**	**4.9**	**100%**	
Total Deficit / (Surplus) above Plan	**2.6**	**3.2**	**2.1**	**4.9**	**12.8**	**7.9**		



- The 2024/25 financial plan reflects the financial challenges from 2023/24 continuing into the new financial year, with the ability to achieve financial balance and the key financial duty challenging in the current climate, despite the receipt of an uplift in funding.
- Welsh Government Strategic Support funding that was to conclude in 2023/24 (totalling £82m per year) has been allocated for an additional year in 2024/25 on a non-recurrent basis. Welsh Government have also confirmed that £74.6m of the non-recurrent additional support issued in 2023/24 has been agreed as recurrent for 2024/25; therefore, the 2024/25 opening recurrent underlying deficit position is £178.2m.
- The Health Board has implemented a Value & Sustainability programme approach this year and will seek to deliver patient benefits and savings within five core domains of (a) Workforce (b) Clinical Variation (c) Non-pay (d) Continuing Healthcare and (e) Medicines Management. Each Theme has an Executive Leads and is being performance managed at the Integrated Performance – Executive Delivery Group, chaired by the Chief Executive.
- The in-month position is reporting a deficit of £3.7m, an improvement of £1.1m from Month 2 and is £2.1m higher than the profiled Financial Plan deficit of £1.6m for Month 3.
- Year to date position is reporting a deficit of £12.8m. This represents a £7.9m adverse variance compared to 3/12^{ths} of the planned deficit, which is driven by the £5.9m shortfall in undelivered savings against profile and pressures in Commissioned Services and CHC. It should be noted that there was a significant increase in savings delivery in Month 3.
- Forecast position is to deliver a deficit of £19.8m, which is in line with the financial plan for the year.

Divisional Positions

	In Month				Cumulative				Forecast Year End Variance against the Plan £000
	Budget £000	Actual £000	Variance to Plan £000	% Variance to Plan £000	Budget £000	Actual £000	Variance to Plan £000	% Variance to Plan £000	
WG RESOURCE ALLOCATION	(172,397)	(172,397)	0	0%	(516,411)	(516,411)	0	0%	0
WEST INTEGRATED HEALTH COMMUNITY									
Management	105	89	16	-15%	314	267	46	-15%	86
West Area	15,935	16,321	(386)	-2%	47,197	48,670	(1,473)	-3%	(7,344)
Ysbyty Gwynedd	10,140	10,802	(662)	-7%	30,053	33,039	(2,986)	-10%	(10,804)
Facilities	1,044	1,201	(157)	-15%	3,133	3,470	(337)	-11%	(1,347)
Total West	27,224	28,413	(1,189)	-4%	80,696	85,446	(4,750)	-6%	(19,409)
CENTRAL INTEGRATED HEALTH COMMUNITY									
Management	91	134	(44)	48%	272	245	26	-10%	(30)
Central Area	20,325	21,071	(746)	-4%	61,219	63,428	(2,209)	-4%	(11,311)
Ysbyty Glan Clwyd	12,290	14,273	(1,983)	-16%	36,960	43,107	(6,147)	-17%	(23,256)
Facilities	1,231	1,330	(99)	-8%	3,693	4,007	(314)	-9%	(1,255)
Total Central	33,936	36,808	(2,872)	-8%	102,143	110,787	(8,644)	-8%	(35,851)
EAST INTEGRATED HEALTH COMMUNITY									
Management	87	85	1	-2%	260	260	(0)	0%	(7)
East Area	22,484	23,840	(1,356)	-6%	67,874	71,893	(4,019)	-6%	(14,650)
Ysbyty Wrexham Maelor	10,949	11,997	(1,048)	-10%	32,435	36,463	(4,028)	-12%	(13,004)
Facilities	1,120	1,313	(193)	-17%	3,359	3,882	(524)	-16%	(2,091)
Total East	34,640	37,236	(2,596)	-7%	103,928	112,499	(8,571)	-8%	(29,752)
Total Midwifery and Women's Services	3,840	3,987	(148)	-4%	11,488	11,811	(323)	-3%	(1,545)
Total Mental Health and LDS	13,976	15,615	(1,639)	-12%	41,722	46,704	(4,982)	-12%	(12,642)
Total Commisioning Contracts	23,710	22,756	955	4%	66,650	69,304	(2,654)	-4%	(407)
INTEGRATED CLINICAL DELIVERY PRIMARY CARE									
Covid Programmes	546	556	(10)	-2%	1,694	1,697	(3)	0%	0
Dental North Wales	2,839	2,497	341	12%	8,516	7,317	1,199	14%	4,000
Community Dental Services	516	546	(30)	-6%	1,550	1,697	(147)	-9%	(500)
Other Primary Care	1,575	1,618	(43)	-3%	4,748	4,863	(115)	-2%	(140)
Total Integrated Clinical Delivery Primary care	5,476	5,218	258	5%	16,508	15,574	934	6%	3,360
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES									
Provider Income	(1,949)	(1,992)	44	-2%	(5,846)	(5,834)	(12)	0%	(69)
Diagnostic and Specialist Clinical Support	6,510	7,225	(715)	-11%	19,578	20,970	(1,392)	-7%	(7,326)
Cancer Services	5,027	5,399	(372)	-7%	15,139	16,284	(1,145)	-8%	(4,072)
Total Integrated Clinical Delivery	9,588	10,632	(1,044)	-11%	28,871	31,420	(2,549)	-9%	(11,466)
Total Service Support Functions	13,715	12,602	1,113	8%	38,472	38,109	362	1%	(4,680)
Total Other Budgets	7,939	2,875	5,064	64%	30,874	7,597	23,277	75%	112,390
Total Deficit above Plan	**1,647**	**3,744**	**(2,097)**	**-127%**	**4,940**	**12,840**	**(7,900)**	**-160%**	**(0)**
Planned Deficit	**(1,647)**	**0**	**(1,647)**		**(4,940)**	**0**	**(4,940)**		
Total Deficit	**0**	**3,744**	**(3,744)**		**0**	**12,840**	**(12,840)**		



- The in-month position is reporting a deficit of £3.7m, an improvement of £1.1m from Month 2 and is £2.1m higher than the profiled Financial Plan deficit of £1.6m for Month 3.
- Pay costs have decreased in June with a downwards trend in agency and overtime.
- Pressures continue within CHC and Mental Health Out of Area Placements costs.

Expenditure – Pay & Non-Pay

Pay Costs	Actual						Cumulative			Full Year Forecast
	P10-24	P11-24	P12-24	P01-25	P02-25	P03-25	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	12.2	12.0	18.9	11.9	11.9	12.1	37.8	36.0	1.9	153.1
Medical & Dental	20.9	18.5	25.9	19.7	20.0	19.5	53.1	59.2	(6.1)	236.3
Nursing & Midwifery Registered	27.6	26.5	39.9	26.6	26.8	26.9	76.0	80.3	(4.3)	327.5
Additional Clinical Services	13.6	13.0	20.4	13.5	13.6	13.5	36.5	40.6	(4.1)	162.1
Add Prof Scientific & Technical	3.4	3.5	5.3	3.5	3.5	3.5	11.3	10.6	0.7	41.4
Allied Health Professionals	5.8	5.6	8.3	5.8	5.7	5.6	16.0	17.1	(1.1)	70.3
Healthcare Scientists	1.5	1.4	2.0	1.5	1.5	1.5	4.4	4.5	(0.0)	17.6
Estates & Ancillary	4.1	3.9	6.2	4.1	4.0	4.1	11.7	12.2	(0.5)	50.6
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	(0.0)	1.0
Health Board Total	89.3	84.5	127.0	86.7	87.2	86.7	247.0	260.6	(13.6)	1,059.7
Other Services (Incl. Primary Care)	2.7	2.7	3.4	2.6	2.6	2.8	6.7	8.0	(1.4)	32.2
Total Pay	92.0	87.2	130.4	89.3	89.8	89.6	253.7	268.7	(15.0)	1,091.9

Non-Pay Costs as per Monitoring Return Table	Actual						Cumulative			Full Year Forecast
	P10-24	P11-24	P12-24	P01-25	P02-25	P03-25	YTD Budget	YTD Actual	YTD Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractor	19.3	19.5	19.5	19.6	18.6	20.0	58.0	58.2	(0.2)	234.3
Primary Care - Drugs & Appliances	10.4	11.4	11.0	10.9	10.5	10.2	28.9	31.7	(2.7)	131.2
Provider Services - Non Pay (excl drugs & depreciation)	14.9	15.6	14.6	19.0	16.1	16.6	67.5	51.6	15.8	188.1
Secondary Care - Drugs	8.3	8.4	8.4	7.9	8.2	7.8	21.0	23.9	(2.9)	98.9
Healthcare Services Provided by Other NHS Bodies	30.9	30.9	30.8	30.5	31.5	30.8	84.3	92.8	(8.4)	366.4
Continuing Care and Funded Nursing Care	10.7	11.1	11.1	10.6	11.9	11.6	32.7	34.1	(1.4)	132.6
Other Private & Voluntary Sector	2.2	2.2	2.2	1.2	1.5	1.6	4.0	4.3	(0.3)	24.4
Joint Financing and Other	0.3	0.3	0.3	0.0	0.3	0.2	0.7	0.5	0.1	2.8
Losses, Special Payments and Irrecoverable Debts	0.2	0.2	0.2	0.2	0.3	0.3	0.7	0.7	0.0	2.5
Non-pay costs	97.2	99.6	98.0	99.9	98.8	99.1	297.8	297.8	0.0	1,181.3
AME/DEL Depreciation	3.2	3.2	3.2	3.2	3.2	4.0	10.3	10.3	(0.0)	39.6
Total non-pay	100.4	102.8	101.1	103.1	102.0	103.0	308.1	308.1	0.0	1,220.9

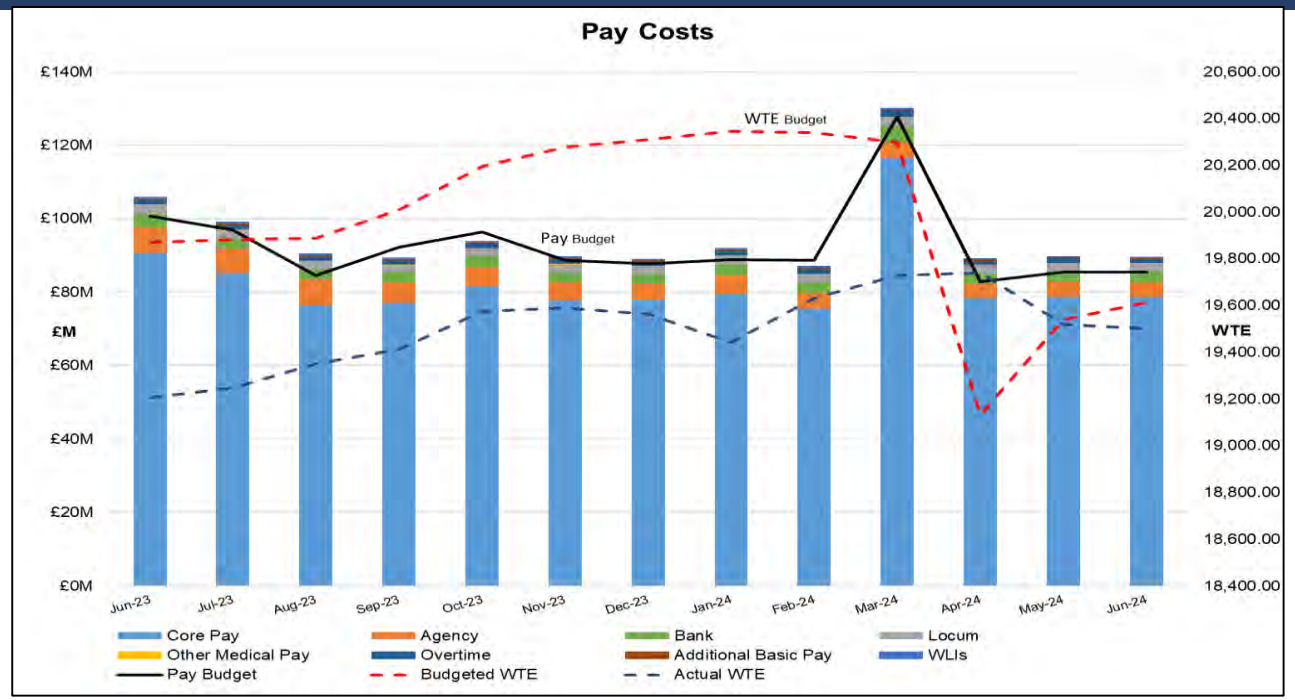
Health Board Pay:

- Month 3 Provider Services Pay expenditure is £0.5m (0.5%) less than Month 2. Agency and overtime expenditure have reduced in-month by £0.3m and £0.1m respectively, with Bank expenditure remaining in line with previous month.

Non-Pay Expenditure (excluding Depreciation):

- Non Pay has increased by £0.3m from previous month, with Primary Care Contractor reporting an increase of £1.5m which is offset by a reduction in several other Non Pay categories.
- Further detail on Non-Pay expenditure movements are reported in Slide 10.
- Unidentified savings are reported within the Non Pay forecast until finalised, when they are re-categorised to the applicable expenditure type.

Expenditure – Pay



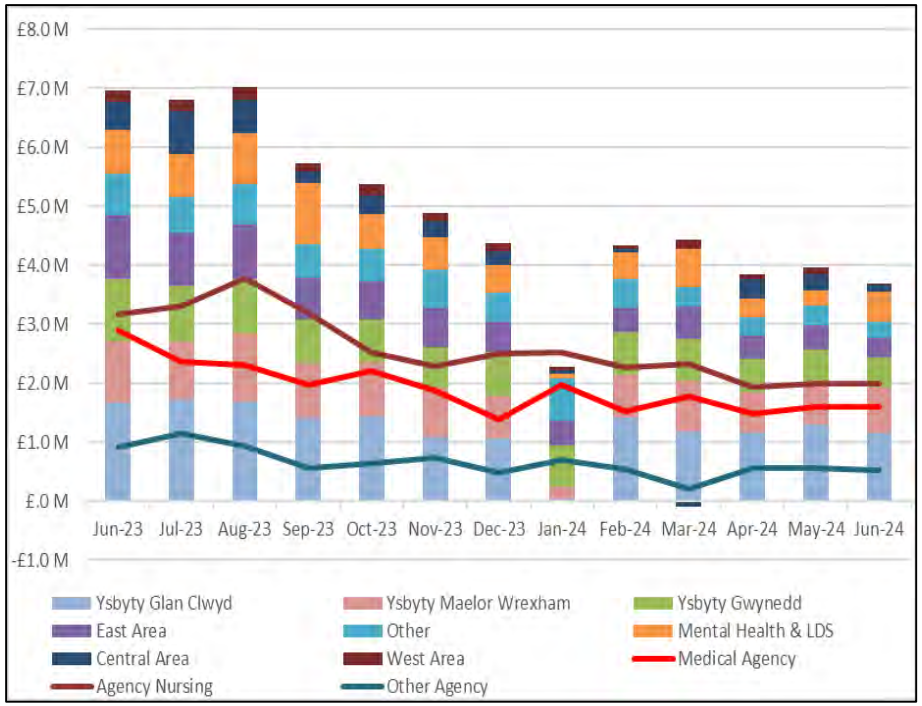
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Budgeted WTE	20,345	20,340	20,298	19,130	19,537	19,611
Actual WTE	19,442	19,630	19,728	19,740	19,518	19,500

Variable Pay	Actual							YTD Total 24/25
	23/24 Dec	23/24 Jan	23/24 Feb	23/24 Mar	24/25 Apr	24/25 May	24/25 Jun	
	£m	£m	£m	£m	£m	£m	£m	£m
Agency	4.4	5.2	4.3	4.3	4.0	4.2	3.8	12.0
Overtime	1.1	1.4	1.5	1.7	1.1	1.3	1.2	3.6
Locum	2.3	2.4	2.2	2.6	2.6	2.3	2.3	7.2
WLIs	0.4	0.4	0.4	0.4	0.3	0.2	0.2	0.7
Bank	2.6	2.8	2.8	4.3	2.6	2.9	2.8	8.3
Other Non Core	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1
Additional Hours	0.4	0.3	0.4	0.4	0.4	0.3	0.3	1.1
Total	11.1	12.5	11.6	13.8	11.1	11.1	10.8	33.0

- Budgeted WTE reduced between March and April due to non-recurrent funding and planned staff savings. The increase from April to May, and May to June relates to some of this additional funding being re-provided either by WG, or by Divisions requesting a continuation of this funding from reserves.
- Actual worked in June is 19,500 WTE, a decrease of 18 WTE from May.
- Variable Pay totals £10.8m for June, a decrease of £0.3m from previous month. Agency spend has decreased by £0.4m whilst overtime costs have also decreased by £0.1m from previous month.

Pay Costs – Agency

	2024-25 Agency Spend £'000												Total Year to Date £'000	Total Forecast £'000
	Actual M01	Acutal M02	Actual M03	Forecast M04	Forecast M05	Forecast M06	Forecast M07	Forecast M08	Forecast M09	Forecast M10	Forecast M11	Forecast M12		
West Area	82	131	3	104	104	104	104	104	104	104	104	104	216	1,156
Central Area	321	261	123	220	220	220	220	220	220	220	220	220	706	2,682
East Area	382	421	331	402	402	402	402	402	402	402	402	402	1,134	4,748
Ysbyty Gwynedd	577	586	505	538	538	538	538	538	538	538	538	538	1,668	6,512
Ysbyty Glan Clwyd	1,168	1,298	1,151	1,244	1,268	1,278	1,268	1,244	1,234	1,244	1,234	1,244	3,618	14,875
Ysbyty Maelor Wrexham	672	686	776	744	744	744	744	744	744	744	744	744	2,134	8,826
Mental Health & LDS	319	268	498	240	233	233	233	233	233	233	233	233	1,085	3,190
Womens	128	181	170	186	186	186	159	159	159	159	159	159	479	1,989
Other incl pan BCU Cancer Servcies and Corporate	321	319	286	312	314	315	313	313	300	300	320	320	925	3,735
Total Agency	**3,970**	**4,150**	**3,844**	**3,989**	**4,009**	**4,020**	**3,981**	**3,957**	**3,934**	**3,944**	**3,954**	**3,964**	**11,964**	**47,714**



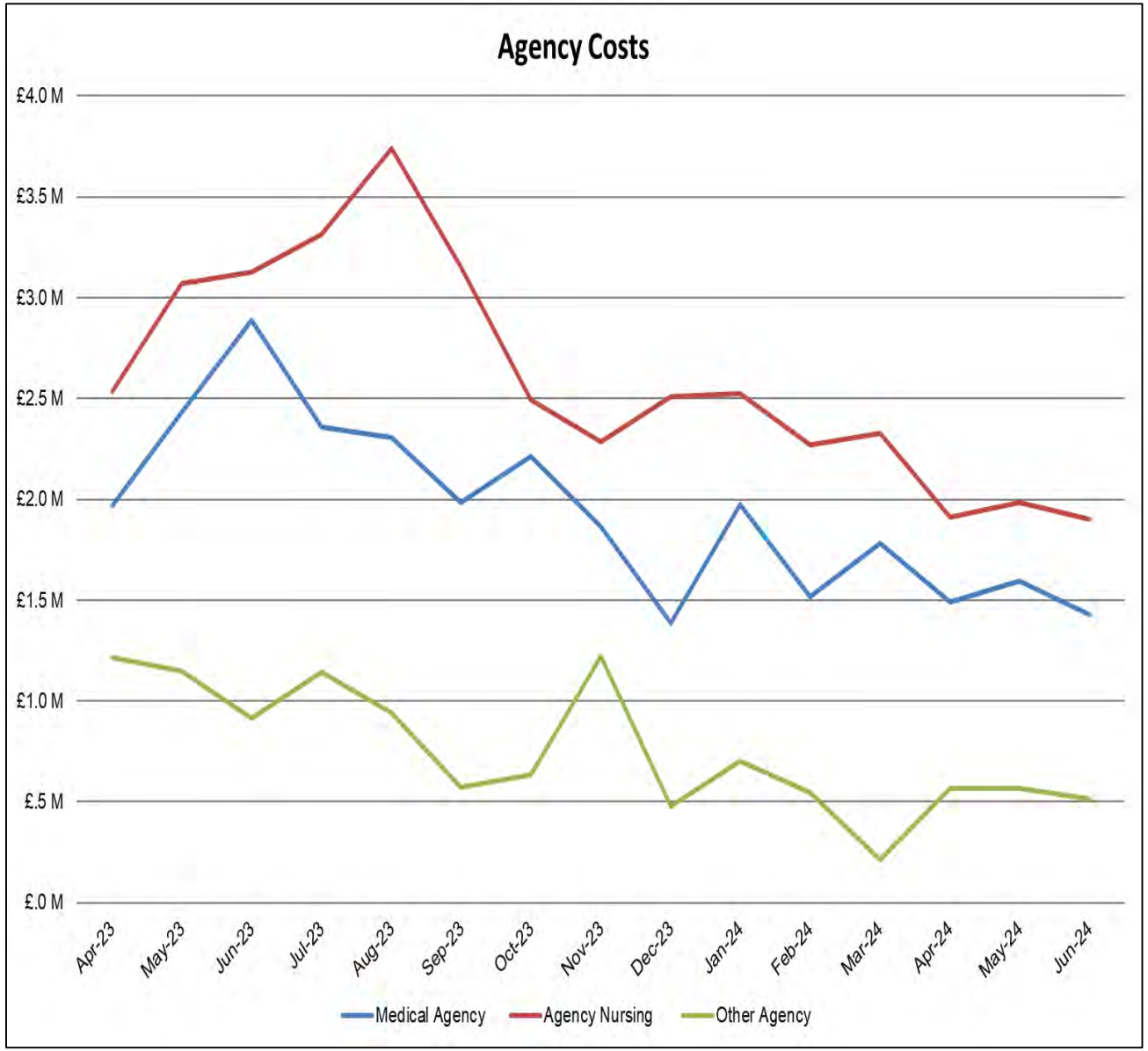
- Agency expenditure for Month 3 is £3.8m, representing 4.3% of total pay and a decrease of £0.4m from May. The 2023-24 monthly average Agency expenditure was £5.6m. 2024/25 Agency year end forecast outturn is £47.7m, which has decreased by £2.2m from the £49.9m reported at Month 2. The forecast continues to be refined as the year progresses.

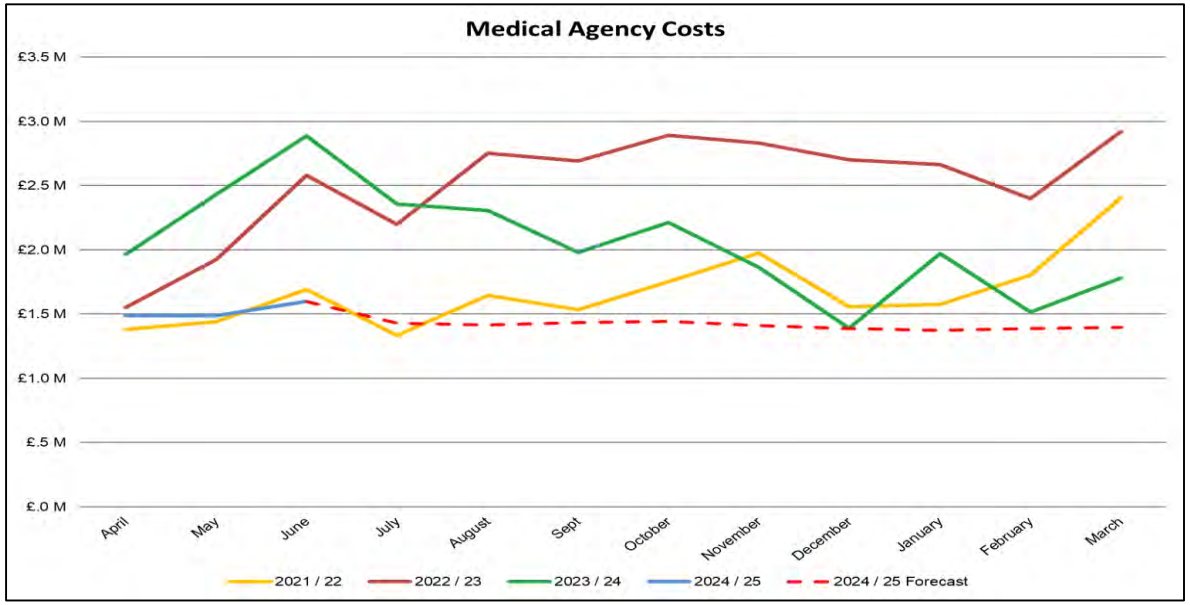
- Month 3 Medical Agency expenditure is £1.4m, a decrease of £0.2m from previous month. The monthly average medical agency expenditure for 2023/24 was £2.1m. The use of agency medical is predominantly within Ysbyty Glan Clwyd (£0.4m), Mental Health (£0.3m), Ysbyty Gwynedd (£0.2m), Ysbyty Maelor Wrexham (£0.2m), Womens (£0.2m), and East Area (£0.1m).

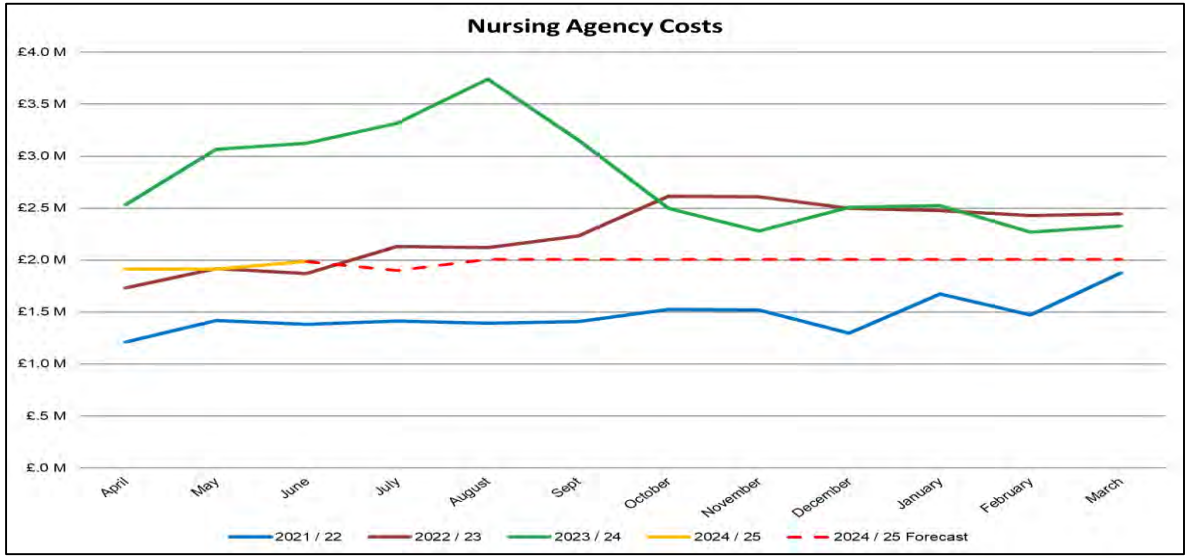
- Nurse agency costs totalled £1.9m for the month, a decrease of £0.1m from previous month, however expenditure is £0.9m lower than the 2023/24 monthly average costs of £2.8m. The use of agency nurses is predominantly within Ysbyty Glan Clwyd (£0.8m), Ysbyty Maelor Wrexham (£0.5m), Ysbyty Gwynedd (£0.3m), Mental Health (£0.2m) and East Area (£0.1m). Nurse Agency costs remain due to covering vacancies and sickness and to ensure that Nurse Staffing Act Ward staffing levels are maintained.

- Other agency costs totalled £0.5m in Month 3, a decrease of £0.1m from previous month. Other Agency costs mainly consists of Allied Health Professionals (£0.4m).

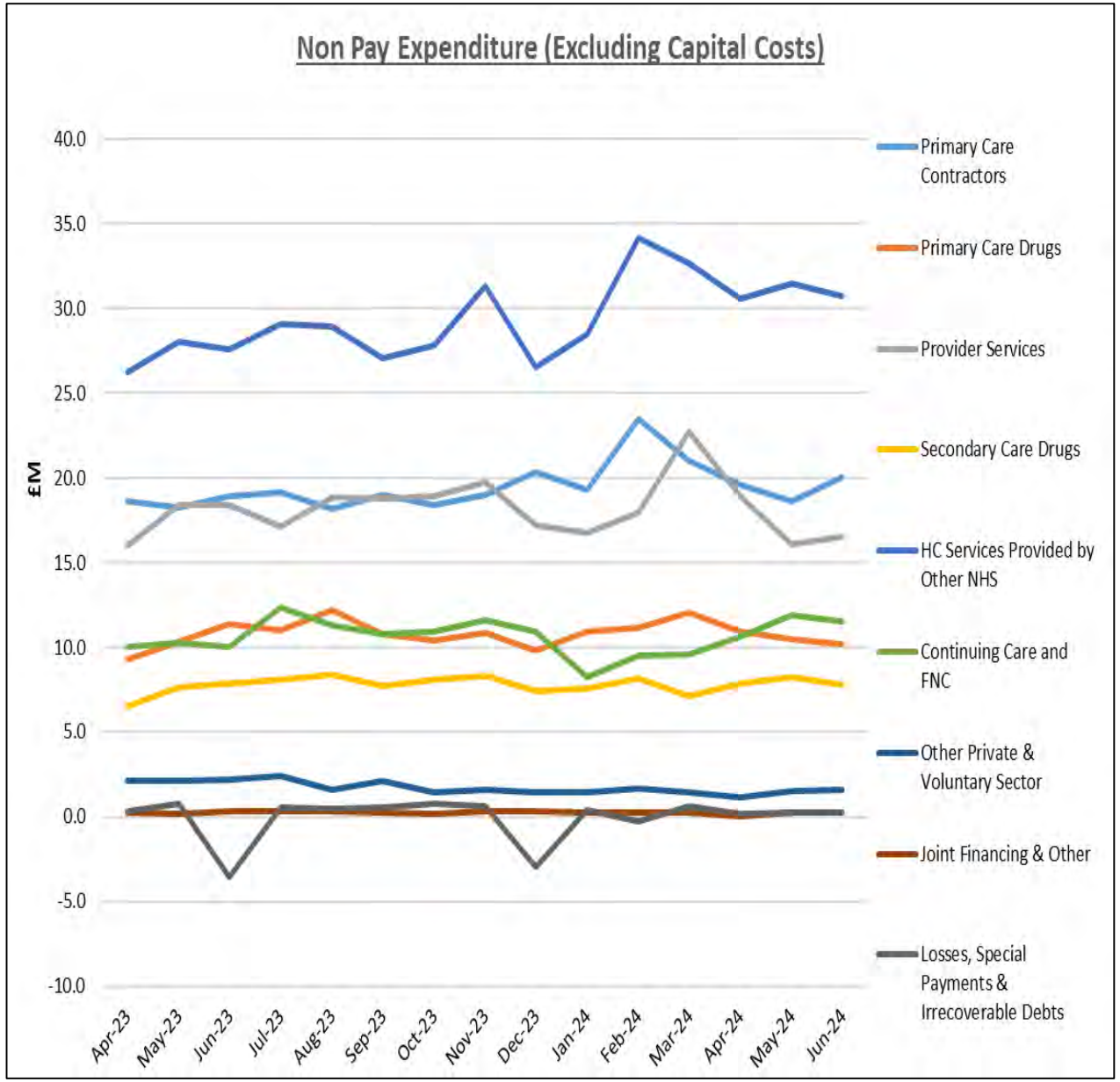
Pay Costs – Agency







Expenditure - Non Pay



- **Primary Care Contractor:** Month 3 expenditure is £1.5m (7.8%) higher than previous due to a £0.2m increase in GMS, £0.6m increase in Other Primary Care Services, of which £0.4m is recategorisation of spend from Provider Services Non-Pay and £0.3m increase in dispensing cost of drugs and fees, offset with £0.2m increase in GDS Dental clawbacks.

- **Primary Care Drugs:** Expenditure is £0.3m (2.7%) less than previous month due to less prescribing days reported in June. June estimate is based on the latest 3-month average cost per prescribing day model x 20 prescribing days for June (May had 21 prescribing days).

- **Secondary Care Drugs:** Expenditure is £0.4m (4.7%) less than previous month, with the reduction being reported against Oncology due to lower Cancer Chemotherapy patient activity in Month 3 and a reduction in high cost Hep C Drugs being particularly volatile depending on when doses are provided.

- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £0.7m (2.3%) less than Month 2. The in-month reduction is impacted by the recategorisation of £1.0m DHCW expenditure from Provider Services Non-Pay to Healthcare Services provided by other NHS Bodies in Month 2. Excluding the recategorisation impact in Month 2, the in-month movement would be an increase of £0.3m.

- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure is £0.3m (2.7%) less than previous month. Month 3 (June) included 30 days compared to 31 days expenditure in Month 2 (May).

- **Other Private & Voluntary Sector:** Expenditure relates to a variety of providers, including Hospices, Mental Health organisations and planned care activity providers. Expenditure is £0.1m (7.8%) higher than previous month due to an increase in the Hospice SLA linked to additional Palliative Care funding.

Allocations

Description	£m
Allocations Received	2,028.9
Total Allocations Received	**2,028.9**

Description	£m
Allocations anticipated	
Capital Depreciation - Impairment	2.3
Removal of IFRS-16 Leases (Revenue)	-4.6
Real Living Wage (Care Homes)	3.5
Substance Misuse	6.0
IM&T Refresh Programme	1.9
Six Goals	1.6
5 percent A4C Pay Award	52.7
5 percent M&D Pay Award	5.9
Increase in Real Living Wage – Band 2 and Certain Points Band 3	1.4
CAMHS – Schools in Reach	1.9
WRP Top Slice for 24/25 as per IMTP	5.7
Early Years and Prevention 24/25	1.2
EPMA DPIF Funding	2.8
Other	2.3
Total Allocations Anticipated	**73.2**

	£m
Total Allocations Received	2,028.9
Total Allocations Anticipated	73.2
Total Welsh Government Income	**2,102.1**

- The Health Board is funded in the main from Welsh Government allocation via the Revenue Resource Limit (RRL). Total Revenue Resource Limit (RRL) for the year is £2,102.1m. £516.4m of the RRL has been profiled into the cumulative position, which is £9.1m less than an equal twelfth as specific programmes of work are profiled into future months.

- Confirmed allocations to date is £2,028.9m. This includes £12.2m allocation for COVID-19, with £2.4m of the COVID-19 funding profiled into the cumulative position.

