Bundle Health Board 30 May 2024

1 PRELIMINARY MATTERS

2 09:30 - 24/91 Welcome, introductions and apologies for absence - Chair

3 09:35 - 24/91.1 Declarations of interest relating to agenda - Chair

4 09:36 - 24/92 Draft minutes of the previous meeting held on 28 March 2024 for approval - Chair

24.92 Health Board Minutes 28.3.24 public session v0.4 draft

5 09:38 - 24/93 Action Log - Chair

24.93 Action Log_Health Board public session

6 09:40 - 24/94 Mental Health: Royal College of Psychiatrists' Invited Review Services Report - Chief Executive

Recommendation
The Board is asked to:
Consider the report of the Royal College of Psychiatrists and the key findings of the review.
Consider the views of families with experience of care, their feedback on the report and critically the consideration of the best way forward
Restate afresh, the apology to people who were let down by the health board that led to the reviews that took place to identify failings.
Agree a period of consideration to draw up a formal response to the findings of the Review and the views of families and other stakeholders, including Llais.
Consider the response in a subsequent Board meeting, currently scheduled for July 2024

24.94a Royal College Psychiatrists IRS report May 2024 3.0

24.94b BCU RCPsych IRS report summary 16 May 2024

24.94c RCPsych IRS BCUHB Reviews Report final version 8-3-24

7 10:00 - 24/95 Patient Story - Community Stroke Prevention Team - Executive Medical Director/ Executive Director of Nursing and Midwifery

Recommendation
The Board is asked to
note the report

24.95 Patient Story Community Stroke Prevention Team v1.0

8 10:15 - 24/96 Citizen Experience Report - Chair

Recommendation
The Board is asked to
note the report

24.96 Citizens Experience Report May 2024 v1.0

9 10:25 - 24/97 Chair's Report - Chair

Recommendation
The Board is asked to
note the report

24.97 Chair Report May 2024 v1.0

10 10:35 - 24/98 Chief Executive's Report - Chief Executive

Recommendation
The Board is asked to discuss and note the report.

24.98a Chief Executive report May 2024 v1.0

24.98b Chief Executive report App1 - Management Response to Independent Review Contract and Procurement Review

24.98c Chief Executive report App2a Director General letter to BCU - formal sharing of SM framework and de-escalation criteria

24.98d Chief Executive report App2b BCUHB Escalation Framework and De-escalation Criteria - April 2024 (Final)

24.98e Chief Executive report App2c BCUHB Special Measures Priorities - April-September 2024

11 10:45 - 24/99 Vice Chair's Report - Vice Chair

Recommendation
The Board is asked to
note the report

24.99 Vice-Chair Report to Board May 2024 v1.0

12 STRATEGIC OBJECTIVE 4 - IMPROVING QUALITY, OUTCOMES AND EXPERIENCE

13 10:55 - 24/100 Planned Care Fund - 2024/25 utilisation - Executive Medical Director / Interim Executive Director Finance

Recommendation
The Board is asked
to note
the opportunity to improve performance through in house enhanced productivity, endorsing implementation of 'treat in turn' and the 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).
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 close of May 2024, performance assessed moving forwards against these revised trajectories and Welsh Government targeted levels of performance.

24.100 Planned Care Resources - Utilisation 2024-25 v1.0

14 11:20 - Comfort Break

15 STRATEGIC ITEMS

16 ITEMS FOR APPROVAL/RATIFICATION/DECISION

17 24/101 No item

18 11:30 - 24/102 Annual Audit report 2023 and Structured Assessment - Director of Corporate Governance
Audit Wales representatives in attendance
Recommendation
The Board is asked to:
receive and support the annual audit report;
receive and support the structured assessment report;
agree that the executive team will address the improvement opportunities as outlined in the management response to the structured assessment (appendix two).
agree that the Audit Committee will continue to scrutinise the delivery of the recommendations

24.102a Annual Audit report and Structured Assessment
24.102b Appendix 1 Annual Audit Report 2023
24.102c Appendix 2 Structured Assessment 2023 BCUHB final

19 11:40 - 24/103 Annual Delivery Plan - Executive Director of Transformation and Planning
Recommendation
The Health Board is asked to
note the overall progress made along with the challenges highlighted.

24.103a Annual Delivery Plan v2
24.103b Annual Delivery Plan - Appendix 1 v2
24.103c Annual Delivery Plan Appendix 2 v2

20 11:50 - 24/104 Integrated Quality Management System (QMS) Framework - Executive Medical Director
Recommendation
The Board is asked to
note this report and support the approach to implementation of a Quality Management System for the Health Board

24.104a Quality Management System
24.104b Integrated Quality Management Framework - V0.5

21 12:05 - 24/105 Research and Development Annual Report 2023/24 - Executive Medical Director
Recommendation
The Board is asked to
note the contents of the Annual Report
note the potential to further develop opportunities to collaborate with both commercial and non-commercial partners
note the opportunity to work closely with our Universities and, in particular, Bangor Medical School.

24.105a RandD Annual report 2023.24
24.105b RandD Annual report 2023.24 Appendix 1
24.105c RandD Annual report - Appendix1-App i

22 12:20 - 24/106 Nurse Staffing Levels assurance report - Executive Director of Nursing and Midwifery

Recommendations
The Board is asked to
receive this report to gain assurance in relation to the following:
1. Betsi Cadwaladr University Health Board (BCUHB) is 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.
2. BCUHB is meeting its statutory duty to provide an Annual Presentation to the Board detailing calculated nurse staffing levels
note that a financial assessment arising from the organisations statutory duty to calculate nurse staffing levels has been submitted via the IMTP scheme for consideration within the financial planning cycle for 2024/25

24.106a Nurse Staffing Levels Annual Assurance Report Spring 2024
24.106b Nurse Staffing Appendix 1 Annual Assurance Report of the Nurse Staffing Level May 2024
24.106c NSL Appendix 2 Assurance Report Summary Reqd Establishment Spring and Autumn 2023
24.106d NSL Appendix 3 Summary of Nurse Staffing Levels for 25B Wards Spring 2024

23 12:30 - 24/107 Funded Nursing Care Interim Annual Fee Rate 2024/ 2025- Executive Director Transformation and Planning
Recommendation
The Health Board is asked to:-
approve 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.
approve 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.

24.107 Funded Nursing Care - May 2024 2025F v1.0

24 12:40 - 24/108 Corporate Governance Report - Director of Corporate Governance
Recommendation
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 30th March 2024; and
note the briefings from the Joint Commissioning Meeting held in April 2024; and
agree to the proposal regarding the circulation of minutes outside of the Board meeting.

24.108a Corporate Governance Report - May 2024 v1.0
24.108b JCC briefing (Public) 9 April 2024
24.108c JCC Briefing (Public) 23 April 2024

25 12:50 - 24/109 Update of Register of Approved Clinicians (All Wales) and Update of Register of Section 12(2) Approved Doctors for Wales - Executive Medical Director
Recommendation
The Board is asked to
note the contents and is recommended to formally ratify previous Chair's Action Letters which contain recommendations to grant approval or re-approval for Approved Clinicians and Section 12(2) Doctors across the Principality.

24.109a AC and S12 Board Report May 2024 v1.0
24.109b Appendix 1 - Approved Clinicians Data v1.0
24.109c Appendix 2 - Section 12(2) Doctors Data v1.0

26 12:52 - 24/110 Board Assurance Framework and Corporate Risk Register - Director of Corporate Governance
Recommendation
The Board is asked to :
note the report;
receive the assurance in relation to the management of risk as outlined in the Board Assurance Framework and Corporate Risk Register;
endorse changes highlighted around the Board Assurance Framework and realigning this to the Objectives of the Health Board, recently approved at the March Board.

24.110 Corporate risk and BAF report V3

27 13:02 - Lunch

28 ITEMS FOR DISCUSSION/ASSURANCE

29 13:22 - 24/111 Improving Quality Report - Executive Medical Director

Recommendation
The Board is asked to
note the report

24.111 Improving Quality Report May 2024 v2.0

30 13:42 - 24/112 Integrated Performance Report 2023/24 Month 12 - Interim Executive Director of Finance
Recommendation
The 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

24.112a Integrated Performance Report May 24 inc App1 v1.0
24.112b Integrated Performance Report - HB - May 24 App2 v1.0

31 13:57 - 24/113 2023-24 Financial Outturn 2023/24 report - Interim Executive Director of Finance
Recommendation
The Board is asked to
review and scrutinise the report

24.113a Finance report_Financial Outturn 2023-24 v1.0
24.113b Finance Report M12 2023-24 HB_AppA

32 FOR INFORMATION

33 14:12 - 24/114 Committee and Advisory Group Chair Reports
Audit Committee
Performance, Finance and Information Governance Committee
Quality, Safety and Experience Committee
Planning, Population Health and Partnership Committee
People and Culture Committee
Mental Health Legislation Committee
Remuneration Committee
Local Partnership Forum

24.114.1 Audit Committee Chair Report 07.05.2024 - V1.0
24.114.2 PFIG Committee Chair report Jan - April 2024 v1.0
24.114.3 QSE Committee Chair Report 18.04.24 V1.0
24.114.4 PPHP Committee Chair Report 23.04.24 v2.0
24.114.5 People_Culture Committee Chair Report 11.04.24 v2.0
24.114.6 MHLCC Chair Assurance Report 02.05.24 V1.0
24.114.7 Remuneration Committee Chair Report 22.03.24_V1.0
24.114.8 LPF Chair Report 26.02.24 v1.0

34 14:14 - OTHER MATTERS

35 24/115 Review of meeting effectiveness - Chair (verbal)

36 24/116 Any other business - Chair (verbal)

37 24/117 Date of next meeting
12:00 - 14:00 10 July 2024

38 14:20 - 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."

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

Betsi Cadwaladr University Health Board (BCUHB)
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on 28 March 2024 at Venue Cymru, Llandudno

Board Members Present	
Name	**Title**
Dyfed Edwards	BCUHB Chair
Karen Balmer	Independent Member
Clare Budden	Independent Member (part meeting)
Russell Caldicott	Interim Executive Director of Finance
Gareth Evans	Acting Executive Director of Therapies & Health Science
Urtha Felda	Independent Member
Dyfed Jones	Independent Member
Prof Mike Larvin	Independent Member
Dr Nick Lyons	Executive Medical Director/Deputy Chief Executive
Phil Meakin	Acting Board Secretary
Dr Jane Moore	Acting Executive Director of Public Health
Mike Parry	Associate Member – Chair Stakeholder Reference Group
Dylan Roberts	Chief Digital and Information Officer
Fôn Roberts	Associate Member – representing Directors of Social Services
Carol Shillabeer	Chief Executive
Helen Stevens-Jones	Director of Partnerships, Engagement & Communications
Dr Chris Stockport	Executive Director of Planning and Transformation
Dr Caroline Turner	Independent Member
Rhian Watcyn Jones	Independent Member
Gareth Williams	BCUHB Vice Chair
Jane Wild	Associate Director – Chair Healthcare Professionals Forum
Angela Wood	Executive Director of Nursing and Midwifery
In Attendance	
Jason Brannan	Deputy Director of People
Paolo Tardivel	Director of Transformation & Improvement
Philippa Peake-Jones	Head of Corporate Affairs
Organisations / Individuals observing the meeting	
Geoff Ryall Harvey	Llais - North Wales
Teresa Owen	Previous Executive Director Public Health BCUHB

Agenda Item	**Action**
OPENING BUSINESS	
HB24/36 Welcome, introductions and apologies for absence **HB24/36.1** The Chair welcomed everyone present including Chris Field and Billy Nichols, attending their first Board Meeting as Independent Members, Pam	

Wenger who was observing and joining the Health Board as Director of Governance in April and Paolo Tardivel who would be presenting the item on Special Measures. Attendees were advised that the meeting would be held bi-lingually and that translation facilities were available. Apologies were noted from Claire Budden for part meeting. **HB24/36.2** Chris Field introduced himself to members of the Board, sharing his background as a Barrister and a local resident with colleagues. Billy Nichols also introduced himself noting that he had started working at Betsi Cadwaladr UHB as a nurse in 2002, he advised that since 2006 he had become actively involved with the Royal College of Nursing (RCN) as Steward and Health and Safety Representative as well as the Secretariat of the Health Board's Trade Union Partner's Committee.	
HB24/37 Declarations of Interest on current agenda **HB24/37.1** Jane Wild, Associate Member declared an interest in the Corporate Governance report as the Chair of Health Professionals Forum (HPF).	
HB24/38 Draft minutes of the previous meeting held on 25.1.24 **HB24/38.1** The draft minutes of meeting held on 25 January 2024 were **approved** as a true and accurate record.	
HB24/39 Action Log **HB24/39.1** The updates provided within the action log were **agreed**.	
ITEMS FOR DISCUSSION/ASSURANCE	
HB24/40 Patient Experience Story – Vascular Service **HB24/40.1** The Executive Medical Director thanked those that had been involved in sharing their experiences with the Board and advised that the patient story video shown at the meeting showed the true importance of staff and the way they worked together, he focussed on the quality issues highlighting that the accompanying paper gave some confidence on these issues, but noted that patients being listened to would be what drives improvements. **HB24/40.2** Discussion ensued on the reconfiguration of the service and referrals between the hub and spoke sites with the Executive Medical Director concluding that the processes were under close attention and that no complex system would always work perfectly and the patient experience was extremely important. **HB24/40.3** The Chief Executive thanked the Executive Medical Director, the Patient Experience Team and those who had shared their experiences she	

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advised that there had been a number of pieces of external work taken place and one which was currently taking place, that those would all be brought together and shared as part of a wider discussion with the Board overseen by the Quality, Safety and Experience Committee. The Executive Medical Director noted that the two services reviews would be published once they were both received and that the Vascular Service would be monitored through normal governance. The Chair thanked everyone who had taken part in the item. **It was resolved that** the Board • **Noted** the report	
HB24/41 – Chair's Report **HB24/41.1** The Chair stated that he wished to draw attention to three things, firstly, that change within Welsh Government had seen a new First Minister being appointed, that the Health and Social Services Minister would stay the same but Jayne Bryant would take over as Minister for Mental Health and Early Years. He looked forward to continuing to work closely with Government and welcomed future Ministerial visits. **HB24/41.2** Secondly, the Chair highlighted Special Measures drawing attention to what had been achieved in the last 12 months, that discussions with partners were ongoing about what had been achieved and what the Health Board hoped to achieve in the future highlighting that there was a real benefit from listening and learning and using that knowledge as a resource for improvement. **HB24/41.3** Finally, he noted that he was privileged to attend a cinema screening in Wrexham about a film on dementia, he said that he was proud of those who had taken part and learnt a lot from the film. He encouraged the Board to watch the film once available on different platforms and thanked the team involved in the film's production. **It was resolved that** the Board • **Discussed** and **noted** the content of the report	
HB24/42 – Chief Executive's Report **HB24/42.1** The Chief Executive highlighted the Inquiries work that had taken place noting that there had been a Covid 19 Inquiry Wales session held in Cardiff and that the Health Board would be keen to see the publications from the Inquiry to understand the learning. **HB24/42.2** The Chief Executive advised that she had been visiting sites and learning more about the services through conversations with both patients and relatives. She advised that two teams had been nominated for a St David's award. **HB24/42.3** The Chief Executive noted that the longest period of Industrial Action had just taken place and that had impacted on the Health Board to be able to	

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provide the full range of services to patients and wanted to see a resolution as quickly as possible while working constructively with colleagues.

HB24/42.4 Partnership meetings held highlighted a number of joint initiatives such as the Royal Alexandra Hospital with more such meetings over the next few months.

HB24/42.5 The Board noted the visits by the Chief Executive and were advised that some Services had made requests and that many were possible. An example was shared around a request for an iPad in one of the services at the Wrexham Maelor site which had been an easy solution.

HB24/42.6 The Chair thanked the Chief Executive for all her hard work.

It was resolved that the Board

- **Discussed** and **noted** the content of the report

HB24/43 – Vice Chair's Report

HB24/43.1 The Vice Chair presented his report sharing that he had attended a great meeting with the Primary Care Senior Leadership Team, he highlighted that if problems were to be solved in the District General Hospitals, then it would be important to be better in Primary Care, similar views were shared during his visit to a Mental Health Ward who advised that the Community Mental Health teams were overwhelmed.

HB24/43.2 The Chair thanked the Vice Chair for his ongoing work and extended his thanks to all of the Independent Members who go above and beyond their contractual hours.

It was resolved that the Board

- **Discussed** and **noted** the content of the report

ITEMS FOR APPROVAL/RATIFICATION/DECISION

HB24/44 – Special Measures Report – Stabilisation phase

HB24/44.1 The Chief Executive introduced the item highlighting that the Health Board was now at the 12 month stage of Special Measures, that the Board had received regular updates throughout the year and thanked Paolo Tardivel, Director of Transformation and Improvement for running the programme.

HB24/44.2 The Director of Transformation and Improvement advised that the comprehensive report linked to the closure report of the 90-day cycle and that it demonstrated that a lot of progress had been made over the past 12 months whilst acknowledging that there was a lot more to do. He advised that the Health Board had been supported by Welsh Government Independent advisors and that the findings of their reviews had been published and action plans being tracked and shared with the relevant Executive Director and progressed through the agreed governance route. It was noted that an outcome focus approach had

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been taken with the third 90-day cycle showing the highest completion but that there was an ambition to improve on delivery going forwards.

HB24/44.3 Each of the eight areas of concern, Governance and Board Effectiveness, Workforce and Organisational Development, Financial Governance and Management, Compassionate Leadership and Culture, Clinical Governance, Patient Experience and Safety, Operational Delivery, Planning and Service Transformation and Mental Health were discussed and an update given on each area with the full details being highlighted in the associated report.

HB24/44.4 With regards to Governance and Board Effectiveness the Acting Board Secretary noted that there were 100 recommendations and that 70% had been completed highlighting the Terms of Reference refresh and the recruitment of a new Board. He acknowledged that there was more to do but was confident further progress would be made with the incoming Director of Corporate Governance.

HB24/44.5 The Interim Executive Director of Finance highlighted that with regards to Financial Governance and Management, the Board had control and oversight through the performance framework which was being embedded into the organisation. The revised Standing Financial Instructions and Scheme of Reserved Delegation were in place as a framework to strengthen control, that a procurement review in collaboration with Welsh Government and supported by Shared Services, had taken place and that over 400 managers had been trained on procurement. It was noted that there was still much to do in a challenging financial climate. The Planning Review had been received later than expected but a draft action plan available and would be shared in due course.

HB24/44.6 It was acknowledged that strong leadership and engagement was a long term target but that a number of months ago the Board had set out its intention to be a compassionate organisation and that the architecture was being drawn up to enable this to happen. The Deputy Director of People shared that an Organisational Development Steering Group, chaired by the Chief Executive , had been set up and the new People and Culture Committee of the Board had been formed and initially chaired by the Health Board Chair but now was being Chaired by one of the Independent Members. The Leadership Conference that had taken place had given a clear steer on what type of organisation it was seeking to be and that, whilst acknowledging that there was a lot to do, it was important to ensure that colleagues felt that they were taken on the journey. The Board noted that an Integrated Leadership Framework would shortly be agreed and that there had been good engagement on the staff survey.

HB24/44.7 The Director for Partnerships, Engagement and Communications highlighted that there was much more of an outward focus in terms of communication, that the Board would go to where people were and that this had started with the Annual General Meeting being held in the Llandudno Community Centre last year. She shared that there was more openness and transparency and that one year on, briefings had been held with both staff and communities and that going forwards there would be a cross section of the organisation coming together to shape what engagement would look like. It was

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noted that as part of the Operating Model work, a lot of engagement would be undertaken.

HB24/44.8 In relation to outcomes and experience the Executive Medical Director acknowledged that this would be about patients, although a lot of staff had been involved. He wished to thank the outgoing Acting Executive Director of Operations for her work in this area noting that there had been a good reduction on the long waits but that focus was now on how things could be done differently citing patient initiated follow up which allowed other patients to be seen. The Executive Medical Director highlighted large waiting lists for dermatology and that different ways of addressing these were being looked at such as tele-dermatology. It was noted that the paper highlighted Orthopaedics and the support from Welsh Government for the Llandudno Hospital changes. The Director of Transformation and Improvement noted that the difficulty would be to ensure that the organisation had the right outcomes but the intention was with the challenged services, to move from people telling the organisation what the problem was to it being identified first.

HB24/44.9 The Executive Director for Nursing and Midwifery advised that with regards to being a learning and self-improving organisation, an action plan had been developed and that the organisation was on track to deliver. A Quality Management System was being developed and would be presented to Board at the May meeting. The Board noted that there was a significant move to an Electronic Records System, with a focus on Public Health including diabetes. A learning framework was being developed by teams on the ground and that this would be scaled up as part of the Quality Management System. A review of investigations had highlighted the need to improve what was being submitted to the coroner, to ensure that learning is being taken forward across the organisation.

HB24/44.10 Attendees noted that longer term the Special Measures approach would inform the development of an organisational strategy for the Health Board. That there would be less of a focus on Special Measures as it would be reported as part of the Annual Plan. The Director of Transformation and Improvement concluded by thanking all those across the organisation, Welsh Government and the Board.

HB24/44.11 A discussion took place around workforce and it was noted that there was a huge improvement on the reduction of interim appointments across the organisation. It was acknowledged that developing workforce opportunities for the population of North Wales would be addressed later in the agenda as part of the three-year plan.

HB24/44.12 Further discussion took place around the Operating Model work noting that as an organisation there was a lot to do and a long way to go but that in order to deliver people needed to be helped to deliver what they had to do. A lot of feedback had been received by the Chief Executive on the Operating Model; she had commissioned work by Internal Audit and the report had now been received and that the next phase would be to start to draw conclusions on what was working well and what was not but that it was important not to cause

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unnecessary disruption to the organisation. The initial feedback was that there was a need to change and a lot of work scheduled in quarter one on this. Independent Members shared that the format and tone of the approach was right and commended the work that had been undertaken in a transparent way. It was noted that as a Board a decision to embrace risk and be transparent about the issues publicly had been agreed, that there was further work to do specifically around Planned Care and Urgent and Emergency Care. **HB24/44.13** A discussion ensued around interim and temporary staffing highlighting that a lot of work had been undertaken in nursing and midwifery with regards to recruitment and that in some areas there would be no vacancies. Conversations were taking place with temporary staff to see if they would be interested in being employed by the Health Board. The Chair advised that the way people work now was very different, in comparison to what it used to be, and the organisation would need to change, accommodate and be flexible wherever possible. **HB24/44.14** In response to the challenge of what Special Measures was achieving and what difference it was making, the Chief Executive advised that a year ago the organisation had been in a fundamentally challenged position and had undergone some dramatic changes which had impacted on how the organisation was functioning. She advised that it was her aim to have a well - functioning organisation and that a twin tracked approach was ongoing whereby, whilst focussing on the long term plan, better care was starting to be identified. The organisation was working night and day to ensure improvements, but that these may not be seen overnight but rather in the long term. **It was resolved that** the Board • **Received assurance** on the progress made during the first 12 months of Special Measures.	
HB24/45 – Audit Wales Report on Board Effectiveness and Responses **HB24/45.1** The Chief Executive asked that the Board formally receive the Audit Wales Report on Board Effectiveness and the organisation's response. She advised that she was grateful for the work Audit Wales had undertaken and that the report was of public interest and had been published with commentary from the Auditor General. She advised that in summary the Board was improving, that relationships were improving and overall, there was a more positive approach with the dysfunctionality no longer evident but that there were fundamental challenges to address and that those would be highlighted in the Plan. It was noted that Board Effectiveness would form some of the work in the Structured Assessment. **It was resolved that** the Board • **Noted and considered** the Board Effectiveness Report and the BCUHB Response	
HB24/46 – Draft 3 Year Plan 2024 – 2027 and annual delivery plan 2024-2025	

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HB24/46.1 The Executive Director of Planning and Transformation presented the item, thanking both Stakeholder Reference Group (SRG) and the members of the Performance, Finance and Information Governance Committee (PFIG) for their support in testing the plan prior to Board. It was noted that PFIG Committee had formally met the previous week to discuss the plan presented in the pack and that changes requested at that meeting had now been completed. Both a Welsh Language and easy read version of the plan were being completed and an Equality Quality Impact Assessment finalised.

HB24/46.2 Attendees noted that it was a Statutory duty under the NHS (Wales) Act 2006 amended by NHS Finance (Wales) Act 2014, to prepare three-year plans that:

- Improve the health of the population
- Improve the provision of health care
- Balance over a 3-year period
- Are approvable by Welsh Ministers

HB24/46.3 If unable to produce an 'approvable Integrated Medium Term Plan (IMTP)' as above, organisations were to submit Annual Plans. The Board accepted that the Health Board would be unable to submit an approvable three year IMTP, as was the case with a number of Health Boards, but that the Annual Plan presented was shared within the context of a three year plan and that a twin track approach would be undertaken. The Board were advised that the five sections of the three year plan correlated with the Special Measures Outcomes and that during consultation it was felt that this was the most appropriate way to structure the plan. The objectives were confirmed as below:

- Objective 1: Building an effective organisation
- Objective 2: Developing strategy and long-lasting change
- Objective 3: Compassionate culture, leadership & engagement
- Objective 4: Improving quality, outcomes and experience
- Objective 5: Effective environment for Learning

HB24/46.4 The Board noted the plan explored in year change, partnership working and acknowledged that the organisation was the biggest employer in North Wales. There was a focus on Objective 4, Improving quality, outcomes and experience and the challenge of how this part of the plan was structured because breaking down this element would always be artificial, with the example shared being Primary Care not just being about Primary Care but also Planned Care, Cancer Care and Urgent and Emergency Care, as was the case with Dementia.

HB24/46.5 With the plan being an integrated one the Interim Executive Director of Finance shared the detail on how the Financial Plan had been developed and how the journey throughout the 2023/24 financial year had taken shape. The deficit plan in 2023/24 had been set at £134m, which was part of the All Wales national deficit plan of £648m. The scale of the financial challenge was discussed and in particular it was noted that a number of control processes were

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put in place around enhanced pay and non-pay control measures and balance sheet flexibility. Members noted that the Welsh Government had allocated additional revenue in-year to NHS Wales: all Health Boards in Wales had received a proportional share of the resource, with the Health Board receiving £101 million which moved the Health Board's deficit plan to an outturn of £33m deficit. The Board noted that this was the comparable figure to the previous year of £101m additional allocation that was endorsed as a Board.

HB24/46.6 When determining an underlying position for 2024/25 the one-off allocations that the Health Board had received for income were removed, these being allocations for performance and transformation of £82m and the original £101m allocation received in the previous year, although elements of those could become conditionally recurrent giving an underlying deficit for 24/25 of circa £253m. The key messages shared being that correction of the balance sheet could only be utilised once and this had been done in 2023/24 and that the Health Board was heavily reliant on significant non-recurrent allocations to support financial sustainability.

HB24/46.7 The Interim Finance Director explained how the underlying deficit of £253 million had been significantly reduced as the result of additional allocations from the Welsh Government, including funding specifically to tackle long waiting times for planned care. Some of these allocations were however non-recurrent. He then highlighted inflationary pressures, leaving the Health Board with a 2.8% savings target for the year, which meant a £48m target. It was noted that the directive had been to have a 2% target, which would mean further challenge would come. The Board noted that this would only be delivered by the values sustainability work which was to enhance service provision, not by cutting services but by utilising what was available in a more efficient way. Despite what was presented, this still left the Health Board with a £19.7m deficit which was akin to the amount for the previous year meaning that the key financial duty to break even would not be achieved. Ongoing work on values sustainability would to continue to enable the Health Board to create a break even plan in future years.

HB24/46.8 The Deputy Director of People highlighted the workforce element of the plan noting that workforce solutions would need to be sustainable and that services required consideration of skill mix, configuration, technology and productivity and that there would be a requirement to review the workforce. In relation to establishment base, establishment reviews for nursing had taken place during 2023-24 with a wider review during 2024. The proposals within the plan had been tested against the likelihood of successful recruitment and redeployment. It was noted that other options needed to be considered, for example, apprenticeships, live well, work well and the requirement for finance and workforce numbers to align.

HB24/46.9 The Executive Director of Planning and Transformation clarified how the delivery of the plan would take place noting that the narrative of the document would be converted into SMART principles which would be outcome focused and evidenced based both on impact and delivery. The delivery of the plan would be cascaded to local plans and then onto personal objectives which

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would be set out in the Integrated Performance Framework which would be received at Committee and Board on a quarterly basis. **HB24/46.10** A discussion ensued around engagement, understanding that the Board had worked flexibly and through workshops to be sighted on the Plan, that there had been a significant improvement in the Plan from the initial draft. The Interim Executive Finance Director clarified the control target being between £20m- £33m. It was noted that the use of AI would be further developed as part of objective 5 with the Chief Digital Information Officer clarifying that a study day with the clinicians was being developed. Further discussion took place around public sector funding and that there were areas that more could be done in terms of outcomes for patients. **HB24/46.11** The Chief Executive thanked colleagues for their work advising that, although the planning function had coordinated the work, many other areas had contributed and that the plan was much improved in comparison to the previous year. An easy read version would ensure that there was an understanding of what is being worked on and that the plan would lead to delivery ensuring that the finance restrictions do not distract from the outcomes and experience that patient should receive. **HB24/46.12** The Chair thanked colleagues for their work and that the process had, as always, been a learning one. He focussed on those who would be delivering the plan, wanting to ensure that they felt part of the delivery and had the shared ambition. The Chair advised that the Plan could now be submitted formally to the Welsh Government. **It was resolved that** the Board • **Received** the three year plan and approved the corporate objectives and the priorities as outlined in the plan; • **Noted** that significant work that had been undertaken to develop the plan but accepted that the plan was still a deficit plan and that strong focus on clear accountability arrangements for delivery was required; • **Supported** the submission of the Annual Plan and supporting documents requiring submission to Welsh Government by 28 March 2024 in accordance with agreed timescales	CS
HB24/47 – Corporate Governance Report **HB24/47.1** The Acting Board Secretary advised that there were three elements to the report, the first being Risk, with 17 corporate risks and an update on 9 with the remainder outstanding with the relevant Executive Director. Further discussion took place around the level of risk rating for not achieving a financial plan noting that the narrative would be reviewed at the Risk Management Group for review at the Executive Team Meeting. **HB24/47.2** In relation to appointments, Jane Wild had been reappointed as Chair of Healthcare Professionals Forum (HPF), Caroline Turner had been appointed as Chair of Quality, Safety and Experience Committee.	

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HB24/47.3 The Chair of the Audit Committee endorsed the progress that had been made in relation to the management of risk advising that it is reviewed at the Audit Committee, however, it was noted that the Committees were not a form of assurance, nor were they a line of defence. **It was resolved that** the Board • **Noted** the Corporate Risk Register and Board Assurance Framework following the review at the committees of the Board; • **Approved** the affixing of the common seal as detailed in the report • **Ratified** Chair's Actions taken since the last Board Meeting • **Noted** the expressions of interest for HPF and SRG Membership	
HB24/48 – Strategic Equality Plan 2024-2028 **HB24/48.1** The Deputy Director of People presented the paper highlighting that it set out the strategic intent for the organisation and had been built on a number of key pillars and done in consultation. It was agreed that in future the Strategic Equality Plan would fall under the People and Culture Committee. Following consideration by the Board, the next steps would be to share the document, noting that some of the language came from the national plan and statutory requirements. The document would remain an iterative document as it was an initial scoping document for 4 years with the aim that it linked with both the Annual Plan and culture and engagement work. Thanks were given to Ceri Harris – Head of Equality and Human Rights, for her work on the plan, who was in attendance at the meeting. **HB24/48.2** An Independent Member welcomed the report noting that it demonstrated the commitment given, that the Health Board represents circa 700,000 people and 20,000 staff and a discussion around engagement on the Equality Plan and the consultation process followed. **It was resolved that** the Board • **Approved** the proposed **six equality objectives** for the Health Board 2024 to 2028 • **Approved** that each of these were high-level priority areas of work. The development and delivery of actions to each of these priority areas would sit with relevant leads across the Health Board and progress would be reported through the Equality and Human Rights Strategic Forum and annual reporting via the Annual Equality Report.	
HB24/49 – Royal Alexandra Hospital Business Case Update **HB24/49.1** The Chief Executive clarified the longstanding history of the Royal Alexandra project, that it had previously been submitted to Welsh Government as a full business case which had not attracted the support of Welsh Government as it had been financially prohibitive. It had been agreed that the Health Board would take a fresh look at what the art of the possible may be and thanked colleagues from both Flintshire, Denbighshire and Welsh Government	

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for their work on helping to produce a more modest cost option while ensuring that the majority of the elements from the original business case still featured. **HB24/49.2** The Executive Director of Planning and Transformation confirmed that he was first involved in the project as a GP some ten years ago, and that although it was a more modest proposal, it was also more realistic, and partnership work was key, especially as the move towards de-medicalising care and understanding different models of care were pursued. He reminded colleagues that Rhyl was in the top two deprived areas in Wales. **HB24/49.3** Further discussion took place around how the process would move forward and ensuring that both the population and staff be involved and agreement that the programme would not be successful without all their involvement. Enthusiasm was shared around the minor accident and ailment unit and the joint working with the Local Authorities. **It was resolved that** the Board • **Noted** and **approved** the briefing note and, following the private discussion, to **approve** the Option Appraisal document for onward consideration by Welsh Government.	

HB24/50 – Three Yearly Assurance Report on Compliance with the Nurse staffing Levels (Wales) Act
 	
HB24/50.1 The Executive Director of Nursing and Midwifery presented the Three-Year Compliance report on the Nurse Staffing levels (Wales) Act noting that every six months reviews were shared with Board. The report shared a summary of the work that had been undertaken and had been shared previously with the Executive Team. Funding had been allocated to ensure that establishment reviews were compliant. It was noted that following receipt at Board the report would be submitted to Welsh Government.
 	
HB24/50.2 A discussion took place around who the Nurse Staffing Act applied to and whether patient information boards that fall under the Act were poorly maintained. An assessment had been undertaken by the Royal College and during Covid this hadn't been maintained, but the Executive Director of Nursing and Midwifery had asked that this be reviewed and amended. Attendees understood that those wards where the Act did not apply, staffing levels would still be reviewed annually at Board.
 	
It was resolved that the Board
• **Received** the report to gain assurance in relation to the following:
 	
  • Betsi Cadwaladr University Health Board (BCUHB) is 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.
  • BCUHB is meeting its statutory duty to provide a Three Yearly Assurance report on compliance with the Nurse Staffing Levels (Wales) Act 2016 to the Welsh Ministers
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HB24/51 Update of Register of Approved Clinicians (All Wales) and Update of Register of Section 12(2) Approved Doctors for Wales **HB24/51.1** The Executive Medical Director presented the report and shared the background as to why the Health Board undertook this approval process for the whole of Wales. It was noted that between Board meetings, delegated authority had been granted to him. **It was resolved that** the Board • **Noted** the contents and formally ratified previous Chair's Action Letters which contained recommendations to grant approval or reapproval for Approved Clinicians and Section 12(2) Doctors across Wales.	
ITEMS FOR DISCUSSION/ASSURANCE	
HB24/52 Improving Quality Report **HB24/52.1** The Executive Director of Nursing and Midwifery presented the report, noting that going forwards the Integrated Performance Report would include the quality data and therefore an exception report was being presented to Board. She highlighted falls and health care acquired infections, pressure ulcers and the three never events shared within the paper. It was noted that the Coroner continued to raise issues around Electronic Health Records, ambulance delays and the quality of investigations. The Board noted that a deep dive on inquests working with Integrated Health Communities was ongoing. **HB24/52.2** Members noted that numbers of complaints were increasing again and a mapping process of the pathway was underway in order to streamline the process and ensure that the learning was embedded. Work was underway to develop the Quality Management System which would be considered at the Board meeting in May. Members noted that 88% of patients who responded to the patient survey stated that they were satisfied with their care. **HB24/52.3** The Board discussed the quality of documents and the overdue complaints and were concerned that the backlog was increasing. It was agreed that the Integrated Performance Report would include the trajectories from May. Discussion around the Clinical Effectiveness Report and how that would feed into the Quality agenda took place concluding that the Quality report was retrospective but the Clinical Effectiveness would be looking forward. There was a suggestion for a focus group to be set up to review the problem and look at a solution. **HB24/52.4** The Chief Executive concluded that quality was a collective responsibility, that when thinking about quality, it should be about building systems, pathways and teams to ensure that they had quality within them all, that this would be the approach of the Quality Management System as the first step to systemising quality. **It was resolved that** the Board • **Noted** the report	RC

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HB24/53 Partnerships Report **HB24/53.1** The Director of Partnerships, Engagement and Communication presented the report highlighting the work of the shared forums, including the Regional Partnership Board and the Public Services Board. **It was resolved that** the Board • **Noted** the report	
HB24/54 BCU Response to EMRTS Engagement **HB24/54.1** The Chief Executive summarised the paper and the history of how the proposal had been formed. It was noted that during the consultation period concern had been raised by communities in North Wales as well as Llais about the potential impact of the proposals especially in rural areas. Following a discussion about the detail shared on the reasons for change being suggested and what was best for North Wales and the concerns raised by the community, it was **agreed** that the Board would hold an extraordinary meeting consistent with other Health Boards across Wales to consider the item, given there was not enough information to consider the recommendations put forward at the meeting. **It was resolved that** the Board • **Noted** and **discussed** the report; and • **Agreed** to hold an extraordinary virtual meeting to consider the proposals	PM
HB24/55 Establishment of the NHS Wales Joint Commissioning Committee as a Joint Committee of Local Health Boards in NHS Wales The Chief Executive provided an update on the establishment of the NHS Wales Joint Commissioning Committee and sought adoption of its governance framework, as a Joint Committee of the Board. An Independent member clarified the process, concluding that Welsh Ministers had made the decision with regards to the establishment of the Joint Commissioning Committee. **It was resolved that** the Board • **Noted** the report and the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1st April 2024, as directed by Welsh Ministers;	

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• **Noted** that the JCC will supersede the Board's current joint committees, Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1st April 2024 • **Noted** the development of the JCC's governance framework, as a key component of the Health Board's governance framework • **Adopted** the amendments to Model Standing Orders and Reservation and Delegation of Powers for Local Health Boards; and the Standing Orders and Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 18th March 2024 • **Adopted** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19th March 2024 • **Noted** the JCC's Accountability Map for information	
HB24/56 Integrated Performance Report **HB24/56.1** The Interim Executive Director of Finance presented the report noting that the Health Board was on a journey to develop a final version of this report with the need to shift the report to focus on assessing future performance. It was anticipated that there would be an introduction of local metrics that would be taken through the Integrated Performance Group to decide on what Committees needed to review. **HB24/56.2** The Executive Director of Nursing and Midwifery highlighted the infection control statistics and that further work was being done to look at national statistics alongside clinical coding. **HB24/56.3** The Deputy Director of People shared that from a workforce perspective there was a mixed picture, that although Establishment Control meetings were taking place, challenge remained around Performance Appraisal Development Review (PADR) compliance with the Health Board sitting third in Wales. **HB24/56.4** The Executive Medical Director noted that in relation to Planned Care and Unscheduled Care, there had been improvement on long waits and that the current focus would be on understanding the gap between demand and capacity and how that could be addressed in a timely fashion. An Independent Member raised concerns around the cancer pathway and the lack of capacity. **HB24/56.5** The Chief Executive concluded that in a lot of areas there was a need to be more productive and that with demand and capacity modelling this could be achieved. It was noted that the next stage would be to develop the Quality Management System which would enable more effective planning and look at quality elements and the trajectories. **HB24/56.6** The Board was refreshed on the issues identified around staff who worked on coding, noting it was an all Wales issue.	

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[Clare Budden, Independent Member joined the meeting]

It was resolved that the Board

- **Noted** the report

HB24/57 Financial Performance Report 2023/24 Month 11

HB24/57.1 The Interim Executive Director of Finance presented the report noting that Health Board's original financial plan has been revised down from £134.1m to £33.0m as a result of additional funding totalling £101.1m following the Welsh Government Budgetary Review. It was noted that the Health Board also received notification from Welsh Government requiring it to improve the deficit plan from the original £134.1m by 10%, the result being an outturn control total of a £20m deficit for the financial year.

HB24/57.2 In relation to capital, it was reported that the approved Capital Resource Limit for 2023/24 was £33m, with the spend to date being £26m and the final excess of £5m to be received in the final four weeks.

HB24/57.3 Independent Members acknowledged that the tight control environment had enabled this to come in on target but that going forwards the ability to live within the Health Boards means would be key, whilst also improving services. The Interim Executive Director of Finance confirmed that he wished to be operating in a controlled environment working towards sustainability and learning from other Health Boards as to how to embed learning and plans within Betsi Cadwaladr.

It was resolved that the Board

- **Received** and scrutinise this report
- **Noted** the additional capital allocations received to date
- **Approved** an improved forecast outturn deficit of £27m as a minimum, pending confirmation on any other opportunities and risks that crystalise in the final month of the financial year.

FOR INFORMATION

24/58 Committee and Advisory Group Chair Reports

24/58.1 The Chair invited Committee and Advisory Group Chairs to raise any matters from their report. The QSE Chair wished to note the engagement from the Integrated Health Communities and advised that for the last twelve months as Chair she had felt very supported. Members thanked the former Chair of the QSE for the hard work she had undertaken in the last 12 months which had set the committee in good stead.

24/58.2 The Chair of SRG highlighted that the group was in a transitional phase, engaging more on plans for the future as well as recruiting new members and was looking forward to more Board engagement.

24/59 Summary of private Board business to be reported in public

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24/59.1 The Acting Board Secretary advised that the Board held discussions in in private at the at the 25 January 2024 meeting on: • Draft Report from Audit Wales on Board Effectiveness • Financial Update • Confidential Corporate Risk Register • High Value Claim • Private QSE Chair's Report	
24/60 Meeting effectiveness **24/60.1** Attendees discussed how effective the meeting had been. Practically an additional table would have been helpful to allow sufficient space. It was noted there had been a really good split between strategic and operational agenda items but that the agenda bundle was heavy with 790 pages, many of the reports having already been through Committee. **24/60.2** The Chair thanked those that had supported the Board and specifically thanked the Acting Board Secretary, for all his work over the previous year, noting that it would be his last meeting in the current role.	
24/61 Any other business No further business was reported.	
24/62 Date of next meeting 30th May 2024 at Venue Cymru, Llandudno and via livestream	
Resolution to Exclude the Press and Public "Those representatives of the press and other members of the public be excluded from the remainder of the meeting which would take place after the Trustee 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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Health Board

Table of actions log – arising from meetings held in public

23.5.24

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status
Open actions						
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 (Submit by 11.7.24)	
Actions suggested for closure						
HB24/46.11	Executive Director Transformation and Improvement	**Annual Delivery Plan** Submit Annual Plan and supporting documents to Welsh Government by 28 March 2024 in accordance with agreed timescales	28.3.24	CS 21.5.24 Action has been completed. The plan was submitted to WG as per the required timescales	Closed	
HB24/50.1	Executive Director of Nursing and Midwifery	**Nurse Staffing Levels** Submit 3 yearly Nurse Staffing Levels (Wales) Act	28.3.24	AW 21.5.24 Action has been completed. The report has been submitted to WG with the	Closed	

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status
		compliance report to WG in accordance with agreed timescales		caveat final sign off in October		
HB24/54.1	Director of Corporate Governance	**BCU Response to EMRTS Engagement** Convene an Extraordinary Board meeting to discuss EMRTS proposal	11.5.24	Action completed. The Extraordinary Health Board meeting took place on 11.4.24	Closed	

RAG	
Action Closed	
Action ongoing	
Action Outstanding	

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

Teitl adroddiad: ***Report title:***	Mental Health: Royal College of Psychiatrists' Invited Review Services Report
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides an overview to the Board of the Royal College of Psychiatrists Invited Review Service (IRS), supported by the Royal College of Nursing Wales examination of the extent to which recommendations from previous reports have been implemented and embedded into the delivery of the service. It further outlines a proposed approach for developing the way forward in response to this report taking into account wider views and considerations.
Argymhellion: ***Recommendations:***	The Board is asked to: • **Consider** the report of the Royal College of Psychiatrists and the key findings of the review. • **Consider** the views of families with experience of care, their feedback on the report and critically the consideration of the best way forward • **Restate** afresh, the apology to people who were let down by the health board that led to the reviews that took place to identify failings. • **Agree** a period of consideration to draw up a formal response to the findings of the Review and the views of families and other stakeholders, including Llais. • **Consider** the response in a subsequent Board meeting, currently scheduled for July 2024.
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive
Awdur yr Adroddiad: ***Report Author:***	Carol Shillabeer, 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* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	4: Improving Quality, Outcomes and Experience			
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 ***Workforce implications as a result of implementing the recommendations***	None to note at this stage			
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been prepared by the Chief Executive following review and consultation with families			
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
Next Steps: The Health Board will now draw up a formal response to the findings of the Review and the views of families and other stakeholders, including Llais. The response will be considered at a subsequent Board meeting, currently scheduled for July 2024.	
List of Appendices: Appendix 1: Royal College of Psychiatrists' Invited Review Services Report Appendix 2: Summary Report	

1. Introduction

This report provides an overview to the Board of the Royal College of Psychiatrists Invited Review Service (IRS), supported by the Royal College of Nursing Wales examination of the extent to which recommendations from previous reports have been implemented and embedded into the delivery of the service. It further outlines a proposed approach for developing the way forward in response to this report taking into account wider views and considerations.

This review was commissioned by the Welsh Government and welcomed by the health board as part of the assessment and intervention work relating to the Special Measures Framework.

The review focused on four reports including:

- The Holden Report (2013)
- First Ockenden Report (2014)
- The Health and Social Care Advisory Service (HASCAS) report (2018)
- Second Ockenden Report (2018).

The Review Team was comprised of a Consultant General Adult Psychiatrist; a Consultant Old Age Psychiatrist working in Wales; a lay reviewer also based in Wales; an independent nurse reviewer (representing the Royal College of Nursing); and an expert nurse reviewer working in mental health improvement in England. The Review Team was supported by advisors at the Royal College of Psychiatrists. The review took place up to December 2023.

2. The Approach

The Independent Review Service approached their work in three steps:

1. Review of documentary evidence provided by the health board, totalling over 370 documents.
2. Interviews with a wide range of staff, external bodies and patients and carers groups.
3. Visits to several mental health units, meeting with staff and offering drop-in sessions for staff, patients and carers.

The Independent Review Service indicated that in very few cases would it be possible to say definitively that a recommendation had or had not been implemented. The IRS presented their findings using red, amber, green rating method, with the following guide:

a. Green rating was given if good or strong evidence that the recommendation had been met and integrated into practice.
b. Amber rating was given if there was some but not good evidence that the recommendation had been met.
c. Red rating is little or no evidence was provided to support implementation of the recommendation.

There were 84 recommendations assessed, and there was some overlap, hence the Independent Review Service grouped the recommendation under themes.

3. Key Findings of the Review

1. Theme one: **Patient and user centred care**

Five of seven recommendations were rated amber, two were rated green.
The Review Team did not think the board was structured in a way that best met 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.

2. Theme Two: **Legislation and clinical guidelines**

Six of eight recommendations were rated green and two amber.
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.

3. Theme Three: **Governance**

Eight of ten recommendations were rated amber, one was green and one red.
The review team were particularly concerned about the lack of electronic health records. The team was shown evidence of the 'putting things right' system and of safety huddles but staff reported there was a lot of duplication and repetition in 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 in clinical areas. The large number of posts being held on temporary or interim basis was also a particular concern for the team.

4. Theme Four: **Staffing**

Two of the seven recommendations were rated green, four were amber and one was red.
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 staffing levels, however there had been many initiatives in recruitment and retention and the Steamliners programme was well received.

5. Theme Five: **Management structure**

Two of the three recommendations were red and one was amber.
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 adult mental health services were adequately represented within the management structures.

6. Theme Six: **Clinical services organisation**

Seven of ten recommendations in this theme were amber, one was red and two were green.

The review team noted that it continued to be difficult to fulfil a substantive post in old age psychiatry especially in the western sector and there was a lack 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 nurse did not focus specifically on dementia care. There was no clear agreed model of clinical care throughout the health board.

7. Theme Seven: **Training and development**

Four recommendations were rated green, three were amber and one was red.
The review team was concerned that there was little engagement with external networks. Further progress is needed to be made in recruiting practice development and consultant nursing staff in the field of dementia. The review team was pleased to see the board supporting healthcare assistants to train as nursing staff.

8. Theme Eight: **Leadership and Staff Engagement**

Four of the six recommendations were rated green and two were amber.
Overall, there was evidence of improved engagement with staff, but this was not consistent throughout the health board.

9. Theme Nine: **Resources**

Two of the four recommendations were green and two were amber.
The review team was concerned about the lack of access to psychological therapies for inpatients 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.

10. Theme Ten: **Physical environment**

Two of three recommendations were amber and one was green.
The review team recommends that urgent attention is given to ensuring that all remedial works necessary ensure patient safety are completed, and this applies to ligature risks. There was no clear timeline to ensure that the recommendations made by Healthcare Inspectorate Wales and the National Collaborative Commissioning Unit in recent inspections have been carried out.

4. Discussions with families with experience of services

Discussions with families with experience of services have been held. It was considered fundamental that those who had experienced poor care in the past were able to influence the way in which the health board considers the Invited Review Service and the potential actions and next steps for improvement. These discussions were enabled by Llais who have been involved over many years in work regarding the concerns raised, in its role as the former Community Health Council.
It was clear in these discussions, that there were a number of comments and views from the families in relation to the IRS report. There was disappointment that not all families with experience had been involved in feeding into the review, but the meeting to consider the way forward was welcomed.

During the discussion a number of key themes were discussed including:
- Accountability
- The purpose of wards/units

- Standards – knowing what good looks like
- Culture – including an environment that welcomes and supports staff speaking out
- Leadership
- Standardisation
- Openness and transparency
- Ambition – setting the bar too low.

It was strongly felt that the way in which families had been treated in the past devalued their views and accounts of the care of their loved ones, in short, they were not believed. There was also a strong belief that HASCAS were wrong in their assessment that there was no institutional abuse with the Nursing and Midwifery case being referenced as key evidence.

Discussions also considered the way forward, with some key themes and actions being suggested including:

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

5. Other key information

A Nursing and Midwifery Council Fitness to Practice hearing has recently concluded. This examined the allegations that centred on a Registered Nurse from the Tawel Fan Ward. The referral to the NMC was made in 2014 by the health board and the substantive hearing took place during April 2024. The outcome of the hearing was that the individual's Fitness to Practice was impaired with allegations being proven on the balance of probability. The allegations proven centred upon the unnecessary use of force to manipulate a patient's knee when assisting him into a wheelchair; that the patient was kicked multiple times to encourage them out of the nurse's office; and that medication was forcibly administered.

The individual was struck off the register of nurses held by the Nursing and Midwifery Council.

6. Initial Response

There is much to consider in relation to the IRS report including the views of key stakeholders including families with experience of services. It is suggested that a period of 4 – 6 weeks is used to carefully consider the next steps, to include the views of families with experience of services that have been described above.

This consideration should take account of the improvement plans already in place with prioritisation undertaken to particularly identify those actions where an 'as soon as possible' approach could be taken.

In relation to some aspects of the findings, action is currently being progressed. One example is the case for an electronic record for mental health. This has been a key priority for the Board and significant discussions have taken place with Welsh Government regarding the way forward to procure and implement such a system. It is anticipated that the case will be put forward in the coming months for decision. The service is already working on the preparation for implementation.

The publication of this report provides an opportunity for the Board to offer a further public apology to that of previous Boards regarding the poor care that was provided in the past and for the experience of those who were raising the concerns. It is clear that the NHS in North Wales, and specifically the health board, let down patients and their families at a time when they were at their most vulnerable. The events that have been subject to fundamental and important review, must continue to be a matter of significant regret and essentially the reason to drive forward improvements.

There is a need to reaffirm the health board commitment to providing the best possible health and care service to people who have dementia specifically, as well as people in need of wider mental health services. The work to reach this goal now moves into the next stage and the report provided by the Royal College of Psychiatrists offers an important point of consideration about further action that is required.

7. Proposed way forward and next steps

The Board is asked to:

- **Consider** the report of the Royal College of Psychiatrists and the key findings of the review.
- **Consider** the views of families with experience of care, their feedback on the report and critically the consideration of the best way forward
- **Restate** afresh, the apology to people who were let down by the health board that led to the reviews that took place to identify failings.
- **Agree** a period of consideration to draw up a formal response to the findings of the Review and the views of families and other stakeholders, including Llais.
- **Consider** the response in a subsequent Board meeting, currently scheduled for July 2024.

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Summary of the key themes arising from the Royal College of Psychiatrist's Invited review of Mental Health and Learning disability services in Betsi Cadwaladr University Health Board.

Introduction

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

On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board (BCU) to special measures with immediate effect.

Mental health services in the health board had been in Targeted Intervention since the de-escalation from special measures in 2020, and alongside the rest of the organisation form part of the current special measures intervention.

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.

The review team was led by Professor Gerard Lynch, a Consultant General adult psychiatrist and included a Consultant old age psychiatrist working in Wales, a lay reviewer, also based in Wales, an independent nurse reviewer who represented the Royal College of Nursing and an expert nurse reviewer working in a mental health improvement support team in England. The team was supported by clinical advisors, the Director of the College's Centre for Quality Improvement (CCQI), the Head of Clinical Audit and Research for the CCQI and the IRS Programme Manager. The review was undertaken from May to December 2023.

The review had three stages:

- In the first stage, the review team reviewed all the documentary evidence supplied by the health board which was over three hundred and seventy documents.
- The second stage involved online interviews with a wide range of staff from across the health board, external bodies and patients and carers groups.
- In the third stage, the review team visited several mental health units in the health board and met with staff members to find out about their experiences. Confidential drop-in sessions for staff, patients and carers were held across various sites.

Methodology

How recommendations were rated

On reviewing the evidence relating to the recommendations under review, it was apparent that in very few cases it would be possible to say definitively that the recommendation had or had not been met across all BCU services. In addition, the review team were asked to say to what extent the recommendations had been met. The review team decided to present their findings using the 'red, amber, green' method. A green rating was given if there was good or strong evidence that the recommendation had been met and was integrated into practice. An amber rating was given if there was some but not good evidence that the recommendation had been met and red was used if there was little or no evidence that it had been met.

The review team made a rating against each of the eighty-four recommendations from across all four reports. Some recommendations had been made over a long period of time and there was some overlap. Because of this, the review team thought it would also be helpful to group the recommendations under themes which are outlined in more detail below.

The ratings of each individual recommendation are presented by review in the main body of the report (pages 12-76). The ratings according to themes, which are summarised below are found in appendix B of the report (pages 79-96).

Results

Theme one: Patient and user centred care

Five of the seven recommendations in this theme were rated amber meaning there was some, but not good evidence of implementation and embedding. Two were rated green. The review team did not think that the board was structured in a way that best met 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.

Theme two: Legislation and clinical guidelines

Six of the recommendations in this theme were rated green and two amber. 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.

Theme three: Governance

Eight recommendations were amber, one was red, and one was green. 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.

Theme four: Staffing

Two of the recommendations in this theme were green, four were amber and one was red. 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.

Theme five: Management structure

Two of the recommendations were red and one was amber. The large number of interim posts was a particular concern to the review team, who were not clear that there was full multi-disciplinary input at a senior management level and did not think that the older adults mental health services were adequately represented within the management structures.

Theme six: Clinical services organisation

Seven recommendations in this theme were amber, one was red and two were green. 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.

Theme 7: Training and development

Four recommendations in this theme were green, three were amber and one was red. The review team was concerned that there was little engagement with external networks. As noted earlier, further progress needed to be made in recruiting practise 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.

Theme eight: Leadership and staff engagement

Four of the recommendations were green and two were amber. Overall, there was evidence of improved engagement with staff, but this was not completely consistent throughout the health board.

Theme nine: Resources

Two recommendations were green and two were amber. 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.

Theme ten: Physical environment

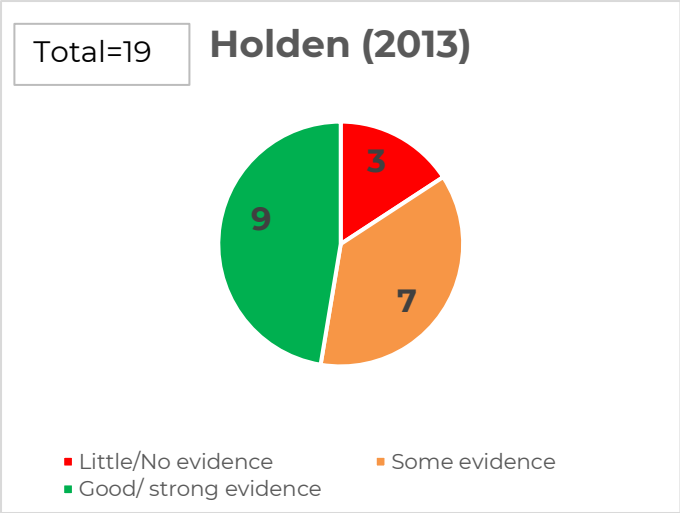
Two recommendations were amber, and one was green. The review team recommend that urgent attention is given to ensuring that all remedial works necessary to ensure patient safety are completed, and this particularly applies to ligature risks. There was no clear timeline to ensure that the recommendations made by Health Improvement Wales and the National Collaborating Commissioning Unit in recent inspections were carried out.

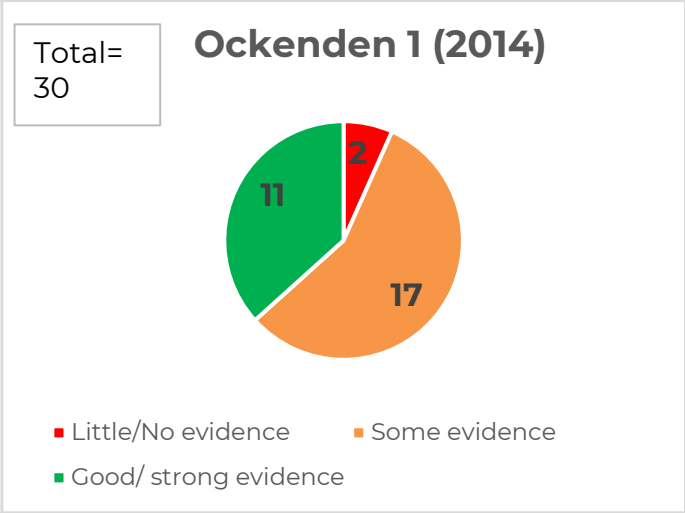
Summary

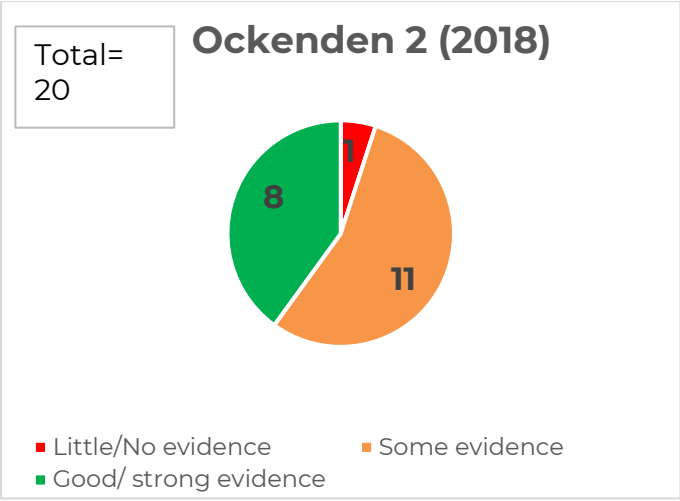
When the review team completed a thematic analysis across the reports, there were a total of 66 recommendations (there are fewer recommendations in the thematic analysis as common recommendations across the reports were amalgamated). 36 recommendations were rated amber (54%), 24 were rated green (36%) and 6 were rated red (9%).

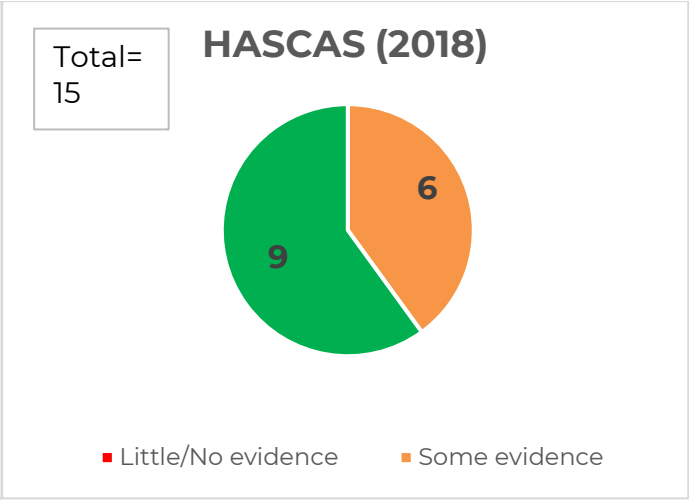
Looking at the separate recommendations across each report; 41 were rated amber (49%), 37 rated green (44%) and 6 were rated red (7%). Breaking this down by report:

- 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.









Conclusion

The review team met very many highly committed and motivated staff during the review and recognise that progress has been made in many areas. .

Areas for further development

- Patient and carer coworking required further development
- There were too many interim posts which led to instability and an inability to provide assurance that recommendations had been fully embedded.
- The management structures did not allow for adequate representation of all disciplines
- The needs of older adults were not adequately represented in the management structures
- The lack of access to electronic records was a particular concern.

The review team tried to be as comprehensive as possible within the short time-scale they had but there are likely to be other pieces of evidence that the review team did not see. It is therefore important that the themes and recommendations set out in this report are read in conjunction with information from other sources and other bodies. The review team have now completed the review and hope that the BCU health board and the Welsh Government will find it helpful in helping to prioritise areas for action and improving safety and quality of mental health services. The review team are happy to take questions of clarification about the report which should be fed back through the representatives of BCU health board and Welsh Government.

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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

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Appendix A: Invited Review Service Team

Appendix B: Feedback on implementation, by service-delivery domains.

1. Introduction

Mental health services in Betsi Cadwaladr University Health Board (BCUHB) have been subject to a series of external reviews and reports over the past ten years. The health board itself has undertaken pieces of work to examine that action has been taken in relation to some of these reports.

On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the intervention status of Betsi Cadwaladr University Health Board to special measures with immediate effect.

This decision reflected serious and outstanding concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership, and financial management.

Mental health services in the health board had been in Targeted Intervention since the de-escalation from special measures in 2020, and alongside the rest of the organisation form part of the current special measures intervention.

In order to understand what progress the health board has made in discharging its actions from historic reviews and reports, the Welsh Government commissioned an independent, external assessment to review the extent to which recommendations from previous reports have been implemented and the extent to which these have been maintained and consistently integrated into 'business as usual' practices.

The Royal College of Psychiatrists' Invited Review Service (IRS), supported by the Royal College of Nursing Wales, was commissioned by the Welsh Government to provide this external assessment.

The scope of the review was to cover the recommendations made in the following reports:

- **Ockenden 1 (2014**): bcuhb.nhs.wales/news/updates-and-developments/updates/archived-updates/tawel-fan/tawel-fan/donna-ockeden-report-september-2014/
- **Ockenden 2 (2018):** Donna_Ockenden_Full_Report_2018.pdf (donnaockenden.com)
- **HASCAS (2018):** Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report (nhs.wales)
- **Holden (2013):** bcuhb.nhs.wales/about-us/governance-and-assurance/publication-of-the-holden-report/robin-holden-final-report-revised-redactions-applied-v1-0/

Whilst the main focus of this review is limited to the reports listed above, the review team also considered any other major reviews or incidents relating to mental health services in the two years prior to this review, if relevant to any of the recommendations, by way of context.

The aim of this review is to provide an independent assessment of:

- how recommendations made by these reviews into mental health services in BCUHB have been implemented by the Board; and
- the extent to which recommendations made by the previous reviews into mental health services in BCUHB have been embedded in the delivery of services.

The review would **not** consider whether the recommendations contained within the relevant reports were the optimal course of action to deliver improvements, either at the time of each relevant report or now.

The review was undertaken by a multi-disciplinary team of clinicians with lay representation, who were supported by the IRS team at the Royal College of Psychiatrists (see Appendix A).

2. Methodology

2.1 Multiple methods

Multiple methods were used for the review:

1) A review of key documents and the recommendations relating to each of the four reports.
   - Ockenden 1-(2014) - containing 30 recommendations (including subsections)
   - Ockenden 2 –(2018) - containing 20 recommendations (including subsections)
   - HASCAS (2018) - containing 15 recommendations
   - Holden (2013) - containing 19 recommendations

2) A review of all relevant documentation sent to the IRS by BCUHB (summarised in section 5).
3) Structured online interviews with key stakeholders (BCUHB staff, patients, and carers, external bodies) to understand the extent to which the recommendations from the four reports have been implemented and embedded (see section 5).
4) Site visits to several units and services, across the health board, during which reviewers would interview staff, patients, carers, and families (see section 5)
5) Regular progress updates to Welsh Government.

2.2 Rating of BCUHB response

The lead reviewer Dr Gerry Lynch, reviewed and summarised the documentary evidence, interview notes and notes from site visits for each of the 84 recommendations.

A traffic light system was used by the lead reviewer to rate the strength of evidence available to the review team demonstrating implementation of each recommendation and the extent to which it had been embedded in practice:

Green: good/strong evidence for implementation and embedding of recommendation

Amber: some/moderate evidence for implementation and embedding of recommendation

Red: little/no evidence for implementation and embedding of recommendation

Next, each member of the review team independently reviewed the evidence summaries and rated the BCUHB response to each recommendation.

The review team then held a consensus meeting to review and agree on the ratings and comment on BCUHB progress against the recommendations .These comments were agreed and have been incorporated into the results section.

The results section provides an assessment of the degree to which recommendations from each of the four reviews have been actioned and embedded by the health board, for the purpose of providing independent assurance to the Board, ministers, and others.

2.3 Presentation of results

The results are presented in two different formats:
In section 4.2, we present a table in which we rate the evidence against all 84 separate recommendations from the four reviews.

In Appendix B, we present a table in which we have grouped the recommendations and our findings across all four reviews by service-delivery domain and give an overview of progress according to these domains.
Given that the reports cover a long time period and there is a degree of duplication, we considered that such a 'thematic' approach may be beneficial to the Commissioners of the report and the health board in deciding on priorities and where best to concentrate efforts and resources for optimum service improvement going forward.

2.4 Review timeline

Month (2023)	Activity
May	Review is commissioned by Welsh Government.
June	Review team is recruited, and terms of reference (TOR) are agreed.
July	Evidence bank aligned to each of the four reports from BCUHB is received.
August	Documentary review commences.
September	25th and 26th September- two days of online interviews with BCUHB staff, and members of the ambulance services.
October	• 2nd and 3rd October, two days of online interviews with BCUHB staff, Caniad patient group, and members of the police service. • 19th and 20th October first site visits: members of the review team visit the Hergest unit, Bangor and several units within Cefni Hospital, Llangefni and Bryn y Neuadd Hospital, Llanfairfechan. • Summarising of documentary evidence.
November	• 14th and 15th November, second site visits: members of the review team visit the Heddfan unit, Wrexham and Ablett Inpatient Unit, Bodelwyddan and several units within Coed Celyn Rehabilitation Unit, Wrexham. • 29th November review team meet to collate Red, Amber, Green (RAG) ratings.
December	• Report compilation. • 22nd December draft report submitted to Welsh Government

3. Evidence sources and reference documents

The review required an assessment against 84 recommendations from four reports produced over a period of five years. The health board delivers a range of mental health services across six local authority areas in north Wales. In order to undertake the review, the review team used information from the following sources:

- Over 370 documents were provided by BCUHB as part of evidence banks aligned to each of the 84 recommendations across the four reports.
- The briefing documents provided by BCUHB also included general documentation aligned to each of the report's findings, and additional documentation was provided upon request.
- Approximately 60 people (BCUHB staff, patients and members of the ambulance and police service) were interviewed over four days of online interviews from 25th September to 3rdOctober.
- "Drop-in sessions" were organised for each of the four site visit days to allow for staff, patients, carers, and families to share their experiences with the review team in confidence.
- 6 sites including a medium secure unit, dementia unit, Learning Disability (LD) assessment and treatment and rehabilitation unit were visited across Bangor, Llangefni and Llanfairfechan.
- 5 sites including acute units, rehabilitation, and a helpline centre were visited across Wrexham and Bodelwyddan.

4. Summary of overarching themes

In this section we outline the main themes based on our findings following the evidence-gathering process described above. We would also like to point out that, whilst we attempted to provide as comprehensive review as possible given the time available, the review should not stand alone and should be seen as part of a suite of evidence to be used to continue to improve standards. We hope that the presentation of the evidence grouped into themes in this section and in appendix B will be helpful to the health board in setting priorities for service development and quality improvement.

The review team was concerned about a lack of investment in infrastructure with a clear need to provide an electronic record system and to improve the quality of the estate in which patients receive care. We think that the lack of an electronic record system in a Board that has many units scattered over a very large geographical area with multiple clinical teams leads to a significant governance risk in terms of information sharing and access to up to date and contemporaneous clinical records. Related to this is what appears to be a GDPR breach in the manner in which on call medical staff have to access medical records in the regional secure unit.

It was noted that the business case for the new unit in Ablett is progressing but, in the meantime, it is vital that ongoing hazards and risks identified by various external reports are dealt with promptly. We observed that there is a lack of separate admission facilities for older adults with functional mental illness in the western sector, which means that this patient group has to be admitted to a unit a considerable distance from their locality.

We were also concerned about the large number of interim posts. We recognise that there has been a significant reduction in their number, but it is unclear to us why so many posts continue to be filled on an interim basis. Although many staff have been in interim posts for a significant period of time, there remains a degree of uncertainty and instability when these posts continue to be labelled as interim, as well as the bureaucratic inefficiency of this system. It also has a 'knock on' effect on grades below the posts to which the person in the interim post has been seconded.

The team was concerned that the management structure did not allow for adequate representation of clinical expertise in the field of older adults' mental health and, perhaps because of this, the delivery of the dementia strategy has not progressed as much as it should have, with more work needed in the area of dementia training, the appointment of a consultant nurse for dementia within the directorate, and in-reach into care homes. Nor does the management structure fully recognise the contributions of all clinical disciplines, especially clinical psychology and professions allied to medicine.

There is also room for improvement in staff engagement and consultation. One example that concerned us was the change in title for the modern matron to clinical service manager which should not have occurred without consultation with the nursing profession. We were also concerned that staff appeared to have as yet very little input of the most recent change management process.

We observed that coproduction and meaningful involvement of patients and carers in service design and delivery requires further work. Patients and carers to whom we spoke did not think that their voice was adequately listened to and documentation with which we were supplied did not give us good evidence of meaningful patient and carer engagement. Improvement in this area must be a priority for the Health Board.

The mental health strategy discusses the development of various new specialist teams and care pathways but the need to drive up standards in core mental health services, particularly inpatient services, must be given equal priority. We noted that there is no agreed model of clinical care throughout the Health Board. Whilst there may be good clinical rationale for variations in service delivery in different areas of the Health Board, there should be a common set of core standards for clinical care in inpatient services. These standards should include access to psychological, psychosocial, and occupational therapies. Acknowledging the difficulties in recruitment to permanent posts, we were particularly concerned about the lack of multidisciplinary working and consistent consultant psychiatry presence in the Hergest unit in Bangor, allied to a lack of provision of psychological and psychosocial therapies.

We observed that the governance system was comprehensive but complex and we think that there is room for rationalisation and simplification of the system, with more emphasis on outcome rather than process. Even with the current complex system, there is not clear evidence that learning is propagated to all levels of staff and disseminated throughout the Board area. The system appears to be very much a 'top down' approach to governance with an emphasis on reporting and we think that more emphasis should be given to listening to and learning from staff experience and patients' and carers' views.

We were particularly impressed by innovative practice involving the third sector in the regional secure unit, although this was subject to funding from a charitable source, and it was not certain that this will continue. We would also like to congratulate the excellent work done by the learning disability service which was recently recognised by the Nursing Times. We were impressed by the work of the staff well-being hub which appears to provide a valuable service and be much appreciated by staff and hope that this service can continue. Lastly, we congratulate the Board on its commitment to enabling Healthcare Assistants (HCAs) to train as nurses, a route which is no longer available in England.

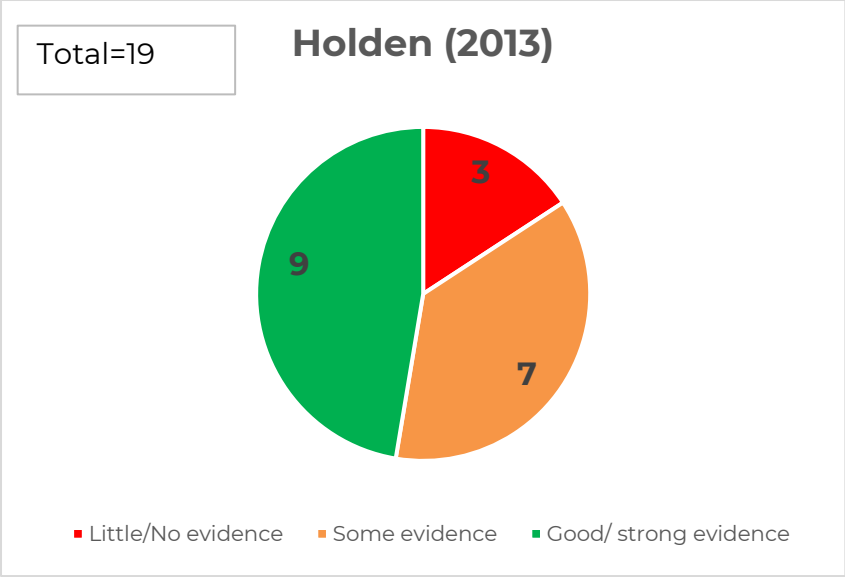
5. Results

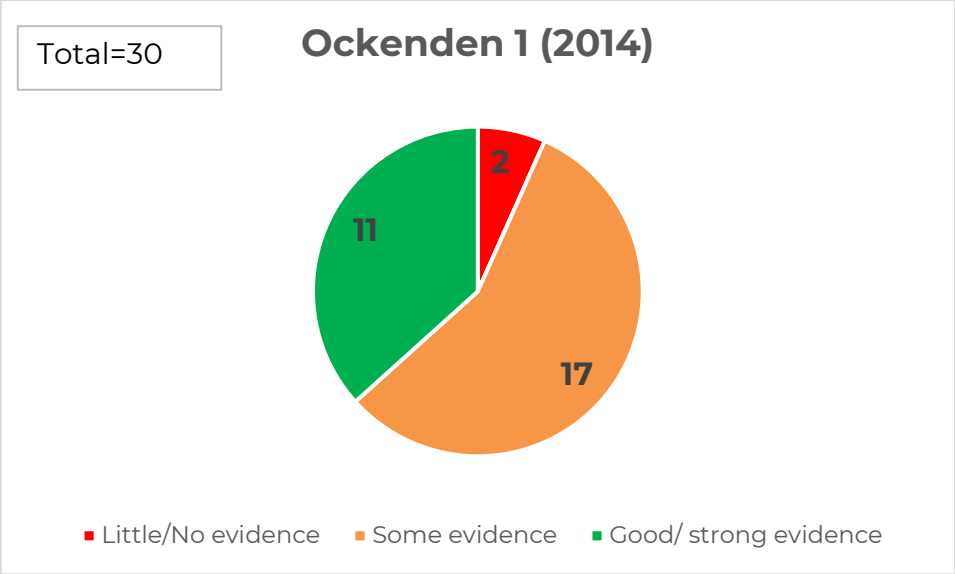
In section 4.1, pie charts summarise the review team's ratings of the strength of evidence demonstrating implementation of recommendations from each of the four reports and the extent to which those recommendations have been embedded in practice. This gives an overview of BCUHB's response to the external reviews and recommendations.

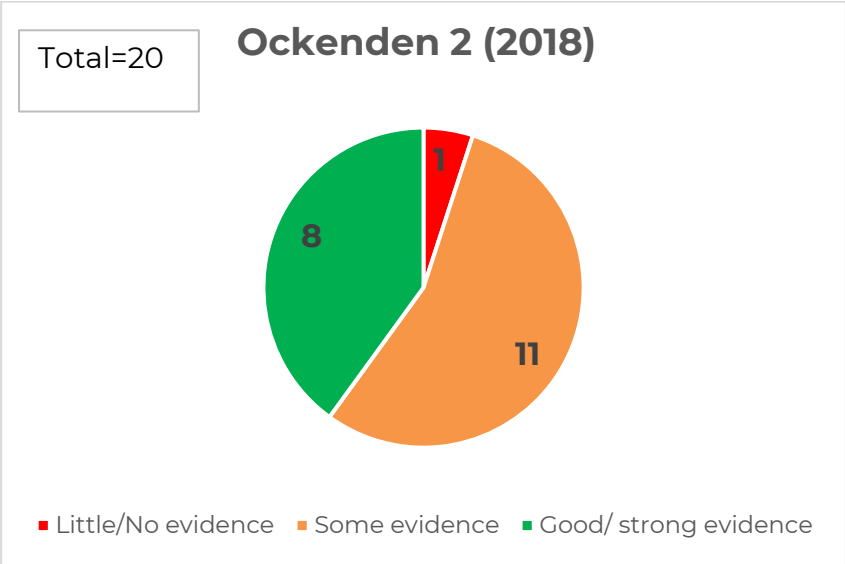
Section 4.2 presents ratings for BCUHB's response to individual recommendations and provides information about the evidence reviewed and the review team findings in relation to each recommendation.

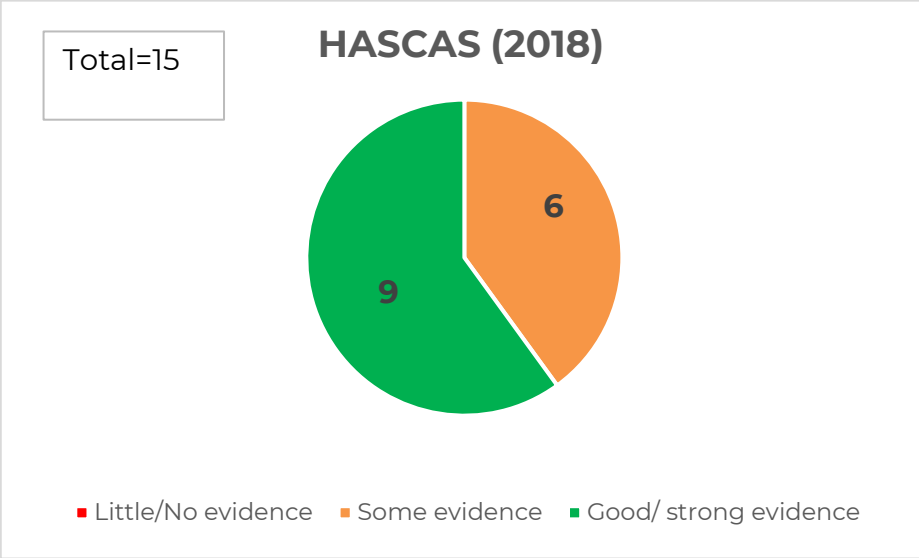
In Appendix B, recommendations are grouped by service-delivery domain.

5.1 Overview of BCUHB response to external reviews and recommendations.









The charts show that there was good/strong evidence for implementation in relation to 37 out of 84 (44%) recommendations in the four external reports. There was some evidence for implementation in relation to nearly half (41; 49%) of the recommendations and little or no evidence for 6 (7%) recommendations.

Of the 19 recommendations in Holden (2013), 16 (84%) are rated as having either some or good evidence for implementation.

There was some or good evidence for implementation in relation to 28 of 30 (93%) recommendations in Ockenden 1 and 19 of the 20 (95%) recommendations in Ockenden 2.

All recommendations in HASCAS (2018) were rated as having some or good evidence for implementation.

5.2 Rating of BCUHB response to each recommendation

Key : Strength of evidence demonstrating the implementation of the recommendation and extent to which it has been embedded in practice.

Good/strong evidence	***Some evidence***	***Little/no evidence***
Green	**Amber**	**Red**

Ockenden 1

Rec no.	Recommendation	Evidence reviewed (BCUHB provided documentation, and briefing documents aligned to each review report).	Domain No.	Review team findings from interviews and site visits.	Agreed rating
1	*Tawel Fan ward should not be considered for re-opening until the final report from this investigation is received alongside a detailed review and understanding of any lessons to be learnt from the currently ongoing Tawel Fan mortality review.*	**Provided documentation:** • Board paper document dated 14/07/2015 **BCUHB briefing document:** Tawel Fan ward has not reopened since its closure in December 2013.	**3**	At the time of writing this report the review team has not had the opportunity to meet the Tawel Fan families.	**Green**
2	*Any new ward or department that may be opened in or around the area that is the currently closed Tawel Fan ward should adopt/ be given a new name.*	**Provided documentation:** • Tawel Fan Response Team (Aligned to 2014) Terms of reference document. • Corporate Tawel Fan Internal Group – meeting minutes examples 2016, 2017, 2018. • Mental Health & Learning Disabilities (MH&LD) Tawel Fan Review Group – meeting minutes example: • Tawel Fan Oversight Panel – meeting agenda example	**3**	See review team finding for recommendation 1.	**Green**

		BCUHB briefing document: "No other ward or department in or around the area of the closed Tawel Fan ward has adopted the same name. Work is undergoing as part of the Ablett Redevelopment Programme for the development and establishment of a new Adult and Older Person's Mental Health (OPMH) Unit on the Ysbyty Glan Clwyd site. This new unit will replace the current Ablett Unit on the acute Hospital site and the OPMH Unit at Bryn Hesketh, Colwyn Bay. Again, there is no reference of the 'Tawel Fan' name incorporated within any future developments or plans." The outline business case was approved by Welsh Government in October 2022, setting the aim to improve the quality of mental health care and services to adults and older people in North Wales. The vision is for the unit to include a 14 bed older person's mental health ward and 13-bed dementia care assessment unit. Incorporated within the plans is also two 16-bed adult wards and an assessment suite to enable timely transfer of patients from the Emergency Department." An announcement in October 2022 noted that subject to further approval, construction is expected to commence during the summer of 2024 with the first patients being accepted two years later, in summer 2026.			
3	*There should be a clear set of measurable standards set for the care of frail older people with dementia across BCUHB. There are excellent examples of practice seen elsewhere across Wales and the wider UK including London and Brighton. However, from the evidence seen to date Tawel Fan ward and the CPG it was part of, somehow became disconnected from this programme of renewal and change. Whilst many documents and action plans were churned*	**BCUHB briefing document:** A full update on progress made to strengthen standards of care and service provision for older people with dementia across BCUHB is noted under recommendation one of the 2018 Ockenden Report." There are five task and finish groups of which feed into the Regional Dementia Operational Group: **Group 1** – Community Engagement	**6**	There has been service redesign with the development of a comprehensive memory assessment service, primary and secondary care dementia teams, older adults' mental health care teams and an older adult's service within the liaison and home treatment teams. The inpatient wards for patients with dementia provide a comprehensive service for those with comorbid illness	**Green**

	out on a regular basis little (if anything) materialised from the vast amount of paper produced that made any difference to the patients and their families cared for in Tawel Fan.	**Group 2** – Memory Assessment Service (MAS) and Dementia Connector **Group 3** – Workforce Development **Group 4** – Hospital Charter and Inpatients **Group 5** – Measurement Group All groups include representation from partners across North Wales, to include carers and patients. All current and future dementia work will be channelled through these structures and a single BCUHB Dementia Improvement Plan is in development of which will capture specific actions aligned to MH&LD.		and behavioural and psychological symptoms of dementia that require inpatient treatment. Deprivation of liberty and safeguarding issues are adequately addressed. The memory assessment service was described to reviewers as providing both pre diagnostic and post diagnostic support. Further work needs to be done in providing education and training in dementia, in reach into care homes and involvement of patients and carers in service development. Some stand-alone units struggle to consistently implement the standards and require further support	
4.	*The Board should consider a full public apology to the patients and families who were admitted to Tawel Fan ward once this final report is received.*	**<u>BCUHB Briefing document:</u>** A report submitted to the BCUHB Board in July 2015 noted that a full apology was being made to the patients and their families by the Health Board.	**n/a**	See BCUHB evidence provided.	**Green**
5	*The Board should consider how they will engage with the remaining families.*	**<u>Provided documentation:</u>** • See documentation for recommendation 2 and Stakeholder Group ToR and report to BCUHB Board in March 2021 **<u>BCUHB briefing document</u>** A single point of contact was made within the health board to coordinate and support family engagement. Additional support was provided by the Tawel Fan Response Team during the period of internal investigations, to include a team of nurse counsellors. To the present day, the Division are actively working to incorporate the voice of patients, carers, and families in developmental and improvement work. This is channelled through the divisional Patient and Carer Experience (PCE) Group."		The review team note the engagement described in the briefing document. It is vital that the importance of engaging with families/carers when untoward events occur is fully recognised by the Board.	**Green**

6	*Or patients/ relatives who have not yet been given an opportunity to share their experience of Tawel Fan ward.*	See review team findings for recommendation 5	**n/a**	See review team findings for recommendation 1	**Green**
7	*There should be a complete overhaul of the concerns/complaints/serious incident reporting structure and an overhaul of the system of learning from these issues.*	**Provided documentation:** • Divisional Putting Things Right (PTR) reports April & May 2023 • Divisional PTR meeting minutes May 2023 • Quality & Safety Learning event May 2023 (under recommendation 17) **BCUHB briefing document** A report to BCUHB Board in July 2015 noted the recruitment of a Governance Lead within the Division to support improved governance systems and processes. Additionally, two task and finish groups reporting into the Mental Health Improvement Group were responsible for reviewing the management of complaints and serious incidents with the aim of facilitating timely and effective investigations, and appropriate dissemination of lessons learnt. Training was also provided to staff aligned to Serious Incident reporting. Reference is made within several sections of the 2018 Ockenden report to the progress made to strengthen the concerns/complaints/serious incident reporting both in BCUHB and the MH&LD Division. This includes the Putting Things Right (PTR) process, initially introduced in 2011 which formed the legislation and systems, structures and processes underpinning the concerns process in Wales. Please see recommendation 7 of the Ockenden 2018 for full update aligned to this recommendation.	**3**	There is in place a comprehensive governance system with extensive use of the PTR system at unit and divisional level. Staff interviewed, described their experience of two recent serious incidents (SIs), which were systematically investigated. Staff participated in the SI process and felt supported throughout. There was learning from the SIs which was implemented. However, concern was expressed that learning from PTR meetings did not always reach staff working 'on the ground' and one patient expressed dissatisfaction with how a complaint they had raised was addressed. In addition, there was frustration expressed by staff about the number of meetings in which there was duplication and repetition, both of information expected to be supplied by staff and of learning lessons. Recognising that learning can occur from areas not in the particular clinical responsibility, some staff expressed the view that they had to attend Safety and PTR meetings that had no relevance to their clinical area. There were also some concerns expressed that staff at band 6 level and below did not have the opportunity to attend the relevant meetings and share in the learning. It was also unclear if the learning was shared across the whole Health Board area.	**Amber**

8	*The Board should ensure that there is a fully operational 24/7 access to services such as diagnostics, medical cover and pharmacy across elderly mental health care in North Wales*	**Provided documentation:** • Example of junior doctor on call rota • June 2023- Highlight report OPMH clinical pathway group • June 2023- Highlight report; inreach support worker into 4 care homes in the Wrexham area (RAG rating red for recruitment as of Jan 23. **BCUHB briefing document** Every patient receiving care and treatment on an OPMH ward in North Wales has medical cover allocated, either by agency locums or substantive consultants. There is also cover from trainees in the units and a rota is produced regularly. A new on-call system was put in place from January 2014 working at 3 levels. Tier 1 is made up of the liaison nurse led service, Tier 2 is made up of junior doctors and Tier 3 is made up of consultants. Pharmacy on-call provision is 24/7 across the Health Board. It is noted in a reporting paper in July 2015 that clinical referral pathways were being reviewed to support timely access to diagnostic/therapies.	**9**	Although there is a shortage of substantive medical staff, access to medical cover out of hours was satisfactory. In the stand-alone units, if there were to be a delay in accessing medical assessment out of hours, there were clear protocols for nursing staff to access appropriate level of medical input. No concerns were expressed about access to diagnostics or pharmacy from the staff that we interviewed.	**Green**
9	*Immediate work should start on a Ward to Board communication strategy across all CPGs. This should include easy access to an NHS Wales email account since a significant number of staff interviewed do not have this facility.*	**Provided documentation:** • Nov 2022- Comms & Engagement Workstream Plan • HASCAS & Ockenden recommendations highlight report July 2019. • North Wales Together For Mental Health (NWT4MH) Communications and Engagement Plan • MH&LD Operating Model Communication and Engagement Plan, V0.9 • July 19- Description of Pioneer training programme specifically designed to improve and sustain staff engagement. • 2018 staff survey showed significant improvement in levels of staff engagement from 2014, but still behind Welsh average	**5**	Staff interviewed, expressed the view that there had been improvements in access to and communication with senior leaders and managers. Initiatives such as 'you said, we did' were welcomed and in most areas, staff were aware of their leadership team who were in general visible. However, this was not consistent throughout the Health Board and was a particular issue in the more isolated units. There were also concerns about potential changes to management structures that had not been communicated to staff.	**Amber**

		BCUHB briefing document: An update provided in a Board report in June 2015, noted a review of IT access was being undertaken across the Division, to ensure easy access to NHS Wales emails which is compliant with the Health Boards' Information Governance policies. The update also noted that corporate teams and Divisional senior managers have been undertaking walkabouts across inpatient units Currently, the Division is developing a MH&LD Communication and Engagement Strategy, which will be based on the North Wales Together for Mental Health Communication and Engagement Plan and also the draft MH&LD Operating Model Communication and Engagement Plan Other Divisional activity which will form part of an MH&LD Communication and Engagement strategy is the Wellness, Work and Us (WW&U) Surveys. An initial survey was undertaken in May 2020 mainly aligned to the impacts of the Covid19 Pandemic, and a further Reflect and Learn Survey was undertaken in November 2021. With both surveys a "You said, We did, We are going to do" was shared with the staff at various meeting forums and also included within the monthly MH&LD Staff Briefings.			
10	*Where they exist 'shared log in' for IT services must be stopped.*	No documentary evidence was provided by BCUHB aligned to this recommendation. **BCUHB briefing document:** An update to BCUHB Board by the Tawel Fan Response Team in July 2015 noted that corporate and divisional teams were progressing through Information Governance systems to ensure discontinuation of any "shared log in" for IT services. Awaiting confirmation information governance to confirm this has happened, and to request evidence of action taken and current position. '. No further evidence was supplied to the review team.	**n/a**	The review team noted a potentially serious GDPR breach with regards to out of hours medical cover in the regional secure unit, where on call medical staff have to use another person's log in detail to access and write entries into the medical notes. There appears to be a 'work around' for agency nursing and healthcare assistant staff but this does not apply to on call medical staff. This points to a wider governance issue in terms of lack of electronic medical records.	**Red**

11	*There should be an immediate review of the scale of all operational, clinical, and managerial roles across the CPG with a realistic assessment of the ability of the current individuals in post to perform in their roles.*	**Provided documentation:** • MH&LD Divisional Structure, • BCUHB Operating Model • MH&LD Proposed Operating Model **BCUHB briefing document:** The MH&LD Operating Model describes the Division which will be led by an accountable Director who will be a clinician, who reports directly to the Executive Director of Public Health. They will work with their senior team to provide leadership, focussing on health and well-being outcomes, aligning the vision, cultural tone and being accountable for all aspects of delivery. They will be supported by a Director Team and wider Divisional Senior Leadership team, comprising of: • MH&LD Lead Doctor – Medical Director • MH&LD Lead Nurse – Director of Nursing • MH&LD Lead Manager – Director of Operations • MH&LD Director of Psychology – Professional Lead for Psychologists. • MH&LD Director of Therapies – Professional Lead of Therapies. • MH&LD Director of Pharmacy & Medicine Mana– Prof Lead Pharmacy • MH&LD Head of Workforce • MH&LD Chief Finance Officer • MH&LD Head of Governance The Divisional Senior Leadership Team will include a Director of Psychology, a Director of Therapies, and a Lead Pharmacist. Discussions are currently being progressed pertaining to how these roles will evolve, including line management structures. In addition, a triumvirate model was established for each area, East, Centre and West and also for Regional Speciality Services. These new roles consisted of Heads of Operations and Service Delivery, Heads of Nursing and Clinical Directors, to strengthen clinical and managerial leadership including	**3 & 5**	Although at one level, there is a clinically led and clear and accountable management structure, the large number of posts that are held on an interim basis for a prolonged period of time leads to uncertainty for staff and difficulty in forward planning. The considerable number of posts held on an interim basis has a knock-on effect at all levels with multiple staff in temporary roles. In addition, the review team did not see evidence that there was full representation of all disciplines in the management structure, particularly in the case of clinical psychology and allied health professionals. The review team did not think that older adults' mental health services were adequately represented at a senior level in the management structure. The title of modern matron has been replaced with that of clinical service manager without any clear rationale or consultation. A new organisational model is in the process of being developed but staff the review team spoke to described they had not yet been consulted and it is not clear what process is being followed.	**Red**

		increasing visibility and accessibility of the leadership team.			
12	*There should be a clearly articulated message from the Executive Directors that all clinical leaders (medical and nursing) should spend a defined portion of their working week within the clinical area alongside and listening to patient and relative feedback. Evidence should be provided at monthly performance reviews with the executive team that CPG leaders have made changes in practice/care/operational service delivery as a direct result of this time within the clinical areas.*	**Provided documentation:** • PCE minutes and Agenda- August 2023 • PCE ward accreditation update. • Patient and Carer Experience Team. Patient Advice and Liaison Service (PALS) **BCUHB briefing document:** Patient feedback continues to be sought in a variety of forums and methods including PALS, Caniad and CIVICA. There is a monthly MH&LD Patient and Carer Group meeting held. In addition, each local area performance report includes compliments from patients, families and carers, any patient complaints are reported through the PTR governance process. A Board report from 2015 noted the Mental Health Improvement group have a number of task and finish groups reviewing both professionalism, supervision and time spent on the front line with staff on inpatient wards and community teams. Quality assurance visits are being undertaken by Executive Directors and senior managers in addition to the dignity inspections which have included the 4 themes arising from the "Trusted to Care" report in 2014.	**1 & 8**	PALS provides a regular method of accessing patient feedback. The review team note that PALS dealt with 5 cases from January to July 2023. However, attempts to provide real time feedback have not so far been successful. The most recent monthly meeting of the patient and carer experience (PCE) group was not quorate. Patients have expressed frustration that Caniad meetings are often more of a vehicle for informing patients about services rather than listening to the experience of patients and carers. Overall, there was not strong evidence of coproduction or meaningful patient involvement.	**Amber**

13	*The BCUHB should implement an extensive and intensive skills and knowledge package around care of patients with dementia and support of their families.*	**Provided documentation:** • Dementia training programme- informed/skilled/influencer levels – evidence summary September 2022. **BCUHB briefing document:** The update reported to the BCUHB Board in July 2015 notes the progress made by the Older People Mental Health (OPMH) development team at that time. This included the promotion of compassionate care, the development of services, dementia mapping and service improvement. Additional staff development initiatives included "compassionate training" and 'Care to Talk' training. A further update on training and development within Dementia services in the present day is noted under recommendation 13 and 14 of the Ockenden 2018 report. However, it is important to note the continued risk identified in relation to dementia education and training. This is being escalated by the Dementia Nurse Consultant via the Regional Governance Framework.	**7**	Whilst there has been significant progress made with the development of dementia care pathways, the failure to appoint to the consultant nurse post within the directorate has had an impact on its ability to provide the skills and knowledge package necessary. Proposals for practise educators are in train, but it is not clear if these posts have been appointed as yet. Progress has been disappointingly slow considering that this recommendation dates from 2014. More work needs to be done particularly in the area of support to stand alone units and more engagement with families and carers. The health board's support of healthcare assistants (HCAs) to train as nurses through secondments is positive and to be welcomed.	**Amber**
14	*There should be an overarching review of all estates providing care of the elderly to assess its fitness to provide care.*	**Provided documentation:** • Ockenden HASCAS Improvement Group Estates Highlight Report. • Feb 2019- MD directorate group established. Funding of £200K allocated to address repairs and commence assessment of Safe Healing Environment procurement • Feb 19-Highlight report from Director of Estates **BCUHB briefing document**: Further, and more recent, developments and on-going work aligned to estates is noted under recommendation 11 of the Ockenden 2018 report.	**10**	Efforts have been made to avoid nursing elderly patients together with younger adults. However, this means that older adults with functional illness from the western sector have to be admitted to a unit a considerable distance away. Large parts of the Hergest unit are used by various community services and it is unclear to the review team if this is the best use of space. The business case for replacement of the Ablett unit is in progress.	**Amber**

15	*The Board should consider the multiple very serious breaches of the Nursing Midwifery Council Standards of conduct, performance, and ethics for nurses (NMC 2010) and Good Medical Practice (GMC 2013) and take appropriate steps with the two regulatory bodies to safeguard the best interests of patients utilising elderly mental health services across the catchment area of the BCUHB.*	**Provided documentation:** • Executive Corporate Safeguarding Annual Report 2021-2022 • Corporate Safeguarding People at Risk of Harm Report Q1&2 2022-2023 • Safeguarding Maturity Matrix Improvement Plan 2021-2022 • ToR Safeguarding Governance & Performance Group • MH&LD Safeguarding Forum minutes example April 2023 • Redacted Ward Dementia Care mapping report. • Person Specification Regional Safeguarding Specialist for Adults and Adults with Dementia • Safeguarding Weekly Activity report example June 2023 **BCUHB briefing document:** The Safeguarding Performance and Governance (SGPG) Group monitor, critique and challenge findings, outcomes and evidence relating to both risk and the reduction of risk and harm. We ensure findings from HIW, Ombudsman, Coroner, Complaints, and Incidents are triangulated; acted upon and learning reviewed. Evaluate the effectiveness of Quality Assurance Reports against the Governance & Performance Reporting Framework. To ensure the effectiveness of all working groups with accountability to the Safeguarding Governance & Performance Group including the production of relevant minutes, action plans, reports, and audit. To ensure the organisation complies with safe recruitment and monitoring arrangements following DBS & ISA, GMC, NMC and other regulatory monitoring guidance. To monitor and support the organisations implementation of recommendations from BCUHB / Regional / Multi Agency and National reviews.	**7**	There is a comprehensive safeguarding and governance framework. There are clear lines of accountability and clinical and professional supervision for clinical staff. There does not appear to be a timely response to reports from external organisations such as HIW and NCCU. Some clinical areas are very isolated so it's unclear how standards are maintained when senior clinical roles (e.g. Director of Nursing) are vacant. The review team have been provided with a report that shows a high degree of compliance with medical appraisal. The review team are unaware of any GMC or NMC referrals and the process for monitoring them.	**Amber**

16	*The Board should consider very seriously the unacceptably low standards of leadership and management exhibited and seen within the CPG during this external review and the events leading up to it. These unacceptably low standards were found within all medical and nursing leadership roles from the top of the CPG to ward manager level. The families whose relatives have suffered great harm and distress will require assurance from the Health Board that such levels of performance are regarded as unacceptable within the NHS in Wales. They will also require assurance that appropriate action will be taken in a timely manner.*	**Provided documentation:** • May 2022- Targeted Interventions self-assessment. • Report from Good Governance Institute; Adult mental health provided evidence to a high standard; rated as 2 in the maturity matrix **BCUHB briefing document:** A Board report noted that an Interim Senior Director has been in place since September 2015 with additional senior support from January 2015. The substantive role of Director of Mental Health Services has been introduced and advertised. A review of managerial and operational structures is now being considered in line with recommendation 11. The substantive MH&LD Director was appointed in May 2016, and in 2017 the Divisional structure replaced the CPG structure.	**n/a**	Report from Good Governance Institute; Adult mental health provided evidence that the health board was rated as 2 in the maturity matrix i.e "Early progress in development." The large number of interim posts is a risk in terms of achieving a high standard of leadership and management. While there has been a reduction in the number of interim posts, they remain unacceptably high, and it is unclear why a more permanent management structure has not been achieved by this time.	**Amber**
17	*The Board should interrogate further and in detail the information from the currently interim Tawel Fan mortality review being undertaken. Whilst it remains interim at the time of submitting this external report it originated from concerns around the potential death rate on/ associated with Tawel Fan as expressed by relatives in interviews. Feedback on the findings once completed therefore should be made public.*	**Provided documentation:** • May 2023 Learning Event agenda • Divisional Training and Development Sub Group Terms of Reference and Operating Arrangements **BCUHB briefing document:** A Board report from 2015 noted a mortality review commissioned by the Executive Medical Director has been completed by a team of Clinical experts. As outlined in the main report and appendices, a number of families have been contacted to outline that the Mortality review has been completed. An offer was provided for Executive Directors to meet with families, to provide their relative specific outcomes. Of those written to, a number requested a meeting with the Executive Director of Nursing and Midwifery and Medical Director. An ongoing Mortality Task and Finish Group commenced in July 2015 within the Division, in line with the Health Board's Mortality objectives. The Divisional Integrated Governance Report will monitor themes and trends from the ongoing process. In relation to the feedback on findings, a	**3**	The review team note the written response provided by the Health Board. However, the review team did not see evidence that there was full consideration given to all potential risks, for example those detected by the helpline in terms of public health approaches to suicide risk.	**Amber**

		"Lessons Learned" Memorandum was shared bi – monthly across the Division at assurance meetings. There is a bi monthly MH&LD Learning from Deaths Group did you see notes from this? that meet to undertake Stage 2 mortality reviews. This Group focuses on the learning and themes identified through the process of mortality review, a chairs assurance report from this group is presented to the MH&LD Quality Delivery Group. In addition to this, the Chair of the MH&LD Learning from Deaths Group attends an organisational-wide learning from mortality group where learning is shared across the organisation. There is a quarterly MH&LD Divisional report presented to the MH&LD Quality Delivery Group that combines the learning from deaths that are reviewed through mortality and serious incident reviews to ensure that themes from different types of review are identified.			
18	*The Board needs to assess (whilst the above mortality review is ongoing) whether other similar reviews may have taken place in the past. There needs to be an urgent review of the DATIX system undertaken to assess whether potential 'clues' to a possibly longer-term problem around the number of deaths within/ associated with Tawel Fan ward have been 'missed'.*	**Provided documentation:** • Local PTR meeting agenda and minute examples. **BCUHB briefing document:** The Mental Health Improvement Group is overseeing two task and finish groups (identified in Recommendation 7) who will review the triangulation of data from Datix and other sources and ensure that the Division are provided with specific actions to ensure that there is an opportunity to identify early warning flags of concerns relating to Inpatient services or team related services. There are now Integrated Governance reports to the senior management team providing information to support identifying areas of concern. A "look back" exercise has been commissioned by the Board to ensure that future Governance arrangements will provide timely indications of concern through our systems and processes.	**3**	During visits and interviews, a comprehensive, if complex system of scrutiny of incidents using the PTR process was outlined to the review team. Minutes of PTR meetings were provided against recommendation 7 of the second Ockenden report, and recommendation 6 of the Holden report. However, the lack of electronic records makes it difficult to link and triangulate Datix incidents with other indications of concern. The lack of electronic notes in itself raises governance and risk issues in terms of communication of clinical information and risk in a Health Board that has a large number of units and teams scattered across a very large geographical area.	**Amber**

		Current scrutiny of incidents continues to take place on a daily basis. The MH&LD Quality Governance team review each Datix across the Division to identify issues that require escalation. Moderate to Catastrophic incidents are discussed at a daily Corporate led meeting where consideration is given to early warning notifications to the NCCU and identify if the threshold for Nationally Reportable Incidents has been met. A daily Quality Bulletin is shared with the organisational leadership teams identifying serious incidents requiring national reporting. Locally, the Heads of Nursing and Service Managers review Datix incidents and undertake Make it Safe reviews, dependant on the level of harm, to provide opportunities to identify and implement make it safe actions. The Learning from Deaths activity undertaken by MH&LD provides the forum for identification of themes relating to deaths and this is reported through the MH&LD Quality Delivery Group and the organisational learning from mortality group.			
19	*At the earliest opportunity the Health Board should liaise with the local Coroner and North Wales Police around the findings of the interim mortality review and take their advice as to whether further steps should be taken from each of their individual perspectives.*	No documentary evidence provided **BCUHB briefing document:** Currently the Deputy Director of Quality and Organisational Inquest Manager meet with HM Coroners for North Wales to discuss issues arising across the Health Board. There are strong links that have been developed between MH&LD and the Organisational Inquest Manager through Inquest Board Rounds and collaborative working that has strengthened the Coronial process.	**n/a**	The review team note the comments provided by BCUHB in the briefing document but were unable to establish if this had been fully implemented.	**Amber**
20.	*There should be a review of the training, support, and supervision of junior doctors by consultant colleagues in mental health services for the elderly in North Wales. Feedback from families appears to indicate that where medical care was provided for their relatives it was often provided by inexperienced doctors who did not appear to have had consultant support and supervision whilst providing that care.*	**Provided documentation:** • MH&LD Medics Supervision update from Business Support Manager 2023. **BCUHB briefing document:** "Every trainee doctor has a designated named Consultant Clinical Supervisor. Trainees perform their duties under Consultant supervision. Every trainee	**7**	Trainee doctors interviewed confirmed that all had appropriate levels of supervision. They were not asked to act outside their fields of competency and felt well supported by consultant staff. This was both in and out of hours. They also had regular meetings in which they had peer support and have access	**Green**

		doctor is also allocated a named Educational Supervisor. Overall, the Wales School of Psychiatry have an oversight of training provision of Junior Doctors in psychiatry in Wales including North Wales with regular annual reviews i.e. annual review of competence progression. On a day-to-day basis, trainee doctors seek the support of their named clinical supervisor. In addition to that support, there is a weekly supervision rota run by the Consultant Psychiatrists to offer group supervision. In addition, a session is held every Monday as part of the post-graduate teaching programme. This forum is attended by all grades of psychiatric doctors in North Wales. Whilst performing on-call duties, support to Junior Doctors is provided by the Consultant Psychiatrists on call, Registrars on call and also the Senior Nursing staff on duty."		to appropriate level of educational supervision and opportunities.	
21.	*According to family's medical care/ provision in Tawel Fan ward was largely on an "as and when called" basis rather than in a planned systematic way. Much medical care appears to have been provided by the on-call doctor rather than as a routine and planned approach to medical care. There needs to be an urgent review of medical care/ provision across elderly mental health services in North Wales to ascertain if this is/ was the case and action taken in a timely way to improve upon the standards of medical care for elderly patients using mental health services if the concerns of families are proven.*	**Provided documentation:** • JustR Medical Photography sessions • MH&LD Microsite Medics section • MH&LD Medical Workforce Establishment spreadsheet 2023 **BCUHB briefing document:** 2015- review of consultant capacity carried out Every patient in an OPMH ward has consultant and trainee cover allocated JDs updated and all vacancies out to advert. Workforce requirements tracked by medical management group Sustainable workforce task & finish (T&F) group established Medical workforce priority for Just R marketing campaign	**6**	Despite attempts to recruit, it continues to be difficult to fill substantive posts in old age and adult psychiatry, especially in the western sector. This has an impact on the Board's ability to deliver high quality of care. The review team recognise that the Board has made and continues to make active attempts to recruit to these posts and that there is a national shortage of suitably qualified candidates.	**Amber**

22	*There needs to be clear standards and expectations articulated across North Wales as to the duties of Consultant colleagues. Families have articulated that their role was often unclear and that their involvement when it happened was of secondary importance. There was no evidence of consultant leadership or clinical standard setting in the care of any of the patients that families discussed in depth as part of this external review.*	**Provided documentation:** • MH&LD Consultant & Junior OOH Standard Operating Procedure (SOP) 2022. **BCUHB briefing document:** A new system was put in place from January 2014 working at 3 levels. Tier 1 is made up of the liaison nurse led service, Tier 2 is made up of junior doctors and Tier 3 is made up of consultants . The detail of arrangements is set out in *Appendix 4* which describes the operational robustness and consistency of the arrangements that are now in place. A paper to the BCUHB Board in July 2015 noted the establishment of a Professionalism group to lead on refining and clarifying roles and professional standards of all disciplines, together with alignment against training plans. Furthermore, and as specified in the above recommendation, each patient has an allocated responsible clinician and a named consultant who leads on the care of the individuals. The Job Descriptions of the posts are approved by the Royal College of Psychiatrists, describe specific standards and expectations from a Consultant Psychiatrist.	**n/a**	This standard is in regard to the rules and responsibilities of consultants. As there is no agreed model of clinical care the role of the consultants within the multidisciplinary team (MDT) varies throughout the Health Board. The medical model dominates care delivery and there is a lack of availability of psychological therapies, particularly noticeable in the inpatient unit in the western sector.	**Amber**
23	*There needs to be clarity and expectations set regarding the role of the Pharmacist / Pharmacy services in the care of the elderly patient using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure to ensure the role of the Pharmacist is central to the delivery of elderly mental health care in North Wales. Families report in some cases concerns regarding overmedication of their relatives and what is referred to by some families as a "lucky dip" approach to medicines management. Some colleagues referred to the use of "old fashioned" medications in Tawel Fan ward that had long fallen out of use elsewhere.*	**Provided documentation:** • Resource Business Case • Highlight Report Improvement Group • Guidance on use of Antipsychotic Drugs • Audit of Antipsychotic drug use **BCUHB briefing document:** By July 2015, a process of regular audit of anti-psychotic drugs used with patients living with dementia had been implemented, together with "Trusted to Care" inspections with the Executive Leadership Team. Following publication of the 2018 Ockenden Report, progress aligned to medicines management reported directly into the Ockenden/HASCAS Improvement Group with the BCUHB Chief Pharmacist as the	**6**	There has been enhancement of pharmacy input as is described in the written evidence and staff interviewed describe being able to access pharmacy as required. There is not the resource to provide a proactive service within the totality of the Directorate. The review team saw evidence of audit of antipsychotic prescribing in dementia from 2019 and 2023 which did not give the team the assurance that regular audit in this area has been embedded in practice. The review team also note that the audit only applied to inpatient units, no evidence was provided that audit of	**Amber**

		Operational Lead. The final highlight report to this forum appears to have been in July 2020 (see appendix). A key point within the report was the completion of an audit of antipsychotic prescribing among people with dementia of which had been presented to the Older Persons Mental Health team. This audit can be viewed within the appendix. Further audits of the use of antipsychotics within dementia wards were planned, forming part of the Delirium National Audit. An inpatient audit is currently being carried out to allow for comparison against the results of the 2019 inpatient audit results. BCUHB also participate in Prescribing Observatory for Mental Health (POMH)UK audits as per their occurrence. Note that EMIS web has recently been purchased for electronic prescribing to facilitate ongoing review of people on antipsychotics through database and audit, this is being rolled out imminently but may take time to embed. The guidance for Prescribing Antipsychotics in Dementia was updated in 2019 and is currently in the process of being updated again. Additionally, an e-learning package on antipsychotics was planned to be added to nurse e-learning however this did not progress due to people moving roles. Preliminary discussions have taken place between the Consultant Mental Health Pharmacist and Dementia Nurse Consultant with the view of developing BCUHB-wide training in relation to antipsychotic medication in care homes. Further work is required to progress the development and enrolment of this training. A pharmacy services response to the Six Dementia Priorities from the BCUHB Dementia Strategy 2019 was developed which sets out the resource position and ability to offer the specialist and quality support required for patients with dementia in all care settings (see appendix). A business case for pharmacy staffing specifically aligned to OPMH formed a part of this response. This enabled successful recruitment of Band 7 pharmacists in 2022/23.		antipsychotic medication prescribed in care homes has been carried out. Enhancement of these services is necessary but is dependent of provision of adequate funding.	

		However, this alone is a minimal resource and does not provide the resource required to review people on antipsychotics as per the recommendations. Reviews are provided on an 'as need' basis in some areas but not as standard. The intention is to present the case for the resource gaps in the near future to the OPMH Pathway Group. All of the above has set the expectations and support with increased clarity regarding the role of the Pharmacist/Pharmacy services in the provision of Older Persons Mental Health Services. The MH&LD pharmacy strategy is currently being developed of which highlights the gaps and the resources requirements to inform the ongoing and future improvement plan			
24	*There was limited if any evidence of Speech and Language Team (SALT) assessment, review / involvement in the care of some of the patients who formed part of this external review. This was the case even where relatives asked ward staff for such support on a number of occasions. There needs to be clarity and expectations set regarding the role of speech and language services in the care of the elderly patient using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure (and resources) to ensure the role of the SALT Team is central to the delivery of elderly mental health care in North Wales.*	**Provided documentation:** • BetsiNet Inpatient Acute SALT referral • BetsiNet Community SALT referral **BCUHB briefing document:** As of July 2023, SALT holds an open referral system to their core adult service. People experiencing mental health-related communication and swallowing needs can access the service equitably to those with physical health needs. Guidance aligned to this is shared on the BetsiNet site to support ease the referral process. There is no specialist mental health SALT's integrated into mental health teams across North Wales, with the exception of a small resource in certain areas; HMP Berwyn (prison) and within learning disabilities team.	**9**	Staff interviewed described an ability to access timely speech and language therapy assessment as required.	**Green**
25	*There was limited if any evidence of physiotherapy, occupational therapy and dietetic assessment, review / involvement in the care of some of the patients who formed part of this external review. This was the case even where relatives asked ward staff for such support on a number of occasions. There needs to be clarity and expectations set regarding the role of physiotherapy, occupational therapy, and dietetic assessment, in the care of the elderly patient*	**Provided documentation:** • MH East Physio referral form • MH&LD Dietetics provision benchmarking exercise outcome • HEIW MH&LD Dietetics Review paper 2021 • Situation Background Assessment Recommendations (SBAR) West OPMH Occupational Therapy • OT OPMH Dementia Service Specification July 2023	**n/a**	Whilst there has been some improvement in the ability to access allied health professionals within the mental health directorate, there is not as yet the resource to provide a comprehensive service. There is insufficient evidence that allied health professional expertise is well used or integrated into a multidisciplinary team approach, especially in the Hergest	**Amber**

	using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure (and resources) to ensure the role of these colleagues are central to the delivery of elderly mental health care in North Wales.	• OT OPMH Prevention and Support Service Pathway • OPMH OT Service Evaluation April 2023 **<u>BCUHB briefing document:</u>** The wider group of Allied Health Professionals (AHPs) across North Wales are linked with cluster developments, where the value and need for additional AHP resource to meet our population health needs assessment is escalated. Issues regarding lack of AHP's on dementia wards has also been escalated by the Dementia Nurse Consultant at the Dementia Delivery Transformation Group, with additional resource to be noted within the BCUHB Dementia Improvement Plan Occupational Therapists provide support to patients across the MH&LD services who have been referred by MDT colleagues. There are Occupational Therapy staff providing a service onto both the organic (dementia) and functional (other mental health diagnoses) inpatient wards in the East, staff within the Memory Assessment Service and Older Persons Community Teams in the East and Centre, and now a more consistent offer in the West within these core services. However, it is acknowledged that the current resource establishment is insufficient to meet our patient needs. Within the mental health inpatient unit in the East, the Occupational Therapists have worked hard with MDT colleagues to support cultural shift in improving the occupational opportunities for patients admitted, which can reduce behavioural events, and the need for PRN medication or 1:1 staffing. A therapeutic garden has been created on the dementia ward where Namaste sessions are being held.		unit. It was noted that limited access to physiotherapy in the Ablett unit had implications for nursing staff in terms of having to take on additional roles. Enhancement of these services is necessary but is dependent of provision of adequate funding.	

		The Occupational Therapy team hold engagement and education sessions with ward staff, alongside setting up the use of Activity Logs. Unfortunately lack of dedicated and appropriately supervised activity staff, remains an issue. Occupational Therapy resource within the core community services remain pressured with no additional funding through the MH&LD division. Additional funding has been secured in the East since 2019, through the Integrated Care Fund (ICF) and now Regional Integration Fund (RIF) monies, to provide an AHP Dementia Team, for post diagnostic support, however the resource is limited. Furthermore, in 2022, Occupational Therapy secured WG regional transformational monies to develop an Occupational Prevention and Support Service pan BCUHB, providing 3 posts per area for early intervention when carers, whether families or care homes, start experiencing challenges in supporting people with dementia. **Dietetics** There is currently no funded dietetic service for mental health in the East, meaning that limited dietetic service is provided to the inpatient acute services (0.1 whole time equivalent (WTE) for referrals and patients already on the caseload). It is noted that the current establishment is insufficient in meeting the service demands and patient needs. There are no specialist mental health dieticians providing outpatients services, with the exception of the resource within the Eating Disorder Service. If patients experiencing mental health difficulties are referred with co-existing physical health difficulties, they are triaged following the same process as that of all other referrals. For patients with eating difficulties related to mental health conditions, these patients are be treated by the wider multi-disciplinary team.			

		Referrals for patients with mental health difficulties who are not included in the above cannot be accepted due to the lack of specialist resource, therefore the inability to provide safe and effective care and treatment. In addition to the above, a small dietetics resource (0.2 WTE) had been secured for Dementia services in Wrexham via the Integrated Care Fund and the corresponding resource for Dementia services in Flintshire through the support of community funds. The dietetics resource for adult mental health in the Central area has remained unchanged, with referral continuing on ad-hoc basis in view of minimal staff capacity. The Central area have also benefitted from the investment in Community Eating Disorder Service, however, does not fulfil the resource requirements for mental health services. Note that the above is aligned to the service provision in the East and Central areas of the Health Board. An update on dietetics mental health services in the West area will follow, however, the specialist dietetics resource in West is also recognised as insufficient. This is supported by a benchmarking exercise undertaken pre-pandemic of which highlighted the lack of dietetic service provision for mental health services in North Wales (see appendix). There has since been further investment in pan-BCUHB Eating Disorder Service, however none for MH&LD. **Physiotherapy** Since 2018, the provision of Physiotherapy services to the MH&LD Division has been formalised with a designated 0.3 WTE resource in the East. This resource provides service to in-patient older people and in-patient adult wards with a standardised referral form used (see appendix) for patients who require 1-1 input. A blanket referral typically occurs within Dementia wards, allowing for all patients to receive a level of physiotherapy input.			

		Weekly classes have also been established on the older person's wards to include chair-based exercises and elements of relaxation. Unfortunately, due to service demands, this does not always take place on a weekly basis. Additionally, there is a Dementia-specific physiotherapist working across the Flintshire and Wrexham communities to provide support for patients who are referred following diagnosis. The designated resource for mental health services in the Central area is also minimal; 0.5 WTE. Note that the above is aligned to the service provision in the East of the Health Board. A detailed update on the Physiotherapy provision within the Central and West areas will follow. Specifically in the West area, there has been developments in transitioning the Older Person's Mental Health Occupational Therapy provision from a transformational project to a core inpatient service. This proposal is included within the appendix. Ongoing work and future plans to strengthen the input of Occupational Therapy services along the OPMH pathway include service specification documents for the prevention and support team and the OPMH Community Team. A similar document is under development for the Memory Assessment Service Offer. The Occupational Therapy SLT are eager to continue working collaboratively with the Division to meet national standards, and to continue the roll out of the Home-Based Memory Rehabilitation programme to Occupational Therapists working within OPMH.			
26	*There should be a review of the risk assessment systems in place for elderly patients who are or become violent / aggressive as part of their conditions. Feedback from relatives seems to indicate that there was either limited or no evidence of risk assessment and no consistent*	**<u>Provided documentation:</u>** • Physical Restraint Reporting Guide • MH&LD Risk Management Group agenda • MAPPA training • PICSS training AAA report May 2023 • Welsh Applied Risk Research Network) (WARRN) training	**1 & 2**	There is an extensive training package and an up-to-date policy for the management of aggression and violence in all patients, including older adults. However, the reliance on paper notes and verbal handovers in the absence of	**Amber**

	standards of care/ treatment /practice where these issues/ episodes arose.	• WARRN training compliance update report June 2023. **BCUHB briefing document:** Therapeutic Engagement and Observation Policy. policy implemented in Spring 2015. Revised policy approved and activated in March 2023 with accompanying training package. Aggression management team working in OPMH wards. Positive Interventions Clinical Support Service (PICSS) provides monthly reports- in depth reporting of any restrictive physical intervention.		electronic records mitigates against a comprehensive risk assessment system.	
27	*There should be a review of standards for 1:1 supervision of patients. Feedback from families indicates an inconsistency in the application of 1:1 supervision (i.e. several instances where despite documented evidence of violence/ aggression/ harm to other patients, self or staff expected standards of 1:1 supervision was not applied). There were also instances from family statements where even with the documentation of 1:1 care other patients were injured, which questions the quality/ accuracy of this.*	**Provided documentation:** • MH&LD Therapeutic Engagement and Observation Policy Document May 2023 • MH&LD Therapeutic Engagement and Observation training May 2023 • SBAR Therapeutic observations/Staffing ward audit reporting April 2023 • Therapeutic observations/Staffing weekly ward audit example undated. **BCUHB briefing document:** T.O. policy implemented in Spring 2015. Revised policy approved and activated in March 2023 with accompanying training package	**2**	There is a comprehensive training package to accompany the therapeutic observation policy. Staff interviewed did not describe difficulties in general in accessing extra staff when required in accordance with the agreed procedures, although it could be difficult and time consuming in the stand-alone units to recruit extra staff when necessary. The review team noted that 1:1 observation levels were very high in Learning Disability inpatient services – which could be leading to a lack of opportunity to resource other therapeutic activity.	**Green**
28	*From evidence obtained in relatives interviews it is clear that on Tawel Fan ward there was inconsistent use of risk assessments from falls and no evidence of protective measures (to reduce harm) in patients who may fall despite the fact that the Tawel Fan patient population were a group at high risk of falling. In a number of cases there was poor/ limited/ no evidence of documentation of injuries or information provided to relatives/ reporting using the DATIX system and referral to/ review by*	**Provided documentation:** • MH&LD Inpatient Falls Report • Service Quality Delivery Group (SQDG) agenda example **BCUHB briefing document:** Datix data to be displayed on each ward. Autumn 2016- Strategic falls group set up and new pathway introduced in 2017. Falls bundle introduced Audit carried out July 2017.	**2**	There is evidence of a falls bundle and regular monitoring of falls by the Datix system, leading to discussion at the PTR groups and learning, action as appropriate. it is, however, imperative that standards continue to be driven up in terms of falls prevention, ensuring that there are adequate staffing levels and ongoing training.	**Green**

	medical staff. Whilst there have been reviews of falls in elderly mental health services across the CPG these appear to have taken as their starting point that the number of falls reported were accurate which is unlikely to be the case. There needs to be the early and timely introduction of a sustained campaign of best practice examples in falls reduction/ prevention across elderly mental health care in North Wales.	Reduction target set. Inpatient falls report shared at the monthly Quality & Delivery Group			
29	*In a number of cases relatives reported failure by ward staff to recognise and respond to deterioration in physical condition. This included either a lack of routine ward observations or in some cases over recording of routine ward observations and failure to recognise or prioritise those patients who needed an enhanced level of observation. There was also a failure to monitor appropriately and act upon problems with fluid intake / output. It was accepted seemingly that "Psychiatric nurses were not good at providing physical care" and there was no evidence from the perspective of relatives that there was any medical leadership ensuring that patients physical and medical needs were attended to. The Board needs to ensure that there is early introduction of All Wales systems in "recognition of the deteriorating patient" across elderly mental health services in North Wales.*	**Provided documentation:** • Dementia Practice Educator Deconditioning pilot proposal • NHS Early Warning Score (NEWS) update **BCUHB briefing document** Training provided to enhance the use of physical observation and the use of NEWS. Medical ward rounds on a daily basis Consideration being given to the recruitment of RGNs Physical health lead and physical health implementation steering group established Physical health suite in Heddfan unit is being developed.	**2 & 6**	The policy on meeting the physical healthcare needs of those admitted to mental health wards was due to be reviewed in September of 2022. . The review team did not see evidence of the recruitment of RGNs. Staff noted that there can be delays in timely access to medical opinions in the Heddfan unit (the DGH site is close but is on the other side of a busy road). However, the opening of the physical health suite in May 2023 has improved the unit's ability to diagnose and manage medical conditions however, nursing staff have obtained training in the use of NEWS and are satisfied that medical opinions and assessments can be accessed in a timely manner. The physical health strategy is in the process of being developed but has not as yet been implemented.	**Amber**

30	*Evidence from former colleagues seems to suggest a lack of DVT risk assessment or use of appropriate prophylaxis in Tawel Fan ward. This issue needs to be considered by the Board and acted upon in a timely manner.*	**Provided documentation:** • An Audit on Venous Thromboembolism Risk assessment in Older persons Mental health inpatient unit in North Wales with the aim of a Quality Improvement Project. January 2023. **BCUHB briefing document:** A Board report in 2015 noted the following update that the health board have placed the required risk assessments to identify the risk of Deep Vein Thrombosis (DVT) as a high priority. The Medicines Safety Thermometer & Fundamentals of Care audits review the completion of these risk assessments and the effectiveness of associated prescriptions. This has been extended to OPMH which includes Anticoagulation assessment. The Medical Directors office is leading on whole system review of DVT risk assessment including doctor training and Induction. Currently there is a Physical health lead identified for the division who has established a physical health implementation steering group to look at ways to implement the Physical health strategy.	**2**	The review team have received verbal reassurances that DVT prophylaxis is used appropriately but has not as yet seen the whole system review as described in the statement of evidence. An audit on venous thromboembolism risk assessment in older persons mental health inpatient unit in North Wales was undertaken from Dec 2022 to Jan 2023. The detail that this audit had been undertaken was immediately known to the OPMH clinical lead but not to other managers. The Older Adult mental health services are not adequately represented in the management structures so useful information may be missed when strategic plans are being developed**.**	**Amber**

Ockenden 2

Rec No	Recommendation	Evidence reviewed (BCUHB provided documentation, and briefing documents aligned to each review report).	Domain No.	Review team findings from interviews and site visits	Agreed rating
1.	*The review, redesign, and development of a new service model for older people and those with dementia across the six counties of North Wales requires urgent prioritisation and action by the BCUHB Board and the Mental Health and Learning Disabilities Division as of May 2018. There will be the need for extensive multi-agency working between BCUHB and a range of partners with continuing robust and outcome focused oversight by the BCUHB Board and Welsh Government as this work progresses. Progress on this work should be reported to the BCUHB Board on a quarterly basis, starting from the progress made by the end of quarter 2 of 2018/19, (the end of September 2018).*	**Provided documentation:** • BCUHB Dementia Strategy 2018-2020 • Dementia Action Plan for Wales 2018-22 • Strengthening Provision On Response to COVID-19 • All Wales dementia Care Pathway of Standards 2021 • The Wales Dementia Friendly Hospital Charter • Regional Dementia Governance Framework • ToR's for each of the five task and finish groups • AAA Dementia report May 2023 • AAA Dementia report July 2023 **BCUHB briefing document:** As part of the work of the Ockenden and HASCAS Improvement Group, a 'logic model' approach was taken in the aim of developing an integrated service model for Older People and people living with dementia across North Wales. A report to the BCUHB Quality Safety and Experience committee in July 2019 notes the refinement of a logic model to include a total of 6 main outputs: • An Integrated Service Gap Analysis. • Integrated Community Rehabilitation Team CRT care pathways with joined up mental health, primary and secondary care services. • Clearly defined BCUHB Older Persons care pathways across all services. • North Wales Integrated OPMH Improvement Hub. • An annual audit and reporting schedule for older person's services and those with a diagnosis of Dementia. • A North Wales Integrated Service Model for Older Persons and Dementia.	**6**	There has been service redesign with the development of a comprehensive memory assessment service, primary and secondary care dementia teams, older adults' mental health care teams and an older adults' service within the liaison and home treatment teams. The memory assessment service was described to reviewers as providing both pre-diagnostic and post-diagnostic support. The inpatient wards for patients with dementia provide a comprehensive service for those with comorbid illness and behavioural and psychological symptoms of dementia that require inpatient treatment. According to the evidence provided to the review team, deprivation of liberty and safeguarding issues are adequately addressed. However, older age practice posts for nursing have not been implemented nor has the consultant nurse post for dementia in the directorate been appointed. There is some evidence of inconsistency in that, on the Ablett unit, older adults do not have consistent access to home treatment and liaison teams.	**Green**

		There are 5 task and finish groups which feed into the Regional Dementia Operational Group: **Group 1** – Community Engagement **Group 2** – Memory Assessment Service (MAS) and Dementia Connector **Group 3** – Workforce Development **Group 4** – Hospital Charter and Inpatients **Group 5** – Measurement Group All groups include representation from partners across North Wales, to include carers and patients. However, it is recognised that there is still space for improvement in ensuring sufficient and sustained patient, and wider stakeholder, engagement.		There is limited evidence that service improvements and developments have included the lived experience of those using services. Further work needs to be done in providing education and training in dementia, inreach into care homes and involvement of patients and carers in service development.	
2 (a)	*The financial position of BCUHB is well known to be of significant concern. The Ockenden governance review was informed that 'Quality Impact Assessments' (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB Board) were 'still in the process of refinement' (as of spring 2017.) This therefore is likely to remain an issue that will require evidence of focused Board attention going forward.*	**Provided documentation:** • MH&LD Service Quality Delivery Group agenda examples May and June 2023. **BCUHB briefing document:** A report submitted to BCUHB Board in March 2021 noted that the requirements of this recommendation were fully implemented and considered business as usual, with agreed monitoring arrangements of the audit tracker undertaken by the Audit Committee. There is a MH&LD Service Quality Delivery Group operational within the division which provides monitoring and scrutiny on quality and deliverables. Local finance and performance meetings also take place within each of the areas on a monthly basis. These report into a divisional Finance and Performance meeting. This, in addition to monthly meeting between the finance team and budget holders, provides a forum for reviewing local resources and finances to inform high quality service delivery.	**3**	The review team have been provided with evidence that there is co-ordination of finance/performance and quality/safety concerns at a Divisional level.	**Green**
2 (b)	*There will need to be further urgent and sustained Board attention to full integration of the systems, structures and processes underpinning financial, corporate, and clinical governance and the Board will need to assure itself that it has effective integration and timely oversight*	**Provided documentation**: • MH&LD programme Overview Group agenda June 23 • Enhanced Advanced and Consultant Practitioner Framework – Launched 9th June	**3**	Following interviews with relevant staff the review team felt there is comprehensive integrated governance system which is also noted in the evidence provided.	**Green**

	and scrutiny of workforce planning, financial planning, performance, and quality going forward.	• Regional dementia governance structure March 2023. **BCUHB briefing document:** A report submitted to BCUHB Board in March 2021 noted that the requirements of this recommendation were fully implemented and considered business as usual, with agreed monitoring arrangements. However, there is considerable work currently ongoing to review and strengthen the governance and oversight of projects within the MH&LD Division. This will be incorporating workforce planning, financial scrutiny and tracking, performance measures and quality measures. Projects that have been funded will be allocated under a digital workbook. These will be tracked through the Programme Oversight Group and a breakdown of each of these will be available via a high-level programme dashboard.			
2c	*BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD Division and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward. The MH&LD Division will need to utilise this support to creatively explore different ways of working and new and effective ways of recruiting and retaining staff. There will need to be efficient, (timely) and effective recruitment processes in place at all times to support the MH&LD Division going forward.*	**Provided documentation:** • MH&LD Monthly Vacancy/Recruitment report • Just R marketing campaign • SBAR for future recruitment/retention initiatives in MH&LD **BCUHB briefing document:** It was reported to BCUHB Board in March 2021 that the requirements of this recommendation had been fully implemented, and subsequently monitored via the Workforce Improvement Group. Nonetheless, it is acknowledged that the position relating to vacancies and recruitment is ever-changing and that close monitoring at divisional level is crucial. Both clinical and non-clinical managers across MH&LD are held responsible for their teams and budgets, meeting with the finance team on a monthly basis to review the vacancy/recruitment status and ensure they have the required resource for staffing.	**4**	There have been many initiatives in the area of recruitment and retention with active recruitment campaigns. The 'Streamliners' programme has been especially well received. The review team note there is an up-to-date recruitment and retention plan and the launch of the 'Just R' marketing campaign in September 2022. The service continues to have difficulty in recruiting staff, especially medical staff in the Western sector. This is having an impact on the quality of care and multidisciplinary team working in the Hergest Unit. Efforts need to focus on areas of particular difficulty.	**Green**

2 (d)	*There is currently only one Consultant Nurse in Dementia for the whole of BCUHB. With the extensive work plan now and going forward to the future this single post-holder is already likely to be stretched very thinly. It is unlikely that BCUHB has sufficient Consultant Nurse resource to even begin to get to grips with the recommendations arising from this review and the HASCAS investigation. BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.* *Recommendations 4a to 4d should start with immediate effect and there should be evidence of significant progress by the end of quarter 2 2018/19, (the end of September 2018.) Taking into account recruitment times it would be anticipated all required post holders would be in place by the beginning of quarter 4 2018/2019 (January 2019).*	**Provided documentation:** • Band 8d Dementia Nurse Consultant JD & PS • Band 8c MH&LD Dementia Nurse Consultant JD **BCUHB briefing document:** This recommendation was reported as open at the time of the Ockenden/HASCAS Improvement Group closure in March 2021. A second Nurse Consultant in Dementia was appointed in July 2019. At the time of a progress update to the BCUHB Board in March 2021, it was noted that recruitment process was in place in view of the retirement of the two Dementia Nurse Consultants in post at that time. "Between July 2021 and September 2022, two Nurse Consultants in Dementia were in post; one pan-BCUHB and one specifically for the MH&LD Division. Since September 2022, there has only been one Nurse Consultant in Dementia covering the Health Board. There has been progress in reviewing the job description and role requirements of the second Dementia Nurse Consultant post and a Band 8c MH&LD Dementia Nurse Consultant post will be out to advert imminently. This post will be a specific resource for the MH&LD Division."	**4**	To the review team's knowledge, there is no consultant nurse with specific responsibility for dementia within the mental health and disability directorate. There is one consultant nurse who has board wide responsibilities together with an academic remit. The lack of a consultant nurse within the directorate is impairing the directorate's ability to take forward the dementia strategy.	**Red**
3	*The Board should assure itself of the current situation by ensuring a review of all clinical policies within all BCUHB Divisions. This review should include quality checks on how the policies and guidelines were ratified, their due date of review and a full understanding of those policies that are overdue for review. This review will need to be undertaken of all BCUHB policies held on the intranet and a BCUHB Board 'amnesty' announced for submission of all paper copies of policies and guidance held within individual clinical areas in hospitals and across the community. Once an appropriate archive of these policies are created, they should be destroyed so that they cannot be returned to clinical practice as a 'work around solution' to lack of access to policies and guidance electronically.*	**Provided documentation:** • Policy Sub-group agenda example June 2023 • Screenshot of BetsiNet policies page • Policy position paper example June 2023 **BCUHB briefing document:** At the time of closure of the Ockenden/HASCAS Improvement Group in March 2021, the requirements of this recommendation were reported as fully implemented with work ongoing to upload revised policy documents onto the intranet and agreed monitoring arrangements. The MH&LD Division uses a policy and procedure subgroup (P&P) to manage the process of monitoring, updating, and ratifying written control documents. This subgroup reports to the Divisional Service Quality Delivery Group (SQDG) which allows for oversight at Director Level and escalation of any issues to the Director of Nursing. The	**n/a**	Whilst there is an active policy review group that reports to the Director's team, and staff reported easy access to relevant policies via BetsiNet, the review team noted that some policies continue to be out of date.	**Amber**

	BCUHB should then undertake a comprehensive review of all existing BCUHB policies to ensure the needs of older adults are specifically considered within all relevant policies. These policies must be readily available to support clinical staff in the effective delivery of care to older adults. There will also need to be reviews of the IT systems available to all clinical areas in hospital, community, and primary care since BCUHB must now move away from 'paper copy' guidelines. However, to do so, means that all staff must have easy access to the BCUHB intranet.	P&P group is chaired and supported by the Quality Governance team, and attendance is expected from all areas within MH&LD.			
4 (a)	*The BCUHB Board and the MH&LD Divisional Senior Management team is recommended first to ask of front-line staff 'what does the term 'staff engagement' mean to you, what would effective staff engagement look like for you?' and then to develop a system of bespoke, meaningful, and sustained staff engagement first across mental health and specifically older persons mental health. The Board may then wish to consider how effective their engagement is with staff across BCUHB and decide whether a new Board approach is required to staff engagement across the whole of BCUHB.*	**Provided documentation:** • NHS Wales staff survey • BCUHB Staff Survey • Stronger Together surveys / engagement event • MH&LD staff survey • WW&U 24-month report • BCUHB Health Needs Assessment 2023 • BCUHB Engagement Initiatives screenshot • Speak out safely • MH&LD Divisional Improvement Plan • Sharing Spaces feedback • Inpatient service managers walkabout • Ward Accreditation Programme • MH&LD Welcome Days • MH&LD Stay Conversations • Dementia Action Week – section from May AAA **BCUHB briefing document:** A number of initiatives have been established across BCUHB to support strengthen staff engagement. Some include: • 'Ask the Panel' events • Tea with the CEO • Chief Executive and Board walkabouts • Staff Engagement ambassadors • 3D Improvement Initiative • Speak out safely ambassadors also play a pivotal role in maximising staff engagement	**n/a**	The board has provided the review team with a comprehensive list of initiatives which have been designed to strengthen staff engagement with the management team. In general, staff who the review team interviewed expressed the view that communication and engagement had improved significantly. Staff described an open-door policy and visible leadership, with management presence and PTR meetings. Some staff on the Ablett unit expressed the view that senior management team did not engage effectively with frontline staff and that they were expected to 'just get on with it' when difficulties arose. In addition. there is some concern that the current process of service redesign has not followed procedure outlined or so far effectively engaged with staff.	**Green**

4b	*The Ockenden review team was informed that the NHS Staff survey across Wales is completed every three years and is next due in 2019. Welsh Government may wish to consider an annual staff survey in line with that carried out in England. A three-year gap in formally ascertaining the views of NHS staff in Wales is considered by the Ockenden review team to be too long*	**Provided documentation:** • June 2023- email confirming participation in national survey & quarterly pulse surveys if provider can be found **BCUHB briefing document:** It was reported to BCUHB Board in March 2021 that the requirements of this recommendation had been fully implemented, and subsequently monitored via the Workforce Improvement Group. The previous NHS Wales staff survey took place in 2020. Health Education and Improvement Wales (HEIW) are currently working with NHS Wales Health Boards and organisations on the development of the next national survey, due to be launched in September/October 2023.	**n/a**	The most recent staff survey available to the review team was from September 2021 and had a response rate of 12.6%. The review team have seen an email from June 2023 confirming participation in national survey and also quarterly pulse surveys if provider can be found, however no evidence was provided of any pulse survey's being carried out. It was not clear that a new provider has been identified.	**Amber**
4c	*Aside from any potential decision by Welsh Government, the BCUHB Board should commence a formal annual BCUHB staff survey starting with all Wales annual staff survey in 2019 and using the same methodology utilised for the All-Wales NHS staff survey at BCUHB on an annual basis from 2020. The actions and progress arising from the new annual BCUHB staff survey should be reported to the public BCUHB Board on a quarterly basis.*	See evidence provided for recommendation 4 (b). **BCUHB briefing document:** The requirements of this recommendation were noted as fully implemented in March 2021 with continued monitoring arrangements via the Workforce Improvement Group. Independent of national staff surveys, the BCUHB commission and enrol local staff surveys which have previously taken place in 2013, 2016, 2018 and 2020 In addition to organisation-wide surveys, the MH&LD Division has undertaken two staff surveys These are in addition to the BCUHB staff wide surveys. The initial survey undertaken in 2020 included six questions relating to support, communication, PPE, and testing. The second survey undertaken in 2021 (Reflect and learn) took a broader look at the experiences of staff in terms of the impact of the pandemic on their wellbeing in work. The results of the MH&LD staff surveys have been developed into a "You said, we did, we are going to do" document which was shared with staff as part of the MH&LD Staff Briefings.	**n/a**	See evidence provided for recommendation 4 (b).	**Amber**

4d	*Following on from the failure of BCUHB's attempt to create a clinically led organisation in 2009, which is well referenced in a number of external reports the BCUHB Board must now take urgent and sustained steps to ensure the continued involvement of all clinical colleagues in the leadership and management of BCUHB. The recommendations a to c above refer to the need to improve staff engagement. BCUHB also needs to engage with a comprehensive BCUHB wide clinical leadership and management development scheme encouraging the widest range of clinical colleagues across medicine, nursing and professions allied to medicine to want to take responsibility for leadership and management of their individual services.*	**Provided documentation:** • Matron Leadership Development Programme • Ward Managers Development • Stronger Together Programme -integrated Leadership Development • Mental Health Strategic Workforce Plan for Health and Social Care in Wales • B6/7 Team Leaders' Induction proposal **BCUHB briefing document:** As part of the BCUHB 'Stronger Together' Programme of work launched in 2021, an 'Integrated Leadership Development' programme is progressing to review all available BCUHB Learning and Development for leaders. The aim is to create a clear and concise development framework to meet the needs of multidisciplinary teams and professionals The MH&LD Training, Development and Well-being lead has also commenced on work to develop a Team Manager Induction Programme (Band 6 and 7) of which will incorporate leadership and management development, supported by the allocation of a Senior Nurse mentor. This forms a part of the MH&LD Training and Development Group which includes clinical representation. A Matron Leadership Development Programme was also developed which commenced in November 2019 A 'Ward Managers Development Programme' was launched in March 2019 with a total of 19 participants as part of the first cohort with expansion for a second cohort to commence in July 2019. There is also participation from members of the Division workforce in the BCUHB-led 'A Step into Management' (ASiM)Programme.	**8**	In addition to the written evidence supplied, staff interviewed described good opportunities for development and some staff described a positive experience from participation in the ward managers' development programme.	**Green**
5	*BCUHB needs to work effectively at a strategic level with the third sector, carers, patient representatives and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales. Again, the*	**Provided documentation:** • Reaffirming our Commitment to the 3rd Sector' ToR • MH&LD Patient and Carer Experience Group • Community Engagement TF • Dementia Pathway Redesign report	**1 & 6**	Caniad meetings have been described as information sessions rather than true partnership working.	**Amber**

	Ockenden team uses the word 'embryonic' to describe progress to date.	• North Wales T4MH Interim Strategy • iCAN Programme Update and Oversight Report – Quarter 2 2023/24 **BCUHB briefing document:** A group has been established within BCUHB, 'Reaffirming our Commitment to the 3rd Sector' which aims to further develop and improve the relationships between organisation-wide services and the third sector. There is existing evidence of excellence partnership working with the 3rd sector within the organisation, but the aim is to build upon this and ensure that they are recognised as a valued partner There is a review of all MH&LD contracts and grants currently underway as part of the divisional aims but aligned corporately to the 'Reaffirming our Commitment to the 3rd Sector' group There are good examples of partnership working across the Division notably through the iCAN programme where in particular the relationships with eleven 3rd sector organisations provide tier 0 low level mental health support in the community for younger and older people. An iCAN Hub Meeting takes place monthly with all providers which has an agenda and action/decision log to support. The division engage with CANIAD at their Big Chat Events attended by patients of all ages to feedback and influence change in our services, including Mental Health. The MH&LD Divisional Patient and Carer Experience (PCE) Group was established in 2018, and is currently undergoing a review of the terms of reference		The review team have been informed of the work of the patient and carer experience (PCE) group. The most recent minutes that were sent to the review team indicate that the meeting was not quorate. There is evidence of innovative practice in the RSU, with third sector organisations providing arts and music sessions together with the OT department. However, funding for this initiative appears to be from a charitable foundation and is not recurrent. The iCAN hubs, set up throughout the Board area, are a good example of partnership working between the Health Board and the third sector. Representatives from outside agencies described generally good partnership working but some difficulties in pockets of the Board with the system not working as consistently as it could be. There has been a recent separation of social workers from the CMHTs, which has led to difficulties in partnership working. Overall, there is not strong evidence that true partnership working has been embedded within practice in the Health Board mental health directorate.	
6	*The current Executive Director of Nursing has committed significant resource and provided energy and determination into developing sound foundations for the safeguarding structure going forward. However, for an organisation such as BCUHB approaching its ninth birthday a very significant amount of work still needs to be done. This will need continued Board scrutiny and oversight, may still yet require external support, and must be reported to*	**Provided documentation:** • Level 3 Mental Capacity Act (MCA) and Deprivation Of Liberty Safeguard (DOLS) training • MCA Training Compliance 2022-2023 **BCUHB briefing document:** The National Safeguarding Maturity Matrix (SMM) quality outcome monitoring tool continues to be utilized for monitoring and collating NHS performance. This enables benchmarking, organisational assurance, shared practice,	**2**	See written evidence supplied. However, the Review Team became aware during the visits of a potential safeguarding issue concerning one of the Section 136 suites, which was escalated using the appropriate College procedures. The Health Board provided the College with a written response and described	**Green**

	Welsh Government if (for any reason) progress in the future falters or slows down. Clear timescales and expectations are set out above.	and a drive for improvement. For the third year BCUHB has achieved full compliance (25 out of 25). The development of the Safeguarding Ambassadors across the organisation has enhanced and ensured best practice safeguarding to ensure consistency, up-to-date competency, and confidence by providing signposting and support to staff. The Safeguarding Team provide a detailed analysis of all Safeguarding Concerns that have been raised in PTR process as well as weekly data to support improved compliance with training and a reduction in safeguarding incidents. The Safeguarding Team receive, analyse, and action Datix Reports that are submitted with the Safeguarding alert having been triggered The Safeguarding Performance and Governance (SGPG) Group monitor, critique and challenge findings, outcomes and evidence relating to both risk and the reduction of risk and harm.		mitigating actions to be taken at a subsequent meeting. Please see the review team commentary against recommendation 11 of this report.	
7	*Whilst it is acknowledged that on many occasions since 2009 BCUHB has made an effort to improve the timeliness of responses to concerns in line with the requirement of Putting Things Right (2011) this has not yet been sustained on an ongoing and long-term basis. BCUHB needs to resolve this situation finally by the end of quarter 2 of 2018/19, (i.e. the end of September 2018). It is clear that the BCUHB Board have very little knowledge of the actual everyday experience of families, patients and patient representatives who try to make complaints to BCUHB as an organisation. Patient representatives also raised with Donna Ockenden the reluctance of families and patients to complain and the fear they have of complaining. This means that the number of complaints from older people and their families is highly unlikely to be an accurate illustration of the real views of patients and their families. Patient representatives and carers in mental health and older peoples mental health (and staff*	**Provided documentation:** • Local PTR meeting's agenda and minute examples • X2 Divisional PTR Chairs Assurance Report • MH&LD Patient Carer Experience group ToR. **BCUHB briefing document:** There are robust arrangements established within the Division for monitoring progress and identifying any barriers to timely completion through weekly local area and divisional 'Putting Things Right' (PTR) meetings. The position relating to local concerns and complaints are discussed at weekly PTR's with a review of current position, outstanding actions and identification of issues for escalation. Alongside this, the Director of Nursing attends a weekly Executive Director chaired concerns meeting to report on divisional compliance. This ensures that the Divisional Senior Leadership team are fully engaged with concerns being investigated at a local level. Information from the PTR meetings are further reported at the MH&LD Service Quality Delivery Group on a monthly	**3**	There is a comprehensive system in place for monitoring and responding to incidents, concerns and complaints in which clinicians and managers are engaged. However, patients interviewed by the review team were not satisfied with how a complaint was addressed and there continue to be a number of overdue complaints In addition, staff expressed a view that the system could at times be 'over-comprehensive,' with multiple meetings at which the same information was repeated and duplication in processes. There was also a view of a 'one size fits all' approach, with processes not always focusing on problems particular to service areas	**Amber**

	involved in patient and carer engagement) have described to the Ockenden review team how carers feel 'saturated' by the multiple ways in which BCUHB attempt to ascertain their views but then perceive that BCUHB do very little with those views and feedback. Therefore, the Ockenden review is reluctant to recommend that the BCUHB Board and the MH&LD senior management team undertake specific and targeted further user engagement looking at complaints and concerns. *However, the BCUHB Board needs to be aware of the considerable and deep-seated unhappiness expressed by a range of carers and patient representatives across a range of issues, one of which is the current inability of BCUHB to effectively respond to concerns in a timely manner.*	basis via a divisional PTR chair's assurance report. As of 12th May 2023, the divisional position included: 15 overdue incidents 18 overdue concerns This compares with 18 overdue incidents and 21 overdue concerns as of 21st April 2023. Additionally, a MH&LD Patient Carer Experience group is held bi-monthly with the purpose of providing scrutiny, advice and assurance on patients, carers and the experience of public members relating to MH&LD services. This is inclusive of both formal and informal complaints, concerns, and compliments to ensure that the voice of patients and carers are captured inform improvements within our services.			
8	*Significant further work still needs to be done by BCUHB in improving the information available to patients with dementia, their carers and patient representatives. It is clear that an attempt has been made to provide information on the BCUHB website, but the BCUHB Board now needs to ensure appropriate resources, skills and time are provided on a substantive basis to ensure a range of high quality and appropriate resources and information are easily available to patients, patient representatives and carers. In order to ensure recruitment to this service the BCUHB Board should provide an update on progress by the end of quarter 2, (end of September 2018) with the launch of a new suite of bilingual (English and Welsh) resources available no later than the end of quarter 3, (the end of December 2018.) Front line clinical staff, carers and patient representatives need to be involved in the development of these resources from the earliest stage to ensure they are relevant and appropriate.*	**Provided documentation:** • BetsiNet Dementia Page • Dementia Action Plan for Wales • Hospital Charter and Inpatients T&F group ToR • X2 Central Dementia Practice Educators (SBAR and JD) • X1 Deconditioning Dementia • Practice Educator • Wales Dementia Helpline. **BCUHB briefing document:** A report to the BCUHB Board in 2021 noted the challenges faced in progressing against this recommendation in view of the COVID-19 pandemic with further action required to fulfil the recommendation requirements. The Dementia Page on the BetsiNet site has experienced a significant development and now serves as an excellent repository and hub for all staff at all levels to access. It sets out the BCUHB approach to dementia care, safeguarding and provides information on care pathways. A Dementia Toolkit incorporated onto the site includes wealth of information relating to dementia.	**1**	The pan BCU role of the consultant nurse in dementia is welcome but a similar post that is Directorate specific has not yet been filled. The recently appointed advanced nurse practitioner and practice development posts are not specific for dementia care and there are ongoing difficulties in data gathering in dementia. There has been limited uptake of tier 2 & 3 training. The Review Team is concerned that the needs of older adults are not given the necessary attention in the Directorate and the current management structure may not be conducive to comprehensively meeting the needs of older adults.	**Amber**

	The BCUHB Board need to commit the appropriate resources to ensure that the currently high level 'Dementia strategy' becomes an achievable and relevant part of everyday care and clinical practice of people with dementia. It appears that as of April 2018 BCUHB still need to ascertain the workforce needed to deliver upon the 'Dementia Strategy' since the Ockenden team has not seen any evidence to suggest that this work is either underway or has already been completed. The 'Dementia Strategy' should also incorporate current and forward-looking workforce and service plans for the provision of appropriate levels of therapy and non-medical care for people with dementia since again, the Ockenden team has not seen evidence to suggest that this aspect of the 'Dementia Strategy' has been completed. This work needs to commence within quarter 2 of 2018/19 with significant progress reported to the BCUHB Board at the beginning and end of quarter 3, (October and December 2018) and quarter 4; ending March 31st, 2019. Progress throughout 2019 will need to be monitored by the BCUHB Board to ensure it does not slip, falter or become delayed. The 'Dementia Strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MH&LD Division. The 'Dementia Strategy' should incorporate care across home, primary care and secondary care.	Approval has been gained for two band 6 Dementia Practice Educators on a 12-month pilot within the Central Integrated Health Community (IHC) and recruitment is currently underway as of July 2023. These posts will support improve the accessibility of information and education to patient, carers and families relating to dementia. Additionally, funding application has been submitted for a Dementia Practice Educator pilot of an 18-month period with focus on care home residents and prevention of deconditioning across the patient pathway			
9	*BCUHB will complete and report to the BCUHB Board in quarter 1 2018-2019, (by the end of June 2019) a review of the 2017-2018 DoLS work plan as set out in the 2017-2018 Annual Report. Any remaining actions are required to be SMART and fully implemented within the third quarter 2018-19, (by December 2018) with progress reported to the BCUHB Board throughout quarter 3.*	See evidence provided for HASCAS recommendation 11 &12 . **BCUHB briefing document:** MCA Level 1 and 2 mandatory training shows an increase in compliance.	**n/a**	There is a high level of compliance with mandatory training. Staff interviewed by the review team were aware of how to access training, and of how to access the policy and procedures via the Intranet.	**Green**

		In addition to the MCA level 1 and level 2 mandatory training the MCA/DoLS Team identified a cohort of staff requiring more in-depth training and further developed a Level 3 training program. This is delivered on a monthly basis. The Team have also further developed a 30-minute awareness training package. MCA awareness raising sessions are delivered directly to the staff and wards with particular focus where non-compliance or concerns with regard to the completion of DoLS paperwork is identified. Legal and Risk Services have been commissioned to develop and undertake bespoke MCA training to support and reinforce staff understanding the importance of completed paperwork and the possible implications to the patient and Health Board if not completed accurately. The compliance rates for MCA Level 1 in June 2023 for the organisation is, 87.34% and 94.06% for the MH&LD division For Mental Capacity Act Level 2 the organisation compliance is 90.47% and 93.91% for the division			
10	*BCUHB needs to undertake a review of all external reviews (including those by HIW, the NHS Delivery Unit and others) where any findings, recommendations and requirement may have concerned older people and specifically the care of older people with mental health concerns*	**Provided documentation:** • Divisional Improvement Plan external reviews alignment • Partnerships Planning and Strategy Team framework • Programme Oversight Group • MH&LD Divisional Governance Reporting Framework (draft as of July 23) **BCUHB briefing document:** A report submitted to BCUHB Board in March 2021 noted that the requirements of this recommendation were fully implemented and considered business as usual, with agreed monitoring arrangements established. Further external reviews have taken place within the MH&LD Division since this date. The MH&LD Divisional Improvement Plan was developed and aligned to HIW standards, internal and external reports, inspections, and incidents which include the Holden Report, Ockenden report and the HASCAS report.	**3**	Whilst there is a structure to ensure that the recommendations of external reviews are acted upon, there continues to be evidence on the ground that the Board has difficulty in achieving a timely response to the various recommendations of external reviews.	**Amber**

		The newly established 'Partnerships Planning and Strategy' team support the delivery of service improvement across the Division. The Programme Oversight Group (POG) provides the overarching governance and assurance against programme implementation within MH&LD.			
11	*BCUHB should prepare a detailed estates inventory across the care settings for all of older people including but not limited to OPMH. Firstly, this should include clarity and specificity of all outstanding estates issues including outstanding repairs and estates issues raised as concerns within internal audits and external reviews and inspections. This estates inventory should be prepared for each ward, clinic, department, inpatient unit and hospital department where care is provided to older people and older people with mental health issues. This includes those areas where care is provided to people with dementia. Secondly, the estates inventory must include for each area set out above an audit based on the work of Enhancing the Healing Environment253. It is recognised that this is a substantial piece of work across BCUHB but the systems, structures and processes underpinning this work can be set up relatively quickly as it is based on work already proven to be successful elsewhere. Further information on the EHE programme and the NHS Trusts where it has been successful associated with dementia is found in the footnote 254,255. Thirdly, there should be an update to the BCUHB Board at the end of quarter 2 of 2018/19, (the end of September 2018, for all elements of this work stream including progress on outstanding maintenance and estates issues,) and quarterly progress thereafter until the end of quarter 2 2019/20. To reduce the amount of time spent on getting projects off the ground BCUHB staff should be encouraged, supported, and funded, (time and their travel costs paid) to*	**<u>Provided documentation:</u>** • BCUHB Estates Strategy • Ablett Redevelopment Programme • MH&LD Clinical Strategy • MH&LD Estates Index • Ward accreditation programme • RSS SCS Estates Group Agenda example **<u>BCUHB briefing document:</u>** A review of the MH&LD estates condition and performance is included within the BCUHB Estates Strategy published in January 2023. At the time of review, it was noted that 70% of the MH&LD Estates was in sound, operationally safe condition. This compares to a national target of 90%, noting that a significant proportion of the estate does not meet statutory compliance. Work is under development to transform the Ablett Unit and Bryn Hesketh Hospital sites as part of the Ablett Redevelopment Programme of work under the BCUHB Capital Programme scheme The MH&LD Clinical Strategy 2022/23 refers to the significance of the estates in improving patient and staff experience. The strategy notes a number of actions underway in the aim of addressing identified estates issues in accordance with the divisional clinical strategy: Provide Light Feasibility studies for all MH&LD estates which will include space utilisation studies and actual available, identified capital spend and options for current and future use Carry out two initial light feasibility studies at Bodnant and Hergest - Identify homes for Early Intervention Psychosis, Eating Disorders, Memory Clinic and Perinatal Staff	**10**	It is vital that the redevelopment programme as described proceeds as quickly as possible. The review team is concerned that there is no ability to admit older adults with functional illness to a suitable unit in the western sector. There continues to be a number of environmental risks and hazards, including ligature risks, which must be addressed promptly. Some units are situated in isolated locations, and it is important for staff and patient safety that there are suitable working alarm systems. In particular, it is imperative that the Board produce a work plan and timeline to mitigate the environmental risks in the Section 136 suite identified as a safeguarding issue during the review team's visit. It is accepted that significant capital funding is necessary for the Estates plan to progress.	**Amber**

	undertake visits to NHS Trusts who have already been successful in this initiative	Work with the Board Head of Estates and Facilities to ensure that MH&LD needs are included in the Estates Strategy Review Engage with the Digital lead to ensure that when space is found for staff it is fit for purpose in terms of IT Create a day to day working relationship with the Board Estates Team and make sure MH&LD estates are invited to the appropriate meetings			
12	*The Ockenden governance review has found a continuing lack of sustainable service development and a lack of clinical strategy development across older peoples care and care of older people with mental health (OPMH) six years after the 2012 consultation 'Healthcare in North Wales is Changing'. This has been and remains an urgent priority for the BCUHB Board to drive forward and one they are acutely aware of. BCUHB must continue to ensure it remains focused on building and sustaining positive relationships with a wide range of partners going forward as this will be fundamental to success going forward.*	**Provided documentation:** • BCUHB Clinical Strategy August 2022 • MH&LD Clinical Strategy **BCUHB briefing document:** Refer to recommendation 1 of the Ockenden 2018 report for an update on service development and strategies relating to dementia services. Additionally, recommendation 5 illustrates the progress and future work to strengthen relationships and collaboration with identified partners. The desire for partnership working is prominent within the Dementia Improvement Plan and early progress has been made to improve, for example through the newly established Regional Governance Framework	**n/a**	There is reference to a MH&LD clinical strategy in the Health Board briefing, but the clinical strategy document in the evidence bundle is high level and not specific to the mental health directorate. There is, however, evidence of service development and clinical strategy against other recommendations.	**Amber**
13	*There will need to be sustained, visible (in the clinical areas), stable leadership within MH&LD Division over a long period of time to ensure that the culture within mental health and specifically OPMH continues to develop in a positive way. There is currently (and has been across almost the whole time period of the Ockenden governance review) a 'perfect storm' of significant vacancies, long term high use of temporary and agency staff, (across medical and nursing positions), very recent long-term absence amongst the senior leadership team, significant pressure associated with patient acuity, patient numbers and insufficient beds. All this is combined with very well-known and significant financial pressure in the MH&LD Division specifically and in BCUHB as a whole organisation.*	**Provided documentation:** • MH&LD Communication and Engagement Plan • MH&LD Training and Development Group • MH&LD Proposed Operating Model v.37 • WW&U Plan – Training & Development • WW&U Strategy • MH&LD Dementia Training & 'Find The Light' • Dementia Toolkit **BCUHB briefing document:** The MH&LD Divisional Improvement Plan notes a sub-theme aligned to increased leadership presence and visibility across the division. A number of arrangements are in place within the division in the aim of strengthening this, to include a system of inpatient manager walk rounds and Ward Accreditation Programme. Additionally, the divisional Communication and Engagement Plan currently in development aims to contribute towards	**n/a**	The number of interim posts continues to be too high. to be too high. The review team note the MH&LD proposed operational model version 0.37 outlines a preferred option for a proposed future operating model, with next steps being a series of stakeholder engagement events. Some staff interviewed were aware of this but had not felt engaged in the process. It is important that there is a communication process and that any proposed changes do not lead to an increase in the number of interim posts	**Amber**

	Some clinically based staff described that they believed that the senior management team within the MH&LD Division did not understand the pressures felt by staff in providing clinical care over a prolonged period of time in such very difficult circumstances. The cultural change and change in attitude that is necessary towards dementia needs to happen across BCUHB, and to happen from 'Board to ward'. This cultural change needs to happen not just within MH&LD Division but everywhere within BCUHB where care and treatment may be provided to persons with dementia, their families, and friends.	developing the desired culture of collaborative and inclusive leadership across all levels of the division. There is active focus on reducing the number of interim posts across the Division, with evidence to support this on downward trajectory across the Division. In September 2021 there were 108 fixed term posts and 21 acting up/seconded posts, in January 2023 the number of fixed term posts reduced to 58 with 24 acting up/seconded posts. The majority of the interim staff are consistent post holders who continue to provide stability. Work has been undertaken to date to support cultural change in attitudes towards dementia, from Board to Ward level. There has been attendance at the Executive Management Group to raise the profile of Dementia and the intention is to deliver further awareness sessions to the Board to raise the profile and influence the culture around dementia at the highest level. The appointment of the Executive Director of Nursing as Executive Lead for dementia in August 2022 has supported the initial work of raising the profile and leadership around dementia.		.	
14	*The Ockenden review team has found little evidence of sustained Board leadership in creating an appropriate culture around dementia and dementia care at BCUHB. This should be the responsibility of every Board member, not just those Executives labelled as 'clinical.'* *It is recommended that understanding of this work should be introduced from 'ward to Board' and across all BCUHB healthcare facilities in hospital and community and into all staff orientation, training, and development at BCUHB. This approach must start at the Board. As leaders of BCUHB the Board must be able to demonstrate a significant knowledge base around dementia and this knowledge base at Board level should be framed according to the standards set by WHO.*	**<u>Provided documentation:</u>** • Regional Dementia Strategic Group ToR • Chairpersons visit to Dementia Ward • Update to WG on Dementia Education • Dementia Learning and Development Framework **<u>BCUHB briefing document:</u>** A report submitted to the BCUHB Board in March 2021 noted that the Executive Director of Nursing and Midwifery determined that this ambition would be best met by the full Board participating within a dementia friendly awareness session which was delivered on 10th January 2019. It was reported that the requirements of this recommendation had been completed as of March 2021 The Executive Director of Workforce & Organisational Development agreed to take forward an action to consider how to incorporate dementia awareness sessions into the Health Board's induction programme. A dementia friendly awareness session for senior managers as members of the Executive Management Group took place on 3rd July 2021	**3**	Recognising that significant improvements have been made, the review team was concerned that the Consultant Nurse post for dementia had not yet been filled and that the practice educator posts are not specific to dementia. The review team also note the low uptake for tier 2 & 3 training in dementia. It has been reported that issues concerning dementia are discussed hurriedly at generic PTR meetings, with the majority of the time being devoted to matters in the general adult services. Although there is a lead consultant for older adults' psychiatry who has a pan-BCU role, management of older adults' mental health services sits within a generic management structure.	**Amber**

		The introduction of the mandatory training module relating to dementia aims to support raise awareness and responsibility of all staff members working within the organisation, to include leaders at Board level. As of 31st August 2022, 84.02% of the workforce (a total of 16,625).		This may impede the promotion of an appropriate culture around older adults' mental illnesses including dementia. There is limited evidence that national initiatives are being implemented or of engagement with national networks.	