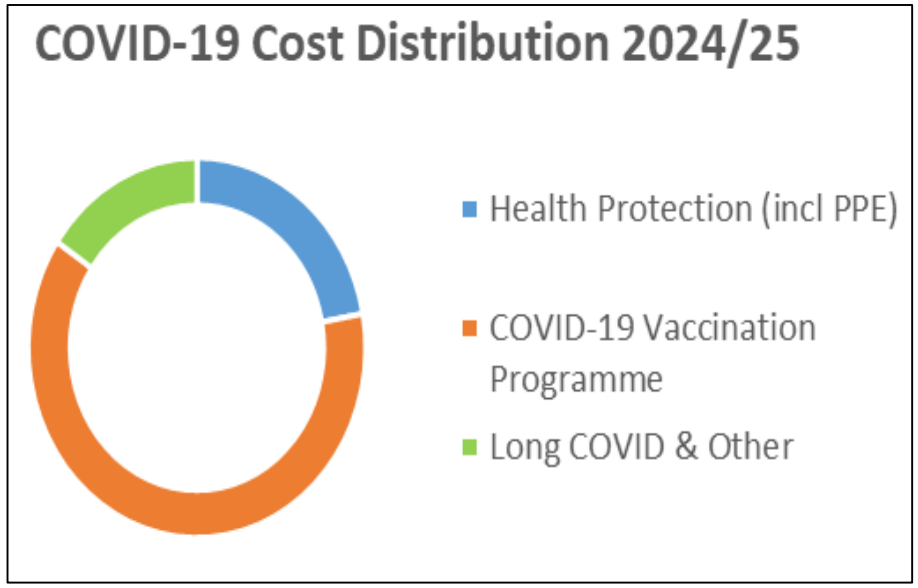
- Further anticipated allocations in year totals £73.2m, consisting mainly of £52.7m 5% A4C Pay Award (23/24), £5.9m 5% M&D Pay Award (23/24), £6.0m Substance Misuse, £1.6m Six Goals, £3.5m Real Living Wage (Care Homes), £1.9m CAMHS School in Reach, £1.2m 24/25 Early years and Prevention and £2.8m EPMA DPIF Funding.

- The anticipated income for Real Living Wage for CHC & FNC is based upon a calculation of National Living Wage £11.44, and the Real Living Wage of £12.00 applied to the estimated affected hours.

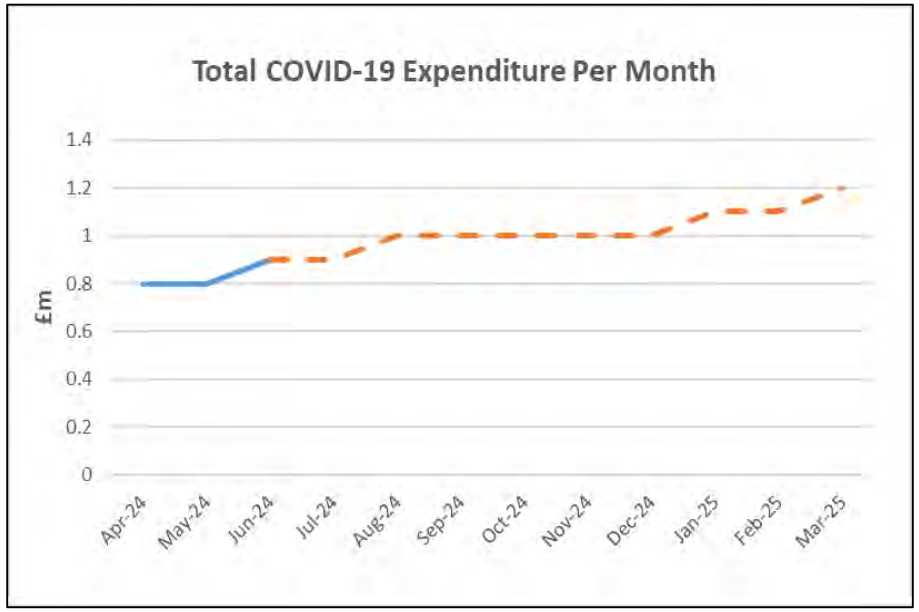
- Also included within the anticipated allocations is the removal of the £5.6m 24/25 Welsh Risk Pool (WRP) contribution top slice and £4.6m removal of IFRS-16 Leases revenue recovery.

Impact of COVID-19

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Year to Date Expenditure £m	Forecast 2024/25 £m
Health Protection (incl PPE)	0.2	0.1	0.2	0.5	2.7
COVID-19 Vaccination	0.5	0.6	0.5	1.6	7.6
Long COVID & Other	0.1	0.1	0.1	0.3	1.9
Total COVID-19 Expenditure	**0.8**	**0.8**	**0.8**	**2.4**	**12.2**
Welsh Gov COVID-19 Income	0.8	0.8	0.8	2.4	12.2
Impact of COVID-19 on Position	**0.0**	**0.0**	**0.0**	**0.0**	**0**



- Total COVID expenditure for WG funded programmes in Month 3 is £0.8m, with a year-to-date cost of £2.4m. Total full year forecast spend is £12.2m against a COVID funding allocation of £12.2m for 2024/25
- Month 3 Health Protection expenditure is £0.1m with an annual forecast spend of £2.7m.
- COVID-19 Vaccination Programme expenditure for Month 3 is £0.6m and annual forecast spend is £7.6m. Discussions are ongoing in relation to the mitigation of a potential pressure on this allocation.
- Month 3 Long COVID expenditure is £0.1m and annual forecast expenditure is £1.9m. Early indications are that there will be an underspend; however, plans for utilising the allocation in full within the total Covid Programme are being considered.
- Service colleagues will engage with the WG Policy Leads, to discuss the possibility of potential virements between funding streams. The forecast in the above table reflects full expenditure against each category.



Risks and Opportunities (not included in position)

- The below are risks to the Health Board's financial position for 2024/25. Where we are clear of specific costs for both risks and opportunities, these are incorporated within the forecast position.

	Risks	£m	Level
1	Continuing Healthcare - continued patient number growth and risk relating to fees.	£5.0m	Medium
2	Prescribing - growth above original plan expectation. April actual data has increased compared to March.	£3.0m	Medium
3	Dental Ringfenced - possible recovery by WG unless retention is approved.	£4.0m	Medium
4	Under Delivery against Savings Plan - 50% of unidentified savings.	£11.0m	Medium
	Total Quantifiable Risks	£23.0m	

Balance Sheet

- The closing cash balance as at 30th June 2024 was £6.916m, which included £4.528m cash held for revenue expenditure and £2.388m for capital projects.

- The Health Board is currently forecasting a closing cash balance for 2024-25 of (£14.734m) made up of (£17.187m) revenue cash and £2.453m capital cash. Strategic Cash Support will be requested from WG later in the year, as per normal timeframes.

	Opening Balance Beginning of Apr-24 £m	Closing Balance End of Jun-24 £m	Forecast Closing Balance End of Mar-25 £m
Non-Current Assets			
Property, plant and equipment	724.0	715.5	730.5
Intangible assets	1.2	1.1	1.2
Trade and other receivables	84.6	84.6	84.6
Non-Current Assets sub total	**809.7**	**801.1**	**816.2**
Current Assets			
Inventories	20.9	20.4	20.9
Trade and other receivables	107.7	121.0	122.7
Cash and cash equivalents	5.0	6.9	-14.7
Non-current assets classified as held for sale	0.4	0.4	0.0
Current Assets sub total	**134.0**	**148.7**	**128.9**
TOTAL ASSETS	**943.7**	**949.9**	**945.1**
Current Liabilities			
Trade and Other Payables	209.6	216.3	201.1
Provisions	47.1	60.7	62.1
Current Liabilities Sub Total	**256.7**	**277.0**	**263.2**
NET ASSETS LESS CURRENT LIABILITIES	**687.1**	**672.8**	**681.9**
Non-Current Liabilities			
Trade and Other Payables	27.5	27.5	27.5
Provisions	85.9	85.9	85.9
Non-Current Liabilities Sub Total	**113.4**	**113.4**	**113.4**
TOTAL ASSETS EMPLOYED	**573.7**	**559.5**	**568.6**
FINANCED BY: **Taxpayers' Equity**			
General Fund	353.6	339.4	348.5
Revaluation Reserve	220.1	220.1	220.1
Total Taxpayers' Equity	**573.7**	**559.5**	**568.6**

Capital

- The approved Capital Resource Limit (CRL) for 2024/25 is £44.830m and is forecast to be spent in full. Year to date expenditure is £1.7m against a year to date plan of £1.7m. The Regional Orthopaedic Hub at LLGH presents the highest risk to delivery of the CRL, progress will be closely monitored and refreshed cashflows to be provided to Welsh Government.

- Additional allocations are expected from Welsh Government following recent confirmation of the successful Backlog Maintenance bids submitted - increased to £4.976m (was £2.4m) following a £30m investment offer across NHS Wales.

BUDGET 2024/25		
1) Capital Resource Limit 2024/25	**£m**	Brief Overview / Update The purpose of this dashboard is to brief the committee on the delivery of the approved capital programme to enable appropriate monitoring and scrutiny. The report provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes. The report also provides a summary on the progress of expenditure against the capital resources allocated to the Heath Board by the Welsh Government through the Capital Resource Limit (CRL).
WG Discretionary Capital	12.448	
All Wales Scheme	32.382	
Total CRL	**44.830**	

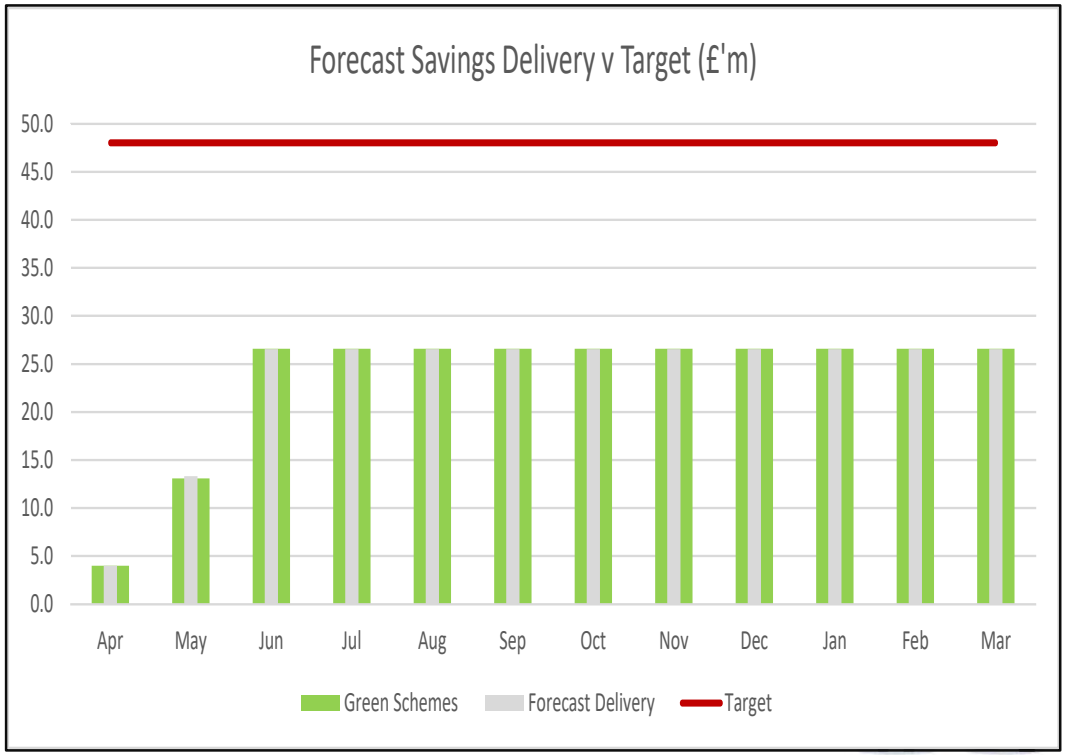
CAPITAL PROGRAMME 2024/25	Initial Programme taking into account 25% reduction (£m)	Year to Date (£m)	Forecast Outturn (£m)	Current Over/Under Commitment (£m)	Comments
Divisions	4.924	0.078	4.924	0.000	Programme leads have confirmed that works will commence, once purchase orders are in place or tenders have been received to progress the planned works.
Operational Estates	1.392	0.058	1.392	0.000	Programme leads have confirmed that works will commence, once purchase orders are in place or tenders have been received to progress the planned works and that the Health Board will meet it's CRL
Medical Devices	1.897	0.615	1.897	0.000	Programme leads have confirmed that works will commence, once purchase orders are in place or tenders have been received to progress the planned works and that the Health Board will meet it's CRL
Informatics	3.386	0.094	3.386	0.000	Programme leads have confirmed that works will commence, once purchase orders are in place or tenders have been received to progress the planned works and that the Health Board will meet it's CRL
All wales funding brokerage to be re-provided from discretionary	0.849	0.000	0.000	0.849	Brokerage managed within the programme
WG Discretionary Capital	**12.448**	**0.845**	**11.599**	**0.849**	**Under Commitment**

MAJOR CAPITAL SCHEMES (with in year spend)	Programme (£m)	Year to Date (£m)	Forecast Outturn (£m)	Over/Under Commitment (£m)	Comments
Conwy & Llandudno Junction Health & Social C	0.820	0.014	0.914	-0.094	The allocation is fees to develop a OBC/FBC business case. The details around the design is currently being agreed.
Efab - Infrastructure	2.770	0.010	2.616	0.154	Estate leads confirmed that projects have been assessed and tenders are issued and received to raise purchase orders. All planned works will be completed in year to meet the CRL
Efab - Fire	0.710	0.039	1.322	-0.612	Estate leads confirmed that projects have been assessed and tenders are issued and received to raise purchase orders. All planned works will be completed in year to meet the CRL
Efab - Decarbonisation	0.360	0.000	0.440	-0.080	Estate leads confirmed that projects have been assessed and tenders are issued and received to raise purchase orders. All planned works will be completed in year to meet the CRL
Regional Orthopaedic Hub at Llandudno Hospit	23.077	0.770	23.297	-0.220	Contractors on site and programme of works are progressing to handover in Quarter 4.
Substance Misuse Building, Llandudno	1.405	0.009	1.402	0.003	Current progress sees them completing for procurement and appointment/deployment of contractor on site. Completion of project in
CAMHS Crisis Hub	0.320	0.004	0.320	0.000	Planning application submitted, procurement of modular supplier near completion. Project target completion September 2024.
Diagnostic Equipment 2024-25 - YG CT	2.920	0.000	2.920	0.000	Allocation for YG CT, fully implemented in the last quarter of the financial year.
All Wales Capital	**32.382**	**0.846**	**33.231**	**-0.849**	**Over commitment**
Total Capital Funding Available	**44.830**	**1.691**	**44.830**	**0.000**	

Savings Performance against Target

- The Health Board's financial plan has set a savings target of £48.0m to be delivered in 2024/25. The £48.0m target is profiled on an equal twelfth's basis.
- Savings reporting and monitoring has moved to a Value and Sustainability thematic model, with work underway to identify opportunities. Some of these opportunities have been converted to deliverable forecasts, with Green schemes (expected to be fully deliverable) totalling £26.5m and Red schemes which still need further work to convert to Green schemes totalling £0.8m. The full year value of further pipeline opportunities totals £3.5m.
- Of the £26.5m savings identified, £4.3m is non-recurring and £22.2m has been identified as recurring, with a full year effect of £32.1m.
- Savings delivered in Month 3 totals £3.4m, of which £2.8m is recurring, against a £2.9m Plan and £4.0m Target. Nil Accountancy Gains reported at Month 3.

Service Performance against Target	Annual			Year to Date		
	Target	Delivery	Delivery v Target (+ve = adverse)	Target	Delivery	Delivery v Target (+ve = adverse)
West Integrated Health Community	8.7	4.7	4.0	2.2	1.3	0.9
Central Integrated Health Community	10.9	4.4	6.6	2.7	1.5	1.2
East Integrated Health Community	11.2	5.8	5.4	2.8	1.5	1.3
MHLD	4.2	7.7	-3.4	1.1	0.5	0.5
Womens Services	1.4	0.1	1.3	0.3	0.0	0.3
Diagnostic and Specialist Clinical Support	2.1	0.7	1.4	0.5	0.2	0.3
Cancer Services	1.6	1.3	0.3	0.4	0.3	0.1
Dental North Wales	0.0	0.0	0.0	0.0	0.0	0.0
Community Dental Services	0.2	0.0	0.2	0.0	0.0	0.0
Other Primary Care	0.0	0.0	0.0	0.0	0.0	0.0
Corporate & Support Services	3.7	2.0	1.7	0.9	0.8	0.1
Reserves	4.0		4.0	1.0		1.0
Saving Total	**48.0**	**26.5**	**21.5**	**12.0**	**6.1**	**5.9**



Savings Performance by Category

Savings - V&S Annual Performance against Target (£'m)	Target £m	Forecast Delivery									Delivery v Target (+ve = adverse) £m
		V&S Board Categories									
Service / Area		Workforce £m	Medicines Management £m	Procurement & Non-pay £m	CHC £m	Pathway £m	Other – Commissioning £m	Other - Primary Care £m	Income £m	Total £m	
West Integrated Health Community	8.7	1.6	1.8	0.4	0.7	0.0	0.0	0.0	0.2	4.7	4.0
Central Integrated Health Community	10.9	0.5	2.8	0.3	0.7	0.0	0.0	0.0	0.0	4.4	6.6
East Integrated Health Community	11.2	1.8	2.7	0.5	0.7	0.0	0.0	0.0	0.1	5.8	5.4
MHLD	4.2	0.5	0.1	0.1	1.5		5.5			7.7	-3.4
Womens Services	1.4	0.0	0.0	0.0						0.1	1.3
Diagnostic and Specialist Clinical Support	2.1	0.0		0.6						0.7	1.4
Cancer Services	1.6	0.2	1.0	0.0						1.3	0.3
Dental North Wales	0.0			0.0						0.0	0.0
Community Dental Services	0.2	0.0		0.0						0.0	0.2
Other Primary Care	0.0			0.0						0.0	0.0
Corporate & Support Services	3.7	1.2	0.0	0.8	0.0	0.0	0.0	0.0	0.0	2.0	1.7
Reserves	4.0									0.0	4.0
Saving Total	**48.0**	**5.9**	**8.5**	**2.7**	**3.6**	**0.0**	**5.5**	**0.0**	**0.3**	**26.5**	**21.5**

Recurring Performance against Target	Annual			Year to Date		
	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m	Target £m	Delivery £m	Delivery v Target (+ve = adverse) £m
Recurring	48.0	22.2	25.8	12.0	4.3	7.7
Non Recurring	0.0	4.3	-4.3		1.8	-1.8
Total	**48.0**	**26.5**	**21.5**	**12.0**	**6.1**	**5.9**

Savings Variance

			Full Year			Year to Date		
Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
Cancer	Biosimilar Initation, switching	R	17,952	40,725	22,773	4,488	8,614	4,126
Cancer	DOAC prescribing	R	39,156	36,475	-2,681	9,789	13,858	4,069
Cancer	Medical Agency	R	83,865	96,865	13,000	24,276	37,276	13,000
Cancer	National agreed contracts for secondary care drugs	R	888,869	911,159	22,290	116,698	155,937	39,239
Cancer	Optimising medicine prescribing within clinical pathways (NICE TA)	R	33,372	25,029	-8,343	8,343	0	-8,343
Cancer	Outsourcing savings (aseptics SACT)	R	17,550	17,550	0	0	0	0
Corporate	Cessation of RPO (Medacs) Gain share Contract	R	387,000	387,000	0	96,750	96,750	0
Corporate	Executive Vacancy - Chief Operating Officer 24/25	NR	112,602	112,602	0	48,258	48,258	0
Corporate	Finance Departement Staff Savings 24/25	R	60,988	60,988	0	13,954	13,954	0
Corporate	Finance Departement Staff Savings 24/25	NR	239,477	239,477	0	97,647	97,647	0
DSCS	Contract Monitoring - Radiology AML	NR	24,316	24,316	0	24,316	24,316	0
DSCS	LINC Project	NR	453,000	453,000	0	113,250	113,250	0
DSCS	Radiotherapy Linear Accelerator Warranty	NR	36,490	36,490	0	15,639	15,639	0
DSCS	Toxicology Service	R	29,202	29,202	0	7,301	7,301	0
Estates	Director of Estates (vacancy)	NR	176,716	176,716	0	58,905	58,905	0
Estates	Disposal of Ala Road	R	60,738	40,476	-20,262	0	0	0
Estates	Disposal of Buildings - Cilan	R	4,969	4,969	0	0	0	0
HC - Centre	Biosimilar Initation, switching	R	538,273	777,234	238,961	157,550	300,298	142,748
HC - Centre	Continuing Health Care Schemes	R	734,000	734,000	0	183,501	183,501	0
HC - Centre	DOAC prescribing	R	1,353,976	1,037,894	-316,081	476,677	476,196	-481
HC - Centre	Dressings review	R	80,000	60,000	-20,000	20,000	0	-20,000
HC - Centre	National agreed contracts for secondary care drugs	R	135,968	50,837	-85,131	16,139	9,912	-6,227
HC - Centre	Optimising medicine prescribing within clinical pathways (NICE TA)	R	38,496	51,289	12,793	9,624	15,743	6,119
HC - Centre	Optomisation of generic prescribing	R	121,666	108,559	-13,107	49,341	45,828	-3,513
HC - Centre	Polypharmacy medication reviews	R	300,000	406,927	106,927	75,000	189,462	114,462
HC - Centre	Review low value medicines prescribed including liothyronine	R	135,432	102,589	-32,843	33,858	1,015	-32,843
HC - Centre	Review of Blood glucose test strips, optomise product selection	R	40,084	40,084	0	0	0	0
HC - Centre	Scriptswitch & Optomise savings	R	250,000	187,500	-62,500	62,500	0	-62,500
HC - East	Biosimilar Initation, switching	R	442,735	443,578	843	0	843	843
HC - East	CHC Cost containment	R	604,512	604,512	0	0	0	0
HC - East	Childrens - Medical Agency Reduction	R	250,000	250,000	0	0	0	0
HC - East	Childrens CHC Package Review	R	120,000	120,000	0	0	0	0
HC - East	DOAC prescribing	R	1,489,958	1,494,435	4,477	566,079	570,556	4,477
HC - East	Increase of catering income	R	88,698	88,698	0	22,173	22,173	0
HC - East	Medical Agency Reduction - Community Services	R	261,163	261,163	0	65,291	65,291	0
HC - East	National agreed contracts for secondary care drugs	R	157,451	155,970	-1,481	21,309	19,828	-1,481
HC - East	Optimising medicine prescribing within clinical pathways (NICE TA)	R	40,704	68,455	27,751	10,176	37,927	27,751
HC - East	Outsourcing savings (homecare)	R	118,128	182,838	64,710	0	64,710	64,710
HC - East	Polypharmacy medication reviews	R	350,004	350,004	0	87,501	87,501	0
HC - East	Reduction in spend on Nursing Agency - EC	R	169,000	168,336	-664	70,000	69,336	-664

Savings Variance

			Full Year			Year to Date		
Service	Scheme / Opportunity Title	Recurrent / Non Recurrent	Plan	Forecast	Variance Forecast vs Plan	Plan	Achieved	Variance Achieved vs Plan
HC - East	Reduction in spend on Nursing Agency - Medicine	R	240,000	242,218	2,218	60,000	62,218	2,218
HC - East	Reduction in spend on Nursing Agency - Surgery	R	230,719	248,569	17,850	74,578	92,428	17,850
HC - East	Urology Scope Stacker	R	75,000	75,000	0	0	0	0
HC - West	Acute paediatric medical staffing - Efficiencies	R	244,569	242,193	-2,376	59,751	57,375	-2,376
HC - West	BCU Accommodation for CHC West team	R	9,876	9,876	0	0	0	0
HC - West	Biosimilar Initation, switching	R	169,915	169,915	0	17,357	44,000	26,643
HC - West	CAMHS - Temporary clinical efficiencies	NR	134,088	141,850	7,762	20,240	28,002	7,762
HC - West	Continence Products	R	50,000	37,499	-12,501	12,501	0	-12,501
HC - West	DOAC prescribing	R	1,095,519	694,142	-401,376	312,549	314,086	1,537
HC - West	Dressings review	R	30,000	22,500	-7,500	7,500	0	-7,500
HC - West	Grip and control measures - Acute Med Locum Reduction	R	248,000	248,000	0	41,000	44,000	3,000
HC - West	Implement Workforce Plan for Health Board Managed Practices	R	90,000	90,000	0	0	0	0
HC - West	Increase of catering income	R	218,024	222,450	4,426	54,504	66,305	11,801
HC - West	Medicine Grip and Control - Non-Pay	R	80,000	80,000	0	0	0	0
HC - West	National agreed contracts for secondary care drugs	R	165,855	165,855	0	22,877	23,000	123
HC - West	Neurodevelopment Service Relocation - Estates rationalisation	R	9,319	9,319	0	0	0	0
HC - West	Optimising medicine prescribing within clinical pathways (NICE TA)	R	30,800	30,800	-0	7,700	24,000	16,300
HC - West	Optomisation of generic prescribing	R	107,361	98,577	-8,784	47,865	45,616	-2,249
HC - West	Outsourcing savings (homecare)	R	28,893	28,893	0	7,223	21,000	13,777
HC - West	Polypharmacy medication reviews	R	250,000	392,020	142,020	62,500	145,816	83,316
HC - West	Review low value medicines prescribed including liothyronine	R	48,156	6,015	-42,141	12,039	501	-11,538
HC - West	Review of Blood glucose test strips, optomise product selection	R	24,375	24,375	0	0	0	0
HC - West	SACC - Efficiency - Reduce Escalated Beds	R	160,000	240,000	80,000	0	70,000	70,000
HC - West	SACC - Grip & Control - Medical Pay	R	260,000	280,000	20,000	24,000	95,000	71,000
HC - West	Scriptswitch & Optomise savings	R	200,000	150,000	-50,000	50,000	0	-50,000
HC - West	West IHC - Continuing Health Care Schemes	R	661,000	661,000	0	165,250	119,241	-46,009
MH&LDS	Medical Agency Reduction	R	44,195	44,195	0	0	0	0
MH&LDS	National agreed contracts for secondary care drugs	R	71,965	71,965	0	0	0	0
MH&LDS	Outsourcing savings (primary care dispensed)	R	60,996	60,996	0	15,249	15,249	0
MH&LDS	Reduction in Nursing Agency Spend	R	254,388	254,388	0	63,597	63,597	0
MH&LDS	Reduction in Out of Area Placements	R	5,450,544	5,450,544	0	0	0	0
MH&LDS	Right Care Programme	R	1,500,000	1,500,000	-0	375,000	335,510	-39,490
Midw & Womens	Ceasing of Pay Protection	R	10,548	10,548	0	2,637	2,637	0
Midw & Womens	Consultant OOHs Intensity Allowance Review	R	25,925	25,925	0	1,994	1,763	-231
Midw & Womens	National agreed contracts for secondary care drugs	R	31,022	31,022	0	0	0	0
Subtotal			**22,797,562**	**22,498,592**	**-298,970**	**4,084,245**	**4,523,170**	**438,925**
Procurement			1,208,051	1,281,046	72,994	350,129	295,518	-54,612
Enhanced mileage rates			229,230	248,549	19,319	57,307	76,626	19,319
Enhanced Recruitment Control Savings			2,272,251	2,499,659	227,407	1,136,126	1,218,348	82,222
Telephone Line Rental			12,914	12,981	67	3,228	3,243	14
Total			**26,520,008**	**26,540,826**	**20,818**	**5,631,036**	**6,116,905**	**485,869**

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

Teitl adroddiad: ***Report title:***	**Corporate Governance Report**
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	The objective of this report is to provide the Board with an update on key Corporate Governance matters and to provide assurance in the following areas: • Chairs Actions • Affixing of the Common Seal • Summary of business discussed in Private • Annual Business Cycle including Board Development Programme • The Terms of Reference for the Remuneration Committee • Approved clinicians and Section 12(2) Doctors across Wales
Argymhellion: ***Recommendations:***	The Board is asked to: • **NOTE** the contents of the report; • **NOTE** the affixing of the common seal; • **NOTE** the matters considered in the Private Board meeting on 30 May 2024; • **APPROVE** the proposed Board Cycle of Business 2024/25 aligned to the Annual Plan; • **APPROVE** the revised Terms of Reference for the Remuneration Committee; and • **RATIFY** previous Chair's Action Letters which contain recommendations to grant approval or reapproval for Approved Clinicians and Section 12(2) Doctors across Wales.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger – Director of Corporate Governance
Awdur yr Adroddiad: ***Report Authors:***	Philippa Peake-Jones – Head of Corporate Affairs

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd:	Arwyddocaol	Derbyniol	Rhannol	Dim Sicrwydd

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this. It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	This is not applicable for this report.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	This is not applicable for this report.

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The effective management of Governance 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 and less waste
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to have effective Corporate Governance can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR-16 – Leadership/Special Measures BAF 2023/24 SP16 Board Leadership and Governance
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: • To continue to improve and report on Corporate Governance	
List of Appendices: Appendix 1 – Board Cycle of Business Appendix 1a – Board Development Programme Appendix 2 – Remuneration Committee Terms of Reference Appendix 3 – Approved Clinicians and Section 12(2) Doctors - July 2024 Board Report	

CORPORATE GOVERNANCE REPORT

1) Introduction and Background

There are a number of corporate governance matters, which have to be reported to the Board as a regular item in-line with Standing Orders. This report encompasses all such issues as one agenda item.

2) Chairs Actions

There have been no Chair's Actions taken since the last Board Meeting.

3) Affixing the Common Seal

In-line with standing orders, a routine report on documents to which the common seal has been affixed is required. The Board is asked to note that the Health Board Seal has been affixed on the documents listed below.

No	Contract Name and Address	Approval Route	Date Signed and Sealed	Seal No
204	BCUHB & The Maggie Keswick Jencks Cancer Caring Centres Trust	Deed of Variation	22/05/2024	692
205	3 x Contracts for the provision of Domiciliary Care	Executive Team 23rd March 2024	22/05/2024	693
206	Lease of Accommodation - Unit 20 & 31 the OpTic Centre	Executive Meeting 5th June 2024	26/06/2024	694
207	Lease of accommodation - Unit 23, Ground Floor the OpTic Centre	Executive Meeting 5th June 2024	26/06/2024	695
208	X-Ray Room Replacements, Deeside Community Hospital, Royal Alexandra & Denbigh Infirmary	Welsh Government (WG) Approval letter 8th December 2023 endorsed Capital Investment Group 12th December 2023	26/06/2024	696

4) Summary of Business discussed in the Private session of the Health Board on 30 May 2024

In accordance with Standing Orders, the Health Board is required to report any decisions made in private session, to the next available public meeting of the board.

The following items were discussed during the private board meeting held on 30 May 2024:

- **Bangor Health and Wellbeing Centre Strategic Outline Case**
  The Board approved the updated Strategic Outline Case for the Integrated Bangor Health and Wellbeing Centre which sought formal approval from Welsh Government on the next steps
- **Continuing Health Care Fees**
  The Board approved the uplifts for Continuing NHS Health Care
- **General Dental Services Contract Award**
  The Board approved the contract award recommendation
- **High Value Claim**

The Board approved a high value claim

- **Updated learning following authority to settle a high value claim**
  The Board noted the report and received assurance on the actions taken as a result of the incident and the actions to be taken
- **Sensitive Quality matters**
  An update on key sensitive quality matters was provided.
- **Corporate Risk Register**
  The risk around digital security and protection was noted along with the mitigations and actions.

5) Annual Business Cycle

As noted at the Board Meeting in May, we have reviewed our Annual Business Cycle for the Health Board and is attached as Appendix 1, for approval. The updated version now aligns with the Annual Plan. Appendix 1a is the current Board Development programme which Board members have engaged with; it will be refined over time.

6) Remuneration Committee Terms of Refereence

As part of our improvement work, we are reviewing Terms of Reference, an amended version is attached as Appendix 2 for approval.

7) Approved Clinicians and Section 12(2) Doctors - July 2024 Board Report

Previously the Board has received the Approved Clinicians and Section 12(2) Doctors report as a standalone agenda item to provide as assurance of compliance with Mental Health Act legislation, policy and process. It has been agreed that this will now form part of the Corporate Governance Report as normal reporting. The Board is asked to note the report contents and formally ratify approvals previously granted through weekly Chair's Action Letters.

Health Board – Annual Cycle of Business

(1st April 2024 to the 31st March 2025)

The Annual Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a "Non-Routine Board Business (Forward Work Plan)" for 'one-off' Ad-hoc items raised during the course of meetings.

The role of the Health Board is set out in the standing orders which is available here: Standing Orders and Financial instructions link

The **Health Board** meets bi-monthly.

Board Chair Dyfed Edwards **Board Vice Chair** Gareth Williams	**Independent Members** Karen Balmer Clare Budden Urtha Felda Chris Field Dyfed Jones Mike Larvin Billy Nichols Caroline Turner Rhian Watcyn Jones **Associate Members** Mike Parry Fôn Roberts Jane Wild	**Executive Members** Russell Caldicott (Executive Director of Finance – Interim) Gareth Evans (Executive Director of Therapies & Health Sciences – Acting) Nick Lyons (Executive Medical Director / Deputy Chief Executive) Jane Moore (Executive Director Public Health – Interim) Carol Shillabeer (Chief Executive) Chris Stockport (Executive Director Transformation & Strategic Planning) Angela Wood (Executive Director Nursing & Midwifery) Vacant (Executive Director Operations)	**In Attendance** Jason Brannan (Deputy Director People Services) Helen Stevens-Jones (Director Partnerships, Engagement & Communications) Dylan Roberts (Chief Digital & Information Officer) Teresa Owen (Executive Lead for Mental Health & Learning Disabilities) Pam Wenger (Director Corporate Governance)	**Preliminary matters to be included on agenda:** Welcome & Apologies Declarations of Interest Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log Patient/Staff Story Citizens Experience Report (alternate meetings) Report of the Chair Report of the Chief Executive Report of the Vice Chair

	MAY (Q1)	JULY (Q2)	SEPTEMBER (Q2)	NOVEMBER (Q3)	JANUARY (Q4)	MARCH (Q4)
PRELIMINARY MATTERS						
STRATEGIC PRIORITIES						
Operating Model (1C)	■	■	■			
10 Year Strategy (2A)	■	■	■	■		
Prioritisation (2F)		■	■			
Urgent & Emergency Care (4G)	■	■	■	■	■	■
QUALITY						
Clinical Services Plan (2B)				■		
Patient Experience (4A)		■	■	■		
Adult Mental Health, Learning Disability, Children and Adolescent Mental Health Services (CAMHS) & Neurodevelopment (4I)	■	■	■	■	■	■
Currently Challenged Services (4J)	■	■	■	■	■	■
Women's Services (4K)				■	■	■
Children (4L)	■	■	■	■	■	■
GOVERNANCE & ASSURANCE						
Annual Plan / IMTP					■	■
Board Effectiveness (1A)	■	■	■			
Legislative Improvements (1F)	■	■	■	■	■	■
Capital Priorities (2D)		■	■		■	■
Digital, Data & Technology (2E)		■	■	■	■	■
Strengthening Planning (2H)		■	■		■	■
Finance Governance Environment (2I)				■	■	■
Citizen Engagement (3B)		■	■	■	■	■
Learning Organisation (5E)	■				■	■
Civil Contingencies			■			
ROUTINE REPORTING						
Annual Delivery Plan		■		■		■

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	MAY (Q1)	JULY (Q2)	SEPTEMBER (Q2)	NOVEMBER (Q3)	JANUARY (Q4)	MARCH (Q4)
Integrated Performance Report	■	■	■	■	■	■
Quality Report	■	■	■	■	■	■
Finance Report	■	■	■	■	■	■
Corporate Governance Report	■	■	■	■	■	■
Corporate Risk Register	■	■	■	■	■	■
Board Assurance Framework			■			■
Internal Audit Reports (as required)	■	■	■	■	■	■
Board Policies for Approval (as required)	■	■	■	■	■	■
Business Cases for Approval (as required)	■	■	■	■	■	■
ANNUAL REPORTING						
Annual Report to Board*	■					
Head of Internal Audit Reporting* (as part of the Annual Reporting Submission)	■					
Annual Audit Report & Structured Assessment					■	
Public Health Annual Report				■		
Health and Safety Annual Report			■			
Research & Development Annual Report						
Duty of Candour Annual Report						
Duty of Quality Annual Report						
Ombudsman Annual Letter			■			
FOR INFORMATION						
Committee & Advisory Group Chairs Reports	■	■	■	■	■	■
Committee Workplan						■
Cycle of Business						■
CLOSING BUSINESS						
Review of meeting effectiveness	■	■	■	■	■	■
Date of the next meeting	■	■	■	■	■	■
Resolution to exclude the Press and Public	■	■	■	■	■	■
PRIVATE AGENDA						

*These items will be part of the additional Health Board in June / July

DRAFT

BOARD DEVELOPMENT PLAN 2024-25

1. INTRODUCTION

Effective Board development is critically important, for both Executive and Independent Members. The Board receives a programme of development sessions delivered at bimonthly informal board meetings. These sessions have included presentations from staff to aid learning and understanding of organisational activities and development.

A proposed plan for Board development has been produced for the Board's consideration.

2. BOARD DEVELOPMENT SESSIONS

The purpose of these sessions is to promote Board engagement, relationships and collaboration and increase the opportunity for Board members to gain a greater understanding of their core responsibilities, develop the skills of the collective Board, work together effectively in developing strategy, strengthening oversight and delivering the collective accountabilities of a Board. The approach will be a structured programme of development, facilitated where appropriate.

Topics for Board Development are predominantly suggested by Executive Leads or via referrals from Board Committee meetings. This will continue, however, as part of this proposal topic requests need to be supported with the following narrative:

Topic Title	Purpose	Session Outcome	Month

Where possible the sessions will be limited to three topics per full day session to allow for sufficient time for robust discussion and learning.

Prior to the Board Development Session the lead Executive will be asked to provide a short briefing with any supporting information or signposting for members to consider in order to support the most effective and efficient use of time at the sessions.

Where there are specific requests for training, these will be arranged separately.

3. BOARD BRIEFING SESSIONS

The purpose of Board Briefing sessions is to brief Board Members on topical issues (including confidential issues) and to raise awareness and understanding to better inform decision-making and scrutiny. Items can be suggested by the Executive, or requested by Independent Members to build a programme of briefings relevant to topical and timely issues.

These sessions will be offered in a hybrid approach allowing for a virtual format and will normally be the session allocated the afternoon prior to the Board Meeting

Executive Leads should notify the Director of Corporate Governance of any Board Briefing requests so they can liaise with the Chair and Chief Executive to schedule these into existing commitments. The dates will be added to the annual schedule of Board and Committee meetings for ease of reference.

The dates for the Board Development and Board Briefing are listed below:

BOARD DEVELOPMENT	BOARD BRIEFING
25 April 2024	29 May 2024
27 June 2024	24 July 2024
29 August 2024	25 September 2024
31 October 2024	27 November 2024
19 December 2024	29 January 2025
27 February 2025	26 March 2025
24 April 2025	

4. PROPOSED SESSIONS 2024-25

It is proposed that the Board will receive the following development in the next 12 months. The plan is part of an iterative process which is informed by individual needs identified during regular performance reviews and also collective needs identified during planned development session.

DATE	TOPIC 1	TOPIC 2	TOPIC 3
25 April 2024	Operating Model	Data to manage and improve quality	Quality Management System
29 May 2024 (Briefing)	Mental Health Review		
27 June 2024	Mental Health Review	Public Health	Risk Management
24 July 2024 (Briefing)	Planning		
29 August 2024	Facilitated Development		
25 September 2024 (Briefing)	IMTP		
31 October 2024	Intelligence Led	Primary Care	North Wales Medical School
27 November 2024 (Briefing)	Royal Alexandra Visit		
12 December 2024	Facilitated Development		
29 January 2025 (Briefing)	Welsh Risk Pool		
27 February 2025	Transformation and Innovation	Inquests & Litigation	Board Effectiveness
26 March 2025 (Briefing)	Corporate Trustee		
24 April 2025	Facilitated Development		

A range of other topics have been suggested which fall into the category of training/awareness, and separate sessions will be facilitated for Board Members, topics currently include:

- Additional Learning Needs Act
- Equality

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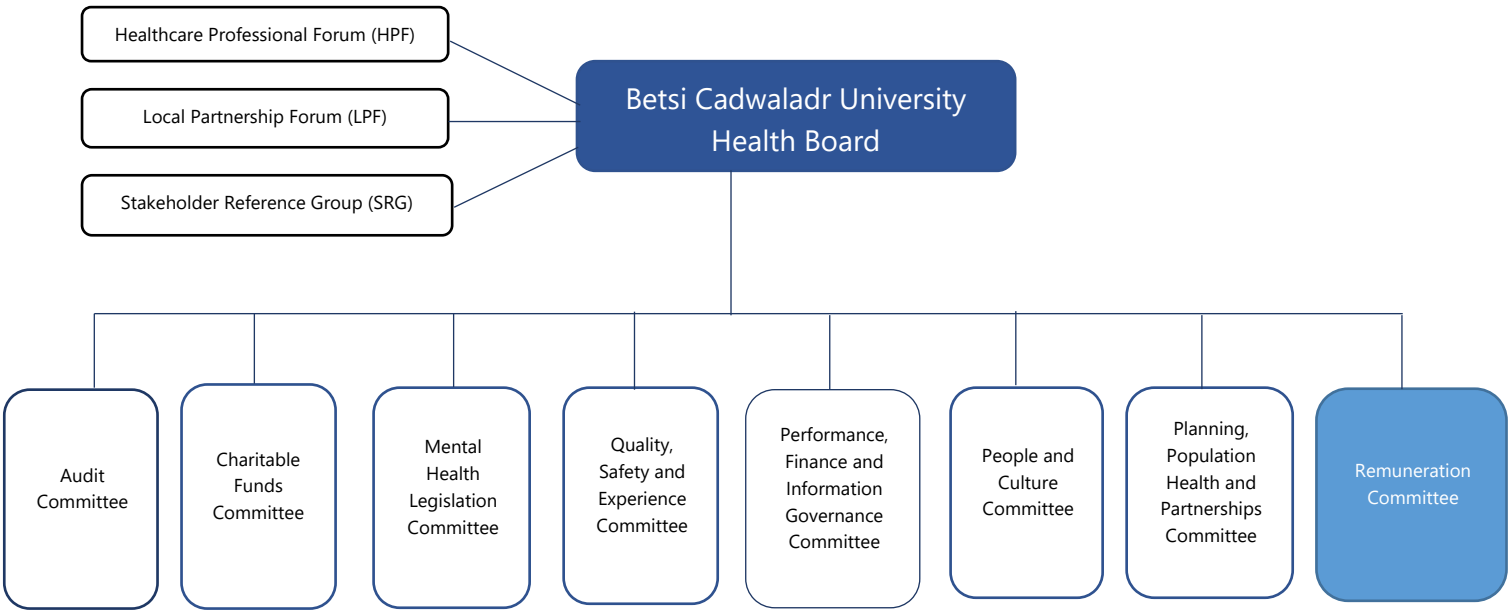
REMUNERATION COMMITTEE

TERMS OF REFERENCE



Version	Issued to	Date	Comments
V0.01 Draft	Audit Committee	16/11/23	Developed as a first draft for review by Audit Committee on 16/11/23
V0.02 Draft	TOR meeting with Committee Chair & Executive Lead	19/12/23	Developed as a draft for review with Committee Chair and Executive Lead. The ToR were also reviewed at the Remuneration Committee held on 23/01/24
V0.03 Draft	Health Board	18/01/24	Final Draft for consideration by the Health Board to be held on 25/01/24
V1.00 Approved		25/01/24	Approved by the Health Board
V1.01 Draft	Remuneration Committee	11/06/24	• To transfer UPSW and Performers List Regulatory Cases directly to the Board • To transfer 3.5 *'The Committee must monitor compliance with issues of professional registration, including the revalidation process*

			for medical and dental staff and registered nurses, midwives and health visitors and all other registered professionals' to the People and Culture Committee
V1.02 Draft	Remuneration Committee		To remove section 7 *'In Committee - 7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.'* as the Committee will routinely be held in closed session.

1) Introduction

1.1 The Betsi Cadwaladr University Health Board (BCUHB) shall establish a Committee to be known as the Remuneration Committee. The Committee is an independent Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference. The detailed operating arrangements in respect of this Committee are set out below. The Committee has no power to modify or develop pay schemes.

2) Purpose

2.1 The purpose of the Remuneration Committee is to provide advice to the Board on the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

2.2 The Committee will approve, on behalf of the Board, the remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by Welsh Government.

3) Responsibilities of the Committee and Delegated Powers

3.1 The Remuneration Committee is required by the Board to provide oversight and assurance on:

3.1.1 The objectives for Executive Directors and other VSMs and their performance assessment.

3.1.2 Performance management systems in place for those in the positions mentioned above and its application.

3.1.3 Proposals to make additional payments to medical Consultants outside of normal terms and conditions.

3.1.4 Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the provision of the Regulations and in accordance with Ministerial instructions.

3.1.5 Proposals to approve Voluntary Early Release applications and redundancy/severance payments in respect of Executive Director/Director posts, in line with Standing Orders and extant Welsh Government guidance: the Committee should be advised also of all Voluntary Early Release Scheme applications and severance payments and should approve or reject them.

3.1.6 The appropriateness of any Strategic Advisor arrangements, including scope and pay: the Committee must approve any such arrangements.

3.2 The Remuneration Committee is required by the Board, within the remit of the Committee to:

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

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

3.3 The Remuneration Committee is authorised by the Board to comment specifically upon:

3.3.1 The remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently.

3.3.2 The objectives set by the Chief Executive for those who report directly to him/her.

3.3.3 Proposals to make additional payments to consultants outside national terms of service.

3.3.4 Proposals regarding resignation and exiting arrangements for executives and very senior managers, ensuring the proper calculation and scrutiny of payments in accordance with the relevant Welsh Government guidance.

3.3.5 Removal and relocation expenses outside standard policy.

3.4 The Committee should consider and approve any Voluntary Early Release Scheme in line with Standing Orders and extant Welsh Government guidance.

3.5 The Committee must consider reports on behalf of the Board on the position as regards whistleblowing and Speak Out Safely affecting executives and senior managers.

3.6 The Committee must consider specifically the Executive Director/VSM Update Report which should include an appendix to the report highlighting all VSM posts in one place.

3.8 The Committee should assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

3.9 The Committee should seek assurance that those individuals who report directly to the Chief Executive have set objectives for their own direct reports, and that appropriate and timely performance reviews are planned/ have taken place.

4) Membership

4.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair) NB: The Chair of the Health Board will be the Chair of this Committee
All Independent Members (one of whom will be designated as Vice Chair)
The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member (to be agreed with Chair of the Health Board)

4.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director of Workforce & Organisational Development (Executive Lead)
Chief Executive
Director of Corporate Governance
Other Executive Directors as required by the Chair

4.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

4.4 Membership of the Committee will be reviewed on an annual basis.

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

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

5) Quorum and Attendance

5.1 A quorum shall consist of at least three Independent Members, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

5.2 Any senior officer of the Health Board or partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.3 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.4 Should any 'in attendance' officer members be unavailable to attend, they may nominate a deputy to attend in their place, subject to the agreement of the Chair.

5.5 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6) Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Lead (Executive Director of Workforce & Organisational Development) at least six weeks before the meeting date.

6.2 The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members. Following approval, the agenda and timetable for request of papers will be circulated to all Committee members.

6.3 All papers must be approved by the Executive Lead.

6.4 The agenda and papers will be distributed/published seven days in advance of the meeting.

6.5 A draft table of actions will be issued within two days of the meeting. The minutes and table of actions will be circulated to the Committee Chair and Executive Lead within seven days to check the accuracy, prior to sending to Members to review within the next seven days.

6.6 Members must forward amendments to the Committee Secretary within the next seven days. The Committee Secretary will then forward the final version to the Committee Chair for final review.

7) Meetings

7.1 The Committee will meet bi-monthly and an annual schedule of meetings will be determined by the corporate calendar.

7.2 The Committee may be convened at short notice if requested by the Chair.

7.3 Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

7.4 The Committee may, subject to the approval of the Health Board, establish Groups to carry out on its behalf specific aspects of Committee Business.

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

7.6 The Committee Secretary shall be determined by the Director of Corporate Governance.

8) Reporting

8.1 The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

8.2 The Committee Chair, supported by the Committee Secretary, shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.3 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

9) Accountability, Responsbility and Authority

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

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

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

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

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

9.6 The Chief Executive will present for approval:

- Any new or amended senior manager roles who are regular Board attenders (or amendments to statutory Officer roles)
- All proposed senior interim appointments that exceed the top of the relevant salary banding.

9.7 The Committee will monitor and approve interim senior manager appointments as follows:

- Range up to £500/day – quarterly report summarising number, location, duration and cost of supernumerary interim appointments.
- Range £501-£1,000/day – all interim roles to be reported on individually including whether supernumerary or covering an established vacancy
- Over £1000/day – role and maximum pay to be agreed in advance for up to six months unless it is to cover an Officer member absence or vacancy; (or in support of a declared Major Incident) with quarterly monitoring.

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

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

10) Review Date

10.1 These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Teitl adroddiad: ***Report title:***	Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinicians (Wales) Directions 2018. Update of Registers of:- **1.** Approved Clinicians (All Wales) **2.** Section 12(2) Doctors (All Wales). Reporting Period: 6th May 2024-1st July 2024
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday 25th July 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report is a standing item provided as assurance of compliance with Mental Health Act legislation, policy and process. The Board is asked to note the report contents and formally ratify approvals previously granted through weekly Chair's Action Letters. The details presented to the Board in this Report are a summary of the approvals which have already received ratification for Approved Clinicians and Section 12(2) Doctor approvals across Wales. The 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. Following approval by the Board Chairman reached at the 30th March 2023 Board meeting, ratification for approval via urgent Chair's Action Letters was delegated to the Executive Medical Director. Approval is sought via a written Chair's Action letter and submitted to the Office of the Medical Director for consideration. Approval is then received in writing from the Executive Medical Director and returned to the All Wales Approvals Team. Upon receipt of written ratification, the Clinician is then informed that they have received approval and this is confirmed in writing in a signed Approval Board approval letter. The Health Board then formally ratifies decisions through this paper which is submitted on a bi-monthly basis – as detailed in Appendices 1 and 2. The Board is asked to note this report and ratify the approvals in line with the requirements of the Welsh Government Guidance Document "Mental Health Act 1983 Approval of Approved Clinicians (Wales) July 2018 for Approved Clinicians", the NHS Wales Mental Health Act 1983 (Approved Clinicians) (Wales) Directions 2018 and the "All Wales Section 12(2) Process and Criteria Document for S12(2) Approved Doctor approvals".
Argymhellion: ***Recommendations:***	The Board is asked to note the contents and is recommended to formally ratify previous Chair's Action Letters which contain recomendations to grant approval or reapproval for Approved Clinicians and Section 12(2) Doctors across Wales.
Arweinydd Gweithredol: ***Executive Lead:***	Dr James Risley, Deputy Executive Medical Director

Awdur yr Adroddiad: ***Report Author:***	Meryl Roberts, All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors.			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Betsi Cadwaladr University Health Board successfully bid to take over the function of the Welsh Ministers for the Approval Process in 2009 on behalf of all former Local Health Boards. Betsi Cadwaladr University Health Board (BCUHB) acting in its capacity as the main Approving Board for Wales, has continued to effectively undertake 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 Approving Board and Process of Approval continue to fully meet all objectives.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The approval process meets Approved Clinician regulatory requirements set out in the Mental Health Act 1983 (as amended) and the 2008 No.1204 Mental Health (Mutual Recognition) Regulations 2008. The Health Board continues to ensure an effective approval, re-approval, suspension and termination of approval processes for Approved Clinicians and Section 12(2) Doctors in Wales is in place.			
Yn unol â WP7 (sydd bellach yn cynnwys WP68), a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Do/Naddo No			

In accordance with WP7 (which now incorporates WP68) has an EqIA been identified as necessary and undertaken ?	Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* It is not applicable.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	To ensure that all Clinicians are approved and reapproved within written agreed timescales, the All Wales Approval Panel assesses applications according to the Procedural Arrangements agreed with Welsh Government and the Section 12(2) Process and Criteria Document. 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 Wales. The Board is asked to note that in accordance with The Mental Health (Mutual Recognition) Regulations 2008, a Section 12(2) approved Doctor in England is also approved in Wales and vice versa. (This does not apply to Approved Clinicians). Due to a lack of Section 12(2) Directions for Wales, there is a risk that a Section 12(2) Doctor approved in Wales may not be lawful in England. Considerable work to date has taken place with Welsh Government, the Approval Team and the All Wales Approval Panel Chair in order to redress the deficit. Draft Section 12(2) Directions have now been written by Welsh Government and the Approval Team is awaiting legal review of the draft Directions by Welsh Government. Until the S12(2) Directions are extant, the All Wales Section 12(2) Process and Criteria Document will continue to remain the reference document used to approve, reapprove, suspend or end Section 12(2) approval.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by Dr N Lyons, Office of the Medical Director.

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	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 Wales. If the Approving Board do not ratify approvals, this could also have an adverse impact on the availability of Approved Clinicians, Responsible Clinicians and Section 12(2) Approved Doctors across the workforce in Wales. The ratification of approvals by the Approving Board for all Health Boards is the final step in the process of granting approval or reapproval to the workforce in all of the Health Boards in Wales.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This is an ongoing process.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Lack of Section 12(2) Wales Directions is recorded on Datix Risk Register number ID: 4134.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:

Implementation of recommendations of this report will be the final step in the ratification of approval process and will fully accord with all legislative and process requirements.

Rhestr o Atodiadau:
List of Appendices:

Appendix 1: Update of Register of Approved Clinicians - Wales.
Mental Health Act 1983 as amended by the Mental Health Act 2007,
Approved Clinician (Wales) Directions 2018.

Appendix 2: Update of Register of Section 12(2) Approved Doctors - Wales.
Mental Health Act 1983 as amended by the Mental Health Act 2007.
All Wales Section 12(2) Process and Criteria Document.

APPENDIX 1

Update of Register of Approved Clinicians in Wales Reporting Period:- 6th May 2024 – 1st July 2024	
	Approved Clinicians
Approvals and Re-approvals	11
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	0
Removed (Left Wales)	1
Retired	0
No longer Registered & Retired:	0
Transferred from AC register (to S12 Register)	1
Removed from S12 – Became AC approved	0
Approval Ended	1
Death in Service	0

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APPENDIX 1

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 Approved Clinician (Wales) Directions 2018

Update of Register of Approved Clinicians - Wales

Reporting Period: 6th May 2024-1st July 2024

Approvals and Re-approvals: 11

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
James-Williams	Alex	Mental Health Care UK Ltd, St David's Independent Hospital, Carrog, Corwen, Denbighshire, LL21 8BG.	4th July 2028	Yes
Thomas	David Roger	Priory Healthcare, Llanarth Court Hospital, Llanarth, Raglan, Abergavenny, Monmouthshire, NP15 2YD.	12th May 2029	Yes
Rakshit	Salil Kumar	Hywel Dda University Health Board, Heddfan Unit, Glangwili Hospital, Dolgwili Road, Carmarthen, SA31 2AF.	19th May 2029	Yes
Al-Hassani	Hayder	Aneurin Bevan University Health Board, St Cadoc's Hospital, Lodge Road, Caerleon, Newport, NP18 3XQ.	22nd May 2029	Yes
Hassan	Amani Osman	Cwm Taf Morgannwg University Health Board, Tonteg Hospital, Church Road, Tonteg, CF38 1HE.	22nd May 2029	Yes
Rafferty	Danika	Cwm Taf Morgannwg University Health Board, Altwood, Graig Penllyn, Cowbridge, Vale of Glamorgan, CF71 7RT.	29th May 2029	Yes
Perera	Mark Navin	Betsi Cadwaladr University Health Board, Flintshire Older Persons Mental Health Service, Wepre House, Wepre Drive, Connah's Quay, Flintshire, CH5 4HA.	29th May 2029	Yes

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
Munoz-Solomando	Antonio Jose	Cwm Taf Morgannwg University Health Board, Tonteg Child and Family Centre, Tonteg Hospital, Church Road, Tonteg, Pontypridd, CF38 1HE.	30th May 2029	Yes
Roberts	Elin Mared	Cwm Taf Morgannwg University Health Board, Supported Recovery Unit, Ysbyty George Thomas, Cwmparc Road, Ystrad Fechan, Treorchy, CF42 6YG.	2nd June 2029	Yes
Oruganti	Balarao	Powys Teaching Health Board, Ty Illtyd, Bridge Street, Brecon, Powys, LD3 8AH.	17th June 2029	Yes
Lafuente	Antonio	Cygnet Healthcare Ltd, Delfryn House Independent Hospital, Argoed Hall Lane, Mold, Flintshire, CH7 6QF.	17th June 2029	Yes

Approvals Reinstated/Returned to Work in Wales: 0

Surname	First Name	Workplace	Date Approval Expires

Removed/Left Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Ahmed	Abdelaal	Betsi Cadwaladr University Health Board, Ty Derbyn, Wrexham Maelor Hospital, Wrexham, LL13 7TE.	30th May 2026

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered & Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Transferred from AC Register to S12 Register: 1

Surname	First Name	Workplace	Date Approval Expires
Clarke-Smith	Elizabeth	c/o Private Address	7th November 2024

Approval Ended: 1

Surname	First Name	Workplace	Date Approval Expired
Khalid	Najeeb	Clinical Partners UK, Cyncoed Consulting Rooms, Dartington Drive, Pontprennau, Cardiff, CF23 8SQ.	24th June 2024

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales Reporting Period:- 6th May 2024-1st July 2024	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	6
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	0
Removed (Left Wales)	1
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	1
Became AC approved	0
Approval Ended	0
Death in Service	0

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APPENDIX 2

Mental Health Act 1983 (as amended by the Mental Health Act 2007)
Mental Health Act 1983 – All Wales Section 12(2) Process and Criteria Document

Update of Register of Section 12(2) Approved Doctors - Wales

Reporting Period: 6th May 2024-1st July 2024

S12 Approvals and Re-approvals: 6

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
Speedy	Kathryn Louise	Cwm Taf Morgannwg University Health Board, Ty Llidiard Inpatient Unit, Princess of Wales Hospital, Bridgend, CF31 1RQ.	13th May 2029	Yes
Flamank	Oscar Henry	Cwm Taf Morgannwg University Health Board, Mental Health Unit, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, CF72 8XR.	15th May 2029	Yes
Slaney	Bertram Michael	Hywel Dda University Health Board, Bro Cerwyn Centre, Fishguard Road, Haverfordwest, Pembrokeshire, SA61 2PZ.	30th May 2029	Yes
Salam	Samia	Cardiff and Vale University Health Board, Cardiff Royal Infirmary, Longcross Street, Cardiff, CF24 0SZ.	30th May 2029	Yes
Kuriakose	Deepak	Betsi Cadwaladr University Health Board, Plas Gororau, Ellice Way, Wrexham Technology Park, Wrexham, LL13 7YY.	20th June 2029	Yes
Davies	Aled Huw	Swansea Bay University Health Board, Community Drug and Alcohol Team, Tonna Hospital, Upper Tonna, Neath, SA11 3LX.	25th June 2029	Yes

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approval Reinstated/Transferred/Returned to Wales: 0

Surname	First Name	Workplace	Date Approval Expires

Removed (Left Wales): 1

Surname	First Name	Workplace	Date Approval Expires
Abou Farha	Khalid Mohamed Mohamed	Aneurin Bevan University Health Board, Community Mental Health Team, 6 Gold Tops, Newport, NP20 4PG.	12th December 2026

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Transferred from AC Register & Became S12 approved: 1

Surname	First Name	Workplace	Date S12(2) Approval Expires
Clarke-Smith	Elizabeth	c/o Private Address	7th November 2024

Became AC approved: 0

Surname	First Name	Workplace	Date Approval Expired

S12 Approval Ended:

Surname	First Name	Workplace	Date Approval Expired

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expires

Teitl adroddiad: ***Report title:***	Risk Report & Corporate Risk Register
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 25 July 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide an update position of the Corporate Risk Register, June Internal Audit report and Risk Management arrangements and role of Risk Management Group proposal. The body of this report draws out one of the recommendations from the Internal Audit report around reviewing the role of Risk Management Group and proposes 3 Risk Management Forum meetings per annum and a monthly Risk Scrutiny Group. This paper further presents the corporate risk dashboard and report highlighting risks and updates following review of the individual risks. Of the 17 Corporate Risks, 139 actions have been developed to mitigate the risks, 29 actions have been completed, 104 actions are progressing and on track and 6 actions are overdue. Appendix 3 & 4 outlines key updates to our organisation's risk framework and procedures. The changes reflect approved changes at the Executive Team Meeting 20/06/24 and Risk Appetite Board Development Session 27/06/24. Appendix 1 - Full corporate risk register as of June 2024. Appendix 2 - Risk Management Framework - highlights key updates and changes.
Argymhellion: ***Recommendations:***	The Board is asked to : • **NOTE** the report; • **APPROVE** changes to the Risk Management Framework; • **APPROVE** the risk appetite for 2024/25; • **RECEIVE** the Corporate Risk Register as at end June 2024, noting that further work on the refinement of risks and actions is required.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	Nesta Collingridge Head of Risk Management

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Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: N/A***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Detailed in the BAF report and how the CRR aligns to the revised BAF			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable for this report			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Not applicable for this report			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Board Assurance Framework due for review			

Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Quality assurance by Corporate Risk Management Team and some have been updated and presented to Risk Management Group. Some risks were delayed and since updated by leads for this paper so not seen at the Risk Management Group, however, they were presented at Executive Team on the 19th June 2024.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	**N/A** **Cyber risk CRR24-17 excluded from the paper**

Camau Nesaf:

Next Steps:

1. To refine the Corporate Risk Register to take into account the actions agreed at the Board Development including feedback from Audit Committee scheduled for 18th July 2024.

Rhestr o Atodiadau:

List of Appendices:

- Appendix 1 – Risk Management Framework
- Appendix 2 - Full corporate risk register as of June 2024.
  https://bcuhb.nhs.wales/about-us/governance-and-assurance/corporate-risk-register/

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

RISK MANAGEMENT REPORT – AS AT END JUNE 2024

1. PURPOSE

The purpose of this report is to provide the Board with an update of the management of risk across the Health Board including, the risk appetite, changes to the risk management framework and the Risk Register as at end of June 2024.

2. INTERNAL AUDIT RISK MANAGEMENT – 'LIMITED ASSURANCE'

Internal Audit have undertaken the planned annual audit of arrangements of risk management noting limited assurance. During the last 12 months significant work has been undertaken to make improvements to the management of risk. This is recognised by the Board and the commentary in the Internal Audit Report is reflective of that progress. The Executive Team recognise the progress made and support the actions outlined to address the 'Limited Assurance' Internal Audit Report.

The Audit Committee has received an update on the actions in relation to the Internal Audit Report and at the recent Board Development session discussions on the management of risk were undertaken and the output of that session will now be taken forward as part of the next iteration of the Corporate Risk Register.

3. RISK FRAMEWORK AND PROCEDURES

The Risk Management Group has been stood down and replaced by a Risk Scrutiny Group and Risk Management Forum. This change emphasises critical review of strategic risks. Furthermore, the Board Assurance Framework reporting cycle to the Board has been modified from previously reporting quarterly to bi-annual, noting that monitoring reports on the delivery of the Annual Plan will be received by the Board quarterly. The updates are designed to strengthen our risk management practices and improve the efficiency of our reporting mechanisms. The revised framework ensures that we maintain robust risk oversight while optimising resource allocation. Committees will receive risks which are above the risk tolerance on a bi-monthly basis and for those in line or below tolerance on a quarterly basis [previous frequency quarterly]. The Risk Management Framework attached at **Appendix 1** has been updated to reflect the changes.

4. RISK APPETITE

In accordance with the Health Board Governance Framework, the Health Board is required to assess the Health Board's Risk Appetite annually. The Board undertook the planned annual exercise on the 27th June 2024 to review the Risk Appetite and set the tolerance for 24/25. This has subsequently been updated in the Appendix of the Risk Framework.

24/25 Risk Appetite

Quality Risk: There was willingness to be '**open**' and accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards, supporting innovation. Broad learning from events influence improvement. Efforts to promote openness and transparency are on a risk basis by repercussion.

Financial Risk: There was an agreed consensus on an '**open**' appetite to be prepared to invest for return but **minimise the possibility of financial loss** by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.

Compliance/Regulatory: There was an agreed consensus supporting an '**open**' risk appetite to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.

Innovation Risk: There was an agreed consensus to **'seek'** and innovation is to be pursued with the desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.

Reputational Risk: There was an agreed consensus to '**seek**' with a willingness to take decisions that may bring scrutiny of BCUHB but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.

5. MANAGEMENT OF RISK

Following the update provided to the Board at the end of May 2024, at the Board Development Session in June 2024, the Board agreed to a number of actions, these have been reflected in the attached Risk Management Framework and are summarised below:

- Remove the levels of assurance from the Risk Register as it is covered in the Board Assurance Framework;
- Changes to the Corporate Risk Register to include shorter number of actions linked to the Annual Plan (as agreed by the Board);
- Separate out the risk in relation to 'Challenged Services' in order that as progress is made, changes to the risks can be monitored; and
- Agree a number of 'principal' risks which will form the basis of the Board Assurance Framework, which will be reported to the Board in September 2024.

6. CORPORATE RISK REGISTER REPORT – AS AT END JUNE 2024

6.1 Changes to the Corporate Risk Register

There are 17 consolidated Corporate Risks. The full details of these risks are highlighted in **Appendix 2** and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

There have been no changes in risks (escalation or de-escalation since the report to the Board at the end of May 2024). However, a number of updates on progress in terms of the actions have been progressed although these have not resulted in any changes to the risk scores.

6.2 Key Highlights

Corporate Risks Dashboard highlights actions required by the Executive Team.

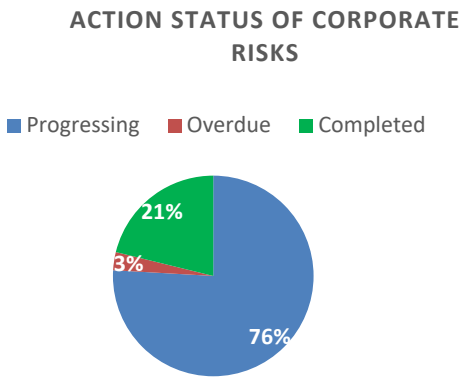
- CRR24-02 'Patient Safety – Falls' (risk score 20) – 4 Overdue actions. However this risk is to be revised to a Patient Safety risk, draft has now been completed and currently being reviewed by the Executive.

Out of the 17 corporate risks, 139 actions have been developed to mitigate the risks as opposed to the previously reported 89. 29 actions have been completed (previously 13), 104 actions are progressing and on track and 6 actions are overdue. However 14 actions have revised dates (risks CRR24 01-04 & 06).

The Risk Management Team met with members of the Executive Team in June 2024 to gain updates on actions and some of these are reflected in the reports in **Appendix 2**. Despite the increase in the completed actions, there are no proposed changes to the risk score to report.

The 6 overdue actions span across 2 different corporate risks, with the Patient Safety - Falls (4) and Harm from the Medical Devices/Equipment (2).

However positive assurances include 75% of open actions being on track, and an increase in the number of closed actions from previous reports (increase from 13 to 29 closed actions) demonstrating management of the risks.



The following summary provides an overview of the corporate risk register as at end of June 2024. There are a number of risks which are outside of the tolerance agreed by the Board and these are highlighted in 'red' in the table below. The Executive Team will be focussing on those risks in particular to those outside of the tolerance set by the Board.

Ref	Risk	Risk Owner	Domain	Tolerance	Previous Risk Score	Risk Score (Q1)	Trend	Target Risk Score
CRR24-01	People, Culture and Wellbeing	Executive Director of People's Services	Quality	15-19	16	16	↔	8
CRR24-02	Patient Safety-Falls	Executive Director of Nursing & Midwifery	Quality	15-19	20	20	↔	12
CRR24-03	Safeguarding	Executive Director of Nursing & Midwifery	Regulatory	20-25	16	12	↓	8
CRR24-04	Failure to Embed Learning	Executive Director of Nursing & Midwifery	Quality	15-19	20	20	↔	5
CRR24-05	Financial Sustainability	Executive Director of Finance	Financial	15-19	20	20	↔	12
CRR24-06	Suitability and Safety of Sites	Executive Director of Finance	Financial	15-19	20	20	↔	12
CRR24-07	Availability and Integrity of Patient Information	Chief Digital and Information Officer	Quality	15-19	20	20	↔	12
CRR24-08	Population Health	Executive Director of Public Health	Reputational	20-25	20	20	↔	12
CRR24-09	Primary Care	Chief Operating Officer	Quality	15-19	20	20	↔	12
CRR24-10	Urgent and Emergency Care	Chief Operating Officer	Quality	15-19	20	20	↔	12
CRR24-11	Planned Care	Chief Operating Officer	Quality	15-19	20	20	↔	8
CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	Chief Operating Officer	Quality	15-19	15	15	↔	12
CRR24-13	Timely Diagnostics	Executive Director of Allied Health Professionals & Therapies	Quality	15-19	20	20	↔	5
CRR24-14	Harm from the Medical Devices/Equipment	Executive Director of Allied Health Professionals & Therapies	Quality	15-19	16	15	↔	8
CRR24-15	Health and Safety	Executive Director of People's Services	Regulatory	20-25	16	16	↔	8
CRR24-16	Leadership	Executive Director of People's Services	Reputational	20-25	16	16	↔	8
CRR24-17	ICT Failure and Cyber	Chief Digital and Information Officer	Reputational	20-25	20	20	↔	15

7. CONCLUSION

This report has provided the Board with an update on the changes to the Risk Management Framework, the Risk Appetite for 2024/25 as well as presenting the Corporate Risk Register as at end June 2024.