HASCAS

Rec no.	Recommendation	Evidence reviewed (BCUHB provided documentation, and briefing documents aligned to each review report).	Domain No.	Review team findings from interviews and site visits	Agreed rating
1	*Care Pathway and Service Design - An integrated service review is required to map the needs of the older adult and those with dementia across North Wales. This review needs to involve all stakeholders (from the statutory, independent, and voluntary sectors) and those with performance responsibilities. The review should include all care and treatment settings (not just those confined to mental health and older adult services) in order to ensure that all interventions are integrated and that patients, patients and their families do not encounter service barriers that prevent them from receiving access to the care, treatment, and support that they need. The review outcomes and options should underpin all current and future health and social care strategies across north Wales and be overseen by the appropriate performance management and inspection bodies.*	**Provided documentation:** • Pathway Redesign Group report July 2023 • OPMH Clinical Pathway Group highlight report example • OPMH Prevention and Support Service Pathway • OPMH Dementia Secondary Care Service Specification July 2023 **BCUHB briefing document** Logic model to develop integrated service model to have 6 main outputs. Dementia pathway redesign group working to develop pathway according to national standards. Recognised need for improved Service User (SU) engagement in this work Active OPMH clinical pathway group Care provider operational group monitors this rec. BCU dementia strategy 2018 superseded by dementia action plan for Wales 2018-22 5 T&F groups with reps from 3rd sector partners and SUs/carers. Single BCU dementia improvement plan developed Executive Director of Nursing appointed Executive lead for dementia.	6	Significant work has been done to develop an integrated service that will meet the needs of those with dementia. Dementia services are managed within the geographical directorate structure. Memory assessment services are operational in all areas and one service has achieved MSNAP accreditation. There are primary and secondary care dementia teams in the three geographical directorates. However, the recently introduced practice development posts do not focus specifically on dementia care and there is no consultant nurse post within the directorate that focuses on dementia. In addition, the links with social work could be improved and patient/carer involvement needs to be further developed.	**Amber**

2	*Dementia Strategy - BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy; the plan should be developed in partnership with the Regional Partnership Board response to the Welsh Government's new Dementia Plan. This work should be undertaken in conjunction with Recommendation One. The action plan should incorporate the consequent implications and requirements for all clinical services (not just the Mental Health Directorate) in all care and treatment settings (community, primary and secondary care). The action plan should take into account all of the clinical and practice deficits that have been highlighted by this Investigation and will require independent clinical input and oversight. Access to therapy and non-medical interventions and treatments should be an integral part of any costed Dementia Strategy plan which takes into account NICE (and all other) best practice guidance in this regard. The capacity and capability of the workforce should be reviewed to ensure that fit for purpose services can be provided. Implementation should be managed and audited in tandem with Recommendation Ten (see below) as the reduction of the use of antipsychotic medication will to a large extent be predicated upon alternative therapeutic interventions being made available. Formal audit and performance management arrangements should be agreed and built into the action plan.*	**Provided documentation:** • BCUHB Dementia Strategy 2018-20 • Dementia Action Plan for Wales • Dementia Action Plan Strengthening Provision COVID-19 • Dementia Standards Pathway document • Dementia Hospital Charter for Wales • North Wales Regional Dementia Governance Framework 2023 • TF Group 1 Community Engagement • TF Group 2 MAS and Dementia Connector • TF Group 3 Workforce Development • TF Group 4 Hospital Charter and Inpatients • TF Group 5 Measurement Work stream • Dementia DDT Triple A report July 2023 • SBAR x2 Central IHC Dementia Practice Educator pilot • Dementia Practice Educator Deconditioning pilot • BetsiNet Dementia Page • Dementia helpline **BCUHB briefing document:** Dementia strategy launched 2018. Superseded by dementia action plan 2018-22. BCU working to this plan, 5 T&F groups with reps from 3rd sector and SUs 2 Band 6 dementia practice educators appointed for Central IHC (pilot July 23) Provision of therapy support variable (OT support good in East) Dementia help line provision Dementia Toolkit on BetsiNet dementia page.	**6**	See provided documentary evidence and review team findings for recommendation 1.	**Amber**
3	*Care Homes and Service Integration - The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.*	**Provided documentation:** • Logic Model Care Home Integration • Single Care Home Action Plan Summary December 2019 • 3 Care Home events March 2019 findings report • BCUHB Record of Dementia Training November 2019	**6**	In terms of practical outcomes, the proposed pilot of inreach workers into four care homes in the Eastern sector is welcome but this work needs to be expanded. The review team recognise that this will require additional recurrent funding.	**Amber**

		• BCUHB in Partnership with Care Homes September 2019 • Dementia 'Study Day' example programme • Care Provider Operational Group ToR • Dementia Practice Educator Care Home Deconditioning pilot • Care Home Action Plan Progress Report May 2022 • Clinical Quality Support Tool (CQST) Cognition & Wellbeing May 2023 (for use in Nursing Homes only) • Care Home Action Plan 2022 • Independent Providers Action Plan 2023/24 **BCUHB briefing document:** In March 2021 it was affirmed that the requirements of this recommendation had been fulfilled with work to continue as part of business as usual through the BCUHB Care Homes Operational Group. The Regional Care Home Action Plan was established in 2021 This plan, together with the Independent Care Providers Plan 2022/23, are monitored via the Care Provider Operational Group. Oversight of the implementation of this HASCAS recommendation remains a principal duty of the group. The Independent Care Providers Plan 2022/23 notes developments relating to Dementia within their key priorities, with links formed to two work streams of the Regional Dementia Governance Framework: Dementia Pathway Work stream – led by the Dementia Delivery and Transformation Group Dementia Standards Work stream – led by the Regional Strategic Dementia Group, with care home representation on two task and finish groups; MAS/Dementia Connector and the Hospital Charter An update aligned to progress against this plan in 2022/23 highlighted the following requirement; *"Work with Consultant Nurses to develop dementia friendly services and identify key training and education".*		The review team have been supplied with two CQST tools which are intended to assess care in care homes across multiple domains, but they were blank, and it is not clear if these are routinely used.	

		" This action was noted as complete in January 2023 following a commitment from the BCUHB Educational Team to support the training of up to 400 delegates of care home HCSW and Registered Nursing staff in the 'Finding the light in Dementia Care' Tier 1, 2 and 3. The above training has been offered to the care homes within the provider brief to include HCSW and RN; further evaluation will need to be gathered regarding uptake of the training. This action feeds back to the QAF Training and Education work stream. Action complete." The Care Home Quality Development Team continue to work closely with the BCUHB Dementia Nurse Consultant to ensure that the care home agenda is integral to the development and implementation of the Dementia Strategy with appropriate links to the MH&LD Division.			
4	*Safeguarding Training - BCUHB will revise its safeguarding training programme to ensure it is up-to date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance. BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance. The responsibility for this will be overseen by the relevant BCUHB Executive Director with responsibility placed on all clinical service managers from all of the clinical divisions within the organisation. BCUHB has not been able to ensure staff attend safeguarding training sessions in the numbers required. There are multiple factors involved which will require a detailed and timed action plan with external oversight.*	**<u>Provided documentation:</u>** • Safeguarding Adults Training • Safeguarding Children and Young People Training • MH&LD Service Quality & Delivery Group example agenda **<u>BCUHB briefing document:</u>** BCUHB will revise its safeguarding training programme to ensure it is up-to date and fit for purpose. The updated-training programme will incorporate all relevant legislation and national guidance. BCUHB will engage with all prior safeguarding course attendees to ensure that they are in receipt of the correct and updated guidance.	**2**	Comprehensive Safeguarding systems and a training programme are in place. Please see recommendations 6 and 11 in the second Ockenden report above.	**Green**

5	*BCUHB has conducted an audit on the compliance of filing safeguarding information in patients' case notes. BCUHB will ensure that the consequent recommendations it set in relation to informatics in its BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017–2018 are implemented – namely: — the use of the dividers to be re-iterated in safeguarding training, briefings, and other communication activities and a key annual audit activity; — process of secure storage of strategy minutes of strategy meetings and outcomes of referrals to be revisited at safeguarding forums with legislative guidance from Information Governance; — team and ward managers to continue to include safeguarding documentation in team meetings and safety briefs. Independent Investigation: Tawel Fan Lessons for Learning Report 327. In addition, BCUHB will reconsider how clinical teams should record safeguarding information and the quality of the information provided. This to include specific guidance on: — the content of protection plans; — the recording of strategy meetings and all decisions taken (guidance should require a standardised approach across all BCUHB clinical divisions); — formal monitoring and review templates should be developed and audited to ensure safeguarding timescales are met and those with key responsibilities in this regard held to account. BCUHB will repeat the audit within 12 months of the publication of this report to ensure that all clinical areas are compliant.*	**<u>Provided documentation:</u>** • BCUHB QSE Corporate Safeguarding People at Risk of Harm report March 2023 • BCUHB Safeguarding Training • MH&LD Ward Accreditation Scoring July 2023 • Ward Accreditation Guidance for Safeguarding Information Reports • Safeguarding Bulletin example March 2023 • Safeguarding Governance and Performance Meeting ToR • Safeguarding Ambassadors Training • SOP MH&LD Safeguarding Dividers patients notes **<u>BCUHB briefing document:</u>** Safeguarding training programme to be revised to ensure it is up to date and fit for purpose.	**2**		**Green**

6	*The BCUHB Corporate Safeguarding Team Safeguarding and Protection of People at Risk of Harm Annual Report 2017–2018 identified that there were priority actions required in relation to safeguarding policies and procedures. This Investigation recommends that these priority actions are incorporated into the action plan consequent to the publication of this report. The actions are: "to identify those policies, procedures and SOPs that firmly sit within the Safeguarding remit and those that should be the responsibility with internal and external partners; agree a priority list and activity timeframe to review documents within the parameters of Corporate Safeguarding; provide safeguarding expert advice to internal and external partners in order that those documents are reviewed appropriately and in line with local and national policy and legislative safeguarding frameworks; agree a governance structure and reporting framework for all safeguarding policies, procedures and SOPs; — update and maintain the Safeguarding Policy webpage; continue to actively participate in the Policy and Procedure sub group of the Regional Safeguarding Boards.*	**Provided documentation:** • Safeguarding Governance and Performance Meeting agenda bundle. • MH&LD Safeguarding Forum exception report example to Division Quality Delivery Group • MH&LD Safeguarding Forum minutes example • Safeguarding BetsiNet page • Safeguarding Policies BetsiNet • BCUHB Safeguarding and Public Protection guide	**2**		**Green**
7	*The Tracking of Adults at Risk across North Wales BCUHB will work with multiagency partners, through the North Wales Safeguarding Board, to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history as they move through health and social care services across North Wales in order to ensure ongoing continuity of protection for that individual*	**Provided documentation:** • North Wales Regional Safeguarding Board (NWSB) membership • North Wales Safeguarding Board Annual Report 2021-22 **BCUHB briefing document:** BCU to work with multiagency partners through NWSB to determine and make recommendations regarding the development of local safeguarding systems to track an individual's safeguarding history	**2**		**Green**
8	*BCUHB will evaluate the effectiveness of its new safeguarding structure in the fourth quarter of 2018/2019. This will be overseen by Welsh Government.*	**Provided documentation:** • BCUHB Corporate Safeguarding Reporting Framework (January 2023) • BCUHB Board Corporate Safeguarding Annual Report 2021-2022	**2**		**Green**

		• BCUHB Targeted Interventions Good Governance Report May 2022 • MH&LD Governance Framework July 2023 **BCUHB briefing document:** Activity and structures monitored via the Safeguarding Governance and Performance group			
9	*BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled case notes. BCUHB needs to ensure that none of the commingling involving living patients could have led to any inappropriate acts or omissions on the part of clinical treatment teams during any episode of care (past and present). BCUHB needs to restructure and redesign its hard copy clinical records archiving and retrieval systems. This redesign needs to provide assurance in relation to the tracking of individual case notes across north Wales together with a set of service level agreements pinpointing the timeframes required for clinical record retrieval and access.*	**Provided documentation:** • MH&LD Health Records Storage Group agenda example 2021 • MH&LD Health Records Storage Group agenda example 2022 • MH&LD Health Records Storage Group agenda example 2023 • MH&LD Health Records Business Case • MH&LD Health Records Storage Group action log • MH&LD Health Records Storage Group Project Plan • MH&LD Missing Case Notes SOP • MH&LD Clinic Preparation Case Notes SOP • MH&LD Merging Case Notes SOP • MH&LD Filing Patients Documents SOP • MH&LD Filing Behind Alert & Safeguarding Dividers SOP • MH&LD Admin SOP **BCUHB briefing document:** Further actions necessary as of March 2021 to progress to full implementation. Health Records Storage Group providing strategic direction.	**2 & 9**	Whilst actions have been taken to improve the quality of paper notes, the plan for introduction of electronic notes appears to have stalled. Wards have difficulty in managing and storing voluminous paper notes. The lack of an electronic notes system leads to a significant governance concern especially as regards OOH or out of sector admissions. The review team acknowledge that the absence of electronic notes may not be within the control of the Health Board, however the team believe this is an issue that should be addressed as a priority	**Amber**
10	*The Prescribing and Monitoring of Antipsychotic Medication The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to a full audit within a 12-month period of the publication of this report. BCUHB will continue to work with care homes across north Wales to provide practical clinical advice, guidance, and training so that residents with behaviours that challenge can be supported and kept safe with the minimal amount of antipsychotic medication possible. The effectiveness of this*	**Provided documentation:** • Audit of Antipsychotic Prescribing people living with Dementia November 2019 • Guidelines prescribing antipsychotics Dementia July 2018 • Highlight Report Antipsychotic Prescribing Dementia July 2023 • CQST Medication Management May 2023 (for use in Nursing and Care **BCUHB briefing document:**	**2**	The review team have been told that antipsychotic medication prescribing is subject to regular audit and review at the medicines management committee. We have not seen minutes from the medicines management committee but have been supplied with two audits of antipsychotic prescribing in dementia wards from 2019 and 2023, The audits do not cover care homes. The CQST tool for monitoring antipsychotic medication in	**Amber**

	should be built into the antipsychotic prescribing guidance audit detailed in the bullet point directly above.	On track to deliver but Covid presenting challenges. Work being taken forward by Consultant pharmacist BCU participates in POMHUK		care homes looks extremely comprehensive but the form presented to the team is blank and the review team have no information as to how regularly it is used.	
11	*Evidence-Based Practice -BCUHB will conduct a review of all clinical policies to determine the ratification processes that were conducted together with an assessment of the appropriateness of content and currency; this will include all hard copy policy documentation still retained in clinical areas, and all electronic documentation held currently on the BCUHB intranet. As part of this work: — A risk assessment should be conducted to prioritise the work that needs to be undertaken and to establish whether there are any urgent policy revisions and alerts required to ensure patient safety is maintained. — Work should be undertaken to review the extant clinical policies across the three BCUHB geographical regions to determine corporate ratification and fitness for purpose. — All clinical policies should be reviewed with the specific needs of the older adult in mind. Policies should either be re-written to ensure that the evidence-base in relation to the older adult and/or those with dementia is specified in detail, or separate clinical policies and procedures should be developed for this particular patient cohort. This work should be conducted with expert multidisciplinary inputs.*	**Provided documentation:** • MH&LD Policy subgroup agenda example • MH&LD Policy position paper example • Mental Capacity Act (MCA) Training • MCA Level 3 Training flyer • Mental Health Capacity Committee DoLS report February 2023 • SOP DoLS Safeguards • SOP Section 21A of the Mental Capacity Act • BCUHB Best Interest Meetings guidance • Mental Capacity Act easy read guide • Mental Capacity Act roll-up banner • BCUHB MCA Training Compliance 2022-2023 **BCUHB briefing document:** Policy and Procedure subgroup reports to Service Quality Delivery Group. BCUHB Governance team maintains a log of written control documents inc. review date.	**1 & 2**	There is clear evidence of a comprehensive system in place as reported by the Health Board, but the review team did see evidence of some out-of-date policies.	**Amber**
12	*BCUHB will conduct a formal audit and provide a progress report in relation to the 2017-2018 action plan. This will include a review of any barriers to implementation (such as office accommodation) together with a timed and resourced action plan to ensure full implementation can be taken forward in 2018 – 2019*	**Provided documentation:** • Mental Capacity Act (MCA) Training • MCA Level 3 Training flyer • Mental Health Capacity Committee DoLS report February 2023 • SOP DoLS Safeguards • SOP Section 21A of the Mental Capacity Act • BCUHB Best Interest Meetings guidance • Mental Capacity Act easy read guide • Mental Capacity Act roll-up banner • BCUHB MCA Training Compliance 2022-2023	**2**	Staff described having access to training and information about the MHA/MCA and patients detained under the MHA described being made aware of their rights and having access to advocacy.	**Green**

		BCUHB briefing document: • Audit of training numbers re MCA • 30 min MCA awareness package developed • SOPs developed • Governance arrangements strengthened • Safety pods purchased for OPMH wards			
13	*Restrictive Practice Guidance - BCUHB will provide assurance that all older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within the BCUHB provision. BCUHB will also ensure that the Royal College of Psychiatrists' Centre for Quality Improvement (March 2007) National Audit for Violence: Standards for In-patient Mental Health Services guidance is embedded in all training and policy documentation in relation to 'taking dementia patients to the floor' during restrictive interventions.*	**Provided documentation:** • PICSS update June 2020 • Restrictive Practice HL Report June 2020 • MH&LD 0047 Physical Restraint Policy • Positive Steps Group example agenda • Positive Steps Group example minutes • PICSS AAA Report May 2023 **BCUHB briefing document:** • PICSS led on the implementation of this rec. • Policies updated • Relevant data gathered by PICSS • Positive Steps group active • Training delivered- aim for 95 % compliance by end of 2023	**2**	There is a comprehensive reporting, monitoring, and training system in place for restrictive practice.	**Green**
`14	*Care Advance Directives and Support to Patients and Families - BCUHB has made significant progress in providing support to patients and families when holding end of life conversations and developing advance directives. This is good practice. BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end-of-life care.*	**Provided documentation:** • All Wales Guidance Care Decisions for Last Days of Life • NACEL MH&LD Spotlight Audit Report 2021 **BCUHB briefing document:** Care Decisions Guidance published in June 21	**1 & 7**	BCUHB took part in the NACEL (National Audit of Care at End of Life) benchmarking audit in 2021.	**Green**
15	*End of Life Care Environments All older adults and people with dementia have the right to the same access to quality end of life care as any other individual (of any age) with any other condition. If a person is to receive end of*	**Provided documentation:** • SOP End of Life (EoL) Care for Person with Dementia under the care of Inpatient Mental Health Services	**1, 7 & 9**	Staff the review team spoke to described good relationships with the local palliative care teams.	**Green**

	life care on an older person's mental health ward (and in particular an acute admission ward) the following should always be undertaken: — a clinical risk assessment to determine the appropriateness of end of life care being provided in an older people's mental health facility – the risk assessment should take into account the levels of patient acuity and any potential conflicts that could be present; — an assurance that out of hours medical cover can be provided if the patient's physical condition requires it; — an assurance that equipment can be resourced with the minimum of delay and that patients are never nursed on mattresses on the floor due to a shortage of hi/low beds; — an assurance that patients can be supervised appropriately and not left unattended due to other challenges that ward might face; — an assessment to confirm patients can be nursed in quiet and peaceful environments and that the ward layout can accommodate this; — an incident form should be completed if a patient receives end of life care due to a lack of appropriate alternative placements and difficulties with transport; — consultation with relatives who should be able to request the transfer of their loved one to a different clinical setting if they feel a mental health facility is in any way unsafe or inappropriate; — the training of all registered nursing staff (including night staff) in end of life and palliative care.	• Meeting the Physical Health Care Needs of People Admitted to OPMH Ward • BetsiNet Palliative Care page • Sources of Palliative Care advice and support • Palliative Care training and education • BCUHB Corporate Nursing Palliative Care training **<u>BCUHB briefing document:</u>** A person receiving EoL care in a MH ward will only receive this care if appropriate requirements are met One unit has a specific room allocated for EoL patients There is ready access to palliative care team		Although only one unit has a room specifically set aside for palliative care, appropriate protocols are in place in all inpatient units. The Learning Disability Service is to be particularly commended for its work with a patient with renal failure who underwent a renal transplant, for which they received a Nursing Times award.	

Holden

Rec no	Recommendation	Evidence reviewed (e.g. BCUHB provided documents, report aligned briefing document, site visits and interviews.)	Domain no.	Review team findings from interviews and site visits	Agreed rating
1	*The current arrangements for the Management of the CPG are unwieldly. Responsibilities and lines of management are unclear. Relationships between significant numbers of Staff and Unit/Senior Managers have broken down. There appears to be a high number of temporary and interim posts. The BCUHB needs to review management arrangements of the CPG with a view to strengthening local management of the whole system. The temporary and interim posts need to filled with substantive post holders as soon as possible*	**Provided documentation:** • 7 Minute Briefing • Staff Briefing content • MH&LD current Structure • ACM meeting minutes example • PTR meeting Agenda example • QSDG meeting Agenda example • WW&U Strategy • WW&U 24-month report. **BCUHB briefing document:** The current senior divisional leadership team, was operationalised between 2016 and 2018, is made up of the MH&LD Director and the supporting triumvirate, namely Medical Director, Director of Nursing, and the Director of Operations. Wider members of the senior divisional leadership team comprise of the Chief Financial Officer, Head of Psychology & Psychological Services, Head of Governance and Head of Workforce. A local triumvirate system of Senior Management Teams has been implemented across the division based on the 5 area services (East, Central, West, Regional Specialist Services and Specialist Commissioning Care) structures. The local triumvirate includes Head of Operations, Head of Nursing and Clinical Director. Senior divisional management provides oversight and ownership of divisional governance processes. The division's substantive structure progressed during 2020, with a focus on ensuring that this aligned to the recommendations from external reviews including HASCAS, Ockenden and Health Inspectorate Wales (HIW), particularly aligned to governance.	**5**	Although there has been some progress in the reduction of the number of interim posts, there remains a considerable number of posts filled on an interim basis, often for significant periods of time. This leads to insecurity for staff in interim posts, for grades below the interim posts and for staff managed by those in interim posts, and difficulty in strategic planning. There is in addition at present a lack of full representation of all disciplines at the senior management team level and the role of the Senior Leadership team is unclear. The input of specialist older adults' clinicians into the management team is limited.	**Red** .

		It further strengthened visible and accessible leadership within the areas, and this saw the inception and appointment of Clinical Operational Managers, Clinical Site Managers, Community Service Managers, three Learning Disabilities Matron posts for Health Liaison across the three District General Hospitals and a Criminal Justice Liaison Manager. A number of communication arrangements, systems and processes have also been implemented with the aim of strengthening the lines of management across the division, namely; • Daily acute care meeting • Daily safety huddle meetings • Ward meetings • Area Putting Things Right (PTR) meetings feeding into Divisional PTR • Area Service Quality Delivery Group (SQDG), formerly Quality, Safety and Experience meetings which feed into Divisional SQDG. • Area Operational meetings including Performance, Estates, Workforce, Health and Safety and Ligature Risk Reduction groups. • Management supervision arrangements in place • Senior Management Team visible and present in the area • BCUHB ward accreditation incorporates staff feedback • Inpatient managers walk rounds in place • Head of Nursing regularly undertaking clinical shifts • Open door approach to management and staff aware they can approach managers at any time • Divisional MH&LD staff briefings.			
2	*The issues surrounding the key relationship between the Modern Matrons and the Ward Managers needs to be addressed urgently. This critical breakdown in communication has created a worrying poverty of leadership in the Unit.*	**Provided documentation:** • Training and Development (T&D) Group meeting agenda. • Sharing spaces engagement event feedback **BCUHB briefing document:** As referenced in recommendation 1.	**4**	Staff spoken to in the Hergest Unit felt there was constructive engagement between the management team and the Unit.	**Green**

		Development in leadership and management across all levels within the division is discussed and supported by the MH&LD Training and Development Group and forms a part of the divisional Wellness Work and Us strategy. Links are also made to organisational and national initiatives aligned to leadership development. The Ward Accreditation Programme (detailed further in recommendation 5) aims to support early identification of issues and offer support to strengthen leadership across the MH&LD wards. A Divisional Communication and Engagement plan is currently in development and aligned to the MH&LD Divisional Improvement Plan local engagement events entitled *Sharing Spaces* have been held to engage with staff, feedback was garnered from MH&LD staff which included thoughts on communications across the division. This feedback has been included to support the draft communication and engagement plan for MH&LD. The next stage in development is to strengthen the plan and engage more widely with all internal and external partners and stakeholders.			
3	*Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit. The recently vacated Programme Manager post, could potentially be redesigned as an Advanced Nurse Practitioner or Nurse Consultant role developing and promulgating excellence in Acute Mental Health Nursing in the Hergest Unit and across the Health Board.*	No documentary evidence provided. **BCUHB briefing document:** A number of Nurse Consultant and Advanced Nurse Practitioners are in post across the division to support, develop and lead on the delivery of excellence in MH&LD nursing. The position as of 30th April 2023 was as follows: Advanced Nurse Practitioners X1 B7 in the Central area X1 B8d in the West area Nurse Consultants now appointed in the Division are -X1 8b in Substance Misuse Services X1 8c in the Central area X1 8d in Dementia Services (covering both MH&LD and wider BCUHB since)	**4**	A comprehensive report on numbers and skill mix in Nursing (Safer Staffing Review) was completed recently by the director of nursing (who has now left the Board). This report has not been accepted and the process is being repeated. Lack of physiotherapy staff on Ablett unit has led to nurses and other allied health professionals taking on the function and duties of a physiotherapist while undertaking their own duties. Nursing staff on the unit also have to respond to the doorbell for the unit as there are no front reception staff. Nursing roles in the Hergest Unit should be enhanced to improve the availability of therapeutic options available, including psychological therapies.	**Amber**

				The role of nurses within the unit is made more difficult by the lack of MDT working, because of a lack of dedicated consultant psychiatrist and clinical psychology input. Role titles have been changed from Modern Matron to Clinical Service Manager with no clear rationale as to why and no consultation with nursing professionals.	
4	*Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers. The commencement of this work may not be possible until after the grievance procedures that are currently ongoing have been resolved. Very skilled mediation will be necessary and HR advice will need to be sought on how best to facilitate this. This is such a critical area that it may be that expertise will need to be brought in if not available within the Health Board*	**Provided documentation:** • WP5 All Wales Respect and Resolution Policy • OLM Minutes Respect and Resolution Policy • MH&LD Coaching Cohort June 23 • WW&U Year 3 plan work stream 10 • SBAR for Senior Leadership Team Development Programme • Workplace Mediator Certificate – IH **BCUHB briefing document** The 'All Wales Respect and Resolution' policy was implemented in BCUHB in May 2021; a policy that aims to encourage fairness and positive relationships within the workplace, together with prevention of bullying, harassment, and any form of unacceptable behaviour. Following implementation of the All-Wales Respect and Resolution policy the division has raised awareness through various forums including the Divisional Workforce meetings, Operational Leadership meeting (OLM) and the MH&LD Staff Briefing Within MH&LD, we have a qualified Mediator who is a part of the 'All Wales Mediation Network', where support from external parties can be sought to facilitate skilled mediation processes. Additionally, there are a total of 5 trained coaches within the division with a further 6 coaches in training. In addition, a work stream within the WW&U year 3 plan, as part of the BCUHB Stronger Together 'Just and Learning Culture' programme of work, aligns to facilitating a better understanding and support system for staff relating to workforce policy processes.	**4**	Staff the review team spoke to were aware of how to act and what supports are available should there be concerns about working relationships. They particularly welcomed the support available via the Wellness Hub. However, staff interviewed by the review team described not being consulted about the change in role title from Modern Matron to Clinical Service Manager which was concerning.	**Amber**

		Concurrent with the wider BCUHB Stronger Together 'Integrated Leadership Development' programme, the division has commenced with work dedicated to investing in our current and future leaders			
5	*A structured programme of safety walk arounds and Ward visits should be implemented by the Senior Management Team in order to improve their presence on the wards.*	**Provided documentation:** • MH&LD Ward Accreditation Scoring Tool • 5.2. MH&LD Prompt Sheet for MDT communication template • 5.3. Example of Ward Accreditation immediate actions sheet • 5.4. West Inpatient Service Manager Walkabout Audit (to follow) • 5.5. West Service Manager Monthly Quality Audit (to follow) • 5.6 Health & Safety Executive Notice of Contravention (HSE NOC) Sub-Group Highlight Report **BCUHB briefing document:** A system of inpatient manager walk rounds take place on a monthly basis with reporting at local areas Quality and Safety groups. These are also reported through SQDG along with a breakdown of the matron's monthly quality audits with the scores for the wards audited in that month. A Ward Accreditation Programme is also in place within the division, some challenges have been faced in securing senior leadership engagement to proactively plan regular Ward Accreditation visits across all sites.	**3**	Most staff described the management team at operational level as being accessible and visible, although less so at Directorate level. The frequent safety huddles and the PTR process allow for comprehensive review of safety and quality concerns. An unintended consequence of staff sometimes feel overburdened by too many meetings is some units there are 3 safety huddles per day together with at least weekly PTR meetings. There is often duplication and repetition of information and staff sometimes have to attend meetings where very little of the content is relevant to their service area. The ward accreditation scheme, although welcomed, was thought to require redesign to reflect the more specific issues within mental health units, and also reflect patient feedback.	**Green**
6	*Arrangements for regular briefing of Staff need to be implemented.*	**Provided documentation:** • Example of RSS Daily Safety huddle minutes • Example of West area Daily Safety huddle minutes • Template agenda for West 'Putting Things Right' sub-group • Example minutes of West PTR sub-group meeting • West Area Memo – Safe and effective patient care • MH&LD Patient Carer Experience Group ToR • Daily Safety huddle agenda • MH&LD Staff Briefing contents • Daily safety huddle ToR • 6.10 WW&U Staff Survey results	**3 & 8**	Whilst there has been general improvement in the level of communication and briefing, some concerns were expressed about the lack of engagement of staff in the most recent process around the development of the proposed operational model.	**Amber**

		BCUHB briefing document: As referenced in recommendation 1, multiple structures are in place for regular staff briefings, communication, and feedback across the division. Daily safety huddles form a critical part of the division's arrangements to ensure regular staff briefing. Huddles take place three times daily within each area where risks and issues are escalated, urgent communication is shared, and plans are formulated in the aim of ensuring that staff are supported and equipped to deliver quality patient care. Monthly Divisional staff briefings are circulated to all members working within the MH&LD division			
7	*Steps need to be taken to better engage Staff in the change process. The current implementation plan is clearly in difficulty.*	**Provided documentation:** • Betsi Pathway Methodology • Better by Betsi • Betsi Way Improvement Toolkit • POG Agenda example • T4MH Delivery Plan 2019-22 • T4MH Strategy 2012-16 • Speak out Safely guardians **BCUHB briefing document:** During April and May 2023, the Division undertook a number of engagement events across BCUHB focused on the divisional improvement plan, these were advertised as *Sharing Spaces events.* Staff from a number of disciplines attended the drop-in sessions that were held by the Improvement Lead for Mental Health and the Interim Project Lead for Mental Health. The 'Better by Betsi' community has been launched corporately using the Yammer Communities platform as its 'hub'. It is an organisational approach to building a culture of continuous improvement. The newly established 'Partnerships Planning and Strategy' team within the division is supporting change processes.	**8**	There is good evidence for this overall, however, there is concern that staff have very little knowledge of or engagement with the current process of organisational change.	**Green**

8	*The Communication Strategy needs to be rethought. It needs to reflect the need for staff to be fully engaged on a personal level.*	**Provided documentation:** • MH&LD Draft Communications and Engagement Plan March 2023 • MH&LD Draft Communications Plan Operating Model **BCUHB briefing document:** A draft of the MH&LD Communications and Engagement framework has been established as a precursor to the divisional Communication and Engagement Strategy of which is currently in development. The future strategy will aim to address the needs of all identified internal and external stakeholders, incorporating mechanisms for a continuous cycle of feedback to maximise inclusivity and coproduction of plans and activity across the division. A communications plan has been developed aligned to the MH&LD Operating Model of which will be executed once the final model has been ratified via the agreed governance route. In addition, a communication and engagement plan has been developed aligned to implementation of the Together for Mental Health interim plan 2023-2024 to ensure all internal and external partners and stakeholders are aware of the plan moving forward.	**n/a**	As noted above (Recommendation 4 of Ockenden 2 report), staff report significant progress in Board to Staff communication. However, there have been concerns expressed about the lack of staff engagement in the current organisational review. It is also unclear to what extent nursing staff were involved in the recently completed safer staffing review of nursing.	**Amber**
9	*Change champions need to be identified throughout the unit, including the more junior and unqualified Staff. Arrangements should be put in place to ensure their time is protected to enable their full participation. This approach would, in part, mirror the successful inclusive approach to change adopted by the current Interim Modern Matron when Ward Manager on Taliesin*	**Provided documentation:** • MH&LD 'You Said We Did' staff survey feedback **BCUHB briefing document:** Staff Engagement Ambassadors are employees of BCUHB who are equipped with the skills, tools, and knowledge to drive forward the engagement agenda, promoting activity under the following headings: **1**.Be recognised. Appreciation of the work we do through the submission of Seren Betsi Award nominations and encouraging regular recognition within their area of work **2**.Be engaged at all levels: Opening the channels of communication with senior managers, promoting Ask the panel events and Tea with the CEO **3.**Be enabled to make change: 3D model (Discover, Debate, Deliver) . A model that involves the entire team in	**n/a**	The review team were satisfied with the information provided by the briefing document from BCUHB.	**Green**

		improvement and development, providing the opportunity to contribute to change within the workplace **4**.Be empowered to speak up: Encouraging participation in staff surveys and opportunity to attend bi-annual meetings with the CEO and Executives for a 'Voices from the floor' session to share positive stories and any challenges that they felt they could benefit from having support with. We have approximately 56 Staff Ambassadors signed up within MH&LD.			
10	*The concurrent implementation of the eight HIP work streams needs to be reconsidered. A glance at the plethora of implementation documents on the HIP notice board is a manifestation of the difficulties being experienced by the current implementation process. A better approach may be to consider the relative urgency of the work streams and prioritise them into smaller steps, in which the staff are engaged.*	**Provided documentation:** • MH&LD Divisional Improvement Plan: Key Performance Indicators. **BCUHB briefing document:** The HIP has been stood down in favour of local supportive governance structures. Direction for major service improvement and changes across the division is now supported by the T4MH strategy, MH&LD Divisional Improvement Plan operating model and a number of HIW Actions plans. The Divisional Governance Framework has been strengthened to ensure regular monitoring, review and reporting occurs from ward to board aligned to the MH&LD Divisional Improvement plan, HIW Action plans and other quality safety action plans. Work streams outlined within the MH&LD Divisional Improvement Plan include sub-themes and task level detail to support staged implementation and action aligned to divisional priorities. The plan has been developed and aligned to HIW standards, internal and external reports, inspections, and incidents which include the Holden Report, Ockenden report and the HASCAS report. The newly established 'Partnerships Planning and Strategy' team support the delivery of service improvement across the division. A number of service improvement programmes are ongoing, of which are broken down into tangible work streams and supported by a nominated Assistant Development Officer.	**8**	The review team were satisfied with the information provided by the briefing document from BCUHB.	**Green**

		The Officers are responsible for ensuring that staff, and stakeholder, engagement is an active element of the project management and change process. The Programme Oversight Group (POG) provides the overarching governance and assurance against programme implementation within MH&LD. It oversees work streams ensuring that each project has set phases which are outlined in the plans and ensures that implementation is on track and still relevant in terms of their prioritisation against the priorities of the division. Stakeholder management is a key thread through each of the implementation phases and is set out within each project workbook. The POG reports into the Operational Leadership meeting which feeds into the Divisional Senior Leadership Team and will escalate any decisions required to support any changes and reviews of priorities.			
11	*Arrangements need to be made for the Ward Staff to have opportunity engage with external networks of similar organisations. This is particularly important considering the relative isolation, geographically, of the Unit. Otherwise, the opportunities for sharing and learning from best practice will be extremely limited*	**Provided documentation:** • Strategic Mental Health Workforce Plan for Health and Social Care Wales • Learning Event November 2021 and May 2023 • Divisional Governance Framework **BCUHB briefing document:** The Division is part of the UK Mental Health Benchmarking analysis. Attendance at external events has inevitably been impacted by the COVID-19 pandemic, however, with the development of the divisional Communications and Engagement strategy, further opportunities for engagement and networking with professionals and wider stakeholders external to the division will be identified.	**7**	Staff appear to have limited opportunities to engage with external networks of similar organisations within Wales or the wider UK. One example was that the PICU's membership of National Association of Psychiatric Intensive Care Units (NAPICU) had lapsed and was only now in the process of renewal. Other staff who were interviewed were not in general connected to external networks either professionally or in other organisations There is very limited evidence that staff access or use national networks or UK wide good practice examples or benchmarks.	**Red**
12	*A training and development programme, including arrangements for Appraisal, Management Supervision and Clinical Supervision, needs to be implemented for all Staff in the Unit. The weekly minuted Ward Managers meetings need to be reinstated without delay.*	**Provided documentation:** • MH&LD Training and Development Group ToR • MH&LD Performance Appraisal Development Review (PADR) compliance data May 22-23 • ASiM status MH&LD June 23 • BCUHB Just and Learning Culture, Stronger Together Programme • MH&LD Supervision Guidance • WARRN training poster	**n/a**	There is a comprehensive system for provision and monitoring of training. Staff the review team spoke to did not express any difficulties in being freed up to attend training. However, as noted in recommendation eleven above, staff appear to have limited opportunity to network with organisations	**Green**

		• PICSS training report • Appraisal update 2023. **BCUHB briefing document:** Performance on compliance with PADR is monitored and reported monthly as part of the divisional Key Performance Indicators (KPIs). Compliance has shown a rise in performance from 81% in May 2022 to 85.4% in May 2023. Mandatory training compliance is also captured and reported monthly within the KPIs, illustrating an increase from 89.5% in May 2022 to 92.3% in May 2023, and MH&LD continues to have the highest compliance rate in BCUHB for Level 1 (91.91%) and Level 2 (84.08%) mandatory training. Compliance for both PADR and mandatory training is monitored locally and reported at the divisional Service Finance Performance Delivery group and the Service Quality Delivery Group on a monthly basis. A MH&LD Training and Development Group was established, taking place on a monthly basis from September 2022, to lead on training and development initiatives A quality audit of supervision notes took place in February and March 2023.		and professional groupings in the rest of the UK or indeed the rest of Wales. In addition, the review team have not seen individual supervision records or how they link to professional development needs or NMC revalidation processes, nor have the review team seen a record of medical staff appraisal.	
13	*A system of recognition would be helpful where the contribution of individual Staff is celebrated.*	**Provided documentation:** • GREAT-ix staff recognition platform • West Performance Report March 23 Good News Stories • Seren Betsi MH&LD Nominations • Long Service & Achievement Awards Nominations **BCUHB briefing document:** BCUHB Achievement Awards take place annually and staff can be nominated or nominate others for recognition and celebration of their work. Since 2019 there has been 127 nominations made for staff within the MH&LD division. The achievement awards were paused during 2020-21 during the pandemic.	**7**	Staff are aware of the achievement awards and concepts such as 'Great-Ix'. The recent Nursing Times award to the Learning Disability Service is to be commended.	**Green**

		There have been 32 MH&LD staff nominated for the Seren Betsi award since 2019, recently the Training, Development and Wellbeing lead was awarded the Seren Betsi award. The 'Cheers 4 Peers' system for staff rewards was implemented in October 2020, being a system of recognition for staff excellence and good practice and is in the process of being rolled out across the Division. Good news stories and compliments from colleagues and patients are also reported into the local Quality Safety and Experience meetings, these stories also then feed into the local Finance and Performance report that is shared with staff for information. 'Great-ix' is a concept stemming from the Learning for Excellence movement providing healthcare staff an opportunity to report episodes of good practice or when things work well. It enables us to show appreciation to staff for their good work and secondly to learn from their excellent practice			
14	*Urgent attention needs to be paid to the how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. This discrepancy is deserving of detailed scrutiny.*	**Provided documentation:** • Safer Staffing report • 14.3 Just R quarter one report **BCUHB briefing document:** The e-roster system provides an indication of whether safe staffing levels are achieved and is regularly reviewed by the inpatient manager and the Head of Nursing. All incidents where staffing drops below required safe levels are subject to Datix reporting and immediate review / action. The establishment of safety huddles within each area three times daily aim to support prompt escalation of risks and issues relating to ward staffing. A MH&LD Safer Staffing review has taken place across the division; a review of ward nursing establishments with a focus on staffing numbers, clinical skills, patient experience and quality outcomes. The review incorporates benchmarking and divisional-specific data to allow for identification of issues and propose recommendations for improved staffing establishments across each of the areas.	**4**	The recent safer staffing review was not accepted by staff as being an accurate reflection of the needs of various parts of the service. Having received this feedback, the review is being repeated.	**Amber**

		The latest MH&LD Safer Staffing review is awaiting full ratification by the health board prior to implementation across the Division, planned for the later part of 2023.			
15	*Staffing should be planned in such a way that it would be exceptional for Staff working a twelve-hour shift to be unable to take a break.*	**Provided documentation:** • MH&LD Safe Staffing Escalation Procedure • 15.2 Auto cascade SOP BCUHB **BCUHB briefing document:** All shifts are created in the E Roster system, with staff breaks taken into account. All incidents where staffing drops below required safe levels are subject to Datix reporting and immediate review /action. The establishment of safety huddles within each area three times daily aim to support prompt escalation of risks and issues relating to ward staffing. Acute Care Meetings (ACM's) also take place for each of the four senior Leadership Teams (Centre/East/West/\Regional) and would address escalations relating to safe staffing. In addition, Site Response is utilised by bank staff to accommodate any staff shortages to ensure that staff are able to take their scheduled breaks. The Division reports on safer staffing levels on a regular basis, and a copy of the report is included in the Appendix. A recent initiative across BCUHB, called auto cascade, has been developed and implemented at the beginning of June aimed at supporting a timelier response to any staffing shortages utilising agency staffing across all MH&LD wards.	**15**	The review team was unable to establish if staff working 12-hour shifts were able to take a break. There continue to be difficulties in recruiting permanent staff and some concerns about ongoing reliance on agency staff. However, the review team was told that incidents where staffing levels drop below required safe levels are rare and subject to reporting. Staffing concerns are brought to the safety huddles which occur up to three times daily. Review team did not see evidence that teams were using the Mental Health Optimal Staffing Tool MHOST or similar evidence-based tools to ensure that staffing levels were adequate for the acuity of the wards. The recently introduced auto cascade system for managing locum and agency staff is no longer operational as staff reported that it was not effective.	**Amber**
16	*The issues surrounding the Junior Doctors Rota needs to be resolved urgently.*	**Provided documentation:** • MH&LD Pan Junior Doctor rota Jan-June 23 **BCUHB briefing document:** The Junior Doctor rota is currently operating successfully with no issues identified relating to rota cover. Occasionally, shifts will include two doctors; a process within the division for ensuring that all new junior doctors are supported by a mentor when joining the rota.	**7**	The evidence provided plus feedback from staff during the site visits and interviews indicate that the rota operates successfully with clarity of supervisory arrangements and clear protocols.	**Green** .

		All Junior Doctors are supportive in managing cover for the rota in exceptional circumstances where a gap may arise. There is an allocated substantive Consultant who provides pastoral support to Junior Doctors within their area of which takes place in the form of weekly supervision sessions A total of 258 applicants were received to Junior Clinical Fellows/CT LAS positions within the MH&LD in quarter 4 of 2022/23. Of total applicants, 8 were appointed. This illustrates success in recruiting to Junior Doctor positions within the division, of which will support ensure the continuation of an efficient Junior Doctors rota.			
17	*The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed. The Ward Staff find the current arrangements difficult, and it is likely that the current situation will have a deleterious effect on recruitment and retention of Senior Medical Staff.*	**Provided documentation:** • Clinical Strategy • Just R Medical recruitment photography sessions • MH&LD Recruitment & Retention Plan **BCUHB briefing document:** The Mental Health & Learning Disability Division has developed a clinical strategy for 2022-23 following the publication of the first document in 2017, incorporating the governed strategic work which started in 2018. During the pandemic, the MH&LD Division continued with improvement and transformation by created or improved services such as Perinatal Mental Health, Early Intervention in Psychosis, Eating Disorders, Liaison Psychiatry, Substance Misuse Services and Prison Mental Health. This Clinical strategy describes the priorities and future direction of clinical services and defines the mission statement that has been agreed in co-production with patients and carers, who remain at the heart of the strategy along with improved engagement with other crucial statutory stakeholders, our partners, the voluntary sector, the wider health board, and the community we serve. The Division has a number of programmes that include evaluating and reviewing the current clinical pathways to standardise them across the Division	**6**	Within adult mental health, there continue to be differing models of medical care but in general a traditional consultant led model is in place. There is a particular concern in the western sector where the in-reach from community model of care impairs the ability to deliver full multidisciplinary team working in the inpatient unit. There is a lack of multidisciplinary working and of access to psychological therapies evident in the Hergest Unit.	**Red** .

18	*The current arrangements for the care of frail elderly Patients needs to be urgently reconsidered. It is clearly unacceptable for the needs of frail vulnerable people to be neglected in the way that has been reported*	**Provided documentation:** • MH&LD Single Sex Wards scoping exercise • SBAR Co-horting • MEMO Over 70's admission Hergest **BCUHB briefing document:** The MH&LD Division established a task and finish group in January 2022 to draw a plan to stop the mixed co-hosting of younger and older people with functional illnesses on the same acute wards in the Hergest Unit. Training is in place to ensure that staff delivering MH&LD services are trained to manage physical health issues and are competent to deliver care to older patients. A new 'physical health' room was launched at the Heddfan Unit in the East area in June 2022 A Dementia Nurse Consultant is in post within the MH&LD division.	**n/a**	The cohorting of older patients with younger adults no longer occurs. However, this means that the elderly functionally ill from the western sector have to be admitted to units at some distance from their homes. Training programmes have been put in place to assist nursing staff in the management of physical health issues in elderly patients. Access to specialist medical advice is in general good with rapid responses from the acute intervention teams. There can be some delays in the Heddfan unit because the patient has to wait for an ambulance to transport him or her across the road to the emergency department	**Green**
19	*The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patients.*	**Provided documentation:** • MH&LD Nurse In Charge SOP • MDT communication prompt sheet (as 5.2.) • MH&LD West Area MDT ToR • West Ward Round timetable **BCUHB briefing document:** The Medical Director has emphasised the importance of weekend ward reviews of patients admitted over weekend and bank holidays to avoid patients waiting for their timetabled ward reviews with sector consultants. The ward round timetabling has been proactively managed by the respective inpatient ward managers to avoid overlap of multiple reviews taking place and disrupting nursing input. This has also led to more predictable inpatient ward reviews which aim to be multidisciplinary. The Ward Accreditation programme enables the regular review of MDTs and Ward Rounds to support evidencing progress against key improvements in MDT communication and handover.	**6**	In the acute units that the review team visited the review team saw good evidence of MDT working, however, within the Hergest ward, there is no evidence that multi-disciplinary ward rounds occur other than on an ad hoc basis. There is no evidence of active engagement of disciplines other than medicine and nursing in ward rounds when they do occur. Nursing staff are often unaware of when to expect consultant staff on the ward. Multidisciplinary team discussions do occur in cases of complexity but there is no evidence that they occur on a regular basis.	**Amber**

		The MDT Communication Prompt sheet is included in the Appendix. Additionally, monthly MDT meetings are held in each area to support strengthen local multidisciplinary team working. Safety huddles take place three times daily on weekdays and twice daily on weekends across all areas of the division. This provides a forum for the escalation of risks and issues, sharing of urgent communication and the formulation of plans with the aim of ensuring that wards are appropriately staffed, supported, and equipped to deliver quality patient care. Arrangements for local Acute Care meetings are also in place across the division. These meetings take place daily for discussion and review of immediate patient needs to ensure effective patient flow. This also provides a forum for early escalation of identified risks or issues. The MH&LD Nurse In Charge (NiC) standard operating procedure was activated in December 2022. This details the roles and responsibilities relating to ward handover, updating staff on changes in patient care plans, and ensuring that patient status, whiteboard, and fireboard are kept up to date.			

6. Acknowledgments

The Health Board's mental health and learning disability services have been subject to a high degree of external scrutiny since 2013. There are eighty-four total recommendations from the reports that this review focused on. In deciding to what extent all the recommendations had been implemented, the team considered that the views of staff, service users and carers, and the findings of reviewers when they visited the various units in person, were as important as the documentary evidence provided.

The reviewers would like to express their appreciation and thanks to all those who gave their time to help us complete this review. We particularly appreciate the input of patients and carers, and of those external to the Health Board. We were made to feel very welcome by all. We would like to thank the Health Board for facilitating our visits and assisting in the arrangements, and for providing the review team with documentation.

Throughout our interactions with members of Health Board staff in all the units we visited, and during our online interviews, we were struck by the dedication of the staff and their clear commitment to patient care and to service improvement. Of the staff we met, we found them to be pleasant, warm, and engaged. They took pride in their work and, despite some pressures and difficulties, appeared in the main to be happy to work in the Health Board.

Appendices

Appendix A: Invited Review Service team

- Dr Mayura Deshpande, Clinical Advisor to IRS
- Sadhbh Fitzgerald, RCPsych, IRS Programme Manager (CCQI)
- Catherine Gamble FRCN, Independent Nurse reviewer
- Paul Hopley RMN, Deputy Director of Mental Health, Mental Health Improvement Support Team, IRS Nurse reviewer.
- Dr Chineze Ivenso, Consultant Old Age Psychiatrist, Aneurin Bevan Health Board, Academic secretary for the RCPsych faculty of Old Age Psychiatry and IRS reviewer
- Professor Gerry Lynch, Consultant General Adult Psychiatrist, Lead IRS Reviewer
- Dr Alan Quirk, RCPsych, Head of Clinical Audit and Research (CCQI)
- Veryan Richards, IRS Lay Reviewer
- Peter Thompson, RCPsych, Director of CCQI

Appendix B: Feedback on implementation, by service-delivery domain

Key : *Strength of evidence demonstrating the implementation of recommendation and extent to which it has been embedded in practice.*

Good/strong evidence	Some evidence	Little/no evidence

Domain 1: Patient and carer centred care

Summary of recommendation	Source	Rating
There should be a review of the risk assessment systems in place for elderly patients who are or become violent / aggressive as part of their conditions.	Ockenden 1 recommendation 26	
The 'Dementia Strategy' should be developed to work across all relevant clinical services across BCUHB, not just within the MH&LD Division.	Ockenden 2 recommendation 8	
BCUHB will conduct a review of all clinical policies.	HASCAS recommendation 11	
Care Advance Directives and Support to Patients and Families.	HASCAS recommendation 14	
End of Life Care Environments.	HASCAS recommendation 15	
Clinical leaders (medical and nursing) should spend a defined portion of their working week within the clinical area alongside and listening to patient and relative feedback.	Ockenden 1 recommendation 12	
BCUHB needs to work effectively at a strategic level with the third sector, carers, service user representatives and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales.	Ockenden 2 recommendation 5	

Review team observations

There is an extensive training package and an up-to-date policy for the management of aggression and violence in all patients. However, the paper-based patient record system mitigates against safety.

The pan BCUHB role of the consultant nurse in dementia is welcome but a similar post that is Directorate specific has not yet been filled. The recently appointed advanced nurse practitioner and practice development posts are not specific to dementia care and there are ongoing difficulties in data gathering in dementia. There has been limited uptake of tier 2 & 3 training.

A view has been expressed that the needs of older adults are not given the necessary attention in the Directorate and the current management structure may not be conducive to comprehensively meeting the needs of older adults.

Caniad meetings have been described as information sessions rather than true partnership working. and service user/carer engagement at a strategic level did not appear to be well developed.

There is evidence of innovative practice in the Regional Secure Unit, with third sector organisations providing arts and music sessions together with the OT department. Patients the review team spoke to find this service extremely valuable.

The iCAN hubs, set up throughout the Board area, are a good example of partnership working between the Health Board and the third sector.

Representatives from outside agencies described generally good partnership working but some difficulties in pockets of the Board with the system not working as consistently as it could be. The Patient and Carer Experience (PCE) group meets regularly but the most recent meeting was not quorate and there is no clear evidence embedding or coproduction.

There has been a recent separation of social workers from the CMHTs, which has led to difficulties in partnership working.

Staff described good relationships with the local palliative care teams. Although only one unit has a room specifically set aside for palliative care, appropriate protocols are in place in all inpatient units. The physical healthcare room in the Heddfan unit is another example of good practice.

Domain 2. Clinical guidelines/legislative requirements

Summary of recommendation	Source	Rating
Systems and resources in place to manage high risk clinical scenarios.	Ockenden 1 recommendations 26-30	
All older adults and those with dementia are in receipt of lawful and safe interventions in relation to restrictive practice management across all care and treatment.	HASCAS recommendation 13	
Medication - The updated BCUHB 2017 antipsychotic prescribing guidance will be kept under review and be subject to audit.	HASCAS recommendation 10	
A DoLS workplan will be developed.	HASCAS recommendation 12	
DoLS - BCUHB will conduct a formal audit and provide a progress report.	Ockenden 2 recommendation 9	
BCUHB will conduct a review of all clinical policies.	HASCAS recommendation 11	
A sound Safeguarding structure is in place.	Ockenden 2 recommendation 6	
BCUHB will revise its safeguarding training programme to ensure it is up-to date and fit for purpose. Clinical Records - BCUHB needs to undertake a detailed check of the clinical records in the investigation cohort to evaluate and re-order all commingled case notes. The Tracking of Adults at Risk across North Wales.	HASCAS recommendations 4-9	

Review team observations

There is evidence of a falls bundle and regular monitoring of falls by the Datix system, leading to discussion at the PTR groups and learning and action as appropriate. However, there was not strong evidence of how wider learning was adopted and spread throughout the Health Board area.

There is a comprehensive training package to accompany the therapeutic observation policy. Staff described some difficulties in accessing extra staff when required in accordance with the agreed procedures, especially in the more isolated units.

There is an extensive training package and an up-to-date policy for the management of aggression and violence in all patients. But as noted elsewhere patient record system mitigates against safety.

The policy on meeting the physical healthcare needs of those admitted to mental health wards was due to be reviewed in September of last year. No evidence was seen of the recruitment of RGNs. The opening of the physical health care suite in Heddfan has improved that unit's ability to diagnose and manage medical conditions however, nursing staff have obtained training in the use of NEWS and are satisfied that medical opinions and assessments can be accessed in a timely manner.

The review team received verbal reassurances that DVT prophylaxis is used appropriately but has not as yet seen the whole system review as described in the statement of evidence. However, an audit of VTE risk assessment in OPMH has been carried out in early 2023. The physical health strategy is in the process of being developed but has not as yet been implemented.

The review team have been told that antipsychotic medication prescribing is subject to regular audit and review at the medicines management committee. The review team also note that a consultant pharmacist is in post. There was evidence of audit of antipsychotic medication prescribing in 2019 and again in 2023, but this was confined to inpatient wards. The CQST tool for monitoring antipsychotic medication in care homes looks extremely comprehensive, but the form presented to the team is blank and no information is available as to how regularly it is used.

There is a high level of compliance with mandatory DOLS/MCA training. Staff the review team spoke to were aware of how to access training, and of how to access the policy and procedures via the Intranet. Staff described having access to training and information about the MHA/MCA and patients detained under the MHA described being made aware of their rights and having access to advocacy.

There is clear evidence of a comprehensive system for policy review in place as reported by the Health Board. However, there was evidence of some out-of-date policies. Comprehensive Safeguarding systems and training programme are in place.

Domain 3: Governance

Summary of recommendation	Source	Rating
The Board should interrogate further and in detail the information from the currently interim Tawel Fan mortality review being undertaken. There needs to be an urgent review of the Datix system undertaken to assess whether potential 'clues' to a possibly longer-term problem around the number of deaths within/ associated with Tawel Fan ward have been 'missed'.	Ockenden 1 recommendations 17, 18	
There should be a complete overhaul of the concerns/complaints/serious incident reporting structure and an overhaul of the system of learning from these issues.	Ockenden 1 recommendation 7	
The Board must respond to concerns in a timely manner.	Ockenden 2 recommendation 7	
Quality Impact Assessments (where the clinical implication of financial savings plans are assessed by Executive members of the BCUHB Board) are in place. There is full integration of the systems, structures and processes underpinning financial, corporate, and clinical governance.	Ockenden 2 recommendations 2a, 2b	
Appropriate culture around dementia and dementia care at every level.	Ockenden 2 recommendation 14	
A review of external reviews will be undertaken.	Ockenden 2 recommendation 10	
There should be an immediate review of the scale of all operational, clinical, and managerial roles across the CPG with a realistic assessment of the ability of the current individuals in post to perform in their roles.	Ockenden 1 recommendation 11	
Arrangements for regular briefing of Staff need to be implemented.	Holden recommendation 6	
The Health Board needs to undertake a detailed check of clinical records to evaluate and reorder all commingled case notes.	HASCAS recommendation 9	
A structured programme of safety walk rounds, and ward visits should be implemented by the senior management team in order to improve their presence on the wards	Holden recommendation 5	

Review team observations

The review team are concerned that there is no electronic notes system and no time scale for the introduction of such a system. This leads, in our view, to a significant governance concern as the Health Board covers a very large geographical area with scattered teams and services across multiple sites. There can be difficulties in timely access to notes and relevant clinical information especially out of hours or when a patient is being admitted or treated out of sector. The absence of an electronic notes system was repeatedly mentioned by staff as a major concern. In addition, on call medical staff cannot use personal login to access notes in the one area which does have electronic notes (the regional secure unit) which appears to us to be a GDPR breach.

There is in place a comprehensive governance system with extensive use of the PTR system at unit and divisional level. The frequent safety huddles and the PTR process allow for comprehensive review of safety and quality concerns.

Staff described their experience of two recent Serious Incidents (SIs), which were systematically investigated. Staff participated in the SI process and felt supported throughout. They especially found the support of the well-being hub valuable. There was learning from the SIs which was implemented. During the course of the review, it was not possible to determine whether that learning from SIs is consistently applied throughout the Health Board and it is important that the Board ensures this happens.

However, there were some concerns expressed that learning from PTR meetings did not always reach staff working 'on the ground' and one service user expressed dissatisfaction with how a complaint they had raised was addressed.

In addition, frustration was expressed by staff about the number of meetings in which there was duplication and repetition, both of information expected to be supplied by staff and of learning lessons. Recognising that learning can occur from areas not in the particular clinical responsibility, some staff expressed the view that they had to attend Safety and PTR meetings that had no relevance to their clinical area.

There is a comprehensive system in place for monitoring and responding to incidents, concerns and complaints in which clinicians and managers are engaged. However, service users interviewed for the review were not satisfied with how a complaint was addressed and there continue to be a number of overdue complaints. In addition, staff expressed a view that the system could at times be 'over-comprehensive,' with multiple meetings at which the same information was repeated and duplication in processes. There was also a view of a 'one size fits all' approach, with processes not always focusing on problems particular to service areas. In addition, the lack of an electronic records system is likely to lead to difficulties in that risk alerts may not be available in a timely fashion.

Recognising that significant improvements have been made, the review team was concerned that the Consultant Nurse post for dementia had not yet been filled and that the practice educator posts are not specific to dementia. The low uptake for tiers 2&3 training in dementia is also noteworthy.

It has been reported that issues concerning dementia are discussed hurriedly at generic PTR meetings, with the great majority of the time being devoted to matters in the general adult services.

Although there is a lead consultant for older adults' psychiatry who has a pan-BCU role, management of older adults' mental health services sits within a generic management structure. This may impede the promotion of an appropriate culture around older adults' mental illnesses including dementia.

Most staff described the management team at operational level as being accessible and visible, although less so at Directorate level. However, this is not a consistent view and there were some in which staff said that managers were not visible and accessible.

The ward accreditation scheme although generally welcomed was thought to require redesign to reflect the more specific issues within mental health units.

Whilst there has been general improvement in the level of communication and briefing, some concerns were expressed about the lack of engagement of staff in the most recent process around the development of the proposed operational model.

Although at one level, there is a clinically led and clear and accountable management structure, the numbers of posts that are held on an interim basis for a prolonged period of time together with the constant reviewing of the management structures has led to uncertainty for staff and difficulty in forward planning. This has a 'knock on' effect of recruitment at all levels, particularly at band 5 and 6 levels and perhaps contributing to high agency use.

A new organisational model is in the process of being developed but there has not been consultation so far with staff and it is not clear what process is being followed. In addition, there was not the evidence presented to us that indicated that there was full multidisciplinary input into the management structure. The review team were also concerned that older adults' mental health services were not adequately represented in the Directorate management structures.

Domain 4. Staffing

Summary of recommendation	Source	Rating
BCUHB should take active steps to appoint a second Consultant Nurse in Dementia.	Ockenden 2 recommendation 2d	
Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit.	Holden recommendation 3	
Urgent attention needs to be paid to the how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. Working patterns should be appropriate.	Holden recommendation 14	
BCUHB will need to provide significant amounts of targeted workforce and organisational development support in the form of extra team members to support the MH&LD Division and specifically OPMH with recruitment and retention expertise across medical, nursing and support services going forward.	Ockenden 2 recommendation 2c	
The issues surrounding the lack of constructive engagement between the Senior Management Team and the staff of the Hergest Unit needs to be addressed urgently.	Holden recommendation 2	
Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers.	Holden recommendation 4	
Staffing should be planned in such a way that it would be exceptional for Staff working a twelve-hour shift to be unable to take a break.	Holden recommendation 15	

Review team observations

To our knowledge, there is no consultant nurse with specific responsibility for dementia within the mental health and disability directorate. There is one consultant nurse who has board wide responsibilities. The lack of a consultant nurse is impairing the directorate's ability to take forward the dementia strategy. There are also no nurse practitioners specifically for dementia care.

It is important that the post of Executive Nursing Director in mental health be filled on a substantive basis as soon as possible.

Nursing roles in the Hergest Unit should be enhanced to improve the availability of therapeutic options available. The role of nurses within the unit is made more difficult by the lack of multidisciplinary working, in particular the lack of dedicated consultant psychiatrist and clinical psychology input.

The recent safer staffing review was not accepted by staff as being an accurate reflection of the needs of various parts of the service. Having received this feedback, the review is being repeated.

It is concerning that staffing levels did not allow for breaks and also had an impact on the ability to allow Section 17 leave patients to leave the area.

There have been many initiatives in the area of recruitment and retention with active recruitment campaigns. The 'Streamliners' programme has been especially well received.

The service continues to have difficulty in recruiting staff, especially medical staff in the Western sector. This is having an impact on the quality of care in the Hergest Unit. Efforts need to focus on areas of particular difficulty.

The title of matron has been changed to 'clinical service manager' with no consultation and no clear change in role. It is unclear why this has occurred and by whom it was authorised.

Domain 5. Management structure

Summary of recommendation	Source	Rating
There should be an immediate review of the scale of all operational, clinical, and managerial roles across the CPG with a realistic assessment of the ability of the current individuals in post to perform in their roles.	Ockenden 1 recommendation 11	
The BCUHB needs to review management arrangements of the CPG with a view to strengthening local management of the whole system. The temporary and interim posts need to be filled with substantive post holders as soon as possible.	Holden recommendation 1	
Board to ward communication including access to NHS Wales emails.	Ockenden 1 recommendation 9	

Review team observations

Although at one level there is a clinically led and clear and accountable management structure, the number of posts that are held on an interim basis for a prolonged period of time ,including posts at a senior management level, together with the constant reviewing of the management structures has led to uncertainty for staff and difficulty in forward planning.

A new organisational model is being developed but there has not been consultation so far with staff and it is not clear what process is being followed.

In addition, as noted elsewhere evidence was not presented to the review team which indicated that there was full multidisciplinary input into the management structure.

It is concerning that older adults' mental health services were not adequately represented in the Directorate management structures

Domain 6. Clinical service organisation

Summary of recommendation	Source	Rating
Urgent review of medical care/provision across elderly mental health services needed and action taken to improve the standards if expressed concerns are proven.	Ockenden 1 recommendation 21	
Systems/resources in place for management of deteriorating patient.	Ockenden 1 recommendation 29	
The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed.	Holden recommendation 17	
The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patient.	Holden recommendation 19	
There should be a clear set of measurable standards set for the care of frail older people with dementia across BCUHB.	Ockenden 1 recommendation 3	
Review, redesign, and development of a new service model for older people and those with dementia across the six counties of North Wales.	Ockenden 2 recommendation 1	
BCUHB needs to work effectively at a strategic level with the third sector, carers, service user representatives and a wide range of multi-agency partners to develop, provide and sustain services to older people and older people with mental health needs and dementia across North Wales.	Ockenden 2 recommendation 5	
Care Pathway and Service Design - An integrated service review is required to map the needs of the older adult and those with dementia across North Wales.	HASCAS recommendation 1	
Dementia Strategy - BCUHB is required to develop a detailed and costed action plan to support the implementation of its Dementia Strategy.	HASCAS recommendation 2	
Care Homes and Service Integration - The current Care Home work streams need to be incorporated into a single action plan, which in turn should dovetail into the pre-existing BCUHB Mental Health and Dementia Strategies.	HASCAS recommendation 3	

Review team observations

Despite attempts to recruit, it continues to be difficult to fill substantive posts in old age and adult psychiatry, especially in the western sector. This has an impact on models of care. This is a particular issue in the western sector where the in reach from community model of care impairs the ability to deliver full multidisciplinary team working in the inpatient unit.

Within Hergest ward, there is no evidence that multi-disciplinary ward rounds occur other than on an ad hoc basis. Multidisciplinary team discussions in the inpatient unit do occur in cases of complexity but there is no evidence that they take place on a regular basis. Nursing staff are often unaware of when to expect consultant staff on the ward. In general, there is a lack of multidisciplinary input into the ward and a need to improve access to psychological and occupational therapies. This has a direct impact on the delivery of high-quality patient-centred care.

The policy on meeting the physical healthcare needs of those admitted to mental health wards was due to be reviewed in September of last year (2022). There was no evidence of the recruitment of RGNs. However, nursing staff have obtained training in the use of NEWS and are satisfied that medical opinions and assessments can be accessed in a timely manner.

Within adult mental health, there continue to be conflicting models of clinical care but there is a dominance of a medical model of care. There is little evidence of implementing and embedding a consistent therapeutic approach throughout the Health Board.

In dementia care, there has been service redesign with the development of a comprehensive memory assessment service, primary and secondary care dementia teams, older adults' mental health care teams and an older adults' service within the liaison and home treatment teams. The memory assessment service is described to us as providing both pre diagnostic and post diagnostic support. The inpatient wards for patient with dementia provide a comprehensive service for those with comorbid illness and behavioural and psychological symptoms of dementia that require inpatient treatment. However, stand-alone units in relatively isolated settings can find it difficult to maintain and embed all standards consistently.

Dementia services are managed within the geographical directorate structure. Memory assessment services are operational in all areas and one service has achieved MSNAP accreditation. There are primary and secondary care dementia teams in the 3 geographical directorates. However, the recently introduced practice development posts do not focus specifically on dementia care and there is no consultant nurse post within the directorate that focuses on dementia. In addition, the links with social work could be improved and service user/carer involvement needs to be further developed.

In terms of practical outcomes, the proposed pilot of in reach workers into four care homes in the Eastern sector is welcome but this work needs to be expanded. The review team were supplied with 2 CQST tools which are intended assess care in care homes across multiple domains, but they were blank, and it is not clear if these are routinely used. Deprivation of liberty and safeguarding issues are adequately addressed.

Further work needs to be done in providing education and training in dementia, in reach into care homes and involvement of service users and carers in service development.

In regard to partnership working with service users and carers, the 3rd sector and statutory organisations, service users expressed disappointment and frustration and the lack of engagement with the Health Board. Caniad meetings have been described as information sessions rather than true partnership working, with no evidence of co-production. It is clear that further work needs to be done to develop an authentic model of service user engagement.

There is evidence of innovative practice in the Regional Secure Unit, with 3rd sector organisations providing arts and music sessions together with the OT department. However, this initiative appears to rely on charitable funding.

The iCAN hubs, set up throughout the Board area, are a good example of partnership working between the Health Board and the 3rd sector

Representatives from outside agencies described generally good partnership working but some difficulties in pockets of the Board with the system not working as consistently as it could be.

In Community Mental Health Teams, here has been a recent separation of social workers from the CMHTs, which has led to difficulties in partnership working.

Domain 7. Training & development

Summary of recommendation	Source	Rating
The BCUHB should implement an extensive and intensive skills and knowledge package around care of patients with dementia and support of their families.	Ockenden 1 recommendation 13	
There should be a review of the training, support and supervision of junior doctors by consultant colleagues in mental health services for the elderly in North Wales.	Ockenden 1 recommendation 20	
The issues surrounding the Junior Doctors Rota need to be resolved urgently.	Holden recommendation 16	
A System of recognition would be helpful where the contribution of individual staff is celebrated.	Holden recommendation 13	
Care advance Directives and support to patients and families. Suitable end of life care environments.	HASCAS recommendations 14, 15	
The Board should take appropriate steps with the two regulatory bodies to safeguard the best interests of patients utilising elderly mental health services across the catchment area of the BCUHB.	Ockenden 1 recommendation 15	
BCUHB should implement an extensive and intensive skills and knowledge package around the care of patients with dementia and support to their families.	Ockenden 1 recommendation 13	
Arrangements need to be made for ward staff to have opportunity to engage with external networks of similar organisations.	Holden recommendation 11	

Review team observations

Whilst there has been significant progress made in the development of dementia care pathways, the failure to appoint to the consultant nurse post within the directorate has had an impact on its ability to provide the skills and knowledge training package necessary. Proposals for practice educators are in train, but it is not clear if these posts have been appointed as yet. Progress since this recommendation was made in 2015 has been disappointingly slow.

The Board's support of healthcare assistance to train as nurses (an initiative no longer supported in England) is very positive. Initiatives such as this should help with recruitment and retention of staff.

The review team are concerned that there is little engagement with external networks and suggest that this be developed and encouraged to aid with service development. This is an essential component of a plan for staff development, which should include coaching/mentorship (including from other services), visits to other services, key external speakers to speak at internal events and reverse mentoring.

Domain 8. Leadership /staff engagement

Summary of recommendation	Source	Rating
All clinical leaders should spend a defined portion of their working week within the clinical area listening to patient and relative feedback.	Ockenden 1 recommendation 12	
There is an urgent need for the board and the divisional senior management team to begin to effectively engage with staff.	Ockenden 2 recommendation 4b	
The board should engage in a management development scheme encouraging the widest range of clinical colleagues who wants to take responsibility for leadership and management.	Ockenden 2 recommendation 4d	
The current implementation of the eight improvement plan work streams needs to be reconsidered.	Holden recommendation 10	
Arrangements for regular briefing of staff need to be implemented.	Holden recommendation 6	
The communication strategy needs to be rethought full stop it needs to reflect the need for staff to be fully engaged on a personal level.	Holden recommendation 7	

Review team observations

There appears to be a general improvement in engagement with staff, but this is not consistent throughout the Board area and particular attention needs to be given to the more isolated units. Training could also be provided in a planned way in the more isolated units.

Domain 9. Resources

Summary of recommendation	Source	Rating
24/7 access to services such as diagnostics, medical cover, and pharmacy for older adults across the health board.	Ockenden 1 recommendation 8	
There needs to be clarity and expectations set regarding the rule of the pharmacist this needs to be urgently followed up by the introduction of an appropriate infrastructure to ensure the rule of the pharmacist is central to the delivery of elderly mental health care full stop.	Ockenden 1 recommendation 23	
There is appropriate resource on infrastructure for the provision of speech and language therapy.	Ockenden 1 recommendation 24	
There needs to be clarity and expectations set regarding the rule of physiotherapy, occupational therapy, and dietetics in the care of the elderly.	Ockenden 1 recommendation 25	

Review team observations

There continues to be a need to improve resources in the field of allied mental health professionals. In addition, there is ongoing need to continue to try to recruit substantive nursing and medical staff. The 'streamliners initiative' for recruitment of nursing staff is welcome. The lack of substantive medical staff in the western sector is of particular concern. This has led to clear difficulties in the field of multidisciplinary working in the inpatient unit. Efforts should be redoubled to try to recruit to this sector. The review team are also concerned about the lack of access to psychological therapies for inpatients in this sector and suggest that there be further recruitment of clinical psychology staff and nurse therapists to enhance the therapeutic environment in the Hergest unit. This should be accompanied by a development of a more multidisciplinary therapeutic model of service delivery.

Domain 10. Physical Environment

Summary of recommendation	Source	Rating
A detailed estates inventory will be undertaken.	Ockenden 2 recommendation 11	
Suitable end of life care environment.	HASCAS recommendation 15	
There should be an overarching review of all the states providing care of the elderly to assess its fitness to provide care.	Ockenden 1 recommendation 14	

Review team observations

Urgent attention needs to be given to ensure all remedial works necessary to ensure patient safety are completed. This particularly applies to ligature risks. A timeline needs to be developed to ensure that the recommendations made by HIW and the NCCU in their recent inspections are carried out.

Teitl adroddiad: ***Report title:***	Patient Story - Community Stroke Prevention Team
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	30th May 2024
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer 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 Hannah Hughes, Patient & Carer Experience Project 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 gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board

Patient Story – Community Stroke Prevention Team
An audio-visual story will be played at the meeting.

Overview of Patient Story

The storyteller met the Community Stroke Prevention Team at a stroke prevention event at Rhyl Train Station in collaboration with Mind who are a mental health charity. The storyteller was offered a blood pressure check and was found to have high blood pressure. The storyteller was provided with brief intervention information on the signs of stroke, healthy lifestyles and a letter to 'fast track' into the GP for ongoing help, support and medication. An ECG diagnosed the storyteller with an irregular heartbeat and a fast heartbeat, which she wouldn't otherwise be aware of.

According to the Stroke Association, around 100,000 people in the UK have strokes every year. Approximately 7,676 of those are in Wales. The Health Board has 711, 489 registered patients of which 15,540 have been diagnosed with a stroke or TIA (transient ischaemic attack). The average cost of care for a stroke patient, from admission to discharge is £23, 315. It is thought that 90% of strokes are preventable. This is the focus of the work of the Community Stroke Prevention Team.

Key Messages

- The storyteller met the Community Stroke Prevention Team at a stroke prevention event at Rhyl Train Station in collaboration with Mind.
- Having high blood pressure, the storyteller was provided with brief intervention information on the signs of stroke, healthy lifestyles and a letter to 'fast track' into the GP for ongoing help and support.
- The storyteller was quickly provided with blood pressure medication by the GP and referred for an Electrocardiogram (ECG). The storyteller was diagnosed with an irregular heartbeat and a fast heartbeat, which she wouldn't otherwise be aware of.
- Meeting the Community Stroke prevention Team enabled the storyteller to access the help she needed and fast. The storyteller acknowledged the kindness of staff within the team and the importance of the events in the community.
- The Community Stroke Prevention team is made up of 3 Community Stroke Prevention Practitioners and their work focuses on three aims:
    - Primary Stroke Prevention and Public Health Awareness
    - Secondary Stroke Prevention
    - Education for Staff, Public and Carers.
- The team are active members of the Welsh Stroke Nurse Forum and they are the only dedicated stroke prevention team within Wales.

Summary of Learning and Improvement

In 2021/22, the Stroke Improvement Plan was initiated to improve stroke services across North Wales in line with the Health Board 'Living Healthier, Staying Well' Strategy to improve

the whole stroke pathway across Primary Care, Acute Care and Community Services, from healthy lifestyles through to specialist intervention and had 4 key areas:

1. **Early Supported Discharge (ESD) Service** to support eligible patients recover at home, rather than in hospital or a clinical setting with specialist stroke rehabilitation from a multi-disciplinary team.

2. **Stroke Specialist Inpatient Rehabilitation (SSIR) Centres** for patients who no longer needed treatment at an acute hospital, but still required specialist stroke rehabilitation that could not be delivered at home located at Ysbyty Eryri, Llandudno General Hospital and Deeside Community Hospital.

3. **Developments in the Acute Service** at Ysbyty Glan Clwyd (Ward 14), Ysbyty Gwynedd (Prysor Ward) and Wrexham Maelor Hospital (Bersham Ward) to improve clinical response and Stroke Sentinel National Audit Programme (SSNAP) scores, performance and patient flow and the introduction of Brainomix 'e-Stroke' to provide rapid and precise support to healthcare professionals diagnosing and treating strokes.

4. **Community Stroke Prevention** to embed prevention as a crucial part of the Stroke Pathway. The Community Stroke Prevention Team was reinvigorated in 2023 with three new Community Stroke Prevention Practitioners who work across the Health Board Integrated Health Communities (IHCs) and they are currently the only dedicated Stroke Prevention Team within Wales and are leading the preventative health agenda in North Wales. Their work focuses on three main aims:

   Aim 1 - Primary Stroke Prevention and Public Health Awareness:

   Primary Stroke Prevention focuses on the prevention of an individual's first stroke event. The aim is to identify people with undiagnosed Atrial Fibrillation (heart arrhythmia), hypertension (raised blood pressure) and hyperlipidaemia (raised cholesterol) and provide early intervention to modify these risks. Stroke prevention also looks at diabetes associated with these risk factors and helping to alter people's unhealthy lifestyles.

   The team attend health promotion events and link in with community hubs and groups to offer brief health checks to those groups who struggle to access primary care such as those who care for someone with a Dementia diagnosis and those who live in rural areas. The team will attend organised events, workplaces, community centres and public spaces. The team currently offer blood pressure and pulse checks, stop smoking advice, alcohol reduction and healthy lifestyle advice, support and onward referrals to different services such as Primary Care where necessary. In the last year, the team have attended over 40 events and engaged with over a thousand members of the community.

   Next steps within Primary Stroke Prevention include conducting a three-month review with Primary Care following up patients with advised intervention and introducing Point of Care Cholesterol Testing at events to provide a more thorough assessment to members of the public including all stroke risk factors.

Aim 2 - Secondary Stroke Prevention:

The second aim focuses on Secondary Stroke Prevention, which supports stroke survivors and their loved ones to manage ongoing risk. This group have increased risk due to the fact they have already had a stroke.

The team have focused on creating relationships with local stroke survivor groups to increase awareness of secondary prevention of stroke, signposting and referring into relevant services available in the community and collecting patient feedback on how post-stroke care could be improved. The team have also been working with Primary Care to improve compliance with the Annual Stroke Reviews for stroke patients and have given talks on risk for those with cardiovascular disease. The team offer regular support sessions to family and caregivers of stroke survivors. The team are trialling this in collaboration with the Specialist Stroke Rehabilitation Units within the Centre IHC and hope to role this out across the Health Board in the future.

Next steps within Secondary Stroke Prevention include the development of s Stroke Self-Care Programme. The team are also in the development stage of a Patient and Public Involvement Group to improve Stroke Prevention service delivery across the Health Board. Participation involves giving feedback and sharing opinions. Everyone is welcome and the team are currently recruiting members who are interested in stroke care, including stroke survivors, stroke carers, people affected by stroke and those who work in stroke care.

Aim 3 - Education for Staff, Public and Carers:

The third aim is education regarding stroke risk and management.

The team have developed a Stroke Prevention Training Programme for all Health Board staff with Electronic Staff Record (ESR) Training starting in January 2024. The team offer face- to-face and Microsoft Teams based sessions to staff to increase competence and knowledge regarding stroke and risk. Tailored sessions are available for both Health Care Support Workers and Registered Nurses. Sessions last between 1-2 hours in length and cover appropriate topics, including definition of a stroke, risk factors, Atrial Fibrillation, Hypertension, pulse checking and the impact of lifestyle improvement. So far, the team have trained over 100 staff and students from different backgrounds across the Health Board. The team are also available for advice and support regarding stroke risk.

The team also offer safe, effective and professional learning opportunities for student nurses. Student nurses can book in for a day with the team to support the achievement of their practice learning outcomes consistent with their scope of practice.

Next steps within Stroke Education include increasing uptake on training, expanding education sessions out to third sector organisations and the public and the creation of a Stroke Prevention E-Learning package to be mandated every 3 years.

Focus on improving patient experiences:

On a national level, the team are active members of the Welsh Stroke Nurse Forum. The forum consists of registered nurses who are in roles across the stroke pathway. It is place for shared learning and experiences, showcasing developments and innovations, networking and sharing best practice with aim of developing stroke services and patient experiences across Wales.

At the end of 2023, the Health Board worked with NHS Wales to undertake a National Stroke Patient Experience Survey. The survey outcomes will be used to review the Stroke Pathways to ensure that services have the voice of the patient at their core. The Community Stroke Prevention Team are also working in collaboration with the Patient and Carer Experience Team to collect regular feedback from patients, relatives and carers who access services to support ongoing service developments.

The Patient and Carer Experience Team will share this feedback and seek assurance from all departments by way of evidence that learning has been embedded. The Patient and Carer Experience Team will widely share this Patient Story during May as part of Stroke Awareness Month to spread the word about stroke prevention, recognition, and treatment. By raising awareness, we can help more people understand the risk factors, warning signs, and actions to take in the event of a stroke. This knowledge can ultimately save lives and improve outcomes for stroke survivors. We encourage staff across the Health Board to **#makemaypurple** for Stroke Awareness Month.

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 adroddiad: ***Report title:***	Citizen Experience Report
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	This is the second report to Board summarising the themes from our involvement with citizens. It covers the last three months from a range of sources. It draws on the day-to-day interactions we have with patients, their carers and families, the conversations we have with the public and partners in their communities and at events, correspondence from Members of the Senedd and Parliament and activites and engagement with citizens undertaken by Llais. It reports on the key themes from those interactions and conversations. It does not go into the detail of how the Heatlh Board is responding to the issues but signposts to those papers in the Board meeting where they are being taken forward. All questions to the Chair and other Board members will continue to be answered and people can expect direct replies to their queries.
Argymhellion: ***Recommendations:***	The Board is asked to note the report.
Report presented by:	Dyfed Edwards, Chair
Awdur yr Adroddiad: ***Report Author:***	Helen Stevens Jones, Director Partnerships, Engagement and Communications

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Involving and understanding the experience of our citizens runs through all the Health Board's strategic objectives and plans
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no legal implications other than noting that all public services in Wales have a duty to engage and consult with citizens. This has been strengthened through a range of UK and Welsh Government policies and legislation such as the NHS (Wales) Act 2006
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 ?***	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)***	There are no specific risks associated with this paper.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no specific financial implications associated with 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 workforce implications associated with this paper.
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)	Not applicable

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

HEALTH BOARD MEETING IN PUBLIC
30th MAY 2024
CITIZEN EXPERIENCE REPORT

1. Introduction

1.1 This report summarises the themes from our involvement with citizens over the last two months. It draws on the day-to-day interactions we have with patients, their carers and families, the conversations we have with the public and partners in their communities and at events, correspondence from Members of the Senedd and Parliament and activites and engagement with citizens undertaken by Llais.

1.2 Listening to and understanding the experiences of the citizens of North Wales is essential to improving how we design and deliver care and services. Gathering the insight enables us to understand the issues that matter to our population. We are determined to make sustained improvements and our staff and the citizens of North Wales are increasingly coming together to solve our ongoing issues.

2. Themes from patients, carers and families through our in-house teams

2.1 Our Patient, Advice and Liaison Service (PALS) provides information, advice and support to resolve issues and concerns about our services. Every week they speak with hundreds of patients, carers and family members.

2.2 Between 1st February 2024 to 30th April 2024 PALS logged 1564 cases. 1334 of those were enquiries, 198 were compliments and 32 were suggestions. The key themes identified from PALS enquiries within this reporting period, which are consistent with the top three areas of complaints, include:

- Delay in appointments/waiting times
- Delay/lack of treatment or assessment
- Communication with family

2.3 From 1st February 2024 to 30th April 2024, 13,077 All Wales Real Time Feedback survey responses were received.

Key findings from the real-time survey feedback include:

- 81.13% of respondents were satisfied with their overall experience
- 80.53% of respondents were always given all of the information needed
- 83.62% of respondents always felt listened to
- 80.27% of respondents felt that staff always took the time to understand what mattered to them as a person and took this into account when planning and delivering their care.

What people have said:

"I would like to say a big thank you to the Betsi Cadwaladr NHS service. A week ago, one of my grandchildren had a fall in our garden, I drove him straight to ED and he went straight through as the 999 operator had already let them know. He was x-rayed and assessed for emergency surgery which took place only 2 and a half hours after we arrived. Every member of staff that helped were fantastic. I can't thank you enough. You really have wonderful people working in your teams"

"Since my referral, I have been so impressed with the pre-hab team at Wrexham. I received friendly and welcoming phone call arranging my appointments which put me at ease during this stressful time. I received a thorough assessment that tailored my exercise programme, expert diet advice and supportive psychological training and help which have prepared more than what I could achieve myself for my operation. The team have gone the extra mile to support me and I can't thank them enough"

2.4 Between 1st February 2024 – 30th April 2024, 106 All Wales Real Time Emergency Department (ED) Feedback survey responses were received. The response rates are currently low and the Patient and Carer Experience Team is working with Heads of Nursing and Emergency teams to improve the feedback response rate, so that patterns and trends and associated learning can be identified, and improvement plans put in place.

2.5 The Patient and Carer Experience Team are also taking forward the implementation of SMS feedback surveys to patients who have attended the Emergency Department this will offer patients the opportunity to provide feedback on their recent experience following their visit to ED.

Key findings from the real-time feedback includes:

- 91.53% of respondents felt from the time they needed to use this service they waited much too long
- 46.23% of respondents felt they were sometimes well cared for
- 21.90% of respondents always felt listened to
- 15.09% of respondents always got assistance when needed
- 20.75% of respondents always felt things were explained in a way that they could understand.

Work is also underway to roll-out the real-time feedback system to all wards and areas in the Mental Health and Learning Disability Service (MHLD) and within Cancer Services.

3. Community conversations

3.1 Community conversations include both formal and informal engagement and discussions with the public, patients, staff and partners. Key engagement activity in the last three months has involved our Health Board "health conversations", Bitesize health, wellbeing events and networks.

3.2 Four Board community engagement sessions have taken place in community centres Denbigh, Wrexham, Bangor and Holyhead. Each event offered an opportunity for local communities to hear from the Heatlh Board about developments in their area and to talk with Health Board members about what is working well and could be better.

There were general and area specific themes emerging from these conversations. General issues included listening to and involving people in their care and treatment, access to appointments, long waiting times, poor communication and signposting people to the right service and information.

Themes specific to Denbigh included no minor injuries unit in the area, an update requested on the developments planned at the Royal Alex Hospital in Rhyl and the difficulty in getting a GP appointment with a practice in Prestatyn

Themes specific to Wrexham included the poor parking situation at the Wrexham Maelor Hospital, the need for open and transparent communication about BCHUB-run GP practices and excellent emergency ophthalmology care with a community optician.

Themes specific to Bangor included a request for better public and partner engagement needed in the planning of the Bangor Health and Wellbeing Hub development, Nefyn Surgery being highlighted as one of the GP practices that works well, community hospitals operating in the area providing good services and the challenges faced by the deaf community as inpatients and at appointments.

Themes specific to Holyhead included the lack of NHS dentists in the Holyhead area and getting timely GP appointments. The Health Board should consider the development of Penrhos Stanley Hospital, creating a more integrated facility with more scope to treat people. On a similar theme the desire for a purpose built “one stop” health centre in Holyhead which could provide more services than GP surgeries currently offer.

3.3 General themes from all our ongoing conversations remain broadly the same:

- Waiting times
- Access
- Communication

3.4 **Waiting times** - many people continue to highlight waiting times as a key concern. This can be broken down to a range of issues including:

- Diagnostic tests
  Concerns about the length of time for children to be referred for ADHD, Autism diagnosis, with some parents saying they have been waiting over four years for help. The consequences of long waiting times for diagnostic test also raised concerns that if a patient was experiencing a serious condition, e.g. cancer, it may be too late for the NHS to provide effective treatment. Other concerns included the time to receive results back.

- Planned care
  Waiting for procedures continue to be highlighted by residents. Although people are waiting for a range of procedures, such as skin cancer treatments orthopaedics is routinely mentioned, particularly the long wait for hip and knee surgery. Some people

were concerned that waiting for a surgery date resulted in their condition getting worse and the level of pain continuing.

Once people do receive a date for their surgery concerns were voiced about the procedure being cancelled or postponed. Some people saying this has happened several times.

Some of the key quotes from our discussions around planned care were as follows:
Those **who had already had hip/knee replacement** were full of praise for the care received and staff.
"fantastic care, couldn't fault it…"
"…the staff were brilliant…"
"…care at Abergele was first class…"

However, were critical of the time it took for them to receive the operation:
"…I waited nearly four years, by the time I had the operation I couldn't walk and was in constant pain…"
"….the time I waited meant that my other hip was taking all the load, and now I need that done and am still waiting…"

For **those who were waiting,** they spoke of the severe impact it had on their life, and frustration at not knowing where they were in the 'queue' (no idea when the operation would happen)
"I used to be active, now I'm reliant on a walker, it's getting worse, and I don't know when I will have the op…"
"…I ring up and ask when I will get my knee replacement and they can't tell me, they tell me they have no idea, it's so frustrating…"

In terms of **how far people were prepared to travel**, all said they would travel anywhere if it meant they would get their hip/knee replacement:
"I'd go to Dundee tomorrow if it meant I'd get it done…"
"…nowhere is too far if you need it…"
"…I'm in my seventies, I couldn't wait so I went to Lithuania to have the operation, that's how far I'm prepared to travel…"

When discussing the prospect of **bringing more services together**, such as diagnostic tests, endoscopy, ophthalmology, and more elective surgery other than hip and knee, people were supportive:
"…sounds a great idea, moving things away from the busy hospital…"
"…makes sense to move it into one place where you can go that isn't so busy…"

The one caveat that was applied to this endorsement was that this should not result in an overcrowded space where it is difficult to access, with a particular focus on car parking:
"…as long as it doesn't become as crowded as the other hospitals in the area where it's impossible to get parked…"

When asked about the **environment of the facilities**, the overwhelming focus was on the service received and a direction that NHS resources should be spent on delivery not the buildings:
"…as long as it's clean and the staff are caring…"
"…don't waste money on fancy buildings, just get the operations done…"

3.5 **Access** - access to services relates mainly to primary care and planned care.

- GPs
  A range of concerns have been raised about access to GP services this includes initial contact with the surgery. Some people have highlighted the length of time to get through to their surgery when they try to telephone for an appointment.

  Getting an appointment is also an issue raised by many people. This could include being told there are no appointments that day and to telephone again the next day,or given an appointment several weeks in advance.

  The inconsistency of how individual GP surgeries offer appointments has been raised. Although some people find it difficult to get an appointment others, found it easy to both get through to their surgery and get an appointment for that day.

- Parking
  Parking is a theme that is raised by people. Hospital parking is difficult for many people and some people have suggested there is not enough disabled bays. Reduced parking spaces often occurs due to development of sites and additional parking needs to be established prior to work being undertaken

- Language
  Some staff at District General Hospitals (DGHs), Local GPs and Dental practices do not seem adequately trained, or aware of their duties to provide a translation service. This has been a huge barrier and frustration for some communities whose first language is not Welsh or English.

3.6 **Communication** – a number of issues have been raised that could be categorised in a theme of communication. This included:

- Departments/wards not answering their phones
- Patients having difficulties getting through to the Health Board to cancel / change their appointments
- Promotion of health prevention information
- Regular updates to public patients and partners
- More education and use of apps such as "askmyGP"

4. Digital conversations

4.1 Over the last two months the digital communications team responded to 385 direct messages. Where possible we look to resolve their issues for messages relating to contact information for certain services or assistance in finding information on our website. Where this isn't possible and this relates to a negative experience we will sign post them to the Patient Advice and Liaison team. Some key themes of the messages were:

- Covid vaccination enquiries
- Recruitment questions or information on job roles
- Experiences of visiting hospitals

- Social messages of compliment for wards across all sites

4.2 We run a series of organic posts and adverts across our channels to highlight alternative services such as pharmacies, MIUs and NHS111 Wales services such as the online symptom checker. Here is a snapshot of some key themes on our content across our channels along with some feedback picked up via social media.

What people say:

"Shame nhs111 press 2 isn't online chat - sometimes it's extremely difficult to voice your issues"

Whilst the pressure needs taking off the GPs has anyone actually thought about the pressures the pharmacists already have? And you're wanting to apply yet more pressure?

Mental health services are non-existent. The outcomes would be the same if they were not there. No treatment, no care, just indifference and more trauma for people who are already very unwell.

Minimise wait times? Been waiting for breast cancer screening mri results four weeks and your reason is staffing? If anything you're getting worse not better

The last two appointments my husband has had in the Maelor have been incredible. In and out very quickly and totally on time if not early.

5. Correspondence from Members of the Senedd and Parliament

5.1 The 24 North Wales elected members write to us on behalf of their constituents on a weekly basis. We have seen a significant increase of around 35% in the number of questions raised in the first four months of 2024.

At the time of writing the report, we have received 371 enquires from Members of the Senedd and MPs, compared with 271 for the same period in 2023. The key issues raised by politicians since January 2024 are:

- Waiting times, in particular orthopaedics, ophthalmology, general surgery and neuro diversity assessments.
- Access to mental health support services.
- Access to NHS dentistry.
- Poor experience in Emergency Departments.

There are a variety of other issues, from access to health records to discharge and ongoing care arrangements, but these are in the low single figures.

The following statements have been gathered from some of the serious issues raised by politicians on behalf of their constituents. They provide a snapshot of the problems experienced by patients across our services, and are either in the patient's own words or in correspondence received from politicians.

What people have said:

Orthopaedic waits

"I am in need of a hip replacement and phoned the department to be told that it would be 10 months before I will see a consultant and after that I should expect to wait another two years. I am 80 this year and the prospect of waiting almost three years when in total agony beggars belief."

"A consultant informed a patient that he had sustained torn muscles and ligaments and might require a shoulder replacement. A follow-up appointment was scheduled six months later to discuss this possibility further, despite being in constant pain. Due to the long wait for treatment, he made the difficult decision to go private and pay for the operation he needed."

"I was just about holding on to the hope of the operation being carried out between July- September 2024 as suggested at my consultation in October. When I came off the phone I wept – the thought of an even longer wait, in chronic pain, is just unimaginable."

Access to Mental Health services

"It would appear that she was referred to Nant-y-Glyn around 12 months ago by her GP but is yet to be seen face to face by a member of the team, having only been subject to a few short telephone assessments before being offered an anxiety course. She then claims to have been discharged inappropriately by the service. My constituent says that she has been experiencing suicidal thoughts and her GP has made a further referral to the Community Mental Health Team but there appear to be communication failings with the team with letters and telephone call backs not being fulfilled."

"His whole life is suffering due to lack of intervention. His relationship is under strain and he believes his wife will leave him if he can't improve his mental health. His two children depend on him, but he is having arguments at work because of his issues and is worried he won't be well enough to work if things continue like this. Can you please confirm why he cannot see a psychiatrist, or even psychologist? Can you please explain why he has not been referred for any therapies in seven years? I would be grateful if you would also explain what you are doing to reduce the waiting list for ADHD assessment, as it is well known that untreated ADHD can cause anxiety and depression."

"My constituent is currently renting accommodation and is being supported by her landlords who today accompanied her to Ysbyty Gwynedd as a matter of urgency. She was turned away from this hospital earlier today despite her double incontinence and frequent vomiting. She is a vulnerable patient in need of urgent mental health support. I understand she is experiencing substance withdrawal symptoms with very bad side effects. She has been prescribed medication and takes 19 tablets daily."

Ophthalmology waits

"My constituent is partially deaf and depends on lipreading to be able to understand and communicate with those around her. Unfortunately, she has developed cataracts which have severely diminished her ability to see and consequently her ability to communicate as she is no longer able to lipread."

"He is a type 1 diabetic, diagnosed 51 years ago and was first diagnosed with retinopathy in 1990. He says that his last appointment was in January 2022 with a

follow up due in a further six months. He is yet to receive an appointment which, given his eye condition and the possible impacts of this, is a cause for some concern."

"A constituent has been in touch regarding cataract surgery. He has been told that he may have to wait up to 18 months for surgery. He can no longer read or drive, and has explained that his quality of life has massively deteriorated."

Access to NHS dentistry

"I am almost 70 and recently been diagnosed with Polymyalgia. I have been told that I have to keep an eye on my dental health regularly, which I do but when I tried to book with my dentist I was told that he has gone private. I am now faced with the dilemma of possibly losing my teeth and having no way of finding out if I have any dental issues such as oral cancer. Or pay well over £300 per annum with an insurance plan to get a basic check every six months, X-rays and teeth cleaned. If I have any fillings, I have to find the minimum of £145, which includes a discount of ten per cent. I am on a pension and trying to live an independent life in my own home, I get no benefits because I put everything I have into living independently. I live alone and really ask myself and you too, is this the way things should be?"

"A mother contacted my office to express concern at her inability to find an NHS dentist for her two daughters, one of whom is aged 13 and in urgent need of extensive dental work; she had 10 teeth extracted when she was aged nine and has severe decay in several of those which are remaining. She is in considerable pain, and this is also a cause of considerable anxiety to her mother and sibling."

General and Gastro-intestinal surgery waits

"Concerns have been raised by my constituent on behalf of his wife, who will turn 81 next week and has been on a waiting list for four years to have her gall bladder removed. He advises that in December 2023 she was in so much pain they had to attend A&E twice and the pain was so severe that she was administered oral doses of morphine."

"He has a hernia which is causing him a lot of pain, he keeps trying to book an appointment at Ysbyty Gwynedd however is unable to do so, this has been ongoing for 2 years"

ND assessment waits

"She states that she has struggled with her son's behaviour and emotions since a young age and self-referred him for diagnosis on 20th December 2018, 11th November 2019 and 30th November 2021. She is now extremely concerned that he will not be assessed before his GCSEs and will therefore not have the reasonable adjustments made for him at school that he needs, neither during lessons nor exams."

"He has been on the waiting list for an assessment with the Neurodevelopmental team for two years, and was recently informed that the wait could extend to another 24-36 months. This effectively means a potential wait of five years or more for a crucial diagnosis."

"For several years now, when we call the Wrexham Maelor Neurodevelopmental Team, we get told that we can't be given a date but we're high on the list. This has been ongoing for years; surely something more can be done to support our daughter, a private referral for assessment, or a referral for assessment at an NHS

board with capacity? She faces many challenges on a daily basis, educationally, physically and emotionally. She suffers with anxiety, sensory overload, becomes closed down, has coordination difficulties, and whilst her family, friends and teachers support her as best they can, how do we know if we're doing the right thing or providing and accessing the right support, without a neurodevelopmental assessment?"

5. Activities and engagement with citizens undertaken by Llais

5.1 Llais is an independent statutory body, set up by the Welsh Government to give the people of Wales much more say in the planning and delivery of their health and social care services.

5.2 Through their day to day interactions with citizens, such as engagement events and social media, Llais North Wales has picked up the following themes:

- Clinical practice (diagnosis, treatment)
- Delays in treatment/waiting times
- Long waits and poor treatment in Emergency Departments
- Communication (conduct and attitude, consent, information, insensitive)
- Access

What people have said/reported:

"I went to Alltwen, after calling 111. It was a Saturday morning at about 12.30pm. I had to wait 30 minutes to be seen. I did not mind as they were busy. I was seen by a doctor and was given medication that I needed. I was well looked after and treated well."

A patient sustaned a head injury in an accident and was discharged from the Emergency Department without undergoing a scan. The patient's symptoms worsened over time and 18 months later he was diagnosed with a brain injury.

One person mentioned that they are registered blind but they keep receiving letters for appointments from BCUHB and they can't read them. The fact they are registered blind is recorded on their medical records.

Patient had an MRI scan but was never given the results. Only found out results by chance when attended ED with a blood clot."

6. Acting on what we are hearing

6.1 At this month's Health Board meeting we will be discussing in detail our plans to improve access, quality and experience for **planned care** and **cancer.**

6.2 Patients, families and carers have been sharing their current experiences of **vascular services** with us, which is giving us a better understanding of what matters most to them. Many of the patients and families/ carers we spoke to talked about how appreciative they were of the care they received, and identified a number of areas of good practice as well as compassionate care. However, some of the experiences shared with us highlighted areas where improvements could be made.

An information booklet containing a summary of the main findings from our improvement work has been developed, and includes the actions we will take in order to improve the way we deliver care.

We are establishing a group of patients, families and carers who might be interested in continuing to work with us and share their views and experiences on what matters most, what services need to look like in the future, and what changes need to be made to the way vascular services are delivered across North Wales.

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:***	May 30, 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
May 30, 2024

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

Board and Committees
I have had an opportunity to observe the work of our various committees over the last period. I attend when I am able to and see first hand the detailed work the committees undertake. They are a significant part of our governance as an organisation and we recognise that we can develop their role further, together with that of the Board. Pam, as our new Director of Corporate Governance, will be able to support this work and bring us further insight from other organisations. Similarly, our Board Development sessions are progressing well with further time now being allocated for additional briefings. We intend to progress a Board Development programme that will help support our growth as a Health Board

Developing the Organisation
The bi-monthly Special Measures Forums with the Cabinet Secretary will now focus on specific areas as well as a general overview of progress. This gives us an opportunity to note our development under Special Measures and also provides the Cabinet Secretary with the detail required to closely monitor progress in areas of concern. This renewed focus in this phase of Special Measures underlines the need for all our activity as a Health Board to promote improved delivery. Carol, as Chief Executive, is leading work around the structure of the organisation which will enable us to ensure clarity of roles and accountability, which will, in turn, help us to improve performance. The current recruitment to key Executive Director roles will be a further significant step for us as an organisation. I attended 2 session of the Executive Team Workshop on Planned Care as an observer. This gave me an insight into the issues we face and some of the work to address performance.

Engaging with others
Amongst the variety of visits I have undertaken recently was to see the Prehabilitation Unit in Wrexham. Neil Agnew gave Carol and I a tour of the facility and we had an opportunity to discuss the service with patients and their families. Neil also gave us a presentation highlighting the evidence showing substantial improved health outcomes for those who commit to the prehabilitation programme prior to any procedure. This visit, together with my visit to the Nifty 60s exercise club in Holyhead, were excellent examples illustrating the positive impact intervention can have for patients. There are opportunities for us across north Wales to work with community groups and others to promote a proactive approach to health and well-being.
I was invited to the North Wales African Society that meets in Bangor on a Saturday morning. The society supports many from African countries who now live in north Wales, and a good number of which are employed by the Health Board. I was encouraged to learn of the way members support each other and share their experiences.

Below is a summary of some of my meetings and visits for the period up to 17 May, 2024

Date	Meeting / Visit
18 March 2024	Monthly meeting with Minister for Health and Social Services
18 March 2024	Flintshire County Council
18 March 2024	Planning, Population Health and Partnerships Committee Development Session
21 March 2024	Performance, Finance and Information Governance Committee
21 March 2024	St. David's Hospice
21 March 2024	Katie Hender, Patient Experience, Ysbyty Glan Clwyd
22 March 2024	North Wales Regional Leadership Board
22 March 2024	Virtual Round Table discussion Royal Alex Hospital Project
22 March 2024	Remuneration Committee
25 March 2024	Information Governance awareness training
27 March 2024	Independent Member quarterly meeting
27 March 2024	Board Development Session
28 March 2024	Health Board
02 April 2024	All Wales Chair Peer Group
04 April 2024	#BetterByBetsi Community Workshop
05 April 2024	Quay Medical Centre, Connah's Quay
05 April 2024	Pathology Department with Yee Ping, Wrexham Maelor
05 April 2024	Retirement event for Gareth Davies, Wrexham Maelor
05 April 2024	Nightingale House Hospice, Wrexham
05 April 2024	Prehabilitation Unit with Neil Agnew, Wrexham
08 April 2024	Judith Hardisty, Chair Hywel Dda University Health Board
09 April 2024	All Wales Board Chairs Meeting
09 April 2024	North Wales Air Ambulance Campaigners and Llais
10 April 2024	Annual General Meeting of the Bangor University Court
11 April 2024	People and Culture Committee
11 April 2024	Extraordinary Board Meeting
12 April 2024	NHS Wales Joint Commissioning Committee, Chair and Chief Executive
23 April 2024	Planning, Population Health and Partnerships Committee
24 April 2024	Monthly meeting with Minister for Health and Social Services
25 April 2024	Board Development
26 April 2024	First Minister and Cabinet Secretary for North Wales Evening Reception, Wrexham
27 April 2024	North Wales African Society, Bangor
30 April 2024	Performance, Finance and Information Governance Committee
01 May 2024	Follow up meeting with Minister for Health and Social Services
02 May 2024	Executive team Planned Care Workshop
03 May 2024	Board Engagement Event – Holyhead
07 May 2024	Audit Committee
09 May 2024	Executive Team Planned Care Workshop - Continuation from 02/05/2024
09 May 2024	Ysbyty Tywyn
10 May 2024	Lesley Griffiths MS, Wrexham
13 May 2024	Extraordinary Remuneration Committee
13 May 2024	Conwy County Borough Council CEO, Leader and Cabinet Members
14 May 2024	Patient Friendly Mental Health Services Conference, Wrexham
15 May 2024	Special Measures Forum
17 May 2024	Ysbyty Bryn y Neuadd with Janet Finch Saunders MS

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

Teitl adroddiad: ***Report title:***	Chief Executive Report
Adrodd i: ***Report to:***	BCUHB Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 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 March to mid May 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:	

1.0 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 March to 22nd May 2024.

2.0 Key Developments/Updates

There are a number of key items on the main agenda of the Board. Whilst the detailed reports will be presented, specific emphasis is given to the following:

2.1 Infected Blood Inquiry

The final Infected Blood Inquiry report was published on Monday, 20 May 2024 following an independent public statutory inquiry into the use of infected blood. The inquiry was established in 2017 to investigate how thousands of people across the United Kingdom came to be infected with HIV and/or Hepatitis C through contaminated blood products between 1970 and 1991.

The UK Government and the Welsh Government has apologised to the people affected by this tragedy. It is clear that there will be considerable reflection and learning required to ensure that improvements needed, even some decades following the failings, are taken forward. The Executive, along with other colleagues, will consider the findings and recommendations of the report, examining opportunity for local improvement action.

The report is high profile, and it is anticipated that some patients, or their relatives/carers, may turn to health care staff for advice and support. In particular, patients who have had blood transfusions during this period may want advice and/or request blood tests. Across the NHS in Wales arrangements have been put in place in response to the Infected Blood Inquiry to help manage patient queries and signpost patients as needed.

More information is available on the website. Infected Blood Inquiry - Betsi Cadwaladr University Health Board (nhs.wales)

2.2 Corporate Parenting Charter – A Promise from Wales

The health board is committed to working with partners and stakeholders to improve outcomes for children and young people in care. NHS Wales has an important role to play in helping care leavers by providing access to health services, education, training, and employment opportunities. This Charter is a set of principles and promises and has been developed in collaboration with care-experienced young people. The Charter is a set of promises that can be adopted by any public sector body when engaging with care-experienced children and young people and sets out shared principles that all bodies and their leaders should follow when providing services to care-experienced children and young people. By signing up to be a corporate parent, the Health Board will be agreeing to consider the following principles when delivering our existing services and support, planning new services and/or engaging with care-experienced children and young people.

2.3 Update on Emergency Medical Retrieval Service – decision at Joint Commissioning Committee

The newly established Joint Commissioning Committee (JCC) met for the first time on 23rd April 2024 and considered the matter of the Emergency Medical Retrieval Service (EMRTS), following a service review undertaken under the former Emergency Ambulance Services Committee (EASC). The Health Board had previously considered the proposed recommendations that emerged from

the review and the several stages of engagement that had taken place, to help inform the collective decision that would be taken by the JCC. It concluded that the Health Board was unable to fully support the recommendations. The JCC decision was made overall to support the recommendations and to put in place the work required to develop the Recommendation 4. This work will continue to be tracked and reviewed by the JCC and regular progress reports will be provided to the Board.

2.4 Special Measures

A number of Independent Reviews have now been finalised and have been considered via Committees and other mechanisms. An overview is provided below.

2.4.1 The *Review of Contract and Procurement Management* was commissioned by the health board and undertaken by the NHS Wales Shared Service Partnership Internal Audit Service. The Terms of Reference were agreed with Welsh Government, to include

- An assessment of the adequacy and compliance with the Health Board's contract and procurement control framework (for both revenue and capital expenditure), incorporating:
  - Assurance, where appropriate, on the current arrangements and controls in place.
  - Identification of areas of good practice
  - Identification of areas of weakness or where improvement is required, and associated recommendations.

The report developed twenty-four actions for consideration by the Health Board, NWSSP Procurement Services and Welsh Government (attached at Appendix 1)

The key themes included:

- Policy, procedure and guidance for staff on procurement and contract management, and the general finance procedures to be brought up to date.
- Roles and responsibilities between the Health Board and NWSSP Procurement to be clear, and to enhance the reporting and escalation process within the Health Board to ensure the Health Board has early sight of issues relating to procurement.
- Ensure contracts are approved and signing of contracts, in line with the Scheme of Reservation and Delegation (SoRD).
- Training and guidance documents to support staff who are responsible for managing contracts.
- Maintain a definitive list of contracts across the Health Board.
- Ensure the eWaiver system, is compliant with the SFIs and SoRD, review interdependency with the e-Financials system, and reduce the use of waivers submitted, to ensure value for money and market competition.
- Provider Procurement Training for Executives and all staff involved in procurement, to ensure full understanding of responsibilities and requirements.

Significant progress has been achieved in addressing the issues raised and this has been in full collaboration with colleagues in NWSSP Procurement Teams. Of the thirteen actions for the health board, eleven of those are completed, with two remaining open and underway.

2.4.2 An independent *Review of Integrated Planning Arrangements* has now been completed. The aims and objectives of the review included:

1) To provide an assessment of integrated planning capacity and capability within the health board in terms of strategic, partnership and operational planning.

2) To assess the organisation's approach to developing their IMTP (Integrated Medium Term Plan) and the associated decision-making mechanisms.
3) To support the development and implementation of a local, integrated planning framework incorporating strategy and planning (internally across the organisation and externally with partners).

The health board had developed, approved and commenced implementation of an Integrated Planning Framework ahead of the review being fully undertaken and reporting. The approval of the Framework in September 2023, enabled the Plan for 2023/24 to be developed using a strengthened approach.

The key recommendations of the Report are outlined as:

1.Collaborating on the **design of a planning system** for the health board including its standards, governance and operating processes. This should address the capacity and capability issues addressed in the review and specifically, consider a long term proposition for strategic planning capacity across the organisation.

2. Developing an **organisational strategic route map** – to display the strategic organisational inputs over the next three years. This will help planning and planners to understand the future environment in the medium term and to make appropriate provision in current plans. It is likely to include early milestone products such as: the agreed clinical model, an OD programme, when a further iteration of the long term strategy will be launched. First year milestones would be planned in detail and resourced in advance of publication of the route map.

3. Developing a **baseline plan** to capture and understand fully the health board's current commitments around change. This needs to include estimates of the financial, workforce, skills and time needed. This baseline plan will provide a firm basis for feasibility, risk assessment and the management of the portfolio.

The Performance, Finance and Information Governance Committee received the final report and the action plan on 30th April 2024. The report can be found here :

2.4.3 As part of the Special Measures preparatory phase, the Welsh Government commissioned an *Assessment of Key Areas of Workforce*, which included:

- Leadership, culture, staff engagement.
- Employee well-being.
- Workforce planning and systems.
- The application of key workforce policies.

The People and Culture Committee, which is a newly established Committee, considered the report, available here, at their meeting in April 2024. It is important to note that the Board approved a Strategic Intent regarding Culture, Leadership and Engagement in September 2023, focusing on nine key actions. The recommendations included:

Leadership and Culture:

1. Visible modelling of compassionate leadership values and behaviours by the Board. This means explaining what compassionate leadership means for the Health Board and the behaviours that underpin this.
2. Review and (if required) reset BCUHB's culture, purpose and values using a selection of culture and leadership diagnostic tools that are available.
3. Strengthen individual, middle-management and team leadership development through a review of existing offerings, and realign with compassionate leadership behaviours.

Employee wellbeing:

1. A long-term strategy around organisational health and well-being is needed. This would set out the direction of travel, priorities and areas of work for the next 10 years, and also include short- and medium-term planning.
2. There is a need to clarify the relationship between the Occupational Health and Wellbeing service and the SWSS in relation to organisational well-being and employee health. This might be helped by considering an overarching "meta" concept including both areas e.g., "employee experience."
3. The Health and Well-being Leadership Group should take a more visible and active role in steering the agenda, and an Independent Member should be asked to join the group to champion the well-being agenda at Board level

Workforce Planning:

1. Build a dedicated central Workforce Planning Team with specialist skills and knowledge to support and embed evidence based strategic workforce planning across the Health Board.
2. Ensure there is clarity of roles and responsibilities and build capacity and skills through a structured development programme.
3. Develop a workforce planning framework across workforce, planning, finance. Create a timetable aligned to the planning framework and timescales for the delivery of the IMTP.

Employment Policies:

1. The investigation process in disciplinary cases needs review to ensure that only appropriate cases are progressed through a formal route. To support this a formal decision tree needs to be developed and implemented in partnership with Trade Union partners and the LNC.
2. A full review should be carried out on all Employment Tribunal cases to better understand why they have been allowed to reach this stage. The review should be done in partnership with Trade Union partners and the LNC.
3. WOD Business Partners require training in the business partner model to enable them to discharge their role in supporting service areas.

2.4.4 The Welsh Government commissioned work to review the organisations approach to engagement. The work entitled *Listening to Citizens, Patients, Staff and Partners* was undertaken by Cath Broderick. The Report made recommendation in four key areas:

1. The role and function of the Partnerships, Engagement and Communication Directorate:

    - Build on the strengths of the team
    - Define a Standard Operating Procedure for engagement and communication
    - Develop a Task and Finish Group
    - Build better strategic partnerships and conversations

2. Patient Experience, Engagement & Insight across the Organisation:
    - Coordinated, cohesive experience, engagement and insight
    - Resolution of complaints and concerns
    - Lay voices and partnerships

3. Finding The Patterns
    - Create an Intelligence and Insight function
    - Governance structure and reporting mechanisms

4. Valuing Staff
    - Prioritise the importance of staff engagement
    - Define responsibility for staff engagement

The outcome of the review was discussed at the Board Development session in March 2024 and an update provided at the Planning, Population Health and Partnerships Committee in April 2024.

The report highlighted the importance of meaningful engagement, strong relationships, partnerships and communication. Every element of the health board's work should be put patients, citizens and staff at the heart of the health board's work.

As part of the recommendations listed above, the key actions recommended included: developing a task and finish group to explore an organisational approach; assessing the efficacy and impact of patient experience, citizen engagement and coproduction in pan organisational and specialist services; reviewing the infrastructure for the lay voice in the Health Board's committee and scrutiny systems; looking at the governance structure and reporting mechanisms.

Progress on delivery will be monitored via the Planning, Population Health and Partnerships Committee.

2.4.5 Finally in this section is the updated *Special Measures Framework and de-escalation criteria* set by the Welsh Government. Each health board is escalation will be issued with a Framework for de-escalation as part of revised arrangements at Welsh Government. The time of Independent Advisers, sponsored by Welsh Government, has now concluded and it is for the health board to consider any further engagement on this matter. Intervention and Support will now be secured by Welsh Government from the NHS Executive, a new function established to work with the NHS in Wales. The updated Framework and de-escalation criteria are attached as Appendix 2 to this report. A process of resetting the current baseline against the criteria will take place over the coming weeks and each Committee will have the specific elements of the de-escalation shared with them to enable tracking and assurance of progress.

3.0 Key Visits and Events

3.1 BetterbyBetsi Community workshop: presented the opening address to a conference of colleagues from across the health board all of whom are taking forward improvement projects and programmes. The BetterbyBetsi social movement approach has been gathering momentum and is open to anyone across the health board who wishes to develop their skills in improvement.

3.2 A series of visits to community hospital services including

- Ysbyty Cefni – visiting patients and staff in Older People's Mental Health services
- Ysbyty Penrhos Stanley – visiting patients and staff across the many services provided at the hospital, learning about the Community Resource Team and the initiatives underway to support people to stay in their own home receiving care and support
- Colwyn Bay Community Hospital – visiting staff and patients, talking with relatives, understanding the work that takes place including some of the challenges and opportunities.

3.3 Quay Medical Centre Visit: meeting Practice partners at The Quays, as well as health board colleagues from a range of services including school nursing and health visiting.

3.4 Pathology Services visits**:** Wrexham Maelor Hospital and Ysbyty Glan Clwyd, seeing the impressive processes and equipment in place that manages the increasing numbers of diagnostic tests being undertaken across the region. This included a demonstration of the use of AI as part of diagnostic procedures for cancer.

3.5 Nightingale House Hospice Visit: meeting with the Chair of Trustees and the Chief Executive to discuss the development of partnership arrangements and to see the impressive, refurbished facilities.

3.6 Prehab Service, Wrexham: the visit included the official opening of the Service, one which has been supported by a charity of former health board colleagues. Consultant Anaesthetist has led the development of the new services, sharing the impressive outcomes for patients

who are undergoing high intensity cancer surgery. This may be a presentation the wider Board may be particularly interested in.

3.7 Roundtable discussion on Abergele Cold site Efficiency with the Orthopaedic Team representatives. As the new development at Llandudno Hospital is underway, in relation to the Planned Care Hub/Orthopaedic centre, the roundtable was an opportunity to discuss progress and challenges in achieving the goals of the programme of work. Recruitment into the additional posts required for the development has now been activated as the timetable on the build progresses. It is envisaged that the service at Llandudno will be operational early in 2025.

3.8 The health board welcomed two Welsh Government officials to discuss the digital agenda. It is essential that support can be achieved for the key major developments that will help transform care, including the Electronic Health Record for mental health and then the wider health board. Understanding the processes in assessing patients in the Emergency Department formed part of the visit for colleagues, presenting the complexities of the current systems in place.

3.9 A visit to the Section 136 Suite at the Ablett Unit, Ysbyty Glan Clwyd: to see the refurbishment that has taken place, improving the safety and security of the environment for staff and patients.

3.10 Marleyfield House Care Home: a visit to learn about the service that supports people who are leaving hospital providing care closer to home, with a specific focus on reablement. The extension was funded through the Regional Partnership Board as part of increasing community care capacity in the area. Further developments are currently being progressed, given the success of Marleyfield.

3.11 Kentigern Hospice Visit: Meeting with the Chair and Chief Executive of the Charity and a tour of the facilities. The Hospice provides an essential services to the people of North Wales and along with the other Hospices in the Region, the health board is keen to progress its partnership further.

3.12 Nursing Conference: an opportunity to speak with guest speakers and nursing colleagues from across the health board, at what was a successful nursing event, led by the Executive Director of Nursing and Midwifery Angela Wood.

4.0 Service matters

There are a number of key areas to draw to the attention of the Board including:

4.1 Vascular Services update

The Health Board has received regular updates on the progress of a Vascular Business Case and North Wales Vascular Network which is also reported regularly through the Quality, Safety and Experience Committee. A strategic item on Vascular Surgery will be considered by the Board in July 2024.

4.2 Learning from Incidents/Investigations/Inquests

The work underway in relation to reviewing the quality and effectiveness of investigations is identified elsewhere on the Board agenda. It is important to indicate that the numbers of Prevention of Future Death notices, issued by His Majesty's Coroner is of key concern. Whilst the development and deployment of a new Quality Management System is essential in moving forward, the opportunity to look back and learn from the incidents and investigations that have already occurred is also important. As Chief Executive I am inviting

those families who wish to do so and for whom their loved one's situation was subject to a Regulation 28 (Prevention of Future Death) notice to share their experience, to hear of the improvements already underway and to influence the way the health board works moving forward. A number of meetings are already scheduled.

5.0 Updates from Executive Directors

This is a new section of the Chief Executive report and will enable brief updates to be provided to the Board periodically.

The Executive Director of Nursing and Midwifery has visited Kinmel Bay Clinic and Bryn Beryl Hospital, attending the Welsh Learner of the Year Awards and was a keynote speaker at East Children's Ward Ball. BCUHB have also hosted several visits from Royal College of Nursing (RCN) Wales as well as a visit from Sue Tranka, Chief Nursing Officer for Wales.

On May 10 the first ever Nursing and Midwifery Conference and Awards were held. The all-day event, sponsored and supported by a number of external organisations saw more than 150 colleagues from across the Nursing and Midwifery family take part in person and online. Coinciding with the International Day of the Midwife and International Nurses Day, the conference provided an opportunity to recognise, celebrate and thank our Nursing and Midwifery colleagues for their support and dedication, delivering the best care to our patients across North Wales. It was a really enjoyable day with a number of key note speakers including Sue Tranka, Chief Nursing Officer (CNO), Helen Whyley, Royal College of Nursing (RCN), Julie Richards, Royal College of Midwives (RCM) and Sam Foster Nursing and Midwifery Council (RCN).

The day concluded with the announcement and presentation of the annual awards along with a raffle with prizes donated by local companies. Footage from the day can be viewed on the intranet - Highlights from our 2024 Nursing and Midwifery Conference and Awards (sharepoint.com)

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

Board meeting 30.5.24 Item 24/98 Chief Executive Report Appendix 1	
Teitl adroddiad: ***Report title:***	Independent Review Management Response (Contract Procurement Review)
Adrodd i: ***Report to:***	PFIGC
Dyddiad y Cyfarfod: ***Date of Meeting:***	30 April 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with the Management Response to the Independent Review of Contract and Procurement Management, which was identified within the Financial Governance and Management Domain of the Special Measures Framework. In July 2023 the Health Board, in agreement with the Welsh Government, agreed the scope of the review to provide: ○ An assessment of the adequacy and compliance with the Health Board's contract and procurement control framework (for both revenue and capital expenditure). ○ A report commissioned from NHS Wales Shared Services Partnership (NWSSP) - Audit & Assurance Services, to set out findings, incorporating: ▪ Assurance, where appropriate, on the current arrangements and controls in place. ▪ Identification of areas of good practice ▪ Identification of areas of weakness or where improvement is required, and associated recommendations. The field work commenced on the 4th September and a draft report was shared on the 31 October 2024. A final report was issued 29th January 2024. The report found several areas of concern and non-compliance with the Standing Financial Instructions (SFIs) in relation to contracting and procurement. The report developed twenty-four actions for consideration by the Health Board, NWSSP Procurement Services and Welsh Government. The key themes were as follows : • Policy, procedure and guidance for staff on procurement and contract management, and the general finance procedures to be brought up to date. • Roles and responsibilities between the Health Board and NWSSP Procurement to be clear, and to enhance the reporting and escalation process within the Health Board to ensure the Health Board has early sight of issues relating to procurement.

	• Ensure contracts are approved and signing of contracts, in line with the Scheme of Reservation and Delegation (SoRD). • Training and guidance documents to support staff who are responsible for managing contracts. • Maintain a definitive list of contracts across the Health Board. • Ensure the eWaiver system, is compliant with the SFIs and SoRD, review interdependency with the e-Financials system, and reduce the use of waivers submitted, to ensure value for money and market competition. • Provider Procurement Training for Executives and all staff involved in procurement, to ensure full understanding of responsibilities and requirements. An immediate response was launched following the receipt of the Draft Report. A detailed programme of work was developed by the Finance Department and the report actions were sub analysed into c50 tasks, to ensure the granular details raised in the report were addressed. A Tracker document containing progresses to date, has been reported regularly to the Welsh Government and NHS Executive (Finance Team) and discussed at the Finance Special Measures Meetings. Significant progress has been achieved in addressing the issues raised and this has been in full collaboration with colleagues in NWSSP Procurement Teams. Key areas: ▪ Revised SFIs and SoRD were endorsed by the Board in November 2023 – this was published on the website and communicated to all staff. ▪ Supporting Procurement Documents and Guidance including the Budget Mangers Handbook have been fully revised to better support staff and to ensure compliance with SFIs and the SoRD. ▪ A wide-ranging Training Programme, covering Procurement, Oracle Requisitions, Governance and Finance has been delivered to applicable staff (including the Executives) and is now a rolling programme being offered to Divisional Staff going forward. ▪ The eWaiver system has been fully revised and strengthened and is compliant with SFIs and the SoRD. ▪ An Annual Assurance Report will be presented to Audit Committee in July, by the NWSSP Director of Procurement Services. ▪ A fully enhanced Conformance Report is now being regularly presented to Audit Committee. ▪ The Finance Team, again supported by NWSSP Procurement colleagues, has a programme of meetings planned with Divisional Leads to ensure Local Contract Register requirements are in place that meet the needs of the organisation and ensure compliance and proactive contract management.
Argymhellion: ***Recommendations:***	The Committee is asked to note the Management Reponses and the actions taken to address the issues raised in the Independent Contract Procurement Review.

Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Andrea J Hughes, Interim Finance Director - Operational			
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:*** *Work continues to develop local contract registers and to maximise the use of NHS Wales Shared Services Procurement Services to ensure contract procurement rules are followed and to achieve the best value for money.*				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***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)	Not applicable			

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

Performance, Finance and Information Governance Committee

30 April 2024

Special Measures Independent Reviews - Management Response

Contract Procurement Review

1) Background and context

Within the Financial Governance and Management Domain, a review of contract and procurement management was identified.

In conjunction with the Welsh Government (Health and Social Services Group), the Health Board agreed the scope for the independent review to include:

An assessment of the adequacy and compliance with the Health Board's contract and procurement control framework (for both revenue and capital expenditure).

A report setting out findings, incorporating:

- Assurance, where appropriate, on the current arrangements and controls in place.
- Identification of areas of good practice
- Identification of areas of weakness or where improvement is required, and associated recommendations.

The Health Board commissioned NHS Wales Shared Services Partnership (NWSSP) - Audit & Assurance Services to undertake the review in line with the agreed scope.

The field work commenced on the 4th September and a draft report was shared on the 31 October 2024. A final report was issued 29th January 2024.

The report found several areas of concern and non-compliance with the Standing Financial Instructions (SFIs) in relation to contracting and procurement.

The Key findings as expressed by NWSSP Audit and Assurance:

- There are detailed operating procedures in place within NWSSP Procurement Services that outline the procurement process. However, the Health Board does not have any policy, procedure or guidance for staff on procurement and contract management, and the general finance procedures are out of date and require urgent review.
- Roles and responsibilities between the Health Board and NWSSP are clear, however there is scope to enhance the reporting and escalation process within the Health Board to ensure sufficient assurance is received from NWSSP, and the Health Board has early sight of issues relating to procurement.
- A detailed review of contracts highlighted some non-compliance with Health Board Standing Financial Instructions in relation to appropriate approval and signing of contracts.

- Contract management within the Health Board is inconsistent, with no instruction or guidance provided to staff who are responsible for managing contracts.
- There is no definitive list of contracts across the Health Board, with information received from services incomplete and inconsistent.
- The eWaiver system, which is used to request and approve single tender and quote waivers, does not ensure compliance with the SFIs, as it has no interdependency with the e-Financials system, and does not require the appropriate level of approval for waivers exceeding £25,000. The analysis of the eWaiver data shows that the Health Board is a significant outlier in terms of the number and value of waivers submitted, which raises questions about value for money and market competition.
- There has been no procurement training for Executives and all staff involved in procurement, to ensure full understanding of responsibilities and requirements, despite the previous recommendations from EY and internal audit.
- NWSSP Procurement Services maintain a forward work plan of areas requiring future contracts based on both current contracts in situ and Waive requests to ensure sufficient time is afforded to plan requirements, competition, quotes etc. We found no evidence of a similar practice for the contracts managed directly by Health Board staff and not recorded on the eCM register.

The report developed twenty-four (24) actions for consideration by the Health Board, NWSSP Procurement Services and Welsh Government.

An immediate response was launched following the receipt of the Draft Report. A detailed programme of work was developed by the Finance Department and the report actions sub analysed into c50 tasks, to ensure the granular details raised in the report were addressed. A detailed progress tracker was maintained on the actions taken, and has been reported regularly to the Welsh Government and NHS Executive (Finance Team) and discussed at the fortnightly Finance Special Measures Meetings. As at the time of writing this report 5 of the 24 actions are ongoing :

- 2 Health Board – linked to Contract Registers and Financial Procedure Reviews
- 2 NWSSP – Linked to Updated Procurement Guidance and Annual Assurance Report
- 1 WG - Linked to a review of the Single Quote/Tender Waiver limits

2) Overview from Development Session

The previous development session reviewed the Internal Audit findings following a commission to review contracting and procurement, the specification endorsed through engagement with Welsh Government.

The findings reported in the meeting directly relate to the actions taken by the Health Board, noting that the action plan evidences a number of elements that have already completed, in no small part owing to the delivery of actions in advance of receipt of the findings from Internal Audit

(management not awaiting the report prior to instigating improvements within the control environment).

As agreed during the session, this report then evidences (a) the recommendations (b) action taken by management and (b) those actions that remain in progress.

It is noted, this report will then be shared with Audit Committee members (the Committee Charged with Governance) for assurance the actions noted as completed can be signed off by Internal Audit, and further to offer continued oversight of delivery within the timeframes articulated below for any actions still to be implemented by management (See table 1 – Management Response Action Plan).

3) Key Themes from the Review

Themes from reviews received to date	Applicable to this review *Check box if applicable*
1. Data, Intelligence & Insight Ensuring that there is an organisation wide approach with prioritised interventions into improving our data, intelligence and insight tools and capabilities. This will be a key enabler for sustainable improvement as well as supporting identification of future potential services of concern.	☐
2. Culture Defining, engaging and committing to the long-term work necessary to improve the culture of the organisation. Integrated into our broader organisational development plan across Culture, Leadership and Engagement.	☐
3. Risk Management Reviewing and refining our approach and appetite to risk, including how risks are identified, managed, mitigated, reported and monitored.	☐
4. Patient, Family, Carer Involvement A single coordinated approach to maximise involvement and engagement with our patients and their families and carers, using their experiences to guide our ongoing service improvement.	☐
5. Operating model Ensuring our operating model is designed to best deliver our strategic priorities, with clarity for everyone across all levels of the organisation on the roles and responsibilities, systems and processes within divisions and Pan BCU services.	☐
6. Organisation Governance and compliance Ensuring organisation wide visibility and understanding of governance best practice and ensuring adherence to it.	☒
7. Integrated Planning A well understood integrated approach to planning as a discipline, as well as contributions to our annual planning process.	☐

4) Recommendations

The committee is asked to **APPROVE** the management response in readiness for onward publication into the public domain.

Table 1: Management Response Action Plan

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
Action 1	The Health Board needs to understand why these four services did not respond by the timeline set.	Health Board	Completed		Reviews with the four areas highlighted that the Internal Audit request, at the beginning of September, providing a 5 working days turnaround for response. Given the short notice and unavailability of some of the leads during the period, the areas were unable to respond in the timeline given. Contact was made with Internal Audit who advised that there would be no allowable extension to the deadline and any response received beyond the stipulated date would not be reviewed. One of the Divisions did submit prior to the audit being completed but when queried, Internal Audit advised that anything received after deadline would not be reviewed.
Action 2	The Executive Director of Finance ensures the current finance procedures are reviewed with urgency and a full review of the Standing Financial Instructions (SFIs) is undertaken to identify gaps in published	Health Board	Completed		**Element 1 = Full Review of SFIs** A full review of Model 2023 SFIs was undertaken and following approval from Board these were adopted on the 30th November 2023. The 2023 SFIs are available on Health Board website. **Element 2 = Published Finance Procedures (see Action 10 for ongoing element)**

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	procedures to guide/instruct the Health Board in complying with the SFIs.				A annual schedule has been drawn up of target dates for completion of reviews of current finance procedures incorporating the timeframe for consultation in line with Health Board's Policy on Policies. On target to complete those procedures assigned for review in Q1 2024/25.
Action 3	NWSSP Procurement Services and Health Board: The 'All Wales Procure to Pay e-Manual for use by Health Organisation' content is reviewed and updated where necessary and NHS Wales Shared Services Partnership (NWSSP) works with the Health Board to actively publicise it.	Health Board and NWSSP	Completed		The 'All Wales Procure to Pay e-manual' has been reviewed and is considered to be aligned to current SFIs. The manual is now available on the BetsiNet Intranet site for staff to access. The Budget Managers' Handbook has been fully updated and is available on the BetsiNet site. The Weekly Bulletin has been used to communicate the availability of revised manuals and guidance. A rolling programme of Procurement Training sessions delivered jointly by NWSSP Procurement Team and Finance Staff, to Budget Managers and other applicable staff, is now embedded.
Action 4	To detail the actions taken / planned actions to address the specific recommendations detailed in the Ernst & Young report.	Health Board	Completed		Many of the recommendations from the E&Y report are included as separate actions in this review. The SFIs and Scheme of Reservation and Delegation (SoRD) have been reviewed and updated and the Health Board has adopted the revised versions in November 2023. A rolling programme of training sessions is now being delivered to applicable staff on the requirements of the SFIs and SoRD as well as training delivered by NWSSP on procurement. Guidance documents including the Budget Managers Handbook have been reviewed and updated and additional

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					internal controls have been included for areas including signing of contracts and single tender waivers.
Action 5	An urgent review of the eWaiver system is completed to ensure it delivers the full requirements of the Standing Financial Instructions and interacts with the e-Financials System and is a key control to corroborate approval/rejection of waivers prior to any requisition and purchase order being approved and actioned.	Health Board	Completed		Finance soft launched a new waiver system following a period of user testing in December 2023. The system went fully live in February 2024. Key areas of improvement are compliance with delegated limits contained within the Scheme of Reservation and Delegation, improved visibility of continuous (year on year) waivers; increased focus on retrospective requests; automated reminders where further action is deemed necessary; and improved tracking which supports reporting to Audit Committee. The Health Board has been approached by other NHS Wales organisations who are looking to adopt this advanced system approach. It is not considered feasible to integrate the eWaiver system with the e-Financials system (Oracle) due to the complexity and cost involved. Actions have been taken to communicate that the waivers will be considered on an exceptional basis and combined with the Procurement training and updated controls

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					implemented; the number of single waivers being requested and approved has been significantly reduced.
Action 6	The Chief Executive ensures the requirements of SFI 11.13.5 is complied with and the Audit Committee receive timely reports on waivers.	Health Board	Completed		Whilst specific Single Tender Waiver reports have been reported to the Audit Committee during 2023/24, a fully revised Conformance Report has been developed and produced for the Audit Committee meeting in January 2024 this now forms part of ongoing 'Cycle of Business'.
Action 7	The Board Secretary ensures Standing Order 9 – Signing and Sealing Documents is always complied with, in particular SO 9.0.1 where the Board has considered "…a transaction to which the document relates has been approved by the Board."	Health Board	Completed		Discussions have been held with the Board Secretary and going forward the minutes of meetings will be explicit in detailing the Board agreement and approval given to signing and sealing of documents by Chief Executive Officer of behalf of the Health Board, in line with the SoRD.

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
Action 8	The Chief Executive ensures contracts are signed in accordance with Standing Order 9.2.2 either by the Chief Executive or nominated officers delegated by the Board.	Health Board	Completed		Linked to Action 7 - this has been discussed with the Board Secretary and going forward, minutes of meetings will be explicit in detailing approval and actions. Chief Executive, or nominated signatory in line with SoRD delegated authority, to sign contracts following Board approval. The rolling programme of Procurement training incorporates governance awareness including requirements of SFIs and SoRD for approval and signing of contracts.
Action 9	The Scheme of Reservation and Delegation (SORD) is reviewed to ensure it complies with the requirements of Standing Order 9 as we noted the SORD delegates contract approval with limits to Executive Directors.	Health Board	Completed		The Scheme of Reservation and Delegation (SORD) has been fully reviewed and updated and the revised version (including delegation of governance approval to Executive Team and Committees) was adopted by the Health Board on 30th November 2023 - this is available on the Health Board website and has been communicated to all staff via the Weekly Bulletin update.
Action 10	The Executive Director of Finance ensures Finance Policies/Procedures are developed that provide all Health Board staff responsible for procurement detailed guidance and expectations to ensure compliance with Standing	Health Board	Ongoing		An annual schedule has been drawn up of target dates for completion of reviews of current finance procedures incorporating the timeframe for consultation in line with Health Board's Policy on Policies. On target to complete those procedures assigned for review in Q1 2024/25. The updates will ensure compliance with SFIs and SoRD.

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	Financial Instructions and expected control in contract management.				In conjunction with NWSSP Procurement, a rolling programme of training sessions is now being delivered to applicable staff which incorporates the requirements of the SFIs and SoRD. Guidance documents including the Budget Managers Handbook have been reviewed and updated and additional internal controls have been included for areas including signing of contracts and single tender waivers.
Action 11	Health Board: Working with NWSSP, develops a composite contract register for the Health Board to ensure the risk of independent contract development is minimised and the Health Board maximises value for money where several contracts with a single supplier can be amalgamated.	Health Board	Ongoing		This is an action for the Health Board to work jointly with NWSSP. NWSSP maintain a contract register for all contracts that they manage on behalf of the Health Board. Other areas within BCU, for example Healthcare contracting, manage their own contract registers. Details of existing contracts are being reviewed on a rolling programme and discussions with Divisions on the robustness of local contract registers forms part of the ongoing improvement programme in this area. Working collaboratively with NWSSP colleagues to maximise their involvement with contract management and procurement to ensure, where applicable, competition takes place to ensure compliance with the law and to achieve value for money.

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					Stronger controls (revised delegated limits for example) and management of single waivers has been implemented.
Action 12	To ensure the Scheme of Delegation is applied appropriately in e-Financials, and is updated to ensure all of the organisation's structure is captured.	Health Board	Completed		A rolling programme of internal reviews are being undertaken across Divisions to ensure that e-Financials (Oracle) and ESR are compliant with revised SoRD. Senior finance staff to ensure ongoing maintenance across their service areas going forward.
Action 13	Review escalation routes within the Health Board for the Head of Procurement.	Health Board & NWSSP	Completed		Relevant escalation policies and routes exist across NWSSP and BCUHB.
Action 14	As part of the monthly meetings between both Finance & NWSSP, ensure reports pertaining to blank email/fax details in purchase orders are reviewed and corrective action taken to address irregularities.	Health Board & NWSSP	Completed		This is a joint action for Health Board and NWSSP. A report is produced by NWSSP each month and remedial action taken where details are not complete on Oracle. Now forms part of business as usual actions. Regular Procure to Pay (P2P) meetings take place between BCU

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					Finance staff and NWSSP staff from payments and procurement teams.
Action 15	To review reporting arrangements with the local procurement team to determine requirements going forward, including Audit Committee reporting and attendance.	Health Board	Completed		Monthly P2P meetings between BCU and NWSSP take place to review activity and issues of concern. Various regular reports are produced by NWSSP to monitor and manage areas such as e-waiver activity levels, No PO No Pay and Invoices on Hold. This is considered to be the relevant forum for operational matters. Revised Conformance Report produced for January Audit Committee meeting. NWSSP to be invited to Audit Committee as appropriate by the Chair. The Procurement Annual Assurance Report is to be produced by NWSSP and will be presented for review to Audit Committee after year end.
Action 16	The Chief Executive receives an update from Officers responsible for facilitating and delivering procurement training which includes the timetable for delivery	Health Board	Completed		Various Training has been undertaken: ▪ Procurement Training delivered by NWSSP to Executive Team and now part of Induction Mandatory Training.

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	capturing all current posts, how new appointees will receive their training and what refresher training will be provided and how e.g. On-line training presentation.				▪ Finance Department - Procurement Lunch and Learn 22 November 23 – attended by c50 Finance Staff; ▪ Pan BCU - Oracle iProcurement Refresher Course 23 October 23 - attended by c400 people (Oracle Account Users). ▪ Finance Department - Lunch and Learn 13 Dec 23 – focusing on SFI/SoRD, Single Waivers, Audit Preparation – attended by c60 staff. ▪ Finance Department –Lunch and Learn session Mar 24 & 27 Mar 24 – Year End in conjunction with Audit Wales - attended by c90 staff. ▪ Contracting Lunch & Learn Session – in partnership with NWSSP - 17 January 24 - attended by c70 staff. ▪ NWSSP and Finance Staff delivering rolling programme on Procurement and SFI/SoRD Training to budget holders over 100 staff reached to date. ▪ NHS Finance Academy Session 24th January 24 – Discussed training resources available and Competency Framework Assessments - attended by c60 staff. ▪ All **new** requisitioners and approvers (budget managers) required to complete I-Procurement training on set-up *(e-mail 29.08.23 20:01)*.

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					▪ Training open to **ALL** requisitioners via Oracle New User Request Form (office.com) *LIVE*; ▪ Budget Managers Handbook now fully revised and includes links to e-learning (bite size) resources. Launched and available on Betsinet.
Action 17	The Supplier Header in 'eCM' data is consistent as set-up in Oracle e-Financial.	NWSSP	Completed		The recording of supplier details on Bravo/eCM is managed by the suppliers who register their details when they create their initial account on Bravo and although the system is set up to advise that they ensure their details are accurate and in line with their official company records, it is not possible to enforce this. Assurance is provided that in the vast majority of cases, the eCM record will always be linked to the supplier account that responded to the relevant Invitation to Tender (i.e., their details are pulled through from the tender process when the contract records are being created in eCM). These records are not shared with suppliers – they are for NWSSP internal records only and they are used to inform the NWSSP Contract Workplan (particularly recording Single Tender Actions on the ECM Register).

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
Action 18	The Director of Procurement Services ensures all policies, procedures and guidance documents are up to date in line with the Standing Financial Instructions.	NWSSP	Ongoing		Updated guidance for Procurement Services to be issued 'early 2024'.
Action 19	The Director of Procurement Services provides an annual assurance report to the Chief Executive, who is ultimately responsible for procurement in the Health Board, of compliance with the Standing Financial Instructions, including a summary of any breaches with expected procurement controls.	NWSSP	Ongoing		The Health Board has identified and advised NWSSP that the Annual Assurance Report will need to be presented to Audit Committee after year end (May 24). NWSSP have confirmed that a report will be ready for Health Board for the July meeting (linked to timing of the papers for May Committee being too early).
Action 20	The Director of Procurement Services ensures NHS Wales is ready for any changes in the Procurement Bill to	NWSSP	Completed		This is a National issue and the Director of Procurement provided an update to the BCU Executive Director of Finance. The Welsh Government circulated Draft Bill for consultation prior to moving towards Royal Assent. An update is expected later in the year. Training is already in

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
	current process and provides updates to all NHS Wales Boards on any impacts of change – This is timebound.				the planning stage, to be provided to all appropriate staff in NHS Wales organisations, and the associated impacts of changes will be embedded in processes and procedures.
Action 21	Ensure all STW/SQW applications are scrutinised to ensure compliance with Standing Financial Instruction 11.13.3 and reject where the criteria has not been met.	NWSSP	Completed		NWSSP are providing additional supporting narrative within the refreshed eWaiver system including reasoning and recommendations for approval or rejection.
Action 22	To provide information to the Health Board on services provided to other Health Boards / Trusts.	NWSSP	Completed		The vast majority of services provided to Health Boards by NWSSP, are identical. There are instances where Health Boards are investing additional resources into specific areas/teams to provide additional support, including: • One Health Board has invested in a Band 7 support officer for Capital Construction projects • Another Health Board has invested in 1 Band 6 and 1 Band 4 to support IT Projects. • A Health Board has provided c£190k recurrently for procurement support to deliver additional savings

Organisation Governance and Compliance

Ref	Action	Lead	Deadline	RAG status[1]	Progress Update
					and increase Insourcing/Outsourcing Commissioned activity.
Action 23	Review of the current tender limit is considered, whilst recognising the financial pressures facing NHS Wales.	Welsh Government	Ongoing		This action is for consideration and response by Welsh Government.
Action 24	Consider enhancing the Standing Financial Instructions to exclude NHS Wales organisations from completing and approving Waivers based on timescales.	Welsh Government	Completed		From a Health Board perspective there is no additional steps required at this stage. The review of the Health Board SFIs which were approved and adopted in November 2023 have strengthened clause 11.13.4 with the additional reference included in SFI 11.13.4 that "A lack of sufficient time to complete the procurement process is not an acceptable reason for the requesting of an Single Quote/Tender Award"

[1] **RAG status definitions: Green**: On track, **Amber**: Off track with mitigations in place to bring back on track, **Red**: Off track without mitigations in place to bring back on track

Cyfarwyddwr Cyffredinol Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar /
Prif Weithredwr GIG Cymru
Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar

Director General Health, Social Care and Early Years /
NHS Wales Chief Executive
Health, Social Care and Early Years Group

Llywodraeth Cymru
Welsh Government

Carol Shillabeer
Chief Executive
Betsi Cadwaladr University Health Board

16 May 2024

Dear Carol

As agreed at the Special Measures Assurance Board on 9 May 2024, I am pleased to enclose the final version of your new special measures framework, which includes the agreed de-escalation criteria. I also attach a copy of the priorities for the next six months which we discussed and agreed at the meeting.

You will wish to arrange for these documents to be shared with the Board and ensure that these are made available via your website as part of the published Board papers.

De-escalation decisions will be based on an overall assessment of progress across the domains rather than absolute achievement of every one of the criteria under each domain. In order for de-escalation to the next level to be considered, there must be a reasonable level of confidence that sufficient progress towards the de-escalation criteria has been made and that improvements are sustainable. De-escalation will be to the next level of the escalation framework from level 5 to level 4, with reduced oversight and reporting at each stage of de-escalation.

We will continue to seek assurance on progress through quarterly Special Measures Assurance Board, and the Joint Ministerial Special Measures Improvement Forum meetings with your Board. There will also be continued scrutiny across all domains of concern, the details of which we will discuss with you.

Yours sincerely

Judith Paget

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Health, Social Care and Early Years Group
Welsh Government

Betsi Cadwaladr University Health Board

Special Measures Framework

April 2024

Llywodraeth Cymru
Welsh Government

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Section A: Introduction

A1: NHS Wales oversight and escalation

The NHS Wales oversight and escalation framework sets out the process by which the Welsh Government maintains oversight of NHS bodies and gains assurance across the system. It describes the escalation, de-escalation and intervention process, the five levels of escalation and the domains against which each health body will be assessed.

An NHS organisation can be escalated for any, or all, of the domains highlighted below:

This document sets out the improvements the Welsh Government expects the health board to realise over the next six month as well as the conditions for de-escalation the health board will need to meet. These conditions are based on learning over the last 12 months and will be subject to change should further issues of concern arise.

To be considered for de-escalation to the next level, the health board must demonstrate good progress towards meeting the majority of the de-escalation criteria, and that these improvements are sustainable.

In line with the NHS oversight and escalation framework, scope for de-escalation will be considered using the escalation domains.

A2: Welsh Government approach to oversight and escalation

Information on the escalation and intervention approach can be found in the NHS oversight and escalation framework.

To optimise the capacity, efficiency and effectiveness across healthcare settings, prudent healthcare principles and value-based healthcare will be the basis on which services are planned and delivered. Value in health is realised when the best possible healthcare outcome is achieved for our population with the resources that we have.

Interventions will be:

- Collaborative – we will seek to minimise duplication by working collaboratively with other national committees, groups and programmes.
- Collective – we will maximise shared knowledge by sharing common approaches, tools and guidance.
- Impact focussed - we will examine and seek evidence how organisations are obtaining assurance over delivery and impact of actions.
- Undertaken with openness; transparency; and mutual trust and respect between the health board, Welsh Government, and the NHS Executive.

Assessment and monitoring

Special measures will result in additional scrutiny being applied across all domains of concern. Whilst in escalation:

- Normal performance management arrangements will continue through the Integrated Quality, Planning and Delivery (IQPD) meetings and Joint Executive Team (JET) meetings.
- There will be quarterly special measures meetings chaired by the Director General of the Health, Social Care and Early Years Group / Chief Executive NHS Wales.
- There will be regular special measures improvement forums with the Board, chaired by the Cabinet Secretary for Health and Social Care.
- The chair of the health board will have a monthly review meeting with the Cabinet Secretary for Health and Social Care
- Regular meetings will take place to ensure progress is made for services of concern.
- A monthly oversight meeting, chaired by Welsh Government will be established to oversee the interventions established to support performance recovery at Betsi Cadwaladr University Health Board.
- A series of “roundtable” sessions will be held to assess progress against the quality intervention.
- Frequency of the finance and planning special measures touchpoint meetings will be agreed with the NHS Executive - these will examine progress made against the action log, review evidence and agree outputs for inclusion at the Welsh Government-led escalation meetings.

- Welsh Government will agree with the health board whether a monthly progress report on the key areas in escalation will be required. For areas such as finance, this will include extant reporting arrangements such as the monthly monitoring return to Welsh Government.
- The Cabinet Secretary for Health and Social Care will publish a quarterly progress report.

Section B: Special Measures

Special Measures (Level 5) is the highest level of escalation within the NHS oversight and escalation framework. It is applied when organisations have serious problems and where there are concerns that they cannot make the necessary improvements without external support. It consists of a set of interventions designed to remedy the problems within a reasonable timeframe. Support will always be designed and delivered within the relevant organisational context and specific support needs will be reviewed through regular oversight meetings and additional enhanced oversight arrangements.

Welsh Government will take and coordinate action and direct intervention to support Betsi Cadwaladr University Health Board to strengthen its capacity and capability to drive improvements.

B1 Approach to de-escalation

The decision to de-escalate will be taken by the Cabinet Secretary for Health and Social Care based on advice from the Director General of Health, Social Care and Early Years Group. This advice will be based on an objective assessment of progress being made across the six escalation domains.

De-escalation decisions will be based on an overall assessment of progress across the domains rather than absolute achievement of every one of the criteria under each domain. In order for de-escalation to the next level to be considered, there must be a reasonable level of confidence that sufficient progress towards the de-escalation criteria has been made and that improvements are sustainable.

De-escalation will be to the next level of the escalation framework from level 5 to level 4. with reduced oversight and reporting at each stage of de-escalation.

B2 Roles and responsibilities

<u>Welsh Government</u>

1. Appoint senior support for various aspects of the intervention and a lead SRO.
2. Support a formal structure for reviewing and reporting progress.
3. Signpost relevant best practice, guidance and frameworks.
4. Act as a critical friend and sounding board on existing practices and new developments.
5. Review and provide feedback on developed products.

6. Provide additional analytical capacity to the health board to develop, undertake and share relevant analysis and deep dives of local and national data.
7. Direct NHS Executive to provide targeted support to areas of concern to help the health board to improve its progress against programme objectives including leading on two supportive and integrated assessments to cover operational improvements and quality management and governance.
8. Work with the health board on critical enablers relating to regional planning, clinical services redesign, and infrastructure (digital and buildings).
9. Enable shared approaches to key national issues across Welsh organisations and promote shared learning.

Betsi Cadwaladr University Health Board

1. Appoint an SRO(s) for the overall escalation and each domain if considered necessary and appropriate project leads.
2. Ensure there is a clear framework in place that provides the Board with timely evidence and updates on progress toward de-escalation. The framework should also allow the Board to take an appropriate level of ownership and oversight of this area.
3. Agree the special measures plan(s) and commit sufficient resources to ensure deliverables are achieved.
4. Provide assurance to Welsh Government through regular progress reports.
5. Strengthen the formal review mechanisms to support urgency in delivering confidence and improvement to the overall position.

Section C: Focus for Special Measures

C1: Finance, Strategy and Planning

The finance, strategy and planning domain within the NHS Wales oversight and escalation framework gives consideration to the following:

- Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
- Is the organisation able to deliver against plan and accountability conditions?
- Is there a significant underlying deficit and/or significant gap to the financial plan?

Finance

The finance special measures actions cover the following areas and the health board will be required to action and demonstrate:

1. <u>Financial governance and control environment</u>

- The financial governance framework at the health board is robust in both design and implementation, including a self-assessment against best practice frameworks.
- The financial committee structure is clearly articulated and addresses key risks.
- Financial reports and supplementary presentations include the analysis and narrative explanation required to enable management and board to discharge their duties.
- Financial controls at the health board are robust in both design and implementation, including a maturity assessment of financial governance arrangements and ensure adequate controls are in place to ensure the success of the changes implemented through the special measures process. Considering if further independent review is required.
- All agreed actions and findings from the review of procurement and contract management are implemented.
- The finance function has the necessary capacity and capability to support the needs of the wider organisation.
- Budget holders and managers are held to account for delivering their financial plans and comply with clear schemes of delegation and accountability.
- That as a result of the above, the health board continue to develop the scope of the action plan to improve the financial governance and financial control environment.

2. <u>Understanding the existing deficit and key drivers</u>

- There is a clear understanding of the cost drivers and investment decisions responsible for the growth in deficit across the organisation, including an explicit breakdown by key service area and cost driver.
- It has reviewed prior year investments to assess whether the planned benefits have been delivered.
- Has a robust process for challenging underlying deficits reported at local divisional levels.

- The drivers and investment decisions responsible for the growth in workforce are well understood; are reviewed for ongoing value; and are monitored.
- The investment in planned care alongside core funding use, is well understood and triangulated across service provision, activity delivery and workforce.
- That as a result of the above there are triangulated approaches to identify and deliver actions to improve efficiency and maximise the use of resources.

3. Development and realisation of opportunities

- Has a clear process and approach across the organisation to support the identification, delivery and monitoring of all savings schemes.
- Development of a comprehensive opportunities framework with a constant pipeline of opportunities, and establish clear roles and responsibilities for developing opportunities into saving schemes and subsequent delivery of these saving schemes.
- Is translating national opportunities identified through the Value and Sustainability Board into local savings.
- Has clear policies and processes in place to enable budget holders and managers to realise and deliver identified savings schemes.
- Value based health care principles have been embedded across the organisation.

4. Clear financial plan and strategy

- An integrated and triangulated annual plan, with clear and realistic planning assumptions to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
- A clear engagement plan to communicate the necessity for financial improvement across the organisation.
- A clear approach to implementing a more strategic approach to the allocation and utilisation of resources to deliver improved outcomes for the population over the medium term through a value-based healthcare approach.

5. Delivery of Plan

- It is delivering clear improvement in the planned financial trajectory for 2024/25 (i.e. significant progress towards delivery of the Target Control Total), including further progress around identification and delivery of recurring opportunities.

Strategy and Planning

The strategy and planning special measures focus covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Delivery of improved integrated planning

- Implementation of the recommendations in the independent assessment of integrated planning approach and processes.
- Board self-assessment against the integrated planning matrix and evidence assessment documentation with a view to achieving level 2/3 on the matrix.
- Quarterly reporting to Board against progress in delivering the annual plan for 2024-25.

2. Submission and delivery of an approvable plan

- Deliver a credible annual plan as a stepping stone towards a full and financially balanced IMTP.
- Make good progress in delivering the ministerial targets, accountability criteria and the special measures requirements.

3. Clinical strategy

- Develop the organisation's multi-professional clinical services strategy and plan within an agreed timeline.
- Demonstrate how the clinical services strategy and plan are driving decision-making across the organisation.

4. Regional service delivery

- Review the learning from the orthopaedic intervention from Welsh Government and the NHS Executive, demonstrate effective partnership working to deliver a regional orthopaedic model that benefits the populations of each respective organisation.
- Deliver on the Llandudno orthopaedic business case.
- Scope and develop regional opportunities for ophthalmology services across the region.
- Scope and develop regional opportunities for urology services across the region.
- Agree the long-term sustainable vision for vascular services.

De-escalation criteria

Finance

1. The health board must demonstrate improvement and evidence of robust financial governance and a robust financial control environment.
2. Substantial progress to be made in delivering the special measures action plan including actions to improve the organisation's understanding of the existing deficit and key drivers and development and realisation of opportunities.
3. Annual plan developed with board approval demonstrating a substantial financial improvement trajectory to deliver as a minimum the target control total.

Strategy and Planning

1. Submission of an approvable annual plan in line with the NHS Wales planning framework 2024 to 2027.
2. Evidence of improving integrated planning across the organisation which supports the development of a coherent and deliverable annual plan.
3. Board clarity on the strategic vision for the organisation.
4. Evidence of a clear roadmap and implementation of the health board's multi-professional clinical services plan.
5. Deliver commitments set out within the annual plan, particularly in relation to the ministerial priorities.
6. Sustained improvements in delivery of the plan throughout the year.
7. Welsh Government's confidence in delivery based on the health board self-assessment against the planning maturity matrix.

C2: Performance and Outcomes

The performance and outcomes domain within the NHS Wales oversight and escalation framework gives consideration to the following:

- Is performance in line with agreed trajectories and national requirements?
- Are issues delivering against plan and accountability conditions identified and addressed appropriately in a timely manner?
- Are outcomes measured and monitored appropriately, with any changes identified, investigated, and actioned promptly?
- Are contracted services managed appropriately?

Performance and outcomes concerns at the health board cover a range of areas, including:

- urgent and emergency care – emergency department waiting times and ambulance handovers.
- planned care – growing waiting lists, long waiting pathways at all stages, delayed outpatient follow-up, diagnostics (specifically radiology and endoscopy) and therapy services.
- Mental health (all age), dentistry, primary and community care.

Performance and Outcomes

The performance and outcomes special measures focus covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. <u>Establish baseline and agree improvement plans</u>

- Undertake a current situation report to highlight the baseline and opportunities. This will be repeated at agreed milestones to provide assurance to Welsh Government and the Board that progress is being made or where further interventions are required.
- Review, for assurance purposes, progress the health board has made against previous external and internal reviews and implementation plans with a performance lens.
- Consolidate previous performance reviews and improvement plans into one core document, reducing the risk of duplication, with the intention of adding value to a clear way forward.
- Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence-based practice and national requirements.

2. <u>Implement improvement plans</u>

- Improve urgent and emergency care performance to ensure that patients access safe, timely and clinically effective urgent and emergency care services, reducing waiting times, delays and improving quality.

- Improve access to planned care with reduced waiting times in line with national requirements.
- Improve the timeliness of access to cancer services and demonstrate improved compliance with the suspected cancer pathway, prioritising improvement in the most at-risk tumour sites.
- Reduce the cancer backlog to agreed levels and site-specific plans are in place for tumour sites of concern.
- Implement an agreed outpatients transformation plan that supports a move towards the requirements of the planned care programme.
- Deliver activity in line with agreed trajectories and implement any necessary changes where performance falls below trajectory.

3. Work with national programmes and respond to external reviews such as GIRFT

- Work with and implement the recommendations from national programmes including but not limited to Strategic Programme for Primary Care, Six Goals for Urgent and Emergency Care, Planned Care Improvement and the National Diagnostic and Endoscopy Programmes.
- Support the implementation and realisation of the GIRFT opportunities as highlighted through the programme reviews.
- Develop and implement an integrated approach to theatre scheduling and management, working with the GIRFT programme to develop and embed the agreed theatre reporting metrics on a bi-weekly basis.
- Implement agreed plans in response to the GIRFT speciality reviews and recommendations.
- Ensure a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendations, developing and completing action plans that demonstrate sustainable evidence.

4. Primary/community care

- Implement a robust plan for primary care transformation making full use of community opportunities, urgent primary care centres.
- Develop the health board approach to GMS managed practices.
- Have robust plans in place to support fragile GMS practices and contingency plans for the disproportionately high number of single-handed practices.
- Re-procure and make contract awards for terminated GDS and PDS dental contracts.
- Establish the community dental service facility at the Bangor Dental Academy
- Develop a clear plan for the commissioning of tier 2 dental services across North Wales.

5. Communications and engagement

- Ensure there are plans in place for all long-waiting patients with a clear communication strategy and appropriate support to keep them well.
- Implement the requirements of the three Ps policy for planned care.
- Ensure that patients are clear where they can and should access support, signposting away from emergency services.
- Ensure that the benefits of new pathways such as straight to test, primary care management, self-management and see on symptoms pathways are communicated effectively.

De-escalation criteria

The de-escalation criteria are set out below. This will need to be met and maintained for at least four months before de-escalation will be considered. If the health board is able to evidence that it has met the de-escalation criteria, the de-escalation will be to the next level of the escalation framework. Performance data will be enhanced by a monthly progress report from the health board across a range of measures.

Planned care and cancer

- 55% performance maintained for 4 months against the SCP target.
- 98% of open outpatient pathways are waiting less than 52 weeks and maintained for 4 months
- Continuous improvement to ensure that 97% of open pathways are waiting less than 104 weeks and maintained/improved for 4 months.
- Continuous reduction in the number of patients delayed by 100% for their follow up appointment.
- 75% of patients waiting for a diagnostic test to be waiting less than 8 weeks maintained for 4 months.
- 80% of patients waiting for therapies to be waiting less than 14 weeks and maintained for 4 months.

Urgent and Emergency Care

- Continuous reduction of ambulance handovers over one hour of at least 17% maintained over 4 consecutive months.
- Median time from arrival at an emergency department to assessment by a clinical decision maker should not exceed 60 minutes.
- Continuous improvement towards no more than 10% of patients waiting over 12 hours at each individual site and across the health board.
- Continuous reduction of 5% in pathways of care delays for 3 consecutive months and then maintained for 4 months.
- Evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.

Adult Mental Health

- 65% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a).
- 65% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b).
- 65% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan for 4 months (Part 2).

CAMHS

- 75% of LPMHSS mental health assessments undertaken within 28 days from the date of receipt of referral for 4 months (Part 1a).
- 60% of therapeutic interventions started within 28 days following an assessment by LPMHSS for 4 months (Part 1b).

- 75% of HB residents in receipt of secondary mental health services who have a valid care and treatment plan for 4 months (Part 2).

Primary and Community Care

- Primary and community care is supported by strong clinical leadership, at Board and Executive level, an effective integrated improvement plan, project management structure and effective transformation support.
- Evidence of improved activity within community opportunities, urgent primary care centres
- A clear strategy and plans for GMS managed practices, and fragile GMS practices.
- All GDS and PDS dental contracts in place with a clear plan for the commissioning of tier 2 dental services across North Wales

The above metrics, and monthly reports will form the basis of an assessment by the Welsh Government and NHS Executive as to the confidence levels of the health board's ability to maintain and sustain improvements.

C3: Fragile Services

The fragile services domain within the NHS Wales oversight and escalation framework gives consideration to the following:

- Does outcome and clinical data indicate that the service is an outlier?
- Are people safe and not at high risk of avoidable harm?
- Are outcomes of care and treatment appropriately monitored and benchmarked with other similar services so any unduly variable or significantly worse are identified and action taken appropriately?
- Are services from other providers commissioned effectively?
- Does people's care and treatment reflect current evidence-based guidance, standards, practice or technology?

Fragile Services

The fragile services special measures focus will alter over time as it is likely that other services may have areas of concern during the timeframe of special measures.

Initial analysis indicates that there are a number of fragile services across the health board. The next stage of the escalation framework will focus on the following:

- Vascular
- Mental health
- Dermatology
- Plastics
- Urology
- Orthodontics
- Orthopaedics
- Ophthalmology
- Ysbyty Glan Clwyd urgent and emergency care department
- Acute stroke services

For each service, there will be a summary document setting out the issues of concern, expectations and de-escalation criteria.

De-escalation criteria

1. Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points, including staffing levels, staff and patient feedback, concerns, incidents, stakeholder feedback (HIW, AW, HM Coroners, Royal Colleges, HTA, MHRA, Llais etc), mortality reviews, duty of quality/candour, infection prevention and control, performance, clinical and medical leadership.
2. For each fragile service evidence:
    - Whether staff have all the information they need to deliver safe care and treatment to people?
    - How are people's care and treatment outcomes monitored and how do they compare with other similar services?

- How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?
- How well do staff, teams and services work together within and across organisations to deliver effective care and treatment?
- How consent to care and treatment is sought in line with legislation and guidance?
- Clear and effective processes for managing risks, issues and performance.

3. Fragile services (as highlighted above) are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support. Where appropriate, key performance metrics will be agreed.
4. Evidence that all recommendations from the Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.
5. Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.

C4: Governance

The governance domain within the NHs Wales oversight and escalation framework gives consideration to the following:

- Are there clearly defined, well understood processes for escalating and resolving issues and managing performance?
- Does the Board have the skills and capability to lead the organisation?
- Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Governance

The governance special measures focus covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

<u>Effective Governance Processes</u>

- Compliance with legislative requirements.
- Responding to and working with regulators effectively.
- Effective and timely response to internal audit reports and where necessary, implementation of internal audit recommendations.
- Effective and timely response to Audit Wales reports including the annual structured assessment and the review of board effectiveness, and where necessary implementation of external audit recommendations.
- Effective and timely response to HIW and Royal College reports.
- Improving and strengthening the governance and assurance framework and decision-making processes across the health board. Ensuring that policies, procedures and other written control documents meet statutory requirements and reflect good practice.
- Clarity of roles and remit of the committees, the Executive and the Board with clear escalation and reporting processes in place.
- Implementation of a Board Development Framework that seeks to address learning and development gaps and needs to improve the Board's overall effectiveness.

De-escalation Criteria

1. A vision, credible strategy and supporting plans to deliver organisational priorities which are underpinned by a culture of quality, sustainable care.
2. Governance and assurance systems in place with performance (quality, resource, activity/outcomes) issues escalated appropriately through clear structures and processes with effective Board oversight and a clear performance and delivery framework that drives improvement.
3. Responsibilities, roles and systems of accountability and escalation to support good governance and management.
4. Effective oversight and scrutiny being consistently provided by the Board and/or the appropriate Committee with clear evidence, recommendations, risks and opportunities outlined in Committee and Board papers.

5. An effective risk management framework for identifying, recording and managing risks across the organisation. The Board and the relevant Committee is sighted on the organisation's strategic risks and areas of concern on a regular basis.
6. Processes ensure the Board and the relevant Committees are provided with regular reports on performance to maintain an appropriate level of oversight and so they can scrutinise effectively.
7. Processes ensure the Board and the relevant Committees are provided with regular reports on fragile services so that they can maintain an appropriate level of oversight and so they can scrutinise effectively and provide guidance.
8. Clinical strategy and supporting plans are developed, agreed and communicated internally and to the public; deliver realistic actions early on to gain confidence and trust that sustainable longer-term continuous improvement is achievable.
9. Regular self-assessment against the agreed governance framework to identify risks and opportunities and ensure continuous improvement.

C5: Leadership, Capability and Culture

The leadership, capability and culture domain within the NHS Wales oversight and escalation framework gives consideration to the following:

- Is the diversity and skills mix at leadership level appropriate?
- Is there a culture of inclusivity, openness and transparency at leadership level?
- Is there leadership capacity and capability to deliver high quality sustainable care?
- Is there clear accountability and delivery framework/processes in place to drive outcomes through the structure?
- Does the executive leadership set the deliverables for directorates/care groups in an effect way that provides clarity of expectation and is there a process in place for remedial action should underperformance occur?
- Is appropriate and accurate information being effectively processed, challenged and acted on?
- Is there a clear vision and credible strategy to deliver high quality, sustainable care to people and robust plans to deliver?
- Is there a culture of high quality, sustainable care?

Leadership, Capability and Culture

The leadership, capability and culture special measures focus covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. <u>Workforce and structure</u>

- Review the scope and breadth of responsibilities, review the effectiveness of the structure to deliver high quality, safe care and experience for patients and their families/carers.
- Review key medical, nursing and allied health professional gaps and capacity for all clinical groups making recommendations for the future.
- Focus on strategic workforce planning and maximising the skills of its current staff.
- Develop and implement an effective approach to recruitment and retention to help ensure a high quality sustainable and flexible workforce.
- Ensure all parts of the organisation are clear on accountability and expectations at all levels to ensure successful delivery. Empowering effective decision-making and a constant focus on performance improvement.
- Support the development of a policy for job planning for consultants, SAS doctors and where appropriate for other senior clinicians.

2. <u>Leadership and development</u>

- Ensure the culture and tone set by the organisation's leaders is inclusive, open and transparent.
- Ensure ongoing development of leadership and management skills at all levels/professions to strengthen scrutiny and assurance and management maturity.

- Ensure clinical leadership is visible and effective, there is leadership development support in place and the consultant body as a whole is actively engaged in driving forward service improvement.
- Complete a review of multi-professional clinical leadership at all levels/capacity and capability/multi-professional working/empowerment of more junior staff/identifying change champions and empower local leadership models.