8. RECOMMENDATIONS

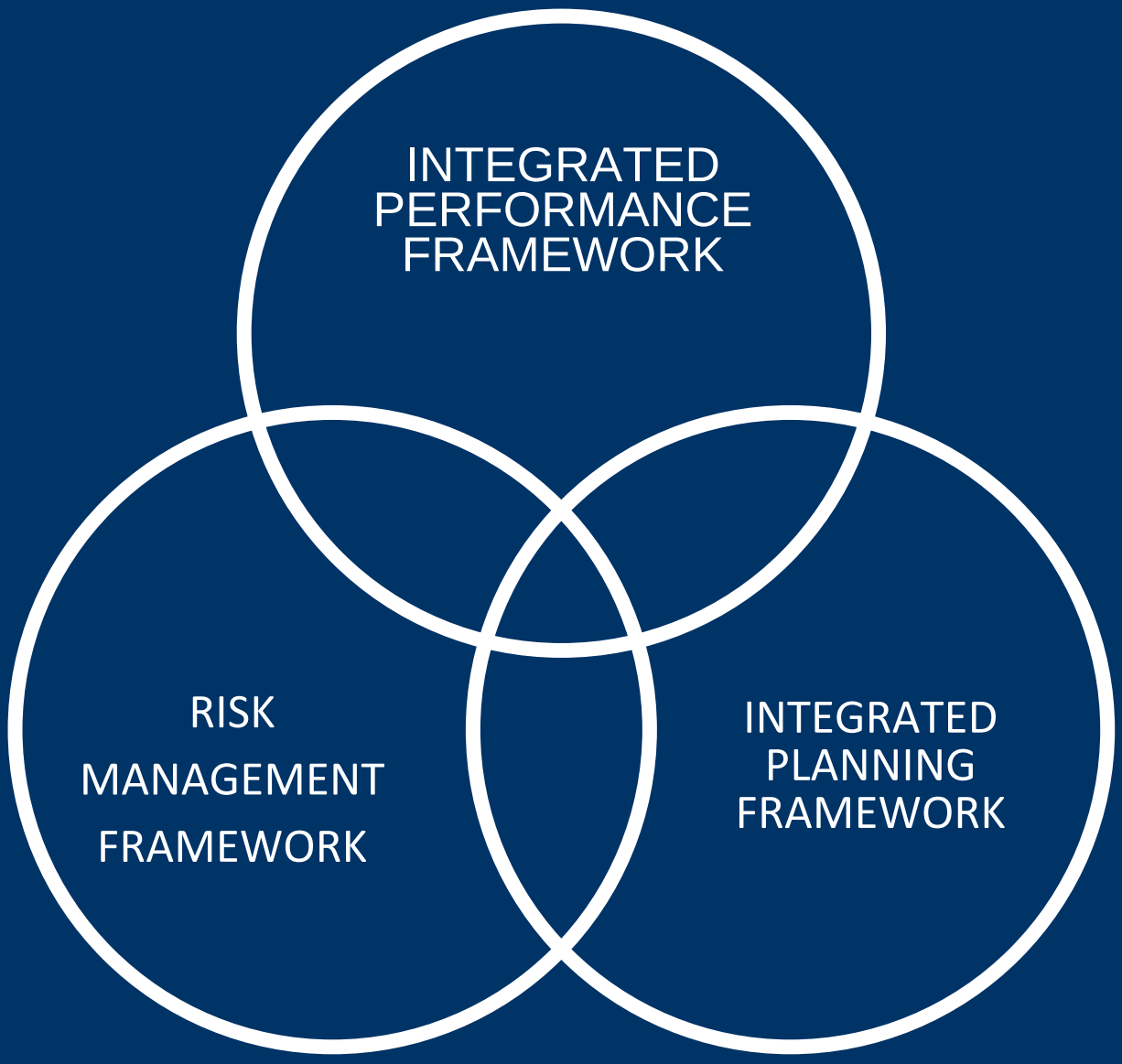
The Board is asked to:

- **NOTE** the report;
- **APPROVE** changes to the Risk Management Framework;

- **APPROVE** the risk appetite for 2024/25; and
- **RECEIVE** the Corporate Risk Register as at end June 2024, noting that further work on the refinement of risks and actions is required.

RISK MANAGEMENT FRAMEWORK

2023-25



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Approved by:	Health Board - 28 Sept 2023 Audit Committee (AC) - 15 Sept 2023 ~~Risk Management Group (RMG) - 8 Aug 2023~~				
Date approved:	~~28 Sept 2023~~ July 2024				
Date activated (live):	~~11 Jan 2024~~ July 2024				
Documents to be read alongside this document:	Risk Management Procedures (RM02) Risk Management Training Procedures (RM03) Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Information Governance Policy Health and Safety Policy Terms of Reference ~~RMG~~ Risk Scrutiny Group BCUHB Integrated Performance Framework BCUHB Integrated Planning Framework				
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First Operational:	28 Sept 2025				
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PROPRIETARY INFORMATION

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GLOSSARY OF TERMS

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. Risk is expressed in terms of likelihood (probability of the risk occurring) and consequence (impact if the risks were to occur).

Distinguishing between a risk and an issue: A risk is an event that might occur and that could have an effect (can be positive but usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty. An issue is something that has already happened or will definitely happen. An issue is a certainty. For example, 'we are short staffed' or 'lack funding to deliver a service', are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of funding to the successful delivery of our operational and strategic objectives. What these uncertainties (doubt) may cause, is what will constitute (give rise) to risks in both cases.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives.

Actions: Actions are the subsequent steps required following the application of controls to address or further mitigate residual (current) risk to as low as reasonably possible (target) level.

Board Assurance Framework: comprises of strategic risks developed by Executives from the Strategic Plans and Objectives that could prevent the Health Board's from fulfilling its strategic objectives/priorities.

Business Continuity: Business continuity is the capability of the Health Board to continue the delivery of products and services within acceptable timeframes at predefined capacity during a disruption. Business continuity is a temporary and alternative measure initiated during a disruption that ensures continuity of service provision whilst a permanent solution is found, or usual services/operations are resumed. The holistic process of business continuity management is an essential tool in ensuring an organisation's resilience.

Controls: These are measures or interventions implemented by the Health Board that reduce the likelihood of a risk and/or the impact/severity of a risk. The types of controls used in reducing risks include preventive, corrective, detective and directive controls. Gaps in control describe the weaknesses identified having put mitigation controls in place.

Corporate Risk Register: A corporate risk register is a repository used to record significant risks that could impact the strategic objectives and operations of the Health Board. Developed by services and corporate functions, The register provides a comprehensive overview of the key risks facing the organisation. It is a pivotal tool to help proactively strengthen risk oversight and management.

Risk Assessment: This is the overall process of risk identification, analysis and risk evaluation. This is achieved by identifying risks, examining the characteristics of

each risk and comparing individual risks against the Health Board's risk appetite. Risk assessment techniques include questionnaires and checklists, workshops and brain storming sessions, and inspections and audits.

Risk Appetite: The amount and type of risk that an organisation is willing to seek or retain in its pursuit of its objectives.

Risk Framework: Set of activities that support the risk management process, i.e., the risk architecture, strategy and protocols.

Risk Management: Coordinated activities to direct or control risks within an organisation. These are management activities that deliver the most favourable outcome and reduce the volatility and variability of that outcome.

Risk Mitigation: This refers to the process of reducing risk exposure through minimising its likelihood and/or lessening the severity of its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Take Opportunity: The type of risk with potential to enhance the achievement of the organisation's objectives. Opportunity risk management is the approach that seeks to maximise on benefits of taking risks i.e., innovation, new systems, processes and procedures, services etc.

Terminate: Risk response that is appropriate when certain activities that give rise to risks are not necessary or worth doing and should be stopped. Also known as avoidance or elimination.

Tolerating: The decision to accept the risk and the impact should the following risk occur without taking any further steps to mitigate it. This is often to avoid significant investment or resources as the response would be disproportionate to the potential harm or gain. Also referred to acceptance or retention. Decision to tolerate any risks that are outside the risk appetite threshold for a particular domain of risk should be made at senior level proportionate to the level of risk.

Transfer: Risk response for risks outside the Health Board's appetite that the organisation wishes to transfer or share with other providers by way of contracts (outsourcing), insurance, joint venture etc. This option is particularly suited to mitigating financial risks or risks to assets.

Treat: Risk response by way of introducing cost effective controls to alter or reduce risk.

Target Risk: Ultimate level of risk that is desired by the Health Board when planned additional controls (see actions) have been implemented to address residual risk to as low as reasonably possible and/or within the Health Board's risk appetite.

RISK MANAGEMENT FRAMEWORK

RISK FRAMEWORK STRATEGY

- 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.
- The Health Board is committed to ensuring a robust infrastructure to manage risks ensuring an integrated approach, and where risks crystallise, to evidence improvement.
- 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, ***maximise*** performance and is ***open*** to opportunity with considered risk taking.
- 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 as a duty of care to the population.

The Board intends to demonstrate an ongoing commitment to improving the management of risk throughout the organisation by:

• Ensuring a dynamic approach to strategic risk management to support achievement of the Health Board's vision, aims, and strategic objectives;

• Promoting considered risk taking, within authorised and defined limits in-line with the Board's appetite for risk (see Appendix 1-Risk Appetite Statement);

• Adopting an integrated approach to risk management in order to facilitate a cross-functional collaboration of system-wide risks that includes risks related to: clinical care, health and safety, staff wellbeing, financial and business planning, workforce planning, corporate and information governance, performance management, project / programme management, research and development;

• Embedding effective risk management systems and processes within the organisation and promoting the ethos that risk management is everyone's business, with clearly defined roles and responsibilities;

• Creating an environment that is as safe as is reasonably practicable, by ensuring that risks are continuously identified, assessed and well managed, i.e. where possible eliminate, transfer or treat risks to an acceptable level;

• Fostering an organisational culture of openness and willingness to report risks, incidents and near misses to ensure organisation wide learning;

• Establishing clear and effective communication mechanisms that enable a comprehensive understanding of risks at all levels of the organisation by the use of directorate, specialist and organisational-wide risk registers; and

•Providing appropriate training to staff to ensure effective implementation of risk management arrangement

1. PURPOSE OF THIS FRAMEWORK

The Framework seeks to ensure:

- that the Health Board's risks in relation to the delivery of services (provided and commissioned) and care to patients are minimised;
- that the wellbeing of patients, staff and visitors is optimised;
- that opportunities are maximised;
- that the assets, business systems and finances of the Health Board are protected; and
- the implementation and ongoing management of a comprehensive, integrated (clinical and non-clinical) approach to the management of risk across the organisation.

2. SCOPE OF THE RISK MANAGEMENT FRAMEWORK

This framework applies to Board members; all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business. It applies to all activities of the Health Board, including those related to the commissioning of services. Managers at all levels within the Health Board must take an active lead to ensure that risks are managed effectively and to support the development of a risk aware culture within the Health Board.

This framework will:

- Outline the risk management philosophy through our risk statement, identifying arrangements for embedding risk management;
- Explain the role, expectations and appetite of the Board in relation to risk and risk management;
- Detail the high-level roles and responsibilities for implementing and complying with this framework;
- Explain the arrangements for complying with all relevant legislation;
- Detail risk priorities for the present year;
- Detail the high-level Committee structure accountability in relation to risk, internal reporting requirements, assurance arrangements and external reporting controls;
- Signpost the specific policies, procedures and terms of reference and which the Health Board will publish to ensure that all staff understand what is required of them.

3. THE BOARD'S APPETITE FOR RISK

The Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that the organisation understands and is aware of the risks it is prepared to accept in the pursuit of its aims and objectives.

Risks throughout the organisation will be managed within the Board's risk appetite, or where this is exceeded, action will be taken to reduce the risk. The Board is prepared to accept some financial risk and regulatory challenges if appropriate controls and defence strategies are in place. The Board support innovation despite potential short-term quality impacts and reputational risks, as long as there is potential for long-term rewards like improved outcomes for stakeholders and opportunities for staff recruitment, retention and development. The Board takes a holistic view of value for money, with price not being the sole determining factor.

The Health Board seeks to be innovative and will challenge current working practices and financial risk in terms of its willingness to take opportunities where positive gains can be anticipated. The Board's annual Risk Appetite, detailing acceptable levels of risk across five risk types (financial, regulatory/compliance, innovation, quality and reputational), is outlined in Appendix 1.

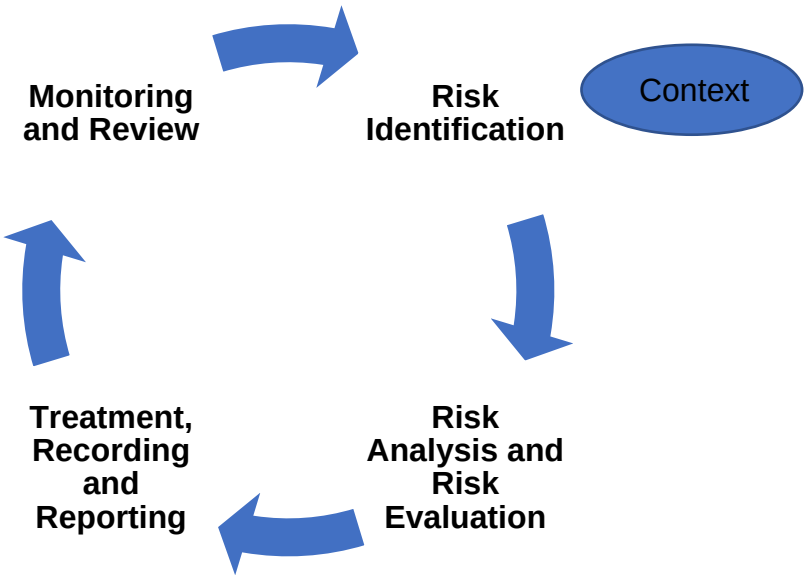
4. RISK MANAGEMENT PROCESS

Risk Management is the systematic application of management policies, practices and procedures to identifying, analysing, assessing, treating and monitoring risk in a way that will enable organisations to minimise losses and maximise opportunities.

The aim of risk management is not to remove risk altogether, but to manage risk to an acceptable level, considering the cost of minimising the risk and reducing risk exposure (the level of risk that the organisation is exposed to, either in regard to an individual risk or the cumulative exposure to the risks faced by the organisation).

The Board has adopted a structured approach to risk management, whereby risks are identified, assessed and controlled, and if appropriate, escalated or de-escalated through the governance mechanisms of the organisation. The process is defined in four key steps:

Figure 1 - Risk Management Process



1. RISK IDENTIFICATION

The Health Board cannot manage risk effectively unless it knows what the risks are. Risk identification is therefore vital to the success of the organisation's risk management process, and ultimately the safe delivery of care. This should be done within context.

2. RISK ANALYSIS AND RISK EVALUATION

Assessment and scoring of risk are used to determine the level of risk, using the Health Board's risk matrix to ensure a consistent approach is adopted across the organisation.

3. TREATMENT, RECORDING AND REPORTING

Treatment is how the risk will be managed, and what the required actions are to achieve an acceptable level of risk. All risks are recorded on a Datix risk register, which is a formal record of all risks raised, which makes up the Operational Risk Register.

4. MONITORING AND REVIEW

Part of managing risk is to continually review and update, and to capture the changes and progress of mitigation.

5. RISK ARCHITECTURE

The current enterprise risk architecture within the Health Board is shown below in a risk management model.

LEVELS OF RISK

The Risk Management Framework defines three levels of risk:

1. Strategic Risks – Risks that represent a threat to achieving the Health Board's strategic objectives or its continued existence. Strategic risks also include risks that are widespread beyond the local area, and risks for which the cost of control is significantly beyond the scope of the local budget holder.

2. Operational Risks – Risks that arise as a result of the day-to-day running of the Health Board and include a broad spectrum of risks comprising clinical risk (e.g., arising from incidents and complaints), financial risk (including fraud); legal risks (e.g., arising from employment law or health and safety regulation); regulatory risk; risk of loss or damage to assets or system failures; etc.

3. Project Risks – Risks that may impact on the delivery of a programme of work or project. All significant projects must be risk assessed before they are progressed, with each project required to have a separate risk register.

RISK REGISTERS

Board Assurance Frameworks, Corporate Risk Registers and Operational Risk Registers can work together in an integrated risk management model:

Board Assurance Framework (BAF)

- Focuses on the top <10 strategic risks that could impact achievement of the Health Boards objectives and priorities.
- Owned by the Board and tied directly to the strategic plan.
- Risks reflect external and internal issues affecting strategy.
- Regularly reviewed by Board and Executive leadership.
- Held by the risk team.

Corporate Risk Register (CRR)

- Consolidates key risks escalated up from the operational level based on the possible impact on Boards objectives and priorities. May include 10-40 major corporate-wide risks.
- Provides Executives with enterprise view of significant operational and strategic risks.
- Enables corporate risk reporting, monitoring and oversight.
- Risk flows to BAF as appropriate.
- Overseen by the corporate risk team, maintained on Datix.

Operational Risk Registers

- Day to day operational risks which impact on service delivery. Includes clinical, financial, compliance, IT risks etc.
- Mandatory for all services to have a register on Datix.
- Service Risk Leads or Risk Champions responsible for maintaining and managing service risk register and escalates higher risks through Executives and Corporate Risk Team for awareness and where appropriate consideration on the CRR.

Project Risks

- Project lead responsible for ensuring risks are captured and maintained.
- Acceptable for the project risk register to be held locally (not on Datix) but significant risks which could impact on day to day operations or have a wider impact on the Health Board should be escalated to a Datix risk register to allow for overview and consistency of reporting.
- Project team escalate higher risks through Executives and Corporate Risk Team for review.

This model provides top-down and bottom-up connectivity to enable robust risk management at all levels and alignment to strategy.

All staff should be aware of the potential for risks to emerge which may affect the business of the Health Board and all staff should be prepared to identify and report risks as appropriate. When a possible risk is identified, staff should aim to discuss it first with their line manager, or for pan BCU risks which have been identified this should also be escalated to the Corporate Risk Team and Executives. This is to avoid duplication of effort, as sometimes risks are identified which are already being managed but have perhaps been articulated differently. Once it is confirmed that a new risk has been identified, the details should be entered onto the Datix system. This will normally be achieved through a service risk lead/champion.

Once correctly identified and assessed, the risk should be logged on a risk register, depending on the seriousness of the risk. Where possible risks should be managed at the lowest level possible, proportionate to the level of exposure to which the risk.

Risks scored ≥15 should be sent to the Executive Director for awareness and consideration on the CRR, if critical/strategic in nature.

Risks scored 9>12, Risk owners are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all risks within their areas. They will be required to periodically present their Divisional risk register reports and assurance of robust risk arrangements to the Risk Scrutiny Group.

Risks scored 1-8 should be regularly reviewed, scrutinised, approved, reduced and managed at the service or departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant quality and safety meeting and/or the triumvirate.

ESCALATION/DE-ESCALATION

Risks should be regularly reviewed and escalated or de-escalated to the appropriate risk register within the Committee or divisional meeting which reviews the risk. Before a risk is presented to an Executive for approval, it should be quality assured by the Corporate Risk Team and take the assurance that robust action plans are in place.

For escalation of a risk on to the CRR the service risk lead should contact their Executive Director through the appropriate channels and the corporate risk team via their regional risk manager.

Figure 2 - Risk Management Meeting & Escalation/De-escalation

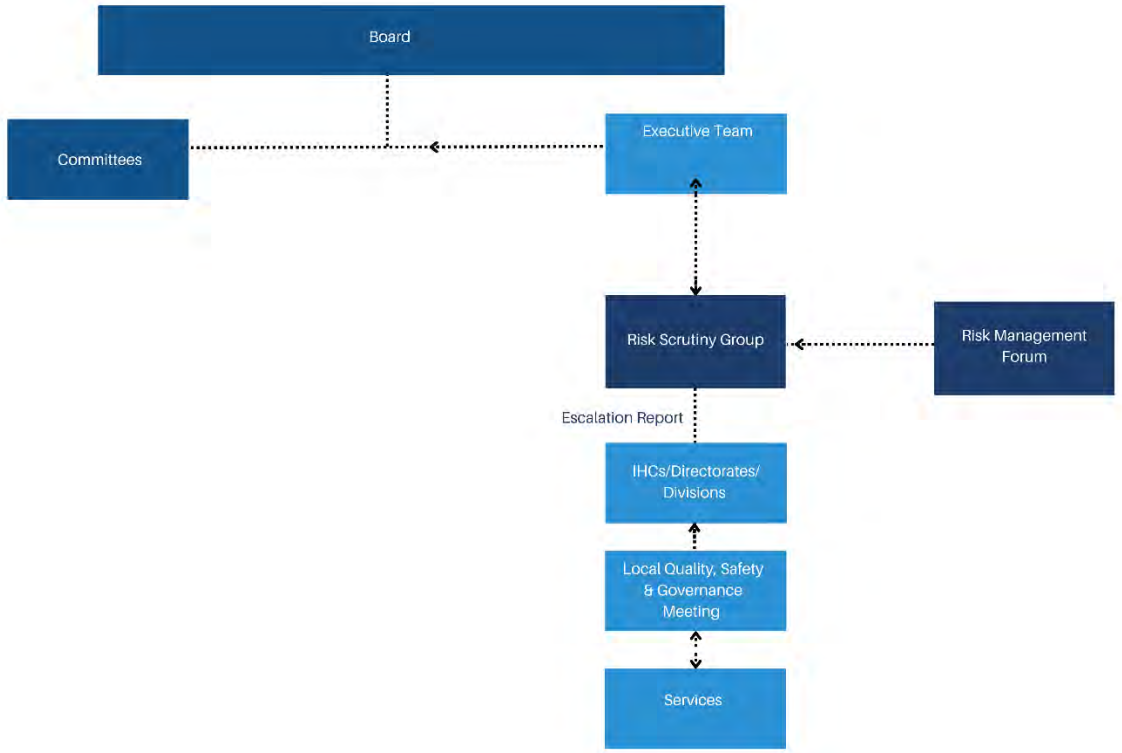
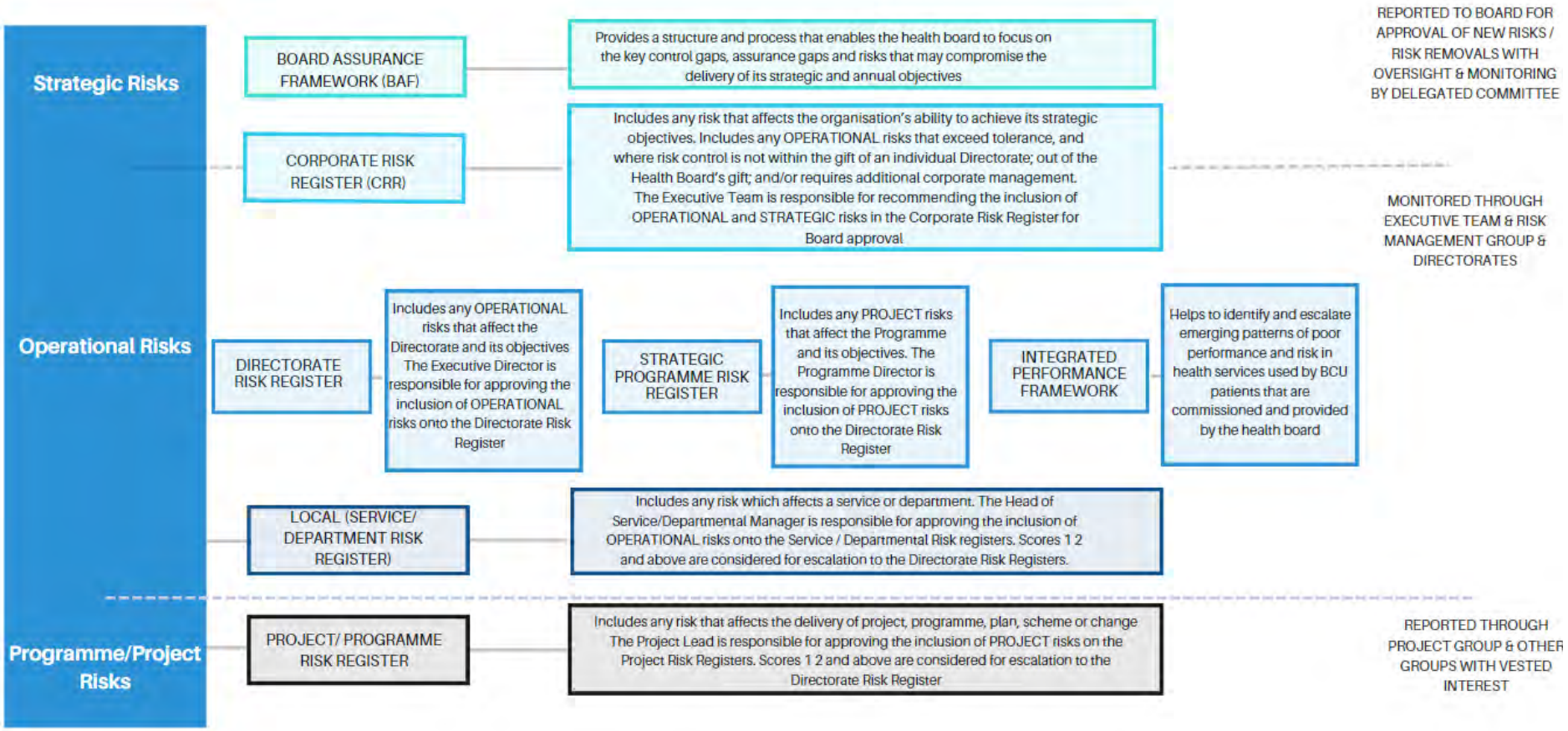


Figure 3 - Risk Management Register



6. RISK STRATEGY

To effectively manage risks, our organisation will take a comprehensive approach across several areas. This will include robust reporting mechanisms to keep leadership and the Board apprised of risks, using systems like risk registers to log and track risks, ensuring staff have adequate training and clear responsibilities, implementing standardised risk management processes, fostering a culture of openness around risks, and continuously monitoring and improving through quality assurance. Together these initiatives across reporting, systems, people, processes, culture and improvement will enable us to better anticipate, manage and mitigate the risks we face in alignment with our values and strategic objectives.

Reporting

- Services to provide their directorates on assurances over the management of the local service risk register.
- Risk Scrutiny Group and Risk Management Forum to oversee risk processes in line with procedures to supports continuous improvement and monitoring of trends in relation to KPIs (outlined in RM02).
- Corporate risk report to Executive team and Committees on risk actions plans and updates. Terms of reference and cycle of businesses for all support risk as a standing agenda item.
- Board Assurance Framework (BAF) risk report to Board.

Figure 4 – Strategic Register Reporting Cycle

Register /Tier	Review	Formal Review	Approval Escalation/ De-	Committee Oversight	Board
Board Assurance Framework	Reviewed Bi-Monthly	Risk Scrutiny Group	Executive Team Meeting	Quarterly	Bi-Annually
Corporate Risk Register				Bi-Monthly	Quarterly

Systems

- Datix to be used to log risks.
- Risk priorities will influence integrated planning.

Processes

- Process in relation to risk management procedures are detailed in RM02 'Risk Management Procedures' and throughout this framework as well as RM03 outlines 'Risk Management Training Procedures' and plans. Risk identification, assessment and treatment processes as detailed in section 4.
- Risk monitoring and review processes, risk reporting and escalation processes.

Culture

- The cultural tone is detailed in the statement and approach to risk as well as supported by the way in which processes are carried out, dynamic and diligence. Risk clearly noted as everyone's business and supported by detailing responsibilities.

People

- Risk management responsibilities are clear for all staff and have been further detailed in section 7.
- The Health Board is committed to continuous learning which applies across risks management. Training as a part of ensuring continuous improvement is crucial. Knowledge of good identification processes and how to manage risk is essential to the successful embedding and maintenance of effective risk management. To support this, a programme of training will be delivered as follows:

Staff Group	Training Need	Frequency
Board Members & Directors & Deputies	Strategic Risk Management Training	Every 2 years
Service managers/Risk owners/Service Risk Leads	Mandatory Operational Risk Management Training	Every 2 years
All staff	Basic awareness on corporate induction as well as a bespoke offer of face to face or virtual risk training	On starting and ad hoc offer as required

The 'three lines of assurance' have been outlined in relation to independent and objective audits and reviews of risk management practices 'The three lines of assurance' includes internal/external audit, regulators, professional body reviews

and scrutiny. Provides assurance to senior management and Board on effectiveness of risk management.

The three lines of assurance also clarify roles for review and oversight:

First line of assurance: Reviews by operational management

Second line of assurance: Oversight by risk management/compliance functions

Third line of assurance: Independent assurance from audit/regulators

This model structures risk management oversight at the Risk Scrutiny Group Executive Team, Committees and Board levels for the Health Board.

7. ROLES AND RESPONSIBILITIES

Effective risk management requires clear definition of the roles, responsibilities, and accountabilities across the organisation. This section outlines the duties and obligations relating to risk for the Board, relevant Committees, key groups and individuals within the Health Board.

THE BOARD:

The Board (Executive Directors and Independent Members) being the governing body responsible for strategy, performance, governance, risk management, and ensuring statutory duties are met. The Board is accountable for effective oversight per NHS (Wales) Act and other healthcare regulations.

The cycle of business for the Board is set to receive the CRR and BAF on a quarterly/bi-annual basis. It is the duty of the Board to discuss and advise on the content and progress of action plans in the BAF. It is also the duty of the Board to appropriately monitor BCUHB's significant risks noted in the CRR, associated controls and assurances outline as well taking a view on the overall decision of tolerating a risk or challenging the possible lack of progression.

The Board is responsible for ensuring that the Health Board consistently follows the principles of good governance; ensuring that the systems, policies and people are in place to manage risks and its effectiveness. The Board will be focused on key risks and driving the delivery of the Health Board's strategic objectives. Gaining assurance demonstrates good oversight of effective risk identification and management; risk architecture as well as due diligence including robust governance. It is a key principle of accountability.

The workplans for the Board and each of its Committees will be aligned to the BAF and CRR, ensuring appropriate focus on areas of risk. In the context of this Framework the Board will:

1. demonstrate its continuing commitment to risk management through the application and interest in the overall compliance with this Framework;

2. ensure, through the Chief Executive, that the responsibilities for risk management outlined in this document are communicated, understood and maintained;
3. take a proactive role in 'horizon scanning' for emerging threats/risks to the delivery of the Health Board's strategic objectives, and ensuring that controls put in place in response, manage risks to an acceptable level;
4. commit financial, managerial, technological and educational resources necessary to adequately control identified risks;
5. ensure that lessons are learned and disseminated into practice from complaints, claims and incidents, and other patient experience data;
6. oversee and participate in the risk assurance process;
7. allocate strategic risks to Committees for oversight;
8. ensure communication with partner organisations on problems of mutual concern including risks;
9. ensure that appropriate structures are in place to implement effective risk management; and
10. receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

AUDIT COMMITTEE (AC):

Provides assurance on governance, risk management, internal controls, financial reporting and internal/external audits. The Committee is responsible for points 1-5 as noted above.

The cycle of business for the Committee is set to receive the CRR and BAF in its entirety on a bi-monthly basis. The Audit Committee, on behalf of the Board, will be responsible for providing oversight of the adequacy and management of the CRR and BAF arrangements.

PERFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE (PFIG):

Oversees financial and operational performance, information governance, and delivery of plans/targets. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

Quality Safety and Experience Committee (QSE):

Reviews quality of care, patient safety issues, clinical effectiveness and outcomes, patient experience. The Committee is also responsible for points 1-5 as noted above. The cycle of business for the Committee is set to receive the section of the CRR and BAF to which it is accountable for on a bi-monthly basis.

Risk Management Forum:

The Risk Management Forum reports to the Risk Scrutiny Group and advises on any risk documentation ensuring the Framework and any other relevant policies and procedures are in place. The Forum will review the processes and report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Forum is responsible for:

• Coordinating the achievement of the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;

• Reviewing high risk recommendations made by the Internal Audit Service, ensuring that where appropriate they are acted upon and recorded through risk registers and the BAF appropriately.

Risk Scrutiny Group:

The Risk Scrutiny Group reports to the Executive Team and advises on any risk management issues, including all significant risks arising from activities within the organisation. The Group is responsible for scrutinising the CRR and BAF ensuring appropriate escalation of operational risks. The Group will report on any weaknesses identified to ensure that the Board has in place effective systems for the reporting of risk, and the management of risk registers (local, directorate and corporate) and the Board's Assurance Framework.

Specifically, the Group is responsible for:

• Operationalising the objectives of the Risk Management Framework through the organisation's directorates, by embedding risk management and establishing local risk reporting procedures to ensure the effective integrated management of risk and assurance;

• Coordinating the escalation of all clinical and non-clinical risks, making recommendations to, and advising the Executive Team and Board accordingly;

• Reviewing and monitoring the CRR and BAF;

EXECUTIVE TEAM MEETING

The Executive team are the accountable leads on individual BAF and CRR risks and support the regular review of the register, noting any risks for escalation and de-escalation. Executives will provide updates on action plans associated with mitigating and controlling the risks they are accountable for.

7.1 INDIVIDUAL RESPONSIBILITIES

All members of staff, and those working on behalf of the Health Board, have an individual responsibility for managing risk. They must understand and adhere to this Risk Management Framework. The following individuals have specific responsibility, accountability and authority for risk management, as part of their existing roles:

CHIEF EXECUTIVE

The CEO is the Accountable Officer of the Health Board and has overall accountability and responsibility for ensuring it meets its statutory and legal requirements, and adheres to guidance issued by the Welsh Government in respect of Governance. This responsibility encompasses risk management; health and safety; financial and organisational controls; and, governance. The CEO has overall accountability and responsibility for:

▪ ensuring the Health Board maintains an up-to-date Risk Management Framework endorsed by the Board;

▪ promoting a risk management culture throughout the Health Board;

▪ ensuring that there is a framework in place, which provides assurance to the Board in relation to the management of risk and internal control;

▪ ensuring that risk issues are considered at each level of business planning, from the corporate process to the setting of staff objectives;

▪ setting out their commitment to the risk management principles, which is a legal requirement under the Health and Safety at Work Act 1974. The Welsh Government requires the Chief Executive to sign a Governance Statement annually on behalf of the Board. This outlines how risks are identified, evaluated and controlled, together with confirmation that the effectiveness of the system of internal control has been reviewed.

EXECUTIVE DIRECTORS

Executive Directors have overall responsibility for the operational management of risks within their Directorates and are the named senior responsible officer for individual risks on the CRR and BAF.

They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate. They shall also be responsible for ensuring that senior managers under their portfolio have effective risk management systems and processes in place in their directorates, divisions, sites, and services to demonstrate robust identification, assessment, mitigation and management of all risks.

They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio. Executives will work with the risk management team to ensure the appropriate use of the BAF and CRR.

Executives play a pivotal role in setting the expected cultural tone, one which is positive and encourages identification, risk is not to be considered as negative or to be avoided. The Executives Directors will do so by ensuring communication is open, and transparent where all staff have the confidence to raise a risk. Executives will seek assurances that risk training is well attended for their regions and departments. Good risk awareness, awareness of roles and responsibilities, timely management of action plans, and a sense of accountability. Executives will seek assurances respective risk registers are maintained regularly, action plans are well managed, well communicated and actions which have blocks are escalated in a timely manner. Registers are expected to be agile and reflective of the service. Executives will foster a culture of continuous improvement supporting teams to engage with Better by Betsi, a community of continuous improvement, enhancing innovation with risk identification, mitigations strategies for their service. Executives will take a proactive identification approach to counter fraud risks.

In addition, Clinical Executive Directors (Executive Medical Director, Executive Director of Nursing & Midwifery, Executive Director of Therapies & Health Sciences, and the Executive Director of Public Health) have collective responsibility for clinical quality governance, which will include patient safety, incident management and patient experience, and will therefore have a responsibility to ensure that clinical risks are appropriately managed in-line with this Framework.

DIRECTOR OF CORPORATE GOVERNANCE

The Director of Corporate Governance is the delegated lead for risk management in the Health Board, and is accountable for leading on the design, development and implementation of the integrated BAF and Risk Management Framework.

The Director of Corporate Governance will:

▪ lead the embedding of an effective risk management culture throughout the Health Board;

▪ work closely with the Chair; Chief Executive; Chair of the Audit Committee; and, Executive Directors, to implement and maintain an appropriate Risk Management Framework and related processes, ensuring that effective governance systems are in place;

▪ develop and communicate the Board's risk awareness, appetite and tolerance;

▪ lead and participate in risk management oversight at the highest level, covering all risks across the organisation on a Health Board basis;

▪ lead the ongoing development of the Risk Management Forum & Risk Scrutiny Group (established by the Executive Team).

HEAD OF RISK MANAGEMENT AND ASSURANCE

The Head of Risk and Assurance is accountable to the Director of Corporate Governance, and in relation to risk management will specifically:

▪ provide specialist advice in relation to controls and assurances for a range of functions at all levels in the organisation to support the effective management of clinical and non-clinical risk and governance;

▪ ensure a central system is in place to collate risk registers across the Health Board, which link to the BAF;

▪ support the management and development of the BAF and Risk Management Framework;

▪ work with directorates and Heads of Service to ensure risks are escalated in accordance with the Risk Management Framework;

▪ compile the CRR and BAF, for Board;

▪ support the development and functioning of the Risk Forum and Risk Scrutiny Group; and

▪ provide training, information and advice to operational staff and corporate functions on risk management and risk registers, ensuring linkage to the BAF.

CORPORATE RISK TEAM

The corporate risk management team will facilitate and ensure effective risk management practices are in place throughout the organisation. The team will support the escalation of risks the CRR and BAF. The risk management team will support services by validating risk registers, including the adequacy of the risk descriptions, controls, and assurances and justification of the risk scoring and take a lead on assurances of compliance pan BCU.

They will advise all colleagues and Executive Directors in managing their risks. The risk team will lead the development of procedures as required under this framework. They will ensure the delivery of training to staff who have responsibilities under this policy. They will be responsible for the overall management of the risk module in Datix.

SENIOR MANAGERS

Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership.

They are also responsible for supporting the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit. The risk service lead and risk team will work with senior managers to ensure risks are articulated appropriately and described in line with procedures and will further support organisational wide learning.

The risk management team will provide healthy challenge and support to those risks that do not have adequate actions or action plans and have not progressed in a timely manner with a route to escalation to Executives. Senior manager will provide Executives with regular assurances around effective management of risk registers.

SERVICE RISK LEADS

Services are required to nominate a risk lead/champion on behalf of the service to ensure the risk register is well maintained and risk is championed throughout the service facilitating good identification processes. Service risk leads will support the operational management of their respective service risk register and will liaise with the risk management team around escalation or de-escalations of risks and will work on any feedback around the quality assurance of the risk register. Service managers and service risk leads will be responsible for ensuring activities and action plans within risks are regularly maintained. All leads and champions will have regular risk management training.

ALL STAFF

All staff including, Trade Union colleagues and contractors are required to comply with this Risk Management Framework, raise any issues of concern to the attention of their line manager and to appropriately minimise and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board. Risk is the responsibility of all staff of the Health Board; agency staff; contractors brought in to undertake work on behalf of the Health Board, for example capital and estates works; students; locums; volunteers; individuals employed on honorary contracts; and, other third parties engaged in Health Board business.

INDEPENDENT MEMBERS (IMs)

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust, positive and effective challenge to the Executive Directors and senior management. IMs are expected to satisfy themselves that the Health Board`s risk management arrangements are effective, efficient and fit-for-purpose. IMs will provide healthy challenge on those risks that are not treated in a timely manner; the overall decision to tolerate the risk and/or the risks alliance to Health Board objectives.

IMs will challenge overall Board decision-making ensuring this is within the Boards risk appetite. In addition, IMs chair Board Committees and in line with the relevant Committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board. IMs should seek assurance in ensuring a measured risk culture.

INTERNAL AUDIT

The relationship between risk management and Internal Audit is critical. Risk management is concerned with the assessment of risk and the identification of

existing and additional controls, whereas Internal Audit's role is to evaluate these controls and test their efficiency and effectiveness. This is undertaken through the Internal Audit programme of work. Accordingly, the Head of Internal Audit will:

a. Provide an overall opinion each year to the Accountable Officer of the organisation's risk management, control and governance; to support the preparation of the Annual Governance Statement;

b. Focus the internal audit work on the significant risks as identified by management, and audit the risk management processes across the organisation;

c. Audit the organisation's risk management, control and governance through operational audit plans, in a way that affords suitable priority to the organisation's objectives and risks;

d. Provide assurance on the management of risk and improvement of the organisation's risk management, control and governance; by providing line management with recommendations arising from audit work.

LOCAL COUNTER FRAUD SERVICES

The Health Board's nominated Local Counter Fraud Specialist (LCFS) provides assurance to the Board regarding risks relating to fraud and/or corruption. The Health Board's Annual Counter Fraud Work Plan, as agreed by the AuditCommittee identifies the arrangements for managing and mitigating risks as a result of fraud and/or corruption. Where such issues are identified they are investigated by the LCFS, and then reported to the Audit Committee as appropriate. The LCFS works with the Chief Executive, Executive Directors and Director of Corporate Governance to review any fraud or corruption risks. Such risks are referred to the relevant risk register for the Directorate concerned, and are then escalated through the Health Board's escalation process. The Executive team recognises that fraud, bribery, and corruption pose significant risks that require proactive management. To protect the interests of our stakeholders, act ethically, and comply with counter fraud laws and regulations, we commit to proactively identify fraud risks and vulnerabilities across the Health Boards operations through audits, reviews of complaints and allegations, and risk assessments. Routinely assess changes that may impact exposure to fraud, bribery and corruption. This also includes effective controls tailored to the highest risk areas identified. This includes clear financial controls, investigation and response diligence, training, and ensuring robust channels for reporting concerns.

SENIOR INFORMATION RISK OFFICER

The Board will nominate an Executive Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

8. MONITORING THE EFFECTIVENESS OF THE RISK MANAGEMENT FRAMEWORK

Compliance with this Framework is monitored by the Executive Committee and the Audit Committee. The Annual Governance Statement is signed by the CEO and sets out the organisational approach to internal control. This is produced at the end of the financial year and is scrutinised as part of the annual accounts process and presented to the Board with the accounts, as part of the Annual Accountability Report. The Corporate Risk Team and Risk Scrutiny Group will take a lead on seeking assurances and providing Committees and Board with an overview of the Health Board's effectiveness and compliance. The Head of Internal Audit will also provide an opinion together with the summarised results of the internal audit work performed during the year.

The Health Board's risk management arrangements are also subject to review annually, as part of the Audit Wales Structured Assessment process. The risk management framework draws from best practice standards ISO31000, policy, and legislative instruction such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. The Health Board understands that risk is inherent in every business and is committed to ensuring full compliance.

This document should be read in conjunction with the 'Risk Management Procedures' (RM02) and 'Risk Training Procedures' (RM03) which are supportive of this Framework and outline all the procedural requirements for managing a risk operationally through to escalation.

Appendix 1

RISK APPETITE

The Board set their risk appetite in a developmental session on the 27 June 2024 and is subject to annual review. The appetite session referenced the Good Governance Institute Appetite Risk Matrix for Sensitive Decision Making, for risk types in order to score appetite.

The output of the session detailed appetite across five risk types:

Quality Risk: There was willingness to be 'open' and accept the possibility of a short-term impact on quality outcomes with potential for longer-term rewards, supporting innovation. Broad learning from events influence improvement. Efforts to promote openness and transparency are on a risk basis by repercussion.

Financial Risk: There was an agreed consensus on an 'open' appetite to be prepared to invest for return but minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.

Compliance/Regulatory: There was an agreed consensus supporting an 'open' risk appetite to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.

Innovation Risk: There was an agreed consensus to 'seek' and innovation is to be pursued with the desire to 'break the mold' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.

Reputational Risk: There was an agreed consensus to 'seek' with a willingness to take decisions that may bring scrutiny of BCUHB but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.

EQUALITY IMPACT ASSESSMENT

The Health Board has undertaken an Equality Impact Assessment on the implementation of the Risk Management Framework and procedures to ensure that it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Any RAG ratings in Datix and other documents will have descriptors for those with colour blindness and RM01-03 will be available in Welsh as well as all risk training. Further support to understand the document is also available through bespoke support and training through the corporate risk team. Any other challenges to implement or apply these Risk Management documents can be communicated to the corporate risk team in order to ensure the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

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Included a desktop review of Welsh Health Boards Risk Frameworks

Appendix 2 - Corporate Risks Dashboard – June 2024.

Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-01	People, Culture and Wellbeing	4 x 4 = 16	8	Quality Open 15-19	People & Culture Committee	Opened Dec 23. 6 actions identified, 1 completed, 5 progressing, **with 2 revised due dates**.
EDoN	CRR24-02	Patient Safety-Falls	4 x 5 = 20	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23. 7 actions identified, 2 completed, 3 revised date, **1 overdue**, 1 new action. Risk to be downgraded to be managed as an operational risk and broader patient safety risk to be presented back for approval.
EDoN	CRR24-03	Safeguarding	4 x 3 = 12	8	Regulatory Seek 20-25	Quality, Safety and Experience Committee	Opened Dec 23. 8 actions identified, 1 completed, 7 progressing, highlighted, some, action deadlines have all been extended to Sept 2024. Scored reduced 18/04/24 from 16 to 12. . Minor Quality Assurance comments sent to the service lead around gaps in controls which will need to be further refined into controls as opposed to statements. Associate Director of Governance met AW on 11 June 2024 and reviewed dates for some actions which would not be delivered on original timescale. (now Sept)
EDoN	CRR24-04	Failure to Embed Learning	5 x 4 = 20	5	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Dec 23, 10 actions identified, 2 completed (rolled into QMS action), 8 progressing. March 2024 **highlighted action deadlines have all been extended** to April-June 2024. The current risk score remains at 20. Some actions delayed due to reliance on NHS Executive National team. Associate Director of Governance met AW on 11 June 2024 and reviewed dates for some actions which would not be delivered on original timescale. (now July)

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Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Risk Management Commentary
EDoF	CRR24-05	Financial Sustainability	4 x 5 = 20	12	Financial Open 15-19	Performance, Finance and Information Governance Committee	Risk score has remained at 20 since opened in March 2023, updated to reflect current financial year. 2 actions identified and progressing. **Risk Score above tolerance set in risk appetite.**
EDoF	CRR24-06	Suitability and Safety of Sites	4 x 5 = 20	12	Quality Open 15-19	Performance, Finance and Information Governance Committee	Opened March 24, 7 actions identified, 2 completed, 5 progressing, 2 revised dates. Backlog maintenance costs **£348m**. **Risk Score above tolerance set in risk appetite.**
CDIO	CRR24-07	Availability and Integrity of Patient Information	4 x 5 = 20	12	Quality Open 15-19	Planning, Population Health & Partnership Committee	Opened Dec 23, 7 actions identified, 1 completed, 6 progressing. The inherent and current risk scores are both high at 20, indicating the existing controls are not adequate to control the risk. **Risk Score above tolerance set in risk appetite.**
EDoPH	CRR24-08	Population Health	4 x 5 = 20	12	Reputational Seek 20-25	Planning, Population Health & Partnership Committee	Redrafted to be more strategic Nov 2023, **No change in score**, 17 actions identified, 0 completed, 17 progressing. 2026 target date. However, the **inherent and current risk scores are both 20**, so the controls are not reducing the risk.
EDoO	CRR24-09	Primary Care	4 x 5 = 20	12	Quality Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 3 completed, 3 progressing. The **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. This risk has been revised and now only reflects primary care and not community. A separate community risk is being drafted. **Risk Score above tolerance set in risk appetite.**

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Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoO	CRR24-10	Urgent and Emergency Care	4 x 5 = 20 ⟷	12	Quality / Open 15-19	Performance, Finance and Information Governance Committee	Opened Feb 24, 10 actions identified, 7 progressing. **Risk Score above tolerance set in risk appetite.**
EDoO	CRR24-11	Planned Care	5 x 4 = 20 ⟷	8s	Quality / Open 15-19	Performance, Finance and Information Governance Committee	Newly developed strategic risk Feb 24, 8 actions identified, 5 progressing, 3 completed. Risk Management Team discussed that the target score should be 12. This will need to be approved by the Executive owner. **Risk Score above tolerance set in risk appetite.**
EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 6 progressing. Further work will be done to separate this risk to the key areas of clinical concern.
EDoTH	CRR24-13	Timely Diagnostics	5 x 4 = 20 ⟷	5	Reputational / Seek 20-25	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 0 completed, 5 progressing. **Risk Score above tolerance set in risk appetite.**
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ⟷	8	Quality / Open 15-19	Quality, Safety and Experience Committee	Opened Feb 24, 6 actions identified, 0 completed, 4 progressing, **2 overdue**. Overdue actions escalated to Chair of Medical Devices committee but need to be addressed. **Risk Score above tolerance set in risk appetite.**

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Lead	Ref	Risk Title	Current Score (Impact x Likelihood)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-15	Health and Safety	4 x 4 = 16 ↔	8	Regulatory Seek 20-25	People & Culture Committee	Opened Feb 24, 14 actions identified, 0 completed, 14 progressing. Work has been completed by the lead to strengthen the action plan and also reflect the recent Internal Audit report recommendations however there remain to be some quality assurance comments sent to the service lead around controls, gaps in controls and dates of **all actions being Dec 24**.
EDoW	CRR24-16	Leadership/Special Measures	4 x 4 = 16 ↔	8	Reputational Seek 20-25	People & Culture Committee	Opened Dec 23. 7 actions identified, 4 completed, and 3 progressing.
CDIO	CRR24-17	ICT Failure and Cyber	5 x 4 = 20 ↔	15	Reputational Seek 20-25	Planning, Population Health & Partnership Committee	Opened Feb 24, 7 actions identified, 4 completed, 3 progressing. Target score of 15 not in line with appetite.

Committee	
Performance, Finance and Information Governance Committee	PFIGC
Quality, Safety and Experience Committee	QSE
People & Culture Committee	P&C
Audit Committee	AC
Planning, Population Health & Partnership Committee	PPHP

Executive Lead	
Executive Director of Workforce	EDoW
Executive Director of Nursing & Midwifery	EDoN
Executive Director of Finance	EDoF
Chief Digital Information Officer	CDIO
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH

Trend	
No trend/Score remains the same	↔
Increase	↑
Decreased	↓

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Full Corporate Risk Register

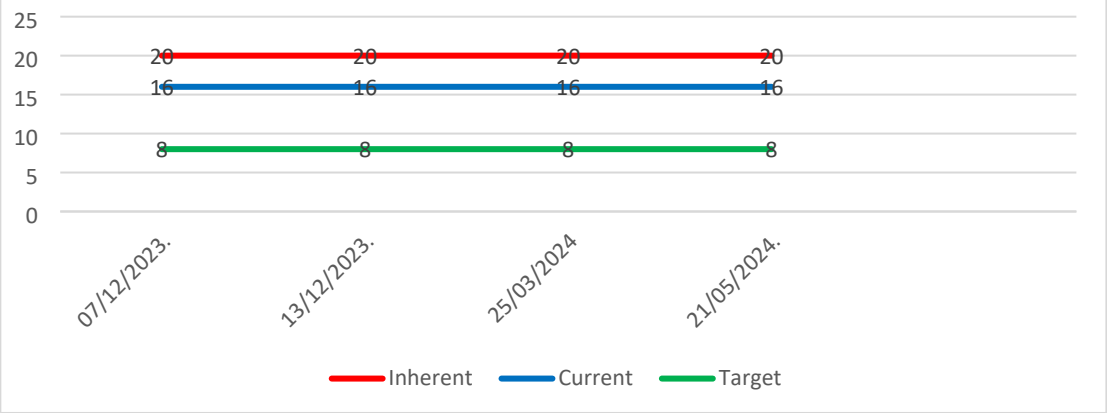
CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP12	**Target Risk Date:** 31/03/2025

There is a risk that BCU do not have a **highly skilled**, engaged and **motivated** workforce which could impact on safe delivery of care. This could be caused by **staffing shortfalls**, organisational reputation and staff not feeling psychologically safe which could lead to burnout. This could lead to the inability to attract and retain high quality and skilled people.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. People Committee oversee delivery of the People Services agenda 2. Local IHC & Pan Services People & Culture Committees in place 3. The Strategic Recruitment team in place to oversee efficient and effective professional recruitment for all senior leadership and medical & dental consultant appointments across the Health Board 4. Local IHC Resourcing Teams are in place across all IHC/Pan Services to drive forward recruitment and staffing priorities. 5. The Recruiting well and Joining Well programmes in place 6. Organisational Retention lead in post for BCU linked with national retention work through HEIW 7. Dedicated Nurse Retention Lead in place to deliver the Nurse Retention Implementation Plan for the organisation 8. New All Wales Flexible working policy has been ratified and is in place 9. Staff feedback conjunction with the NHS Wales Staff Survey in place. Development of Pulse surveys to ensure staff have a voice across the organisation 10. Speak out Safely MDT in place 11. Work in Confidence platform for staff to safely raise concerns. 12. Workstreams associated with this risk which links into the Special Measures Framework are monitored via the governance of the Framework and reported to Executive Team and Board 13. An Agreed scope to the operating model review is underway	**1st** – eg. Operational: 1. Organisational Development Steering Group 2. People Services Senior Leadership Team **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team oversight **3rd** – eg. Independent: 1. Internal Audit 2. Welsh government through quarterly IQPD meetings with executive team 3. HEIW through National Retention programme meetings	1. The programme of work through the Education and Learning Committee to be finalised 2. Increased measures on employee engagement 3. Development of a programme of work to ensure line manager's full involvement in employee engagement 4. Feedback from the HEIW Nurse retention tool.

14. A range of employee engagement tools have been agreed at the OD steering group in March 2024 15. The Culture Change Plan, which incorporated the results from the Staff Survey, was agreed at People & Culture Committee in March 2024 16. Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts		

Actions	Due Date	Progression Analysis
REF Gaps in controls; A. Education and Learning Committee is being established as a control measure	31.07.24	Progressing
REF Gaps in controls; B. NHS Staff Survey action plan to be developed and implemented across 24/25. The corporate action plan has been developed, the next steps is to take it forward at IHC level. This work is scheduled to be completed by end of June	30.06.24	Progressing
REF Gaps in controls; C. Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed. A full report of the findings is due to be submitted by Ararna by the end of May. The Findings will determine what the next steps will be, therefore they cannot be agreed until the full report has been received. The findings will inform the PID for the Operating Model which is one of BCUHB's 3 major transformation programmes of work.	30/06/24	Revised Date 2 weeks (Progressing)
Clinical engagement: Progress demonstrated in the part of the OD plan relating to clinical engagement field work conducted in previous cycles. Recommendations made were reviewed by the Organisational Development Steering Group on 5.2.24. As agreed there, further work is being undertaken to understand the barriers to engagement of clinicians, which will inform proposals for the development of a broader corporate engagement offer. A draft OD Plan was presented to the Steering Group on 4.3.24 for feedback before being finalised.	29/02/2024	Complete
REF Gaps in controls; B. Revisit the values of the organisation: Views on the existing values and suggestions for modifications presented to Exec Team prior to scheduling for review at Board. Previously collected staff feedback on the existing values to be analysed and proposals of methods of co-production with the staff including comms and engagement plans to be submitted via an appropriate Executive governance process. Culture World Café to take place at Leadership Conference 04.06.24. The revised date for the culture world café is scheduled for 4th June, the feedback will be collated and available by the end of June 2024	**30/06/2024**	Revised Date from April (Progressing)
REF Gaps in controls; D. The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce. The programme for Recruiting Well, Joining Well, Leaving Well will now be incorporated into the **Staff Journey** programme of work. An illustrative map is currently being developed showing all areas within People Services and OD that employees typically encounter, from Hire to Retire'. Work in being undertaken to identify gaps in each of the services with regards to policies and procedures. This will enable the Staff journey programme plan, which will include timescales, to be drafted.	30/06/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	People		4 - Seek

Rationale for Corporate Risk

This is a corporate risk due to the current position across the Health Board with high turnover rates across certain key staff groups. Staff engagement score at 72%, comparable with all Wales average of 73%.

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

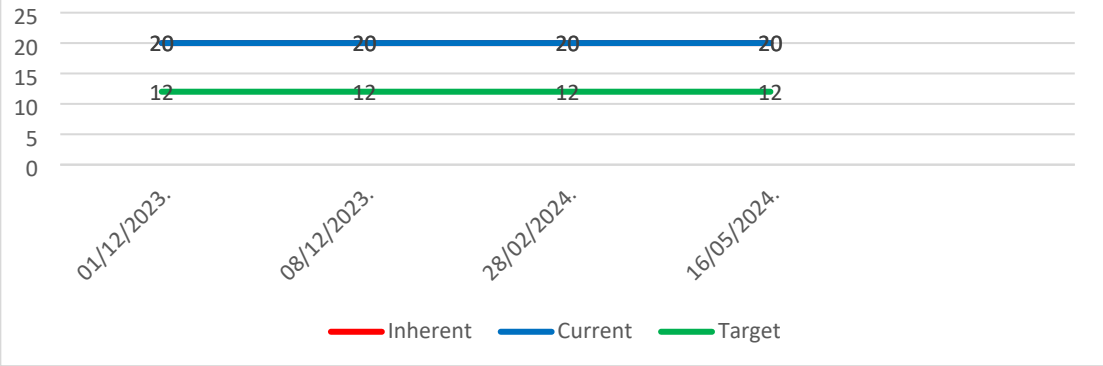
CRR 24-02	**Risk Title:** Patient Safety - Falls		**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 16/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 30/10/2024

There is a risk to patient safety, in particular harm, as a result of slips, trips and **falls** within Secondary Care acute sites. This may be caused by patients acuity/clinical condition/frailty alongside contributory factors such as **reduced staffing**, segregated areas and **premises** which do not allow for ease of oversight, compliance with **manual handling training,** compliance of falls risk assessment and subsequent implementation of mitigating actions. This could result in poorer patient health outcomes, extended hospital stay, regulatory non-compliance and litigation and associated financial impact.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling training data cascaded monthly to respective IHC's/Division Director of Operations to include compliance, Did Not Attend rates and available capacity for upcoming 2 months. 3. Welsh Nursing Care Record (WNCR) has been implemented which has an electronic version of the Falls and Bone Health Multifactorial Assessment (FBHMA) that is identified on the dashboard if not completed and monitored for compliance by the Ward Manager. 4. How to /good practice guide developed and implemented to support with completion and quality of FBHMA across all Adult Inpatient wards: 5. Peer review process in place for 3 months to improve quality of the FBHMA across adult inpatient wards. 6. Falls review groups in place across the Health Board with exception reporting, updating of improvements to Strategic Inpatient Falls Group.	**1st** – eg. Operational: 1. Strategic Inpatient Falls Group - Integrated Health Community (IHC) and Divisional falls review groups report to the falls leads who report to the strategic group. 2. Ward accreditation metrics 3. Ward accreditation review process 4. Peer reviews 5. Patient Safety Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1. Internal Audit 2. HSE 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews	1. Falls prevention and management policy to be ratified and relaunched - has been updated to include a clear step by step approach to completion of the Falls and Bone Health Multifactorial Assessment (FBHMA) and post falls management and currently under review with Patient Safety Group. 2. Assurance and training of agency workers. 3. Improved compliance with manual handling training. 4. Sustained improvement in the quality of completion of FBHMA.

Actions	Due Date	Progression Analysis
New updated and revised Falls Prevention and Management Policy NU06 reviewed in BCUHB Patient Safety Group to be ratified and re-launched. Policy approved at Patient Safety Group, disseminated and uploaded to Betsinet	30/12/2023	Completed
Audit of Ward Managers induction for agency/temporary staff to ensure falls training has been completed. A review of the checklist is underway to make it more user friendly and compliance is being reported in the strategic falls group a question on compliance is being added to the ward accreditation audit	30/08/2024	Progressing (revised date from April 2024)
Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce The Workforce Directorate are exploring options for another supplier to address this risk – propose to change the review date as further work to address this.	30/09/2024 (30/04/2024)	Progressing (revised date from April 2024)
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity The Workforce Directorate are exploring options for another supplier to address this risk – propose to change the review date as further work to address this.	30/09/2024 (30/04/2024)	Progressing (revised date from April 2024)
Outcome of peer review pilot to be evaluated Peer reviews discussed at strategic falls group and quality of risk assessments have shown some improvement. Review of quality of risk assessments need to form part of business as usual and this is part of the ward metrics. The patient safety team are conducting spot checks of the Risk Assessments on the acute wards. Some areas are also conducting spot checks via the Weekly Harms Meetings and chairs of the groups know 'what good looks like'. Plans to embed as part of Board Round process to be discussed with Senior Nurses – New action created	30/04/2024	Completed
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis. still no progress from All Wales group	31/05/2024	Overdue (Revised date from April)
Embed sample review of Falls Risk Assessment at Board Rounds	31/07/2024	New action

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open



N.B. Inherent and Current score lines stacked as both are 20.

Rationale for Corporate Risk

This is in line with the Falls Internal Audit limited assurance report. Disproportionate high number of avoidable falls across the Health Board compared to other NHS providers.

CRR 24-03	**Risk Title: Safeguarding**		**Date Opened:** 07/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 20/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

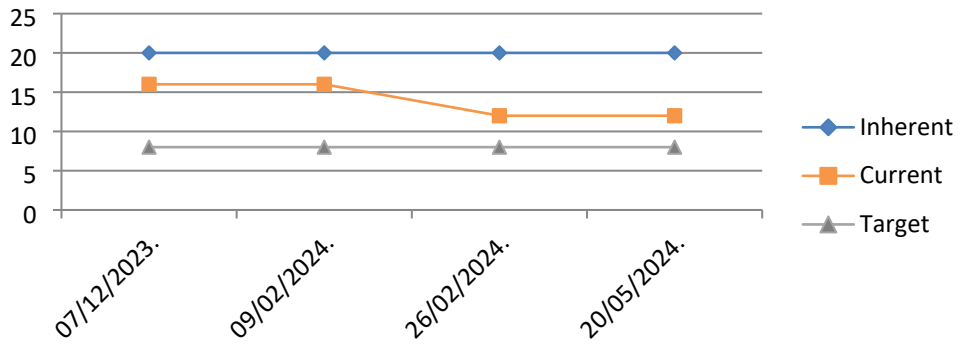
There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, **insufficient** workforce **training** and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The impact may result in harm to at-risk adults, children or young persons, victims of violence/abuse, patients unlawfully detained, financial penalties, reputational damage and non-compliance with Safeguarding legislation which includes but is not exclusive to the Social Services and Wellbeing (Wales) Act 2014, the Deprivation of Liberty Safeguards, and the Mental Capacity Act.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented in line with Health Board Governance and Reporting Frameworks. 2. Audit findings and data are monitored and escalated. Risk Management has been embedded into the processes of the reporting framework. 3. BCUHB mandatory safeguarding training is in place for all staff. 4. Welsh Government interim monies has supported temporary the implementation of additional Mental Capacity Act (MCA) training, the completion of Deprivation for Liberty (DoLS) applications, and	**1st** – eg. Operational: **17.** The risks is monitored monthly and reviewed at the Safeguarding Governance and Performance Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent:	1. New legislation and statutory guidance driven by case law, UK and Welsh Government impacts upon the organisation and the date of implementation is not within BCUHB control. 2. The increase in safeguarding activity with enhanced complexity has resulted in the delay of the implementation of strategic and operational interventions.

strengthened the implementation of Court of Protection DoL for 16/17-year-olds. 5. BCUHB local work programmes are in place and aligned to the National Strategies which are regularly reported to Welsh Government. 6. Safeguarding support the Sexual Abuse Referral Centre (SARC) implementation, compliance and accreditation but the accountability remains with the Central Integrated Health Community (IHC). 7. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews.	1. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. 2. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. 3. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.	3. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming and can result in reduced compliance. 4. The rise in the number of DoLS assessments has resulted in a backlog. Current post holders work additional hours, weekends and evenings. There are local and national staffing challenges with regard to the recruitment of Safeguarding, MCA and DoLS specialist staff. This is recognised by Public Heath Wales and WG. We support flexible working arrangements within the team to ensure staff retention. Reduced leadership team capacity due to absences. . A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required. 5. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. Immediate safeguards are in place and work is taking place to develop a standard procedures.

Actions	**Due Date**	**Progression Analysis**
Review of the safeguarding team and structure A review of the safeguarding team structure has started, a report will be submitted in March 2024 This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024	31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Approved at SGPG being shared at QDG during February2024.	31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, discussions ongoing. This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised

		from March 2024
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP)	31/07/2024	Date Revised from March 2024
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration This date has been amended to reflect an achievable and realistic date given the interdependencies that are required to deliver it	30/09/2024	Date Revised from March 2024
Whilst awaiting the All Wales Data Module conduct a review of the current data capture processes that inform current service demand and future projections which will identify potential gaps and manual data collection practices The timescale for this will be reviewed next month once the action dependencies (team resource) are understood	31/07/2024	Date Revised from March 2024
Risks associated with the DoLS & MCA May 2024 Audit	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Actions are on track and progressing well, risk mitigation best to the ability of the Health Board and yet to receive further steer from legislation. Due to high risk associated with DoLS and MCA the risk is unlikely to reduce until statutory actions confirmed and taken following the next General Election.

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CRR 24-04	**Risk Title:** Failure to Embed Learning		**Date Opened:** 19/10/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/24
Date Last Reviewed: 21/05/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: SP18 **-** Quality, Innovation and Improvement	**Target Risk Date:** 30/09/2024

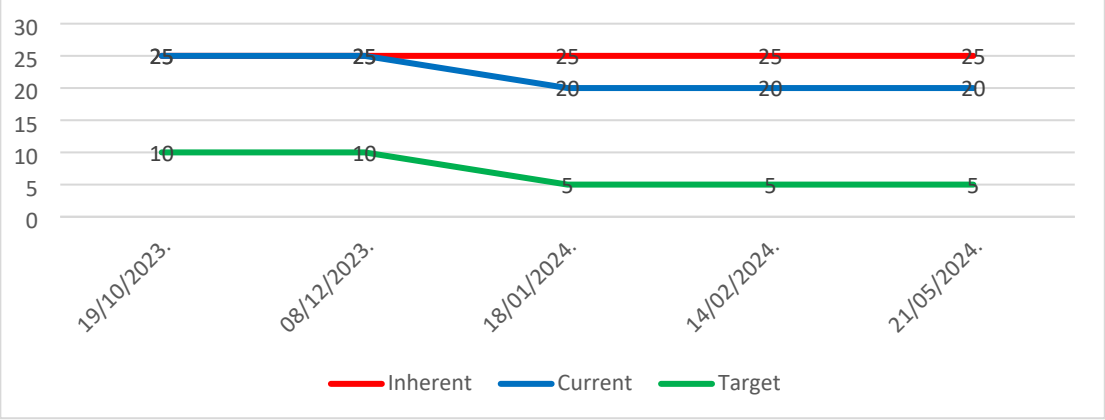
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance on single personnel. The impacts may include missed opportunities for improvement, lack of family/carer engagement, potential patient harm events going undetected, non-compliance with national frameworks or legislation, and reputational damage.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Putting Things Right and clinical review processes and monitoring 2. Risk management processes 3. Audit programmes & monitoring arrangements 4. Patient and carer feedback and involvement processes 5. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 6. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 7. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 8. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 9. Ward accreditation schemes and ward manager/matron checks/audits. 10. Tracking of regulatory action plans 11. Internal Reviews against External National Reports	**1st** – e.g. Operational: 1. Service and IHC Quality Groups (with reporting) 2. Quality Delivery Group, its sub-groups (with reporting) 3. Executive performance reviews with IHCs 4. Clinical audit 5. Regulatory Assurance Group and oversight/assurance reporting 6. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report **2nd** – e.g. Risk and Compliance: 1. Executive performance reviews with IHCs 2. Risk Management Group 3. Executive Team Meeting **3rd** – e.g. Independent:	1. Development of a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Clarity on quality leadership, structures and accountabilities 3. Review of the quality governance framework of meetings and reporting 4. Development of a quality learning framework, aligned to the overall learning organisation programme 5. Review of Putting Things Right and clinical review processes and monitoring 6. Resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests

12. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 13. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	1. Internal Audit 2. Clinical audit 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews 6. Royal College Reviews	

Actions	**Due Date**	**Progression Analysis**
The Quality Governance Framework will be reviewed and refreshed and will include greater clarity on the roles, responsibilities and authorities of all groups including the reporting expectations, process and templates. This will include mapping meetings into an overall cycle and introducing standard templates and a single document repository This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June 24. A QSE Committee workshop is being held on 29/05/2024.	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements This work is being taken forward with the support of the NHS Wales Executive	30/06/2024 due dates to end of July 30/07/24	Date Revised from March 2024
A Quality Dashboard will be developed underpinned by a series of specialist dashboards (i.e. falls, complains, etc). These dashboards will create a single version of the truth using agreed metrics directly connected to the quality systems for real time data Work is progressing on the Dashboard and a test version is live however technical issues remain in extracting and presenting data – these are being resolved and the Dashboard will be soft launched on 01 June 2024.	31/05/2024 due dates to end of July 30/07/24	Date Revised from April 2024
A central and digital library of learning will be established which will be launched alongside a revised approach to the collation, analysis and dissemination of learning. The system prototype is in place and will be tested with MHLD during Q1 with a view to refinement based on the feedback and roll-out over the summer.	30/09/2024	Date Revised from April 2024
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed This work is being taken forward with the support of the NHS Wales Executive as part of the Quality Governance Intervention, who are currently observing to inform their recommendations, therefore the work will take slightly longer and a revised date of 30 June This action is being discontinued with the work rolled into the QMS (see below).	30/06/2024	Completed (action rolled into QMS action)

The new Quality Strategy will be developed through a co-design process A refreshed approach to planning arising from Special Measures - a separate Quality Strategy will not be produced and quality will be part of the overall organisational strategy underpinned by a QMS, see below. A quality section for the ongoing planning process has been written and submitted – May 2024 – Revised date from 03/24 to 05/24 due to external dependencies. This action is being discontinued with the work rolled into the QMS (see below).	31/05/2024	Completed (action rolled into QMS action)
A Quality Management System will be developed in line with the Duty of Quality, which will describe how Quality Planning, Quality Control, Quality Assurance and Quality Improvement will work together as a collective quality system Update - The initial draft of a QMS is due at Board in May 2024. Therefore, the deadline will be extended. A QMS working group is in place, the first meeting was 13 December 2023. There was a workshop at the Executive Team on 24/01/24, at the Senior Leadership Team on 30/01/24, and at the Board on 29/02/24.The Quality Team visited ELFT (an Outstanding rated English Trust) on 26/02/24.The Quality Team are part of the all-Wales working group. Research has been undertaken into work in Wales and Scotland. Support is being provided by Improvement Cymru and the NHS Wales Executive National Quality Team. We plan two further meetings of the working group, and a wider engagement workshop in April May 2024 – Revised date from 03/24 to 05/24 due to external dependencies	31/05/2024 due dates to end of July 30/07/24	Date Revised from March 2024
The Terms of Reference and Cycle of Business for the Organisational Learning Forum is being refreshed and revised to build on and strengthen the work of the group.	30/06/2024 due dates to end of July 30/07/24	New action
A project has been commissioned to develop a new, integrated approach to Investigating and Learning from Incidents, Complaints and Mortality Reviews – this new policy is due at Board for approval in July 2024	31/07/2024	New action
A Learning from Investigations Project has been commissioned to review all open cases due at inquest and to ensure the investigations and evidence of learning is robust. Phase 1 of this project is due for completion by the end of June 2024. The learning from this work will inform the new Investigating and Learning from Incidents, Complaints and Mortality Reviews Policy and process.	30/06/2024	New action



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Reputational		4 - Seek

Rationale for Corporate Risk

Significant backlog of incidents waiting investigation and new cases demonstrating learning has not been embedded

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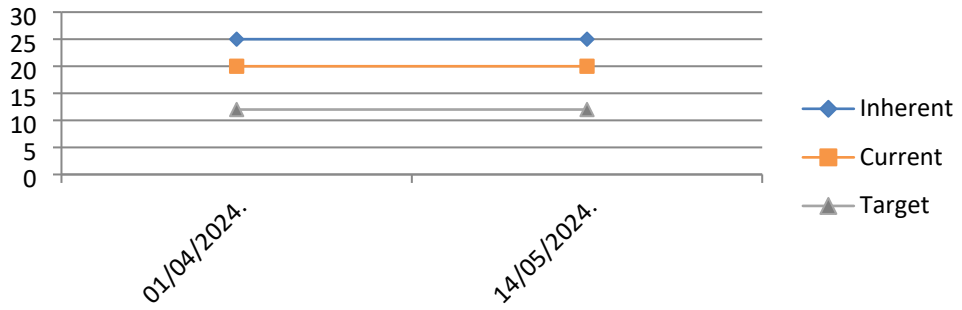
CRR 24-05	**Risk Title:** 2024/25 Financial Plan		**Date Opened:** 01/04/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 14/05/2024	**Director Lead:** Executive Director of Finance	**Link to BAF**:	**Target Risk Date:** 31/03/2025

Failure to achieve the Annual Plan for 2024/25 (£19.7m deficit), due to non-delivery of planned level of financial improvement
The financial plan for 2024-25 requires the achievement of financial improvement (expenditure savings) totalling £48.0m.
Failure to deliver the target for financial improvement could adversely impact the achievement of the financial plan and increase the deficit.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions have been issued and performance to be challenged at Integrated Performance Executive Delivery Group – chaired by the Chief Executive. 2. Value and Sustainability programme approach to 2024/25 savings has been endorsed by the Executive and Board. Executive Leads have been assigned and a flow chart issued setting out the governance process for sharing of costed savings opportunities and Divisional delivery. 3. Continuation, for a period of at least six months, of the Enhanced Establishment Control Group (executive approval before advertising) to review all requests for A&C posts and all Band 7+ posts (Non-Patient Facing), moratorium on requests for Permanent recruitment to Band 8D and above (non clinical posts) and minimising interim staff appointments. 4. Internal scrutiny by Central Finance Team, of the Divisional financial assumptions, overspends and forecasts. 5. Financial reporting to Welsh Government on a monthly basis, with the MMR.	**1st** – eg. Operational: 1. Divisional Directors holding Budget Mangers to Account for spending within delegated budgets and delivering the savings targets. 2. CEO led, Divisional Performance Management of Directors at IPEDG and individual performance reviews 3. Regular review of Risks and Opportunities for mitigation 4. Regular Check and Challenge meetings between FD's and CFOs and Divisional Directors on in-month\forecast outturn and savings delivery **2nd** – eg. Risk and Compliance: 1. Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation – defining expectations, roles and responsibilities. 2. IPEDG setting goals for Directors, for implementation. 3. Risk management framework in place. 4. Early identification of emerging issues through horizon scanning and trends in run rate and alerting Operational Management to changes to regularity requirements. 5. Monitoring the adequacy and effectiveness of internal control, accuracy and completeness of financial	1. Welsh Government (WG) expectation to achieve financial balance, due to the financial settlement/allocations to Health Boards and to enter into financial stability.