De-escalation Criteria

1. Succession and development plan in place to ensure adequate capacity and capability in all areas of the organisation.
2. A clear organisational structure led by an effective and complete executive team with the leadership capacity and capability to deliver high quality, sustainable care.
3. Effective leadership programme in place to support ongoing development of leadership and management skills at all levels/professions to strengthen management maturity.
4. Strategic workforce planning is undertaken to maximise skills of current staff.
5. Continued embedding of a values and behaviours framework throughout the organisation.
6. Systems and processes for learning, continuous improvement and innovation.
7. Mechanisms in place to ensure lessons learned are recorded, communicated and used to drive improvements.
8. Positive staff engagement in NHS Wales surveys.
9. Local surveys showing increasing confidence and trust in the organisation's leaders and an awareness of strategies.
10. Plans are in place and being implemented to reduce the number of interim and agency staff.
11. Positive feedback from leadership programmes.
12. A culture of listening, learning, and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources, including patient, user and staff feedback.
13. Demonstrate how people's concerns and complaints are listened to, and responded to, and used to improve the quality of care and how the people who use services, the public, staff and external partners are engaged and involved to support high quality sustainable services

C6: Quality of Care

The quality of care domain within the NHS Wales oversight and escalation framework gives consideration to the following:

- Does the leadership, governance and culture support the delivery of high-quality, person-centred care?
- Do people receive effective care and/or is there sufficient assurance in place?

Quality of Care

The quality of care special measures focus covers the following areas and the health board will be required to action and demonstrate areas as highlighted below:

1. Quality Management – clinical governance

- Review current systems and procedures to ensure high quality care, consistent with the Duty of Quality guidance.
- Review data surrounding incidents, complaints, Datix, never events to establish any patterns and investigate the extent to which learning is taking place across the organisation.
- Overall review and assessment of clinical governance.
- Assessment of clinical staff capability and overall wellbeing.
- Review the quality management system linking quality control, assurance, planning and improvement, to include the management of complaints, incidents, claims, safeguarding and other related activities in line with agreed guidelines.
- Review how patient experience and staff feedback is being used to support quality management.
- Review safeguarding arrangements.
- Ensure there are standard operating procedures for undertaking and responding to:
    - Clinical risk assessment
    - Mortality and Morbidity reviews
    - Incident reporting, investigations and learning
    - Coroner's requests and inquests
    - Capability and capacity issues
    - Record keeping
    - Understanding consent, as well as the fundamentals of care practice

2. Quality Management – complaints and HCAIs

- Undertake oversight of the PTR process including PTR compliance, inquests and claims management, complaints and serious incidents and external investigation processes.
- Implement a recovery plan to ensure complaints are responded to in line with Welsh Government targets.
- Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has

oversight and monitoring by Quality Safety and Experience Committee and Board.

3. Planning and service management

- Reassess the clinical strategy and support the immediate development of a clinical plan to lead future planning and investment decisions.
- Review the models for agreed services including clinical leadership, capability, regional and service configuration options.
- Assess patient risk within the ophthalmology pathway, assess whether the clinical risk is being well managed and options for an improved clinical model.
- Review and strengthen commissioning arrangements including the development of standard operating procedures for external providers to ensure continuity of care for patients to agreed standards.
- Review the clinical approach for regional delivery models.

De-escalation criteria

1. An integrated and effective quality management system operating throughout the organisation.
2. Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by Quality, Safety and Experience Committee and Board.
3. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.
   - C-Diff: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 13 cases to no more than 11 per month)
   - E-coli: reduce the number of hospital onset infections by 15% and maintain for 4 months (from a baseline of the average number of cases in quarter 3 of 10 cases to no more than 8 per month)
4. 68% of complaints that had final reply (Reg 24)/interim reply (Reg 26) to be closed within less than 30 working days of concern received maintained for 3 months
5. Effective response from the health board to external reports and reviews including those from Audit Wales, Public Services Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.
6. Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.
7. Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards throughout the organisation from Board to service area delivery.
8. Oversight of safeguarding arrangements to ensure the Board has sufficient, meaningful assurance that the organisation is delivering against its safeguarding statutory responsibilities.

9. Use of national clinical audit and outcome review programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care (including the use of patient and staff feedback to influence service design).

Health, Social Care and Early Years Group Welsh Government **Betsi Cadwaladr University Health Board** **Specia Measures Priorities** **April – September 2024**	Llywodraeth Cymru Welsh Government

On 27 February 2023, Betsi Cadwaladr University Health Board was placed into special measures as a result of serious concerns about board effectiveness, organisational culture, service quality and reconfiguration, governance, patient safety, operational delivery, leadership and financial management.

There have been four progress reports published, which reflect on progress made over the first 12 months of special measures, lessons learned, and improvements and challenges that have been identified. The health board has also published its own reflections on its response to special measures over the past 12 months. The focus over the first 12 months of special measures has been on stabilising the organisation and putting in place building blocks for the future. The next stage of special measures will be focused on making and embedding sustainable improvements with a focus on improved operational performance, and quality management and governance systems.

The health board has made some good progress on enabling actions since its escalation to special measures as demonstrated by the planning, performance and risk frameworks now embedded within the organisation, supported by numerous corporate improvements. The health board is focused on building upon these to ensure they are further embedded, resulting in sustainable improvements.

It is essential that the outcomes and impact of the work undertaken so far translate into the delivery of real improvements and benefits to patients and staff, that quality and safety processes start to improve and waiting times for urgent and emergency care and elective care are in line with national metrics.

The Welsh Government expects the following areas to be prioritised over the next six months:

Governance

1. Response to the issues raised by the Audit Wales follow up review of Board effectiveness at Betsi Cadwaladr University Health Board.
2. Demonstrate improved Board awareness and consideration of the quality, safety and experience of services.
3. Board's committees to be operating effectively with appropriate escalation and reporting arrangements in place that ensures Board oversight.
4. Implementation of the agreed action plan in response to the recommendations from the review of the office of the board secretary to be completed.

Quality of care

1. Develop and agree with the Board an integrated quality management system for operation across all aspects of the health board.
2. Improved data process about clinical pathway delivery, clinical outcomes and patient experience used to identify service failures and drive through quality improvements.
3. Ensure effective procedure/process for incidents, patient and staff feedback, inspections, internal audit, complaint resolution and reviews are in place, and begin to embed learning across the organisation.
4. Outline quality management system developed and shared with the Board.
5. Implementation of the recommendations from the review of concerns raised affiliated to patient safety to be completed, working with the NHS Executive to develop the required clinical governance processes.

Performance and outcomes

1. Improve access and experience as measured by improvement in 52-week waits at first outpatient stage month-on-month, zero patients waiting over 156 weeks for treatment, zero 4-hour ambulance handovers and improved 4- and 12-hour emergency department waiting time performance.
2. To adopt and implement key elements of the national programmes to ensure sustained and effective operational improvement. This will include as a minimum:
    - Embedding the principles which link the primary care and secondary care interface to reduce avoidable conveyance and/or admission to hospital, and drive reductions in length of stay.
    - Continuing the roll-out of the continuous flow model across all three acute sites, aligned to pathways of care delay reductions.
    - Fully embedding SDEC and Urgent Primary Care Centres, alongside work to support people in the community.
    - Reviewing capacity and demand in each service and starting to embed a clinical operational delivery plan for all challenged specialities.
    - Commencing implementation of community health pathways, GIRFT recommendations and theatre productivity actions.
    - Commencing the implementation of enhanced community service provision to support older patients in the region.

Leadership, capability and culture

1. Commence the recruitment to a full executive team and implement a leadership development programme centred on the needs of the new team.
2. Clinical engagement and leadership of improvement to be apparent across services demonstrating joint working and leadership of “clinical executives” and an understanding of all executives of clinical areas of risk
3. Ensure a focus on consultant and speciality (SAS) doctor job planning.
4. Continue implementation of a programme of work focussed upon strengthening culture, compassionate leadership, values and behaviours and engagement with a practical focus on driving change.

5. Continue to embed the agreed approach to build trust and confidence within the organisation and with stakeholders, including the establishment of an effective mechanism for monitoring and improving staff engagement.
6. Complete implementation of action plans in response to recommendations from each of the independent reviews.
7. Underatke a robust and consistent approach to internal investigations, ensuring that appropriate actions are taken as quickly as possible and that appropriate learning takes place.

Financial governance and management

1. Continue to deliver, embed and evidence against the key priorities set out in the special measures finance action plan, currently described under the following themes:
    - Financial governance
    - Contract procurement and management review
    - Financial savings
    - Future financial and value opportunities
    - Finance team and capacity
2. Continue to develop the scope of the action plan to support the organisation to evidence progress towards:
    - Demonstrating both a robust financial governance and a robust financial control environment.
    - Demonstrating clear policies and processes supporting the identification, delivery and monitoring of all savings schemes. This should include having a clear and robust Opportunities Framework (and Pipeline) that contains realistic opportunities to support and manage the short-term challenges being faced, as well as driving the larger-scale transformational changes that will support long-term sustainability.
    - Clear articulation of the drivers of the current deficit to inform a triangulated approach to identify and deliver actions that will improve efficiency and maximise the use of resources.
    - Demonstrating a clear strategy to deliver a (recurrent) breakeven position over the medium-term, with a clear roadmap and key milestones for delivery.
3. Evidence clear improvement in the planned financial trajectory for 2024/25 including significant progress towards delivery of the Target Control Total; improved grip and control of the existing financial and operational pressures; and further progress around identification and delivery of opportunities.

Planning and service transformation

1. Develop an approach to address the recommendations from the independent assessment of integrated planning approach and processes, having commenced delivery of those most urgent.
2. Develop and deliver a credible annual plan and understand the improvement steps to be taken to be able to move towards the development of a balanced, three-year IMTP in future years.

3. Ensure there are robust alternatives to emergency departments across the region. Take ongoing actions to ensure improvements across the three emergency departments with a clear focus on Ysbyty Glan Clwyd.
4. Commence a process with agreed timescales for the development of a clinical services plan, informed by stakeholder engagement.
5. Ensure there are robust mechanisms in place to deliver the requirements of the orthopaedic business case, whilst ensuring existing sites operate against the agreed operating model and that productivity and activity levels are maintained.

Fragile Services

1. Commence implementation of a CAMHS and neurodevelopment action plan to improve performance.
2. Respond to the recommendations from the:
    - independent safety review of BCUHB mental health and learning disabilities inpatient services,
    - follow-up safety review of mental health and learning disabilities inpatient services
    - Vascular services assurance assessment review
    - Royal College of Psychiatrists review of mental health reviews
    - Royal College of Surgeons of England review of urology surgical services
3. Implement clear improvement and transformation plans including but not limited to vascular (including enabling phase two of the vascular review), urology, ophthalmology, oncology, oral health (to include orthodontics and max fax), dermatology and plastics.

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:***	30 May 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

In the last two months I have continued to learn, although after six months in the post I am losing the right to claim my ignorance is the result of being new!

Mental Health

In terms of **Mental Health and Learning Disabilities (MHLD),** I have undertaken a number of visits focused on Community Mental Health Teams CMHTs). These have included:

- Nant y Glyn, Colwyn Bay (covering East Conwy)
- Ysbyty Alltwen and Hafod Hedd (covering South Gwynedd)
- North Gwynedd team at Hergest
- Llys Dyfrig (covering West Conwy)

There is much good work being done by these teams and I was particularly impressed by the excellent facilities and great teamwork of the older people's team at Hafod Hedd.

But these visits also highlighted again the considerable pressure on our CMHTs, with in many cases patients waiting a considerable time (many weeks) to be allocated a care coordinator (a statutory requirement under the Mental Health Measure). This is an area of considerable risk, and the situation has been exacerbated by the withdrawal in most cases of local authority social work teams who used to be co-located with our CMHTs: the Gwynedd teams were going through this 'divorce' as I visited them at the end of April. In the Gwynedd case, I was told that a joint review of patients/clients had resulted in only around a quarter of cases being allocated to the Local Authority, although they had previously contributed half of the staff. This will inevitably lead to greater pressure on staff and longer waits to be given a care coordinator

Re-establishing good working relationships with local authorities is a key priority for me. I have agreed with Alwyn Jones (Director of Adult Social Services in Wrexham and vice-Chair of the Together for Mental Health Partnership) that we will undertake research with CMHTs and Local Authorities Directors of Adult Social Services to understand the current state of joint working and what has caused tensions in the past. The findings from this should have emerged by our next Board meeting and will lay the ground for one or a number of workshops with front line staff of both the local authorities and the Health Board.

In this context, I chaired an in-person meeting of the Together for Mental Health Partnership which I believe went reasonably well. At the Chief Executive's suggestion, I am also embarking on a series of meetings with the Cabinet Members for Adult Services (and in some cases, those for Childrens' Services as well) in all six of our local authorities.

I also had a useful meeting with the directors of Conwy Mind and Vale of Clwyd Mind, and this has re-established links with the Health Board which apparently had fallen into abeyance. The Director of Conwy Mind Denise Roberts will be joining the Together for Mental Health Partnership.

Internally, I continued my regular meetings with Teresa Owen and with Ros Alstead, our external advisor and met Vicky Jones, Head of Strategy for MHLD.

I had a very interesting visit to the North Wales Adolescent Service (NWAS) at Abergele where I was able to speak to a range of senior staff from **Children and Adolescents' Mental Health Services (CAMHS)** and hear about the intensive strategic improvement work which has been underway**.** I will be visiting more of the community CAMHS teams in the next few weeks.

I also attended a North Wales consultation event on the draft Suicide and Self-Harm Prevention Strategy and consultation events organised by the Welsh Government on the draft Mental Health and Well-Being Strategy.

Finally, I sat in on the Power of Discharge Group which brings together representatives of the Associate Hospital Managers (independent appointees who review decisions made under the Mental Health Act) which linked well to the first full meeting of the Mental Health Legislation Committee, and attended the first day of the excellent conference on *'Patient Friendly Mental Health'* organised by the Board (and in particular Dr Alberto Salmoraghi) with the support of the Royal College of Psychiatrists.

Primary and Community Care

In terms of Primary and Community Care, I have undertaken quite a wide range of meetings and visits over the last two months. These have included:

- Ffion Johnson who has been asked by the CEO to co-ordinate work on Primary Care and who with Chris Stockport has convened the long-promised Primary Care Board.
- Bethan Bailey, from the Transformation Team who is working on primary care issues.
- Richard Price the Board's Optometry Adviser, who is driving forward an important 'Train and Treat' initiative, in conjunction with Cardiff University, to upskill primary care optometrists to provide treatment normally done in secondary care while making inroads into the waiting lists for such treatment
- Simon Jones, the Associate Director for Primary Care in the East
- Healthy Prestatyn, a large managed practice, with an impressive range of services provided by a multi-disciplinary team
- The Gwyrch Medical Practice in Abergele, a thriving GMS contracted practice
- The Audiology service, which is rolling out (albeit with a hiatus caused by financial constraints) a front-line service in all GP practices across the region, which in my view could be a model for other specialist services
- The Community Resource Team at Eirias Park and the Colwyn Bay Community Hospital

There is a huge amount of good practice and innovation to build upon but many of those working in primary care (perhaps particularly outside the provision of GP services) feel isolated, relatively unsupported by the wider organisation and somewhat frustrated that they have what they believe is under-utilised potential to deliver significantly on the Welsh Government's agenda of early intervention.

Moreover, as I have previously reported, a strong focus is needed firstly on developing and implementing a coherent approach to managed practices and secondly on developing a much more coherent system to provide out of hours care away from Emergency Departments, by better integration of the GP Out of Hours service, Urgent Primary Care Centres, Community Hospitals and Minor Injury Units, Community Resource Teams and the 111 service.

Finally, I attended the Inaugural HEIW Primary and Community Care Education and Training Conference in Cardiff.

Vice-Chair Network

I have continued to participate in the Vice-Chair Network, convened by the Welsh NHS Confederation which had a very useful face-to-face meeting in early May, together with a separate meeting of a new task and finish group on managed practices. I continue to circulate a briefing

note on key issues discussed at network meetings, along with presentations made, to colleagues who may have an interest in items on the agendas.

Gareth S. Williams *16 May 2024*
Vice-Chair

Teitl adroddiad: ***Report title:***	**Planned Care Fund – 2024/25 utilisation**
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	The international pandemic resulted in unprecedented urgent and emergency care demand, displacing elective care previously and historically undertaken. Post the pandemic, the Welsh Government allocated non-recurrently resources to support recovery of the long waiters within elective care. In 2024/25 this allocation (whilst remaining ring fenced for elective planned care recovery) is now recurrently within baselines, BCUHB receiving £34 million. Welsh Government have set challenging targets for use of the funding to improve patient waiting times, and will hold performance meetings to assess utilisation rates to ensure specialities are operating efficiently and productively (seeing patients expected within the resources deployed) This paper highlights the essential work needing to be undertaken to determine true demand and capacity modelling within each speciality for the Health Board, the steps needing review centring upon; • Confirmation of in house capacity (theatres and outpatients) • Productivity of our capacity (opportunity to see more patients) • Speciality demand on an annual basis (review referrals) • Future models of care to service demand There are metrics we can use to assess current performance, such as for theatres what sessions are available, do we start on time, do we finish early, are we cancelling patients at short notice and do we book patients into all of the available in-house capacity. The unvalidated performance data highlighting there to be real opportunity for improvement (the challenge being how we achieve this). The Executive have reviewed this existing Performance data for Theatres, which is to be further debated within the next Performance, Finance and Information Governance Committee meeting on current outputs. However, for 2024/25 it is clear we will need to commit funds to premium working whilst we determine future in house models for delivery, with the paper seeking approval for a variety of measures supported by the Executive (noting some elements will require re-presentation owing to value and the external nature of the placement of contracts). The final consideration is to note the Executive are to consider how we enhance demand and capacity modelling for the Health Board. With oversight through the Integrated Performance Executive Delivery Group and via Quality Management Systems the Quality Committee and performance via the Performance, Finance and Information Governance Committee (Value & Sustainability).

Argymhellion: ***Recommendations:***	The paper therefore recommends; The Health Board notes the opportunity to improve performance through in house enhanced productivity, endorsing implementation of 'treat in turn' and the 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). The paper 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 close of May 2024, performance assessed moving forwards against these revised trajectories and Welsh Government targeted levels of performance.
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Interim Executive Director of Finance.
Awdur yr Adroddiad: ***Report Author:***	Russell Caldicott, Interim Executive Director of Finance.

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 commissioning of healthcare services by the Health Board is to be strengthened to ensure services are reflective of that required by the local population and further that quality measures are to be developed to support assessment of performance levels by external partners.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This paper aligns to the strategic goal of delivery of high-quality affordable services to our local population.

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health Boards are required to report performance against long waiters (noting a Performance forum is to be implemented for 2024/25 by Welsh Government)
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 ?***	Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The Health Board fails to secure productivity and efficiency from capacity, limiting the ability to service the local population health needs and requires resources to be committed at premium rates, which may not represent value for money
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Costs associated with the paper are underwritten from the Welsh Government Planned Care Fund allocation of £34m for 2024/25.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The 2024/25 plans are reliant on premium working, which places risk of potential impacts upon health and well-being for our workforce. Further, substantive increase in capacity would require increased establishments to deliver services.
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 C** **BAF risks** BAF 21-01, Safe and effective management of planned care
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:*** Appendix I – Planned Care Allocation Fund	

Betsi Cadwaladr

Planned Care Allocation Fund

Executive Director of Finance - Interim

1.0 Introduction

The Covid pandemic resulted in the suspension of normal elective care throughout Wales and Internationally, as the world sought to manage the urgent and emergency care demands placed upon it. As the country has emerged from the pandemic, this has resulted in a substantial backlog in servicing patients waiting for elective care, with waiting times significantly beyond pre-pandemic levels across the United Kingdom.

The Welsh Government responded to the challenge through annual allocations of additional funding on a non-recurrent basis, ring fenced for use on servicing elective planned care (a focus placed on reduction of long waits within the Health Boards of Wales).

This resource was largely utilised on premium working (waiting list initiatives / insourcing / outsourcing / additional hours for staff) owing to the non-recurrent nature of the resources and difficulty in identifying where demand exceeded capacity, as theatres and outpatients responded to the challenge of moving back towards productivity and efficiency in utilisation of in-house capacity post the pandemic.

In 2024/25 the Welsh Government Planned Care allocation has been awarded recurrently, with a drive to assess and deliver productive theatre and outpatient sessions within the Health Board and build sustainable healthcare services to service the local population.

GIRFT and other measures are to be utilised to assess if actual patients seen within in-house capacity represents a productive service (are we seeing as many patients as can be expected within our core services). Services that can evidence being productive and experiencing increased waiting times owing to excess demand able to access these resources recurrently, supporting expansion of in house capacity and where estate restrictions exist, the extending of operating lists into the evenings or weekends.

This paper seeks to clarify for the Health Board the recommendations for endorsement by the Executive for utilisation of the Planned Care Resources of £34m for 2024/25 and further the journey to understanding existing speciality demand, current utilisation of in-house capacity and future and current models to productively service demand. This work identifying where waiting times continue to grow by speciality how resources are best deployed to meet this demand.

2.0 Regulatory Ask

The Welsh Government have placed a focus on productivity, an assessment centring upon substantial investments being made from Government allocations (NHS Wales being c50% of the devolved budget) the Health Board seeing a substantial increase in workforce , see below;

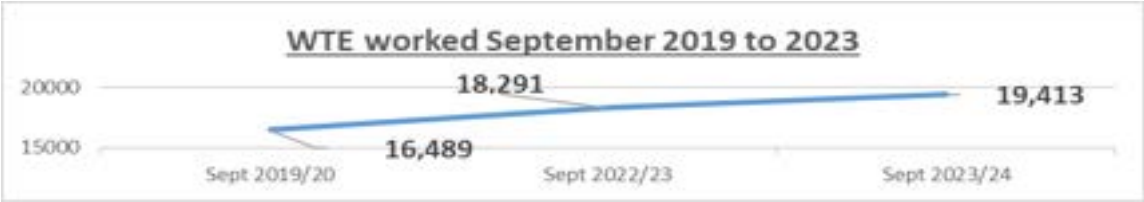

Table 1 :- WTE worked from 2019/20 to 2023/24 (increasing to over 20,000 for 2024/25)

In 2024/25 the Health Board received further resource allocations (3.67% inflation, retention of 2023/24 in year allocation and continuation of the performance fund allocation of £82m non-recurrently). However, Welsh Government is seeking delivery of enhanced performance from these allocations and substantial reductions in 2024/25 for patients waiting times, as detailed within the below table;

Ref	Measure	September 2024 Target	December 2024 Target	March 2025 Target
1	Number of patients waiting more than 52 weeks for an outpatient appointment	40% reduction		Zero
2	Number of patients waiting more than 104 weeks for treatment		Zero	
3	Number of patients waiting more than 8 weeks for a diagnostic		95% zero	
4	Percentage of patients awaiting their first treatment within 62 days from point of suspicion		60%	70%
5	Number of Ambulance handovers over one hour		30% reduction	
6	Number of patients spending 12 hours or more from arrival in emergency department	20% reduction		Further 20% reduction
7	Percentage of therapeutic interventions started within 28 days following LPMHSS under 18		80%	
8	Percentage of therapeutic interventions started within 28 days following LPMHSS Adults		80%	

Table 2: - WG targeted performance 2024/25

The above delivery will present a substantial challenge for the Health Board based on current performance, with an initial focus placed upon attainment of no patients waiting more than 156 weeks within the Health Board.

It is also of note, the Health Board is engaging with Welsh Government in relation to a Planned Care Workstream, where initial specialities of focus have been identified as being;

- Ophthalmology / Dermatology / Urology / Diagnostics

This will place focus on enhanced modelling of demand and capacity, with in house provision benchmarked against relative metrics (such as GIRFT) to assess productivity within the Health Board, with changes in booking methodology and further oversight referred to below;

- Treat in turn, so patients do not wait excessive times owing to clinical prioritisation and become a long waiter, then seen through premium working models
- A performance forum to assess productivity metrics (baseline and improvements) with theatre productivity measures an example

3.0 Comparative Health Board data

Patients waiting by Health Board for Elective Care is as indicated below;

3.1 Three Year Waits

Health Board	156 weeks July 2023	156 weeks April 2024	Reduction in patients	% movement
Aneurin Bevan	318	58	260	81%
Betsi Cadwaladr	2,214	1,686	528	24%
Cardiff & Vale	594	119	475	80%
Cwm Taf Morgannwg	970	190	780	80%
Hywel Dda	1,305	168	1,137	87%
Swansea Bay	2,699	213	2,486	92%
Grand total	8,100	2,434	5,666	69%

Table 3: - Relative performance across HB three year waits

The adoption of 'treat in turn' alongside use of planned care allocations has supported reduction in long waiters across Wales. Whilst BCUHB continues to reduce three year waits, the improvement centres upon our using expensive premium working and officers being prepared to work unsocial hours.

A combination of the change in philosophy to treat in turn, initial continued use of high cost premium working and targeted enhanced utilisation of in house capacity will dramatically improve performance in patients waiting excessive times for treatment.

3.2 Outpatients

Health Board	Total	Pathways over 105 weeks	Patients waiting over 52 weeks	% movement
Aneurin Bevan	135,729	3,862	14,342	6
Betsi Cadwaladr	181,311	8,568	18,061	12
Cardiff & Vale	147,608	2,578	11,304	7
Cwm Taf Morgannwg	109,343	2,364	13,914	11
Hywel Dda	95,974	1,458	3,479	4
Powys	7,588	1	-	1
Swansea Bay	91,346	1,805	-	7

Table 4: - WG comparison of performance for outpatients

Whilst the highest in those waiting over 52 weeks, when compared taking into account population base Health Boards are largely comparable in numbers of patients waiting.

3.3 Summary

The Health Board will place focus on improved performance on long waits and specialities in escalation, combining;

a) a change in philosophy that further aligns to Emergency and then 'treat in turn'
b) Initial use of premium working from resource issued to the Health Board 2024/25
c) improved productivity of in house available capacity during 2024/25 and for future years

The Executive supporting the above, so as to ensure the Health Board doesn't continue to experience excessive waits for treatment of patients.

4.0 Planned Care environment

It is important to state that at this time substantial further development is required for modelling of demands for specialities and capacity to service this demand. The Health Board not possessing robust demand and capacity models at this time resulting in a reliance on historic levels of activity in assessment of capacity. The theatres utilisation and GIRFT assessment of current practice indicating the Health Board has opportunities to improve productivity and the numbers of patients seen within existing inhouse elective capacity.

A 'Theatre Optimisation' group has been established within the Health Board, overall performance for the Health Board monitored for oversight through this group. Current performance evidences an opportunity to improve productivity from focus being placed upon the below areas;

- Elective theatre sessions starting on time (limiting delays to starts)
- Focusing on elective theatre sessions that finish early (ensure lists booked to capacity)
- Avoidance of late or on the day cancellations
- A focus on using all planned elective theatre sessions available
- Targeting improved elective (planned care) theatre utilisation

The Theatre Optimisation Group will report into the Integrated Performance - Executive Delivery Group where officers will be held accountable for delivery of targeted improvement within the above areas.

The improved utilisation a key element of the Value & Sustainability approach endorsed for improvement within the Health Board (under clinical variation) to improve access to care for patients through improved utilisation of our core theatres. The current long waiters for Elective Care evidenced within the below table;

Description	Over 104 weeks	Over 156 weeks	Over 208 weeks

Patients waiting (no)	8,044	1,686	203

Table 5: - Analysis of patients waiting in excess of 104 weeks to 208 weeks

Analysis of Patients waiting over 104 weeks by Speciality					
Specialty	**West**	**Cent**	**East**	**Unknown**	**Total**
Cardiology	1	0	0	0	**1**
Community Paediatrics	1	0	0	0	**1**
Dermatology	830	289	94	0	**1,213**
ENT	103	256	219	0	**578**
Gastroenterology	1	799	4	0	**804**
General Medicine	1	0	0	0	**1**
General Surgery	441	639	609	1	**1,690**
Gynaecology	29	24	284	0	**337**
Maxillo Facial Surgery	478	263	148	1	**890**
Nursing episode	1	0	0	0	**1**
Ophthalmology	3	0	964	0	**967**
Orthodontics	427	211	82	0	**720**
Orthopaedics	389	319	544	1	**1,253**
Paediatric Surgery	0	1	0	0	**1**
Paediatrics	1	0	0	0	**1**
Pain Management	0	0	299	0	**299**
Plastic Surgery	5	3	0	0	**8**
Rehabilitation	1	0	0	0	**1**
Respiratory Physiology	1	0	2	0	**3**
Urology	81	408	358	0	**847**
Vascular Surgery	33	73	211	0	**317**
Total	**2,827**	**3,285**	**3,818**	**3**	**9,933**

Table 6: - Elective care by speciality waiting over 104 weeks

The Health Board would need to target delivery of the 9,933 patients to deliver the ask of no one waiting more than 104 weeks, noting further cohorts of patients will be moving into these analysis tables as the months progress (those currently waiting 100 weeks moving into this category in 5 weeks as an example).

This will feature as a key component of the Quality Management System implementation, with the Value & Sustainability workstream (within clinical variation) reporting enhanced performance trajectories and therefore numbers of additional patients seen within our base capacity, this is important for two reasons;

- Patients are seen in core times, which limits inconvenience and improves treatment times and the number of patients being seen and receiving treatment
- Our dedicated staff are not asked to work additional unsocial hours, this helps with their health and well-being and work life balance

To achieve this ambitious target the Health Board will look to implement;

a) Treat in turn methodology

b) Oversight and driving productivity of in house capacity (for 2024/25 and future years)
c) Use of the Planned Care Funding of £34m, initially for 2024/25 through premium working (WLI external contracts)

5.0 Use of Resources Plan 2024/25

The Health Board has a £34m allocation to support Planned Care for 2024/25, the resources ringfenced and held in reserve to support enhanced performance on long waiters (elective and outpatients).

Initial plan to tackle over 156 week waits (to include 208 weeks) centre upon a combination of targeting a cohort of patients through Waiting List Initiatives, and applying 'treat in turn'.

The result is to then through a combination of treat in turn and use of waiting list initiatives for the patients waiting over 156 weeks to be seen by the Health Board. The split of these patients by speciality articulated within the below table;

2024/25 > Targeted greater than 156 weeks (Waiting List Initiatives)	
Specialty	**Additional Patients**
Trauma & Orthopaedics (IP/DC)	**105**
General Surgery (IP/DC)	**413**
Vascular (IP/DC)	**40**
Urology (IP/DC)	**141**
Gastro (IP/DC)	**1**
ENT (IP/DC)	**50**
Gynae (IP/DC)	**92**
Ophthalmology (IP/DC)	**34**
Max Fax (IP/DC)	**164**
Total	**1040**

Table 7: - WLI targeted performance to remove over 156 waits

Further measures

Outpatients - Action to improve overall 52 week position

Stage 1 – Supporting effective and efficient access to first appointment

Establishing sustainable centralised booking and in house validation functionality, resourced through a previously funded business case totalling £0.8m that will ensure:

- We improve our treat in turn rates and ensure our clinics are booked to capacity in line with national guidance
- Our lists are validated in a timely fashion and so are patients are on the correct pathway from the start of their treatment journey
- We deploy technology to support efficiency and improved patient experience, our use of chatbot technology to enable patients a way to interact with us at their convenience is a vanguard initiative in Wales

Demand Management – The follow-on from making booking more efficient and ensuring we are universally working to 6:4:2 principles, aligning capacity to job planning and booking effectively, is the need to better manage demand and upstream in the referrals process.

Utilisation of the Planned Care Fund 2024/25

Delivery of all of the Welsh Government ask requires an improvement in outpatients and patients awaiting elective care beyond 104 weeks. As such, further initiatives are required to be resourced as part of the Planned Care recovery and use of the £34m allocation received for the 2024/25 financial year. The measures for Cancer enhanced performance, mental health and reduction in eight weeks diagnostic also featuring within the ask of Welsh Government in targeting improvements in performance.

The Health Board is required to model the use of the planned care allocation (£34m) into enhanced performance trajectories by May of 2024. These revised trajectories then used to monitor actual performance during the 2024/25 financial year and compare against attainment of the Welsh Government targeted levels of performance.

A series of initiatives has been compiled for review and endorsement as appropriate within the following table for Health Boards consideration, the targeted areas for improvement required in long waiters as detailed in the below table;

Ref	INITIATIVE FOR UTILISATION OF PLANNED CARE RESOURCES (£34M)	BENEFITS TARGETED BY INITIATIVE	GOVERNANCE & OVERSIGHT ROUTE	Proposed to be funded £000's
1	Stabilisation of Dermatology	Removal of backlog only	Approved via Executive Team – to be mobilised	1,500
2	Elective waits exceeding 156 waits to be removed	Aligns to WG ask for reduction in long waiters	Approval through sign off by Waiting List Initiative (WLI) process	1,900
3	Strategic Support for Cancer	Delivery of cancer services	A series of business cases, approval route dependant upon values	2,000
4	Gynaecology WLI	Recovery of backlog	Approved through Executive & WLI Process	83
5	Cancer performance	Targeted WLI either at 1st apt, 14 days or treatment at 62 days	Executive oversight of WLI sign off	500
6	Colorectal Robot	Accelerated competency/deploy robotic surgical	Executive approval / case to be presented with activity	80
7	Straight to Test Prostate Pathway	Maintenance of essential cancer pathways	Executive supported case	140
8	Colorectal Nurse Triage	Maintenance of essential cancer pathways	Executive supported case	300
9	Prostatectomy additional costs	Maintenance of essential cancer pathways	Executive supported case	300
10	Validation and booking	Improved compliance with RTT	Outpatient booking - business case endorsed in Executive 2023/24	625
11	Recruitment of 8 anaesthetists	Improved theatre utilisation	Subject to endorsement of business case	1,100
12	Recruitment of 2 ESPs (lower limb orthopaedic)	Remove follow up & improved performance at 52 week OP	Executive approval / case to be presented with activity	125
13	Support for Orthodontics	Mitigation of clinical risk	Executive oversight of WLI sign off	499
14	Countess of Chester Opportunity	Orthodontics reduced for 104 week improved performance	Executive approval / case to be presented with activity	499
15	Planned Care Corporate Capacity	Support for oversight and delivery of Planned Care	Business case will be required for oversight team	600
16	Abergele/Llandudno	Optimised arthroplasty performance	Health Board endorsed business case	1,500
17	Imaging In sourcing	Targeted benefits of 8 weeks to referral	Executive endorsed tender commenced needs Executive & HB endorsement	5,200
18	Endoscopy Recovery / In Sourcing	Mitigation of list growth	Executive endorsed tender commenced needs HB endorsement	3,000
19	Max Fax In Sourcing	Support to remove longest waits	Executive approval / case to be presented with activity	300
20	Clinical Lead Sessions	Ophthalmology, Dermatology, Urology, Orthopaedics, General Surgery, Theatres	Executive approval / case to be presented with activity	250
21	Development of Diagnostics sustainability	Business case to describe long term sustainability	Executive approval / case to be presented with activity	350
22	Gastro Dieticians	Improved management of referrals	Executive approval / case to be presented with activity	217
23	Neuro Physiology Backlog removal	Backlog removal	Executive approval / case to be presented with activity	300
24	Reduction in follow up validation	Reduction in overdue follow up waiting list position benefit circa £0.5m	Executive approval / case to be presented with activity	240
25	Attend anywhere	Improved outpatient performance	Executive supported case	393
26	Neuro development waiting lists - CAMHS	Improved Mental Health performance	Executive oversight of WLI sign off	1,400
27	Vasular and Diabetic Foot pathway	Required to service patient co-hort	Executive supported, value requiring Health Board endorsement	3,000
28	Elective over 104 weeks targeted delivery	Movement towards delivery of reduction in long waiters and 104 week target	Executive oversight of WLI sign off	4,000
	Total			**30,401**

Ok to proceed, where relevant subject to WLI form being completed
Agreed in principle, business case to be supported through Executive
Supported, potential for further approvals for governance

Table 8: - Utilisation of Planned Care Fund

6.0 Enhancements to be completed during 2024/25 & for 2025/26

6.1 Introduction

The span of schemes for this coming financial year will largely focus on waiting list reduction and long waiter removal. However, it is vitally important we use resources productively to see as many patients as possible, treating at the earliest opportunity.

In order to effectively deliver productive healthcare for our local population it is vitally important we develop a clear understanding of current capacity, actual delivery and potential future delivery from enhancements in in-house productivity. In comparing our true capacity to demand (offset by demand management) we can then clearly define;

a) Is the in house capacity sufficient to meet annual patient demand
b) Is in-house capacity productive and seeing patient numbers expected (GIRFT)
c) Develop speciality plans (enhance or invest within in-house capacity)
d) How are we to service long waiting patients. Premium working or does the work undertaken in (c) above provide excess capacity over annual demand

To get to this place, there are key elements of oversight and delivery required to be implemented during the 2024/25 financial year, which if completed would support enhanced in year delivery of Elective care and compliment delivery of targeted performance in year.

6.2 Initial Speciality focused work

As referenced earlier, the four key specialities of Ophthalmology / Dermatology / Urology / Endoscopy will initially be reviewed, though this work will be required across all specialities.

A demand and capacity model is to be completed to determine current in house capacity, opportunity to enhance in house performance compared to demand and then articulation of the interventions through premium working (as described below);

Ref	Speciality	Capacity & historic activity delivered	Opportunity for in house capacity increase (GIRFT)	Demand (net of demand management initiatives)	Activity to be serviced through premium working
1	Ophthalmology	The development of these clear capacity and demand models will be required for business case presentation to the Executive and Health Board in supporting placement of contracts for premium working to support 2024/25 delivery.			
2	Dermatology				
3	Urology				
4	Endoscopy				

Table 9: - Specialities in focus with WG and required outputs

It will be important to have robust modelling of demand and capacity for all specialities, with clear identification of patients that should be seen within the existing baseline

capacity of the Health Board, comparing this to actual performance and developing measures to hold officers to account for delivery.

6.3 Theatres and Outpatient booking

Ensuring patients are booked within elective capacity to use the theatres to a maximum is a further piece of work needed, key steps being;

- Reporting of theatre utilisation by Hospital and speciality
- Visibility within clinical forums of current productivity
- Targets developed that reflect expected productivity (GIRFT as an example)

The Integrated Performance – Executive Delivery Group will receive monthly reporting of performance in regards to use of our theatres, the Theatres Optimisation Group reporting into this Committee where officers are held to account for delivery.

6.4 Future 2025/26 modelling and work

The outputs from the demand and capacity modelling will be required for assessment of use of the now recurrent Planned Care Fund for 2025/26, with incremental benefits targeted in 2024/25 from enhanced utilisation of in house capacity (seeing more patients) used to determine recurrent investment models moving into the 2025/26 financial year.

This ensures we move to utilisation of the £34m Planned Care Allocation through core capacity to offer best value for money for the local population (avoiding premium working) resulting in more resources being available to invest in the treatment of our patients.

In summary, there is a significant amount of work required to enhance modelling of current funded capacity and demand, with a need to evaluate capability and capacity within existing teams to deliver on the opportunity to realise the benefits others are seeing.

7.0 Key risks

Key risks and assumptions to consider:

Whilst we develop our demand and capacity modelling and seek to where appropriate realise in house opportunities for enhanced productivity, there will be a need to utilise premium working for 2024/25. This leads to clear risks as defined below;

- Requires clinical teams to support unsocial working (work life balance)
- Operational model impact on ability to determine speciality capacity and demand
- Capability and capacity constraints within the existing workforce to determine future speciality care model delivery, and realise any benefits beyond current actual delivery

We will be relying on the current workforce to support premium working in the short term, and will need to use existing oversight mechanisms to model improvement and gain ownership throughout the organisation of the increase in booking of patients for enhanced in house productivity (subject to evidence for change through measures such as GIRFT).

8.0 Summary & Next Actions

The Health Board have an allocation of £34 million for 2024/25 that is recurrent and ringfenced to support elective recovery, with Welsh Government seeking improvements in long waiters through a combination of;

- Utilisation of funds for specialties where long waiters exist (Outpatients and Elective)
- Application of the 'treat in turn' methodology

The Health Board is to model demand verse capacity for each speciality, assessing in house capacity based on actual performance and then the opportunity to enhance the numbers of patients seen in these areas, what capacity would the Health board have if services were efficient and productive (using benchmark references such as GIRFT to evidence where opportunity exists).

Whilst initial data on theatres indicates opportunity to improve productivity and treat patients earlier, it is also clear there is a substantial amount of work needed to realise this opportunity.

This paper therefore sets forward a proposal for endorsement by the Health Board for utilisation of in year planned care funds largely through premium working in 2024/25, though also seeking gains to be realised in year on productivity as described within this report that will also improve and enhance patient care, positively impacting on patients as their wait for treatment is further reduced.

The paper therefore recommends;

The Health Board notes the opportunity to improve performance through in house enhanced productivity (subject to evidencing through appropriate benchmarking) and endorsing implementation of 'treat in turn' and the plans articulated for use of Planned Care resources detailed within table 8 of the report, 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 approval (owing to value).

The paper also references consideration to be 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 close of May 2024, performance assessed moving forwards against these revised trajectories and Welsh Government targeted levels of performance.

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

Teitl adroddiad: ***Report title:***	Annual Audit Report and Structured Assessment
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	The Annual Audit report (appendix one) to board members sets out the key findings from the audit work undertaken at Betsi Cadwaladr University Health Board by Audit Wales during 2023. The Structured Assessment report (appendix two) examines the health board's arrangements that support good governance and the efficient, effective and economic use of resources.
Argymhellion: ***Recommendations:***	The Board is asked to: • **RECEIVE** and support the annual audit report; • **RECEIVE** and support the structured assessment report; • **AGREE** that the executive team will address the improvement opportunities as outlined in the management response to the structured assessment (appendix two). • **AGREE** that the Audit Committee will continue to scrutinise the delivery of the recommendations
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad: ***Report Author:***	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: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 1 Building an Effective Organisation
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 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)***	CRR-16 – Leadership/Special Measures BAF 2023/24 SP16 Board Leadership and Governance
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no financial implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no workforce implications
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 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)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** • Implementation of recommendations	

Rhestr o Atodiadau:

List of Appendices:

- Appendix 1: Annual Audit Report
- Appendix 2: Structured Assessment

ANNUAL AUDIT REPORT AND STRUCTURED ASSESSMENT

1. Background

The annual audit report now being presented to the board is reflective of any amendments that were agreed to the structured assessment report, and it is concurred that the report presents a fair and balanced view of the organisation, recognising both the positive aspects identified and those areas where further progress is required.

The report sets out the findings under three themes:

- Governance arrangements;
- Approach to strategic planning; and
- Wider arrangements that support the efficient, effective and economical use of resources.

2. ANNUAL AUDIT REPORT

This report summarises the work undertaken by the Audit Wales and allows the Auditor General for Wales: to discharge his responsibilities under the Public Audit (Wales) Act 2004 in respect of the audit of the accounts and the health board's arrangements to secure efficiency, effectiveness and economy in its use of resources.

Key findings included:

- The Auditor General for Wales (AGW) issued a qualified true and fair opinion on the Health Board's 2022-23 accounts as he was unable to obtain sufficient appropriate audit evidence over the accuracy of the opening balances due to the qualifications arising in 2021-22.

- The true and fair opinion for 2022-23 was also qualified for expenditure reported in year as the AGW could not ascertain the value of the £122 million uncertainty reported in 2021-22 that should have been included within 2022-23 expenditure.

- The regularity opinion for 2022-23 was also qualified, as the Health Board incurred irregular expenditure for payments made to an interim executive member of the Board.

- Alongside the AGW audit opinion, he placed a substantive report on the Health Board's accounts to highlight the true and fair and regularity qualifications noted above and the failure of the Health Board to have an approved three-year plan in place.

- Following a period of significant disruption and churn during 2023, the board is now in a more stable position. The dysfunctionality described in my previous report on board effectiveness is no longer evident and working relationships amongst senior leaders are more positive in overall terms. However, the new board still has some fundamental challenges to tackle as part of the organisation's response to the Welsh Government's special measures framework.

- As part of the wider stabilisation of the organisation, key corporate assurance arrangements are being strengthened. However, the Health Board needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand.

- The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations.

- Urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There's a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.

- The Health Board has made limited progress in implementing previous recommendations on follow up outpatients and it continues to carry significant clinical risks associated with delayed follow up appointments across a number of specialties.

- At an all-Wales level, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.

- Whilst the Health Board has set out a reasonably clear and ambitious workforce strategy, it needs to significantly strengthen its implementation plans along with its workforce planning capacity and capability.

Further information is included in Appendix 1.

3. STRUCTURED ASSESSMENT 2023

The Structured Assessment 2023 focused on our corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

The overall assessment concluded that "*following significant challenges in 2023, the Health Board is more stable and in the process of strengthening key corporate assurance arrangements, but it needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand. The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations*"

The key focus of the work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively and economically. Key messages in this regard from the Audit Wales Structured Assessment include;

- **Board Transparency and Effectiveness** – Audit Wales found that found that the Health Board is increasingly demonstrating public transparency of board business, however there are opportunities to improve and standardise these arrangements for board committee meetings. whilst the Health Board has formal and up-to-date standing orders and standing financial instructions to support its Board and committee business, there remains a backlog of policies that are overdue for review.

- **Corporate Systems of Assurance** – Audit Wales found that the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is needed to properly embed these new arrangements, to further develop the Board Assurance Framework (BAF), strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations.

  The Health Board has made progress revising its BAF and risk management arrangements, but it needs clear strategic objectives to align strategic risks to, and a stronger focus on the impact of actions it takes to mitigate risks. The Board's arrangements for hearing directly from patients is improving, and it is planning to increase opportunities to hear directly from staff through service visits and hearing staff stories at People and Culture Committee meetings.

- **Corporate Approach to Planning** – Audit Wales found that the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand. There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts.

- **Corporate Approach to Managing Financial Resources** – Audit Wales found that despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service model.

  The Health Board's approach for financial planning is driving a transactional approach to financial management and while delivering some in-year savings this isn't significantly addressing the Health Board's underlying deficit. There is a clear need for a financial strategy to underpin medium- to long-term planning that fully considers growth in healthcare demand and supports financially sustainable clinical service models, whilst also reducing the underlying deficit.

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Betsi Cadwaladr University Health Board

Audit year: 2022-23

Date issued: March 2024

Document reference: 4079A2024

This document has been prepared as part of work performed in accordance with statutory functions.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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

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Detailed report

About this report

1 This report summarises the findings from my 2023 audit work at Betsi Cadwaladr University Health Board (the Health Board) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Health Board, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Health Board has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 25 August, meaning the deadline was not met due to significant issues with the Health Board's accounts and the qualification of the 'true and fair' and 'regularity' opinion.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing

that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Health Board this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Interim Executive Director of Finance have agreed the factual accuracy of this report. We presented it to the Audit Committee on [date]. The Board will receive the report at a later Board meeting and every member will receive a copy. I strongly encourage the Health Board to arrange its wider publication. I will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Health Board's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I issued a qualified true and fair opinion on the Health Board's 2022-23 accounts as I was unable to obtain sufficient appropriate audit evidence over the accuracy of the opening balances due to the qualifications arising in 2021-22.

13 The true and fair opinion for 2022-23 was also qualified for expenditure reported in-year, as I could not ascertain the value of the £122 million uncertainty reported in 2021-22 that should have been included within 2022-23 expenditure.

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

14 The regularity opinion for 2022-23 was also qualified, as the Health Board incurred irregular expenditure for payments made to an interim executive member of the Board.

15 Alongside my audit opinion, I placed a substantive report on the Health Board's accounts to highlight the true and fair and regularity qualifications noted above and the failure of the Health Board to have an approved three-year plan in place.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

16 My programme of Performance Audit work has led me to draw the following conclusions:

- following a period of significant disruption and churn during 2023, the board is now in a more stable position. The dysfunctionality described in my previous report on board effectiveness is no longer evident and working relationships amongst senior leaders are more positive in overall terms. However, the new board still has some fundamental challenges to tackle as part of the organisation's response to the Welsh Government's special measures framework.
- as part of the wider stabilisation of the organisation, key corporate assurance arrangements are being strengthened. However, the Health Board needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand. The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations.
- urgent and sustainable action is needed to tackle the long waiting times for orthopaedic services. There is a clear commitment to improve waiting times, however, it could take three years or more to return the orthopaedic waiting list to pre-pandemic levels.
- the Health Board has made limited progress in implementing my previous recommendations on follow-up outpatients and it continues to carry significant clinical risks associated with delayed follow-up appointments across a number of specialties.
- at an all-Wales level, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- whilst the Health Board has set out a reasonably clear and ambitious workforce strategy, it needs to significantly strengthen its implementation plans along with its workforce planning capacity and capability.

17 These findings are considered further in the following sections.

Audit of accounts

18 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

19 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Exhibit 4**, **Appendix 3**.

20 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

21 I issued a qualified true and fair opinion on the Health Board's 2022-23 accounts as I was unable to obtain sufficient appropriate audit evidence over the accuracy of the opening balances due to the qualifications arising in 2021-22. I was also unable to quantify the exact level of misstatement as the Health Board had not addressed the issues reported in 2021-22.

22 The true and fair opinion for 2022-23 was also qualified for expenditure reported in-year, as I could not ascertain the value of the £122 million uncertainty reported in 2021-22 that should have been included within 2022-23 expenditure. We were therefore unable to conclude that expenditure was fairly stated in all material respects.

23 I also encountered some significant issues that undermined the quality of the draft financial statements that led to inefficiencies in the audit and which I reported to the Audit Committee.

24 The quality of the draft financial statements submitted for audit where not to the standard we would expect. Considerable additional work had to be undertaken by the audit team to fully understand the disclosures within the financial statements. The working papers to support Note 8 'Operating Leases', Note 11.1 'Property Plant and Equipment and Note 11.2 'Right of Use Assets' where particularly poor and our work identified errors in the preparation of the accounts and a fundamental lack of understanding of the required entries for the implementation of IFRS16 Leases and the treatment of accounting adjustments for revaluation, indexation and impairment.

25 Our initial review of declarations of interest to support the disclosures in Note 30 'Related Parties' identified several missing declarations relating to officers and independent members who had left the Health Board during the year. Considerable work was undertaken by the audit team and the Health Board to ensure the disclosures where complete.

26 The Remuneration Report submitted for audit, after an extension to the Welsh Government deadline, required a significant number of amendments to ensure the information reported was factually accurate.

27 We identified issues within the governance arrangements where staff payments exceeded amounts approved and where the Health Board had failed to comply with its own standing financial instructions. Two officers were paid on terms not approved by the Health Board's Remuneration Committee. One of these officers was also paid in excess of the pay scale set by the Welsh Government and for which we qualified our regularity opinion.

28 In addition to the issues above, we also encountered some significant delays in receiving responses to requests for explanations and supporting audit evidence.

29 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 24 August 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	The £9.4 million of expenditure we identified during the audit of the 2021-22 financial statements that related to 2022-23, but which had been included within 2021-22, had not been amended to be included within the 2022-23 financial statements. The reported 2022-23 expenditure within Note 3.3 'Expenditure on Hospital and Community Health Services' is understated by this amount. My testing of Note 11.1 'Property Plant and Equipment' identified that amounts for 'Reversal of Impairments' and 'Revaluations' had not been properly calculated by the Health Board's fixed asset register system. Although the Health Board was unable to fully quantify the impact on the relevant lines of the note, we were able to carry out sufficient work to give us assurance that the lines within the note for the Gross Cost or Total Depreciation were not materially misstated. My review of the Health Board's implementation of the new accounting standard IFRS 16 Leases identified errors, due to the incorrect treatment of assets and liabilities when assets were transferred from Note 11.1 'Property Plant and Equipment' to Note 11.3 'Right of Use Assets. The Health Board was unable to

Issue	Auditors' comments
	create a liability for four assets that were already held on the balance sheet as this would have needed accounting adjustments directly through the general fund which requires Welsh Government approval. Consequently, the reported payables balance in Note 18 was understated by £661,069.
Corrected misstatements	Numerous amendments were made to the Financial Statements and the Remuneration Report. The amendments impacted on the prime statements within the financial statements: the Other Comprehensive Net Expenditure, Statement of Financial Position as at 31 March 2023, Statement of Changes in Taxpayers' Equity, and Statement of Cashflows for the year ended 31 March 2023. A large number of amendments were made to notes 11.1 'Property Plant and Equipment' and Note 11.3 'Right of Use Assets' due to errors we identified in the implementation of IFRS16. The Remuneration Report required significant revisions to ensure the information reported was factually accurate.

30 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Health Board's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

31 My separate audit of the charitable funds accounts is being finalised. We have not identified any significant issues to report to the trustees.

Regularity of financial transactions

32 The Health Board's financial transactions must be in accordance with authorities that govern them. The Health Board must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Health Board does not have the powers to receive or incur.

33 Where a Health Board does not achieve financial balance, its expenditure exceeds its powers to spend and so I must qualify my regularity opinion.

34 The Health Board achieved financial balance for the three-year period ending 31 March 2023. Following on from the 'true and fair' qualification of the 2021-22 accounts, we reviewed non-NHS manual accruals to identify whether any balances from 2021-22 were still included and to determine what accruals were overstated. Our work identified £8.29 million had been removed from the Health Board's expenditure in 2022-23 as it determined that the 2021-22 accruals were overstated, were not required, or they did not exist. If the Health Board had not reversed these accruals, it would have overspent against its 2022-23 resource allocation by £7.094 million and would not have achieved the three-year break-even financial duty. The regularity opinion was not qualified for this.

35 The Health Board made payments to the Interim Executive Director of Nursing and Midwifery in excess of the terms and conditions approved by the Health Board's Remuneration Committee and also in excess of the pay point stipulated by the Welsh Government for the role. The Health Board's Standing Financial Instruction (SFIs) paragraph 14.1.2 requires the appointment of officer members of the Board be reserved for full Board approval. SFI 14.1.4 also requires Welsh Ministers' approval where an officer member of the Board is paid more than the Welsh Government's approved salary band. We established that the SFI requirements were not followed as approval was not obtained from the Board or Welsh Ministers. I considered this expenditure to be unlawful and qualified the regularity opinion due to this.

36 I have the power to place a substantive report on the Health Board's accounts alongside my opinions where I want to highlight issues. Due to the issues set out above, I issued a substantive report setting out the factual details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

37 I have a statutory requirement to satisfy myself that the Health Board has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Health Board over the last 12 months to help me discharge that responsibility. This work has involved:

- following up progress on immediate areas for action contained in my review on Board Effectiveness, which I published earlier in February 2023;
- undertaking a structured assessment of the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically;
- commenting on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments;

- undertaking a follow-up review of my previous report on follow-up outpatients;
- publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally; and
- reviewing the effectiveness of the Health Board's workforce planning arrangements.

38 My conclusions based on this work are set out below.

Follow-up review of Board Effectiveness

39 In February 2023, I published a report in the public interest on the effectiveness of the board at Betsi Cadwaladr University Health Board. The report described a worrying degree of dysfunctionality within the board and wider senior leadership of the organisation. I concluded that collectively the concerns identified were fundamentally compromising the ability of the board to work effectively and in an integrated manner to address the significant challenges the Health Board faces. My February 2023 report set out a number of areas for immediate action.

40 My team have since undertaken a follow-up review to consider the extent to which the immediate areas for action identified in the report have been addressed, and to provide an up-to-date commentary on the effectiveness of the current board.

41 My work found that **following a period of significant disruption and churn during 2023, the board is now in a more stable position**. There is a new substantive Chief Executive in post, the dysfunctionality within the board described in our previous report is no longer evident and working relationships amongst senior leaders are more positive in overall terms.

42 However, some fundamental challenges still remain in the context of an organisation that is in special measures. Substantive appointments to the board need to be completed as quickly as possible to bring the board up to full capacity. Work must continue to build a united and effective Executive Team, to resolve the ongoing personnel issues in the Finance Department, and to strengthen corporate governance leadership arrangements within the organisation. These activities need to be supported by continued progress with a board development programme that builds a cohesive and unified board that supports a positive organisational culture by setting the right 'tone from the top'.

Structured assessment

43 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate

emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

44 My team focussed on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency and effectiveness; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

45 At the time of my structured assessment work, the Health Board was subject to 'Special Measures' as part of the Welsh Government's Escalation and Intervention framework.

46 Overall, I found that **following significant challenges in 2023, the Health Board is stabilising, and in the process of strengthening key corporate assurance arrangements, but it needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand. The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations**.

Board transparency and effectiveness

47 My work considered whether the Health Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- public transparency of Board business;
- arrangements to support the conduct of Board business;
- board and committee structure, business, meetings, and flows of assurance;
- board commitment to hearing from staff, users, other stakeholders; and
- board skills, experiences, cohesiveness, and commitment to improvement.

48 My work found that **following a period of disruption in 2023 described in our separate review of board effectiveness, the Health Board has re-established a full committee structure which in overall terms is operating effectively. However, there are opportunities to improve public accessibility to committee meetings and papers and address the backlog of policies that are due for review**.

49 There are proper and transparent arrangements to support the conduct of Board and committee business. Board meetings are accessible to the public both virtually and in-person, however, the public cannot currently observe most committee meetings. Private Board and committee meeting sessions are appropriately reserved for the most sensitive matters and private discussions are summarised in subsequent public meetings. However, confirmed and unconfirmed committee

minutes are not all routinely uploaded to the Health Board's website. We also identified that there is a backlog of policies that are overdue for review.

50 Disruption in 2023 meant that some committees were stood down due to the temporary reduced number of independent members. However, following successful independent member recruitment, the Health Board reintroduced a full committee structure in January 2024. Annual committee self-assessments are due to commence in 2024 and board and committee members regularly reflect on the effectiveness of meetings. The Board and the Quality, Safety and Experience Committee listen to patient stories and the newly established People and Culture Committee has committed to receiving regular staff stories going forward.

Corporate systems of assurance

51 My work considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- overseeing strategic and corporate risks;
- overseeing organisational performance;
- overseeing the quality and safety of services; and
- tracking recommendations.

52 My work found that **the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is needed to properly embed these new arrangements, to further develop the Board Assurance Framework, strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations**.

53 The Board approved a revised Board Assurance Framework although it requires further strengthening by linking required assurances to new strategic objectives, once developed. The Health Board is in the process of implementing its recently updated Risk Management Framework. The Health Board recently introduced a new Integrated Performance Framework. Whilst the narrative set out in performance reports is improving, there is a need to focus more clearly on the action the Health Board is taking to improve performance and whether it is achieving the desired outcomes. The Health Board is also developing a new Quality Management System as part of its requirement to comply with the Health and Social Care (Quality and Engagement) Act (2020). This is needed as recent patient safety reports have shown poor performance in responding to complaints and incident investigations. Many investigations are overdue and there needs to be a stronger approach for learning and sharing lessons when things have gone wrong.

54 The Audit Committee regularly receives an audit recommendation tracker report but there is a need to focus more on whether the actions taken are addressing the issues identified in audit reports. The Health Board is taking steps to strengthen

executive ownership of updates to the tracker, which should reduce the amount of time the Office of the Board Secretary is spending to quality assure the information on it.

Corporate approach to planning

55 My work considered whether the Health Board has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- producing and overseeing the development of strategies and corporate plans, including the Integrated Medium Term Plan; and
- overseeing the delivery of corporate strategies and plans.

56 My work found that **the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand**. **There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts**.

57 The Health Board's planning approach demonstrates a good understanding of its key strategic risks and challenges. It is now five years into its ten-year Living Healthier Staying Well Strategy 2018-28. Acknowledging the longer-term consequences of the pandemic, many of the Health Board's services are struggling to meet demand and the position is not currently financially sustainable.

58 We have previously recommended that the Health Board needs to develop plans to support the implementation of its clinical strategy and that remains the case. While there are some limited examples of service developments and change, the Health Board's shorter-term approach to planning and programme delivery has not created a supportive environment for the level of transformation needed. The Health Board needs create a plan for sustainable services and engage key stakeholders in its development.

59 The Health Board agreed its shorter-term initiatives in its 2023-24 Annual plan, but reporting on progress is often task rather than impact or outcome focussed. This makes it difficult to see what difference it is making.

Corporate approach to managing financial resources

60 My work considered whether the Health Board has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- achieving its financial objectives;
- overseeing financial planning;
- overseeing financial management; and
- overseeing financial performance.

61 My work found that **despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant**

underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service models.

62 The Health Board met its duty to spend within its financial allocation over the three-year rolling period 2020-23 supported by additional strategic financial assistance from the Welsh Government. However, the overall financial position remains a significant concern because of the underlying deficit. In the current financial year, the Health Board received £82 million as part of a Welsh Government funding allocation to support targeted intervention as part of a 3½ year financial package. It received a further £34 million to support performance improvements, and in October 2023, the Welsh Government allocated an additional £101.5 million to the Health Board to help respond to increasing financial challenges across NHS Wales. In total, as of December 2023, the Health Board received an additional £217.5 million non-recurring financial allocation in 2023-24. Despite this, it is forecasting a £33 million deficit. The historic short-term approach to financial planning is driving a transactional approach to financial management. While there is a clear need for transactional financial control, there is also a need for a financial strategy to improve the position on the underlying deficit and that is linked to financially viable and sustainable clinical models.

63 The Health Board demonstrates reasonable approaches for scrutinising routine financial management arrangements and issues. However, given the financial issues identified in the audit of the 2021-22 and 2022-23 accounts, there is a need to fully assure the Board, through its committees, that the issues identified by Audit Wales, and the recommendations made in the subsequent EY investigation report are fully addressed.

Orthopaedic Services in Wales

64 In March 2023, I commented on orthopaedic services across Wales. My national report Orthopaedic Services in Wales – Tackling the Waiting List Backlog sets out the scale of orthopaedic waits, changes in demand, aspects of service capacity and some of the nationally co-ordinated work to modernise services. My report also set out key actions NHS Wales needs to take to tackle the challenges in orthopaedic services.

65 My work found that securing timely treatment for people with orthopaedic problems has been a challenge for the NHS in Wales for many years, with the COVID-19 pandemic making this significantly worse. Previous monies allocated by the Welsh Government have resulted in short-term improvements but have not achieved the sustainable changes to services that were necessary with orthopaedic waiting list targets not met since they were first established in 2009.

66 Since the impact of the pandemic has lessened, orthopaedic services have been slow to restart, and while necessary infection control regimes will continue to have an impact on throughput, there is scope for current capacity to be used more efficiently. My scenario modelling indicates that it could take between three to five years to return orthopaedic waits to pre-pandemic levels across Wales. This is

based on both a significant drive on community-based prevention and an increase in capacity and activity. Without this, services may never return to pre-pandemic levels.

67 My work found that there is a clear commitment to improve orthopaedic services. NHS Wales commissioned efficiency and effectiveness reviews both nationally and locally, which set out a suite of recommendations. A national clinical strategy for orthopaedics was also commissioned which sets out service options and a clear clinical voice on what needs to be done. However, urgent action is needed to secure short-term improvements in waiting times to minimise how long people wait in pain and discomfort, as well as creating more sustainable longer-term improvements.

68 In addition to my national report, my team set out how the Health Board's orthopaedic services compare to other health boards across Wales. My comparative report highlighted that the Health Board has:

- higher levels of patients waiting longer than a year for a first outpatient appointment, with an above average proportion of patients on the waiting list for longer than two years, although overall, the number of patients on the waiting list per head of population is below the all-Wales average position;
- a below average level of potential latent 'lost' demand as an impact of patients not going to their GP during the pandemic;
- lower levels of orthopaedic bed capacity but higher levels of medical workforce capacity;
- some of the highest waits for radiology services, and physiotherapy; and
- low uptake of new initiatives to reduce unnecessary follow-up outpatient appointments.

69 My scenario modelling indicates that optimistically the waiting list for the Health Board could return to pre-pandemic levels by late 2026, but without concerted effort may take many years to return to pre-pandemic levels, if at all. My local report sets out a series of prompts and questions for Board members to inform debate and obtain assurance that improvement actions at a local level are having the desired effect.

Follow-up review of follow-up outpatients

70 I have reviewed follow-up outpatient services at Betsi Cadwaladr University Health Board (the Health Board) twice, first in 2015 and then subsequently, in 2017, I reported on the progress against the 2015 report recommendations. My 2023 work considered overall progress made by the Health Board addressing the 'open' recommendations and follow-up outpatient waiting list performance with a particular focus on the longest waits.

71 My work found that **the Health Board has made limited progress in implementing our previous audit recommendations on follow-up outpatients**

and continues to carry significant clinical risks associated with delayed follow-up appointments across a number of specialties.

72 My fieldwork found that the Health Board has made some improvements to its follow-up outpatient services. In response to my previous audit recommendations, the Health Board has:

- ensured it is appropriately reporting its follow-up outpatient wait figures to the Welsh Government;
- improved the provision of management information on follow-up outpatients to clinicians and managers; and
- started a programme of work to develop new approaches for, and improvement of follow-up outpatients.

73 However, overall progress has been slow. Of the five original recommendations from our 2015 report, only one is fully complete and further work in required fully implement the remaining recommendations. There are significant and growing waiting lists with alarmingly long follow-up outpatient delays within specific specialties such as ophthalmology. Since our 2015 report, the overall numbers of patients waiting for a follow-up outpatient appointment at the Health Board have increased substantially.

74 Most of those patients who are delayed are waiting at least twice as long as they should be, and many of those are in specialties where their condition could increase the risk of harm because of a delay. My fieldwork identified that arrangements for reporting and oversight of clinical risks associated with delayed follow-up appointments still require strengthening. The Health Board's outpatient improvement programme is successfully driving the ongoing implementation of new patient pathways, however, several challenges remain.

NHS workforce data briefing

75 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that, in some instances, the growth in staff levels, particularly in nursing and some medical specialties has not kept up with increasing demand.

76 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

77 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

78 My review examined whether the Health Board has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

79 My work found that **whilst the Health Board has set out a reasonably clear and ambitious workforce strategy, it needs to significantly strengthen its implementation plans along with the organisation's workforce planning capacity and capability. Arrangements to oversee the delivery of strategic and operational workforce aims also need to be strengthened**.

80 The Health Board is facing significant workforce challenges across a range of services and professions, causing greater workload pressures on existing members of staff. Despite the Health Board increasing its workforce numbers over the past decade, it still faces serious recruitment and retention challenges, which threaten the stability of services. The Health Board's staff turnover and sickness rates present ongoing challenges. This caused a sharp rise in the use of agency staff in 2022-23, which cost the Health Board £72 million, further exacerbating an already pressured financial situation.

81 The Health Board's People Strategy is ambitious, but there needs to be a realistic and deliverable medium-term implementation plan with clear priorities to effectively support its delivery. The Health Board is strengthening its 'people team' however, it does not yet have sufficient resources to support workforce planning at corporate or service levels. Between 2017-18 and 2022-23, the Health Board's total annual pay costs increased by 48% to £1.04 billion. If historical growth in staffing levels continue to grow, overall workforce costs are very unlikely to be sustainable into the long term. The Health Board understands its most significant workforce challenges, however, the scale of these means that mitigating actions are having minimal impact on reducing workforce risk.

82 Operational workforce information has been appropriately scrutinised by the Health Board's Performance, Finance, and Information Governance Committee. The Health Board has now introduced a new People and Culture Committee that assumes responsibility for workforce strategy oversight.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Health Board in 2023-24.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	August 2024
Opinion on the Financial Statements	August 2024
Performance audit reports	
Orthopaedic Services in Wales – Tackling the Waiting List Backlog	March 2023
Orthopaedic Services in Wales – Tackling the Waiting List Backlog: A comparative picture for Betsi Cadwaladr University Health Board	March 2023
Follow-up review of follow-up outpatients	August 2023
NHS Workforce Data Briefing	September 2023
Follow-up review of Board Effectiveness	February 2024
Review of Workforce Planning Arrangements	February 2024
Structured Assessment 2023	February 2024

Report	Date
Other	
2023 Audit Plan	May 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Health Board. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Unscheduled Care Phase 1 – Patient flow	April 2024
Review of Financial Efficiencies	April 2024
Unscheduled Care Phase 2 – Managing demand for urgent and emergency care	July 2024
Review of Planned Care Services Recovery	August 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £482,384. My latest estimate of the actual fee, on the basis that some work remains in progress, is £605,384. The £123,000 increase is a result of additional costs incurred due to issues identified within the 2022-23 accounts and the qualification matters reported as part of the audit of accounts.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Health Board's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	On a sample basis, my team tested both journal entries and accounting estimates and found no evidence of the management override of controls.
There is a risk of material misstatement due to fraud in revenue recognition and as such is treated as a significant risk [ISA 240.27]. We have noted below the movement in the year-end forecast position. Part of this movement has been attributed to additional Welsh Government funding	The audit team will: • agree funding received around the year-end has been included within the correct year; • confirm Welsh Government funds not utilised in-year have been treated correctly; and • consider the completeness of	My team agreed the correct treatment of funding received from the Welsh Government and around the year-end. On a sample basis, my team considered the completeness of miscellaneous income and did not identify any issues.

Audit risk	Proposed audit response	Work done and outcome
received in-year and the retention of unused monies by the Health Board.	miscellaneous income.	
There is a risk of material misstatement due to fraud in expenditure and as such is treated as a significant risk [PN 10]. The 2021-22 accounts incorrectly included £9.4 million of expenditure and £9.1 million of accruals that related to 2022-23. Further testing of a risk assessed population was stopped by the Health Board, leaving uncertainty on £74 million of payables and £122 million expenditure in the balances brought forward.	The audit team will: • substantively test all material areas of pay and non-pay expenditure; • review the basis of accruals for any estimation bias; • review the year-end cut-off of expenditure; • review the basis of new provisions and changes in provision levels in year; and • review the amendments made to brought forward balances to ensure validity.	My team did not identify any instances where expenditure had been included erroneously within 2022-23. However, our work identified £8.29 million had been removed from the Health Board's expenditure in 2022-23, as it determined that the 2021-22 accruals were overstated, were not required, or they did not exist. If the Health Board had not reversed these accruals, it would have overspent against its 2022-23 resource allocation by £7.094 million and would not have achieved the three-year break-even financial duty.
The Health Board forecast position for 2022-23 has moved considerably in the last months of reporting in the financial year. The January 2023 reported actual position was a £7.5 million deficit with a forecast year-end deficit of £10 million. The reported February 2023 actual position	The audit team will focus its testing on areas of the financial statements which could potentially contain reporting bias.	As noted above, my team did not identify any instances where expenditure had been included erroneously within 2022-23. However, our work identified £8.29 million had been removed from the Health Board's expenditure in 2022-23, as it determined that the 2021-22 accruals were

Audit risk	Proposed audit response	Work done and outcome
was an £8.1 million deficit with a forecast year-end breakeven. We are aware that the Health Board is still reviewing accruals and estimates that were present within the 2021-22 accounts. Any amendments to these balances will impact on the year-end outturn. The current financial pressures increase the risk that management judgements and estimates could be biased to achieve the financial duty. There is still a risk that the Health Board will fail to meet the first financial duty to break even over a three-year period. Where you fail in this financial duty, we will place a substantive report on the financial statements highlighting the failure and qualify your regularity opinion.		overstated, were not required, or they did not exist. If the Health Board had not reversed these accruals, it would have overspent against its 2022-23 resource allocation by £7.094 million and would not have achieved the three-year break-even financial duty.
A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for as they will need to be recognised as assets and liabilities in	My audit team will: • consider the completeness of the lease portfolios identified by the health board needing to be included in IFRS16 calculations; • review a sample of calculated asset and	My audit team identified a large number of errors with the accounting treatment and implementation of IFRS16. The majority of these errors were amended within the financial statements.

Audit risk	Proposed audit response	Work done and outcome
the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	liability values and ensure that these have been accounted for and disclosed in accordance with the Manual for Accounts; and • ensure that all material disclosures have been made.	
The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	My review of the accounting entries made to include the revaluation movements within the Financial Statements identified a large number of errors, some of which were amended within the financial statements. Others were reported as unadjusted misstatements.

Audit risk	Proposed audit response	Work done and outcome
The Remuneration Report contains important disclosures required by the Welsh Government and accounting standards. There have been significant changes to Senior Management and Independent Members during the year which will need to be accurately reflected within the Remuneration Report.	The audit team will review the disclosures to ensure they are in line with our understanding of the changes that have occurred during the year and that they are complete and accurate.	My audit team identified significant errors in the disclosures within the Remuneration Report which were subsequently amended by the Health Board.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Archwilio Cymru
Audit Wales

Structured Assessment 2023 – Betsi Cadwaladr University Health Board

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This document has been prepared as part of work performed in accordance with statutory functions.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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

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Summary report

About this report

1 This report sets out the findings from the Auditor General's 2023 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement under section 61 of the Public Audit (Wales) Act 2004 to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources.

2 Our 2023 Structured Assessment work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies are also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. More than ever, therefore, NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to themselves, the public, and key stakeholders that the necessary action is being taken to deliver high-quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of this work has been on the Health Board's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on:

- Board transparency and effectiveness;
- Corporate systems of assurance;
- Corporate approach to planning, and
- Corporate approach to financial management.

Our separate review of board effectiveness is described in the following Background Context section, and our structured assessment work has not reviewed the Health Board's operational delivery arrangements.

4 Our work has been informed by our previous structured assessment work, which has been developed and refined over several years. It has also been informed by:

- Model Standing Orders, Reservation and Delegation of Powers
- Model Standing Financial Instructions
- Relevant Welsh Government health circulars and guidance
- The Good Governance Guide for NHS Wales Boards (Second Edition)
- Other relevant good practice guides

We undertook our work between January and February 2024. The methods we used to deliver our work are summarised in **Appendix 1**. We also provide an update in this report on the Health Board progress in addressing outstanding

recommendations identified in previous structured assessment reports in **Appendix 2**.

Background context

5 In February 2023, the Auditor General published a report in the public interest on Board Effectiveness at Betsi Cadwaladr University Health Board. The report described a worrying degree of dysfunctionality within the Board and wider senior leadership of the organisation. It concluded that the concerns identified were fundamentally compromising the ability of the Board to work effectively. One week after the publication of the Auditor General's report, the Health Board was escalated into special measures[1], and the Board's Independent Members all resigned.

6 Since February 2023 there has been a period of upheaval and change within the Board that initially saw the appointment of an interim Chair and three fixed term Independent Members, and then the recruitment of substantive Independent Members including a Vice Chair as the year progressed. In January 2024 the substantive appointment of the Chair was announced. There have also been changes in the make-up of the Executive Team since February 2023, most notably the announcement of the appointment of a substantive Chief Executive in November 2023.

7 In February 2024 we published the findings of our follow up work on Board Effectiveness. This work concluded that after a period of significant disruption during 2023, the board is in a more stable position and working relationships amongst senior leaders are more positive overall. However, the report indicated that there are there are still fundamental challenges to address, including building a high performing executive team, recruiting substantively to remaining posts on the board, and ensuring the new board demonstrates the unified and effective leadership that is needed to tackle the challenges the organisation faces.

8 The structured assessment findings contained in this report need to be considered in the context of, and alongside, our separate Board Effectiveness Follow-up report.

[1] Special Measures is the highest level of escalation on the NHS Wales escalation framework. Further information can be found via https://www.gov.wales/sites/default/files/publications/2019-04/nhs-wales-escalation-and-intervention-arrangements.pdf

Key findings

9 We found that **following significant challenges in 2023, the Health Board is more stable and in the process of strengthening key corporate assurance arrangements, but it needs a clear strategy to enable it to develop financially sustainable service models that provide good quality services to meet current and future healthcare demand**. **The Health Board also needs to ensure there is a sufficient assurance on the impact of actions taken to deliver its plans, to mitigate risk, improve service performance and address audit recommendations.**

Board transparency and effectiveness

10 **We found that following a period of disruption in 2023 described in our separate review of board effectiveness, the Health Board has re-established a full committee structure which in overall terms is operating effectively. However, there are opportunities to improve public accessibility to committee meetings and papers and address the backlog of policies that are due for review.**

11 Board meetings are accessible to the public both virtually and in-person, however, the public cannot currently observe most committee meetings. There is confusion regarding the deadline for making board and committee papers available to the public in advance of meetings. Confirmed and unconfirmed committee minutes are not all routinely uploaded to the Health Board's website. However, private Board and committee sessions are appropriately reserved for the most sensitive matters and private discussions are summarised in subsequent public meetings.

12 Whilst the Health Board has formal and up-to-date standing orders and standing financial instructions to support its Board and committee business, there remains a backlog of policies that are overdue for review.

13 Disruption in 2023 meant that some committees were stood down due to the temporary reduced number of independent members. However, in January 2024, following successful and ongoing recruitment of independent members, the Health Board reintroduced a full committee structure. Each committee is supported with a revised term of reference and cycle of business. Annual committee self-assessments are due to take commence early in 2024 and board and committee members regularly reflect on the effectiveness of meetings.

14 The Board and the Quality, Safety and Experience Committee continue to regularly hear from patients and the newly established People and Culture Committee has committed to receiving regular staff stories going forward.

Corporate systems of assurance

15 We found that the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is

needed to properly embed these new arrangements, to further develop the Board Assurance Framework, strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations.

16 The Board has approved a revised Board Assurance Framework (BAF). However, the BAF is still in early stages and requires further strengthening and linking to new strategic objectives, once developed. The Health Board's recently updated Risk Management Framework implementation is progressing, focussing on fewer higher priority risks that are linked to 2023-24 Annual Plan priorities and the special measures framework.

17 The Health Board recently introduced a new Integrated Performance Framework and Integrated Performance Report. Whilst the narrative set out in performance reports is improving, there is a need to focus more clearly on the action the Health Board is taking to improve performance and whether it is achieving the desired outcomes.

18 The Health Board is developing a new Quality Management System (QMS) as part of its requirement to comply with the Health and Social Care (Quality and Engagement) Act (2020). However, it has not provided assurance to the Board that it has reviewed the arrangements in place to support new requirements set out in the Act. Recent patient safety reports have shown poor performance in responding to complaints and incident investigations and many investigations are overdue. We have also noted a sudden and unexplained decrease in complaints in 2023-24, the reasons for which are currently unknown, but the Health Board is investigating.

19 The Audit Committee continues to regularly receive an audit tracker report but there is scope to provide further clarity and focus on whether actions taken are addressing the issues identified. The Health Board is taking steps to increase executive ownership of updates to the tracker, which should reduce the amount of time the Office of the Board Secretary is spending to quality assure the information on the tracker.

Corporate approach to planning

20 We found that the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand. There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts.

21 The Health Board's planning approach demonstrates a good understanding of its key strategic risks and challenges. It is now five years into its ten-year Living Healthier Staying, Well Strategy 2018-28. Acknowledging the longer-term consequences of the pandemic, many of the Health Board's services are struggling to meet demand and the position is not currently financially sustainable.

22 We have previously recommended that the Health Board needs to develop plans to support the implementation of its clinical strategy and that remains the case. While there are some limited examples of service developments and change, the Health Board's shorter-term approach to planning and programme delivery has not created a supportive environment for the level of transformation needed. The Health Board needs to create a plan for sustainable services and engage key stakeholders in its development.

23 In the Annual Plan 2023-24 the Health Board has agreed and aligned improvement initiatives, but reporting on progress is often task rather than impact or outcome focussed. This makes it difficult to see what difference it is making. The Health Board needs to think about the sustainable configuration of its services and engage its key stakeholders as part of the process ensuring an honest discussion on the challenges ahead.

Corporate approach to managing financial resources

24 We found that despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service models.

25 The Health Board met its duty to spend within its financial allocation over the three-year rolling period 2020-23 supported by additional strategic financial assistance from Welsh Government. However, the overall financial position remains a significant concern because of the underlying deficit. In the current financial year, it has received £82 million as part of a Welsh Government funding allocation to support targeted intervention as part of a 3½ year financial package. It received a further £34 million to support performance improvements, and in October Welsh Government allocated an additional £101.5 million to the Health Board to help respond to increasing financial challenges across NHS Wales. In total, as of December 2023, the Health Board received an additional £217.5 million non-recurring financial allocation in 2023-24. Despite this, it continues to forecast a £33 million deficit. The historic short-term approach to financial planning is driving a transactional approach to financial management. While there is a clear need for transactional financial control, there is also a need for a financial strategy to improve the position on the underlying deficit and that is linked to financially viable and sustainable clinical models.

26 The Health Board demonstrates reasonable approaches for scrutinising routine financial management arrangements and issues. However, given the financial issues identified in the audit of the 2021-22 and 2022-23 accounts, there is a need to fully assure the Board, through its committees, that the issues identified by Audit Wales, and the recommendations made in the subsequent EY investigation report are fully addressed.

Recommendations

27 Exhibit 1 details the recommendations arising from our work. These include timescales and our assessment of priority. The Health Board's response to our recommendations is summarised in **Appendix 3. Appendix 2** provides an overview of progress against last year's recommendations.

Exhibit 1: 2023 recommendations

Recommendations
Transparency of board and committee business R1 Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings. **Paragraph 34** R2 The minutes for some committee meetings are missing from the website many months after the meeting date. This affects timely public access to committee discussions. The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business. **Paragraph 35**
Changing trends in complaint numbers 2023-24 R3 There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported. **Paragraph 68**
Recommendation tracking R4 Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion. **Paragraph 72** R5 Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales. **Paragraph 75**

Recommendations

Clinical engagement plan

R6 More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand. **Paragraph 82**

Financial strategy

R7 It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit. **Paragraph 98**

Monitoring progress against accounting issues

R8 Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and the subsequent EY review has been slower than intended. **Paragraph 104**

Detailed report

Board transparency and effectiveness

28 We considered whether the Health Board's Board conducts its business appropriately, effectively, and transparently.

29 We found that following a period of disruption in 2023 described in our separate review of board effectiveness, the Health Board has re-established a full committee structure which in overall terms is operating effectively. However, there are opportunities to improve public accessibility to committee meetings and papers and address the backlog of policies that are due for review.

Public transparency of Board business

30 We considered whether the Board promotes and demonstrates a commitment to public transparency of board and committee business. We were specifically looking for evidence of Board and committee:

- meetings that are accessible to the public;
- papers being made publicly available in advance of meetings;
- business and decision-making being conducted transparently; and
- meeting minutes being made publicly available in a timely manner.

31 **We found that the Health Board is increasingly demonstrating public transparency of board business, however there are opportunities to improve and standardise these arrangements for board committee meetings.**

32 In-person Board meetings take place in locations across North Wales on a rotational basis and are open for the public to observe. Meetings are broadcast live on YouTube with recordings made available to the public shortly after. The Board no longer addresses questions raised by the public during meetings, having reflected that questions submitted were based on a narrow view of patient experiences and subsequently commenced wider work on citizen engagement. However, The Board continues to respond to queries raised by the public outside of meetings.

33 Committee meetings are not live-streamed or recorded for the public to view, and the Health Board's website indicates that only two of the eight committees currently allow the public to observe meetings by request. Questions from the public can be submitted to all committees before meetings.