6. Financial Position (including Savings) oversight arrangements in place through the Performance, Finance and Information Governance Committee (PFIG) 7. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent rather than non-recurrent.	reporting and forecast, compliance with laws and regulations, and timely remediation of deficiencies. **3rd** – eg .Independent: 1. Internal Audit 2. WG in the form of a monitoring return submission – detailing for example, expenditure run rates and reasons for movements, savings profile delivery and risks and mitigating actions. 3. Fortnightly performance meeting with the WG and NHS Executive.	

Actions	**Due Date**	**Progression Analysis**
Value and Sustainability Programme approach to savings – assign Exec Leads and Support Teams to each theme and cost up Opportunity Plans for consideration by the Divisions.	31/06/2024	Progressing
Progress Savings Opportunities by generating Saving Scheme Documents setting out the planned delivery agreed by Executive Lead or Divisions and monitor actual delivery.	31/03/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Financial		2 – Cautious

Rationale for Corporate Risk

to the Board approved the Annual Plan in March 2025, which set out to achieve a control total of £19/7m deficit. The risk will assess each month progress against the delivery of the Plan.

M3 - Year to date, £7.9m above Planned Deficit

CRR 24-06	**Risk Title: Suitability and Safety of Sites**		**Date Opened:** 04/01/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 13/06/20224	**Director Lead:** Executive Director of Finance	**Link to BAF**: SP14	**Target Risk Date:** 31/03/2026 (10 year capital investment requests aligns with the capital prioritisation form that will submitted to Welsh Government – completion target date 2035).

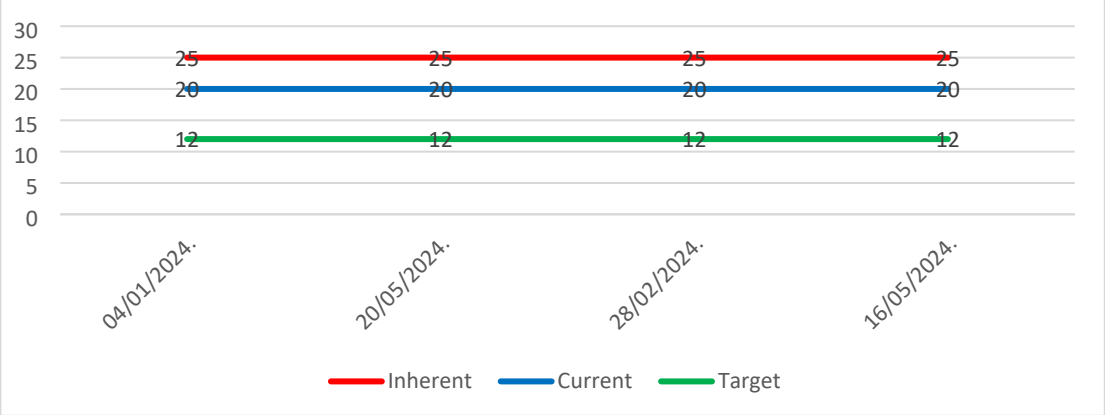
There is a risk that the suitability and safety of the estates and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and unsuitable buildings, backlog maintenance issues, non-compliance with regulations, inadequate space capacity, and lack of capital funding. The impacts may include inability to meet service needs, reduced access to diagnostics and treatment, risks of infection, fire, asbestos, legionella and other hazards, increased costs, regulatory enforcement action, and significant reputational damage. This presents risks to the continuity of care, patient outcomes, staff wellbeing, and the Health Board's ability to provide safe, therapeutic environments across the region.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Estates Strategy developed and approved by the Health Board in January 2023. 2. Internal Governance for capital allocation in place within the Health Board. 3. Business Cases to Welsh Government to resolve major infrastructure issues in line with the Estates Strategy 4. Priority bids against Welsh Government Estates Funding Advisory Board (EFAB) for the allocation and prioritisation of funding in relation to infrastructure funding, decarbonisation, fire and Mental Health and Learning Disability. 5. Discretionary Capital Allocation of £12.448m for 24/25 approved by Welsh Government with an allocation of approximately £3.208m aligned to improvements within the Estates. Prioritisation is based on Operational Estates Risk Register 6. Regular Welsh Government /Health Board Capital Meetings – which provides a direct link with Welsh Government to raise concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff.	**1st** – eg. Local Assurances: Existing groups in operation within the Health Board where capital prioritise are reported: 1. Capital Planning Management Team 2. Capital Investment Group 3. Risk Management Group 4. Executive Team meeting Existing groups in operation within the Health Board where environmental issues and safety are escalated: 5. Strategic Occupational Health and Safety Group **6.** Strategic Infection Prevention Group 7. Risk Management Group 8. Executive Team meeting	1. 6 facet survey to be undertaken to obtain an updated report of the condition of the Estate. 2. Assurance around the development control plan aligned with both the Estates strategy and the Clinical strategy. 3. Business Case Review Group to be set up to review all business cases to provide scrutiny prior to submission to Executive team. 4. Standardised approach by the Health Board in relation to management of Estates and Capital between the Integrated Health Community IHC's) and other services and the Estates/Capital teams. 5. Ensure that the Health Board Capital prioritisation plan is shared with Welsh Government (WG) to identify required investment. The end date is dependant of how much capital investment is provided to

7. Operational Estates Safety Groups in place to provide assurance, the safety groups are as detailed below a) Fire Management b) Asbestos Management c) Water Safety, d) Ventilation Safety e) Electrical Safety 8. Welsh Government Capital Resource Meetings in place to provide route for escalation. 9. Estates and Facilities Performance Management System (EFPMS) reporting template and recording of backlog maintenance	**9.** Internal Audit **2nd** – eg. Board/Committee Assurances: 1. Performance, Finance and Information Governance Committee **3rd** – eg. External Assurances: Internal Audit External Audits undertaken by NHS Wales Shared Services Partnerships, Specialist Estates Services, Authorising Engineers in the following disciplines: a. Fire b. Water Safety c. Ventilation d. Electrical (HV / LV) e. Medical Gases f. Decontamination Inspections by the North Wales Fire and Rescue service within inpatient areas.	the Health Board from WG. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government. 6. Ensure that the Health Board has an Estates rationalisation programme in place that will support the capital prioritisation programme and reduce backlog maintenance. 7.Updated agreed protocol for use of Annual Discretionary Slippage to be put in place by developing Business Justification Cases (BJC) for essential estates works and discretionary capital schemes that could be aligned with in-year additional Capital Funding provided by WG.

Actions	**Due Date**	**Progression Analysis**
Business Case Review Group to be developed by Health Board. Development of Business Case Review Group agreed in principle by the Health Board. To be progressed in conjunction with a multi-disciplinary team representing service and technical support leads and has been trailed on a recent Business Case. The process is being finalised and will be presented to Capital Investment Group for ratification.	30/09/2024	Revised from Feb 24 Progressing
Completion of Welsh Government Prioritisation exercise. Welsh Government Prioritisation exercise completed and approved by the Health Board	31/03/2024	Completed
Undertake action to deliver an Health Board Estates Rationalisation Programme Estates Rationalisation Programme being developed and in draft format. This will be in conjunction with the new Director of Environment, once appointed. A Draft will be submitted to a multi disciplinary group for initial comment, with a final version to be ratified by Capital Investment Group .	30/09/2024	Revised from March 24 Progressing
Agreed protocol for use of Annual Discretionary Slippage to be put in place. Protocol for the use of Annual Discretionary Slippage in place and approval route is through the Capital Investment Group.	31/03/2024	Completed
Review / Standardisation of IHC's / Mental Health Learning Disability Estates and Capital Group 'Terms of Reference' and escalation process	30/09/2024	Progressing

Undertake actions to deliver a 6 facet survey across the Health Board over the next 5 years	31/03/2026	Progressing
Review and update Development Control Plans	30/04/2025	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	2	4	12
Risk Appetite	Quality		3

Rationale for Corporate Risk

Current Risk score of 20 aims to be reduced to a 12 by April 2035. Backlog maintenance is the cost to bring estate assets that are below acceptable standards (either physical condition or compliance with mandatory fire safety requirements and statutory safety legislation) up to an acceptable condition. Total 2021/22 backlog costs for all BCUHB properties was£348.4m. Cost to achieve physical condition B is c. £213m. Cost to achieve condition B for fire and safety statutory compliance is c. £136m. Total risk adjusted backlog is c. £240m. The majority (73%) of backlog relates to the 3 acute hospitals. Backlog for MH&LD, Community and Local Hospitals, and Community Facilities each comprise c.10% of total backlog.
Our estate is facing significant risks and challenges and severe limitations on expected future funding. The current estate is not sustainable or viable in the long term and will not support the implementation of key BCUHB strategies and is a significant risk to the Board.
To aid with supporting a Capital Programme the Health Board will commence with a programme to deliver a 6 facet survey for the Estates, these surveys will commence in 2024 focussing on Acute sites and then community hospitals with a target to complete within 2 years. This will be a significant part of the estates portfolio and backlog maintenance cost. As sites are completed the cost associated with backlog maintenance will be identified and capital funding requested. The end date is dependant of how much capital investment is provided to the Health Board from Welsh Government. The 10 year capital investment requests aligns with the capital prioritisation form that we will submit to Welsh Government.

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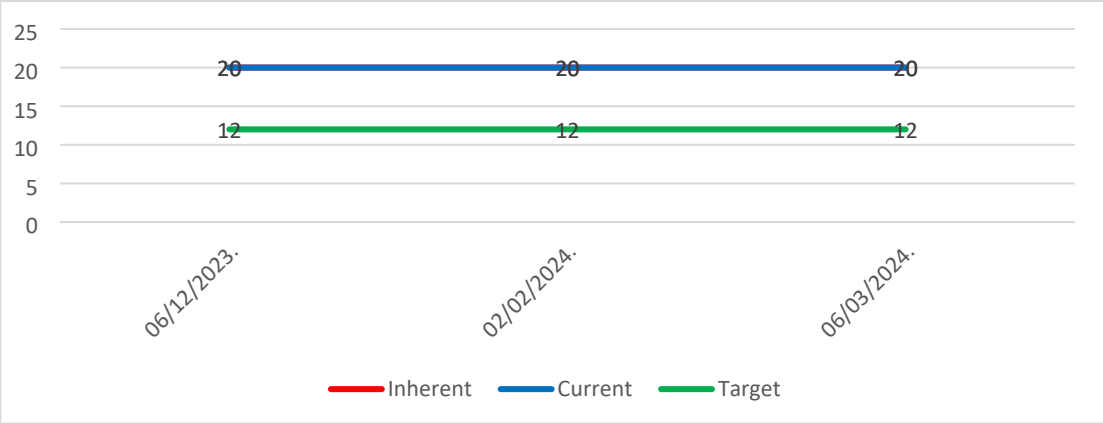
CRR 24-07	**Risk Title:** Availability and Integrity of Patient Information		**Date Opened:** 06/12/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 18/06/2024
Date Last Reviewed: 14/05/2024	**Director Lead:** Chief Digital and Information Officer	**Link to BAF**: SP13	**Target Risk Date:** 31/03/2029

There is a risk that patient harm will be caused due to the lack of a joined up longitudinal Electronic Healthcare Record system that digitalises clinical workflow, alerts, hand overs and scheduling under a single patient identifier, which could lead to deaths and harm.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Current paper file identified as the Master Copy of the full record. 2. Access to current clinical systems to print clinical information ready to store in the Master File. 3. CITO Contract in place to house scanned document as a repository. 4. Mandate process in place to control the adoption of new functionality within existing systems to capture patient data. 5. Current system training and standard operating procedures around searching for and registering new patients to prevent the creating of duplicate records in place. 6. Standard operating procedures involving searching for and storing patient information to prevent harm in cases where duplicate records exist is in place within Patient Administration System. 7. Lack of quality within the content of current patient records. Meeting organised with Office Medical Director to consider address improvements in the quality of record keeping moving forward.	**1st** – eg. Operational: 1. Information Governance Toolkit embedded with operational group oversight and monitoring. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee which focuses on performance indicators. **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team meeting **3rd** – eg. Independent: 1. Information Commissioners Office Audit. 2. Internal Audit Annual Information Governance Compliance Audit.	1. Establish and implement the governance arrangements for overall management of the Electronic Health Record Programme. Steering Group set up and will be captured as part of the outline business case requirement. 2. Lack of current system capabilities systems to integrate into the fuller Electronic Health Record. Optimisation programme underway with a focus on EPOC, EPRO, WCP and CITO to review current systems interoperability and functionality. 3. Availability of current paper records within digital environment. The Electronic Health Care Record outline business case will analyse resource requirements to consider scanning or dual processing of records. 4. Patient Records Group currently not meeting. A review of the remit and establishment is underway with the Senior Information Risk Owner and Caldicott Guardian. 5. Standard practice registration across the three acute sites. Proposal developed including resource funding required

		based on the East Health Records service coverage. 6. No agreement to fund additional Health Records staff to address backlog of duplicate patient records / identifiers. Standardised procedures in place to prevent re-occurrence. 7. Establishment of a Change Advisory Board led by Clinicians to standardise the collection, storage and access of digital patient information. 8. Although agreement in principle to fund additional patient record staff to undertake the duplicate patient record issue, funding stream still not approved.

Actions	**Due Date**	**Progression Analysis**
Assessment to be undertaken of what is required for the development of an Outline Business Case for an Electronic Health Record (EHR) Business Justification Case to seek funding for compilation of Outline Business Case being completed with submission due in September 2024.	30/12/2024	Progressing
Seeking approval and funding for the Strategic outline case for Electronic Health Record	31/12/2024	Completed
Establish the cost and resource requirements to back scan all live records	31/01/2025	Progressing
Standardise the way in which using existing systems (paper and electronic) as part of the DDaT optimisation workstreams Paper will be presented mid-June to DDaT SLT for discussion and decision on prioritisation.	31/03/2025	Progressing
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record report will be available in mid-June for presentation at the DDaT SLT meeting for decision and prioritisation agreement.	30/04/2025	Progressing
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project) BCUHB only Business Case due to be finalised 24th May 2024. A multi-disciplinary steering group has been set up, and continuing to work collaboratively on an All Wales basis.	30/04/2025	Progressing
Recruitment of additional health records staff to standardise the registration practice across three acute sites. Funding request submitted for approval to Executive Team.	30/11/2024	New action



N.B. Inherent and Current score lines stacked as both are 20

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Organisational wide risk based on potential patient safety and negative impact if the risk were to materialise. In addition the financial and resource requirement to implement the controls and mitigations required are significant.

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CRR 24-08	**Risk Title:** Population Health		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 18/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Executive Director of Public Health	**Link to BAF**: SP1	**Target Risk Date:** 31/03/2026

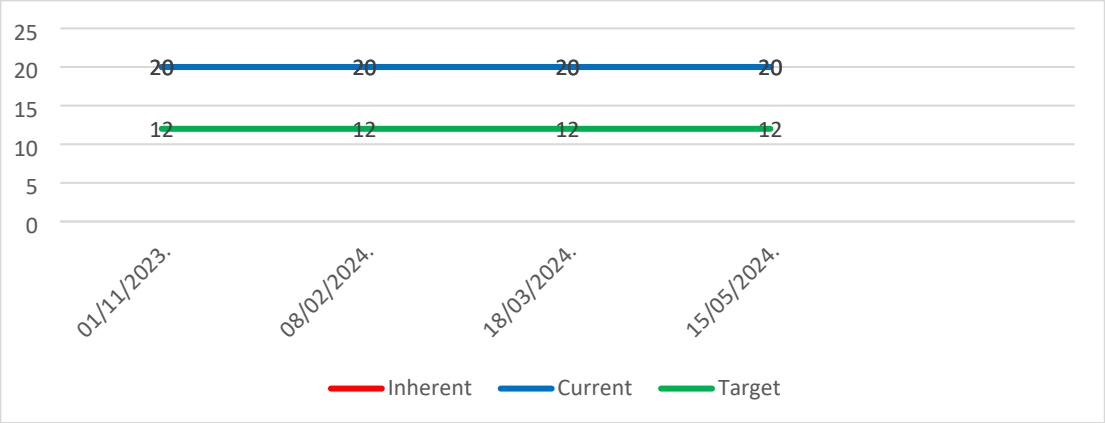
There is a risk that the Health Board fails to adequately support the improvement of population health and reduce health inequalities. This may be caused by a lack of sustainable services, financial and resource constraints within the Health Board, dependency on grant funding to support prevention activity and demand for delivering the urgent and immediate healthcare needs of the population.
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic factors or the accesibility of health care services.
This may lead to continuation and increases in largely preventable non-communicable diseases including Type 2 Diabetes, Respiratory conditions, Cardiovascular disease, Cancer, Musculoskeletal conditions, mental health and wellbeing and multiple co-morbidities. It may also lead to to increasing rates of infectious disease. Failure to address the risk could potentially lead to avoidable morbidity and mortality within the population of North Wales

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Population Health Executive Delivery Group provides strategic direction. 2. Grant funding secured from Welsh Government supporting prevention and early years activity. Grant funding associated with Prevention, Whole System Approach to Healthy Weight, Whole School approach to Mental Health and Healthy Schools/Healthy Pre-schools awarded via Public Health Wales has been confirmed for 24/25 3. The Executive Director of Public Health provides consistency to the regional strategic approach and prioritisation. 4. Annual development of Public Health work plan to reflect current and emerging need. 5. Consultants in Public Health are linked to delivery of key programmes of work, Public Health Wales and with IHC areas, providing expertise and guidance. 6. Public Health Team provide review and feedback on planning applications. 7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of risks and issues.	**1st** – eg. Operational: 1. Population Health Executive Delivery Group and the Public Health Senior Leadership Team. 2. The Public Health Team provide the Health Board, its partners and the public with evidence informed information and approaches to improve health and wellbeing. 1. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans. 3. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. **2nd** – eg. Risk and Compliance: 2. Risk Management Group 3. Executive Team. 4. A 'Whole System Approach' is being implemented across a number of key priority areas 5. **3rd** – eg. Independent:	1. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand. 2. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 3. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available. 4. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.

8. Funding associated with Healthy Weight Healthy Wales which was formerly non-recurrent grants has now been added recurrently to the Health Board core budget. 9. Prevention and health inequalities form key part of the Health Board Integrated plan 24-27. 10. The RIGA process has agreed continuation of funding for 24/25 to support the Well North Wales programme including ICL. 11. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects	1. Internal Audit 2. Representation by senior Public Health team members at Public Service Boards, Partner Boards, Regional Partnership Board and National forums. 3. A number of national programmes of work are underway including implementing the Weight Management Pathway and Smoke Free Sites regulations. 4. National Performance Framework measures. 5.	

Actions	**Due Date**	**Progression Analysis**
Infant Feeding Strategy 2019 (current refresh underway to 2025) forms part of Public Health team deliverables in conjunction with Womens Directorate	31/12/2024	Progressing
Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan confirmation that all smoke free site officers are in place.	31/03/2026	Progressing
All Wales Weight Management Pathway 2021 continuation of funding for 24/25 to support weight management services.	31/03/2026	Progressing
Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways) the HCPH Diabetes programme is part of deliverables within the Health Board approved integrated plan.	31/03/2026	Progressing
Together for Mental Health Strategy (local / national) delivery managed via MH&LDS Directorate	31/03/2026	Progressing
Well North Wales targeted partner programmes Extension of Strategic Partner Development Manager post confirmed to 31/3/25. Discussion paper to PPHP in June.	31/03/2026	Progressing
Health Board Annual Plan / 3 year milestones and associated activity The Health Board plan approved for 24-27 reflects prevention priorities and deliverables.	31/03/2026	Progressing
Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases Confirmation of the funding to support the Health Protection Team. Development of processes for data sharing across organisations. Training and development for LAs and Partners. Measles response plans.	31/03/2026	Progressing
Immunisation Strategy 2023-2026 under review	31/03/2026	Progressing
Recruitment to the post of Executive Director of Public Health	31/12/2024	New action
Public Health team and DPH to meet with DDaT to discuss data and intel gaps to inform planning to support strategic focus for Public Health	31/07/2024	New action

Delivery of the 1st year deliverables from the Health Board's 3 year plan.	31/03/2025	New action
Deliver 24/25 Welsh Government and Public Health Wales grant funded programmes of work	31/03/2025	New action
Deliver 24/25 BCUHB funded programmes of work – Health Care, Public Health (Diabetes) programme	31/03/2025	New action
Deliver 24/25 BCUHB funded programmes of work – Well North Wales programme (Including inverse care law)	31/03/2025	New action
Develop a case for long term sustainable funding Local / Nationally	31/03/2025	New action
Through provision of recognised evidence contribute to the development and delivery of local partner plans (Regional Partnership Board and Public Service Board)	31/03/2025	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

The population health of North Wales is worsening and has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities through loss of involvement. Worsening health outcomes, increasing ill health and widening inequalities directly affects the Health Board ability to deliver excellent healthcare services meaning the Health Board purpose must retain clear focus on improving the health and wellbeing of the population

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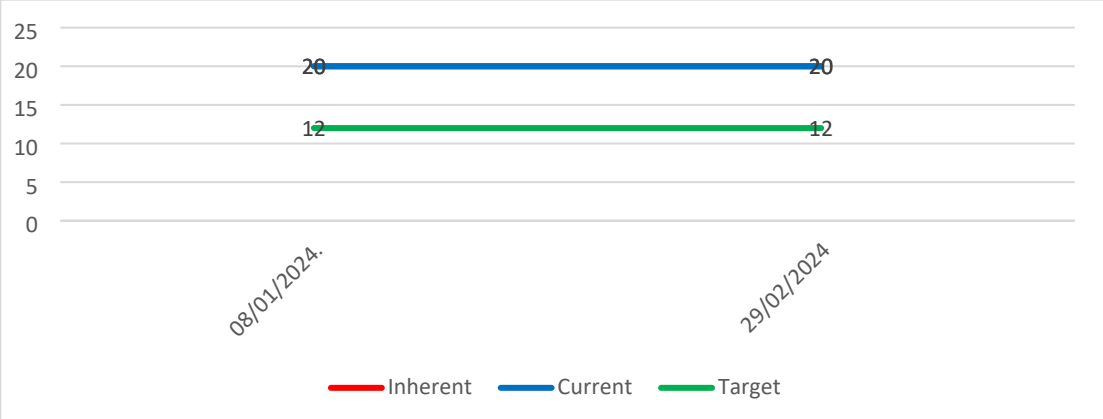
CRR 24-09	**Risk Title: Primary Care**		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Executive Director Transformation And Strategic Planning	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

There is a risk of the Health Board not fully meeting its legal obligation to provide accessible and high-quality primary care. This may be due the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This may result in a demoralised primary care workforce, increased strain on emergency services, prolonged hospital stays, preventable admissions, lapses in care, regulatory non-compliance, and declining population health indicators. Consequently, there is a cascading effect on patient flow, service performance, care quality, collaborative partnerships, cost-effectiveness, and the viability of primary care and community care models. The ultimate consequence is a rise in mortality rates, treatment delays, and extended hospitalisations, exacerbating patients' health conditions.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Escalation and sustainability report to address risks associated with workforce and workload pressures allows for early identification and management. 2. Risk management training completed Q3 2023 for all primary care leaders for better identification and management. 3. Programme management implemented to monitor and drive strategic priorities. 4. Primary Care Quality and Delivery Group established Q3 23/24 5. Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board. 6. Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits 7. Greater Health Board oversight of Primary Care issues and risks via PPHP Committee with first report to committee during April 2024 with further reporting in June 2024.	**1st** – eg. Local Assurances: 1. Primary Care Quality and Delivery Group 2. Primary Care Panel **3.** **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team Meeting 3. **3rd** – eg. External Assurances: 4. 1. Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. 2. Equity of resource to support primary care transformation, management and governance.

Actions	Due Date	Progression Analysis
Primary Care Board established Primary Care Board has now been established with the first meeting held May 2024, monthly meetings planned moving forwards. Sub group reporting into the Primary Care Board.	30/05/2024	Completed

Primary Care strategic plan National Primary Care model being reviewed with HB input which will inform the Betsi Strategic plan.	31/03/2025	Progressing
Escalation and sustainability implementation Primary Care contractor services audits of sustainability matrix ongoing periodically – Programmes in place to undertake the audits which were included in the annual delivery plan.	30/06/2024	Completed
Health Board Managed Practices – recommendations for improved governance report Managed practices governance and assurance sub group reporting into Primary Care Board	31/01/2024	Completed
Focused on implementation of recommendations from the National Strategic Programme for Primary Care. July workshop planned to review the recommendations and programme of work for 24/25	31/03/2025	Progressing (revised date from 30/06/2024)
Primary Care academy to utilise SPPC monies to further progress multi-professional working with a review of cluster monies spend to allow introduction of new roles, ways of working and models of service delivery.	31/12/2024	New action



N.B. Inherent and Current score lines stacked as both are 20.

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Optometry reform delivery compromised, continue to have further managed practices and financial implications to the Health Board. Dental access compromised.
Recognition of inherent score currently further controls needed.

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CRR 24-10	**Risk Title:** Urgent and Emergency Care		**Date Opened:** 26/02/2024
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 25/06/2024
Date Last Reviewed: 07/06/2024	**Director Lead:** Executive Director of Operations (Executive Director Therapies & Health Science)	**Link to BAF**: N/A	**Target Risk Date:** 30/03/2025

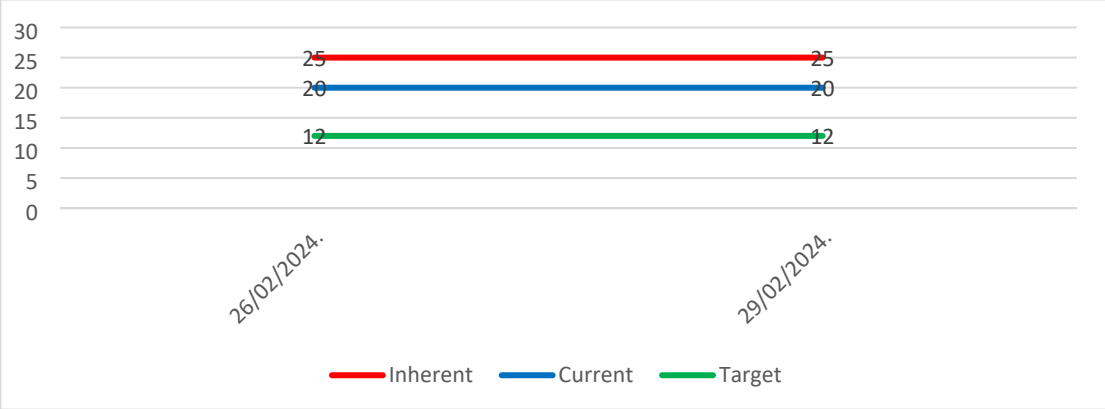
There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This could impact on pressures for other services, reputation and litigation implications.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
Daily management system in place to manage patient flow including multiple daily local and national calls. Continuous focus on reducing delays for health and social care reasons including complex care management, fast track cases and implementation of a home first ethos. Regular reviews of long stay patients in acute & community hospitals to reduce average length of stay. Training on discharge and complex care management is provided to ward based staff through the Complex Care and Unscheduled Care Team. System lead management 5/7 to have a singular point of escalation with external agencies and internal IHC concerns. Single Integrated Clinical Advice Triage (SICAT). Ambulance escalation process to support peak periods of demand. Hospital full protocols to support rapid de-escalation during peak periods of demand. Care Home risk and escalation plans to support care home capacity with community team's support.	**1st** – eg. Local Assurances: 1. Operational Meetings ensure a Pan North Wales approach for managing daily UEC demand with external stakeholders 2. Clinically optimised reviews across all IHCs take place on a regular basis with access into social care providers for support on getting patients care closer to home. 3. IHC Management team led reviews with clear focus on action to support reducing LoS with a full multi-disciplinary team representation. 4. Nurse led discharges being rolled out across North Wales to support timely discharges and utilisation of STREAM (IT System) to track planning. 5. Senior operational managers managing daily demand across North Wales and being a singular point of escalation when Unplanned and Emergency Care (UEC) demand and capacity increases. 6. Each Acute site has a process of internal escalation when delays occur with ambulance handovers occur with triggers for escalation and actions to be completed. 7. Each IHC has a bed escalation process that supports triggers for escalation and gives triggers to support de-escalation in a timely fashion.	1. Fragility and gaps in social care assessment, delivery and social care market provision (including both domiciliary care and independent care home sector) resulting in substantial delays and patients being stranded in community hospitals and out of county beds. 2. Delays in assessment of complex care cases and inefficient brokering resulting in increased delays and cost. 3. Resources – System lead runs alongside staffs day to day roles and is extremely fragile in the current climate and requires either extending criteria of staff to support or development of a permanent hub similar to that of IA. 4. Funding spot purchasing of beds to assist with stepping up of patient care rather than hospital admissions. 5. Vacant essential roles across BCUHB that will impact on patient care and operational management resulting in inability to drive system change.

Winter Plan developed to manage whole system pressures. Urgent review of escalation options in development between health and social care to increase community care capacity and to reduce delays. Industrial action command and control structure in place to manage service impact and to minimise disruption to services. Winer plan reviewed and signed off by Executives/Board December 2023, with planning under way to commence resilience planning from April 2024 for season 2024/2025, planning is inclusive of local authorities and voluntary sectors to support a North Wales approach 0800-2000hrs funded GP service working alongside WAST/111 to reduce ambulance responses and manage patients through alternative pathways reducing the need for ambulance attendances Monthly updates from WAST to confirm care home at risk for escalation, with regular reviews and training to support managing the patients care closer to home, this is further expanded by Immedicare (Remote advice) being in place across 15 care homes across North Wales. Increasing periods of industrial action occurring, IHCs planning continues along with weekly Silver and Gold reviews to ensure accurate communication with all stakeholders along with assurance for national agencies Review of Complex Care arrangements in place to improve system improvements and to reduce delays, this is now managed via Goal 6 of the six goals programme and also via each IHC's Clinically optimised weekly meetings. Industrial action (IA) management plans in place and require review for sustainability in light of on-going planning for IA throughout 2024 Urgent escalation plan to secure additional system impact to improve community care capacity and flow, amended from lessons learnt	**2nd** – eg. Risks/Compliance: 1. Escalation to Executive Team 2. Risk Management Group **3rd** – eg.External Assurances: 1. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW. 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews 5. National Trauma Peer REVIEW. 6. Internal Audit	6. Trusted assessors development, ongoing work for the last 18months, support required to progress at pace. 7. Review of system lead/on call to support a 24/7 provision with an equal service provision. That amends the narrative from On call to shift focus. 8. Winter resilience, earlier national feedback on any support available over the winter periods, in place of the November/December notification that does not allow maximum utilisation. 9. Continuous flow modelling – National presentation on a model to decompress the Emergency department and create movement to reduce delays.