34 The Health Board's Standing Orders require Board and committee papers to be circulated to members and uploaded to the website ten days in advance of meetings. However, internally, a standard of seven days is reported against, and the public website cites that papers are published five days in advance of Board meetings and seven days for committee meetings **(Recommendation 1).** Breaches are routinely reported to the Audit Committee. The Health Board is clarifying its Board and committee meeting forward calendar, which also provides

the opportunity to provide clear paper publication dates which should help ensure timely submission of papers.

35 We have also noted inconsistencies in the timeliness of uploading unconfirmed and confirmed minutes after meetings. When we reviewed the website in January 2024, we found that minutes for some committee meetings were missing months after the meeting date2. Given that committee meetings are not livestreamed, and recordings are not available to the public, it is important that minutes are added to the website soon after minutes to enable the public to see what has been discussed in meetings. To increase transparency further and ensure that the public has timely access to committee business, the Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business **(Recommendation 2)**.

36 The Board continues to appropriately reserve private Board and committee sessions for sensitive and commercial matters only. However, there is scope to clarify the rationale on report coversheets to explain why items are considered in private. The Health Board appropriately reports a summary of matters discussed in private in the subsequent public meeting.

37 As discussed in more detail in our Board Effectiveness Follow-up report 2024, we have observed more open and honest discussions in recent public Board and committee meetings.

Arrangements to support the conduct of Board business

We considered whether there are proper and transparent arrangements in place to support the effective conduct of Board and committee business. We were specifically looking for evidence of:

- a formal, up-to-date, and publicly available Reservation and Delegation of Powers and Scheme of Delegation in place, which clearly sets out accountabilities;
- formal, up-to-date, and publicly available Standing Orders (SOs) and Standing Financial Instructions (SFIs) in place, along with evidence of compliance; and
- formal, up-to-date, and publicly available policies and procedures in place to promote and ensure probity and propriety.

38 We found that **whilst the Health Board has formal and up-to-date standing orders and standing financial instructions to support its Board and**

[2] At the time of our fieldwork, confirmed minutes for the Remuneration Committee had not been uploaded since July 2023 and there were no confirmed minutes for the Audit Committee since August 2023.

committee business, there remains a backlog of policies that are overdue for review.

39 The Board, supported by the Audit Committee regularly and appropriately reviews its Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions. They were most recently updated in November 2023, but the most recent versions are not yet available on the Health Board's website.

40 The Board and its committees adopt good governance procedures at the beginning of meetings including requesting declarations of interest. The Audit Committee annually reviews the procedures for declaring, registering, and managing interests, gifts, and hospitality. Current registers for Board members are available on the Health Board's website but are not easily accessible. The Health Board launched a new system for recording declarations of interests, gifts and hospitality in August 2023. The new system, alongside focussed communication is positively resulting in an increase in declarations across the wider organisation.

41 The position relating to Health Board policies is more concerning; 84 (59%) of the Health Board's 143 policies are currently overdue for review. The Health Board's policy for the review and update of policies, is currently being reviewed and will set out a new process for ensuring written control documents are kept up to date with current legislation and other requirements. The revised policy for the review and update of policies has been discussed by operational groups and the Audit Committee. The Audit Committee expects to receive the final version of the policy alongside a plan to prioritise the backlog of policies overdue for review in March 2024 **(Appendix 2, R4 2022)**.

Effectiveness of Board and committee meetings

We considered whether Board and committee meetings are conducted appropriately and effectively. We were specifically looking for evidence of:

- an appropriate, integrated, and well-functioning committee structure in place, which is aligned to key strategic priorities and risks, reflects relevant guidance, and helps discharge statutory requirements;
- Board and committee agendas and work programmes covering all aspects of their respective Terms of Reference as well being shaped on an ongoing basis by the Board Assurance Framework; and
- the Board and its committees regularly reviewing their effectiveness and using the findings to inform and support continuous improvement; and

42 We found that **there is now a full Board committee structure in place, with each committee supported by a term of reference, cycle of business and a commitment to regularly review the committee effectiveness.**

43 As discussed in more detail within our Board Effectiveness Follow-up report 2024, Board and committee business was significantly disrupted by the events that took place early in 2023. The Health Board was placed in special measures and each of the Board's then independent members resigned. In the following weeks and

months, Welsh Government directly appointed an Interim Chair and a small number of interim independent members. The reduced independent member capacity necessitated a temporary reduction in the number of committees between March 2023 and January 2024, as described in Exhibit 2. The Board continued to satisfactorily discharge core duties during this time, including ensuring coverage of the key duties of committees that had been stood down. However, there was an inevitable impact on the available time for discussion in meetings, including discussions on strategic planning as well as more specifically opportunities to hear staff stories.

44 There have since been several substantive independent member appointments which has now enabled the full reinstatement of the Board's committees. Each committee has an up-to-date terms of reference and cycle of business3 that align to the Health Board's strategic priorities and key risks.

Exhibit 2: changes to committee structures and meetings during 2023

Committees that were stood down in February 2023	Committees that continued to meet during 2023	New/adapted committees established in January 2024
Partnerships, People and Population Health Committee	Audit Committee,	Planning, Population Health and Partnerships Committee
Mental Health and Capacity Compliance Committee	Performance, Finance and Information Governance Committee,	Mental Health Legislation Compliance and Capacity Committee
	Quality, Safety and Experience Committee,	People and Culture Committee
	Remuneration Committee	

[3] The cycle of business is an annual calendar of core agenda items for a committee.

Committees that were stood down in February 2023	Committees that continued to meet during 2023	New/adapted committees established in January 2024
	Charitable Funds Committee[4]	

45 Each committee chair provides a high-level summary of key decisions and matters considered during meetings to the Board. We understand that the Health Board intends to establish a committee chairs group to enable cross-referral of issues and inform meeting agenda setting.

46 The Board and its committees regularly reflect on the effectiveness of meetings and are planning to commence annual reviews of committee effectiveness early in 2024. Following the challenges and reshaping of the Board in 2023, the Health Board is in the process of developing a formal board development program to start early in 2024.

Board commitment to hearing from patients/service users and staff

47 We considered whether the Board promotes and demonstrates a commitment to hearing from patients/service users and staff. We were specifically looking for evidence of:

- The Board using a range of suitable approaches to hear from patients/service users and staff.

48 We found that **the Board's arrangements for hearing directly from patients is improving, and it is planning to increase opportunities to hear directly from staff through service visits and hearing staff stories at People and Culture Committee meetings.**

49 The Board continues to receive patient stories at each meeting. During 2023, patient stories covered a range of services and included recordings of patients speaking about their experiences. The Health Board recently introduced its citizen experience report, which at the January 2024 Board meeting, generated good and open discussion on the quality of services from a patent's perspective and was

[4] The Charitable Funds Committee was temporarily stood down between February and July 2023

helpfully enhanced with feedback from Llais[5]. The Quality, Safety and Experience Committee continues to receive patient stories which are also summarised in its annual report and help to set the tone of its meetings. However, there has been an absence of staff stories at the Board and committee meetings over the last year. We understand that staff experience will be a regular feature of the People and Culture Committee following its establishment in January 2024.

50 Informal visits by Board members to a variety of service areas were held during much of 2023 to enable them to hear directly from patients and staff. However, the number of visits by each Board member varied due to differences in geography and capacity. However, by October 2023, the Health Board began to organise more formal service visits as part of the Board's development programme. It is adopting a targeted approach by linking the type and location of visits to current strategic risks and priorities. For example, prior to the Board's consideration of the Health Board's 2023-24 winter plan, the Board visited Ysbyty Gwynedd's Emergency Department and the Same Day Emergency Care facility to inform their understanding of key issues and barriers.

Corporate systems of assurance

51 We considered whether the Health Board has a sound corporate approach to managing risks, performance, and the quality and safety of services.

52 We found that **the Health Board has revised its risk and performance frameworks and is developing a new quality management system. However, more work is needed to properly embed these new arrangements, to further develop the Board Assurance Framework, strengthen the management of complaints and incidents and strengthen processes for tracking audit recommendations.**

Corporate approach to overseeing strategic and corporate risks

53 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising strategic risks. We were specifically looking for evidence of:

- an up-to-date and publicly available Board Assurance Framework (BAF) in place, which brings together all the relevant information on the risks to achieving the organisation's strategic priorities / objectives;
- the Board actively owning, reviewing, updating, and using the BAF to oversee, scrutinise, and address strategic risks;

[5] Llais is a national, independent body to give the people of Wales a stronger voice in health and social care services.

- an appropriate and up-to-date risk management framework in place, which is underpinned by clear policies, procedures, and roles and responsibilities;
- the Board providing effective oversight and scrutiny of the effectiveness of the risk management system; and
- the Board providing effective oversight and scrutiny of corporate risks.

54 We found that **the Health Board has made progress revising its BAF and risk management arrangements, but it needs clear strategic objectives to align strategic risks to, and a stronger focus on the impact of actions it takes to mitigate risks.**

55 The Audit Committee approved the new BAF in November 2023. Given that the Health Board did not set strategic objectives in 2023-24, the BAF has been aligned to the nineteen priorities set out in its 2023-24 Annual Plan. The Board recognises the clear need to set longer-term strategic objectives and intends to do so during 2024-25. When devising its new strategic objectives, the Board should also review its well-being objectives to ensure compliance with the Well-being of Future Generations Act 2015[6], noting that the Health Board has not reviewed its well-being objectives since 2018. Our work also found scope to strengthen the BAF to better articulate some strategic risks, by ensuring controls and lines of assurance are robust and mitigating actions are designed to have impact. The Board should also ensure that the BAF becomes a live and embedded approach for providing assurances to the Board and its committees and a tool for shaping and informing meeting agendas.

56 The Board approved its updated Risk Management Framework in September 2023. The framework is supported by key policies and clear processes. However, we note that underpinning arrangements including risk management training are still in development. During 2023, the Health Board revised and rationalised its corporate risk register focussing on the key corporate risks which impact on the achievement of the Board's priorities and referencing the Special Measures work where relevant. This rationalisation should usefully provide more time for committees to focus on the highest scoring risks. The approach also incorporates the Board's recently agreed risk appetite which was the focus of a board development session during summer 2023.

57 The Audit Committee is appropriately overseeing the Health Board's BAF and risk management framework. The Board and its committees routinely discuss the BAF and risk registers in their meetings, but there remains a need to focus more on the

[6] Public bodies subject to the well-being duty in the Well-being of Future Generations Act 2015, are required to review their well-being objectives annually as part of annual reporting duties. In addition, in July 2023, the Minister for Social Justice set out the requirement for organisations to review their well-being objectives as soon as possible after April 2024, following the introduction of the Social Partnership and Public Procurement (Wales) Act 2023 and the resulting change made to a national well-being goal.

impact that actions are having to address risks. If mitigating actions are not having the desired impact, there will be a need to change the Health Board's approach for managing the risk **(Appendix 2, R1 2022)**.

Corporate approach to overseeing organisational performance

58 We considered whether the Health Board has a sound corporate approach to identifying, overseeing, and scrutinising organisational performance. We were specifically looking for evidence of:

- an appropriate, comprehensive, and up-to-date performance management framework in place, underpinned by clear roles and responsibilities; and
- the Board and committees providing effective oversight and scrutiny of organisational performance.

59 We found that **the Health Board is making improvements to its performance management framework and performance reporting, but there needs to be a greater focus on reporting the impact of actions the health board is taking to improve performance.**

60 The Board approved the new Integrated Performance Framework 2023-24 in September 2023. The framework outlines roles and responsibilities across the organisation and internal escalation arrangements. The Health Board has, however, recognised that the framework could be strengthened in some areas, including closer alignment to the Special Measures framework.

61 The Health Board has also revised its Integrated Performance Report (IPR), and its development was informed by engagement with executive groups and committees. The January 2024 IPR highlights several concerning performance trends and missed targets. These include ambulance handover times; Emergency Department waits and Referral to Treatment waits and waits for some mental health and ophthalmology services.

62 Board members have recognised some improvement in the reporting of performance, including more succinct narrative focusing on key concerns and emerging risks, and greater use of analysis tools such as Statistical Process Control (SPC) charts. Our analysis continues to indicate a need to focus on summarising the action the Health Board is taking to improve performance and whether that action is achieving the desired outcomes **(Appendix 2, R2 2022).**

Corporate approach to overseeing the quality and safety of services

63 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the quality and safety of services. We were specifically looking for evidence of:

- corporate arrangements in place that set out how the organisation will deliver its requirements under the new Health and Social Care (Quality and Engagement) Act (2020);
- a framework (or similar) in place that supports effective quality governance;
- clear organisational structures and lines of accountability in place for clinical/quality governance; and
- the Board and relevant committee providing effective oversight and scrutiny of the quality and safety of services.

64 We found that **the Health Board is taking action to implement a quality management system, but has not provided assurance to the Board that the required arrangements under the Duties of Quality and Candour are in place or progressing. In addition, timeliness of responses to incidents and complaints remains a concern and the reason for the significant drop in complaints in the first half of 2023/24 needs to be explained.**

65 Disruption to Board and committee business during 2023 meant that the Board has not received assurance that the organisation has reviewed its corporate arrangements for delivering the requirements under the Health and Social Care (Quality and Engagement) Act (2020) (the Act). We are aware that the Health Board is progressing work on a Quality Management System in line with requirements set out in the Act, which should be in place by April 2024. The revised arrangements will include a new quality dashboard and a learning portal to capture and analyse incidents and complaints and share learning.

66 The Quality, Safety and Experience Committee's regular patient safety report sufficiently details incidents and never events, highlighting actions taken on areas of concern, such as healthcare acquired pressure ulcers. Health Board reporting indicates that it has a high number of overdue complaints and incident investigations which need progressing. There has also been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to 2022-23, which the Health Board is currently investigating, at the time of reporting, this had not been highlighted to the Quality, Safety and Experience Committee **(Recommendation 3).**

67 The Quality, Safety and Experience Committee's regulatory and legal report covers work of regulators including Healthcare Inspectorate Wales, the Health and Safety Executive, the Coroner and the Public Services Ombudsman for Wales (PSOW). The report provides the committee with a summary of work and briefly reassures the committee that actions are in place to address concerns and respond to requests from regulators. However, the information contained within the report is of a very high-level. There are opportunities for the report to demonstrate more clearly how it is implementing learning from these incidents, as well as embedding those lessons across the organisation. It is positive that the Health Board has taken action to ensure the accuracy of its reporting figures for complaints from the PSOW **(Appendix 2, R3 2022).**

Corporate approach to tracking recommendations

We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising systems for tracking progress to address audit and review recommendations and findings. We were specifically looking for evidence of:

- appropriate and effective systems in place for tracking responses to audit and other review recommendations and findings in a timely manner.

68 We found that **whilst there is regular oversight of the audit tracker by the Audit Committee, and steps are being taken to strengthen executive ownership of tracker updates there is a need for clearer commentary on the impact of actions in response to recommendation and to strengthen recommendation monitoring in other committees.**

69 During 2023, the Health Board has seen new recommendations being added to the audit tracker at a faster pace than it has been able to close previous recommendations. In addition, we note that recommendations made in our 2023 reports have not been added to the tracker7

70 The Audit Committee continues to regularly receive the audit **(Recommendation 4).** tracker and accompanying summary report. While the audit tracker now contains an improved level of detail on management's rationale for recommending the closure of actions, the narrative tends to focus on tasks completed. This means committee members are not receiving adequate assurance that actions taken to close existing recommendations have achieved the desired effect and resolving the issues identified in the original audit report **(Appendix 2, R5 2022).**

71 The Office of the Board Secretary currently spends a significant amount of time quality assuring information provided by directorate to update the tracker. Greater executive ownership of these updates is needed, and we understand that, future submissions to the Audit Committee will require sign-off from the Executive Team.

72 We also noted that the approach for monitoring progress of recommendations by other committees needs strengthening. Beyond the Audit Committee, committees do not receive regular recommendation tracking reports, nor do they always receive routine assurance on progress made to address regulator recommendations. The Health Board should introduce effective committee oversight for monitoring progress against recommendations made by external review bodies. This includes strengthening existing mechanisms, such as the regulatory and legal report discussed in paragraph 69. Oversight should include all relevant regulators and inspectors, including but not necessarily limited to Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the PSOW **(Recommendation 5).**

[7] This includes recommendations made in our 2023 Structured Assessment and our 2023 follow-up report on Follow-Up Outpatient Services.

Corporate approach to planning

73 We considered whether the Health Board has a sound corporate approach to producing strategies and corporate plans and overseeing their delivery.

74 We found that **the Health Board has a good understanding of its significant strategic risks and challenges, but it is struggling to meet service demand and its services are not currently financially sustainable. The Health Board needs a clearer and longer-term planning approach that appropriately considers service reconfiguration to sustainably meet current and future healthcare demand. There is also a need to focus reporting, monitoring and assurance of plan delivery of the success of achieving intended outcomes and impacts.**

Corporate approach to producing strategies and plans

We considered whether the Health Board has a sound corporate approach to producing, overseeing, and scrutinising the development of strategies and corporate plans. We were specifically looking for evidence of:

- a clear Board approved vision and long-term strategy in place which are future-focussed, rooted in population health, and informed by a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- an appropriate Board approved long-term clinical strategy;
- appropriate and effective corporate arrangements in place for developing and producing the Integrated Medium-Term Plan (IMTP), and other corporate plans; and
- the Board appropriately scrutinising the IMTP and other corporate plans prior to their approval.

75 We found that **despite the challenges that the Health Board has faced in the last year, its planning approach has helped identify short-term improvement activity. However, it needs to give greater thought to the development of sustainable future focused service models and configurations and ensure that key stakeholders and the public are engaged in the process.**

76 The Health Board is five years into its Living Healthier, Staying Well Strategy 2018-28. Its improvement priorities cover a breadth of services within the Health Board's remit, including providing care closer to home, supporting mental health and well-being, and tackling health inequalities. Whilst the Health Board is now over half-way through the delivery of its strategy, performance in many areas is off target, there is a growing underlying financial deficit, and the longer-term outlook may see healthcare demand growing further[8].

[8] Analysis of Health Board demand over the last decade show growing levels of referrals and emergency department attendances, which now clearly exceed pre-pandemic levels.

77 Alongside the Living Healthier, Staying Well Strategy, the Health Board's 2022 clinical strategy, demonstrates a good understanding of the strategic opportunities and challenges that the organisation faces. While the clinical strategy provides logical high-level aims, it does not sufficiently set out the configuration of financially and clinically sustainable service models. Consequently, the enabling corporate strategies and plans for estate, digital and people, while reasonably focussed on addressing some key short-term challenges, are not sufficiently future focused to support the implementation of new, more sustainable care models. Last year we recommended that the Health Board needed to develop clinical strategy delivery plans to help provide the necessary clarity on service configuration. We understand that action in response to that recommendation is still in progress **(Appendix 2, R7 2022).**

78 Reconfiguring services to ensure they sustainably meet current and future population healthcare needs is likely to require some difficult decisions on the future shape and location, services. As such, the Health Board will need to effectively engage its key stakeholders, patients, and the **public (Recommendation 6).** As discussed in **paragraph 57**, the Health Board is required to review its well-being objectives during 2024-25 in accordance with the sustainable development principle. This provides the opportunity to align well-being objective setting to organisational objectives and also ongoing strategy development.

79 The 2023-24 Annual Plan has provided some clarity on current improvement programmes and initiatives, but there is a need to become more strategic and balance short- and longer-term aspirations. The Health Board's short-term approach to planning in recent years, in lieu of an approvable integrated medium-term plan, has not sufficiently enabled the level of transformation or sustainable solutions needed as highlighted above.

80 In its July 2023 meeting, the Board approved the 2023-24 Annual Plan, following scrutiny at its previous meeting. Historically, the Health Board has demonstrated a good track record of committee-level scrutiny on annual plan development. Understandably this stopped when the Partnerships, People and Population Health Committee was stood down early in 2023. Nevertheless, the Board was able to adequately consider the annual plan before its approval.

Corporate approach to overseeing the delivery of strategies and plans

81 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising the implementation and delivery of corporate plans. We were specifically looking for evidence of:

- corporate plans, including the IMTP, containing clear strategic priorities/objectives and SMART[9] milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board appropriately monitoring the implementation and delivery of corporate plans, including the IMTP.

82 We found that **temporary changes to the Board's committee structure during 2023 reduced its ability to scrutinise the delivery of strategies and plans. Whilst the reinstatement of a full committee structure in early 2024 will rectify that, there is still a need to improve monitoring of the intended impact, outcomes and business benefits from the Health Board's strategies and plans.**

83 The Health Board's plans often contain reasonable high-level objectives and actions that set out a broad intent and are linked to its strategic risks and opportunities for improvement. In general, the Health Board's plans are sufficiently timebound and clearly identify senior responsible officers. However, they rarely set out sufficiently measurable outcomes that would allow the Health Board to report and assess the outcome achieved and impact as a result of delivering the objectives and actions.

84 During 2022 and into early 2023, the Board maintained good oversight and scrutiny of the progress to deliver key strategic plans at its Partnerships, People and Population Health Committee. This included the Living Healthier, Staying Well Strategy 2018-28, the Clinical Strategy, Mental Health Strategy, Learning Disability Strategy, and People Strategy as well as scrutinising the delivery of annual plans. The Board has continued to oversee annual plan delivery progress, but since the Partnerships, People and Population Health Committee stood down in February 2023, the scrutiny of the implementation of other strategies and plans substantially reduced. The reintroduction of the Committee in January 2024 provides the opportunity to strengthen the scrutiny of plan development, delivery and success in achieving intended outcomes and impact.

Corporate approach to managing financial resources

85 We considered whether the Health Board has a sound corporate approach to managing its financial resources.

86 We found that **despite meeting the statutory duty to spend within allocation for the period 2020-23, the Health Board is facing a significant underlying financial deficit. There is a clear need for a robust financial strategy linked to sustainable and good quality clinical service models.**

[9] Specific, measurable, achievable, relevant, and time-bound

Financial objectives

87 We considered whether the Health Board has a sound corporate approach to meeting its key financial objectives. We were specifically looking for evidence of:

- the organisation meeting its financial objectives and duties for 2022-23, and the rolling three-year period of 2020-21 to 2022-23; and
- the organisation being on course to meet its objectives and duties in 2023-24.

88 We found that **with the support of substantial additional Welsh Government financial assistance, the Health Board met its duty to spend within allocation over the three-year rolling period 2020-23. However, the overall financial position continues to present a significant risk and the Health Board is projecting that it will not achieve the year-end position expected by Welsh Government**

89 The Health Board has experienced longstanding financial challenges. In November 2020, as part of Welsh Government's announcement to de-escalate the Health Board to 'targeted intervention'[10], the Health Board received an additional financial allocation worth £297 million. The additional allocation was split over the three-and-a-half-year period from October 2020 to April 2024. With this additional funding, alongside other in-year allocations and its savings delivery[11], the Health Board met its duty to spend within its funding allocation over the three-year period 2020-23. In respect of the financial year 2022-23, the Health Board met its duty to manage its spend within its £1.993 billion allocation[12], supported by additional financial assistance.

90 As in previous years, the Health Board did not meet its statutory duty to prepare a financially balanced three-year financial plan for 2023-26. Instead, it developed an annual plan for 2023-24, which set out a predicted financial year-end deficit of £134 million. During 2023-24 the Welsh Government provided additional financial support to all health boards to help alleviate pressures from COVID legacy costs and inflation, including energy costs. This resulted in the Health Board receiving £101.5 million from Welsh Government. This came with a conditional requirement to reduce the deficit within its annual plan by a 10% (equating to a need to work towards a "control total" deficit of £20 million at the end March 2024). In addition to the £101.5 million the Health Board has received £34 million performance improvement funding and final year's £82 million funding from the £297 million targeted intervention allocation. In total, as of December 2023, the Health Board has received an additional £217.5 million for the financial year 2023-24. Despite this, the Health Board continues to report a forecast year-end deficit of £33 million.

[10] Betsi Cadwaladr University Health Board taken out of special measures | GOV.WALES

[11] The Health Board achieved £18.4 million savings in 2020-21, £19.2 million savings in 2021-22 and £31.2 million savings in 2022-23.

[12] The Health Board underspent against its allocation by £0.389 million in 2022-23.

The Health Board's substantial reliance on additional non-recurring annual funding clearly demonstrates the scale of the challenge in bringing the Health Board to a balanced financial position.

Corporate approach to financial planning

91 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial planning. We were specifically looking for evidence of:

- clear and robust corporate financial planning arrangements in place;
- the Board appropriately scrutinising financial plans prior to their approval;
- sustainable, realistic, and accurately costed savings and cost improvement plans in place which are designed to support financial sustainability and service transformation; and
- the Board appropriately scrutinising savings and cost improvement plans prior to their approval.

92 We found that **the Health Board's approach for financial planning is driving a transactional approach to financial management and while delivering some in-year savings this isn't significantly addressing the Health Board's underlying deficit. There is a clear need for a financial strategy to underpin medium- to long-term planning that fully considers growth in healthcare demand and supports financially sustainable clinical service models, whilst also reducing the underlying deficit.**

93 The approach for financial planning for 2023-24 was significantly affected by senior finance staff absence following the investigation into irregularities in the 2021-22 accounts13 and the need to secure interim leadership arrangements for the Finance Team. This resulted in the financial management team preparing a limited briefing which outlined anticipated cost pressures for review by the Performance, Finance and Information Governance committee in January 2023. Following this, the Board, at its first meeting with the new interim Board members, received only a high-level outline 2023-24 financial budget which it approved in March 2023. This was understandably a difficult period both for the financial management team and the recently appointed interim board members. The Board received and agreed the final financial plan as part of the 2023-24 Annual Plan in July 2023.

94 When considering the full 2023-24 Annual Plan, it is not clear whether the Health Board's improvement initiatives and aims set out in the plan are financially affordable. This suggests a need for a more integrated approach to financial planning. While the 2023-24 Annual Plan provides reasonable information on

[13] Auditor General qualifies his audit opinions on Betsi Cadwaladr University Health Board's 2021-22 Accounts | Audit Wales

spend, financial pressures and risks, it is clear that there is a need for a financial strategy to help enable financially sustainable services **(Recommendation 7).**

95 In March 2023, the Health Board set out a requirement to achieve £38.7 million savings (inclusive of a £7 million stretch target) in 2023-24. By May 2023, the Health Board had revised this target down to £30.9 million (inclusive of a £5.7 million stretch target). The Health Board was initially slow to identify sufficient saving schemes but had made reasonable progress by December 2023. At this time, it had identified £25.6 million deliverable 'green' savings14 against the £30.9 million target. Having developed the saving schemes, the Health Board made slow progress to deliver them, having achieved only £12.8 million by October 2023. However, by December 2023, delivery of financial savings had improved to £17.5 million.

96 The Board and the Performance, Finance and Information Governance Committee both appropriately oversee and challenge the delivery of savings plans, although there is clearly a need for earlier sight of the development of savings plans. The Auditor General will be commenting further on the Health Board's approach to identifying, delivering, and monitoring financial savings in a separate piece of work that we will report in the early part of 2024.

Corporate approach to financial management

97 We considered whether the Health Board has a sound corporate approach to overseeing and scrutinising financial management. We were specifically looking for evidence of:

- effective controls in place that ensure compliance with Standing Financial Instructions and Schemes of Reservation and Delegation;
- the Board maintaining appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- effective financial management arrangements in place which enable the Board to understand cost drivers and how they impact on the delivery of strategic objectives; and
- the organisation's financial statements for 2022-23 were submitted on time, contained no material misstatements, and received a clean audit opinion.

98 We found that **there are reasonable corporate approaches for scrutinising routine financial management arrangements and issues. However, the Health Board needs to appropriately assure itself that the financial controls improvements identified in previous audits and independent reports are effectively and fully addressed.**

[14] The Health Board assesses its proposed savings as "Red, Amber or Green". Those identified as green are considered deliverable within the financial year.

99 The Health Board has reasonable processes in place to ensure compliance with statutory instructions, and to report and challenge breaches. As set out in **paragraph 40**, the Standing Financial Instructions and Schemes of Delegation have been reviewed by Audit Committee and approved by the Board. The Health Board adopted the model Welsh Government Standing Financial Instructions with some minor tailoring to make them specific to the Health Board. The number of single tender waivers[15] have started to reduce as a result of stronger management oversight and control (**Appendix 2, R10 2022**). The Audit Committee routinely reviews and scrutinises losses and special payments, breaches of standing orders, counter-fraud activities and the management of overpayments.

100 The Health Board is responding to the issues identified in our audits of the 2021-22 and 2022-23 accounts, as well as those identified in the EY review. However, progress to address these issues has been slower than intended. The Health Board prepared a financial control action plan, which covered some but not all of the EY recommendations. This was reported to the Audit Committee in May 2023, but is no longer reported to the Audit or Performance, Finance and Information Governance committees, and as of May 2023, the actions were not fully completed (**Recommendation 8**).

Board oversight of financial performance

101 We considered whether the Board appropriately oversees and scrutinises financial performance. We were specifically looking for evidence of:

- the Board receiving accurate, transparent, and timely reports on financial performance, as well as the key financial challenges, risks, and mitigating actions; and
- the Board appropriately scrutinising the ongoing assessments of the organisation's financial position.

102 We found that **the Health Board continues to have good arrangements for monitoring and scrutinising its in-year financial position. However, it needs to strengthen assurance reporting on the extent that actions it is taking to support financially sustainable services are making a difference.**

103 As set out in our 2022 structured assessment, there are regular financial reports to the Performance, Finance and Information Governance Committee and the Board. Reports are generally timely and transparent, providing good analysis on areas of spend, overspend and financial expenditure trends. The reports set out the short-term financial challenges and identify where there are specific financial concerns. Notwithstanding the challenges the Health Board is facing in delivering its savings plans, the separate report on financial savings provides good analysis of progress

[15] A single tender waiver is used to allow procurements without a full tendering process and competition.

identifying and delivering savings schemes, the proportion of cash releasing schemes, and the extent that schemes are generating recurring savings.

104 The Health Board has a good understanding of the financial challenges set out within financial assurance reports. However, there is limited narrative on the mitigating actions, beyond the need to identify additional savings or strengthen accountability. The reports do not enable the reader to fully understand whether action taken to improve finances has been successful, nor the extent that the Health Board's approach to service transformation is helping to, or likely to put the organisation on a more sustainable financial footing. The Board and the Performance, Finance and Information Governance Committee have open and frank discussions on financial performance and is keenly aware that the Health Board approach to financial planning is not sustainable.

Appendix 1

Audit methods

Exhibit 3 below sets out the methods we used to deliver this work. Our evidence is limited to the information drawn from the methods below

Element of audit approach	Description
Observations	We observed board meetings as well as meetings of the following committees: • Board meeting: 28 September 2023; 30 November 2023; and 25 January 2024 • Quality, Safety and Experience Committee: 27 October 2023 • Performance, Finance and Information Governance Committee: 2 November 2023; and 22 January 2024 • Audit Committee: 16 November 2023; and 12 January 2024

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interest, and Registers of Gifts and Hospitality; • key organisational strategies and plans, including the IMTP; • key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • relevant policies and procedures; and • reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.

Interviews	We interviewed the following Senior Officers and Independent Members: • Chief Executive Officer; • Chair; • Board Secretary; • Chair of Audit Committee; • Chair of Quality, Safety and Experience Committee; • Chair of Performance, Finance and Information Governance Committee; • Deputy Director of Quality; • Head of Risk Management; • Executive Director of Nursing and Midwifery; • Executive Director Transformation, Strategic Planning, and Commissioning; and • Interim Executive Director of Finance.

Appendix 2

Progress made on previous recommendations

Exhibit 4 below sets out the progress made by the Heath Board in implementing recommendations from previous structured assessment reports

Recommendation from 2022	Description of progress
2021 Structured Assessment **Financial reporting** R1 Ensure improved focus on financial efficiency of services within finance reports. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting. Planned completion date contained within original management response: 28 February 2022.	We will comment on progress for this recommendation as part of our review of our cost savings review, which we will publish later in 2024.

Recommendation from 2022	Description of progress
Review and where needed, strengthen risk mitigating actions R1 Despite recent changes to the Health Board's strategic and corporate risk arrangements, risk scores in some key areas are not decreasing. The Health Board should review the mitigating actions on the corporate risk register and Board Assurance Framework to ensure they are having the intended impact. Planned completion date contained within original management response: 28 September 2023.	**In progress.** The Health Board has reviewed and revised its Board Assurance Framework (BAF) and Corporate Risk Register (CRR), which the Audit Committee approved in November 2023. These assurance tools remain at an early stage of implementation. As such, it is too early to determine whether the changes are helping to drive improvements in the management and assurance to support the scrutiny of operational and strategic risks. There remains a need to focus more on the impact that actions to address risks are having.
Review of performance management assurance reporting R2 The Health Board is continuing to refine performance reporting into board and committees. However, there remain concerns around the quality of the performance report and the extent that stated actions will lead to the intended improvements. The Health Board should improve its performance assurance reporting, focussing more on the impact of performance improvement actions. Planned completion date contained within original management response: 31 July 2023 with continued review.	**In progress.** The Health Board has revised its Integrated Performance Report (IPR) which was approved by the Board in November 2023. Members of the Board have recognised that the new reports demonstrate progress with more succinct narrative focussing on key concerns and emerging risks, as well as greater use of and training for analysis tools such as Statistical Process Control (SPC) charts. Our analysis shows that there remains scope to increase the report's narrative on the impact of mitigating actions.

Recommendation from 2022	Description of progress
Ensure accuracy of reporting Public Services Ombudsman for Wales figures R3 There have been discrepancies between the complaint figures reported by the Public Services Ombudsman for the Health Board and the Health Board's own figures within previous annual reports. While the Health Board rectified this in its 2021-22 annual report, the Health Board should ensure such discrepancies do not reoccur. The Health Board should validate and verify Public Service Ombudsman for Wales complaint numbers prior to inclusion in annual reports. Planned completion date contained within original management response: Completed at time of reporting (August 2023)	**Complete.** The Health Board instigated monthly meetings with the office of the Public Services Ombudsman for Wales to validate data to ensure accurate annual reporting.
Review Health Board policies R4 The Health Board has a significant number of policies overdue for renewal, which exposes the organisation to service and administrative risks. The Health Board should review and update Health Board policies, prioritising high importance policies first, including the policy on policies. Planned completion date contained within original management response: September 2023	**In progress.** The revised policy on policies has been discussed by operational groups and the Audit Committee along with a proposed plan for addressing the Health Board's backlog of policies. The Health Board anticipates that it may take 18 months to complete.

Recommendation from 2022	Description of progress
Review audit recommendation tracker R5 The audit recommendation tracker and report in their current format provide limited detail, particularly around actions considered complete. The Health Board should work with Audit Committee members to review the format of the audit tracker and report to ensure it provides sufficient information to provide assurance. Planned completion date contained within original management response: September 2023	**In progress.** The Health Board has revised the format of its audit tracker since last year. There is an improved level of detail in relation to actions which are recommended for closure. However, the information is more focussed on actions taken rather than reporting if the original recommendation has been addressed. This can sometimes lead to false assurance that the recommendation is complete.
Implementation of the new operating model R6 The Health Board should complete the implementation of the new operating model as a matter of urgency, particularly in respect of recruiting substantial post holders and reducing reliance on interim appointments. Planned completion date contained within original management response: Continued review required.	**In progress.** The Health Board has recruited substantively to several senior posts, reducing its reliance on interim roles. The Health Board intends to reflect on the implementation of the operating model during 2024.

Recommendation from 2022	Description of progress
Develop a supporting clinical delivery plan R7 The Health Board has developed a clinical strategy for its services, however, there is lack of detail on how it will be implemented. The Health Board should develop supporting clinical delivery plan/plans and delivery structures to shape and implement sustainable service models. Clinical plans should inform workforce, estate, financial resource, and digital services planning. Planned completion date contained within original management response: Quarter 4 2023-24	**In progress.** The Health Board will be taking stock of strategic commitments as part of the revised approach to planning. Given service pressures and related performance, potential for growth in demand in the medium- to long-term, and the underlying financial deficit, there remains a clear need for the Health Board to prepare financially sustainable clinical strategy delivery plans that set out new configurations of services.
Reporting on the impact of value-based healthcare initiatives R8 We found limited evidence of how the Health Board is implementing value-based healthcare operationally to its services to maximise value and efficiency. The Health Board should ensure reporting on its value-based healthcare programme focusses on the outcomes achieved. Planned completion date contained within original management response: December 2023 with continued review	**In progress.** The Health Board indicates that its approach will be considered as part of its Planning Framework. Specific projects including on Lymphoedema & Cellulitis and Patient Reported Outcome Measures led follow up arthroplasty are underway. There remains a need to assess and report on the impact and outcomes of the initiatives.

Recommendation from 2022	Description of progress
Urgently implement financial recovery approaches to strengthen the financial position R9 As of January 2023 the Health Board is off-track with its current savings plan and is slow to progress the savings plan for 2023-24. The Health Board should: • prepare appropriate financial recovery programmes as a matter of urgency for both the remainder of this, and the next financial year. • review options for estate and service disinvestment (i.e., where services are not demonstrating sufficient patient impact and outcomes). • introduce stronger reporting and oversight of the medium-term financial position, financial strategy and recovery approaches. • target digital investments on areas of clear business benefits, i.e., where digital can be used to release service efficiency and/or quality gains elsewhere. Planned completion date contained within original management response: Completed at time of reporting (August 2023)	**In progress.** From a slow start, the Health Board improved the identification and delivery of saving schemes for 2023-24. Although forecast to meet the revised lower target of £25.2 million, these fall short of the original savings target identified at the beginning of the year. There remains a need for a stronger focus on financial strategy which links to options for estates and service disinvestment in instances where value and efficiency is not demonstrated. The Health Board has improving transparency of financial reporting, but there needs to be a stronger focus on the medium-term financial position linked to financial strategy and recovery approaches. Limited capital is affecting investment in digital and there continues to be a need to target digital investments where this would release service efficiency gains and transformation.

Recommendation from 2022	Description of progress
Introduce stronger financial planning and control to reduce reliance on single tender waivers R10 The Health Board has a track-record of substantial and growing use of single tender waivers. The Health Board should improve procurement planning and strengthen single tender waiver financial controls. Planned completion date contained within original management response: Completed at time of reporting (August 2023)	**Complete.** The Health Board has strengthened single tender waiver controls which has reduced the overall extent of their use and associated expenditure committed to through waivers.
Ensure effectiveness of staff well-being services R11 The Health Board has introduced a programme of services to support staff wellbeing. However, it is not currently undertaking sufficient evaluation to ensure these are meeting the needs of staff. The Health Board should evaluate the impact of its staff wellbeing services to inform future investment decisions. Planned completion date contained within original management response: Quarter 2023-24	We will review the progress against this recommendation later in 2024 as part of our next structured assessment review.

Recommendation from 2022	Description of progress
Improve performance and financial oversight for digital and estates R12 There is a need to put in place arrangements to understand the impact of digital and estates strategies, as well as the financial feasibility of the strategy. The Health Board should: • review any funding gaps in the digital and estates strategies to determine if they are financially feasible. Update the relevant committee on the findings of the financial feasibility review and how any associated risks will be managed. • introduce periodic committee reports that not only focus on actions completed but the impact its digital and estates strategies are having on the organisation.	**In progress.** The Health Board has indicated that it will seek to address the recommendation through the implementation of the new Planning Framework and Integrated Performance Framework.

Appendix 3

Organisational response to audit recommendations

Exhibit 5: Betsi Cadwaladr University Health Board response to our audit recommendations

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R1	Currently, there is confusion about how many days in advance of meetings papers for Board and committee papers should be made publicly available. The Health Board should agree and communicate a consistent target date for publishing agendas ahead of Board and committee meetings.	Agreed. The Health Board has confirmed the standard target date of Board and Committee papers will be 7 days' notice in advance of meetings. The Director of Corporate Governance will communicate this timescale to all Board and Executive Team Members to ensure there is no confusion of timescales.	End April 2024	Director of Corporate Governance

Ref	Recommendation	Organisational response	Completion date	Responsible officer
R2	The Health Board should introduce arrangements to ensure the public have timelier access to records of committee meetings as part of its wider efforts to enhance transparency of Board business.	Agreed. The Director of Corporate Governance will review the current process and the Standing Operating Procedure for Board and Committee meeting and agree this with the Board.	31 May 2024	Director of Corporate Governance
R3	There has been a significant unexplained drop in the number of complaints received for the first six months of 2023-24 compared to the previous year. The Health Board should urgently work to discover the reason to ensure complaints are not being missed or mis-reported.	Agreed. The Executive Director of Nursing & Midwifery with the Director of Digital, Data and Technology will lead work to check the data quality. that information is still being received and no specific reason for this drop has been confirmed. The Health Board has also committed to the development of a Quality Management System that will enable learning from complaints / feedback to be fully understood and reflected in the Health Board's quality planning	30 June 2024	Executive Director of Nursing & Midwifery

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.		
R4	Our work identified that not all Audit Wales recommendations made in 2023 were added to the audit tracker. The Health Board should ensure there is a process to add all recommendations made by Audit Wales to the audit tracker in a timely fashion.	Agreed. A process has been agreed with the Executive Team and Chair of the Audit Committee which includes Audit recommendations being received at Executive Team Meetings (bi-monthly) prior to risks being received for formal closure at Audit Committee. This process will allow for Executive Team to check that Audit Wales recommendations are added to the audit trackers in a timely fashion before updates are received at the Audit Committee for assurance. This allows Audit Wales colleagues (who attend Audit Committee) to check compliance with this process.	31 May 2024	Director of Corporate Governance

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		Whilst this process has been agreed and has commenced a further cycle of it needs to have taken place before this recommendation can be evidenced as being effective and complete.		
R5	Currently, there is insufficient committee oversight to monitor progress made against recommendations made by non-audit bodies. The Health Board should introduce effective committee oversight for monitoring progress made against recommendations of regulators, including, but not limited to, Healthcare Inspectorate Wales, the Coroner, Welsh Language Commissioner, the Health and Safety Executive and the Public Services Ombudsman for Wales.	Agreed. A recent review of all of the Board Committee cycle of business (received at the Board in January 2024) has made some provision for recommendations received by non-audit bodies. This includes QSE Committee and a People and Culture Committee. The Director of Corporate Governance will put in place a process and system to ensure that recommendations by other bodies are co-ordinate and have appropriate oversight at Committee and where appropriate Board level.	31 July 2024	Director of Corporate Governance Executive Medical Director and Executive Director of Nursing & Midwifery

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		The Health Board has also committed to the development of a Quality Management System that will enable learning from regulatory reports to be fully understood and reflected in the Health Board's quality planning process. A draft of the Quality Management System will be considered by an informal Executive Team meeting by the end of May 2024.		
R6	More needs to be done to reconfigure services to ensure they sustainably meet current and future population healthcare needs. To accompany its clinical strategy, the Health Board should undertake key stakeholder engagement plan to help it shape sustainable service models designed to meet current and future demand.	Agreed. The Health Board recognises the importance of this recommendation. As part of the priority actions for 2024-25, as laid out in the Three Year Plan, the Health Board has planned significant actions that together progress this recommendation. The following actions will be taken forward:	End of Quarter 1, 2024-25	Executive Director of Transformation, Strategic Planning & Commissioning with support from Executive Director of Population

Ref	Recommendation	Organisational response	Completion date	Responsible officer
		During 2024-25 the Health Board will commence the development of a new Health Board strategy and Clinical Services plan. To support this, priorities are already identified to maximise the effect of the stakeholder engagement being planned to support this. These specific priority areas include general work to improve the Health Boards approach to citizen engagement, being a Good Partner, engaging with the national Value and Sustainability Board to incorporate learning from other organisations within NHS Wales, and engaging with clinicians within and outside of the Health Board.		Health and Director of Partnerships, Engagement and Communications
R7	It is difficult to see the extent to which the Health Board's improvement initiatives and aims set out in the 2023-24 Annual Plan were financially	Agreed. The Board approved the financial plan in May 2023 with the Annual Plan approved at the end of June 2023	End of July 2024	Executive Director of Finance

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	affordable. The Health Board should develop a financial strategy, supported by a medium-term financial plan with the aim of supporting good quality and sustainable service models and reducing the Health Board's deficit and underlying deficit.	following agreement with Welsh Government. The HB developed revised plans in year with the expressed intention of balancing improvements in quality and performance within an affordable financial envelope. The focus from close of 23/24 financial year and moving into 24/25 and beyond has been to endorse a value and sustainability approach to delivery of improvements for staff, patients and visitors that will also result in a sustainable financial for future health care.		
R8	Ensure that the Audit Committee receives assurance on the progress that the Health Board is making to address the complete range of issues identified in the Audit Wales 2021-22 and 2022-23 audit of accounts, and	Agreed. Progress reports will be schedule of part of the Audit Committee Programme of work.	End of August 2024	Executive Director of Finance

Ref	Recommendation	Organisational response	Completion date	Responsible officer
	the subsequent EY review has been slower than intended.			

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Teitl adroddiad: *Report title:*	Annual Delivery Plan
Adrodd i: *Report to:*	Health Board
Dyddiad y Cyfarfod: *Date of Meeting:*	30th May 2024
Crynodeb Gweithredol: *Executive Summary:*	The purpose of this paper is to provide an overview of the end of year delivery position of the 2023/24 Annual Delivery Plan, as well as the latest status of the 2024/25 plan development.
Argymhellion: *Recommendations:*	The Health Board is asked to **NOTE** the overall progress made along with the challenges highlighted.
Arweinydd Gweithredol: *Executive Lead:*	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)
Awdur yr Adroddiad: *Report Author:*	Paolo Tardivel, Director of Transformation and Improvement

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 4 2023/24 Monitoring Report Appendix 2: 2024/25 Annual Delivery Plan	

HEALTH BOARD 30 May 2024

Annual Delivery Plan Update

▪ Introduction

This report seeks to provide Board Members with an overview of the end of year delivery position of the 2023/24 Annual Delivery Plan, as well as the latest status of the 2024/25 plan development.

▪ 2023/24 End of Year Monitoring Report

The 2023/24 Annual Delivery Plan contained 180 key actions to be delivered by the 31st of March 2024. Subsequently, 42 of these actions were incorporated within the Special Measures 2023/24 response plan and reported through the Special Measures reporting framework. As these were reported through Special Measures reporting they have been excluded from this report to avoid duplication.

The following high level summary table provides an overview of the remaining 138 key actions in the Annual Delivery Plan to be delivered by the end of Quarter 4 of 2023/24.

Ref	Total	Key Performance Area	Completed by Q4	Not completed by Q4
P1	23	Prevention and Health Protection	20	3
P2	19	Primary Care	10	9
P3	5	Planned Care	3	2
P4	1	Urgent and Emergency Care	0	1
P5	10	Cancer	4	6
P6	3	Mental Health	3	0
P7	4	Substance Misuse	3	1
P8	3	Learning Disability	3	0
P9	7	Women's Services	1	6
P10	2	Children	1	1
P11	3	Wider Delivery	0	3
P12	4	Workforce	3	1
P13	12	Digital, Data and Technology	9	3
P14	14	Estates and Capital	10	4
P15	13	Partnerships	9	4
P16	1	Board Leadership and governance	1	0
P18	3	Quality, Innovation and Improvement	3	0
P19	11	Social and Civic leadership and responsibility	10	1
Total	**138**		**93**	**45**

Table 1 – 2023/24 Annual Delivery Plan completion overview

The table shows a delivery rate of **67%** (93/138) against the actions due by Quarter 4. Those actions that were not completed are being tracked as '2023/24 overdue actions'

A full breakdown of the individual overdue actions is included in Appendix 1.

▪ 2024/25 Annual Delivery Plan

Following the approval of the 3 Year Plan at March Board, the underpinning Annual Delivery Plan for 2024/25 has been developed and is in the process of being deployed. This plan also incorporates the Special Measures response plan within it, in order to create a single integrated plan and monitoring arrangement.

In order to ensure that the Annual Delivery Plan stays aligned to the latest challenges and plans to address them, the change control process that was used within Special Measures will be applied to the Annual Delivery Plan. This will enable the plan to be agile enough to incorporate, amongst other things, the latest Welsh Government Special Measures expectations as they are received.

This is an important step in the organisation's Special Measures journey, as it is incorporating the learning from the last year into 'business as usual' processes and capability that is part of efforts to build an effective organisation for the long term.

The full 2024/25 Annual Delivery Plan can be found in Appendix 2.

▪ Recommendation

The Health Board is asked to **NOTE** the overall progress made along with the challenges highlighted.

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

Appendix 1: 2023/24 Delivery Plan Monitoring Report

Actions outstanding at the end of Quarter 4 with revised timescales

Ref	Organisational Delivery Objective		Lead	Revised Completion Timescales 2024/25 (Quarters)
P1.2	Implement the priority actions to reduce use and impact of smoking:		EDPH	
	P1.2.4	Progress the implementation of actions to make smoke-free the accepted position (as per the All-Wales Tobacco Control Delivery Plan) Assessment of delay in completion: The recruitment to Smoke Free Environment Officers was paused in line with the Health Board's revised financial recovery plan for 2023/24. The posts are now progressing via procurement, therefore on target to appoint by Q2 2024/25. New date has been approved by DPH.		1 2 3 4
P1.4	Implement the priority actions to reduce use and impact of smoking:		EDPH	
	P1.4.2	Implement communication, data collection and monitoring mechanisms that increase access to services for the Gypsy and Traveller communities Assessment of delay in completion: **OBJECTIVE RETIRED FROM DELIVERY PLAN AS SUPERSEDED BY ACTIONS FROM THE STRATEGIC EQUALITY PLAN**		1 2 3 4
P1.7	Reshape and deliver a new Health Protection Service		EDPH	
	P1.7.2	Development of proposals to implement the National Immunisation Framework Assessment of delay in completion: This is a multi-year project. Proposal to approve transformation programme in 2024/25 supporting the National Immunisation Framework has been produced and will be considered by the Executive Team for approval in Q1.		1 2 3 4
P2.1	Implement actions to improve access to GP and community services including:		DPC	
	P2.1.5	Review 3rd sector primary care commissioning, linking with the review of social prescribing approaches. Assessment of delay in completion: Approval was given to extend all third sector contracts for a further 12-month period ending 31st March 2025. This will enable the review of third sector agreements to be completed and allow for revised planning decisions in advance of 2025/26.		1 2 3 4

	P2.1.6	Review and develop a forward plan for the further development of palliative care and bereavement services. Assessment of delay in completion: A number of actions will be rolled forward into 2025/26 however good progress has been made throughout the year. Final draft strategy expected to be completed in Q1 2024/25	1 2 3 4
P2.4	Implement actions to improve access to dental services, including:	DPC	
	P2.4.1	Commission additional community dental activity using the Oral Needs Assessment to identify areas of highest need Assessment of delay in completion: Review work has been completed; however, the award of contracts was delayed and did not take place in 2023/24	1 2 3 4
	P2.4.2	Commence work with HEIW to address barriers to recruitment of international dental staff Assessment of delay in completion: Work is ongoing in line with Strategic Workforce Plan actions.	1 2 3 4
	P2.4.3	Explore options for supportive model of contracting for salaried model of delivery Assessment of delay in completion: Ongoing review of alternative models for delivery of service including salaried model. Review taking into account requirements from an estates, workforce, equipment, capital and revenue perspective. Chief Dental Officer included in discussions. Planned new General Dental Services (GDS) contract not available and will be introduced 2025/26 contract year. This will impact on salaried model of delivery as will the lack of available capital funds and suitable estate.	1 2 3 4
P2.5	Implement actions that improve the use of community pharmacy, including:	DPC	
	P2.5.2	Expansion of the Pharmacist Independent Prescribing Service Assessment of delay in completion: As at 27th March 2024, 39 pharmacies were commissioned to provide the service. Work continues with the small number of pharmacist prescribers employed in pharmacies that do not currently provide the service to commission these sites. A number of pharmacists will complete the training imminently. Aim is to commission 50 sites by the end of Q1 2024/25, this target is set out in the agreed Ministerial Template for 2024/25.	1 2 3 4
	2.5.5	Implement the pilot project for robotic dispensing of urgent medicines Assessment of delay in completion: Delays in development of the robot have meant that it has not been possible to implement this solution as planned. Training and pre-implementation activities are now planned for late April/early May 2024 to enable teams to work with the robot following installation.	1 2 3 4
P2.6	Implement actions that improve the use of optometry services, including:	DPC	
	P2.6.2	Implement plans to enhance independent prescribing to enable additional capacity for advanced glaucoma management and management of medical retina.	1 2 3 4

		Assessment of delay in completion: Requires changes to optometry contracts. Contract reform is progressing through the national implementation board and sub-groups.		
P2.7	Development of an integrated Primary Care function within the Health Board			
	P2.7.1	Develop proposals for an integrated Primary Care function within the Health Board that supports and enables effective and joined up primary care commissioning and development Assessment of delay in completion: Changes to operational arrangements and personnel		1 2 3 4
P3.4	Undertake a stocktake of diagnostics:		EDO	
	P3.4.1	Establish a stocktake of diagnostics and develop a short-, medium- and long-term plan for improving access, particularly focused on community and regional diagnostics. Assessment of delay in completion: Focus has been on securing in year additional capacity to deal with backlog and other operational pressures.		1 2 3 4
P3.6	Over 156 week waits for treatment		EDO	
	P3.6.1	Achieve a standard 99% of all over 156 week waits booked into appointments by end of Q2 Assessment of delay in completion: The Health Board has 2 areas where it is breaching this standard - orthodontics and gastroenterology There are currently 135 patients in orthodontics who are awaiting a first appointment. The Health Board is out to recruitment for an additional consultant and has an outline agreement with Countess of Chester NHS Foundation Trust Hospital to take additional patients. These two measures will have a substantial impact if delivered. In mitigation, patients are being offered treatment at a different site within the Health Board wherever practical bearing in mind that travel distance is an issue for this cohort. Gastroenterology long waits result from a single-handed substantive consultant and reliance on locum and agency on one site. Locum and agency use has been curtailed in order to balance significant financial pressure.		1 2 3 4
P4.1	Revised Whole-system Urgent and Emergency Care Programme		EDO	
	P4.1.1	Establish a revised Whole-system Urgent and Emergency Care Programme that develops and delivers an Urgent and Emergency care Strategic Plan, for short, medium and longer term, working with all component parts aligned to the 6 Goals Approach Assessment of delay in completion: Programme established, Programme Initiation Document (PID) due for completion by the end of Q1 2024/25		1 2 3 4
P5.3	Implement immediate targeted actions to improve access in diagnostics and key specialities, including:		EDO	

	P5.3.1	Aim for first appointment within 10 days Assessment of delay in completion: Challenges continue to be worked through with dermatology		1 2 3 4
P5.4	Implement actions to support local delivery:		EDO	
	P5.4.1	Finalise four local cancer pathways this year prostate, colorectal, breast and gynaecology Assessment of delay in completion: Work on breast and gynaecology pathways ongoing, re-profiled to Q2 2024/25 due to complexity of service provision and availability of workforce to support		1 2 3 4
	P5.4.2	Continue to work towards filling all Consultant Clinical Oncologist vacancies by the end of the year, recognising the challenge presented by the national shortage of cancer doctors Assessment of delay in completion: Currently three vacancies, mitigation in place therefore revised delivery date.		1 2 3 4
	P5.4.3	Continue to support the development and use of new NICE approved cancer treatment regimens Assessment of delay in completion: Managed via the Cancer Medicines Management Group		1 2 3 4
	P5.4.4	Develop a capital estates plan for the Shooting Star Unit, which will provide additional capacity for treatments and outpatient clinics Assessment of delay in completion: Development of revised design underway and discussions ongoing with East Integrated Health Community		1 2 3 4
	P5.4.5	Our Haematology service will maintain Referral to Treatment (RTT) time at 26 weeks throughout the year and aims to undertake substantive recruitment of consultants and reduce the number of NHS locums working within the speciality by the end of 2023/24 Assessment of delay in completion: Recruitment process took longer than anticipated		1 2 3 4
P7.2	Support the implementation of initiatives to reduce Blood Borne Viruses, Hepatitis B and Hepatitis C		EDPH	
	P7.2.1	Implementation of plan to reduce blood borne viruses undertaken Assessment of delay in completion: There has been progress during Q4 for all areas of the plan there are still some areas of the plan that require further work will be incorporated into the 2024/25 BCUHB hepatitis B and C elimination plan, which will be submitted to Welsh Government by the end of May 2024, with a target completion date of March 2025.		1 2 3 4
P9.1	Implement the organisation's Maternity and Neonatal Strategic Plan, aligned to the National Strategy for Wales		EDO	
	P9.1.1	Implementation undertaken Assessment of delay in completion: Awaiting clarification from the Welsh Government regarding NHS Executive (NHSE) management of Phase 2/ Implementation of the project		1 2 3 4

		and actual recommendations/ actions required for implementation by Health Boards - this is due on the 15th May 2024. This has resulted in a significant delay in clarification for Health Boards and Service providers. In addition to the 134 recommendations the NHSE identified three priorities for action to be progressed during the transition phase (up to end March 2024).		
P9.2	Implement the Maternity and Neonatal Safety Support Programme (Priorities for Improvements and the PERIPrem Programme in Wales):		EDO	
	P9.2.1	Complete and monitor delivery of initial recommendations for year 1 Assessment of delay in completion: See 9.1.1		1 2 3 4
P9.3	Consider and implement the Digital Maternity Cymru Strategic Plan		EDO	
	P9.3.1	Work to implement the Plan, including local rollout of national Maternity Information Service (MiS) Assessment of delay in completion: National Programme delayed. Likely implementation is Q4 2024/25. Service is planning for pre-implementation phase and required resource for this phase will be submitted as an Informatics Capital and Resource requirement.		1 2 3 4
P9.4	Implement next stages of the Welsh Government Quality Statement for Women and Girls Health		EDO	
	P9.4.1	To include completion of work to develop plans for the endometriosis centre Assessment of delay in completion: Progress subject to funding review in line with Health Board's financial recovery plan.		1 2 3 4
P9.5	Consider the women's Health Plan for Wales and develop a deliverable Plan for North Wales		EDO	
	P9.5.1	Work with the third sector and with women's representative groups to develop proposals Assessment of delay in completion: The NHSE is currently in the process of establishing a Women's Health Network to lead the development of a Women's Health Plan, to be published in 2024. As a holding position Women's Services has contacted Welsh Government's Health Policy Manager to confirm expectations whilst the 10 Year strategy is awaited. Welsh Government has confirmed that the Health Board's current priorities should focus on pelvic health and endometriosis in the interim, these remain the Services priorities.		1 2 3 4
P9.6	Implement the planned care Gynaecology Specialty Plan, aligning the Getting It Right First Time (GIRFT) recommendations		EDO	
	P9.6.1	Work with improvement team to develop and implement GIRFT recommendations Assessment of delay in completion: GIRFT recommendations cover operational and strategic change and therefore are not all deliverable in 2023/24		1 2 3 4

P10.1	Review and revise the approach to Neurodiversity, including implementing the plan to improve access times for assessment		EDTSP	
	P10.1.1	Review and confirm proposals for increasing capacity. Assessment of delay in completion: Transformation requires co-design with Regional Partnership Board (RPB) and WG, as there are significant multiagency and multi-disciplinary workforce opportunities and challenges.		1 2 3 4
P11.2	Implement mechanisms to identify and respond to early warning signs of fragile services of concern		EMD	
	P11.2.1	Develop proposals for quality surveillance mechanisms including performance data, workforce, quality Assessment of delay in completion: Methodology to be completed by Q1 with implementation later in 2024/25.		1 2 3 4
P11.3	Stroke Services		EMD	
	P11.3.1	Implement key improvements in Stroke services in order to achieve level B score in the Stroke Sentinel national Audit Programme Assessment of delay in completion: Identified challenges include access to a stroke specific bed within four hrs. Due to continuous pressure for beds, stroke beds are often filled with general medical patients and protecting the thrombolysis bed has also been challenging. Scanning performance has dropped as stroke nurses do not provide a 24/7 service and in their absence, there can be delays in the request for a head CT scan. It should be noted that once the request for a scan is made, the scan is carried out promptly.		1 2 3 4
P11.4	Working with Welsh Health Specialised Services (WHSSC), implement the Integrated Commissioning Plan for Specialised Services		EDTSP	
	P11.4.1	Implementation of the Integrated Commissioning Plan for Specialised Services Assessment of delay in completion: The Health Board Planning Team continue to meet regularly with (WHSSC) to ensure that the commissioning plan is aligned to organisational priorities, and has the correct governance in particular for monitoring quality. Further work has been undertaken between Planning and WHSSC during Q4 2024 to ensure delivery of the plan		1 2 3 4
P12.1	Address priority issues for workforce including:		EDWOD	
	P12.1.2	Further development of the Apprenticeship/Grow our Own Models Assessment of delay in completion: *Health Board Apprentices* Significant challenges lie in a lack of staffing resources to support delivery and sustainable support. The appointment of a member of staff seconded from a partnership college until March 2024 is having an impact on raising the awareness of apprenticeships with service managers as well as supporting and providing a focus point for apprentices in the organisation.		1 2 3 4

		Supported Shared Apprentices This work has not progressed due to resource being unavailable and has been rolled forward to 2024/25.		
P13.2	Progress the implementation of current Digital Programmes including:		CIDO	
	P13.2.6	Eye care digitisation programme Assessment of delay in completion: Changes nationally have led to this programme moving from Cardiff and Vale University Health Board, as the lead organisation, to Digital Health and Care Wales (DHCW). As a result of commercial contract issues, the programme is being reconsidered and new options are being explored including re-procurement. The project remains significantly delayed. DHCW is continuing to consider alternative options including re-procurement as well as Health Boards adopting a limited scope of the system hosted in Cardiff and Vale Health University Board but this would still require Cyber Security assurances as well as a number of other requirements.		1 2 3 4
	P13.2.7	Welsh Community Care Information System (WCCIS) Assessment of delay in completion: In line with a change of direction nationally, it is anticipated that the BCU linear project (WCCIS) will be split into a programme involving multiple projects/systems going forwards.		1 2 3 4
P13.3	Commence Major Digital, Data and Technology Programmes, including:		CIDO	
	P13.3.4	Welsh Intensive care Information System (WICIS) Assessment of delay in completion: On the 6th of December 2023, the BCU Executive Team made the decision to pause the WICIS project. This decision was due to: ***Affordability:*** There is a significant increase in costs associated with the system in both one off capital and reoccurring revenue (linked to having to procure hardware and licences for the full 51 bed ICU footprint rather than the 36 commissioned beds). ***Safety:*** BCU wanted assurances around the safety of the system, including full visibility of all the issues and a plan for resolution. Health Boards are also awaiting the outcome of the requested safety review, which is dependent on the Aneurin Beavan University Health Board testing outcome. ***Benefits/Value for Money:*** BCU is seeking evidence that the new WICIS solution is fit for purpose and delivers value in other Health Boards. The decision made by the Executive Team was endorsed by the BCU WICIS Project Board at the Board meeting which took place on the 11th December 2023. The project remains paused until there are assurances around the safety of the system.		1 2 3 4
14.2	Progress the major Capital programme Schemes, including:		CIDO	
	14.2.1	Wrexham Maelor Continuity Programme Assessment of delay in completion: The Full Business Case (FBC) has been approved by the Board and submitted to Welsh Government. It is currently going through the scrutiny process, there are some challenges over benefits in terms of decarbonisation and the non-works costs. Discussions with WG also suggest		1 2 3 4

		that the programme may need to be phased over more than the two years proposed in the case. Its anticipated phased approach will now be submitted during 2024/25	
	14.2.2	Ysbyty Gwynedd Compliance Programme Assessment of delay in completion: Welsh Government have agreed to fund further survey work, to inform the development of a more detailed Programme Business Case (PBC). There has been a delay in re-establishing the project board and progressing this section of work due to other competing priorities for both capital and operational teams. The project board will restart in Q1 2024/25, with a plan to submit an updated PBC by Q1 2025/26.	1 2 3 4
	14.2.3	Nuclear Medicine/PET CT Assessment of delay in completion: Projected capital costs have increased significantly since the Strategic Outline Case (SOC) stage. A review is being held to explore the causes, which will also involve considering option appraisal around the capital and operational solutions.	1 2 3 4
	14.2.7	Ablett Unit redevelopment Full Business Case (FBC) Assessment of delay in completion: The FBC is nearing completion, but complexities related to the electrical infrastructure on the site have impacted the date of submission of the case. The FBC costs are also in excess of the Outline Business Case (OBC) costs. There are some potential revenue pressures which are being explored. Agreement with Welsh Government that a separate Business Justification Case (BJC) will be submitted covering the Ysbyty Glan Clwyd site electrical infrastructure upgrade, the case is in development and will be submitted in September 2024.	1 2 3 4
P15.1	Partnership priorities	DPEC	
	P15.1.1.E	Respond to the 'Further, Faster' strategic action plans being developed by WG to enhance further our partnership working in North Wales Assessment of delay in completion: Delay in Health Board approval process. Health Board workshop held on 18th April 2024 agreement to complete objective in 2 months.	1 2 3 4
	P15.1.1.W	Work with partners in the Regional Partnership Board (RPB) to implement agreed priorities within the North Wales Area Plan Assessment of delay in completion: Two West Integrated Health Community capital scheme priorities (Stage 0 Applications) required revision and resubmission to the RPB Prioritisation Panel.	1 2 3 4
	P15.1.1.W	Collaborate with the North Wales Public Services Boards in delivery of the Well-being Plans Assessment of delay in completion: Continued work needed with partners to complete a suite of measurable indicators to accompany the detailed delivery plan.	1 2 3 4
	P15.1.1.W	Continue to develop and collaborate with other strategic partnerships across Wales and cross-border Assessment of delay in completion: Ongoing discussions regarding Bronglais Hospital - catchment population and relative geographical isolation, and the role that the Health Board could play as a system partner.	1 2 3 4
P19.1	Develop a strategic plan for improving organisational impact to the Foundational Economy	EDF	

	19.1.1	Review current initiatives, refresh leadership and develop a strategic plan Assessment of delay in completion: Staffing issues/capacity constraints new lead(s) to be identified.	1 2 3 4

DPC Director of Primary	**EDPH** Executive Director of Public Health
EDO Executive Director of Operations	**EDTSP** Executive Director of Transformation & Strategic Planning
EDOF Executive Director of Finance	**EDWOD** Executive Director of Workforce & Organisational Development
CDIO Chief Digital Information Officer	**EMD** Executive Medical Director
DPEC Director of Partnerships, Engagement and Communication	

Appendix 2: 2024/25 Annual Delivery Plan

Ref	*Descriptor*	*Lead Executive*	*Qtr1*	*Qtr2*	*Qtr3*	*Qtr4*
1: Building an effective organisation						
1A: Board Effectiveness						
1A.1	Complete substantive recruitment of Executive members of the Board	CEO		Q2		
1A.2	Progress a Board Development Programme, supporting a substantively appointed Board.	DoCG	Q1			
1A.3	Complete the re-establishment of a full complement of Board Committees	DoCG	Q1			
1A.4	Review the approach to the Board Assurance Framework and Risk Management Framework, under the leadership of the recently appointed Director of Governance	DoCG		Q2		
1B: Risk Management						
1B.1	Alignment of the Board Assurance Framework with risks appetite, this Three Year Plan, and the emerging strategic objectives of the Health Board	DoCG			Q3	
1B.2	Development of a risk management dashboard to improve triangulation with planning and performance as well as other directorates	DoCG				Q4
1C: Operating Model						
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	CEO	Q1			
1C.2	Assess the Business Partnering model across the organisation, drawing together proposals for revision where necessary	CEO	Q1			
1C.3	Develop proposals for any revision to the current Operating Model, considering a careful approach to supportive change	CEO		Q2		
1C.4	Review and revise where necessary the clinical leadership model in the organisation, drawing in the learning from the Rapid Review of (Clinical) Engagement, to build a stronger clinical leadership and engagement approach	EMD		Q2		

1C.5	Identify opportunities for greater efficiency through using digital tools e.g. Microsoft Office 365	CDIO		Q2		
1C.6	The Health Board will monitor the effectiveness of the Integrated Performance Framework, making revisions where necessary to reflect learning and to ensure it remains aligned to the Health Board's corporate governance structure and Operating Model changes	EDoF		Q2		
1D: Performance and Accountability Framework						
1D.1	The Health Board will continue to fully implement the Integrated Performance Framework, enhancing the capability of the organisation, and individuals, to manage performance	EDoF		Q2		
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	CEO	Q1			
1D.3	The Health Board will review and redesign the approach of reporting through Executive Team, to Board Committees and to Board to further enable openness, transparency, accessibility, analysis, and a focus upon improvement	DoCG		Q2		
1E: Value and Sustainability						
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	EDoF	Q1			
1E.2	Continue to embed the principles of *Value Based Care* into all decision making throughout the Health Board	EDoF		Q2		
1E.3	Identify a clear and forward looking programme of work for Value Based Care within the Health Board	EDoF		Q2		
1F: Legislative Improvements						
1F.1	Undertake a comprehensive gap analysis that informs a clear Health and Safety Improvement Plan approach	DoWOD		Q2		
1F.2	Review the programme of Health and Safety training across the Health Board, and engaging with managers to enable the right level of support to improve health and safety practice, including the Managing Safely course and the Leading Safely course for Executives and senior managers	DoWOD		Q2		
1F.3	Review the effectiveness of rotational support visits from Health and Safety Advisors to individual areas across the Health Board, revising approaches where necessary	DoWOD		Q2		
1F.4	Develop systems that identify, record and provide focused and escalated support to areas that require the greatest improvement	DoWOD		Q2		
1F.5	Appoint to a substantive Head of Civil Contingencies, and develop a team approach across the organisation to take forward civil contingencies priorities	EDoPH	Q1			

1F.6	Review Business Continuity Plans and arrangements across the Health Board	EDoPH				Q4
1F.7	Review Emergency Plans across the Health Board	EDoPH				Q4
1F.8	Consider any emerging findings from the UK Covid-19 inquiry evidence hearings that might improve our Civil Contingencies preparation by addressing in advance of formal recommendations	DoCG			Q3	
1G: Workforce Planning						
1G.1	Undertake a review of current workforce establishment numbers, and supported by principles against which workforce planning will occur going forwards. This will provide the basis upon which all other priorities outlined below will build	DoWOD		Q2		
1G.2	Design an organisational 'Approach to Workforce Planning', building on the already established 6-step approach of HEIW. The Health Board will systematically assess services against the workforce planning approach, starting with 'challenged' services. Each 'challenged' service will have an agreed workforce plan	DoWOD		Q2		
1G.3	Strengthen partnership work with Health Education and Improvement Wales (HEIW) and focus on key 'challenged' services to identify and build strategic approaches	DoWOD		Q2		
1G.4	Continue to identify opportunities for innovative skill-mix redesign in addressing hard to recruit vacancies	DoWOD			Q3	
1G.5	Continue to develop local training opportunities through the Primary Care Academy and Dental Academy approaches adopted in North Wales	DoWOD			Q3	
1G.6	Support Bangor University to ensure that the experiences of students in the North Wales Medical School are high, thus encouraging graduates to remain in North Wales once qualified	DoWOD			Q3	
1G.7	Support all academic partners to ensure that the experiences of students across all professional groups are high, encouraging graduates from across healthcare sectors to remain in North Wales once qualified	DoWOD			Q3	
1G.8	Support ongoing and new initiatives to streamline national and international recruitment	DoWOD				Q4
1G.9	Continue to work with local education providers in Higher and Further Education to support 'Grow our Models' initiatives that ensure development opportunities are available for staff progression, and for others across North Wales, supporting a local Health Board workforce supply	DoWOD				Q4
1G.10	Continue to support flexible working and the redesign of services in order to stabilise the current workforce by optimising the way in which we work across services and localities	DoWOD				Q4
1G.11	Continue to reduce agency usage, reviewing fixed term and locum arrangements to provide a more sustainable workforce. Remain focused upon maintaining the improvements in nursing and midwifery staff turnover seen in 2023-24	DoWOD				Q4

1G.12	Ensure that enablers, such as digital, continue to be considered in respect to the improvements they offer for workforce skill-mix, recruitment and retention, as well as the improvements offered to service quality	DoWOD				Q4
1H: Quality Management System						
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	EMD	Q1			
1H.2	During 2024-25 the Health Board will complete the redesign of an appropriate Quality Management System (QMS) for deployment across the organisation	EMD			Q3	
1H.3	During this time, the Health Board will apply the emerging QMS to arising quality improvement initiatives, so that they follow a whole system QMS ethos, and to also learn so that the overall QMS deployment is successful	EMD			Q3	
1I: Welsh Language						
1I.1	Encouraging staff to make the most of the opportunities that improving Welsh language skills can provide within work and within their local communities	CEO*		Q2		
1I.2	Establishing a consistent approach to the delivery of the Welsh Language Standards, by adopting Standard Operating Procedures for specific compliance areas	CEO*			Q3	
1I.3	Aligning short and medium-term targets established within 'More than just words' with the Welsh Language Standards work programme, to enable the Health Board to focus delivery for specific areas and groups	CEO*			Q3	
1I.4	Incorporating an additional Service Level Agreement into the in-house translation demand, which will see the Health Board maximising its potential and expertise, providing a translation service to two health sector organisations in Wales	CEO*				Q4

*CEO as lead pending Exec Portfolio Confirmation

1J: Decarbonisation						
1J.1	Appoint to the post of Director of Environment	CEO		Q2		
1J.2	Continue to support our workforce to identify other decarbonisation opportunities for wider adoption	DoE				Q4
1J.3	Install onsite renewable energy generation facilities where viable to do so	DoE				Q4
1J.4	Prepare to be able to progress low carbon heat generation for non-acute sites larger than 1,000m^2 by 2030	DoE				Q4

1J.5	Ensure that all new medium and large freight vehicles procured after April 2025 meet the future modern standard of ultra-low emission vehicles in their class	DoE				Q4
1J.6	Progress the procurement of 100% REGO-backed electricity	DoE				Q4
1J.7	Continue the programme of replacing all existing lighting with LED lighting	DoE			Q3	
1J.8	Consider carbon impact when procuring services, sourcing locally where possible	DoE				Q4
1J.9	Continue to make the case for digital solutions that offer the potential of using less paper, in addition to the patient safety opportunities that digital solutions can provide	DoE				Q4

2: Developing strategy and long-lasting change						
2A: 10 year strategy						
2A.1	Collaboratively refresh Health Board well-being objectives in line with the requirements of the Well-being of Future Generations (Wales) Act 2015 and Social Partnership and Public Procurement (Wales) Act 2023	EDoT&SP			Q3	
2A.2	Establish a systematic approach, commencing with identified health needs, collation of evidence, design principles, and clinical and citizen reference groups	EDoT&SP			Q3	
2A.3	Collaboratively agree Health Board strategic 'Design Principles'	EDoT&SP	Q1			
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	EDoT&SP	Q1			
2A.5	Undertake conversations as scheduled, continually evolving the conversations based upon what has been heard in earlier events	EDoT&SP		Q2		
2A.6	Collation of a high level summary of findings, and commence identifying the key strategic opportunities to test with stakeholders	EDoT&SP		Q2		
2B: Clinical Services Plan						
2B.1	During 2024/25 the Health Board will develop a draft CSP that adequately incorporates the *known* clinical requirements of the next 3 years	EMD			Q3	
2C: Commissioning						
2C.1	Appoint a Director of Performance and Commissioning, with specific experience of whole system NHS commissioning	CEO		Q2		
2C.2	Design and commence implementation of a new organisational framework approach to commissioning and contract management, built upon learning from best practice across the UK	DoP&C			Q3	

2C.3	Review current block purchase NHS contracts, applying our commissioning framework	DoP&C			Q3	
2C.4	Monitor NHS contracts against the agreed Health Board commissioning framework	DoP&C			Q3	
2C.5	Support operational teams within the organisation to apply commissioning principles to services provided directly by the Health Board, using best practice 'demand and capacity' modelling and prioritising additional support to areas of highest clinical need	DoP&C				Q4
2D: Capital Priorities – supporting change to happen						
2D.1	Llandudno Orthopaedic Centre. In 2024-25 the Health Board will deliver the Llandudno Orthopaedic surgical hub, with surgery commenced on site, delivering 1,900 orthopaedic procedures per year when fully operational	EDoT&SP				Q4
2D.2	Ablett replacement programme. In 2024-25 the Health Board will complete the business case for the construction of the Adult and Older Persons Mental Health facility on the Glan Clwyd Hospital site, aiming to commence construction within 2024-25, and continuing into 2025-27	DoE				Q4
2D.3	Royal Alexandra Hospital. In 2024-25 the Health Board will continue to work with partners, including Denbighshire County Council, to complete a review of the proposed redevelopment of the Royal Alexandra Hospital in order to resubmit the proposal for capital funding support. Work in subsequent years will be scoped in line with the proposal outcome	DoE (EDoF)				Q4
2D.4	Estate disposals. In 2024-25 the Health Board will identify an approach that enables the Board to consider disposal of estate that is no longer fit for purpose or required	DoE (EDoF)		Q2		
2E: Digital, Data and Technology						
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.	CDIO		Q2		
2E.1b	As well as standardising the delivery of care and associated operational arrangements across the Health Board the EHR will replace a number of currently unsupported applications, developing and agreeing a wider digital plan for North Wales with the EHR at its core.	CDIO			Q3	
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	CDIO		Q2		
2E.3	Transformation of the DDaT Operating Model. 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.	CDIO				Q4

2E.4	Essential Services Programme. The Health Board will upgrade infrastructure technology to prevent major IT failures and protect against cyber-attack.	CDIO				Q4
2E.5	The DDaT team will be active contributors to the activity outlined in other priorities within the plan including *5D Intelligence Led* and *5E Learning Organisation*	CDIO				Q4
2E.6	Major Projects. The Health Board will work on the following priority projects which for which the Health Board is dependent on to continue operating:	CDIO				Q4
2E.6a	Patient Numbering/WPAS : Providing clinical staff with a patient-centric view of information to support high quality care to support patient flow and clinical decision making.	CDIO				Q4
2E.6b	Optimisation of Existing Systems: Optimising the functionality of our existing systems, making sure that the system meets user expectations and provides maximum value	CDIO				Q4
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	CDIO				Q4
2E.6d	Therapy Manager Replacement: Replacement of our at risk Therapy Manager system	EDoTHS				Q4
2E.6e	Mental Health System: Provide MH with a suitable system for their needs and to enable patient information to be captured effectively and shared with partners appropriately.	CDIO				Q4
2E.6f	Joint Medical School: Improve WiFi and network connectivity providing blanket coverage and high-speed reliable connectivity into Medical School locations within the BCU Estate.	CDIO				Q4
2E.6g	Electronic Prescribing Management System (ePMA): Paper medicines charts and prescriptions will be replaced by a digital prescribing and medicines administration system Pan BCU	CDIO				Q4
2E.6h	Teledermoscopy: Implement a specialist digital image storage and viewer to enable dermatologists to assess suspected skin cancer without the need for a face-to-face	CDIO				Q4
2E.6i	Attend Anywhere/Virtual Consultations: Increase in the number of pathways where appointments and reviews are carried out virtually	CDIO				Q4
2E.6j	Single Sign on: Further roll-out beyond the ED's (Phase 1) to clinical areas such as wards/clinics etc.	CDIO				Q4
2E.6k	Cancer Network Information System Cymru (CANISC): To recreate MDT forms, and cancer dataset forms, for clinical management. As well as specific forms for palliative care and screening.	CDIO				Q4
2F: Prioritisation						
2F.1	Refresh current Prioritisation Framework approach used within the Health Board, to incorporate local learning gained during 2023-24 and the learning and approaches in place in other NHS organisations.	EDoT&SP		Q2		
2F.2	Formalise the refresh into an approvable Prioritisation Policy for the Health Board	EDoT&SP		Q2		

2G: Effectively Delivering Major Change						
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 outlines those areas *currently* thought to be of greatest priority for inclusion in the major change portfolio	EDoT&SP	Q1			
2G.2	Finalise and agree the process of regular review of the major change portfolio to ensure it continues to be focused upon the areas when this approach offers greatest value, and with regular reporting of impact	EDoT&SP		Q2		
2H: Strengthening Planning						
2H.1	Implement the agreed action plan produced in response to the Planning Review to enhance capacity and capability for planning	EDoT&SP				Q4
2H.2	Undertake further work with staff and stakeholder to refresh the design of the planning system in the Health Board. This will build upon the Integrated Planning Framework. This will specifically include building operational planning capacity	EDoT&SP		Q2		
2H.3	Undertake a review of current and future commitments, drawing out the planning capacity needed to plan and implement it. This will form a baseline from which feasibility, risk and inter-dependencies can be assessed	EDoT&SP		Q2		
2I: Finance Governance Environment						
2I.1	Enhance and monitor the Financial Governance Environment, key elements being continual refinement of the recently endorsed Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions	EDoF				Q4
2I.2	In accordance with Audit Wales and Internal Audit support the enhancement of the control environment through active participation in the setting of the Internal Audit Plan, in conjunction with the Audit Committee of the Health Board	EDoF			Q3	
2I.3	To ensure recommendations from review of the financial governance control environment by internal audit are implemented, supporting the end of year Head of Internal Audit Opinion offering assurance over the Health Board having a sound, strong system of internal control	EDoF			Q3	
2I.4	To develop further the training and support offered to managers in application of the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, with specific focus on training in relation to procurement in securing value for money and engagement with the wider market in placement of orders for goods and services	EDoF			Q3	
2I.5	A key component of the Procurement of goods and services centres upon the review of single tender waiver and contract approval process controls, including Welsh Government approval where required,	EDoF				Q4

	and compliance with those controls to include approval of contracts and appropriate segregation of duties					

2J: Early identification and support of Challenged Services						
2J.1	Reflection exercise to identify the common themes and flags identified from addressing the first tranche of challenged services	EMD	Q1			
2J.2	Learn from Hywel Dda Health Board, who have already undertaken similar design work	EMD	Q1			
2J.3	Taking the activities above, commence a clear triangulation approach in the Health Board that is designed to identify challenged services at an earlier point	EMD		Q2		
2J.4	Engage with the national work looking at 'fragile' or 'challenged' services that forms part of the work programme of the clinical variation and service configuration workstream within the Value and Sustainability Board work	EMD		Q2		

3: Creating compassionate culture, leadership and engagement						
3A: Compassionate Leadership and Organisational Development						
3A.1	Develop and commence the implementation of the Cultural Change Programme	EDoWOD		Q2		
3A.2	Approve and implement the organisation's Leadership Development Framework	EDoWOD	Q1			
3A.3	Introduce approaches to enable a Board and Committee focus on staff experience, including staff experience stories	EDoWOD			Q3	
3A.4	Support the establishment and effective working of the new People and Culture committee	EDoWOD	Q1			
3B: Citizen Engagement						
3B.1	The Health Board will build a wide-ranging engagement programme with communities across North Wales, providing opportunities to ask questions and find out more about the plans for the future	DoPEC		Q2		
3B.2	A Citizens Experience Report, produced every other Board meeting, will inform Board members about the key themes of interest and concern to the public	DoPEC				Q4
3B.3	An Engagement Working Group will act as a catalyst for stronger cooperative working across the organisation and with independent colleagues and citizens (eg Llais, Forum Chairs). It will build genuine coproduction in engagement and patient experience and bring together expertise and knowledge. The Group will develop the *Betsi Way: Engagement* and embed this across the organisation	DoPEC			Q3	
3B.4	The Health Board will learn from engagement with families as well as patients themselves, listening to family stories during reviews, understand what families continue to need and how they can be routinely involved and build an approach which becomes embedded	DoPEC			Q3	

3C: Being a Good Partner						
3C.1	The Health Board will review attendance at Regional Partnership Board (RPB) and Public Service Boards (PSBs) to ensure that attendees have the required delegated authority to allow consistent attendance and prioritisation of, and effective contribution and decision making in, those fora	DoPEC		Q2		
3C.2	The Health Board will review internal governance processes to ensure that, where possible, they dovetail and complement RPB and PSB governance processes to allow timely decision making, whilst still maintaining appropriate internal scrutiny	DoCG		Q2		
3C.3	The Health Board will seek to achieve greater integration of services, shared approaches to improving the wellbeing of the population and innovative and transformative ways of working that tackles much wider social, economic and environmental factors. Working in this way will enable a shared values approach, where community is at the heart of decision-making	EDoPH				Q4
3C.4	The Health Board has already adopted a refreshed approach to using the Stakeholder Reference Group for advice and guidance as early as possible, with discussions including the contents of this three year plan, and on the next phases of special measures. The Health Board will continue to grow this approach with the Stakeholder Reference Group during 2024-25	DoPEC		Q2		
3C.5	The Health Board will continue to make improvements in involving Local Authority colleagues in the creation of our operational and strategic plans, including our Annual or 3 year plans	EDoTSP		Q2		
3C.6	The Health Board will establish regular stakeholder briefings and listen to partners through an annual survey. This will be in addition to the routine update mechanisms already in place. The feedback will shape and improve how the Health Board works with its partners	DoPEC			Q3	
3C.7	The Health Board will explore opportunities to prioritise collaborative activities that offer the potential to address mutual challenges in ways that have greater impacts for North Wales residents. These include (but are not limited to) opportunities to procure more locally and to co-locate or position services in locations that best meet population needs whilst simultaneously improving value and efficiency for the partners involved	DoPEC				Q4
3C.8	The Health Board will fully commit with the expectations of the Social Partnership and Public Procurement (Wales) Act, recognising it to be an opportunity to further deepen its commitment as an anchor institution	DoPEC				Q4

4: Improving quality, outcomes and experience						
4A: Patient Experience						
4A.1	Expand the offer to patients to complete Patient Experience questionnaires during, or immediately after Emergency Department visits. This will include the use of SMS text invites building upon the learning from outpatients	EDoN		Q2		
4A.2	Test the use of feedback mechanisms in more "real time" ways for acute hospital inpatients, using a few wards to test different approaches	EDoN			Q3	
4A.3	Embed a system of feedback analysis that allows the recognition of good practice (to be disseminated) and early warning opportunities where additional intervention and support may be required, and demonstrate it is being used	EDoN			Q3	
4A.4	Embed feedback reporting for public, Board and partner assurance	EDoN			Q3	
4B: Prevention						
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)	EDoPH	Q1			
4B.2	Immunisation. The Health Board will continue to reduce variation and improve uptake of immunisations across the life-course, encouraging local teams to signpost patients, staff, families and carers to trusted sources of information on immunization. Currently, cases of Measles are on the increase and the Health Board is delivering targeted campaigns for increased delivery of MMR vaccination levels	EDoPH		Q2		
4B.3	Well North Wales and associated programmes. The Health Board will continue to develop the framework that makes the case for keeping people healthy utilising outcomes from the ICL workshops to work with partners to develop system approaches to delivery of wellbeing solutions in our communities	EDoPH		Q2		
4B.4	Smoking remains the biggest cause of preventable ill health and whilst progress has been made in North Wales, continued work to increase referrals of smokers to the Help Me Quit (HMQ) Smoking Cessation Services will support a reduction in those smoking and the delivery of a smoke free Wales by 2030. The Health Board will continue to deliver to the Smoke Free Regulations (2020) and the Board's No Smoking Policy	EDoPH			Q3	
4B.5	Healthy Weight. The Health Board will continue to implement a Whole System Approach to the Healthy Weight Delivery plan with key priorities of influencing the spatial planning system through local delivery	EDoPH			Q3	

	plans and planning applications, influencing the food environment in workplaces and educational establishments and through maintaining the delivery within the All Wales Weight Management Pathway					
4B.6	Physical activity. The Health Board will continue to work with partners to support and encourage communities, including the Health Board's workforce, to think about physical activity as being a normal part of their daily lives	EDoPH			Q3	
4B.7	Alcohol – The Health Board together with partners will continue to deliver the North Wales Alcohol Strategy 2020-24 and contribute to the refresh	EDoPH			Q3	
4B.8	Respond to the Gypsy, Roma and Travellers Needs Assessment and identify the opportunities to improve health for those in vulnerable communities including Asylum Seekers and Refugees; those in contact with the Criminal Justice System; and those with Learning disabilities	EDoPH			Q3	
4B.9	Corporate Parenting. The Health Board will commit to the Welsh Government Corporate Parenting Charter and consider ways in which it can support care experienced children and young people to have the same opportunities in life as all children and young people in Wales	EDoN				Q4
4B.10	Mental well-being. Through supporting delivery against the North Wales Together for Mental Health Strategy the Health Board will aim to improve mental health and well-being across all ages, and to promote the 5 Ways to Wellbeing for service users and staff	EDoPH				Q4
4B.11	Continue to develop the work of the Health Board pathways of care team to maximise prevention and a public health approach within them	EDoPH				Q4
4B.12	The Health Board will continue to implement plans which support elimination agendas including Hepatitis B & C, and Tuberculosis	EDoPH				Q4
4B.13	As an anchor organisation with 20,000 employees the Health Board will encourage employees and their families to lead healthy lifestyles since doing so will have a big impact upon the health of the North Wales population	EDoWOD				Q4
4C: Primary Care and Early Intervention						
4C.1	Continue to implement the national 'Primary Care Model' for Wales, and engage fully in the national Primary Care Programme	COO (EDTSP)	Q1			
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	COO (EDTSP)	Q1			
4C.3	Continue to develop a pathways of care approach, working with primary care professionals to ensure they have access to the resources they need so that secondary care referrals only occur where they will add value to the patient	COO (EDTSP)		Q2		

4C.4	Continue to take a 'Primary Care Academy' approach to support healthcare professionals to develop advanced skills within primary care that allow skill-mix changes and increased workforce stability	COO (EDTSP)			Q3	
4C.5	Continue work to improve access to primary care dentistry	COO (EDTSP)		Q2		
4C.6	Continue to provide sustainability support to contractors that are in difficulty	COO (EDTSP)	Q1			
4C.7	Progress our strategic approach to a mixed model of primary care that supports contractors to remain independent contractors, and identifies ways in which directly managed practices can innovate, support independent contractor 'neighbours', test new ways of working, and increase involvement of primary care in research	COO (EDTSP)		Q2		
4C.8	Implement the new GMS Contract Assurance Framework	COO (EDTSP)		Q2		
4C.9	Improve Board visibility of primary care performance data	DoP&C			Q3	
4C.10	Continue to develop proposals that address areas of poor primary care estate impacting upon care delivery, including the proposals currently progressing in Penygroes (Canolfan Lleu), in Conwy West locality, in Bangor, and in Holyhead	COO (EDTSP)		Q2		
4C.11	Continue to work with Primary Care providers in North Wales to prepare suitable training environments for Medical Students from the North Wales Medical School	COO (EDTSP)			Q3	
4D: Community Care and Clusters						
4D.1	Implement the community resilience, social prescribing and early intervention programmes of care plans outlined within individual cluster plans	COO (EDTSP)	Q1			
4D.2	Roll out of the All Wales Diabetes Prevention programme, targeting the avoidance of developing type 2 diabetes	EDoPH				Q4
4D.3	Continue developing community-based support and engagement approaches for people living with dementia and their carers	COO (EDTSP)		Q2		
4D.4	Increasing implementation of the Discharge to Recover then Assess (D2RA) model[1], focusing upon what matters most to the individual, maximising recovery and independence and reducing the over-prescription of statutory services	COO (EDTSP)		Q2		
4D.5	Continue and expand the use of cluster-based Care Home support services that can provide timely assessment in order to minimise otherwise avoidable hospital conveyances	COO (EDTSP)			Q3	
4D.6	Further development of 'one stop' models of care to enhance the delivery of care for people with diabetes and related conditions	COO (EDTSP)				Q4

4E: Planned Care						
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	COO (EMD)	Q1			
4E.2	Make improvements in the way that appointments and procedures are booked, to make this more efficient and more convenient and accessible for patients	COO (EMD)			Q3	
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	COO (EMD)	Q1			
4E.4	Maintain, and in places increase, momentum in applying Getting It Right First Time (GiRFT) recommendations. Planned care areas where GIRFT recommendations are being progressed include general surgery, ophthalmology, urology, gynaecology and orthopaedics, where there are too many patients waiting long periods for treatment. This will include the roll out of High Volume Low Complexity (HLVC) theatre lists	COO (EMD)		Q2		
4E.5	Conclude the new build areas and refurbishment of Llandudno Hospital to create an elective orthopaedic centre, with the first patients scheduled to receive treatment during 2024-25. Alongside the Health Board is progress work to design a phase 2 expansion of the Llandudno elective surgical hub development	COO (EMD)			Q3	
4E.6	Continue work to address 'challenged' planned care services, including in orthodontics and dermatology. Improvement plans in these areas are covered in more detail under Priority 4J	COO (EMD)	Q1			
4E.7	Undertake further work to understand the increase in referral rates in North Wales in comparison to benchmarking information from other Health Boards. In doing so the Health Board will specifically seek to understand the impact of implementing the Community Health Pathways platform in other Health Board. As an organisation seeking to apply the best evidence to all decision making the Health Board will agree an implementation plan for Community Health Pathways if the evidence of impact supports this including incorporating the learning of Health Boards that have already deployed it	COO (EMD)				Q4
4E.8	Continue to embed use of the redesigned pathways referred to above, which have been focused upon long-term conditions, and which take an end to end approach covering from prevention through to tertiary care where applicable. In addition during 2024-25 the Health Board will continue the implementation of those pathways currently in development, including diabetes, and will review the impact of this approach	COO (EMD)		Q2		
4E.9	Undertake work to identify the potential for different service configurations and the impact they would have for those living with multiple long-term conditions, seeking to deliver more coordinated care resulting in less hospital visits. This will inform the work covered elsewhere on our 10 year strategy (priority 2A), and upon value and sustainability (priority 1E) in particular. Depending upon the findings	COO (EMD)				Q4

	and recommendations of this work, the Health Board will seek to implement a different offer for those with multiple LTCs during the 2025-26 year					
4E.10	The Health Board has made progress in modelling 'Demand' against 'Capacity' (D&C modelling) in planned care, and in factoring in productivity opportunities arising from GIRFT best practice and other benchmarking but recognises that it would be beneficial to further mature our approach to this. During 2024-25 the Health Board will take the opportunity of support from colleagues in NHS Wales to further develop these skills and capacity. This will include local use of the benchmarking data that will be provided to us as part of the work being undertaken by the national Value and Sustainability Board	COO (EMD)		Q2		
4E.11	Actively monitor the impact of additional planned care and sustainability funding support to ensure it makes maximum impact in delivering against planned care ministerial priorities. This includes ensuring that applying principles such as those laid out by GIRFT have been maximised in service areas before committing additional resource	COO (EMD)		Q2		
4E.12	Commit 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	COO (EMD)		Q2		
4E.13	The Health Board has made significant improvements in waiting times in some areas, for example in prostate cancer referrals, by using approaches that offer patients direct access to secondary care diagnostic tests before being seen by specialist clinicians. Whilst considering this is a key component of Health Board pathway re-design, during 2024-25 the Health Board will explore further opportunities to implement 'straight to test' in areas where wider pathway redesign is not currently scheduled	COO (EMD)			Q3	
4F: Cancer Care						
4F.1	Maintain access standards for treatment within 62 days by the end of 2025	COO (EMD)				Q4
4F.2	Implement our clinically led 'Cancer services road map' for the Health Board, and in so doing contribute to the overall shaping of the Health Board 10 year strategy	EMD				Q4
4F.3	Eliminate the backlog of suspected cancer referrals in dermatology, including implementing the use of Teledermoscopy	COO (EMD)				Q4
4F.4	In Urology, build on the success of the Health Board mpMRI biopsy pathway redesign where diagnostic times have been significantly shortened, using this impetus to revise our overall future model of urology cancer care and additional pathways	EMD			Q3	
4F.5	In colorectal cancer, sustain improvement in endoscopy waiting times made during 2023-24, and review Health Board colorectal pathways including undertaking work to more closely align workforce	COO (EMD)			Q3	

	requirements to support future demand. This will include building on the successes of nurse led triage models of care within the Health Board					
4F.6	Progress with implementing Postmenopausal Bleeding (PMB) clinics in gynaecology on each acute hospital site	COO (EMD)			Q3	
4F.7	In Oncology the Health Board will further develop the sustainable services plan for oncology, focusing upon workforce strategy	EMD		Q2		
4G: Urgent and Emergency Care						
4G.1	Alignment of the local Six 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	COO (EDTHS)	Q1			
4G.2	Improvements in Same Day Emergency Care Services (SDEC), including improved consistency across the whole Health Board, increased activity in SDEC, and an increase in ambulance attendances directed straight to SDEC	COO (EDTHS)		Q2		
4G.3	Improvements in ambulance and non-ambulance use of Minor Injury Units (MIU's)	COO (EDTHS)			Q3	
4G.4	A continued focus upon reducing inpatient length of stay (LOS) through Pathway of Care Delay initiatives, including reducing delays in assessment	COO (EDTHS)		Q2		
4G.5	Expansion of community pharmacy services as an alternative to the use of urgent care GP and hospital services	COO (EDTHS)			Q3	
4G.6	Conclude a review of the feasibility of consolidating patients that are medically fit for discharge in support wards optimised for reablement rather than medically-focused care	COO (EDTHS)		Q2		
4G.7	Aligned to bringing the local Six Goals programme into a firmer change control environment, under the PMO Major Change Portfolio, the Health Board will draw in the expertise of NHS Wales colleagues to develop a refreshed five year improvement plan for Urgent and Emergency care in the Health Board	COO (EDTHS)				Q4
4G.8	Improvements in ambulance handover times, operating within agreed system tolerances and in alignment with Full Hospital Protocols in North Wales	COO (EDTHS)		Q2		
4H: Diagnostics						
4H.1	The Health Board will continue to implement recruitment and retention plans in radiology, ultrasound, cardiology diagnostics and neurophysiology	COO (EMD)		Q2		
4H.2	The Health Board will identify additional 'straight to test' opportunities and implement them within 2024-25	COO (EMD)		Q2		

4H.3	The Health Board will work regionally and nationally to progress critical digital infrastructure solutions in Pathology and Radiology	EDoTHS		Q2		
4H.4	For 2024-25 the Health Board will procure additional insourced endoscopy provision to bridge the gap between internal Health Board capacity and endoscopy demand	COO (EMD)			Q3	
4H.5	The Health Board will, within quarter one of 2024-25, finalise a detailed plan to address internal Health Board endoscopy provision in order to reduce reliance upon additional insourced endoscopy provision. That plan will include a robust workforce plan that maximises non-medical skill-mix, trajectories for internal increases in capacity to inform the need for ongoing additional insourced contracted activity, and attainment of JAG (Joint Advisory Group on GI Endoscopy) accreditation	COO (EMD)			Q3	
4H.6	The Health Board will maintain progress on delivering business cases for Nuclear Medicine enhancements and PET scanning in North Wales	EDoTHS)			Q3	
4H.7	The Health Board will continue to maximise laboratory diagnostic capacity, optimize diagnostic pathways and explore increasing the use of digital solutions to best meet demand on services	COO (EMD)				Q4
4H.8	In medical physics, the Health Board is currently progressing capital proposals to improve nuclear medicine provision in North Wales, including the delivery of Positron Emission Tomography (PET) scanning within North Wales	EDoTHS				Q4
4I: Adult Mental Health, Learning Disability, CAMHS and Neurodevelopment						
4I.1	**AMH**: An improved approach to Crisis Resolution for Community Mental Health Teams	EDoTHS	Q1			
4I.2	**AMH**: Development of an Eating Disorders Service providing Tier 2 and emergency provision, in line with Royal College of Psychiatry standards	EDoTHS				Q4
4I.3	**AMH**: Development of perinatal services to support compliance with the Royal college of Psychiatry perinatal community standards	EDoTHS				Q4
4I.4	**AMH:** Introduction of a trauma informed approach to the inpatient and community aspects of the North Wales Forensic Service and Specialist Rehabilitation Services	EDoTHS				Q4
4I.5	**AMH**: Development of the Early Intervention in Psychosis Service	EDoTHS			Q3	
4I.6	**AMH:** Completion of anti-ligature work	EDoTHS				Q4
4I.7	**AMH:** Local Primary Mental Health Support Services Pathways development work	EDoTHS				Q4
4I.8	**CAMHS**: Progress plans to expand our crisis service to include periods of out-of-hours provision	COO (EDTSP)		Q2		
4I.9	**CAMHS**: Continue to reshape our delivery model to provide more in-reach into primary care settings and school settings, seeing children closer to home	COO (EDTSP)			Q3	

4I.10	**CAMHS**: Expand the CAMHS specialist community intensive support service to support young people and their families in their homes as an alternative to hospital admissions	COO (EDTSP)			Q3	
4I.11	**CAMHS**: Develop transition pathways for long-term conditions within childhood	COO (EDTSP)			Q3	
4I.12	**CAMHS:** Continue to develop, with partners, the 'Right Door Approach'	COO (EDTSP)			Q3	
4I.13	**CAMHS:** Reinforce and embed work undertaken with Adult Mental Health services to improve transition between services	COO (EDTSP)			Q3	
4I.14	**ND:** Progress the development of a ND model for North Wales that better balances demand and capacity	COO (EDTSP)		Q2		
4I.15	**ND:** Reduce long waits within the service by implementing the agreed ND model	COO (EDTSP)			Q3	
4I.16	**ND:** Explore less medicalised approaches to triage assessment and for addressing lower acuity presentations in order to help balance demand and capacity, leading to shorter waits	COO (EDTSP)			Q3	
4I.17	**LD:** The Health Board will progress delivery of the national action plan including: • early intervention and crisis response providing access to prudent specialist learning disability healthcare close to home • increasing access to specialist care that is reflective of current best practice improving timely transition from specialist hospital care to community settings	COO (EDTSP)				Q4
4I.18	**LD**: The Health Board will focus upon increasing service provision to reduce avoidable and premature deaths and reduce health inequalities in those learning with learning disabilities	COO (EDTSP)		Q2		
4J: Currently Challenged Services						
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	COO (EMD)	Q1			
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	COO (EMD)	Q1			
4J.3	**Dermatology:** Establish the viability of an expanded GPWSI (GP with special interest) model for referrals to secondary care that could be managed differently, for triage of referrals, and for the provision of minor operations	COO (EMD)		Q2		
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	EMD	Q1			

4J.5	**Oncology**: Implement nursing staff rotational opportunities to improve cover arrangements and skill mix	EMD		Q2		
4J.6	**Oncology**: Implement further offers of non-medical prescriber training	EMD				Q4
4J.7	**Oncology:** During the first half of 2024-25, complete the review of all current cancer regimes to ensure all of those that are suitable for home delivery are being offered in that way	EMD		Q2		
4J.8	**Oncology:** Progress plan to deliver more anti-cancer therapies from Ysbyty Gwynedd for residents living in the West of North Wales	EMD			Q3	
4J.9	**Oncology**: Complete planning to repatriate the delivery of Stereotactic Ablative Radiotherapy (SABR) into the Health Board, reducing travel requirements as patients currently receive this treatment in England	EMD				Q4
4J.10	**Oncology**: Continue to expand the use of 'Attend Anywhere' software, delivering greater convenience for appropriate patients and improving clinic capacity	EMD				Q4
4J.11	**Oncology:** Build on successful recruitment to the first Consultant Radiotherapist post to ensure post holder is supported to achieve training goals within 18 months of appointment	EMD				Q4
4J.12	**Ophthalmology:** Collaboratively agree a service model for ophthalmology in North Wales that delivers a sustainable service footprint	COO (EMD)		Q2		
4J.13	**Ophthalmology:** Continue to monitor service performance against GIRFT standards in Ophthalmology, challenging areas of variance before then proceeding to identify and then implement improvements in response	COO (EMD)		Q2		
4J.14	**Ophthalmology:** Progress to implement fully the Optometrist Train and Treat higher certification training programme, in order to then maximise non-secondary care pathway opportunities	COO (EMD)		Q2		
4J.15	**Ophthalmology:** Expand the utilization of patient feedback questionnaires to support the redesigned clinical pathways in Cataract care, Glaucoma care, and Macular Degeneration care. This relates to both Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMS)	COO (EMD)			Q3	
4J.16	**Orthodontics:** Continue with our recruitment to key clinical roles, implementing revised workforce models that increase opportunities for recruitment and retention	COO (EMD)		Q2		
4J.17	**Orthodontics:** Consider alternative treatment pathways and packages to maximise the combination of both local and regional provision	COO (EMD)			Q3	
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	COO (EMD)	Q1			
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	COO (EMD)	Q1			

4J.20	**Plastic Surgery:** Confirm the effectiveness of revisions in waiting list management for visiting clinicians, including initial triage by Health Board clinicians. This includes identifying those waiting longer than clinically appropriate and making necessary expedite arrangements	COO (EMD)		Q2		
4J.21	**Plastic Surgery**: Implement additional dressings clinics to address current variation in provision across North Wales	COO (EMD)		Q2		
4J.22	**Plastic Surgery:** Once assured that above priorities are fully implemented and resilient, commence work to agree the future longer-term model for plastics provision for residents in North Wales	COO (EMD)			Q3	
4J.23	**Urology**: Progress implementing GIRFT recommendations, monitoring impact	EMD			Q3	
4J.24	**Urology**: Increase the delivery of diagnostic and day case urology on all three sites, aligned to providing care closer to home principles	EMD		Q2		
4J.25	**Urology:** Monitor revised administration processes to ensure they deliver their intended outcomes of better supporting referral, pathology and radiology result management	EMD		Q2		
4J.26	**Urology**: Implement delivery of a complex stone surgery, female urology and andrology service in Wrexham	EMD			Q3	
4J.27	**Urology:** Stabilise the delivery of the pelvic oncology service in Bangor	EMD			Q3	
4J.28	**Urology:** Continually review the delivery of prostatectomy services that cannot currently be delivered in North Wales, and use the learning from this to inform a viable plan and timescales for robotic-assisted urology provision in North Wales	EMD				Q4
4J.29	**Vascular:** Continue to strengthen the recording of outcomes and learning points at Morbidity and Mortality meetings	EMD	Q1			
4J.30	**Vascular:** Review hub and spoke vascular sites in order to identify areas of good practice as well as areas for improvement	EMD	Q1			
4J.31	**Vascular**: Develop a Memorandum of Understanding (MOU) to support increased regional working	EMD		Q2		
4J.32	**Vascular**: Create and launch a vascular dashboard reporting performance activity and outcomes, and use this to better inform service planning	EMD		Q2		
4J.33	**Vascular**: Increase the collection of patient reported experience data in vascular services, and publish this	EMD		Q2		
4J.34	**Vascular**: Develop a refreshed vascular plan covering the next three years to enable structured clinical services planning	EMD			Q3	
4J.35	**Vascular**: Build integrated performance, activity and outcomes dashboard for vascular, to better inform service planning	EMD			Q3	

4J.36	**Stroke**: Implement improvement plans that enable each of our health communities to achieve a level B for Sentinel Stroke national Audit Programme standards	COO (EDTHS)				Q4
4J.37	**Stroke:** In line with the national stroke programme, implement digital solutions to aid the evaluation of imaging and decisions for reperfusion therapies including thrombolysis and thrombectomy for patients with symptoms of stroke	COO (EDTHS)			Q3	
4J.38	**Stroke:** Continued recruitment and retention of key clinical posts for medical and nursing	COO (EDTHS)			Q3	
4K: Women's Services						
4K.1	Supporting Local Delivery of the Women's Health Plan for Wales	COO (EDoN)				Q4
4K.2	Implementation of the Maternity and Neonatal Safety Support Programme recommendations	COO (EDoN)				Q4
4K.3	Progression and implementation of national recommendations including Mothers and Babies: Reducing Risk through Audits ad Confidential Enquiries (MBRRACE)	COO (EDoN)				Q4
4K.4	Preparing for the introduction of the Digital Maternity Cymru Solution	COO (EDoN)				Q4
4K.5	Implementing the North Wales Women's Planned Care and Cancer Recovery Plan in line with GIRFT recommendations	COO (EDoN)			Q3	
4K.6	Supporting the implementation of the Preconception Strategy and population health work streams	COO (EDoN)				Q4
4K.7	Supporting Healthy Start by raising awareness and reducing inequality	COO (EDoN)			Q3	
4K.8	Raising awareness of, and supporting the effects of, menopause on women's physical, emotional, mental and social well-being	COO (EDoN)			Q3	
4K.9	Reviewing the best configuration for endometriosis services in North Wales	COO (EDoN)				Q4
4L: Children						
4L.1	Maintain ways to provide safe, needs focused care as close to home as possible	CEO*	Q1			
4L.2	Continue to progress the strong work in children's safeguarding services that the Health Board and partners have already prioritised retaining strong adherence to the principles of the All-Wales Safeguarding Multi Agency Procedures	CEO*		Q2		
4L.3	Establish the Health Board Charter for Children and youth leadership board with a remit to listen to, consult and engage with children across North Wales to better understand their needs	CEO*		Q2		
4L.4	Focus further work on the integration of services for Children with Complex Needs, improving access and timeliness of provision	CEO*			Q3	

4L.5	Maintain engagement with the national programmes to improve and develop services for children with health and well-being concerns and the needs of children and families related to growing awareness of neurodiversity	CEO*				Q4
4L.6	Progress the UNICEF's Baby Friendly Initiative (BFI); the Healthy Weight, Healthy Wales Initiative; The Right Door Approach, and the National Immunisation Framework, as well as the Health and Social Care Ministerial Priorities	CEO*				Q4
4L.7	Signing of Corporate Parenting Charter and consider ways of implementing the charter commitments	CEO*				Q4

*CEO Leading with Nominated IHC Director Support

4M: Pharmaceutical Services						
4M.1	Consider the RPS review of the provision of hospital clinical pharmacy services within the context of the Health Board to identify those opportunities identified that would make the biggest differences to patient experience and outcomes	COO (EMD)		Q2		
4M.2	Establish a strategic '*Medicines Value Group*' to provide over-sight and direction to implementation and system cascade for full system medicines value programmes. This will include consideration of the evidence base that can be drawn into current and projected financial opportunities and patient outcome impact assessments	COO (EMD)			Q3	
4M.3	Transform how some of the most innovative and life-saving medicines including cancer therapies, intravenous antibiotics, radiopharmaceuticals and parenteral nutrition are prepared by commencing a five-year '*Transforming Access to Medicines (TRAMS)*' programme. This will not only focus on the technical pharmacy services itself, but will also be an investment in people, providing the opportunity for professional leadership and innovation in pharmaceutical treatments	COO (EMD)				Q4

5: Establishing an effective environment for Learning						
5A: University Partnership						
5A.1	Continue to work closely with colleagues at Bangor University to ensure that the first intake of students to the North Wales Medical School progresses smoothly	EMD		Q2		
5A.2	Develop joint academic posts that underpin the teaching and research agendas (see Priority 4C)	EDoWOD				Q4
5A.3	Continue to work with Bangor University to support training of Physician Associates, and subsequent placement within the Health Board	EMD				Q4
5A.4	Work with Bangor and Wrexham Universities to identify advanced learning opportunities for other healthcare professionals, and non-clinical staff, to progress academic knowledge.	EDoWOD				Q4

5A.5	Undertake further work to ensure that the Primary and Dental Academies in North Wales are supported to thrive and develop as Centres of Excellence	COO (EDTSP)			Q3	
5B: Research, Development and Innovation						
5B.1	Continue to increase commercial research and innovation activity	EMD	Q1			
5B.2	Sustain and increase clinical research facility activity in early phase trials	EMD		Q2		
5B.3	Develop and deploy an Innovation Pathway aligned to our strategy and strengthening of planning priorities already outlined earlier in the Plan	EMD		Q2		
5B.4	Increase honorary research appointments and clinical academic posts (see priority 5C)	EMD			Q3	
5B.5	Generate additional RD&I commercial opportunities in device and technology development, learning from successful models elsewhere	EMD				Q4
5B.6	Build further upon a number of already research-rich primary care practices to expand the opportunity that directly managed primary care can provide in research and innovation delivery	EMD				Q4
5C: Academic Careers						
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	EDoWOD	Q1			
5C.2	The Health Board will then explore how to resource the created proposal in order to proceed to implementation	EDoWOD		Q2		
5D: Intelligence Led						
5D.1	Establish a Health Board data quality and governance forum	CDIO	Q1			
5D.2	Introduce a data kite mark system	CDIO		Q2		
5D.3	Further develop BCU's data warehouse, broadening the range of datasets available	CDIO			Q3	
5D.4	Undertake a skills / training needs analysis to inform a data literacy workplan	CDIO			Q3	
5D.5	Develop organisational capability around demand and capacity analysis and planning	CDIO		Q2		
5D.6	Identify priority areas and improve clinical engagement with data using CHKS as the chosen clinical benchmarking tool	CDIO	Q1			
5D.7	Implement dashboard standards, applying design principles and embedding data stewardship	CDIO				Q4

5E: Learning Organisation						
5E.1	The Health Board will complete its review of how the organisation investigates and then learns from, serious incidents	EDoN	Q1			
5E.2	The Health Board will then implement change to address the potential improvements identified through the review. In doing so, the Health Board will apply the principles of the emerging Quality Management System redesign, further increasing the opportunity to implement learning	EDoN				Q4

Teitl adroddiad: ***Report title:***	Integrated Quality Management System (QMS) Framework
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	30th May 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with an update on the development of a Quality Management System Model and Framework
Argymhellion: ***Recommendations:***	The Board is asked to note this report and support the approach to implementation of a Quality Management System for the Health Board.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director Angela Wood, Executive Director of Nursing and Midwifery Gareth Evans, Executive Director of Therapies and Health Sciences
Awdur yr Adroddiad: ***Report Author:***	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:

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Outcome 1 – Building an effective organisation Outcome 5 – Establishing an effective environment for learning
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 all healthcare organisations in Wales to secure improvements in the quality of services we provide, through a system wide way of working. To enable this, the Health and Care Quality domains must be embedded with a culture of continuous learning and improvement.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	N/A

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?***	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:*** Integrated Quality Management Framework	

Integrated Quality Management Framework – May 2024

INTRODUCTION

The Duty of Quality Act applies to NHS bodies in Wales and came into effect in April 2023. It also applies to Welsh Ministers in relation to their health functions.

It has two overarching aims:

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

The guidance sets out a definition of quality and describes the overarching requirements to strengthen our Quality Management Systems (QMS) with quality driven decision-making and planning. In turn, this strengthens our learning and sharing responsibilities and opportunities, enabling us to achieve the overall aims.

It requires the NHS to establish effective quality management systems that focus on learning and driven by their boards. It explains how Quality Control, Quality Planning, Quality Improvement and Quality Assurance must work together to form the quality management system that is required.

This paper provides the Board with an understanding of QMS, provides insight, and outlines how we will build the conditions to enable an effective QMS here in Betsi.

BACKGROUND

A Quality Management System in Healthcare enables a consistent and coordinated approach to managing quality. There are various definitions of quality across healthcare, including definitions from the Institute of Healthcare Improvement (IHI) and the World Health Organisation (WHO).

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 provides a consistent definition of quality across Wales for Welsh Ministers and NHS bodies; ***"continuously, reliably, and sustainably meeting the needs of the population that we serve"***.

Key to achieving this is ensuring that Welsh Ministers and NHS bodies provide health services that are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**.

QUALITY MANAGEMENT SYSTEM (QMS)

Central to the QMS is the commitment to being **a learning, self-improving, data led organisation that serves the people of North Wales.**

To enable this at both a clinical service and corporate service level are four core activities that need to be aligned:

• **Quality Planning** – this involves understanding the "customer" needs for that service and the standards and best practice to be achieved, the current challenges and successes, and developing clear plans to meet those needs and standards. This is enabled through the planning framework.

• **Quality Control** – this involves activities at the "front line" of the service to understand quality at an operational level so that the service meets the needs and standards (as above) with day to day corrections were needed. This is enabled through the performance and risk frameworks. This element is the first line of defence from the three lines model.

- **Quality Improvement** – this involves systemically improving quality where the service does not meet the needs and standards, and also includes efforts to exceed those needs and standards to achieve excellence and continuously improve. This is enabled through the "Betsi Way" improvement approach as the single QI methodology to be adopted.

- **Quality Assurance** is the independent understanding of quality and consists of both the second and third lines of defence, with the aim of ensuring minimum standards are achieved or there are plans in place and good quality management structures are in place. It consists of the organisational level activities to provide assurance.

RESEARCH AND INSIGHT

The IHI is a globally recognised institute which has undertaken research into the challenges faced by healthcare organisations for a number of years and are renowned for improving health and care worldwide, through improvement science.

Within their *Whole System Quality* white paper that was published in 2021, they recognised that whilst healthcare organisations have advanced their approaches to improving the quality of care, there are challenges which remain. Notably, these challenges are in relation to "*building resilient and responsive organisations that continuously, reliably and sustainably meet the evolving needs of their communities"*.

The white paper, confirms that the key to addressing the challenges we face in pursuing quality in healthcare is through *"rigorous learning".* The IHI's holistic approach to quality management, builds on the ideas and theory of those who are recognised in the area of quality movement. The paper provides a guidance and tools for healthcare organisations to; *close the gap between the quality that customers are currently receiving and the quality that they could be receiving".*

Their advised approach to this, is to integrate the quality components; quality planning, quality control and quality improvement. This approach, together with leadership principles that foster a culture of learning and taking a customer centric approach to quality (defining quality goals to meet customer needs), enable a whole system approach.

East London Foundation Trust (ELFT) visit on 26 February 2024

ELFT provides mental health and community services to a population of approximately 1.5 million people across East London, Bedfordshire and Luton. The core to their approach is their commitment to quality and involvement of service users. The Care Quality Commission (CQC) rated ELFT as overall 'outstanding' in 2021, namely for providing services which are caring and well led. Key to this was leadership, governance and culture.

ELFT have used quality improvement across all areas of the trust since 2018, which has helped them to solve some of their most complex quality and safety challenges. Much of their quality improvement work is based on the IHI improvement science.

The Health Boards Deputy Director of Quality and Quality Lead Manager visited the trust in February of this year in order to understand how they operate an effective QMS. The trust has operated an effective QMS at a local / delivery level for the past ten years. Key to its success, was the work undertaken at the outset with each service, service users and stakeholders, to understand what quality means to them and how they measure quality. Furthermore, ELFT leadership has set principles and ways of working which have empowered and allowed its managers within services, to work with autonomy.

Ten years on, ELFT are at the point of starting to operate QMS at an organisational level. They have emphasised the importance of the time which it takes to build the capability to operate as a QMS through assessing and understanding the organisation and the needs of its people and staff. Appendix A provides an overview of ELFT's Guide to Quality Management.

Healthcare Improvement Scotland (HIS)

HIS is a national healthcare improvement organisation for Scotland which is part of the Scottish National Health Service. Working with their stakeholders, HIS have developed a QMS Framework (below) which supports health and social care organisations to apply a consistent and coordinated approach to how they manage the quality of their health and care services.

They highlight the need for support from senior leadership, across all components of quality management and a learning system which is fundamental to an effective QMS.

The QMS Framework is in the process of being tested and adapted in real time. HIS also continue to learn and gain insight from their own experience of quality management, and of those across health care.

APPROACH

A QMS Working Group is in place with representatives from all key specialist functions and a rapid design workshop took place with leaders, including clinical leads across Betsi, on 23 April 2024 in order to support the development of a QMS Framework.

The workshop was virtual in order to encourage as many services as possible to engage of which 40 senior staff attended, including the support of the NHS Wales Executive.

The QMS Design workshop was split into 3 areas;

1. **Design** – what does good look like?
2. **Enable** – how will we enable our services to operate as a QMS?
3. **Deploy** – what tools do we need to deploy a QMS?

Building on from the IHI white paper, ELFT QMS, and feedback from the workshop, the 'Betsi QMS Principles' located within the Framework, is a first draft, a foundation of values which will be developed further with staff, patients and stakeholders over time.

Staff who attended the initial workshop, collectively agreed there is a need for a 'product', something which is tangible such as a platform or portal where they can access advice, guidance and tools for their service, for each quadrant of the QMS cycle.

They also felt an illustration of the aim, vision and output would be helpful. This is also located in the QMS Framework, with design input underway from the Director of Transformation and Improvement.

A series of engagement discussions, Executive Team discussion and Board development sessions have also taken place. These have focussed on ensuring that we develop a QMS that is useable, accessible and informs our quality planning.

When fully implemented the QMS will anticipate areas for quality improvement and focus and our approach to quality will shift from a reactive approach, all too often after harm has occurred, to a proactive approach where triangulated information informs us on areas, teams and pathways where support is needed.

The 'Betsi QMS Toolkit' are resources that will enable us to test operating as a QMS with services.

Again, this has been informed from the initial workshop and will be developed further over time and will be key to the testing phase in.

IMPLEMENTATION ACTIONS AND NEXT STEPS

Our work with organisations that have successfully implemented and used a QMS tells us that the journey is not an easy one if the QMS is to be effective,

It is proposed to use the QMS tool initially in our Clinical Areas of Concern within the special measures framework. The first two services to adopt this approach will be vascular and urology, two services that have quality issues that are well recognised and are on different stages of the development journey.

CONCLUSION AND RECOMMENDATIONS

The Duty of Quality sets the expectation that our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. In addition, that our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision and that they have the appropriate skills and capacity to create the conditions for a functioning quality management system.

The Board is asked to note the progress made to date and to support the direction for implementation of a Quality Management System that serves the population of North Wales.

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

QUALITY MANAGEMENT SYSTEM:

A Framework for Improvement

2024 – 2025

VERSION 0.5

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Introduction

Betsi Cadwaladr University Health Board is absolutely committed to improving the quality of care for the people of North Wales to achieve comparable outcomes and experiences of the best healthcare providers across the UK and internationally. Whilst this is a significant commitment, it is stated so clearly to help drive the ambition of the organisation and to enable this in practice. Quality must be at the heart of the health board, and increasingly the work of the Board as well as the wider organisation, will seek to deliver improvements that make a real difference to both patients and to the staff who deliver services, that impact directly and indirectly.

The **Quality Management System: A Framework for Improvement** provides a vehicle to articulate the purpose of a quality focused system as well as the approach to delivering such a system. This is the first time the health board has so fundamentally taken this step, and whilst there are areas of the board that already work within a quality management system approach, it is not currently widespread and embedded. The Board wants to change this.

This document provides the outline of the Quality Management System approach being proposed. It will be supplemented by an Implementation Plan, and crucially a Quality Management System Hub that will interactively guide and assist individuals, teams and departments across the organisation to develop their quality management assessment and improvements.

Strategic Context

Betsi Cadwaladr University Health Board was formally escalated to the highest level of escalation and intervention, Special Measures, by the Welsh Government in February 2023. The fundamental issues, amongst others, driving the escalation included governance, culture, quality and sustainability of services.

The Health Board's Special Measures Response Plan was approved by the Board in May 2023 and outlined five key areas of focus, including:

1. A well-functioning Board
2. A clear, deliverable Plan for 23/24
3. Stronger leadership and engagement
4. Improved access, outcomes and experience for citizens
5. A learning and self-improving organisation.

As part of that Plan early work on the development of a Quality Management System for the whole organisation commenced. The preparation took into account a number of key and specific strands of work and insights including:

- Patient Safety Review undertaken by a Welsh Government Independent Advisor supporting the organisation.
- Advice and input from Improvement Cymru, considering the evidence and learning from other systems in the UK and internationally.
- Knowledge and development work with the Institute of Healthcare Improvement with the Board, including the aspects of leadership for quality and being data-led. This drew on the evidence paper from the IHI *A Framework for Safe, Reliable and Effective Care* (2017) and the more recent work of the IHI in its '*Whole System Quality'* (2021).

Progressing alongside the work in developing a quality management system for the organisation is the Boards work on Culture, Leadership and Engagement. The Board made nine commitments in its Strategic Intent document in September 2023, outlining the work to be undertaken in these three key areas. The aspects of culture, leadership and engagement are fundamental and underpin the effective development and deployment of quality management systems.

Health Board Strategic Objectives 2024/25

Having made progress during Year One of Special Measures, the Board has set five Strategic Objectives (figure 1). These are focused on

1. Building an Effective Organisation
2. Developing strategi and long-lasting change
3. Creating compassionate culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Establishing an effective environment for learning

Fundamentally, the aspects of quality management run through all strategic objectives, as a golden thread.

Figure 1: Strategic Objectives 2024/25, quality as a golden thread

Legislative Framework

The legislative framework in Wales underpins the commitment to the provision of high-quality health and care services. The Welsh Government, in developing this legislation, places a duty on NHS organisations, particularly health boards is several respects.

The NHS Finance (Wales) Act (2014) places a duty on health boards to plan services in an integrated way, utilising its resources to improve the health and wellbeing of the population and to provide/secure excellent health services. It also places a duty of financial balance over a 3-year period.

The Social Services and Wellbeing (Wales) Act (2014) places a duty of health boards to work with partners, particularly Local Authorities, to develop plans to improve the wellbeing of the population, particularly those requiring care and support.

The Wellbeing of Future Generations (Wales) Act (2015) places a duty on health boards to give regard to the long term, making decisions that will improve outcomes for the future, rather than focusing on the here and now. It further places a duty to work collectively with others to improve wellbeing of the population particularly through the assessment of needs and the planning of services and approaches.

Of central importance in relation to quality management system is the Health and Social Care (Quality and Engagement) (Wales) Act (2020) which aims to:

- Strengthen the existing Duty of Quality on NHS bodies, extending it to Welsh ministers for their health service functions
- Create a Duty of candour on NHS service providers for openness and honesty with patients and service users harmed during care
- Amplify voices by replacing community health councils with Llais, an all-Wales citizen body for health and social care

The Health and Social Care Act requires a quality management system to be developed and implemented and taken together the legislative framework above underpins the requirement to plan for provision of high-quality care that improves wellbeing for the population.

What is a Quality Management System?

A Quality Management System in healthcare enables a consistent and coordinated approach to managing quality.

There are various definitions of quality across healthcare, including those from the Institute of Healthcare Improvement (IHI) and the World Health Organisation. In Wales, the Health and Social Care (Quality and Engagement) (Wales) Act 2020 provides a consistent definition of quality across Welsh Ministers and NHS Wales bodies, which is **"continuously, reliably, and sustainably meeting the needs of the population that we serve"**.

Key to achieving this is ensuring that Welsh Ministers and NHS bodies provide health services that are **safe**, **timely**, **effective**, **efficient**, **equitable** and **person-centred**. To drive this, Welsh Ministers have withdrawn the Health and Care Standards (April 2015) and introduced the new Health and Care Quality Standards which consist of the six quality domains above, and five enablers (**leadership**, **workforce**, **culture**, **information**, **learning improvement and research** and **whole systems approach**).

- The quality domains and enablers set the high level of standards that people in Wales can expect when they access health services.
- They will emphasise quality driven decision making and help the planning, delivery and monitoring of health care services.
- They also provide a framework for quality management as it connects together the duty, the standards and the wider quality management process.

Having a **system wide approach to quality**, means that the Health Board is quality driven in its decision making, moving away from quality being a component of its health strategy, to being the driver of the health strategy.

The duty of quality sets a requirement for Welsh Health Ministers and NHS Bodies to make all strategic decisions through a quality lens which will ultimately improve the quality of health services and outcomes for people in Wales.

The Quality Management approach

Delivery of high quality care requires the Health Board to have a consistent and coordinated approach to managing quality that is applied from team through to board level. This is known as a **Quality Management System (QMS)**.

Historically, quality in health has been through the lens of quality improvement or quality assurance. However, reliable delivery of high quality care requires an organisational approach that goes beyond these areas to one which is inclusive of all the key components of quality management.

The Institute for Healthcare Improvement (IHI) set out an approach to quality management in their white paper, *Whole System Quality*, which describes the integrated approach as:

- integrated **quality planning**, **quality control**, and **quality improvement** activities that inform an organisation-wide, interlinked, and patient centred strategic approach to quality, underpinned by **quality assurance**.
- the organisation-wide pursuit of quality through management practices that facilitate a culture of learning;

Effective quality management should lead to a variety of benefits for those who access services as well as those who deliver services.

It will help the Health Board to:

- develop and implement approaches to understand the current level of quality of service being provided, including an assessment against national standards, identifying areas of potential risk to high quality delivery
- develop processes to help services understand their priorities for improvement;
- design appropriate interventions to make those improvements;
- develop processes to help maintain acceptable levels of quality and early warning to highlight when quality slips; and
- build knowledge and accelerate improvement in outcomes.
- Create an environment, when taken with the work on culture, leadership and engagement, where quality is hard-wired as a strong organisational feature, impacting positively on both patient and staff

This will support every member of staff, from service to board level, to feel confident:

- that they understand what is important to those who use their services;
- that they are supported and connected to deliver high-quality services;
- that they have access to relevant data to enable them to know when they are doing well and to know quickly if quality slips; and

- that they are supported to deliver high quality services and improve those services every day.

The Betsi Cadwaladr Quality Management System model

The QMS model being developed in the Health Board adopts the four domains of quality management, as equal and aligned priorities.

Central to the QMS model is the commitment to being **a learning, self improving, intelligence led organisation that serves the people of North Wales.**

The QMS model isw holistic approach to integrating quality planning, quality control, and quality improvement across multiple levels of the system. The aim is the reduce the gap between the current and the potential level of quality in the system and to build resilience and alignment in the system.

Figure 1 - The Betsi Cadwaladr QMS Model

The IHI identify that a clear strategy, values and a culture of quality are essential to ensuring effective quality management, with the following core actions:

- **Build a shared sense of purpose**: A participative process of establishing a shared vision focuses the learning objectives and ensures that all activities and efforts are aligned toward a singular purpose.
- **Practice systems thinking**: Systems thinking serves as a critical tool to appreciate the complexity of the dynamic, interconnected health care system and identify the challenges and opportunities in pursuing quality goals.
- **Engage in collective learning and dialogue**: Team learning, or the process of collective inquiry, dialogue, and co-production, expands the problem-solving capacity of the organization by providing access to insights, information, and expertise across different levels and groups.
- **Practice personal inquiry and reflection**: The discipline of self-reflection, unearthing deeply-held belief structures, and understanding how these

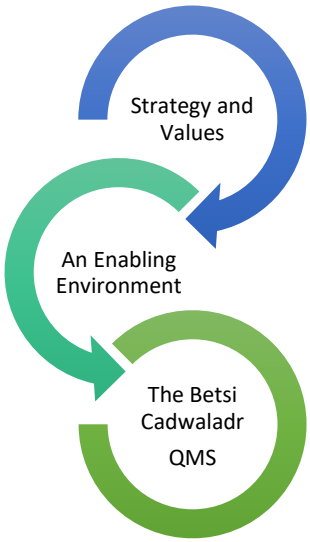


Figure 2 - Whole System Approach to Quality

structures dramatically influence behaviours enables each member of the organization to contribute to dialogue in a meaningful way.

The four domains of the QMS are:

- **Quality Planning** – this involves understanding the customer (patients/client/citizen) needs for that service and the standards and best practice to be achieved, the current challenges and successes, and developing clear plans to meet those needs and standards.

  In practice this domain, is at least in part, enabled through the Integrated Planning Framework.

- **Quality Control** – this involves activities at the front line of the service to understand quality at an operational level so that the service meets the needs and standards (as above) with day to day corrections were needed.

  This is domain is very much about systems of quality and management control and is supported through access to data and intelligence, systems and processes that promote and protect quality, and the performance and risk frameworks.

- **Quality Improvement** – this involves systemically improving quality where the service does not meet the needs and standards, and also includes efforts to exceed those needs and standards to achieve excellence and continuously improve.

  This is enabled, a least in part, through the "Betsi Way" improvement approach as the single quality improvement methodology to be adopted in the organisation.

- **Quality Assurance** – this is the independent understanding of quality with the aim of ensuring minimum standards are achieved or there are robust plans and capability in place. The evidence available is key to being able to assess levels of assurance.

  This domain consists of the organisational level activities, and external activities such as regulators, to provide assurance.

The following infographic outlines the Betsi Cadwaladr Quality Management System model with supporting statements which will be used across the organisation:

Betsi Cadwaladr UHB Quality Management System Framework	
Quality Planning Understanding the needs	Quality Control Systems and process to consistently meet standards
- Understand the standards and models that provide the best outcomes and experience - Evaluate current services with the input of those who provide and use them - Assess the gap between current and potential quality - Design services to meet the needs and provide the best outcomes and experience, as well as sustainability for the longer term - Identify the culture, systems, processes and structures needed to deliver the best quality model	- Identify the systems and processes, protocols and practice in place that help enable quality - Design and implement measures/metrics that indicate clearly the performance of the service including the systems and process that help ensure quality - Enable an understanding and active discussion of data and wider intelligence to identify where early quality gaps
Quality Improvement Targeting improvement work	Quality Assurance Assessing and evidencing the impact
- Identify the areas that need improving - Identify the approach to be taken/methodology - Galavanise colleagues and service users as a team around a common improvement goal(s) - Sharing learning, but success and failure, spreading and scaling practice that works	- Identify the evidence that indicates the level of quality being provided - Identify gaps in evidence 'we don't know what we don't know' - Draw wide perspectives in relation to the evidence of quality, including data, feedback, external/peer approaches. - Share evidence amongst teams/service users/others

Implementing the Betsi Cadwaladr QMS model

At an organisation-level, the quality management system model will help align roles, responsibilities, accountabilities, systems and processes.

The QMS is being implemented at a time of significant change for the organisation as it emerges from year one of Special Measures (moving from stabilisation to standardisation phases), as a new Independent Board Membership is now in place, and following the appointment of a permanent Chief Executive with a refreshed Executive Team is forming (with new roles and review of existing portfolios).

The QMS for 2024-2025 therefore comes as a catalyst for further change and improvement, helping to build a more effective organisation.

How will the QMS be implemented?

Recognising that 2024-2025 will include further, significant change in the organisation as part of its improvement journey, the development of the overall strategy, values and enabling environment for the QMS will be led by the Chief Executive and the Executive Team.

These enabling changes and improvements will include:

- A review of the executive portfolios including leadership roles and responsibilities;
- Continued development of the leadership culture in the organisation;
- A review of the operating model to ensure our structures best support our people;
- Continued development of the planning, risk and performance frameworks;
- A review of the quality leadership roles and corporate team alignment;
- Continued development of the learning organisation framework and supporting tools;
- A review of the quality governance structures, systems and process.

Domain	How will this operate?
Quality Planning	Quality will be integrated within, and will be the co-equal driver of, the Health Board's strategy and plans. Over the year, the approach to planning at all levels of the organisation will be reviewed and strengthened, and quality will be weaved throughout. This will support our commitment to quality driven decision making in line with the Duty of Quality. The approach to planning will include clearly identifying the needs of our population, the standards we should be achieving and the actions needed to achieve those. A new, improved Integrated Planning

	Framework will be developed, taking into account the findings of the Planning Review. Building on the review of the organisations approach to engagement an increased focus on improving the voice of the population we serve and the voice of our people in understanding our challenges, priorities and successes will be enhanced at service and at corporate level. A strengthened expectation of evidence of involvement and engagement with service users/patients/carers will feature as a core part of planning and evaluation. Service reviews will take place that support the quality planning aspects in particular, enabling a clear picture of the current and potential quality status to be established. This is particularly important given the work on the organisations Strategy and the Clinical Services Plan.
Quality Control	Quality control is an area of health quality that requires significant improvement, with the previous reliance on assurance (external assessment). Over the year a focus on improving and enabling services to better understand the effectiveness of their quality systems and processes and to take action to address quality concerns before they become quality crisis. To enable this a roll-out of the Quality Informatics Portal to enable team, service, directorate and divisional level access to quality insight and data. There will also be a roll-out of the Quality Learning Portal to enable learning to be shared in a targeted manner to team, service, directorate and divisional level. The approach to investigating and learning from incidents, complaints and mortality will change to better inform learning and improvement. It will include a significant change in our approach to using patient, carer and family feedback to drive improvement. In line with the Integrated Performance Framework, a clearer escalation process (a service of concern process) will be developed to enable earlier triangulation of data and insight to better support challenged services and to enable corrective actions to be taken. The Integrated Risk Management Framework and Integrated Performance Framework will also be strengthened alongside a new Integrated Quality and Performance Report for the Board.

Quality Improvement	The Health Board has adopted an improvement methodology, *The Betsi Way*, and this will be embedded systematically as the improvement approach for use in the organisation. This methodology is underpinned by the IHI Model for Improvement. Improvement capacity and capability at all levels of the organisation, however a more focused approach will be adopted ot enable a prioritisation of those services/areas where the greatest need exist in relation to improving quality. The Learning Organisation Framework will be finalised, and supporting tools such as the Quality Learning Portal, and will begin embed these across the organisation. Work will take place to ensure our quality processes are underpinned by the principles of candour and learning. A new portal will be established for the capture of all major and significant improvement projects and actions, and the Programme Assurance Team will enable greater confidence in measuring the impact of these initiatives on patient outcomes and organisational effectiveness. Learning events will be held to enable a spread of learning across the organisation.
Quality Assurance	The approach to quality assurance will evolve to a more proactive, model to better support the Executive Team and Board understand the quality position and enable more timely, proactive corrective actions as well as learning and building on good practice and success. After reviewing quality leadership roles and corporate team alignment a systematically review our corporate processes to ensure they are effective will take place. We will continue to enhance role of the Health Board Senior Leadership Team in understanding assurances as well as the Quality, Safety and Experience Committee assurance role. A review of the underpinning quality governance structure at service, division and corporate levels.

Alongside the specific actions above, a key outcome of the QMS will be to develop an *integrated* approach to quality management. This integration is across the domains of quality and across the domains of the QMS. Alongside the re-alignment of portfolios and teams, the Executive Quality Delivery Group will drive implementation of the QMS reporting to the Executive Team (ensuring that quality and the QMS is seen as something to be owned and implemented by all, and not just the quality function).

Implementing the approach across services

The aspiration of the Health Board is that the QMS model is used in every clinical service, at a local level, to support that service develop its approach to integrated quality management.

The QMS model is not intended to be another layer of action planning or reporting, but rather a model that can help service leaders to understand their approach to integrated quality management and to make changes to existing processes and structures to improve outcomes.

By building processes and structures around an integrated quality management system approach, services will be in a better position to:

- Understand the needs of their population and the standards and good practice to be achieved;
- Understand how their service currently meets those needs and standards;
- Establish measures to monitor ongoing achievement of those needs and standards and facilitate early corrective action or escalation;
- Understand how external assurance can support their local management;
- Create plans to manage the service focussed on a clean picture of quality alongside performance, risk, workforce and finance;
- Identify and deliver improvement interventions to improve quality;
- Provide confidence to those us use services, those who deliver services, senior leaders and stakeholders that quality is an integral part of the service management.

This approach is new to the Health Board, and new to health. Therefore, in line with the principle of co-production the approach to locally implementing the QMS model will be co-designed, tested, evaluated and enhanced with a sample of clinical services.

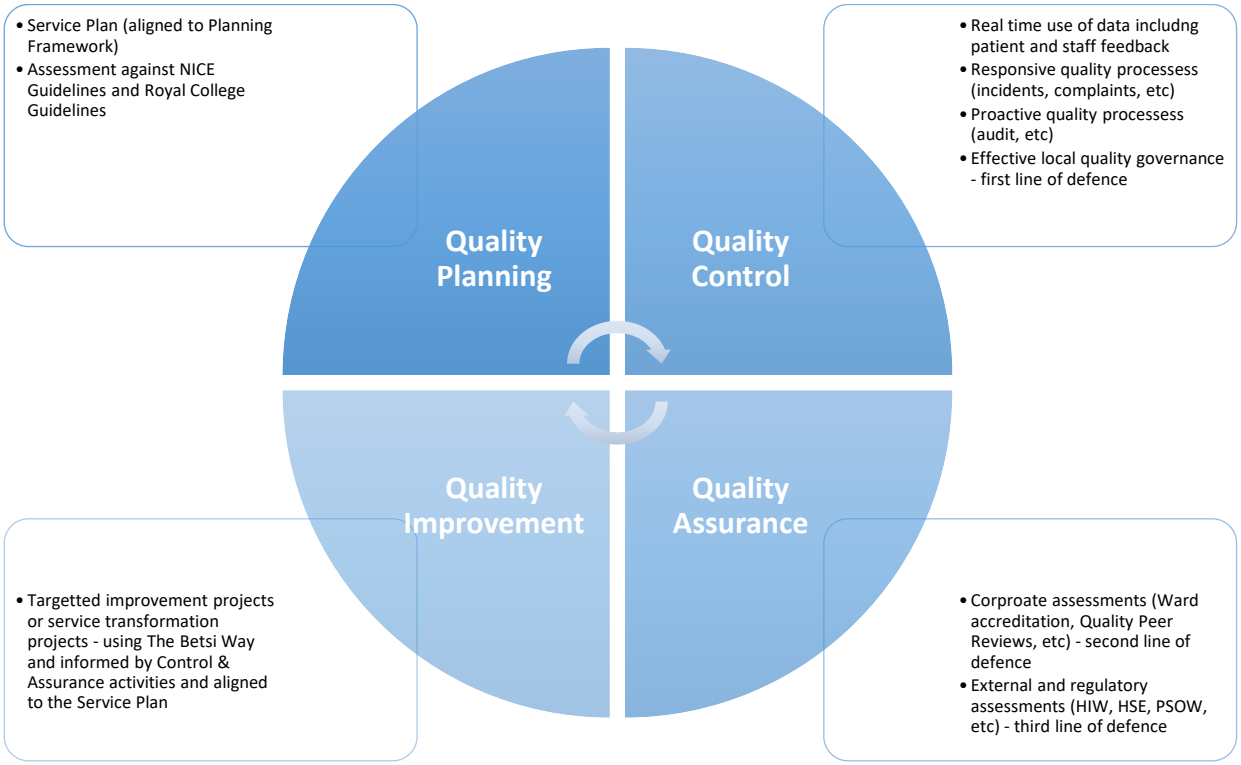
The identified services for this co-production will be vascular services, urology services and dermatology services.

The co-production will take place over the summer of 2024 which will inform how this approach will be developed prior to wider roll-out across the organisation. The exact timelines and scope will be informed from their first stage testing.

A “collaborative model” will be used to undertake this co-production and subsequent wider roll-out. Collaboratives involve groups of professionals coming together to learn from and motivate each other to improve the quality of health services. Collaboratives use a structured approach, such as setting targets and undertaking rapid cycles of change.

A maturity matrix will be developed for each domain to assess the pre- and post- implementation.

Simple example of the QMS model being applied to a clinical service



Evaluating the impact

A QMS implementation plan will be developed to enable this work, led by the Executive Medical Director, owned by all Executive Directors and their senior teams. This implementation plan will include the evaluation of its impact.

Implementing a Quality Management System has the potential to significantly improve how quality is managed within the Health Board, with the resultant impact on better patient outcomes and improved organisational effectiveness.

For the first stage of the QMS, involving initial development corporately and co-production locally with some services, a narrative assessment will be undertaken of the early feedback. However, during this phase an evaluation criteria will be developed to measure impact as wider roll-out takes place.

Acknowledgements

The Health Board has developed the Quality Management System with input from stakeholders across the organisation, in particular the Quality Directorate, Corporate Governance Directorate and Transformation and Improvement Directorate.

The Executive Medical Director has served as the Senior Responsible Officer.

Engagement via surveys and workshops have been held with clinical and operational leaders across the organisation and corporate service leaders.

Support has been provided by the NHS Wales Executive Quality Improvement Directorate (formerly Improvement Cymru) and the Performance and Quality Assurance Directorate, and we wish to acknowledge those teams for their support.

Experience and knowledge has been drawn from the work of the Institute for Healthcare Improvement (IHI), Chartered Quality Institute, the Health Foundation, NHS Scotland and East London Foundation Trust (ELFT). We particularly acknowledge the Quality Management and Assurance Team at ELFT for hosting a small delegation from the Health Board to learn and share best practice.

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Teitl adroddiad: ***Report title:***	Research and Development Annual Report 2023/2024
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to update the Board with regard to Research and Development (R&D) activity and opportunities. Research drives improvements and developments in patient care. There is a growing body of evidence demonstrating that research active organisations provide better care and have better patient outcomes than those NHS organisations that conduct less research. The Cross Party Group on Medical Research Inquiry Report (2023) reported that a culture of innovation and research can make our NHS a more attractive place to work and support Wales to fill critical vacancies across the health service. The Research and Development Annual report 2023/2024 details current BCUHB research activity, key collaborations, achievements and successes. It also includes a snapshot of our patient feedback. Key opportunities moving forward include UK funding to increase commercial research, and opportunities for joint appointments with the North Wales Medical School. The R&D team intend to take forward the work outlined in the report, and to further develop the aims and priorities as described.
Argymhellion: ***Recommendations:***	The Board is asked to • **note** the contents of the Annual Report • **note** the potential to further develop opportunities to collaborate with both commercial and non-commercial partners • **note** the opportunity to work closely with our Universities and, in particular, Bangor Medical School.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad: ***Report Author:***	Dr James Risley, Deputy Executive Medical Director Lynne Grundy, Associate Director of Research and Development

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):***	Improve health and wellbeing for all and reduce inequalities Use resources wisely, transforming services through innovation and research.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health Research Authority UK Policy Framework for Health and Social Care Research The Medicines and Healthcare products Regulatory Agency Related research legislation and policy
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 indicated
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 indicated
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)***	No risks are associated with this paper

Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith ***Financial implications as a result of implementing the recommendations***	May result from further development of the strategic objectives.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	May result from further development of the strategic objectives.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Previous version of this paper presented to the Executive Team
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable

Introduction

The Health Board continues to develop and deliver high quality research, and during the last 12 months we have continued to re-start or start non-COVID-19 trials following the pandemic, which has enabled us to deliver innovative and ground-breaking research across the NHS.

This Annual Report outlines the Research and Development (R&D) initiatives undertaken by BCUHB in the past 12 months, showcasing several notable clinical research accomplishments, as well as highlighting our collaborative work and our future plans.

We continue to work closely with our Bangor University colleagues and the North Wales Medical School to actively participate in the development of research initiatives and the growth of future research leaders, with the establishment of the new school introducing exciting prospects for advancing research delivery.

Research Activity

Over the past 12 months research activity has increased, with over 5000 participants recruited to both commercial and non-commercial studies and over 300 research studies currently open to recruitment or in follow-up.

This success has been facilitated by the North Wales Clinical Research Facility (NW CRF), situated on the Wrexham Maelor Hospital site. It has integrated into the community of North Wales through patient and public involvement and engagement, which has included work with local GP practices, pharmacies and dental surgeries.

The NW CRF has enhanced links with the North Wales Medical School, Bangor University, and Wrexham University; this has included supporting new research degrees, welcoming undergraduate students on placement, and has now had its first doctors on formal training

programmes through the Facility with Health Education and Improvement Wales (HEIW) approving for the first time Clinical Pharmacology and Therapeutics Higher Speciality medical training in North Wales.

Collaborations and Successes

Examples include:

- The TRICORDER collaboration with Imperial College London and the NHS North West London Integrated Care System is a real-world evaluation of an artificial intelligence enabled stethoscope to aid General Practitioners in the early detection of heart failure.

- Ysbyty Gwynedd's haematology team has been awarded the Myeloma UK Clinical Service Excellence Programme Award, in recognition of its outstanding care and dedication to patients with myeloma.

- Working with the Bevan Commission to support the successful adoption and spread of innovative Children and Adolescent Mental Health Services (CAMHS) projects, with the local authority, third sector and industry partners collaborating with BCUHB CAMHS and R&D teams to deliver and evaluate innovative schemes that span early intervention and prevention right through to crisis care.

- One of the recipients of our R&D grants has won a coveted national research scholarship for 'inspiring' work at Colwyn Bay Medical Centre.

Financial implications

Research activity brings positive financial impact, with funding for research support and delivery provided by Welsh Government Research Division. Costs associated with research are fully funded for commercial trials by the commercial sponsors.

The voluntary scheme for branded medicines pricing, access and growth (VPAG) has been agreed by the government, NHS England and the Association of the British Pharmaceutical Industry (ABPI) to invest £400 million over 5 years to drive forward innovation, sustainability and growth. The programme will be ring-fenced, and £300m has been allocated to bolster the NHS's capacity to deliver commercial clinical research. A proportion of this funding will come to Wales, and this offers opportunity for BCUHB to build its infrastructure to deliver increased commercial research activity, with the opportunities this offers to generate funding to re-invest in R&D.

Research studies, particularly drug trials, also offer cost savings locally. The trial drugs, which are often high cost, are provided free of charge, and often standard care drugs are not required.

Opportunities

The opportunity exists to strengthen our research infrastructure and increase our research commercial income as described above.

The formation of the North Wales Medical School offers the opportunity to develop joint clinical academic and honorary clinical research appointments, strengthening research leadership and activity in the region.

Collaborations with academic, commercial and third sector partners will continue and increase, in order to lead and deliver high quality research and development.

Activity in the North Wales Clinical Research Facility (CRF) will also increase, which provides a space where early phase clinical trials can be carried out in a safe and regulated way.

Summary and Looking Forward

Research generates revenue through commercial partnerships, drives developments in patient care, and provides an enhanced job role for colleagues which in turn develops leaders and critical thinkers who contribute positively to the environment that they are working in.

There continue to be opportunities to increase research activities in BCUHB, which will have positive effects on our patients and colleagues; notable priorities for 2024/2025 include:

1. Increasing commercial research and innovation activity.
2. Sustaining and increasing Clinical Research Facility activity in early phase trials.
3. Increase honorary research appointments and clinical academic posts.
4. Generate additional RD&I commercial opportunities in device and technology development, through establishing a Tritech (North) model within BCU.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1: Research and Development Annual Report 2023/24

2023/2024

RESEARCH & DEVELOPMENT ANNUAL REPORT

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

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EXECUTIVE SUMMARY

Dr Nick Lyons
Executive Medical Director,
Interim Deputy Chief Executive

Research drives improvements and developments in patient care. There is strong evidence to show that people participating in clinical trials have better health outcomes than those cared for outside of trials. A growing body of evidence demonstrates that all patients receiving care in research active hospitals have better health outcomes and improved survival rates. There are strong links between patient survival and a hospital's active participation in clinical research.

Betsi Cadwaladr University Health Board (BCUHB) develops and delivers high quality research. During the last 12 months we have continued to re-start or start non-COVID-19 trials following the pandemic. Despite the challenges faced by BCUHB, we have continued to deliver innovative and ground-breaking research across the NHS. We recognise that research is core to many roles and is integral to informing policies, guidelines, and practices to provide improved, effective, efficient, and high-quality care, and we have contributed to many R&D policy and governance developments.

We have continued to develop our Clinical Research Facility (CRF) which offers the local population the opportunity to participate in high quality research trials.

The hard work and commitment from the R&D teams, our patients, staff and members of the public make the achievements possible, making a real contribution to the improvement in patient care and treatment.

Introduction

This report outlines the key strategic policy drivers that shape the current research landscape nationally and locally. It details the research and development initiatives undertaken by BCUHB in the past 12 months, showcasing several notable clinical research accomplishments. The report also highlights our collaborative work and our future plans.

Research is a key driver in providing evidence based improved prevention, diagnosis, treatment and care options for patients. There is a growing body of evidence demonstrating that research active organisations provide better care and have better patient outcomes than those NHS organisations that conduct less research.

Opportunities for greater development through research provides an enhanced job role which in turn develops leaders and critical thinkers who contribute positively to the environment that they are working in. The Cross Party Group on Medical Research Inquiry Report says a culture of innovation and research can make our NHS a more attractive place to work and support Wales to fill critical vacancies across the health service.

Research and development (R&D) delivery in Wales is funded by Welsh Government through Health and Care Research Wales (HCRW). This funding allows us to employ dedicated research teams that work in collaboration with clinical teams to establish and conduct high quality research. In addition, we can generate revenue for commercial trials income, which funds the research activities and provides additional funding to reinvest in R&D and increase our capacity and capability. Funding opportunities are also available through grant awards and personal development awards.

Over the past 12 months, the R&D team has collaborated closely with clinical colleagues, resulting in a significant increase in our research activity, which has provided more opportunities for our patients to take part in research. We have highlighted some of the achievements in our research community in the report.

We are working closely with our Bangor University colleagues and the North Wales Medical School to actively participate in the development of research initiatives and the growth of future research leaders. The establishment of the new school introduces exciting prospects for advancing research delivery and developing research leaders.

Strategic Overview

National Strategies

A research active organisation is a distinguishing character of University Health Boards and a key enabler for NHS Wales to deliver 'A Healthier Wales.' Research is also prominent in many Welsh Government Frameworks, including the NHS Planning Framework 2022-2025, the NHS Delivery Framework, and Healthcare Standards.

The NHS Framework for Research and Development – 'Research Matters – What Excellence Looks Like in NHS Wales' (2023) was launched in August 2023. NHS organisations are expected to report against each of the ten pillars in the Framework at their annual reviews. The Framework aims to support the drive to embed and integrate research into all aspects of health and care services in NHS Wales. It outlines what research excellence looks like within NHS organisations in Wales where research is embraced, integrated into services, and is a core part of the organisation's culture.

Health and care research and innovation are critical to the delivery and development of services and NHS organisations in Wales have a critical role to play to support research.

Local Strategy

The BCUHB Research and Innovation Strategy has been in place since 2020, however we are aware that there have been some changes locally and nationally. Our aim is to ensure that the strategy remains impactful and aligned with our goals, adapting to the evolving landscape and remaining fit for purpose. Therefore we have reviewed our R&I Strategy and intend to refresh the strategy for 2024 to ensure it remains impactful and fit for purpose.

Research Activity

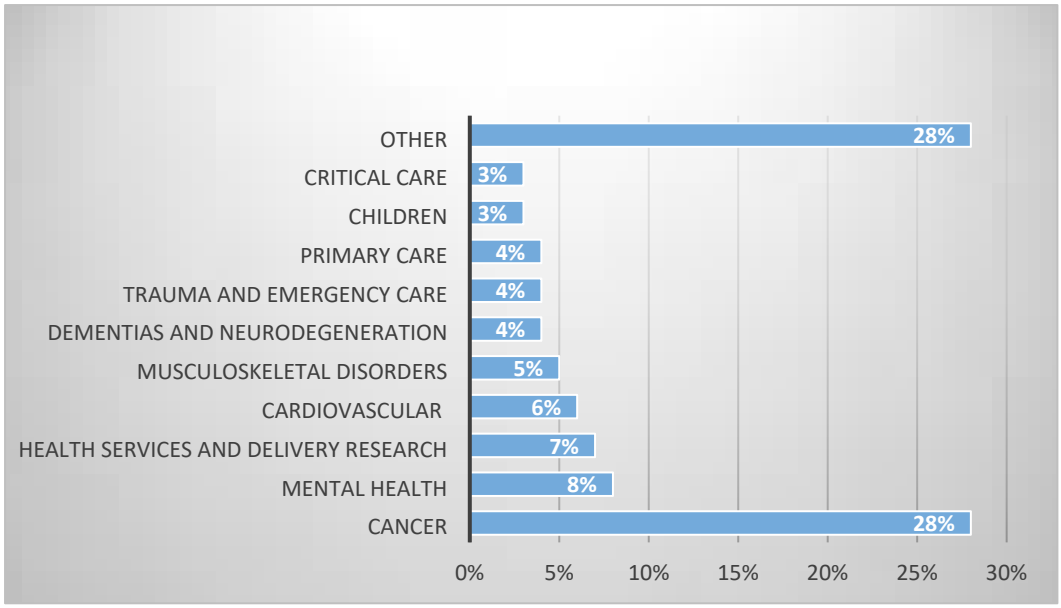
Over the last 12 months, our research activity has increased. To date we have recruited 5298 participants to portfolio non-commercial and commercial studies, increasing our activity from the previous year.

We currently have 316 research studies open to recruitment or in follow up. Of these 208 are portfolio studies, and 108 are non-portfolio studies. Each study has a named Principal Investigator (PI) from the Health Board and a Health Board Chief Investigator (CI) leads 41 of these.

The increase in research activity highlights our significant contribution to health research in Wales.

The graph below shows the wide area of research studies in 28 specialty areas across the Health Board.

Managing Specialty



Other specialties:

Anaesthesia Respiratory disorders Surgery Dermatology Neurological disorders, Reproductive health and childbirth, Gastroenterology, Ageing Ear, nose and throat Ophthalmology Diabetes Genetics Oral and dental health Stroke Injuries and emergencies Public health Infection Renal disorders.

North Wales Clinical Research Facility

The North Wales Clinical Research Facility (NW CRF) is situated on the Wrexham Maelor Hospital site and serves the population of North Wales, and beyond. The NW CRF delivers a variety of studies, but has a focus on early phase commercial studies.

The NW CRF has integrated into the community of North Wales through patient and public involvement and engagement. This has included work with local GP practices, pharmacies and dental surgeries. As part of this, we have developed new primary and secondary care Participant Identification Centres (PIC) sites to enhance our recruitment to clinical trials. These activities have helped us launch the NW CRF Consent for Contact (C4C) database of over 750 potential participants who are interested in research.

Over the past 12 months, the NW CRF has enhanced links with the North Wales Medical School, Bangor University and Wrexham University. This has included supporting the development of an MScRes in Clinical Pharmacology and Experimental Therapeutics at Bangor University. The NW CRF has also welcomed undergraduate students on placement from Bangor University. In linked developments, the NW CRF has had its first doctors on formal training programmes rotate through the facility. These innovative hybrid posts include funding for the MScRes, and have proved very popular. This feedback and other developments have led to HEIW approving Clinical Pharmacology and Therapeutics ST4 Higher Speciality Training in North Wales, the first time this has ever occurred. These posts will support doctors to undertake a PhD in research linked to Clinical Pharmacology and Experimental Therapeutics, and develop them into future Principal Investigators.

The NW CRF has developed an Experimental Medicines Group (EMG). This is a specialised research group that advises on the suitability of studies and the development of risk mitigation plans in early phase studies of high risk investigational medicinal products. To the best of our knowledge, the NW CRF EMG is the only such group of its kind in Wales. The development of the EMG has led to the development of First in Human (FiH) capability, with the NW CRF recently being site selected for two FiH studies.

The NW CRF has also recently been selected for phase I and II studies in the areas of oncology, infectious diseases and diabetes, which are due to open in Q1 2024.

Collaborations and successes

We hosted a Research and Innovation Symposium and Awards event on 14 September 2023. The symposium showcased the work of our BCUHB research and innovation teams and also provided an opportunity for colleagues to hear about some of our successful collaborative projects with Imperial College London and Moondance Cancer.

Awards

The research and innovation awards were in four categories: Patient impact: Research, Patient impact: Innovation, Novice innovator and Commitment to research.

Novice Researcher Award: Dawn Griffiths for her outstanding contribution to the development and testing of digital solutions to increase cancer patients' safety.

Patient Impact Research Award: Rebecca Pope for her work expanding the gastroenterology research portfolio.

Patient Impact Research Runner-up Award: Alberto Salmoiraghi and Chris Mckeown for their exceptional work on the ENROLL-HD study which seeks to improve the lives of patients with Huntington's disease.

Novice innovator Award: Robert Bonwick Salisbury, Senior Biomedical Scientist. Bob has collaborated with CellPath to create a prototype of a novel device that seeks to revolutionise the resection and processing of pathological specimens.

Novice Innovator Runner- up Award: **Mr Soroush Sohrabi**, who has created the We Care app.

Commitment to Research Award: **Mr Oliver Blocker** who has been instrumental in introducing research in the Trauma and Orthopaedic Department at Ysbyty Gwynedd.

Runner-up: Lucie Parry and Charley Rutter of West End Medical for the work they have done implementing and embedding clinical research in West End Medical Centre.

Patient Impact Innovation Award: **BCUHB Pathology Team led by Dr Mohamad Aslam** and IBEX delivering an SBRI project to identify a robust, validated, clinically assured Artificial Intelligence (AI) technology solution to process high-volume of pathology slides and to analyse using high-power computing and machine learning technologies to support pathologists to 'triage' prostate cases and the runner up

Runner- up: **Mr Muthu Ganapathi** for his novel introduction of a "virtual joint school" 'Virtual Joint School' (VJS) model was introduced at the Arthroplasty unit at Ysbyty Gwynedd in order to provide patient education prior to hip and knee arthroplasty in a non-face-to-face format.

What our patients say about research

Our patients share their experiences and motivations behind participating in research, which range from personal benefits to contributing to future advancements in care

Patients express gratitude for their quality of care and the feeling of regaining control over their treatment through their participation.

Their desire to contribute to the improvement of future care is seen across different types of research.

"My treatment has been second to none with every concern afforded to me."

"I am fuelled by the hope that my involvement could potentially lead to breakthroughs, improving treatment options and outcomes for others facing this challenging condition"

"I felt out of control with my cancer diagnosis. Being part of the study gave me some control over my care and treatment."

"I'm so grateful to be part of this trial as without it I wouldn't have known the cancer had come back"

"The service I have received from the research team has been first class"

"Very happy to be approached and participate. I was pleased to be part of a study helping others. It was all very relaxed from the start and I can only thank the Cardiology Research Nurses sincerely"

"In one word – "Brilliant"

"I simply want to help and contribute to improving future care. Dad went in a trial and the care he received was outstanding"

"Over the course of my time in this trial you haven't just treated me as another patient, you have treated me like a human being. That means a lot".

"I want to take part in this research to help people in the future such as my family and my daughters"

"For my sons and their future care"

"When I was doing my nurse training we were always told that with knowledge comes power. Research was important then just as it is now and if I can play a small part in the process then I am happy to".

"If it helps other people in the future then I am more than happy to take part"

PARKINSON'S UK
CHANGE ATTITUDES.
FIND A CURE.
JOIN US.

"Huntington's Disease is a less well known illness and so it is even more important for as many people as possible, especially if they are gene positive, to take part in research. I have found it helpful to take part in the research. Completing the research questionnaires and assessments in clinic with the research team, helps to manage my situation. Socialising and talking also helps me to prepare for the future"

Enroll-HD

Case Studies

The TRICORDER collaborative innovation project with Imperial College London and the NHS North West London Integrated Care System is a real world evaluation of an artificial intelligence (AI) enabled stethoscope across Primary Care. The Eko DUO device is a 'smart' stethoscope that records an electrocardiogram as well as heart sounds, and is used like a standard stethoscope. It can provide an immediate diagnosis of heart failure using an AI algorithm.

The project will evaluate if providing General Practitioners with artificial intelligence enabled Eko DUO stethoscopes increases early detection of heart failure for patients.

Ysbyty Gwynedd's Haematology team has recently been awarded the Myeloma UK Clinical Service Excellence Programme Award, in recognition of its outstanding care and dedication to patients with myeloma, and Ysbyty Glan Clwyd have been named runners up in the National Acute Myeloid Leukaemia Trial Team of the Year Award.

One of our Haematology trials, the VICTOR trial enables us to offer patients with acute myeloid leukaemia who, in standard care, would require urgent intensive chemotherapy over many months as a hospital inpatient, to potentially access an intensive modified regime that they can administer themselves in their own home. In April 2023 Ysbyty Glan Clwyd Hospital were reported to be the top UK recruiters to the trial.

The Rapid Diagnostic Centre Biomarker Study (RDC-Bio) has recently opened in BCUHB. Rapid Diagnostic Centres have been developed to improve early diagnosis of cancer. Patients are invited to take part in the study to help improve cancer diagnosis by analysing data collected during routing care and additional samples looking for biomarkers for cancer diagnosis

Ysbyty Gwynedd is the only site in Wales to open the 'Nightlife' study. This is a randomised trial where patients have the opportunity to have their dialysis overnight compared to the standard of care day time dialysis. The aim of the study is to compare the Quality of Life in the two groups of patients.

The development of the cardiology research portfolio over the last two years at Ysbyty Glan Clwyd has enabled patients across North Wales to access clinical trials across a range of specific sub-specialties including acute coronary syndromes, percutaneous coronary intervention, hypercholesterolaemia and arrhythmia management.

This has included the opening of the ZODIAC trial, in which we hit our recruitment target of 33 patients within 10 weeks of opening. The ZODIAC trial is a cluster randomised controlled trial into the implementation of a decision support system and its effects on early optimisation of Lipid Lowering therapies in patients with Acute Coronary Syndrome.

In April 2023 BCUHB became the first site in Wales to open the GBS3 trial. The study aims to recruit 320,000 women from 80 hospitals across England and Wales in order to try and reduce the number of newborn babies that develop serious Group B Streptococcus (GBS) infections. GBS is carried by an estimated 25% of pregnant women and can be passed from mother to baby during birth.

BCUHB was been selected to offer a Point Of Care rapid swab test for women admitted in early labour or for induction of labour. The results are available within 60 minutes, and women receiving a positive result will be offered antibiotics during labour which reduces the risk of women passing the GBS onto their baby.

We are working with the Bevan Commission supporting successful adoption and spread of innovative CAMHS projects. The project teams are local authority, third sector and industry partners from across North Wales, collaborating with BCUHB

CAMHS and R&D teams to deliver and evaluate innovative schemes that span early intervention and prevention right through to crisis care.

We are delighted that one of the recipients of our R&D grants last year has won a coveted national research scholarship for 'inspiring' work at Colwyn Bay Medical Centre.

Advanced nurse practitioner (ANP) Lucie Parry was awarded the Foundation Scholarship Award by the Chief Nursing Officer for Wales, Sue Tranka. The award recognises individuals who have achieved excellence in their field of nursing.

We have recently concluded a research project funded by Innovate UK, in collaboration with our industry partners, Medwise.ai have developed a sophisticated clinical decision support system that assists doctors and healthcare professionals in making accurate diagnoses.

The project involved colleagues from IT, Corporate Governance, Information Governance, and our own Research Governance teams. The project's execution

was led by a BCUHB Consultant Physician, supported by doctors in training and research nurses from R&D.

Cardiology: One trial currently recruiting patients within the cardiac catheter laboratory is using software newly installed to assess patients for microvascular angina. This procedure is only offered at Ysbyty Glan Clwyd for patients across North Wales. For one research participant, involvement in this trial may have saved his life.

Research saves lives

Rachel Manley, Clinical research specialist nurse

Problem | Measure | Analyse | Ideas | Test | Sustain

1. Introduction

This case study discusses a patients journey through an interventional clinical trial and how his involvement may have saved his life. There are approximately 340,000 people living with cardiovascular disease in Wales. A proportion are experiencing a poor quality life due to anginal symptoms. Developing technology in the cardiac catheter labs has led to software which can assess the microvascular function of coronary arteries. Patients attending for angiograms to investigate angina symptoms are invited to the iCorMicA research study to determine if stratified medical therapy based upon coroventis results, leads to better patient outcomes.