Actions	**Due Date**	**Progression Analysis**

Health board to identify permanent Executive lead for UEC to allow sustainable programme development over the next 3 years.	01/09/2024	Progressing.
Health board to support development of a pan North Wales UEC (SICAT remodelling) hub prior to Winter 2024 to ensure 24/7 service support, in conjunction with national support and forthcoming escalation triggers	01/09/2024	Progressing.
Transformational development of urgent care system (6 Goals) including ministerial priorities; in light of major change programme completion date has been amended to End of August 2024 to support a singular approach for one system.	31/08/2024	Revised from March Progressing
GIRFT/SEDIT reviews ongoing to support demand management across North Wales, supported by the national programme team, capital funding being sourced from the national programme.	30/09/2024	Progressing.
BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 2024- WXH IHC have been the sight supported by Executives as initial trial site. Ongoing assurance discussions with East IHC and Swansea Bay continue in light of concerns raised. Final meeting planned for end of June 2024	30/06/2024	Progressing
Confirmation of national requirement for winter resilience plan going forwards or focus on a North Wales resilience plan for 2024-2025	31/08/2024	Progressing
Communication – BCUHB requires a singular approach to communication on UEC planning to prevent conflicting information occurring due to planned care forecasting	30/07/2024	Progressing.
Review of Complex Care arrangements in place to improve system improvements and to reduce delays, this is now managed via Goal 6 of the six goals programme and also via each IHC's Clinically optimised weekly meetings.	30/04/2024	Completed
Industrial action (IA) management plans in place and require review for sustainability in light of on-going planning for IA throughout 2024	30/04/2024	Completed.
Urgent escalation plan in development to secure additional system impact to improve community care capacity and flow to be reviewed and amended from lessons learnt since implementation	31/05/2024	Completed



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Regulations 28, preventing future death reports (2020-2023),

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CRR 24-11	**Risk Title:** Planned Care		**Date Opened:** 04/12/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** New
Date Last Reviewed: 12/06/2024	**Director Lead:** Executive Director of Operations (Executive Medical Director)	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024 (interim review)

There is a risk of further deterioration in patients' health, **harm**, mortality or need for more complex treatment in relation to planned care services with a, resulting in failure to meet national access targets. This could be caused by **long waits and delays** for planned care, insufficient **capacity**, staffing shortages, increasing demand, and backlogs exacerbated by COVID. The impact would be worsening patient outcomes and experiences, increased complaints, financial penalties for target breaches, and reputational damage.

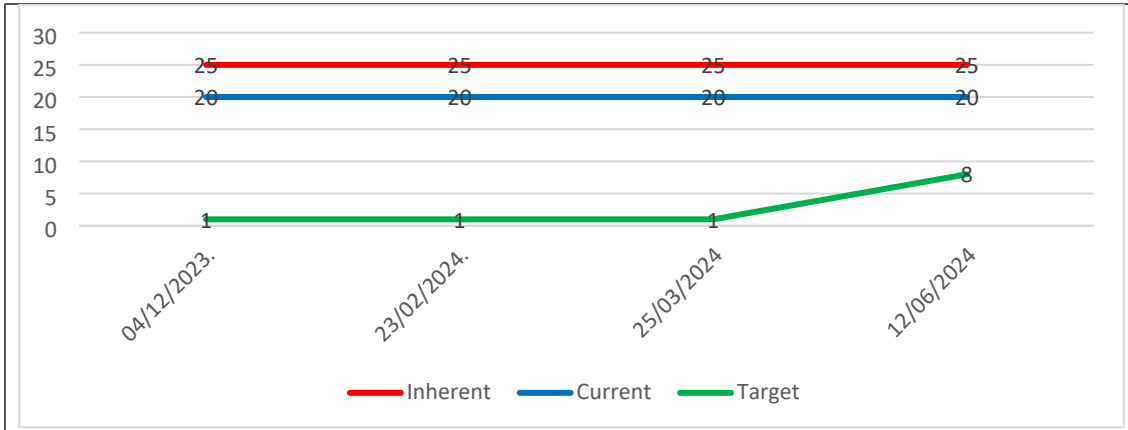
Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Routine prioritisation of patients by clinical risk according to national Referral to Treatment Time (RTT) guidance (Cancer > Urgent > Routine) 2. Performance monitored via weekly corporate access meeting and locally via IHC weekly access meetings including long waits and clinical prioritisation. 3. Clinical prioritisation and review of waiting lists ongoing. 4. Validating waiting list cohorts.	**1st** – eg. Local Assurances: 1. Routine operational performance monitoring (weekly corporate access meeting). 2. Application of RTT guidance in maintaining and improving treat in turn rates 3. Escalation to Planned Care Board **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg.External Assurances: 1. Internal Audit Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 2. WG performance monitoring and assurance 3. Welsh Government Reviews 4. Royal College Reviews	1. Capacity and demand modelling and trajectory tracking 2. Development of sustainable service models to mitigate existing clinical risks 3. Application of GiRFT and other performance improvement approaches (monitor progress of implementation via planned care board and performance outputs via access). 4. The planned care funds available will mitigate the risks and will be closely monitored through the Planned Care Programme Board 5. Chief Operating Officer vacancy. 6. Refresh and renew INNU policy to ensure referrals are appropriate. 7. Commissioning services where there is need

Actions	Due Date	Progression Analysis
Recruitment to the Llandudno/ Abergele business case (orthopaedic site). Funding not released, action overdue. Partial recruitment complete others ongoing	Original date March	Progressing

	revised 10/06/2024	
Approval of the application of sustainability funds and authority to deploy in line with Plan. Phase 1 completed as planned	Original date March revised 08/05/2024	Complete
Senior Responsible Officer appointed for Planned Care Board	Original date March revised 01/04/2024	Complete
Recruiting to programmes of work in order to support successful delivery	01/06/2024	Progressing
Board Development session for Executives on planned care	Original date Dec revised 06/05/2024	Complete
Chief Operating Officer Recruitment underway	01/07/2024	Progressing
Procurement for insourcing for endoscopy and diagnostics	01/05/2024	Progressing
Endoscopy business case approval	19/05/2024	Progressing

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk



RTT 52 week waits stage one - NHS Wales Performance Framework 2024-25 Target = 0. Current positions RTT 52 Stage 1 - 17,505 (although surgical West actuals are nearly 500 lower than the trajectory)

RTT 104 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0. Current positions RTT 104 all Stages -11,503 (9,435 over 104w +1,734 over 156w + 334 over 208w) To achieve this within 12 months would mean an additional 2,417 cases per month, at least 1,459 of which would be stage ones.

RTT 52 week waits all stages - NHS Wales Performance Framework 2024-25 Target 0 by 30.06.2025 Follow up backlog 100% overdue - Target reduction compared to same month last year. East has a bigger share of stage ones over 52w by 2k so there is room to make the pan-BCU list more equitable. Continue to prioritise eliminating 156 or 208 weeks as early in the new financial year as possible.

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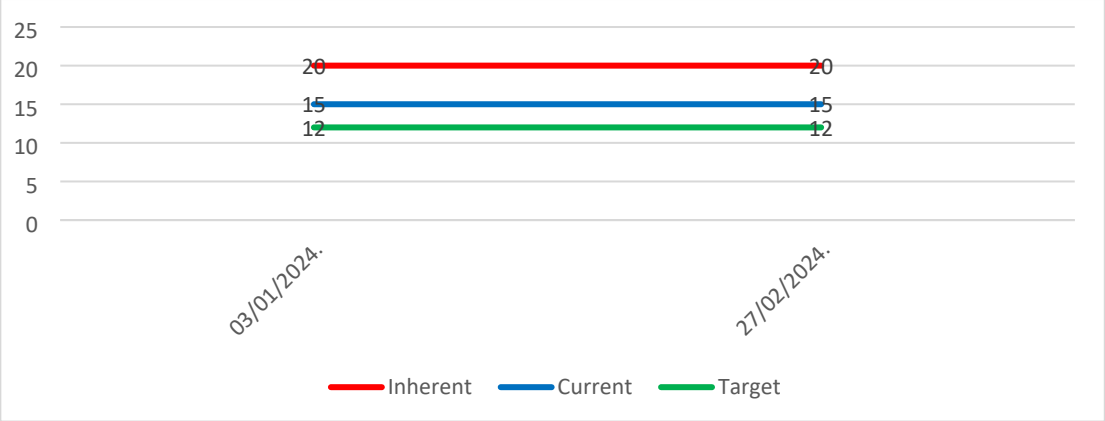
CRR 24-12	**Risk Title:** Clinical Areas of Concern		**Date Opened:** 15/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review: New**
Date Last Reviewed: 29/05/2024	**Director Lead:** Executive Medical Director/ Executive Director of Operations	**Link to BAF**: N/A	**Target Risk Date:** 01/03/2025

There is a risk of service failure leading to patient harm across a number of fragile clinical specialties. This could be caused by staffing shortages, clinical leadership gaps, lack of productivity, demand backlog, increasing patterns of demand and estates and equipment deficits. The impact may be delayed diagnosis and treatment of significant conditions. This impacts patient safety, healthcare access and public health outcomes.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Strategic Improvement Groups for the fragile clinical specialities. 2. Progress review groups for ophthalmology, dermatology and urology to develop and review progress of improvement plans. 3. Improvement plans for fragile specialities for specialities with clinical leadership. 4. Prioritising/triaging cases in specialities with backlog.	**1st** – eg. Local Assurances: 1. Special Measures meeting and assurances to committees on 90 day cycle 2. Quality Delivery Group **2nd** – eg. Risk/Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. External Assurances: 1. Internal Audit **2.** National touch point meetings with NHS Executive colleagues	1. Implement plans for integrated electronic patient records 2. Dermatology, ophthalmology, urology continue to have clinical leadership gaps 3. Address lack of consistent medical cover in some specialities. 4. SLA for services provided by non-BCUHB organisations 5. Development of clinical model/pathways for fragile specialities with limited leadership incorporating relevant GIRFT and College recommendations 6. Clinical validation of waiting lists.

Actions	Due Date	Progression Analysis
Engagement with National Procurement Processes (i.e. eye record system) and National Programmes (i.e. Robotics) Ongoing engagement with Welsh Government is taking place and is satisfactory.	01/07/2024	Progressing
Ongoing recruitment for substantive medical leadership roles. Now recruited into an Ophthalmic Clinical lead role (May 2024). Start date to be confirmed. In addition the team has now had authorisation to appoint a Clinical Lead for Dermatology	01/01/2025	Progressing
Recruitment efforts including substantive, locum and agency staff. Work continues on a cycle of recruitment. Locum dermatological cover in Ysbyty Gwynedd from June 2024 has been confirmed in May 2024.	01/01/2025	Progressing
SLAs to be signed off through governance structures Work has now commenced on the process to implement a Dermatology Outsourcing SLA with national lead input. In relation to governance. Updates and any approvals will be sought through the Executive Team. (for SLA approval)	01/08/2024	Progressing

Clinical pathway events Engagement during May 2024 with NHS Wales Executive on the development of the Community Clinical Pathway system. This will be received at Executive Team for consideration.	30/07/2024	Progressing
Non-clinical and clinical validation exercises Andrew Oxberry from BCUHB has commenced work on this and this will be able to reported at the next update to this risk.	30/07/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	3	12
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

The impact of the inherent risk has not been altered by current actions, although its likelihood has been reduced by the identification of the clinical issues and improved governance around the services.

- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

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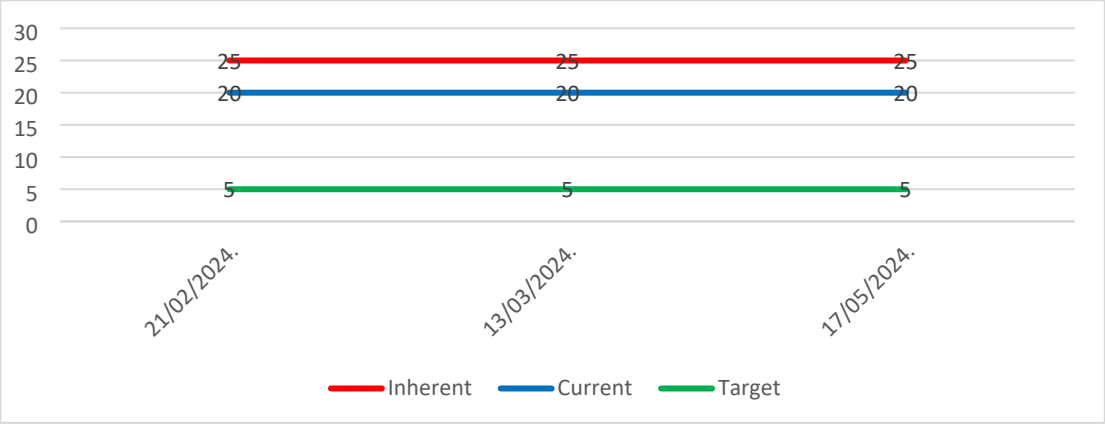
CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2025

There is a risk of delay in diagnostics, service failure, poor performance or disruption to **radiology** and **pathology** services across. This could be caused by shortages of specialist staff, aging or inadequate IT systems and infrastructure, and insufficient governance structures. The impacts may include delays in diagnosis, treatment and discharge, increased outsourcing costs, patient harm events, preventable deaths, regulatory non-compliance, and significant reputational damage. There is also additional risk related to clinicians failing to act on results of diagnostic tests.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Insourcing of CT, MRI and ultrasound to deliver required capacity 2. Work commenced on new radiology staffing model for the identification of significant restructuring of the service with succession planning, career development, staff wellbeing etc. 3. Significant guidance and steer with National Imaging Programme workforce work. 4. Outsourcing of radiology reporting to maintain Welsh government turnaround times 5. Waiting list & capacity and demand management is in place to monitor radiology required resources.	**1st** – eg. Operational: 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. 2. Radiology RISP project board in place **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent: 1. Internal Audit 2. RISP being monitored via National and BCU implementation boards	1. Replacement of Radiology Informatics System (RISP) – implementation underway go live planned for April 2025 2. Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally 3. Radiology workforce model not suitable for meeting the current demands being placed on the service from both clinical activity and supporting activity required to deliver service e.g. governance, regulatory and accreditation requirements 4. Escalate to BCU Clinical Effectiveness Group – issues around failure to act. Procedure MD (Office of the Medical Director) 23 – 'Mitigation of the risk of failure to act on diagnostic results' needs updating which is being led by the Executive medical director.

		5. PHW Collaborative Executive group. 6. Diagnostic Strategy for BCU needs to be developed

Actions	Due Date	Progression Analysis
Replacement of Radiology Informatics System (RISP) – implementation with anticipated go live date of the 14/04/2024.	14/04/2025	Progressing
Replacement of LINC (national pathology IT system) - Contract signed with current supplier plans to implement by September 2025 being progressed nationally	30/09/2025	Progressing
Procedure MD23 (Mitigation of the risk of failure to act on diagnostic results) to be updated	31/12/2025	Progressing
Radiology workforce revised model to be developed by June 2025	30/06/2025	Progressing
Diagnostic Strategy to be developed by diagnostic group	30/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	Reputational		4 - Seek

Rationale for Corporate Risk

Increasing demand for both radiology and pathology
Outdated IT infrastructure in both Radiology and Pathology that carry significant clinical and operational risks. – National programmes in place to resolve these issues
Additional work required to mitigate the risks from failure to act and update procedure MD23
Waiting lists longer than the national targets which results in delay in diagnosis which results in harm to patients. In addition, staffing stress related to demand in the service leading to burn out. 31st January 6,801

	diagnostic waits over 8 weeks with Endoscopy (2,163) and Cardiology (1,552) being the largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.

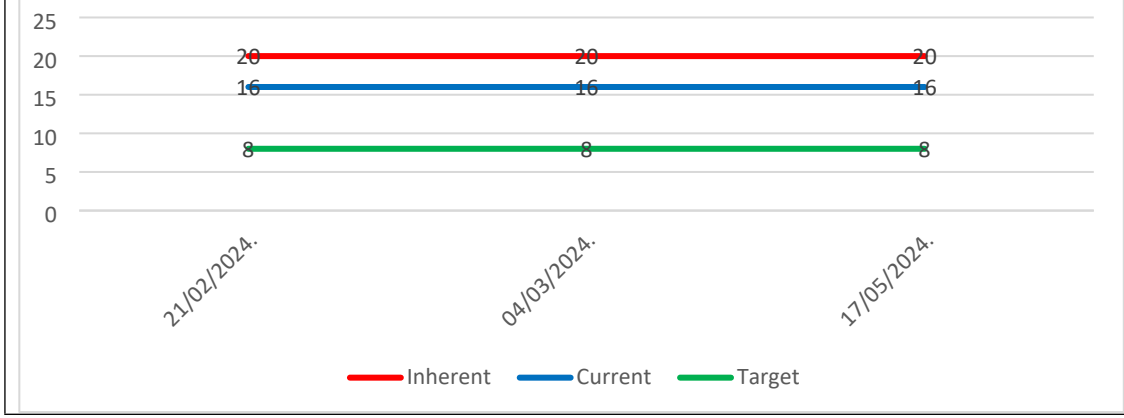
CRR 24-14	**Risk Title:** Harm from the Medical Devices/Equipment		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 06/06/2024
Date Last Reviewed: 17/05/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/09/2024

There is a risk of harm and infection from aging, **unsuitable** or unreliable **medical equipment** and devices. This could be caused by equipment breakdowns, **lack of replacement funding**, ineffective cleaning and **decontamination**, insufficient **staff training**, improper use and poor traceability. The impacts may include inability to deliver essential services, delays in diagnostic and treatment leading to incidents and poor patient outcomes, increased costs and reputational damage.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Medical Devices Oversight Group leads on the capital investment and replacement plan. 2. Annual capital planning process reflects known priorities taking account of key pieces of equipment due for replacement with a risk assessment that support the overall outcome. 3. Scrutiny and assessment of the capital programme at Capital Programme Management Team (CPMT) and Capital Investment Group (CIG). 4. Welsh Government Capital review meeting to escalate and discuss potential risks and requirements for key medical equipment e.g. Linac. 5. An effective medical devices management system is utilised through EBME. 6. EBME uses the management system to monitor the condition and performance of medical devices including device failures	**1st** – eg. Operational: 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1. Internal Audit 2. National Endoscopy and Diagnostic Programmes	1. Internal risk assessment and priorities are flagged in the context of fully depreciated equipment (£34.659m) to understand priorities and potential risks. 2. External links with National Endoscopy and Diagnostic Programmes are documented and appropriately reported through correct channels to ensure transparency and potential benchmarking. 3. Lack of comprehensive governance structure around ensuring equipment **all** is safe and in line with regulations. 4. Lack of training around equipment and good governance of safety of equipment has been lacking and documented as a risk since 2016. 5. Robust risk assessments of how often certain equipment breaks down, the scale of difficulty sourcing spare parts to

and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed.		be considered for included in requests for capital replacement. 6. The number of bids not approved now reaching over millions in capital and resources required. Backlog of equipment beyond end of life, some 10 years+

Actions	Due Date	Progression Analysis
CPMT and CIG to review annual planning process to ensure risk scoring to inform prioritisation	31/03/2024	Overdue
Review of internal and external group membership and communication to ensure all opportunities and risks are reported and escalated as appropriate.	31/02/2024	Overdue
Medical physics have been tasked with testing all ultrasound equipment to ensure its safety and will consider compliance	31/09/2024	Progressing
Review medical devices capital replacement to ensure all services have a medical devises replacement programme in place	31/09/2024	Progressing
Medical Devices strategy review	31/9/2024	Progressing
Recruitment to medical devices team	31/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	Quality		3 - Open

Rationale for Corporate Risk

Significant funding capital required, lack of robust controls and governance to ensure safety of equipment, £33M represents the value of capital medical equipment which is fully depreciated and at end of life.

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CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 11/06/2024	**Director Lead:** Deputy Director of People	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024

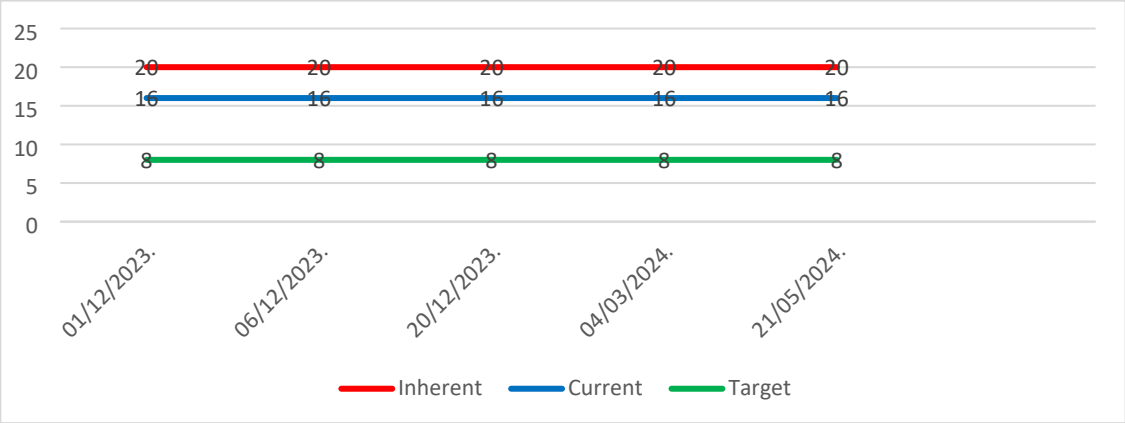
There is a risk of avoidable harm to patients and staff. This is may be caused by a failure of the Health Board to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation due to the lack of Health and Safety Leadership. The impact is patient and staff harm, financial implications, and reputational impact to the Health Board.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. 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. Further training commenced January 2024 with the NEBOSH General Certificate and NEBOSH Award. 2. Policies and subgroups have been established including asbestos, water safety, fire electrical safety etc. to monitor and report into the Strategic Occupational Health & Safety Group. 3. 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. 4. There is a three-year Occupational Health, Safety and Security strategy in place that supports the Strategic Objectives of BCUHB. 5. Gap Analysis has been repeated to establish areas of non-compliance and to inform a new 3 year strategy 6. Falls are closely monitored by H&S advisors to review under RIDDOR reporting requirements 1. The H&S team have additional controls around learning from near misses and mistakes, participating in Falls investigation meetings and learning panels	**1st** – eg. Operational: 3. Strategic Occupational Health & Safety Group 4. Estates overseeing the high level risks as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire and report to the Strategic Occupational Health and Safety Group. **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team **3rd** – eg. Independent: 1. Internal Audit 2. RIDDOR reporting to the Health and Safety Executive in place with robust timeline.	1. HS01 to be updated when the Executive portfolios have been finalised. This will go out of date in December 2023 and a six month extension has been requested. 2. There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3. Manual handling training compliance is currently at 68%. The team have moved back to the BCUHB sites as the two year contracts for external training venues have ended. The effects of these moves is not fully known yet. 4. 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 resulting in. prosecution. 5. A Further intervention has been made by HSE in respect of the deaths of 3 patients following patient falls, a prosecution is expected

2. Professional training and qualifications provided by H&S team to ensure a whole system approach around Health & Safety learning and development 7.		6. Lack of formal arrangements in place to protect premises and people in relation to CCTV, violence and aggression, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed

Actions	**Due Date**	**Progression Analysis**
A clear strategy and framework. The HS01 Policy, and supporting procedures and documents on BetsiNet require a review to ensure staff are provided with up-to-date requirements and guidance relating to Health & Safety.	31/12/2024	Progressing
NEBOSH training courses to go forward for the General Certificate and the Award.	31/12/2024	Progressing
Business case for security provision approval process underway.	31/12/2024	Progressing
H&S not noted as a deliverable on the Annual Plan for priorities and Strategic Objectives are due to be reviewed.	31/12/2024	Progressing
Executive level responsibility for Occupational Health and Safety should be considered, to ensure Health and Safety is a key focus within the Health Board.	31/12/2024	Progressing
Management ensure regular monitoring, reporting, communication, escalation and de-escalation of Health & Safety issues through the appropriate governance structure, in line with the HS01 policy and terms of reference for relevant meetings (Strategic Occupational Health and Safety Group, Quality Safety and Experience Committee and Risk Management Group).	31/12/2024	Progressing
The Strategic Health and Safety Operational Group to confirm the reporting required to the group by services and ensure this is communicated to all relevant areas. Instances of non-reporting should be communicated to the services and escalated appropriately, via the Executive or QSE.	31/12/2024	Progressing
The Health Board Executive Lead for Health and Safety ensures Policy reference 5.1.3 Training for Health Board Executive Directors and Independent Members is adhered to: “the Health Board will provide suitable and sufficient training and instruction to Members of the Board in respect of H&S Management. This will also include responsibilities under section 37 of the Health and Safety at Work etc. Act 1974 and the Corporate Manslaughter and Corporate Homicide Act 2007”.	31/12/2024	Progressing
Health Board Policy 5.3.4 is reviewed to ensure that all Corporate Health & Safety recommendations are agreed, assigned to owners, allocated appropriate dates and are subject to follow-up.	31/12/2024	Progressing
The gap analysis is reviewed and management identify what further work needs undertaking to ensure areas of risk / focus remain relevant. This should be considered alongside the strategy to inform Health and Safety activity across the Health Board.	31/12/2024	Progressing

Estates to standardise action plans resulting from Health and Safety reviews and ensure regular review and update of actions to monitor progress.	31/12/2024	Progressing
A process to monitor and review department self-assessments should be put in place to ensure departments are adhering to the Health and Safety Policy. This should also include escalation where self-assessments are not completed, reviewing self-assessments for potential risks / issues and identifying areas of similarities / opportunities across departments.	31/12/2024	Progressing
An up-to-date list of Health and Safety leads / champions be developed to ensure there are contacts in place for all departments who are required to undertake self-assessments.	31/12/2024	Progressing
New role of Director of Environment to be recruited to reporting to CEO, which will review Estate business cases. Director of People Services being recruited to.	01/09/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	2	4	8
Risk Appetite	People		4 - Seek

Rationale for Corporate Risk

There is an inherent risk that the failure of Health & Safety management systems could lead to RIDDOR Reportable. Specified Injuries to Workers. Patient mismanagement, long-term effects. Death or significant irreversible harm which will result in prosecution by the Health and Safety Executive consequently leading to loss of reputation and financial penalties. The risk is extenuated by Non-compliance with national standards with significant risk to patients/public. An unacceptable level or quality of treatment/service. Gross failure of patient safety leading. Inquests and Coroners reports. Low staffing level that reduces the service quality. Low staff morale. Poor staff attendance for mandatory/key professional training. Uncertain delivery of key objective/ service due to lack/loss of staff within the Health and Safety team. Structural changes will be implemented in summer 2024, with Health and Safety moving from Workforce Directorate to a new role of Director of Environment, reporting directly to CEO.

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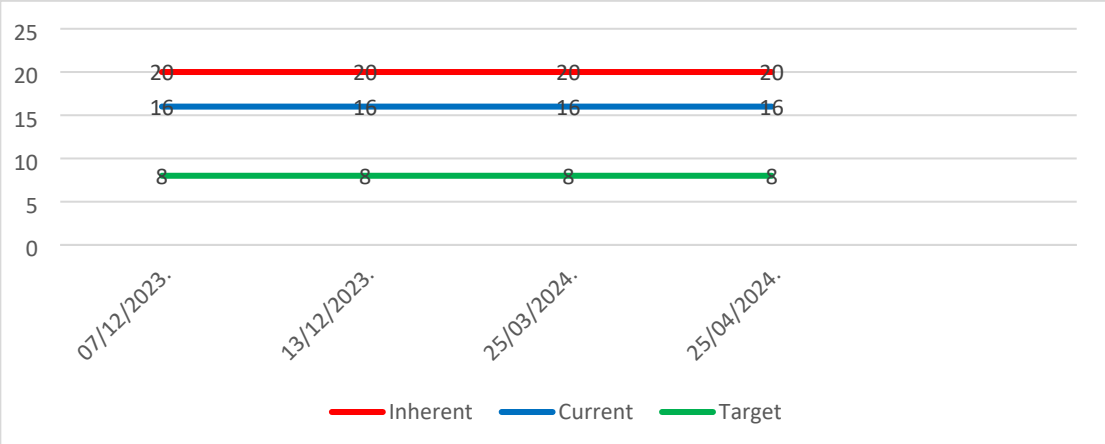
CRR 24-16	**Risk Title:** Leadership/Special Measures		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 13/06/2024
Date Last Reviewed: 12/06/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP17	**Target Risk Date:** 30/09/2024

There is a risk of traditional models of leadership which do not define the expectations, values and behaviours of our leaders to transform the organisation. We recognise a compassionate leadership approach supports the delivery of safe and reliable care. This could be caused by inadequate governance arrangement and lack of integrated leadership development pathways across the Health Board. This could have an impact on the sustainability of staffing and subsequently patient care and safety and service delivery.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Board Workshop with Professor Michael West on compassionate leadership 2. Suite of leadership conferences, networking and masterclasses on compassionate, inclusive leadership and engagement. 3. Work associated with this risk which links into the Special Measures Framework now monitored via the governance of the Framework and reported to Executive Team and Board. 4. Full Board now in place and all committees now chaired and attended by full complement of Independent Members 5. The new Integrated Leadership Development Framework (ILDF) has been ratified and is live on BetsiNet, this includes the 'Approach to Leadership' which was approved by the OD Steering Group in March 2024 6. The OD Steering Group now in place since February 2024	**1st** – eg. Operational: 1. Organisational Development Steering Group 2. Local Integrated Health Communities & Pan Services People & Culture Committees **2nd** – eg. Risk and Compliance: 1. Risk Management Group 2. Executive Team Meeting **3rd** – eg. Independent: 1.Internal Audit 2.Welsh Government JET meetings	1. Integrated Leadership Development Framework has been signed off by OD Culture group and will be tabled at P&C Steering group mid-June. 2. New compassionate approach to leadership and how to adopt it, aligned with the work on values and behaviours 3. Formal Culture Change Plan and accompanying Comms and Engagement plan 4. A Behaviours Framework, will be derived from the culture change workstream 5. Fully resourced Culture Change programme and realignment of resources within the OD function

Actions	Due Date	Progression Analysis
Integrated Leadership Development Framework socialised across the organisation for feedback. Work has taken place on further co-design and to socialise the draft Integrated Leadership Development Framework (ILDF) across the organisation. This has involved members of the OD team attending meetings already in place to share the proposed framework, inviting staff to feed back on the design and logo as well as the content of the framework. MS Teams virtual sessions (including evening and weekend sessions) have also been hosted inviting staff from across the organisation to attend and share their feedback and comments. Based on the feedback, amendments have been made, a recent copy of the draft ILDF can be found on BetsiNet.	31/01/2024	Complete
Integrated Leadership Development Framework implementation plan presented to Executive Team. The ILDF is currently being updated following feedback from March's OD Steering group where it was presented. The revised ILDF will go to May's OD Steering group for agreement.	29/02/2024	Complete

The ILDF has been tabled and approved by the OD Steering group in May 2024		
Exploration of approach to leadership: Draft proposal of the approach and how to adopt it presented via an appropriate Executive governance process. The Approach to Leadership is integral to the culture development work, the approach was agreed at the ODSG in March	29/02/2024	Complete
REF Gaps in controls; A & B. Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring) With OD resources in place, the ILFD training is expected to be live in September 2024	30/09/2024	Progressing
REF Gaps in controls; C & D. Draft OD plan in development (forms part of special measures monitoring) and has been initially approved by the culture steering group. The next steps is to ratify the plan with the senior team and People & Culture Steering Group	31/08/2024	Progressing
REF Gaps in controls; C& E. Examine the current pervasive culture: Final results from NHS Wales Staff Survey shared with all relevant managers and thematic analysis fed into Culture Change Plan The culture world café in June will deep dive into key themes of the current culture with 800 staff members expected to attend. The results will be analysed and available by end of August 2024	31/08/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Regulatory		3 - Open

Rationale for Corporate Risk

Structures currently being embedded to ensure IHCs, Divisions and Services have clear accountable delivery plans so new ways of leading are embedded locally. Organisational expectations being defined.

Reporting Committee:	**Audit Committee**
Committee Chair:	Karen Balmer, Independent Member
Date of last meeting:	9th July 2024
Paper prepared by:	Jody Evans, Corporate Governance Officer

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that; the Audit Committee met on 9th July, (with the Health Board Chair and Chief Executive in attendance).

The Committee considered the financial statements, the audit report on the accounts (ISA 260), Head of Counter Fraud Annual Report, Head of Internal Audit Opinion and the Annual Report (including the Performance Report, Accountability (and Annual Governance Statement) as follows;

- **Financial Annual Accounts 2023/24**
  The Audit Committee recommended the Board approval of the 2023-24 Annual Accounts to the Health Board, following consideration of Audit Wales findings on their review of the Financial Statements.

- **Response to Audit Enquiries Letter**
  The Audit Committee noted the response to the Audit Enquires Letter and recommended the acceptance by the Health Board.

- **ISA 260 Audit of Financial Statements - Audit Wales**
  The Audit Committee noted the report and recommended the approval of the statements to the Health Board.

- **Local Counter Fraud 2023/2024 Annual Report**
  The Audit Committee considered and noted the Local Counter Fraud Annual Report for 2023/24.

- **Head of Internal Audit Opinion and Annual Report 2023/2024**
  The Audit Committee received the Head of Internal Audit opinion and annual report for 2023/24. The level of 'limited assurance' was reported, as anticipated. It was clarified that improvements to internal controls are a key priority for the Executive team.

- **Annual Report 2023/2024**
  Subject to minor updates, the committee; formally recorded, received and considered the Annual Report 2023-24, The Committee recommend to the Board the approval of the Report for onward submission to Welsh Government, following the incorporation of the accounts, subject to the Board approval.

The Committee recognised and commended the hard work of the Teams and noted in particular some of the challenges in relation the Remuneration Report. It was noted that the Health Board would continue to work closely with Audit Wales.

The Annual Report and Annual Governance Statement was wholly received and the Committee recommend to the Board to receive, consider and to approve the annual report and accounts for onwards submission. Approved minutes and papers are available on our BCUHB website : Audit Committee - Betsi Cadwaladr University Health Board (nhs.wales)
ITEMS TO BE ESCALATED TO THE BOARD
N/A – Extraordinary Meeting
NEXT MEETING
The next meeting of the Audit Committee will be held on 18th July 2024

V1.0

Reporting Committee:	**Performance, Finance and Information Governance Committee**
Committee Chair:	Gareth Williams, Vice Chair
Date of last meeting:	25.6.24
Paper prepared by:	Diane Davies, Corporate Governance Manager

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the meeting held on 25 June 2024 at Carlton Court Boardroom :

The Committee

Noted

- Performance Report
- Finance Report Month 2 2024/25 including
  - additional Capital Funding offered by Welsh Government for the CT Scanner £2.9m and Backlog Maintenance £2.4m
  - request to Welsh Government for fee funding support to develop the Royal Alexandra Hospital Full Business Case
- Divisional Finance and Performance report – Integrated Health Community (IHC) West
- Information Governance (IG) report
- Business Case Tracker
- Transformation & Strategic Planning Executive Delivery Group Chair's Assurance Report
- Corporate Risk Register relating to the Committee

Agreed

- the recommendation to approve submission of the All Ages Mental Health Digital Solution Outline Business Case to the Board in order to secure national funding

The Committee Chair draws Board Members' attention to the following points:

- BCUHB was not currently on financial target and there was a need to prioritise profiling of Savings
- The importance of reassessing BCUHB's engagement with the Regional Partnership Board which was an important forum in moving forward important work together in partnership
- Good examples of Primary Care and Partnership working were demonstrated by the IHC West team.
- A One Betsi approach was an encouraging positive message emerging from discussion with the IHC which would require a different level of clinical engagement to move forwards.
- There was a need to focus on the following areas to improve performance: Treat in Turn, Theatre utilisation, validation of waiting lists, booking centre resources
- A new IG campaign would be run to remind staff of their responsibilities in regard to accessing records eg family and friends and advise of the potential employment implications of non-compliance.

- There was strong support provided for the All Ages Mental Health Digital Solution Outline Business Case to be submitted for approval by the Board, and to include enhanced details on financial aspects eg benefits and business as usual costs.

In the private session the Committee considered

- Therapy Services Electronic Health Record and Patient Administration System Replacement. **Ratifying** the preferred option 3 presented ie "Bespoke system with a technical partner, using existing Therapy Services resources"
- **Approved** the declaration of two Clinic properties to be surplus to the Health Board's requirements and to seek Ministerial Approval for disposal.

Approved minutes and papers are available on the BCUHB website : Performance, Finance and Information Governance Committee - Betsi Cadwaladr University Health Board (nhs.wales)

ITEMS TO BE ESCALATED TO THE BOARD

None

NEXT MEETING

The next meeting of the Performance, Finance and Information Governance Committee will be held on 27.8.24

Reporting Committee:	**Planning, Population Health and Partnerships Committee**
Committee Chair:	Clare Budden, Independent Member
Date of last meeting:	18th June 2024
Paper prepared by:	Laura Jones, Project Support Manager (Corporate Governance)

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the Planning, Population Health and Partnerships Committee held on 18th June 2024 in the Boardroom, Carlton Court.

Population Health – Focus on System Approaches to Weight Management
The Committee received a presentation from the Principal Public Health Practitioner on the Whole System Approach to Healthy Weight. The presentation highlighted the Healthy Weight Healthy Wales strategy that was introduced by Welsh Government. A team within the Health Board was formed to deliver the strategy focussing on long term sustainable change and engagement with partners and stakeholders. A strategic delivery plan was launched in 2023/24 and has now been presented to a wide range of partners. The team will now concentrate on building relationships, strengthening systems, ensuring access to healthy and affordable food and promoting activity in schools and workplaces. It was confirmed that this item would be reviewed in further detail at a Board Development session focusing on health intervention, potential opportunities for investment in prevention and a building a sustainable health system.

Major Change Programmes Update
The Committee received an overview of the three major change programmes that have been identified. An additional major change programme focussing on planned care is also being proposed. It was confirmed that a paper would go to the Executive Team on 19.06.24 to finalise the Project Initiation Documents and gain sign off.

Primary Care Board Update
The Committee received an update from the Primary Care Board confirming that an initial meeting has taken place and the Group have agreed a working structure. The Committee were assured that the Primary Care Board is now in place. Going forward there will be a focus on strategic factors including the financial elements of primary care. The Vice Chair raised an interest in being involved in the strategic element of the agenda.

ITEMS TO BE ESCALATED TO THE BOARD

- No items were raised

NEXT MEETING

The next meeting of the Committee will be held on 20th August 2024

Reporting Committee:	**People and Culture Committee**
Committee Chair:	Dyfed Jones, Independent Member
Date of last meeting:	13th June 2024
Paper prepared by:	Laura Jones, Project Support Manager (Corporate Governance)

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the People and Culture Committee held on 13th June 2024 in the Boardroom, Carlton Court.

People Operations Report
An outline report was presented and it was noted that this is currently work in progress. There was detailed discussion around the key elements of the report and further work is required outside of the meeting to refine the information and metrics that the Committee will focus on going forward. In relation to recruitment, there was discussion around the length of time it takes for a vacancy to progress through the process before we are able to advertise and appoint. It was confirmed that work is taking place to review the cycles of business to ensure they align with the annual delivery plan which will allow the Committee to factor in areas of focus for each meeting which will start to provide assurance up to the Board. It was also agreed that the language used in reports needs to be simplified as this information is shared in the public domain.

Update on Culture, Leadership & Engagement Improvement Work
There is work to be progressed in this area and reported back to the Committee. There is a need to identify touch points in relation to cultural change by recognising a start and end point over a specific period of time to measure the progress being made. There is also a need to set our own aims rather than looking to reach the national statistics.

On-Call Arrangements - Final Internal Audit Report
Following a recommendation from the Audit Committee, the report was shared with the Committee and it was agreed that it would come back to a future meeting for further discussion.

WHC (2024) 017 Implementation of Non-pay Elements of the 2022-24 Collective Agreement - Report to WG for Welsh Partnership Business Committee
This item was reported to the Committee to provide assurance that the relevant measures are in place to implement the non-pay elements of the 2022-24 collective agreement.

Corporate Risk Register Report
Three corporate risks were presented noting that significant work is required in relation to the Health & Safety risk to provide assurance to the Committee. The risk process will be discussed in further detail at the Board Development session at the end of June 24 where the Board will have the opportunity to discuss the top risks, agree mitigations and propose processes.

Health & Safety Annual Report
This item was discussed in private session and it was agreed that it would come back to the next meeting of the Committee before being reported to the Board in September.

ITEMS TO BE ESCALATED TO THE BOARD
• Health & Safety to be reported to the Board in September.
NEXT MEETING
The next meeting of the Committee will be held on 8th August 2024

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Reporting Committee:	**Remuneration Committee**
Committee Chair:	Dyfed Edwards, BCUHB Chair
Date of meetings since the last Board meeting:	11th and 21st June 2024, and 4th July 2024
Paper prepared by:	Llinos Roberts

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the Committee meetings held in private sessions on 11th and 21st June 2024, and 4th July 2024:

- Executive and Senior Management updates, approving actions to progress where required
- Review of the Committee Terms of Reference
- Managed Practice Staff Changes to Terms and Conditions to ensure consistency
- A report on Principles of Appointment – JESP salary confirmation for applicants
- Consideration of case for GP pay uplift
- Receive the Remuneration Committee Annual Report 2023/24
- Received WHC 2024(013) – Governance in Recruitment
- Challenges being faced by the Health Board in terms of recruitment to VSM posts

ITEMS TO BE ESCALATED TO THE BOARD

None

NEXT MEETING

August 19th, 2024

Reporting Committee:	**Charitable Funds Committee**
Committee Chair:	Dyfed Jones, Independent Member
Date of last meeting:	1st July 2024
Paper prepared by:	Kirsty Thomson, Charitable Support Team

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

Charitable Funds Committee meetings took place on 15th April 2024 and 1st July 2024.

At the 15th April 2024 meeting the Charitable Funds Committee (CFC):

- Noted the Charitable Funds Finance Report for Quarter 3 and the Investment Manager's Report and the Charitable Support Team Update for Quarter 4 2023/24.
- Recommended the approval of the Charity Operational Budget for 2024-27 by the Health Board
- Approved the Charity's Reserves Policy, Investment Policy and revised Charity Procedures.

At the 1st July 2024 the Charitable Funds Committee (CFC):

- Noted the Charitable Funds Finance Report for Quarter 4 2023/24 and the Charitable Support Team Update for Quarter 1 2024/25.
- Received a presentation from a representative of Brewin Dolphin, the Charity's Investment Managers

At the 1st July 2024 meeting the figures were presented for the year 2023/24. These figures are draft subject to future adjustment of the figures up to the audit of the accounts for the year ended 31 March 2024 which will take place in December 2024 and January 2025. Key information from the main report:

- Total income (donations, fundraising, legacies and investment income) for the year ending 31 March 2024 is £2,288,000, an increase of £355,000 on last year.
- The increase in income is predominantly due to legacy income, up £242,000 to £680,000.
- All types of expenditure have been consistent over the last two years. Total expenditure was £1,725,000 compared to £1,737,000 last year.
- Grant funded expenditure in 2023/24 was £1,326,000 compared to £1,336,000 in 2022/23.
- The Charitable Support Operational Team costs were £62,000 underbudget in the year.
- Long term investments were valued at £11,032,000 at 31 March 2024 compared to £9,827,000 at 31 March 2023.

During the two Charitable Funds Committee meetings, the CFC accepted the 05/02/24, 20/05/24, 08/04/24 and the 20/05/24 Charitable Funds Grants Decision (CFCGD) meeting minutes as a true record of the meetings held. Since March the Charitable Funds Committee has approved the following expenditure for items and programmes over £5,000:

- Ty Croeso Parental Accommodation: £180,000
- Older Persons Mental Health Programme: £97,325
- Chemo Care secondment and interface: £72,000
- Cardiac Diagnostic Equipment, Wrexham: £56,400
- Arts in Mental Health Programme: £40,160
- Cancer Related Fatigue Service Cancer Services: £40,000

- Shooting Star Unit (SSU) Waiting area refurbishment: £38,500
- Staff Achievement Awards: £37,000
- Arts and Minds Year 2: mental health and arts with prisoner populations Public Health (Arts in Health): £31,565
- Installation of HD Points in the Renal Unit, YGC: £12,852
- Dermatology Wigs: £10,000
- Cardiac Rehabilitation, West: £8,000
- Local Data Insight licence, Public Health: £7,920
- Children's Learning Disabilities Services Volunteer training and expenses: £6,600

ITEMS TO BE ESCALATED TO THE BOARD

The Board is asked to ratify the 2024-27 Charity Strategy, which was approved by the Charitable Funds Committee on 15/04/24, *subject to the approval of the Health Board.* (Appendix 1)

NEXT MEETING

The next Charitable Funds Committee will take place on Tuesday 13th August 2024

THE NORTH WALES NHS CHARITY, AWYR LAS, STRATEGY 2024-2028

INTRODUCTION

Everyone who gives time or money to our NHS does so because they want to make sure others can access the best possible care. Our aim is to help communities across North Wales receive excellent treatment and support, whilst making sure those who support our healthcare services feel informed, appreciated, and recognised for what they are: significant.

Much of Wales' healthcare was delivered by voluntary hospitals and other voluntary organisations prior to the formation of the NHS in 1948, when receiving charitable gifts became prohibited. The 1980 Health Services Act changed this and allowed for significant charitable activity to take place. Hospitals began to launch fundraising appeals, and now with over 230 NHS Charities in the UK, more than £1 million is gifted each day to enhance and transform NHS services.

North Wales Health Trust charities merged in September 2010 to create the Betsi Cadwaladr University Health Board Charities (registered charity number 1338976), and in 2013 the working name Awyr Las (Blue Sky) was introduced. More recently, the charity has been referred to as The North Wales NHS Charity as it better reflects what the charity does to support North Wales with its 400+ charitable funds. For most Health Board staff, the charity is known as 'charitable funds'.

Within a decade of the establishment of the NHS, there were over 500 independent charitable organisations set up with the purpose of supporting specific hospitals, and by the late 1970s, there were over 1,200 across the UK. Set up by former patients and staff, North Wales is home to more than 25 of these longstanding charitable partners who all add a different special touch to the health service in North Wales, whether that is through supporting a hospital or a specific ward or department. All of the groups encourage volunteering an fundraising in different ways. 'It's so rewarding, 'I just want to show my appreciation', 'I want my family and friends to receive the very best care', 'I get to feel the impact of what I do every time I'm in the hospital. Patients and staff members give me a knowing smile. It's then I know that giving my time is worthwhile', are all phrases we hear often from volunteers, donors and charitable partners. People give time and money because they want to enable our communities, our NHS, to flourish. Times are changing, with the digitalisation of services and changes in treatment and care that patients receive, but the desire to give time and money to improve the experiences of our patients, service users and staff remains.

Times are changing, with the digitalisation of services and changes in treatment and care that patients receive, but the desire to give time and money to improve the experiences of our patients, service users and staff remains.
We recognise the important contribution that our charity supporters, charitable partners and volunteers make, and we value them all equally. Voluntary activity has long played an essential role in helping create the very best healthcare services in the region, and we firmly believe that we can all play a part in doing something extra to help our NHS be even better, help our communities be healthier, and help future generations live well and thrive.

We know that in order for people to volunteer and donate money, we need to have well-managed and adequately resourced support functions to provide advice, guidance, and the helping hand that volunteers, charitable supporters and partners need to effect real change. We must ensure everyone giving time and money can be well informed, kept abreast of and involved in decision, and most importantly, that they can help make a genuine difference for those who are vulnerable and need our support.

We are committed to become a volunteer and supporter centric organisation by 2050. This may sound a long way away, but we know we have far to go to make sure all volunteers, charitable supporters and partners feel as though they are at the core of the organisation, along with patients, service-users and staff. This 2024-28 strategy presents the road map for taking an important step from towards the 2050 milestone, and should be considered alongside the Health Board's Partnerships, Engagement and Communication Strategy and its Volunteering Strategy.

> "Voluntary support provided in our hospitals, health centres and in community settings complements – or adds to – what the NHS already provides. It enhances the experience patients receive. Volunteering and charitable funding doesn't replace staff and statutory funding, it just allows NHS staff to do their roles even better."
>
> *Lord Barry Jones, Honorary President of the North Wales NHS Charity and Vice President of the League of Friends membership.*

Dyfed Jones, Chair of the Betsi Cadwaladr University Health Board Charitable Funds Committee, May 2024

YOUR NORTH WALES NHS CHARITY

Together, the enhancements made possible by donations to the charity help make sure that people in North Wales can benefit from better NHS services when they need them most. Everything the charity can do is thanks to donations and grants from individuals, organisations and foundations. The charity funds projects and ideas in hospitals and the community, from emergency departments to community resource teams, maternity wards to eye clinics. Through its 450+ designated funds, which are overseen by NHS teams from across the Health Board who have a deep understanding of the needs of the population they serve, the charity can support all areas of healthcare in North Wales.

Since 2010, patients have seen significant improvements to their hospitals and community services as a result of the £30+ million that the charity has invested in new services, better facilities and equipment, additional resources, research and education. More of this positive change and more of the passionate support we have all witnessed is needed to ensure patients in North Wales can have the very best experience possible.

VISION

Exceptional care in our hospitals. Healthier in our communities. Thanks to those who go above and beyond what the NHS alone can provide.

MISSION

We will seek to maximise the resources of the Charity and ensure use of these resources enhance patient healthcare and the well-being of our workforce, going above and beyond what the NHS alone can provide, the offering greater enhanced care and treatment through working in collaboration with partners, so together we can help people within our hospitals and in our communities receive exceptional care and lead healthier lives.

> Small donations have gone a long way to help make a real difference for our patients. Comfy chairs, complimentary refreshments and therapies, access to additional counselling and new equipment. These are important extras, all possible thanks to donations to our charitable fund.
>
> *Ward Clerk, Cancer Services*

> I wanted others to benefit from the excellent care I had, and I wanted to say thank you to those who have taken such good care of me. Taking on the challenge and smashing my target was a great feeling. Seeing the gratitude from the nursing staff, and knowing I've helped others, is something that will stay with me forever.
>
> *Half marathon runner, Denbighshire*

THE WELL-BEING OF FUTURE GENERATIONS (WALES) ACT 2015

We are committed to becoming a volunteer and supporter centric organisation by 2050 because we believe that instilling a culture within our NHS services that celebrates and encourages voluntary activity will help strengthen our healthcare services. This ambition aligns with the milestones laid out in Wales' Well-being of Future Generations (Wales) Act (2015).

The Well-being of Future Generations Act requires organisations in Wales like our Health Board to think about the long-term impact of decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty and health inequalities. The Act puts in place seven well-being goals, which we have used to underpin what is important to us:

A Prosperous Wales, which 'develops a skilled and well-educated population'.
A more equal Wales, which 'enables people to fulfil their potential no matter what their background or circumstances'.

These two goals relate directly to our commitment to developing volunteering and learning opportunities, especially for young people and those from disadvantaged communities.

A Resilient Wales, which creates a 'healthy, natural environment and better health and well-being'.

This goal reflects our commitment to create more green spaces for patients and staff to enjoy time outside when at our hospitals and health centres, and to provide opportunities for our staff and service-users to make the most of our natural environment through organising and supporting events and funding outdoor activities.

A Healthier Wales, which will see a 'society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'.
A Wales of cohesive communities, which will 'deliver a coherent approach to planning, resourcing and delivery of services and infrastructure within communities'.
A Globally Responsible Wales, which sees us 'making the right financial decisions now, to enable future generations to thrive'.

These three goals will influence grant making decisions, providing a basis upon which we can prioritise charitable funding for our healthcare services.

A Vibrant Culture and Thriving Welsh Language, which provides 'a society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation.'

This goal fosters our commitment to helping all voluntary supporters and partners provide a bilingual service wherever possible.

The Well-being of Future Generations Act's Five Ways of Working will also be adopted as principles which will be considered in all charitable funding decisions:

Long-term | Integration | Prevention | Involvement | Collaboration

LONG-TERM STRATEGIC OBJECTIVES

To serve as a guide for managing charitable funds centre upon the continued enhancement of healthcare for the local population of North Wales, which includes engaging with other charitable partners and developing volunteering programmes.

1 We shall look to invest in the physical and technical environment of our healthcare facilities in North Wales to ensure the very best patient experience. This will result in the enhancement of hospital buildings, the latest equipment and the best technology. Patients will benefit from enhanced care and a high-quality environment for patients and staff alike.

2 We shall invest in and develop our NHS staff and volunteers. We will support staff health and wellbeing to ensure our staff are taken care of, helped to remain resilient and feel supported to do their best every day. We will also invest in staff development, training, mentoring and ongoing development programmes to ensure they are supported to work well in the challenging and dynamic environment of 21st century healthcare. We will develop and resource a Health Board volunteering strategy that both embodies our long-term ambition and provides a feasible plan with clear milestones, which can be adopted easily.

3 We shall invest in innovation and research to help drive improvements in the quality of care and the patient experience in North Wales. We support pilot projects, digital platforms, quality improvement initiatives and activities that are focused on improving the quality of our patients' care and treatment.

4 Where this supports the strategic vision of future healthcare provision and enhancement of services for the local population, we shall collaborate with health and social care providers, local charities, our communities, and our patients and their families to build strong relationships with partner organisations that enable us to find creative solutions to the challenges we face. Whether with local businesses, fundraising groups, volunteer groups or healthcare providers, our primary focus is working together to support excellent health care across North Wales.

5 We shall continue to build and develop our support team infrastructure, particularly our digital offering, to ensure that our charitable funds become leading causes to support in North Wales, making a difference to patients every day.

THE CORE PRINCIPLES UNDERPINNING CHARITABLE FUNDS MANAGEMENT

CONSISTENCY

We support patients, staff and volunteers with different needs who are accessing and working in multiple healthcare services. We must focus on being consistent in all aspects of what we do in order to achieve real impact.

VALUE-BASED

When serving communities across North Wales, we will bring all our energies together to achieve the best possible healthcare outcomes for communities across North Wales with the resources that we have. Through charitable grants, we will, where possible, seek to improve how patients, service users and their loved ones are involved in decision making. NHS teams will be encouraged to adapt and become more creative to help determine how charitable support can best provide improvements to patient and service user outcomes. Both potential socio-economic impact and the inclusion of preventive healthcare interventions will be considered when prioritising charitable grants and during the monitoring and evaluation of charitable grant schemes.

EVIDENCE-BASED

We want to ensure that we test and measure what we do and track the impact that our support team has and will commit to determining meaningful measures to assess performance, ensuring we are both efficient and effective in supporting enhancement of Health and Well-being within the population of North Wales. These measures will enable us to build an evidence base of what works and what does not and help the implementation of new and exciting practices within the wider Wales community. This will allow us to share our learning with our partners and create new ways of working that achieve meaningful change over time.

OPEN-MINDED

New ideas need time, resource and space to flourish and grow. We want to work with staff, patients, volunteers and partners to take a long-term view, invest in ideas and ensure that they have the opportunity to thrive. We will pump-prime projects and be willing to take risks and support good ideas.

CHARITY OBJECTIVES 2024-2028

OBJECTIVE 1

Our grants will support the overarching strategies deployed by the Health Board in enhancing healthcare for the local population of North Wales, ensuring charitable activity is impactful by:

- Targeting alignment with the clinical, workforce, digital and estates strategies for the Health Board
- ·Resources awarded are to people who have the greatest needs through oversight within the Charity's governance and allocations approvals process. Helping to reduce health and well-being inequalities and improving health outcomes
- Enhancing patient and service user experience, encouraging use of and visibility of how funds are to be utilised.

We will actively encourage the Charity's Fund Advisors to plan the use of the resources, with an aspiration to develop a new, improved, streamlined online grant-management system.

OBJECTIVE 2

We will support Betsi Cadwaladr University Health Board staff through:

- Providing a staff wellbeing grant scheme to help fund improvements, training and wellbeing programmes, and funding the continuation of this scheme through a staff lottery
- Developing and investing in volunteering programmes.

> "My colleagues talk to our patients and their relatives as well as our third sector partners and other NHS teams to help decide how we should use donations given to our charitable fund. We decide together what changes we want to see and then we use the donations we receive to make sure those changes happen for our service users."
>
> *Senior Nurse, Cardiology*

OBJECTIVE 3

A helping hand will be given to those who choose to support their NHS services by

- Offering ongoing fundraising and communications support
- Giving opportunities for supporters to become more involved in supporting our NHS in North Wales in regular communications
- Ensuring supporters regularly have the chance to keep up to date on how charitable support is making a difference through social media and other communications platforms.

OBJECTIVE 4

We will ensure the financial sustainability of the charity by updating all of the charity's financial policies and procedures, and reviewing these on an annual basis.

CHARITABLE PARTNERSHIP COLLABORATIONS

'Charitable partner' is used to describe the organisations that provide fundraising, catering, retail and radio services for, and on the premises of the Health Board. For the most part, these charities donate directly to the Health Board and not through the North Wales NHS Charity. Many of these organisations have been operating alongside the NHS in the region for decades, for example, the wonderful Good Companions of Holywell Hospitals which runs a tea bar and book stall in the hospital has been in existence for 56 years.

The term charitable partner can also be extended to charitable organisations that do not exclusively support North Wales' healthcare services but importantly do choose to give grants to the North Wales NHS Charity, for example the grant-making and membership organisation NHS Charities Together.

When serving communities across North Wales, we will bring all our energies together to achieve the best possible healthcare outcomes for communities across North Wales with the resources that we have. Through charitable grants, we will, where possible, seek to improve how patients, service users and their loved ones are involved in decision making. NHS teams will be encouraged to adapt and become more creative to help determine how the resources the charity and charitable partners will be best used to improve patient and service user outcomes. Both potential socio-economic impact and the inclusion of preventive healthcare interventions will be considered when prioritising charitable grants and during the monitoring and evaluation of charitable grant schemes.

CHARITABLE STRATEGY OBJECTIVES CONTINUED - PARTNERSHIPS SUPPORT 2024-2028

OBJECTIVE 1

Engagement to ensure where the priorities of the charity align to those of the partners, we work together to enhance healthcare and well-being of the population throughout North Wales.

OBJECTIVE 2

We will engage with partners to understand how they can support the charity's objectives and (where there is alignment with their charitable objectives) work together to enhance the use of these funds, an example being to support Health Board staff to apply for charitable support from these voluntary partners through

- Active dialogue and feedback from users on systems, including partner grant making processes.
- Working with partners to offer support in their development and monitoring of grants to support enhancement, clarity and transparency within partner organisations.

OBJECTIVE 3

A helping hand will be given to charitable partners, as appropriate, by

- Giving opportunities for partners to share best practice and ideas, and collaborate with, other partners through hosting and coordinating events where they can be invited to attend and network.
- Ensuring partners have the opportunity to keep up to date on Health Board news and how charitable support is making a difference through regular monthly communications.

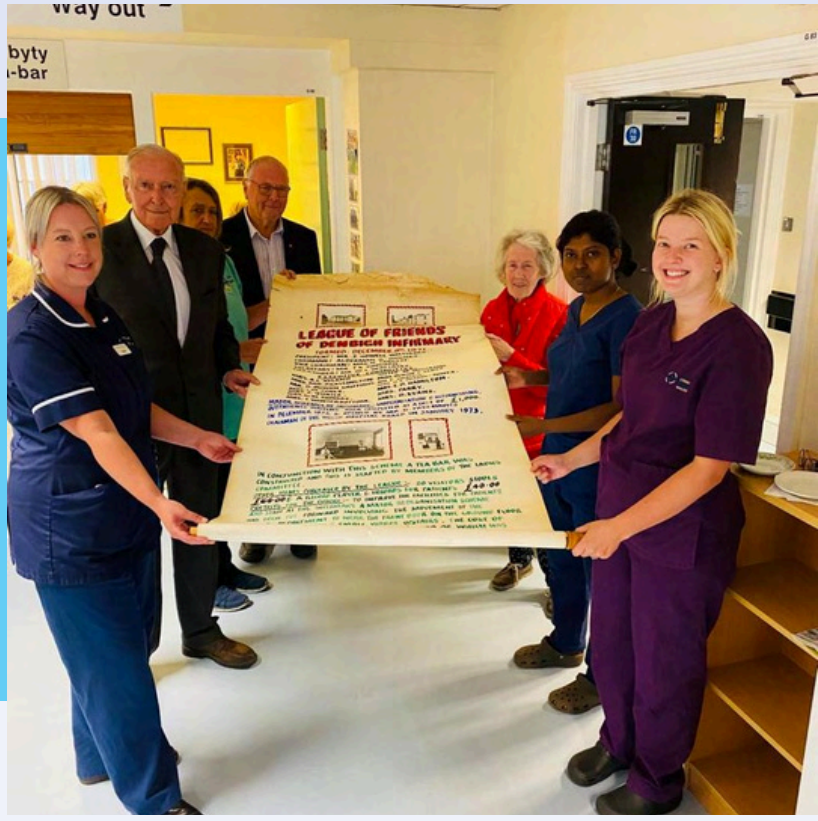
THE CHARITABLE SUPPORT TEAM

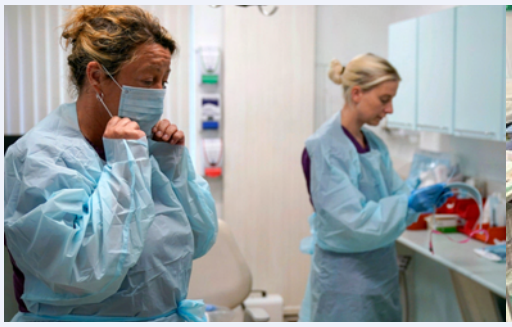
We have a dedicated Charitable Support Team that engages with the local population, national forums and Charitable Partner organisations for the benefit of patients, staff and local residents. The Charitable Support Team leads on the delivery of this strategy and vision, manages the necessary systems and processes in place. We recognise that the only way we will achieve our ultimate ambition for the Health Board to be a volunteer and supporter centric organisation by 2050, is if all Health Board staff play a role in empowering our communities to give time, give money and give their suggestions on how we can best do this. Everyone within the Health Board has the opportunity to demonstrate leadership in developing voluntary activities.

Together the Charitable Support Team has financial management expertise, charity governance and grants management knowledge, experience of engaging and working with partners, communications, fundraising and supporter care experience. In order for this strategy to be successfully executed, it is imperative that the Team works closely with colleagues from across the Health Board including Clinical teams, Digital Technology, Communications, Engagement, Public Affairs, Finance teams, Workforce and Organisational Development, Planning and Estates, Patient Experience and Office of the Board Secretary's teams.

"Over the next four years, we can all step up to help patients and healthcare staff meet the challenges and opportunities that face our National Healthcare Service now and in the future."

Lord Barry Jones





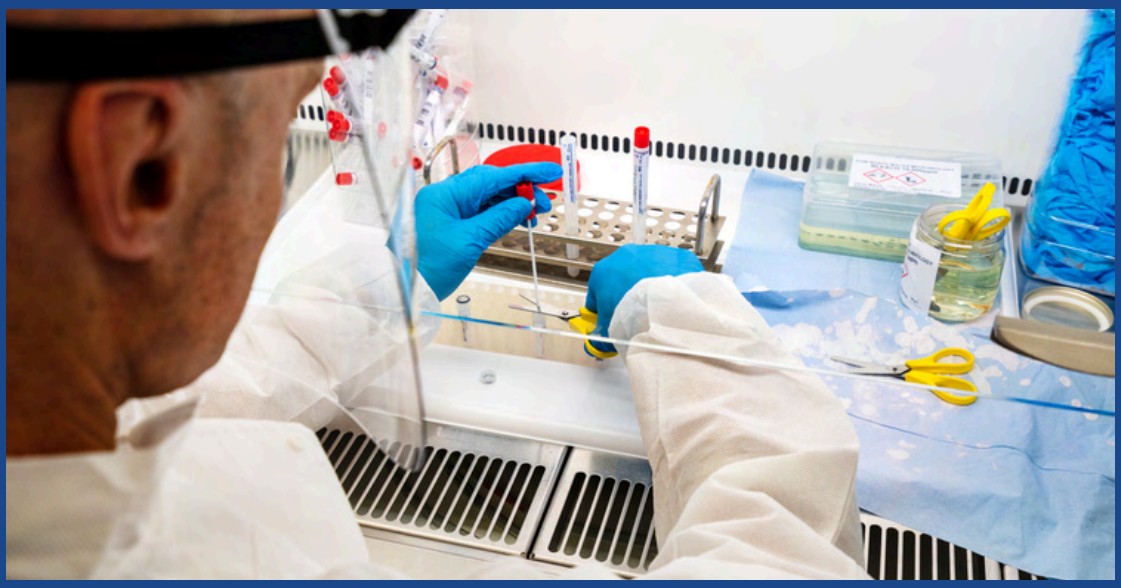
The 2024-28 Charitable Support Operational Plan provides further details on how this strategy will be executed. Income and expenditure targets are not included in this strategy, though they will be considered as a measure of success of the North Wales NHS Charity. The aim is for current levels of income and expenditure to be maintained for charitable funds over the 2024-28 period. Over this period resource will be applied to help increase awareness of giving time, money and remembering our NHS services with a legacy gift to lay foundations to grow income.

For more information:
Charitable Support Team: BCU.CharitableSupport@wales.nhs.uk / 01248 384395

The North Wales NHS Charity: Charity overview, BETSI CADWALADR UNIVERSITY HEALTH BOARD CHARITY AND OTHER RELATED CHARITIES - 1138976, Register of Charities - The Charity Commission

The Betsi Cadwaladr University Health Board Charitable Funds Committee:
Charitable Funds Committee - Betsi Cadwaladr University Health Board (nhs.wales)

NHS Charity Governance:
NHS charities guidance - GOV.UK (www.gov.uk)



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Reporting Advisory Group :	**Stakeholder Reference Group**
Advisory Group Chair	Mike Parry
Date of last meeting:	3rd June 2024
Paper prepared by:	Fiona Lewis, Corporate Governance Officer
KEY DECISIONS / MATTERS CONSIDERED BY THE GROUP	

The last meeting of the Stakeholder Reference Group (SRG) took place on 3rd June 2024.

The Board is asked to note that the following matters were discussed at the meeting:

- **Organisational Design Principles (ODP) –** The SRG was provided with the ODP draft report, and asked to provide their thoughts and input. Dylan Roberts agreed to return to Members once the final report becomes available, to provide Members with an insight into how the organisation will ensure that these practices are being adopted.
- **Organisation Update from SRG Member** – Cllr. Haydn Jones (North Wales Cancer Patients' Forum (NWCPF)) provided an insight into the work of the NWCPF. Dyfed Edwards asked to be kept informed as to how Cllr. Jones felt the experiences of service users was helping shape services going forward.
- **Director's Report** – Members received updates on the Board's approval of options for development of the Royal Alexandra Hospital, Rhyl, and were pleased to note that following January's SRG Workshop, Members' comments regarding the Integrated Medium Term Plan (IMTP) had been incorporated..
- **Special Measures and how this works as part of the Annual Planning Process** – Members of the SRG welcomed the progress that had been made by incorporating the Special Measures Plan into the Annual Planning process. The SRG was assured that no information, learning and new practices brought about by Special Measures intervention would be lost if and when the organisation comes out of Special Measures and that the Executive Team remained committed to reducing the number of interim appointments within the organisation.
- **Stakeholder Reference Group Annual Report to the Board** – Members were pleased to note the influx of new Members, following the efforts of the Chair to broaden the Group's base and bring important input from more stakeholders. The

SRG was pleased to be given the opportunity to discuss proposals for Phase 2 at Llandudno.

- **Feedback from Visits to the three Acute Mental Health Units across North Wales** – The Chair provided feedback from his recent visits to the three acute Mental Health units across North Wales, noting the huge challenges and costs associated with providing care in these secure units.
- **Feedback from the Health Board Meetings on 28.03.24 and 30.05.24 –** SRG Members were assured that the Health Board's encouraging and stabilising financial conditions, along with the new Board's direction of travel, were both contributory factors as to why Welsh Government's Health Minister had decided to reduce the frequency of her meetings with the Health Board from bi-monthly to quarterly.

Group Action Log

The Group received and discussed the Committee Action Log.

ITEMS TO BE ESCALATED TO THE BOARD

There were none.

NEXT MEETING

The next meeting of the Stakeholder Reference Group will be held on 2nd September 2024.

Reporting Committee:	**Healthcare Professionals Forum (HPF)**
Committee Chair:	Jane Wild, Scientific Advisory
Date of last meetings:	7 June 2024
Paper prepared by:	Secretariat HPF

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the Healthcare Professionals Forum on 7 June 2024:

Clinical Strategy – Urgent and Emergency Care Six Goals Programme
The HPF was pleased to welcome Geraint Farr, Associate Director for Emergency Care, to provide an update on the Urgent and Emergency Care Six Goals Programme. Members were encouraged to see the breadth of work being undertaken and particularly the increased focus on goals 5 and 6, the improved flow of patients through the hospital and back home and into communities. The Forum noted that it was important that the Health Board continued to ensure that there was effective two-way communication with external contractors and partners, both to raise awareness and understanding of this important area of work, and to ensure that contributions can be maximised. The Forum also noted the significant number of Senior Responsible Officers and Clinical Leads that had been assigned to this programme of work over the last few years and the current gaps in confirmed leadership. The Forum encouraged the Health Board to ensure confirmation and continuity of leadership so that this programme can progress effectively.

People Strategy – Engagement, Culture and Leadership
The Forum was also pleased to welcome Jason Brannan, Deputy Director of People, and to hear about the Engagement, Culture and Leadership work that is underway. Members particularly supported the approach of bringing the various streams of work together under an aligned plan and oversight structure. The Forum noted the importance of ensuring that this reaches all staff and that information and opportunities are aligned across all areas and for all staff. The members were able to share some of their thoughts and experiences around values and behaviours.

Members Reports
Members reports are shared at each meeting and whilst there were no formal items for escalation there were some issues that resonated across the membership. The Forum would like to highlight the following two points:

- It was noted that there was a significant amount of good news related to the sharing of good practice, staff achievements and the wider contribution of staff within clinical and professional networks. Members recognise the importance and value of this to individuals, the team and the wider Health Board, all leading to

better care for the people of North Wales. The HPF are keen for the Health Board to continue to recognise, support and enable this to continue. • Whilst acknowledging that this issue is related to operational processes and systems, Forum members wish to highlight the negative impact of current recruitment processes on delivery of care. Delays and barriers within the systems are resulting in extended periods of vacancies, inefficiencies and ultimately additional pressures on service delivery and patient care.
ITEMS TO BE ESCALATED TO THE BOARD
None
NEXT MEETING
The next meeting of the Healthcare Professionals Forum will be held on 13 September 2024.