2. Problem Statement

The patient attending had a significantly reduced quality of life. Unable to enjoy even short walks without experiencing symptoms of chest pain. The patient had been through routine cardiac investigation and had undergone stress testing; in which all results were negative. He had been discharged back to his GP.
On the day of the procedure he was found to have significant obstruction to one of his main vessels which led to inpatient transfer to Liverpool Heart and Chest Hospital. Incidentally, during the work up to surgery, an early stage lung cancer was identified on his Chest X-Ray.

3. What we did

The patient was reviewed by the Lung team and plans made for a biopsy to be taken once he had recovered from his heart surgery. The patient was transferred to Liverpool Heart and Chest Hospital and underwent Coronary Artery Bypass Graft.
He is making a good recovery and has not had one episode of chest pain since his surgery!

4. Results, Key Learning & Conclusion

One of the key learnings from this patients experience is that we should always listen to our patients. The patient had highlighted his chest pain continued and had the software not been installed alongside the research study, due to the patient having negative testing, the consultants may not have felt that another angiogram would have given much further information. The availability of the software meant they could rule out microvascular angina as being a cause and incidentally found something much more significant.

5. Next Steps

Patients that have had previous normal angiograms who are re-presenting with chest pains are now being offered microvascular testing and the opportunity to take part in the iCorMicA study to see if knowing the results of this test are improving patient outcomes.

@TransformBetsi | #BetterByBetsi | #TheBetsiWay

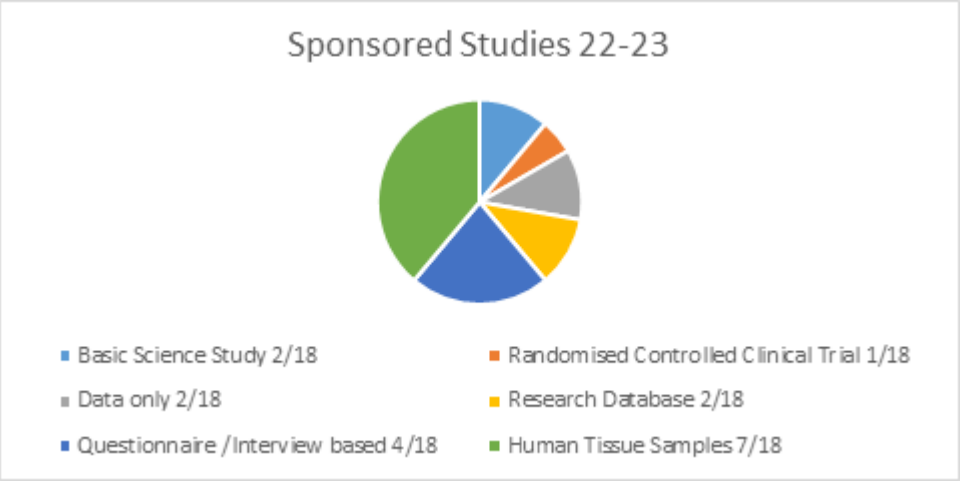
Contact:
Rachel Manley, Research Nurse

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

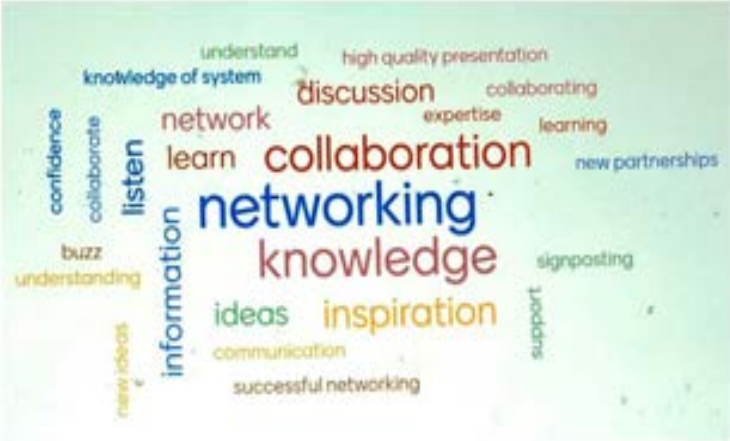
Increasing capacity and capability

Key to developing a positive research culture in BCUHB is recognising the need to increase research capacity and capability and support our research leaders.

We are currently sponsoring 18 research studies, supporting staff who are developing and leading their own research.



In September 2023 we held a research event at Venue Cymru in collaboration with Health and Care Research Wales, the Community of Scholars (CoS), and the North Wales Organisation for Randomised Trials in Health (NWORTH). This event aimed to raise awareness about research funding support and foster fruitful collaborations within our research community. We aim to support our staff to access HCRW faculty opportunities, and for the CoS to develop a pipeline of successful applications.



Libraries

The BCUHB Library Service continues to have a role in research within the Health Board. The three libraries offer a variety of support to firmly embed research within the organisation.

In an effort to improve research discoverability library staff are working on a published papers SharePoint site - an institutional repository that will provide a record of our research output, which can then be preserved, re-purposed and showcased effectively. Most of the preliminary work has been completed but, additional functionality will be a work in progress. The site is currently being reviewed internally prior to rollout. It is hoped the site will be up and running in the next few months.

Over the 12 month period September 2022 – September 2023 211 papers were published/affiliated to the Health Board. There are potentially more given only the Ovid Medline bibliographic database is searched at present to draw in content.

BCU Public Health Team

The BCU Public Health Team (BCU PHT) works with colleagues in the Health Board and with other partners across North Wales to improve the health and wellbeing of the population of North Wales and reduce health inequalities. The team has cooperated with university departments on a number of recent innovative projects and maintains close links with both Bangor and Wrexham Universities.

The BCU PHT worked with the Public Health Collaborating Unit of Bangor University to develop a report to look at the impact of Covid-19 on the mental wellbeing of the population of North Wales and interventions that could address the issues raised (Ford et al, 2022). This work was presented a number of conferences, won a poster prize at the Welsh Rural Conference and informed the new together for mental health strategy for North Wales.

BCUHB Help Me Quit (HMQ) Services are implementing an innovative pilot incentivisation scheme for pregnant women to stop smoking. Voucher incentive schemes have proven to be effective and cost-effective, with women receiving incentives more than twice as likely to quit and remain quit compared to those not receiving incentives. The results of the evaluation of the pilot scheme will help inform future learning and incentivisation schemes across Wales.

A Strategic Violence Needs Assessment was commissioned by the BCU PHT and developed by the Violence Prevention Unit (Wales), funded by the WG Building a Healthier Wales fund (Barton, 2022). The assessment provides a baseline assessment of interpersonal violence across North Wales to support the delivery of the Serious Violence Duty.

A survey developed by the BCU LPT to explore professionals' role in alcohol use in pregnancy found low awareness about the BCUHB Substance Misuse Specialist Midwife Liaison Service. The findings have shaped the next steps for the Alcohol in Pregnancy work focused on developing and promoting the Specialist Midwife Liaison Service referral pathway to support substance misuse services for pregnant women.

The BCU PHT recently asked the Behavioural Science Unit of Bangor University for an insight into understanding barriers and enablers to childhood immunisation

uptake in North Wales (Sharp & Parkinson, 2022). The purpose of the insight project was to seek health professionals and service users' views on how to improve uptake of childhood immunisation in children & young people most at risk of not being immunised in North Wales.

The BCUHB Public Health Whole System Approach to Healthy Weight Team have worked in partnership with Leeds Beckett University to undertake system mapping of the causes of unhealthy weight in North Wales and social network analysis to identify and analyse the inter-connections and influences between different people or organisations within the healthy weight system in North Wales. These two pieces of work have been accepted as poster presentations at the European Congress on Obesity conference that took place in May 2023 in Dublin.

The BCU PHT has long worked closely with the Centre for Health Economics and Medicines Evaluation at Bangor University (CHEME).

Health Economics and public health research at the Centre for Health Economics and Medicines Evaluation, Bangor University

The Centre for Health Economics & Medicines Evaluation (CHEME) was founded in 2001. CHEME's, aim to promote and sustain high-quality research across various health economic and medicines evaluation research activities. Part of the research undertaken at CHEME adopts a life-course model applying methods of health economics evaluation to trials and other study designs in the evaluation of public health and psychosocial interventions at both programme and system level.

A recent infographic created by Professor Rhiannon Tudor Edwards and colleagues at CHEME reflects an underlying concept of "the wheel of life." (Edwards, 2022). The infographic represents movement through the life course at its centre, with concentric rings summarising personal, local, national and global factors that impact the well-being and

well-becoming of individuals through the life course. It also includes death, which is a topic often avoided.

Future ways of financing prevention across health systems and wider society

Researchers at CHEME are partners in a new £4 million Horizon Europe project, Invest4Health, 'Mobilising novel finance models for health promotion and disease prevention'. Invest4Health aims to investigate new ways of incentivising where the costs and benefits of preventing avoidable ill health and premature mortality lie across multiple sectors of economy. Invest4Health will bring together stakeholders across healthcare ecosystems to plan and finance health promotion and disease prevention at the population, community and individual levels to facilitate a paradigm shift from hospital-centred to community-based, people-centred and integrated services.

Reducing unnecessary prescribing in Wales

Senior research fellow at CHEME, Dr Emily Holmes, is undertaking a fellowship project funded by health and care research Wales exploring "The Economics of Rapid Diagnostics to reduce Antibiotic Prescribing in NHS Wales (TRaDe)". The TRaDe project will gather public and professional opinions on quick and easy tests that can be performed during a clinic appointment, such as a finger prick, and help identify whether or not the patient needs antibiotics. It will assess how peoples' views and behaviour affect the value (cost-effectiveness) of these tests and make recommendations on the best way to organise testing services to reduce antibiotic prescribing in NHS Wales (Holmes, 2023).

Supporting evidence-based policy for Welsh Government with the Health and Care Research Wales Evidence Centre

A team of researchers at CHEME are part of the Health and Care Research Wales Evidence Centre. The team has produced six rapid reviews to date, reviewing evidence from existing research studies (Spencer, Hartfiel, et al., 2022; Spencer, Hendry, et al., 2022).

Summary and looking forward

The capacity of health services with unscheduled care demands and the backlogs in clinical care putting pressure on space, support services and clinical time creates service pressures. There are opportunities to increase research activity in BCUHB, which will have positive benefits for our patients and staff. The research we conduct may offer solutions to the current pressures.

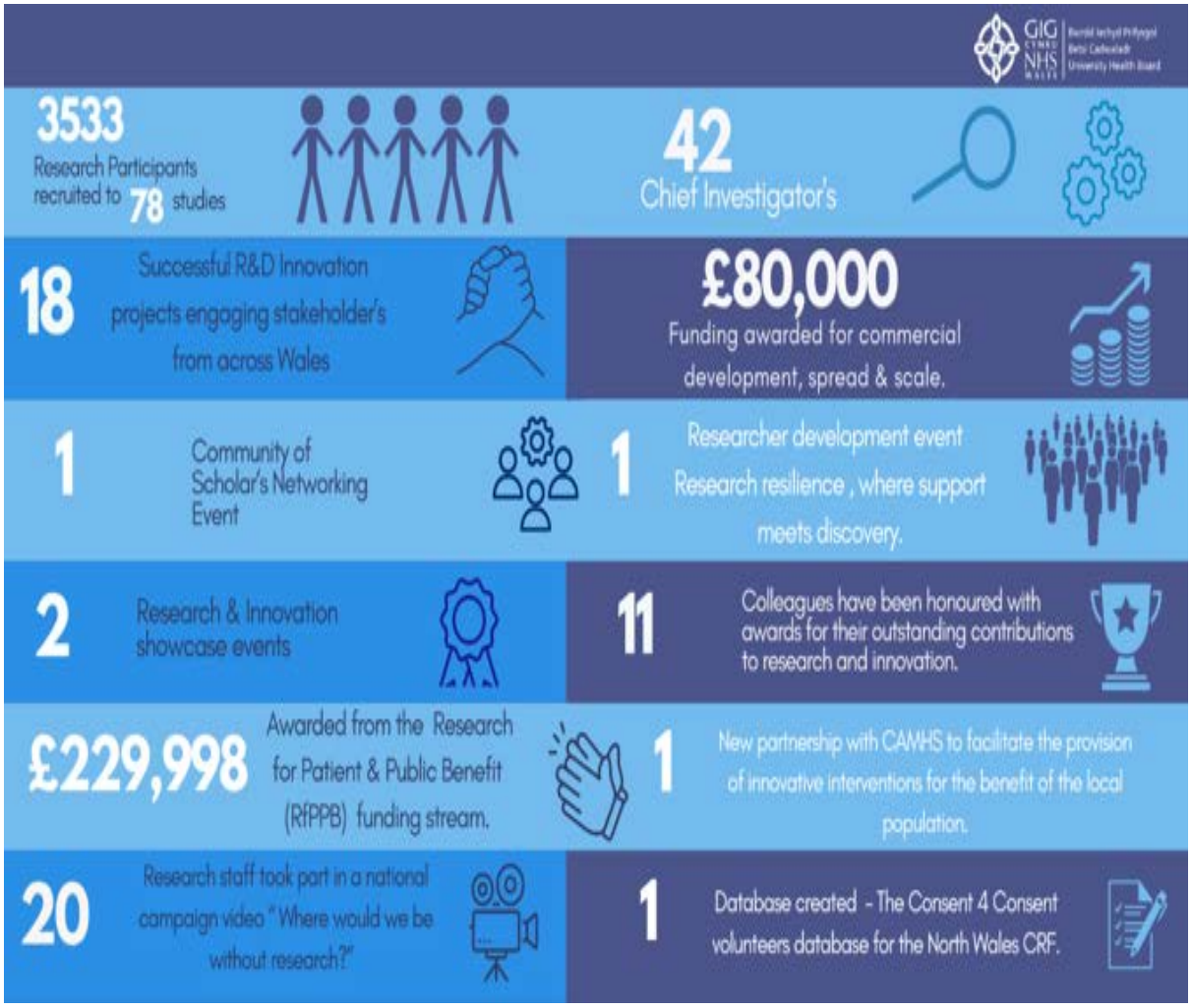
Commercial research

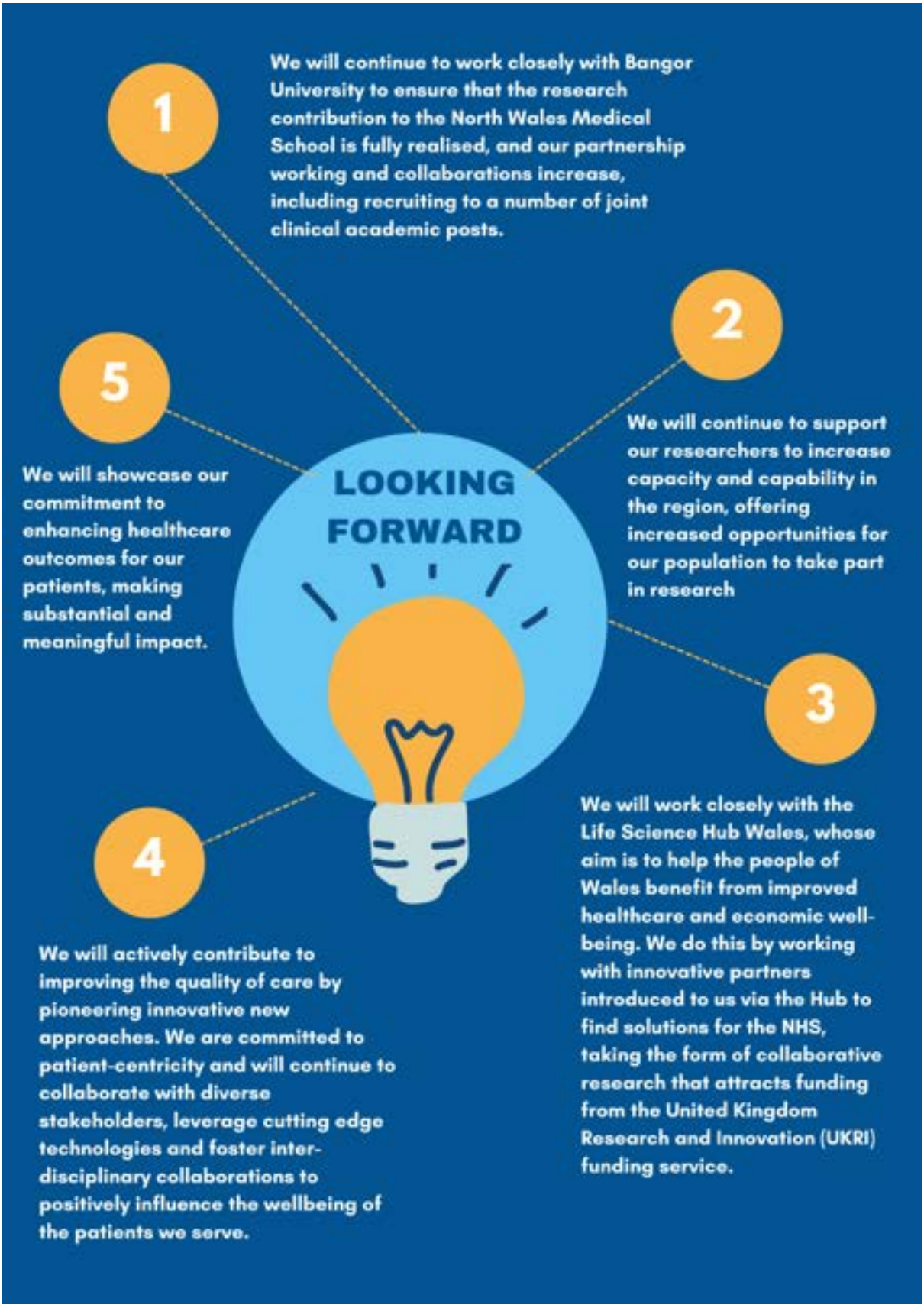
The voluntary scheme for branded medicines pricing, access and growth (VPAG) has been agreed by the government, NHS England and the Association of the British Pharmaceutical Industry (ABPI) to invest £400 million over 5 years until 31 December 2028 to drive forward UK innovation, sustainability and growth. The programme will be ring-fenced, and £300m has been allocated to bolster the NHS's capacity to deliver commercial clinical research. A proportion of this funding will come to Wales, and this offers opportunity for BCUHB to build its infrastructure to deliver commercial research, with the opportunities this offers to generate funding to re-invest in R&D.

Collaborations

Working with our university colleagues and the North Wales Medical School offers opportunities to work in partnership to further develop research and innovation in the region.

We will work with colleagues across Wales and the UK to deliver the UK Clinical Research Strategy. We are committed to increasing our research activity and our CRF activity across all three integrated health communities.


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
3533
Research Participants recruited to 78 studies
42
Chief Investigator's
18
Successful R&D Innovation projects engaging stakeholder's from across Wales
£80,000
Funding awarded for commercial development, spread & scale.
1
Community of Scholar's Networking Event
1
Researcher development event Research resilience , where support meets discovery.
2
Research & Innovation showcase events
11
Colleagues have been honoured with awards for their outstanding contributions to research and innovation.
£229,998
Awarded from the Research for Patient & Public Benefit (RfPPB) funding stream.
1
New partnership with CAMHS to facilitate the provision of innovative interventions for the benefit of the local population.
20
Research staff took part in a national campaign video " Where would we be without research?"
1
Database created - The Consent 4 Consent volunteers database for the North Wales CRF.


1
We will continue to work closely with Bangor University to ensure that the research contribution to the North Wales Medical School is fully realised, and our partnership working and collaborations increase, including recruiting to a number of joint clinical academic posts.
2
We will continue to support our researchers to increase capacity and capability in the region, offering increased opportunities for our population to take part in research
3
We will work closely with the Life Science Hub Wales, whose aim is to help the people of Wales benefit from improved healthcare and economic well-being. We do this by working with innovative partners introduced to us via the Hub to find solutions for the NHS, taking the form of collaborative research that attracts funding from the United Kingdom Research and Innovation (UKRI) funding service.
4
We will actively contribute to improving the quality of care by pioneering innovative new approaches. We are committed to patient-centricity and will continue to collaborate with diverse stakeholders, leverage cutting edge technologies and foster inter-disciplinary collaborations to positively influence the wellbeing of the patients we serve.
5
We will showcase our commitment to enhancing healthcare outcomes for our patients, making substantial and meaningful impact.
LOOKING FORWARD

Appendix i

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

Teitl adroddiad: ***Report title:***	Nurse Staffing Levels Assurance report
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	In line with the Nurse Staffing Levels (Wales) Act 2016, Health Boards are required to calculate and take all reasonable steps to maintain the nurse staffing levels in acute adult medical & surgical inpatient wards and paediatric inpatient wards using the processes prescribed within the Act. This paper introduces the 2023/24 Betsi Cadwaladr University Health Board (BCUHB) annual assurance report for the period 6th April 2023 - 5th April 2024. The All Wales Nurse Staffing Group has produced the standard template which must be used to form the annual assurance report to ensure consistency in the information from each Health Board within Wales.
Argymhellion: ***Recommendations:***	The Board is asked to • receive this report to gain assurance in relation to the following: 1. Betsi Cadwaladr University Health Board (BCUHB) is 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. 2. BCUHB is meeting its statutory duty to provide an Annual Presentation to the Board detailing calculated nurse staffing levels • note that a financial assessment arising from the organisations statutory duty to calculate nurse staffing levels has been submitted via the IMTP scheme for consideration within the financial planning cycle for 2024/25.
Arweinydd Gweithredol: ***Executive Lead:***	Mrs Angela Wood, Executive Director of Nursing & Midwifery
Awdur yr Adroddiad: ***Report Author:***	Mrs Anne-Marie Rowlands, Director of Nursing Professional Regulation & Education Miss Joanna Brown, Nurse Staffing Programme Lead

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

Lefel sicrwydd:	Arwyddocaol *Significant*	Derbyniol *Acceptable*	Rhannol *Partial*	Dim Sicrwydd *No Assurance*

Assurance level:	☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	*Nurse Staffing Levels (Wales) Act 2016*[1] Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards, adult acute surgical inpatient wards, and paediatric inpatient wards. *A Healthier Wales: Our Plan for Health and Social Care*[2] identifies a requirement to "*drive the changes we need to see in our health and social care system, so that it is able to meet the needs of current and future generations in Wales*" Recruitment and retention are key themes within these plans, and notes that while health and social care services have capability to attract the best talent in the world, there is evidence of fragility in specific services that have affected the delivery of quality care to patients. *A Healthier Wales: Our Workforce Strategy for Health and Social Care*[3] draws a direct link between vacancy rates and high agency expenditure. *The priorities of the Chief Nursing Officer* includes an ambition to *attract, recruit, train, educate and retain the nursing and midwifery workforce so that the nursing and midwifery vacancy factor is reduced, working towards no vacancies over 3-5 years*			

[1] https://gov.wales/healthier-wales-long-term-plan-health-and-social-care
[2] https://gov.wales/healthier-wales-long-term-plan-health-and-social-care
[3] https://socialcare.wales/cms_assets/file-uploads/Workforce-strategy-ENG-March-2021.pdf

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Statutory reporting requirements aligned to the Nurse Staffing Act (Wales) 2016 *"duty to calculate and take steps to maintain nurse staffing levels"*
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)***	CRR2113 - Nurse Staffing (Continuity of service may be compromised due to a diminishing nurse workforce). There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. Inability to provide appropriate nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Boards ability to deliver health care effectively, and compromise the reputation of Health Board nursing services. This could be further exacerbated by the impact on the resilience of the workforce due to; 1) the ongoing Covid 19 pandemic 2) the increasing age profile within the workforce 3) retention rate of nursing staff across the Health Board. CRR15 Recruitment & Retention (this applies to all staff across the Health Board but the nursing workforce is a significant element of the risk). There is a risk that the Health Board will have difficulty recruiting and retaining high quality staff in certain areas. This may be due to UK shortages for certain staff groups and the rurality of certain areas of the health board. This could lead to poor patient experience and outcomes, low morale and well-being and attendance of staff
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Financial assessments arising from the organisations statutory duty to calculate nurse staffing levels will be considered within the financial planning cycle for 2024/25.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Workforce implications relate to the ability to both finance and recruit a sufficient workforce of both registered nurses and healthcare support workers
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	As detailed above - Risk ID1976
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	*Not applicable*
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Annual Assurance Report of the Nurse Staffing Levels May 2024 Appendix 2 – Annual Assurance Report Summary of Required Establishment Spring 2023 & Autumn 2023 Appendix 3 – Summary of the Nurse Staffing Levels for 25B Wards Spring 2024	

GIG NHS | Staff Nyrsio Nurse Staffing

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Betsi Cadwaladr University Health Board		
Date annual assurance report is presented to Board	Executive Meeting 8th May 2024 Board Meeting 30th May 2024 This annual report refers to the reporting period 6th April 2023 – 5th April 2024 and forms part of the 3 yearly assurance report for the reporting period from 6th April 2021- 5th April 2024, that will be presented to Welsh Government during April 2024 (caveated) and September 2024 (finalised).		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Total **lowest** number of Medical Wards = 25 Ysbyty Gwynedd 7 Ysbyty Glan Clwyd 9 Ysbyty Wrexham Maelor 9 Total **highest** number of Medical wards = 26 Ysbyty Gwynedd 8 Ysbyty Glan Clwyd 9 Ysbyty Wrexham Maelor 9	Adult acute surgical inpatient wards have remained unchanged/static during the reporting period: Total Surgical wards = 17 Ysbyty Gwynedd 5 Ysbyty Glan Clwyd 6 Ysbyty Wrexham Maelor 6	Paediatric inpatient wards have remained unchanged/static during the reporting period: Total Paediatric Wards = 3 Ysbyty Gwynedd 1 Ysbyty Glan Clwyd 1 Ysbyty Wrexham Maelor 1
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	Adult acute medical inpatient ward staffing levels have been reviewed / recalculated on two occasions outside of the bi-annual calculation process. Following a ward reconfiguration within the Ysbyty Gwynedd site both Aran & Tryfan wards were recalculated in December 2023 with Tryfan ward no longer meeting the definition of a Section 25B ward from this date	Staffing levels have not been reviewed / recalculated outside of the bi-annual calculation periods.	Staffing levels have not been reviewed / recalculated outside of the bi-annual calculation periods.

The process and methodology used to calculate the nurse staffing level.	Section 25A of the Nurse Staffing Levels (Wales) Act 2016 sets out the responsibilities of each health board to ensure that there are appropriate nurse staffing levels across their respective organisations to ensure safe, effective and timely care to patients. This report will focus on the wards to which Section 25B of the Nurse Staffing Levels (Wales) Act pertains within BCUHB[1]. In line with the requirements of the Nurse Staffing Levels (Wales) Act 2016, wards pertaining to Section 25B are subject to bi-annual reviews[2] in order to appropriately calculate planned nurse staffing levels. The organisation has been fully compliant with the requirements of bi-annual nurse staffing calculations since the operational inception of the Nurse Staffing Levels (Wales) Act 2016 in April 2018. The narrative detailed within the annual assurance report appendices has attempted to demonstrate the rationale for any changes to the nurse staffing levels, for example changes to care quality outcomes, or sustained change in the pattern of patient acuity and ward activity. **Methodology used to calculate the nurse staffing level:** Section 25C of the Nurse Staffing Levels (Wales) Act 2016 describes the triangulated method of calculation that must be applied when undertaking the nurse staffing level calculations / reviews. The triangulated methodology involves collecting, reviewing and interpreting data relating to Patient Acuity, Care Quality Indicators, and Professional judgement. Patient Acuity data is measured using Welsh Levels of Care[3] evidence-based workforce planning tool. This measure of patients' levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care. Within BCUHB the RL Datix SafeCare system[4] captures acuity data on a shift by shift basis, however across Wales, in all wards where section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies, formal acuity audits are undertaken every 6 months (January and June). To support the acuity audits a monthly dashboard[5] has been developed which provides information regarding patient acuity, patient flow and nurse staffing levels.

[1] Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatient wards; adult acute surgical inpatient wards; and paediatric inpatient wards. Excluded from the definition of Section 25B wards are outpatient departments, admission portals/assessment units, critical care/high dependency units, day case areas, rehabilitation areas, theatres, procedural units, coronary care units. These areas ordinarily undergo a (minimum) annual nurse staffing review to ensure there are sufficient nurses to provide timely and sensitive care to patients.

[2] Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

[3] The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to Level 1 where the patients condition is stable and predictable, requiring routine nursing care.

[4] RL Datix (formally known as Allocate) SafeCare is a daily staffing software system that displays real time nurse staffing levels and patient acuity enabling informed decision making on staffing levels across a hospital site. It enables visibility of staff to support deployment of resource in addition to the recording of red flags and professional judgement reasons and mitigating actions taken.

[5] Acuity report - Power BI Report Server

	Care Quality Indicators are measures that are particularly sensitive to care provided only by a nurse and must be considered during the calculation process. The quality indicators shown to have an association with low nurse staffing levels are identified as: • Patient falls - any fall that a patient has experienced whilst a patient on the ward • Pressure ulcers - total number of hospital acquired pressure ulcers considered to have developed, or worsened, while a patient on the ward; • Medication administration errors - any error in the preparation, administration or omission of medication by nursing staff • Complaints – wholly or partly about care provided to patients by nurses made in accordance with the complaint's regulations. Paediatric inpatient wards also include infiltration/extraversion injuries as part of their care quality indicator measurements. In addition to the indicators set out above, any other indicator that is sensitive to the nurse staffing level may be considered. Examples may include, but are not limited to, patient experience, unmet care needs, failure to respond to patient deterioration, staff experience & well-being and compliance with mandatory training and performance development reviews. Professional judgement is the application of nursing knowledge, skills and experience in order to make an informed decision regarding nurse staffing level calculations. Professional judgement will take into account the qualifications, competencies, skills, experience, professional development, and mandatory training requirements of the nurses providing care to patients within the ward. It will also consider the use of temporary staffing, conditions which may affect care provision, support to students and learners, ward layout, the turnover of patients and overall bed occupancy, the complexity of patient needs in addition to their medical or surgical nursing needs (for example, patients with learning disabilities), and staff health and well-being. During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence, with equal weighting given to all the information that informs this process. The designated person[6] will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

[6] The designated person must act within the health boards governance framework authorising that person to undertake the nurse staffing calculation on behalf of the health boards Chief Executive Officer. In view of the requirement to exercise nursing professional judgement, the designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a Nurse staffing level in the clinical environment, such as the Executive Director of Nursing and Midwifery.

In line with the Nurse Staffing Levels (Wales) Act 2016, and following consideration of these factors, an uplift of 26.9% is applied to both the registered nurse (RN) and health care support worker (HCSW) establishments to cover staff absences[7]. As per the requirements of the Nurse Staffing Levels (Wales) 2016 Act all Band 7 Ward Managers are supernumerary and are therefore not included in the required establishment figures.

Process used to calculate the nurse staffing level:

In line with the Nurse Staffing Levels (Wales) Act 2016, nurse staffing calculations are to be approved by a designated person who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh health boards the designated person is the Executive Director of Nursing.

BCUHBs process of calculating nurse staffing levels has 3 steps:

Step 1: Initial Review
The review process is commenced at ward level with the Ward Manager presenting ward acuity data, care quality indicators, and professional judgement. Each ward completes the designated proforma to evidence the review process and application of the triangulated methodology described above. This also ensures a consistent and transparent approach to undertaking nurse staffing level calculations. This is presented at site level, for review, discussion and supportive challenge.

The Integrated Health Community (IHC) Director of Nursing (DON) / Associate Director of Nursing (ADoN) leads the site reviews to calculate nurse staffing levels in collaboration with the Heads of Nursing, Matrons, Ward Manager, and colleagues from finance. The review is informed by both qualitative and quantitative information comprising of information and data gathered using the triangulated methodology covering Patient Acuity, Care Quality Indicators, and Professional judgement.

Additional information provided at the initial review includes, though is not limited to:

- Current ward bed numbers and speciality, including specific treatments or procedures.
- Ward environment, layout and geographical position
- Detail of service and patient pathway changes
- Ward based initiatives, improvement programmes or action plans
- Current nurse staff provision, including those that are not included in the core roster (supervisory ward manager, frailty/rehabilitation support workers, dementia support workers, ward administrators etc.).

[7] The 26.9% covers absences relating to annual leave, sickness and study leave but excludes maternity leave.

	• Workforce/Staffing related metric data i.e. budgeted and actual establishments, Performance & Development Review (PADR) compliance, mandatory training compliance, sickness, maternity leave. • Patient flow/activity related data for the previous 12 months. • Finance related data i.e. pay/non pay expenditure/utilisation of permanent/temporary staff. **Step 2: Health Board Wide Review** A health board wide (multi-site, service specific) review is undertaken, led by the Director of Nursing for Workforce, Staffing and Professional Standards, taking into account national guidance and best practice evidence, to ensure a consistent health board wide approach. The review includes sharing good practice and lessons learnt and providing assurance of compliance with the Nurse Staffing Levels (Wales) Act 2016 requirements in that all workforce models must include an uplift of 26.9% and that a supernumerary Band 7 Ward Manager has been calculated within the overall workforce plan for each ward. Supportive challenge and discussions are undertaken between the senior nurse leadership team[8], and colleagues from workforce and finance to ensure the legitimate and validated application of the triangulated methodology. **Step 3: Formal Presentation of Nurse Staffing Levels to Executive Director of Nursing & Midwifery** Each Integrated Health Community Nurse Director / Associate Director of Nursing formally present their proposed nurse staffing levels to the Executive Director of Nursing and Midwifery as the confirmed designated person. In attendance are the Executive Directors for Workforce & Organisational Development; & Finance (or their nominated deputies). Final approval of the Nurse Staffing Levels is agreed by the Executive Director of Nursing and Midwifery as the confirmed designated person and on approval, these are formally presented to the Board in November each year. The formal autumn 23 presentation to the Executive Director of Nursing & Midwifery took place on 5th October 2023 with the Finance Director for Commissioning & Strategy and the Deputy Director of People in attendance with the outcome of these presented to Board on 30th November 2023[9]. The formal spring 24 presentation to the Executive Director of Nursing & Midwifery took place on 12th April 2024 with the Chief Finance Officer (East) and the Associate Director Workforce Optimisation in attendance with the outcome of these presented in appendix 3.
Informing patients	In line with the requirements of the Nurse Staffing Level (Wales) Act 2016, information boards are located at the entrance to each of the wards displaying the planned nurse staffing levels on the wards and the date these were presented to the Board. Nationally agreed bilingual “Once for Wales” templates are utilised to display the planned staffing levels, with supplementary information available via a poster explaining the purpose of the Act and a Frequently Asked Questions leaflet (available bilingually in standard and easy read versions) to answer any more detailed questions a patient or a visitor may have about

[8] Director of Nursing for Workforce, Staffing and Professional Standards, Integrated Health Community Nurse Director / Associate Director of Nursing and Heads of Nursing
[9] bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/agenda-bundle-health-board-301123-final-revision-published-to-web-11223/

the Act. Ward staff are aware of, and endeavour to maintain Welsh Language Standards and translation services to ensure that patients are offered the opportunity to communicate through their language of choice.

It is acknowledged that this particular method has been limited at times and during the COVID-19 pandemic, as patient information boards are displayed in communal areas, the stringent infection control protocols in place may have led to inconsistencies in the approach to displaying the required patients' information.

Ward Managers and Senior Nurse Managers have been issued with renewed guidance regarding their duties to inform patients under the Nurse Staffing Levels (Wales) Act 2016 and regularly assurance is sought via the Nursing Workforce & Staffing meetings that these duties are being met. During 2024 audits will be undertaken across the wards pertaining to Section 25B to measure compliance with the informing patient requirements, the results of which will be shared with the respective Integrated Health Community Nurse Directors and Associate Directors of Nursing and the Executive Director of Nursing & Midwifery.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within adult acute medical and surgical wards.

NB: First cycle: spring 2023 following January audit
Second cycle: autumn 2023: following June audit

	6th April 2023 – 5th April 2024		
	Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	**42**	**813.94**	**730.47**
WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	**42**	**792.73**	**541.43**
Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	**43**	**839.4**	**759.51**
WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	**43**	**836.98**	**741.30**
WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 43**		

Accompanying narrative:

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of

additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

During the reporting period 40 wards have seen **no** changes to their required establishment, 2 wards have required a change and 1 additional ward has met the definition of a ward pertaining to Section 25B of the Act. Of the 2 wards requiring a change to establishment, 1 was due to service redesigns across the orthopaedic speciality. Changes associated with service redesigns will be monitored and staffing levels adjusted as appropriate as these progress and mature.

Details of individual wards and their calculated nurse staffing levels can be found in the annual assurance report appendices. The narrative detailed within the annual assurance report appendices demonstrates the rationale for any changes to the nurse staffing levels. Financial implications of the Autumn 2023 nurse staffing level calculations review will be considered within the 2024/25 financial planning cycle however, to mitigate the risks all Section 25B wards have been able to recruit and staff to the calculated required establishment figures utilising temporary staffing as necessary to achieve these levels.

The nurse staffing reviews have again identified the regular (and in some areas sustained) use of “escalation beds” in response to system pressures and as such funding for these beds are included for consideration in the planning and prioritisation schedule of the Integrated Medium Term Plan (IMTP). Staff are utilised from across the site to support the staffing of these wards/beds alongside the use of temporary staffing. Seasonal and temporal pressures historically experienced during winter months, build throughout the year and it is evident that this pressure is placing significant stress on staff and creating significant risks for patients.

Although staffing requirements associated with escalated beds is not included in the data relating to Section 25B wards this information will continue to be captured as part of the nurse staffing levels review process and included within the respective Integrated Health Community IMTP plans.

The extent to which wards pertaining to Section 25B have repurposed during this reporting period is less than was seen across previous reporting periods. Patient acuity however has remained higher than pre-covid periods across all inpatient areas. In line with the rest of Wales, the health board is showing a trend of reduced Level 1 and 2 patients, and increased levels 3 and 4 patients in our adult acute medical and surgical wards. Acuity data for wards pertaining to Section 25B during the reporting period in June 2023 shows that an average of 78% of patients requiring care were Level 3 and 4, with 10% of patients requiring Level 5 care.

<u>Developments and processes for achieving required establishments across all Section 25B wards (adult & paediatric)</u>:

As a health board there has been underpinning work to secure and assure plans for maintaining Nurse staffing levels and compliance with the 2016 Act to date, and ongoing. There is continual development as greater information, analysis and comprehension is gained locally and nationally. There are a range of both short and long term actions being taken by the

	health board to improve the extent to which a sufficient workforce is available to work within the registered nurses (RN) and healthcare support workers (HCSW) establishments across all health settings. People Services continue to work closely with senior nursing and midwifery colleagues to maximise recruitment and retention of nursing and midwifery staff initiatives which include: • Initiatives being led by People Services and Corporate Nursing teams to develop and implement innovative approaches to recruitment of registered nurses and healthcare support workers • Continued engagement with the national All Wales International Nurse Recruitment Programme with 231 FTE Internationally Educated Nurses recruited since October 2022. • Bachelor of Nursing Part Time and Open University fast track for healthcare support workers employed by the organisation to ensure that we are able “grow our own” • Assistant Practitioners (Band 4) integrated well within establishments, and undertaking extended duties on a competency assessed basis in line with the All Wales Framework. Ongoing work at a national basis regarding the potential professional regulation/ registration of these care workers. • Annual establishment reviews for areas exempt from Section 25B of the Act to ensure the health board is fulfilling its statutory duty to provide sufficient nurses to allow them to care for patients sensitively wherever nursing services are provided or commissioned. • Utilisation of the RL Datix SafeCare system to provide live visibility of staffing levels and patient demand to ensure the deployment of resource effectively. Weekly reports are provided to the DoN/ADoN to ensure targeted support to areas of poor compliance. • Introduction of the roster autocascade system to ensure the efficient sourcing of temporary staffing; and Wagestream to provide financial wellbeing for all staff. • Continual review and enhancements of BCUHB careers framework • Introduction of quarterly nursing workforce optimisation presentations by the IHC DoN/ADoN to the Executive Directors of Nursing & Midwifery; Finance; and People Services or their nominated deputies. The meetings focus on several workforce elements including staffing establishments, vacancies, recruitment, rostering compliance and temporary staffing utilisation. • Short-term mitigation remains through the use of temporary staffing (bank and agency workers) and deployment of substantive staff internally

Extent to which the required establishment has been maintained within paediatric inpatient wards NB: First cycle: spring 2023 following January audit Second cycle: autumn 2023: following June audit		**6th April 2023 – 5th April 2024**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of paediatric inpatient wards calculated during first cycle (May)	**3**	**83.46**	**31.27**
	WTE of required establishment of paediatric inpatient wards funded following first (May) calculation cycle	**3**	**79.45**	**31.27**
	Required establishment (WTE) of paediatric inpatient wards calculated during second calculation cycle (Nov)	**3**	**83.46**	**31.27**
	WTE of required establishment of paediatric inpatient wards funded following second (Nov) calculation cycle	**3**	**80.98**	**28.95**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 3**		

Accompanying narrative:

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

The number of Section 25B wards within paediatrics has not changed during the reporting period and there have been no changes made to the required staffing establishments. Details of individual wards and their calculated nurse staffing levels can be found in the annual assurance report appendices. Financial implications of the Autumn 2023 nurse staffing level calculations review will be considered within the 2024/25 financial planning cycle however, to mitigate the risks all Section 25B wards have been able to recruit and staff to the calculated required establishment figures utilising temporary staffing as necessary to achieve these levels.

Acuity data for the paediatric inpatient wards during the reporting period in June 2023 shows very few patients at level 1 on the paediatric wards, with the majority of patients being levels 2 and 3. There were no days without some patients at level 4 or 5 across the units. The paediatric wards have a very high turnover with average length of stay lower than that seen on adult wards. This is supported by the flow data with an average of 41 admissions recorded across the three paediatric units per day.

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	46575	14451	4216	12150	10862	89.49%
		31.03%	9.05%	26.09%	23.32%	

Accompanying narrative:

During April 2023 to April 2024 BCUHB has utilised the SafeCare system to capture data for the adult acute medical & surgical wards. SafeCare provides the ward user with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients on a shift by shift basis. The information reported for the extent to which the planned roster has been maintained within adult acute medical and surgical wards is based on the Early, Late and Night shifts only, includes both substantive and temporary staffing as recorded on the rosters, and the response provided by the nurse in charge who utilises their professional judgement to record the appropriateness of the staffing levels on each of these shifts.

This is the third year of reporting in this way and significant improvements have been made in the quality of the data being reported with overall data completeness rising from 37.82% (first year) to 89.49% across the adult medical and surgical Section 25B during this reporting period. Work will continue to ensure that the improvements are sustained with data being monitored and validated at regular intervals throughout the year.

Extent to which the planned roster has been maintained within paediatric inpatient wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	3142	2066	145	578	151	93.57%
		65.75%	4.61%	18.40%	4.81%	

Accompanying narrative:

	During this reporting period the paediatric inpatient wards have utilised both the Health Care Monitoring System (HCMS) and SafeCare system to enable the capture and analysis of data. Operational pressures impacted on the organisations ability to implement SafeCare to the paediatric wards within the desired timeframe, with the paediatric ward in Ysbyty Maelor Wrexham having successfully moved to capturing data fully within the SafeCare system from 1st February 2023 and the paediatric wards in Ysbyty Glan Clwyd and Ysbyty Gwynedd Bangor completing this from 1st June 2023. Whilst there has been a slight decrease in the data completeness across the paediatric inpatient wards from 98.54% during the last reporting period to 93.57% in this reporting period it is important to note that the frequency of data capture has increased as the HCMS system enabled the data to be captured once daily whilst the SafeCare system provides the ward user with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients three times daily. Data completeness is monitored and validated at regular intervals throughout the year. From 1st June 2023 the information reported for the extent to which the planned roster has been maintained within the paediatric inpatient wards is based on the Early, Late and Night shifts only, includes both substantive and temporary staffing as recorded on the rosters, and the response provided by the nurse in charge who utilises their professional judgement to record the appropriateness of the staffing levels on each of these shifts.
Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.	NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. Extensive work has been undertaken across NHS Wales to implement a national informatics system to enable health boards/trust to meet the reporting requirements of the Act and follow the Once for Wales approach to ensure consistency. Each health board/trust is committed to implementing the RL Datix SafeCare system with each organisation at different stages of implementing this system within their areas, prioritising section 25B wards. Prior to the national steer BCUHB had implemented SafeCare across all their Section 25B adult acute medical & surgical wards, with the paediatric inpatient wards having completed their implementation in June 2023. Whilst SafeCare has been implemented health boards/trusts have also utilised the Health Care Monitoring system (HCMS) which has been adapted to ensure consistency in the data collection and analysis to aid reporting. Due to the transitional arrangements whereby health boards/trusts are implementing the RL Datix SafeCare system alongside the HCMS system to capture the data required to inform the calculation and reporting of the nurse staffing level, the data presented in the above tables will be a combination of information generated from SafeCare and HCMS. Within BCUHB all data presented for the adult acute medical and surgical wards is generated from SafeCare whilst the paediatric inpatient wards has been generated from both SafeCare and HCMS for this reporting period.

	BCUHB has worked closely with the All Wales SafeCare Implementation Group to support and ensure a consistent All Wales approach. An All Wales SafeCare Standard Operating Procedure has been developed and is in use across BCUHB. Enhancements continue to be made to the SafeCare system to ensure the reporting requirements of the Act can be met.
Process for maintaining the Nurse staffing level	The Nurse Staffing Levels (Wales) Act 2016 statutory guidance requires that the health board takes 'all reasonable steps' to maintain its staffing levels. As a health board there has been underpinning work to secure and assure plans for maintaining nurse staffing levels and compliance with the 2016 Act to date, and ongoing. There is continual development as greater information, analysis and comprehension is gained both locally and nationally. The ongoing impact of Covid 19, vacancy rates and variability in skill mix continues to be a challenge which cannot be under estimated. The competency, skill and experience of the nurses providing care to patients is a crucial component that has influenced the nurse staffing requirements within the bi annual calculation. Operational teams apply their professional judgment to ensure that the staffing levels wherever possible, are maintained – and, where not possible, mitigated, whilst also having regard for the health board's overarching duty of "providing sufficient nurses to allow the nurses time to care for patients sensitively". There are established processes in place within the Integrated Health Communities (IHC) nursing structures which allow for reviews of nurse staffing levels operationally on a daily basis, and support operational risk based decisions about the deployment of staff. The process for maintaining nurse staffing levels is a continuous process which includes both long and short term planning with specific examples of actions which have been taken at both strategic/corporate and operational levels provided below, demonstrating that "all reasonable steps" have been explored and/or taken in order to maintain staffing levels, not only within Section 25B wards but across all services of the health board: • The RL Datix SafeCare system provides real-time data in relation to staffing, skill mix and patient acuity. The system is reviewed on a shift-by-shift basis (as a minimum) by the Senior Nursing teams. The system, in addition to professional judgement, enables the temporary redeployment of resource to support timely and sensitive patient care. • Daily site operational meetings involving discussions relating to capacity, staffing and system risk to inform decisions regarding opening/closing additional capacity, planned care, and the redeployment of available staff. • Clinical site management team and on call arrangements in place providing 24/7 management and leadership to all services • Nurse staffing escalation processes are outlined in the BCUHB - Nurse Staffing Levels Policy and BCUHB Paediatric Escalation Policy • Band 7 Ward Managers are ordinarily supernumerary however they will have been included in care delivery numbers at times of increased capacity needs, and when providing sickness/absence cover. • Where appropriate study leave and non-essential meetings are stood down

	• Offer for staff to work additional hours or overtime to support their areas • Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered in advance to the temporary workforce team in order to optimise fill rate. Where appropriate, block booking is supported to ensure stability, and regular workers to aid continuity • Nurse managers and non-patient facing/corporate nursing teams deployed to support their clinical areas in order to maintain nurse staffing levels, and staff health and well-being through ensuring appropriate break times • An increase in the Band 6 establishments across identified wards pertaining to Section 25B with a primary purpose of strengthening senior support out of hours, whilst enhancing professional development and leadership. • Annual workforce planning undertaken which informs nursing education commissioning • Close working relationships with allied health professionals and non-nursing colleagues in order to utilise additional support where nurse staffing is unavailable, for example, therapy support/theatre staff/pharmacy and administrative progress chasers • Reporting potential compromise to patient care and/or experience considered to be attributed to nurse staffing via the Datix system and review. • Roster optimisation – ensuring that all rosters are completed in line with Rostering Policy WP28a. Rosters are subject to a double approval process which is monitored by the senior nursing team to ensure safe and effective rosters • A streamlined fast track recruitment process • Partnership working with local universities to maximise opportunities for recruitment and retention including innovative opportunities for post graduate development • Continued investment in education and development for staff including subscription to Florence Nightingale Foundation, Clinical Skills Modules and internally facilitated Continuing Professional Development programme to ensure wide range of opportunities available to staff • The introduction of additional roles to support nurse staffing such as Assistant Practitioners (Band 4) Progress Chasers (Band 3) to support the safe and timely discharge of patients • Career progression for healthcare support workers through completion of Qualification and Credit Framework Level 2 and 3 which enable progression to the Level 4 Certificate in Healthcare Practice. • Maximising opportunities for healthcare support worker development through Level 4 Certificate in Healthcare Practice qualification fast track route for healthcare support workers employed by the organisation into pre-registration nurse training, to ensure that we are able “grow our own”, options available include Open University and Part Time Bachelor of Nursing routes • Supporting career progression for health board employed healthcare support workers with an international nursing registration to progress to Band 5 registered nurse once successfully completed Objective Structured Clinical Examination. • Updating and implementation of fast track process for student nurses wishing to join the bank as a healthcare support worker • The appointment of new graduates via the streamlining process continues to be a success as does the internationally educated nursing recruitment programme.

	• The provision of pastoral support and a structure preceptorship programme for graduates and internationally educated nurses to ensure they settle well and have a rewarding and fulfilling career within BCUHB • Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally informed by workforce data/analysis and feedback • Staff wellbeing strategies are in place Work is ongoing to ensure there is a strong focus on staff retention with preceptorship programmes for new graduates, an ethos of support for lifelong learning and staff development, and the ability to provide a positive work-life balance and focus on staff work satisfaction. The BCUHB People Strategy & Plan is an essential enabler to the delivery of a sustainable nursing workforce, which is further supported by the All Wales National Workforce Implementation Plan and the subsequent Nurse Retention Plan, which places a focus on retention and innovation. This reporting period has seen the funded establishments across the Section 25B wards[10] for registered nursing posts increase from 912.8 (WTE) in April 2023 to 973.3 (WTE) in March 2024, an overall funded increase of 60.5 (WTE). Actual registered nursing staff in post have also risen across the period from 739.3 (WTE) in April 2023 to 824.5 (WTE) in March 2024, an increase of 85.2 (WTE). Successful recruitment into the Section 25B wards has meant that the vacancy rates for registered nurses within these areas has fallen from 19.0% (April 2023) to 15.3% (March 2024). Across the healthcare support worker funded establishments for the Section 25B wards[10] posts have increased from 611.5 (WTE) in April 2023 to 825.1 (WTE) in March 2024, an overall funded increase of 213.6 (WTE). Actual healthcare support worker staff in post have also risen across the period from 681.9 (WTE) in April 2023 to 752.4 (WTE) in March 2024, an increase of 70.5 (WTE). Following the significant investment in the funded healthcare support worker establishments during 2023/2024 the vacancy rate for this staff group initially rose to 16.8% during June 2023 however successful recruitment has seen this reduce month on month to its current level of 8.8% (March 2024).

[10] Applicable to those wards pertaining to Section 25B as at 31st March 2024. As previously stated the number of wards pertaining to Section 25B will have fluctuated throughout this reporting period.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards					
Incidents of patient harm with reference to quality indicators and complaints about nursing care	**Hospital acquired pressure damage (grade 3, 4 and unstageable)**		**Falls resulting in serious harm or death (i.e. 4 and 5 incidents).**	**Medication errors never events**	**Any complaints received about nursing care** NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	TOTAL		**TOTAL**	**TOTAL**	**TOTAL**
	Avoidable	**Unavoidable**			
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	YWM 14	YWM 21	YWM 3	YWM 0	YWM 1
	YGC 13	YGC 70	YGC 2	YGC 0	YGC 1
	YG 10	YG 87	YG 5	YG 0	YG 0
	Oncology & Haematology 0	Oncology & Haematology 8	Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 1	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**38**	**186**	**10**	**0**	**2**
Total number of incidents/ complaints not closed and to be reported on/during the next year	YWM 7		YWM 0	YWM 0	YWM 0
	YGC 14		YGC 1	YGC 0	YGC 10
	YG 8		YG 2	YG 0	YG 7
	Oncology & Haematology 1		Oncology & Haematology 1	Oncology & Haematology 0	Oncology & Haematology 1
	Womens Gynaecology 0		Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 1
TOTAL	**30**		**4**	**0**	**19**
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	YWM 4		YWM 0	YWM 0	YWM 0
	YGC 2		YGC 0	YGC 0	YGC 0
	YG 0		YG 1	YG 0	YG 0
	Oncology & Haematology 0		Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0

	Womens Gynaecology 0		Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**6**		**1**	**0**	**0**
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster)was considered to have been a contributing factor	YWM 1		YWM 0	YWM 0	YWM 0
	YGC 1		YGC 0	YGC 0	YGC 0
	YG 0		YG 0	YG 0	YG 0
	Oncology & Haematology 0		Oncology & Haematology 0	Oncology & Haematology 0	Oncology & Haematology 0
	Womens Gynaecology 0		Womens Gynaecology 0	Womens Gynaecology 0	Womens Gynaecology 0
TOTAL	**2**		**0**	**0**	**0**

KEY: YWM - Ysbyty Wrexham Maelor / YGC - Ysbyty Glan Clwyd / YG - Ysbyty Gwynedd.

Accompanying narrative:

Based on a review of the health boards/trusts first 3 yearly reports and feedback from operational leads on their experience completing the reports; a report was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour[11] set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020[12] and broaden the reporting scope of incidences of harm to provide more meaningful data.

The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2025. The agreed quality indicators for the adult acute medical and surgical inpatient wards from 6th April 2024 will be as follows:

- Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.

[11] The NHS Duty of Candour | GOV.WALES
[12] Health and Social Care (Quality and Engagement) (Wales) Act: summary | GOV.WALES

- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained
- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

Following the Executive Nurse Directors agreeing the recommendations in August 2023 it became apparent that the Duty of Candour (DoC), which came into force on 1st April 2023, would impact the reporting metrics within the annual assurance reports as previous reports have reported on the actual harm sustained without validation, as opposed to the number of incidents found to be resulting from an act or omission when in receipt of NHS Care. Therefore to align with patient safety incident reporting to Welsh Government from 6th April 2023 this report, and all future reports, will report on closed patient safety incidents which have been validated with a reportable level of harm (as per patient safety incident definition) and whether the nurse staffing levels contributed to the incident. Consequently, the number of incidents reported within this, and subsequent, annual assurance reports may be lower than those in previous years.

Previously BCUHB have reported hospital acquired pressure damage in its totality for both avoidable and unavoidable incidents. The work undertaken on an All Wales basis has highlighted that this is inconsistent with other health boards / trusts who only report avoidable incidents. In line with the agreed reporting metrics and to ensure consistency across Wales from 6th April 2024 onwards BCUHB will only report avoidable hospital acquired pressure damage. For transparency the numbers of closed unavoidable hospital acquired pressure damage incidents (grade 3, 4 and unstageable) recorded during this reporting period have been displayed separately in the table above.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on paediatric inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Infiltration and extravasation injuries	Any complaints received about nursing care NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	0	0	3	0

Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	0	0	0	0	1
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	0	0	0	1	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	0	0	0	0	0

Accompanying narrative:

The work of the Reporting Sub-Group, mentioned previously, included the measures for the paediatric inpatient wards and these were presented to the Executive Directors of Nursing & Midwifery in August 2023, along with the amended measures for the adult acute medical and surgical wards. The changes to the paediatric measures were agreed, with the intention that the amended measures come into effect at the beginning of the next reporting period i.e. 6th April 2024.

The quality indicators for the paediatric inpatient wards will be as follows:

- Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)
- Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).
- Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).
- Infiltration and extravasation injuries
- Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))
-

The data to be reported for each of the above will be:

- Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.
- Total number of incidents/ complaints not closed and to be reported on/during the next year
- Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained
- Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor
- Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained

- Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *)
Actions taken if the nurse staffing level was not maintained in wards where section 25B applies	As previously detailed the process for maintaining nurse staffing levels is a continuous process which includes both long and short term planning with actions taken at both strategic/corporate and operational levels, which demonstrate that "all reasonable steps" have been explored and/or taken in order to maintain staffing levels, not only within Section 25B wards but across all services of the health board. These include all reasonable steps being implemented to reduce the risk when the nurse staffing level was not maintained with appropriate action, mitigation and escalation undertaken in line with the BCUHB - Nurse Staffing Levels Policy and the BCUHB Paediatric Escalation Policy The impact on care quality when nurse staffing levels have not been maintained is monitored operationally with the senior nursing teams applying their professional judgment to ensure that the staffing levels wherever possible, were maintained – and, where not possible, mitigated. In addition to the actions previously noted above, the below are also undertaken: • Wellbeing support for staff where there has been significant staffing shortfalls on a continuous basis and provision of bespoke support sessions via Staff Wellbeing Service for example. • Shared learning through the Ward Managers and Matrons monthly meetings • Increased visibility of the senior nursing team (Matrons/ Heads of Nursing / Directors of Nursing) and Patient Advice & Liaison Support Service (PALS) team (where appropriate) through walkabouts/audit/patient feedback surveys • Daily incident reviews within the IHCs and Divisions with Heads of Nursing and Matrons allows insight into the Falls and Hospital Acquired Pressure Ulcers (HAPU) incidents reported enabling an initial review within the target timescale of 24 hours of reporting and a focused review within 72 hours with escalation of major and catastrophic incidents • Weekly harms scrutiny meetings are in place and supported by relevant leads e.g. practice development nurses, fall champions, HAPU lead nurse. • Increased audit activity in areas of concern to support improvement work • Nursing Quality Assurance Framework - to ensure deep dives are conducted into each clinical area in support of Ward Accreditation • A quality and assurance dashboard is currently in development which upon completion will provide strategic and operational oversight of patient experience, patient harms incidents, patient complaints and staffing metrics.

	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	Section 25A of the Nurse Staffing Levels (Wales) Act 2016 sets out the responsibilities of each health board to ensure that there are appropriate nurse staffing levels across their respective organisations to ensure safe, effective and timely care to patients across all of its nursing services. This section will provide a summary of the wider work that has been undertaken in relation to Section 25A areas during 2023/24. The processes for maintaining the nurse staffing levels, including the recruitment, retention and education strategies described previously within this paper are applicable to all areas where nursing services are provided. BCUHB has developed a Calculating Nurse Staffing Levels Standard Operating Procedure[13] which informs the process which all nurse staffing level reviews, undertaken in any nursing service, should follow. Whilst the statutory requirement to undertake nurse staffing level reviews following the triangulated approach, described within Section 25C of the Act, may only apply to those wards that pertain to Section 25B, the Executive Director of Nursing & Midwifery has endorsed this as the approach to be used for all nurse staffing level reviews. The triangulated approach requires that information related to the following needs to be considered when calculating the nurse staffing levels in any setting where nursing services are provided: • Patient acuity/dependency/workload (using validated tools wherever possible) • Care quality indicators (pertinent to the service in question) • Professional judgement (as applicable within the clinical setting under review) In addition, nationally endorsed professional nursing workforce guidance/standards are used to underpin the review processes wherever they exist. BCUHB nursing services which have undertaken/commenced reviews of their nurse staffing levels using the above approach over the 2023/24 reporting period are: • Community hospital wards • Emergency quadrant wards and departments • 24/7 medical & surgical wards who do not pertain to Section 25B of the Act • Mental Health and Learning Disability wards Upon the conclusion of all 24/7 nursing ward and department nurse staffing level reviews a paper will be formally presented to Board detailing the outcome and associated recommendations of these.

[13] Calculating Nurse Staffing Levels Standard Operating Procedure is currently in draft format awaiting ratification

	Conclusion & Recommendations
	The report provides assurance to the health board that in line with statutory guidance the health board is fully compliant with the requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for 25B adult inpatient medical and surgical wards; and paediatric inpatient wards. Throughout the past year, nurse staffing levels for all healthcare settings across BCUHB have been calculated at a level which demonstrates the commitment to having 'regard to the importance of providing sufficient nurses to allow time for the nurses to care for patients sensitively'. This statutory requirement has ensured that the staffing levels for all wards and areas across BCUHB caring for inpatients have been set and, wherever possible maintained. When it has not been possible to maintain staffing levels, appropriate action, mitigation and escalation is in line with BCUHB - Nurse Staffing Levels Policy and the BCUHB Paediatric Escalation Policy The Board are asked to note and support the following next steps: 1. Undertake a review of the resource requirements to support the Nursing Workforce, Staffing and Professional Standards agenda to ensure the organisation is able to fulfil its statutory duties in relation to the Nurse Staffing Levels (Wales) Act 2016; focus on meeting the nurse staffing establishments through ambitious and successful recruitment campaigns; focus on the retention of committed and skilled staff. 2. The BCUHB People Strategy & Plan is an essential enabler to the delivery of a sustainable nursing workforce, which is further supported by the All Wales National Workforce Implementation Plan and the subsequent Nurse Retention Plan, which place a focus on retention and innovation. 3. Corporate finance teams will work with operational finance teams to adjust budgets as part of the annual planning cycle to reflect the revised approved rosters. 4. The E-Rostering team will adjust roster demand templates to reflect the agreed 'planned rosters' 5. Ward Managers will process the recruitment of staff, based on the revised nursing establishment (where applicable) 6. Ward Managers will ensure the planned roster is accurately displayed on the ward boards at the ward entrance and that patient information regarding the Nurse Staffing Levels (Wales) Act is readily and easily available.

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2023 (Spring review cycle) - 5th April 2024 (Autumn review cycle)
Adult Acute Medical Inpatient Wards	26

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Medical Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2023 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2023 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
YWM	Acton	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	ACU	1	31.27	14.21	1	31.27	14.21	Yes	No	No change to staffing	No			
YWM	Bersham	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	Bonney	1	19.9	19.9	1	19.9	19.9	Yes	No	No change to staffing	No			
YWM	Cunliffe	1	19.9	17.06	1	19.9	19.9	Yes	Yes	HCA staffing reconsidered due to harm profile.	No			
YWM	Fleming	1	11.37	5.69	1	11.37	5.69	Yes	No	No change to staffing	No			
YWM	Morris	1	17.06	21.32	1	17.06	21.32	Yes	No	No change to staffing	No			
YWM	Pantomime	1	15.63	14.21	1	15.63	14.21	Yes	No	No change to staffing	No			
YWM	Prince of Wales	1	14.21	14.21	1	14.21	14.21	Yes	No	No change to staffing	No			
YG	Aran				1	22.74	21.3	Yes	No	Stepped up in Autumn 2023 as an Act ward following return to medical ward after reconfiguration	Yes	Dec-23	Yes	Following a ward reconfiguration within YG site staffing was reviewed in December 2023
YG	Glaslyn	1	19.9	25.58	1	19.9	26.58	Yes	Yes	HCA staffing adjusted to include funded post previously omitted as historically recorded as other ward support role.	No			
YG	Glyder	1	14.21	11.37	1	14.21	11.37	Yes	No	No change to staffing	No			
YG	Hebog	1	22.74	22.74	1	22.74	22.74	Yes	No	No change to staffing	No			
YG	Moelwyn	1	28.43	22.74	1	28.43	22.74	Yes	No	No change to staffing	No			
YG	Prysor	1	12.79	10.95	1	12.79	10.95	Yes	No	No change to staffing	No			
YG	Tryfan	1	19.9	22.74	1	19.9	22.74	Yes	No	No change to staffing	Yes	Dec-23	Yes	Following a ward reconfiguration within YG site staffing was reviewed in December 2023 with Tryfan no longer meeting the definition of a 25B ward from this date
YGC	Ward 1	1	19.07	23.21	1	19.07	23.21	Yes	No	No change to staffing	No			
YGC	Ward 2	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 4	1	19.07	16.34	1	19.07	16.34	Yes	No	No change to staffing	No			
YGC	Ward 6 (formally Ward 11)	1	24.52	16.34	1	24.52	16.34	Yes	No	No change to staffing	No			
YGC	Ward 9	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 10	1	19.07	20.49	1	19.07	20.49	Yes	No	No change to staffing	No			
YGC	Ward 12	1	21.79	19.07	1	21.79	19.07	Yes	No	No change to staffing	No			
YGC	Ward 14	1	21.79	20.49	1	21.79	20.49	Yes	No	No change to staffing	No			
YG	Alaw	1	16.24	14.21	1	16.24	14.21	Yes	No	No change to staffing	No			
YGC	Enfys	1	17.06	17.06	1	17.06	17.06	Yes	No	No change to staffing	No			

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2023 (Spring review cycle) - 5th April 2024 (Autumn review cycle)
Adult Acute Surgical Inpatient Wards	17

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Surgical Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2023 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2023 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
YWM	Arrivals	1	14.21	11.37	1	14.21	11.37	Yes	No	No change to staffing	No			
YWM	Erddig	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YWM	Mason	1	19.9	24.16	1	19.9	24.16	Yes	No	No change to staffing	No			
YWM	Glyndwr	1	25.58	17.06	1	25.58	17.06	Yes	No	No change to staffing	No			
YWM	U5 (formally Samaritan)	1	13.4	7.72	1	13.4	7.72	Yes	No	No change to staffing	No			
YG	Tegid	1	25.58	19.9	1	25.58	19.9	Yes	No	No change to staffing	No			
YG	Dulas	1	28.43	19.9	1	28.43	19.9	Yes	No	No change to staffing	No			
YG	Ogwen	1	19.9	25.58	1	19.9	25.58	Yes	No	No change to staffing	No			
YG	Enlli	1	14.21	14.21	1	14.21	14.21	Yes	No	No change to staffing	No			
YGC	Ward 3	1	21.79	21.79	1	21.79	21.79	Yes	No	No change to staffing	No			
YGC	Ward 5	1	21.79	19.07	1	21.79	19.07	Yes	No	No change to staffing	No			
YGC	Ward 7	1	21.79	21.79	1	21.79	21.79	Yes	No	No change to staffing	No			
YGC	Ward 8	1	19.07	19.07	1	19.07	19.07	Yes	No	No change to staffing	No			
ABH	Ward 6 Abergele	1	13.62	16.34	1	16.34	20.24	Yes	Yes	Staffing reconsidered as part of the orthopaedic surgical services review.	No			
YGC	Ward 19a Glaslyn	1	11.13	7.68	1	11.13	7.68	Yes	No	No change to staffing	No			
YWM	Bromfield	1	11.37	5.69	1	11.37	5.69	Yes	No	Stepped up in Spring 2023 as an Act ward following return of elective Gynae patients after covid reconfiguration.	No			
YG	Ffrancon	1	11.37	8.53	1	11.37	8.53	Yes	No	Stepped up in Spring 2023 as an Act ward following return of elective Gynae patients after covid reconfiguration.	No			

Appendix 2: Annual Assurance Report

Health Board/Trust:	Betsi Cadwaladr University Health Board
Period of the report	6th April 2023 (Spring review cycle) - 5th April 2024 (Autumn review cycle)
Adult Acute Medical Inpatient Wards	3

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Paediatric Inpatient wards

		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the start of this report (Spring 2023 calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward manager	Required Establishment at the end of the period of this report (Autumn 2023 calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Site	**Name of Ward**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**		**TOTAL WTE RN (band 5,6)**	**TOTAL WTE HCSW (bands 2,3,4)**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
YWM	Childrens Unit	1	28.43	8.53	1	28.43	8.53	Yes	No	No change to staffing	No			
YGC	Childrens Unit	1	28.43	11.37	1	28.43	11.37	Yes	No	No change to staffing	No			
YG	Childrens Unit	1	26.6	11.37	1	26.6	11.37	Yes	No	No change to staffing	No			

Appendix 3: Summary of Nurse Staffing Levels for wards where Section 25B applies Spring 2024.

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2023 - March 2024
Adult Acute Medical inpatient wards	25

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Medical inpatient wards

Site	Name of Ward	Calculated during spring 2023 cycle						Reported to the Board in November 2023						Calculated during spring 2024 cycle						Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2022)		Required Establishment as stated within the annual presentation to the Board report (in November 2022) including		TOTAL WTE Band 7 supernumerary ward manager	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
YWM	Acton	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	05/10/2023	Early	5	4	25.58	19.9	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	3											
YWM	ACU	Early	6	3	31.27	14.21	1	Early	6	3	31.27	14.21	1	05/10/2023	Early	6	3	31.27	14.21	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	6	3				Late	6	3					Late	6	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	5	2				Night	5	2					Night	5	2											
YWM	Bersham	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	05/10/2023	Early	5	4	25.58	19.9	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	3											
YWM	Bonney	Early	4	4	19.9	19.9	1	Early	4	4	19.9	19.9	1	05/10/2023	Early	4	4	19.9	19.9	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YWM	Cunliffe	Early	4	3	19.9	17.06	1	Early	4	4	19.9	19.9	1	05/10/2023	Early	4	4	19.9	19.9	1	12/04/2024	Yes	Yes	HCSW staffing was reconsidered in Autumn 23 due to harm profile.	No			
		Late	4	3				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YWM	Fleming	Early	2	1	11.37	5.69	1	Early	2	1	11.37	5.69	1	05/10/2023	Early	2	1	11.37	5.69	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	2	1				Late	2	1					Late	2	1											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
YWM	Morris	Early	4	4	17.06	21.32	1	Early	4	4	17.06	21.32	1	05/10/2023	Early	4	4	17.06	21.32	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	3				Late	4	3					Late	4	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	4				Night	2	4					Night	2	4											
YWM	Pantomime	Early	4	3	15.63	14.21	1	Early	4	3	15.63	14.21	1	05/10/2023	Early	4	3	15.63	14.21	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	3				Late	3	3					Late	3	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	2				Night	2	2					Night	2	2											
YWM	Prince of Wales	Early	3	3	14.21	14.21	1	Early	3	3	14.21	14.21	1	05/10/2023	Early	3	3	14.21	14.21	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	3				Late	3	3					Late	3	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	2				Night	2	2					Night	2	2											
YG	Aran	Early						Early	5	4	22.74	21.3	1	05/10/2023	Early	5	5	25.58	25.58	1	12/04/2024	Yes	No	Stepped up in Autumn 2023 as an Act ward following return to medical ward after reconfiguration. Reviewed outside of bi-annual calculation due to site reconfiguration with changes to establishment made as per Spring 2024 numbers.	Yes	Dec-23	Yes	Following a reconfiguration within the Ysbyty Gwynedd site Aran ward was recalculated
		Late						Late	5	4					Late	5	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight	0	1					Twilight	0	0											
		Night						Night	3	3					Night	4	4											

YG	Glaslyn (Tues - Fri)	Early	4	5	19.9	25.58	1	Early	4	6	19.9	26.58	1	05/10/2023	Early	4	6	19.9	26.58	1	12/04/2024	Yes	Yes	Autumn 2023 HCSW staffing adjusted to include funded post previously omitted as historically recorded as other ward support role.	No			
		Late	4	5				Late	4	5					Late	4	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	4				Night	3	4					Night	3	4											
	Glaslyn (Sat - Mon)	Early	4	5				Early	4	5				05/10/2023	Early	4	5											
		Late	4	5				Late	4	5					Late	4	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	4				Night	3	4					Night	3	4											
YG	Glyder	Early	3	2	14.21	11.37	1	Early	3	2	14.21	11.37	1	05/10/2023	Early	3	2	14.21	11.37	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	2				Late	3	2					Late	3	2											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	2				Night	2	2					Night	2	2											
YG	Hebog	Early	5	5	22.74	22.74	1	Early	5	5	22.74	22.74	1	05/10/2023	Early	5	5	22.74	22.74	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	5				Late	5	5					Late	5	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YG	Moelwyn	Early	6	4	28.43	22.74	1	Early	6	4	28.43	22.74	1	05/10/2023	Early	6	4	28.43	22.74	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	6	4				Late	6	4					Late	6	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	4				Night	4	4					Night	4	4											
YG	Prysor (Mon - Fri)	Early	3	3	12.79	10.95	1	Early	3	3	12.79	10.95	1	05/10/2023	Early	3	3	12.79	10.95	1	12/04/2024	Yes	Yes	No change to staffing	No			
		Late	2	2				Late	2	2					Late	2	2											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	2	1				Night	2	1					Night	2	1											
	Prysor (Sat & Sun)	Early	3	2				Early	3	2					Early	3	2											
		Late	2	2				Late	2	2					Late	2	2											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	2	1				Night	2	1					Night	2	1											
YG	Tryfan	Early	4	5	19.9	22.74	1	Early	4	5	19.9	22.74	1	05/10/2023	Early							N/A	N/A	Reviewed outside of bi-annual calculation due to site reconfiguration with Tryfan no longer meeting the definition of a Section 25B ward	Yes	Dec-23	Yes	Following a reconfiguration within the Ysbyty Gwynedd site Tryfan ward no longer met the definition of a Section 25B ward
		Late	4	5				Late	4	5					Late													
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night													
YGC	Ward 1	Early	4	5	19.07	23.21	1	Early	4	5	19.07	23.21	1	05/10/2023	Early	4	5	19.07	23.21	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 2	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	05/10/2023	Early	4	4	19.07	20.49	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 4	Early	4	3	19.07	16.34	1	Early	4	3	19.07	16.34	1	05/10/2023	Early	4	3	19.07	16.34	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	3				Late	4	3					Late	4	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 6 (was Ward 11)	Early	5	3	24.52	16.34	1	Early	5	3	24.52	16.34	1	05/10/2023	Early	5	3	24.52	19.07	1	12/04/2024	Yes	Yes	HCSW staffing reconsidered during spring 24 due to increased patient care acuity and harms profile	No			
		Late	5	3				Late	5	3					Late	5	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	4											
YGC	Ward 9	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	05/10/2023	Early	4	4	19.07	20.49	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 10	Early	4	4	19.07	20.49	1	Early	4	4	19.07	20.49	1	05/10/2023	Early	4	4	19.07	20.49	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 12	Early	5	4	21.79	19.07	1	Early	5	4	21.79	19.07	1	05/10/2023	Early	5	4	21.79	19.07	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 14	Early	5	4	21.79	20.49	1	Early	5	4	21.79	20.49	1	05/10/2023	Early	5	4	21.79	20.49	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight	0	1				Twilight	0	1					Twilight	0	1											
		Night	3	3				Night	3	3					Night	3	3											

YG	Alaw (Mon - Fri)	Early	4	3	16.24	14.21	1	Early	4	3	16.24	14.21	1	05/10/2023	Early	4	3	17.66	14.21	1	12/04/2024	Yes	Yes	RN staffing reconsidered in Spring 24 review due to increased patient care acuity and out of hours triage requirements.	No			
		Late	4	3				Late	4	3					Late	4	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight	1	0											
		Night	2	2				Night	2	2					Night	2	2											
	Alaw (Sat & Sun)	Early	3	3				Early	3	3				05/10/2023	Early	3	3											
		Late	3	3				Late	3	3					Late	3	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight	1	0											
		Night	2	2				Night	2	2					Night	2	2											
YGC	Enfys	Early	4	3	17.06	17.06	1	Early	4	3	17.06	17.06	1	05/10/2023	Early	4	4	19.9	19.9	1	12/04/2024	Yes	Yes	RN & HCSW staffing reconsidered in Spring 24 review due to increased patient care acuity, harms profile and out of hours triage requirements.	No			
		Late	4	3				Late	4	3					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	3				Night	2	3					Night	3	3											

Appendix 3: Summary of Nurse Staffing Levels for wards where Section 25B applies Spring 2024.

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2023 - March 2024
Adult Acute Surgical Inpatient Wards	17

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

		Calculated during spring 2023 cycle						Reported to the Board in November 2023							Calculated during spring 2024 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	Name of Ward	SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2022)		Required Establishment as stated within the annual presentation to the Board report (in November 2022) including		TOTAL WTE Band 7 supernumerary ward manager	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
YWM	Arrivals	Early	3	2	14.21	11.37	1	Early	3	2	14.21	11.37	1	05/10/2023	Early	3	2	14.21	11.37	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	2				Late	3	2					Late	3	2											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	2				Night	2	2					Night	2	2											
YWM	Erddig	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	05/10/2023	Early	5	4	25.58	19.9	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	3											
YWM	Mason	Early	4	6	19.9	24.16	1	Early	4	6	19.9	24.16	1	05/10/2023	Early	4	6	19.9	24.16	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YWM	Glyndwr	Early	5	3	25.58	17.06	1	Early	5	3	25.58	17.06	1	05/10/2023	Early	5	3	25.58	17.06	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	3				Late	5	3					Late	5	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	3											
YWM	U5 Mon - Fri	Early	3	2	13.4	7.72	1	Early	3	2	13.4	7.72	1	05/10/2023	Early	3	2	13.4	7.72	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	2				Late	3	2					Late	3	2											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
	U5 Sat & Sun	Early	2	1				Early	2	1					Early	2	1											
		Late	2	1				Late	2	1					Late	2	1											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
YG	Tegid	Early	5	4	25.58	19.9	1	Early	5	4	25.58	19.9	1	05/10/2023	Early	5	4	25.58	19.9	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	3											
YG	Dulas	Early	6	4	28.43	19.9	1	Early	6	4	28.43	19.9	1	05/10/2023	Early	6	4	28.43	22.74	1	12/04/2024	Yes	Yes	HCSW staffing reconsidered in spring 24 due to patient care acuity	No			
		Late	6	4				Late	6	4					Late	6	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	3				Night	4	3					Night	4	4											
YG	Ogwen	Early	4	5	19.9	25.58	1	Early	4	5	19.9	25.58	1	05/10/2023	Early	4	5	19.9	25.58	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	5				Late	4	5					Late	4	5											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	4				Night	3	4					Night	3	4											
YG	Enlli	Early	3	3	14.21	14.21	1	Early	3	3	14.21	14.21	1	05/10/2023	Early	3	3	14.21	14.21	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	3	3				Late	3	3					Late	3	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	2				Night	2	2					Night	2	2											
YGC	Ward 3	Early	4	4	21.79	21.79	1	Early	4	4	21.79	21.79	1	05/10/2023	Early	4	4	21.79	21.79	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	4	4				Night	4	4					Night	4	4											

YGC	Ward 5	Early	5	4	21.79	19.07	1	Early	5	4	21.79	19.07	1	05/10/2023	Early	5	4	21.79	19.07	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
YGC	Ward 7	Early	5	4	21.79	21.79	1	Early	5	4	21.79	21.79	1	05/10/2023	Early	5	4	21.79	21.79	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	5	4				Late	5	4					Late	5	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	4				Night	3	4					Night	3	4											
YGC	Ward 8	Early	4	4	19.07	19.07	1	Early	4	4	19.07	19.07	1	05/10/2023	Early	4	4	19.07	19.07	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	4	4				Late	4	4					Late	4	4											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	3	3				Night	3	3					Night	3	3											
ABH	Ward 6 ABH (Mon - Fri)	Early	3	3	13.62	16.34	1	Early	4	5	16.34	20.24	1	05/10/2023	Early	4	3	15.57	13.62	1	12/04/2024	Yes	Yes	Staffing reconsidered during autumn 23 & spring 24 as part of the orthopaedic surgical services review.	No			
		Late	3	3				Late	4	5					Late	4	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	3				Night	2	3					Night	2	2											
	Ward 6 ABH (Sat & Sun)	Early	3	3				Early	4	3					Early	3	3											
		Late	3	3				Late	4	3					Late	3	3											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	3				Night	2	3					Night	2	2											
YGC	Ward 19a Glaslyn (Mon - Fri)	Early	2	2	11.13	7.68	1	Early	2	2	11.13	7.68	1	05/10/2023	Early	2	2	11.37	7.72	1	12/04/2024	Yes	No	Whilst no changes have been made the planned roster staffing there have been changes in the WTE required due to amendments in shift times.	No			
		Late	2	2				Late	2	2					Late	2	2											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
	Ward 19a Glaslyn (Sat & Sun)	Early	2	1				Early	2	1					Early	2	1											
		Late	2	1				Late	2	1					Late	2	1											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
YWM	Bromfield	Early	2	1	11.37	5.69	1	Early	2	1	11.37	5.69	1	05/10/2023	Early	2	1	11.37	5.69	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	2	1				Late	2	1					Late	2	1											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											
YG	Ffrancon	Early	2	2	11.37	8.53	1	Early	2	2	11.37	8.53	1	05/10/2023	Early	2	2	11.37	8.53	1	12/04/2024	Yes	No	No change to staffing	No			
		Late	2	2				Late	2	2					Late	2	2											
		Long Day						Long Day							Long Day													
		Twilight						Twilight							Twilight													
		Night	2	1				Night	2	1					Night	2	1											

Appendix 3: Summary of Nurse Staffing Levels for wards where Section 25B applies Spring 2024.

Health board/trust:	Betsi Cadwaladr University Health Board
Period of the report	April 2023 - March 2024
Paediatric Inpatient Wards	3

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric Inpatient Wards

		Calculated during spring 2023 cycle						Reported to the Board in November 2023							Calculated during spring 2024 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	Name of Ward	SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2022)		Required Establishment as stated within the annual presentation to the Board report (in November 2022) including		TOTAL WTE Band 7 supernumerary ward manager	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward manager	Date designated person calculated the nurse staffing level							
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
YWM	Childrens Unit	Early			28.43	8.53	1	Early			28.43	8.53	1	05/10/2023	Early			28.43	8.53	1	12/04/2024	Yes	No	No change to staffing	No			
		Late						Late							Late													
		Long Day	5	2				Long Day	5	2					Long Day	5	2											
		Twilight						Twilight							Twilight													
		Night	5	1				Night	5	1					Night	5	1											
YGC	Childrens Unit	Early			28.43	11.37	1	Early			28.43	11.37	1	05/10/2023	Early			28.43	11.37	1	12/04/2024	Yes	No	No change to staffing	No			
		Late						Late							Late													
		Long Day	5	2				Long Day	5	2					Long Day	5	2											
		Twilight						Twilight							Twilight													
		Night	5	2				Night	5	2					Night	5	2											
YG	Childrens Unit (Mon - Fri)	Early			26.6	11.37	1	Early			26.6	11.37	1	05/10/2023	Early			28.43	8.53	1	12/04/2024	Yes	Yes	RN & HCSW staffing adjusted during Spring 24 review due to patient care acuity	No			
		Late						Late							Late													
		Long Day	5	2				Long Day	5	2					Long Day	5	2											
		Twilight	1					Twilight	1						Twilight	0	0											
		Night	4	2				Night	4	2					Night	5	1											
	Childrens Unit (Sat & Sun)	Early						Early							Early													
		Late						Late							Late													
		Long Day	5	2				Long Day	5	2					Long Day	5	2											
		Twilight						Twilight							Twilight	0	0											
		Night	4	2				Night	4	2					Night	5	1											

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

Teitl adroddiad: ***Report title:***	Funded Nursing Care Interim Annual Fee Rate 2024/ 2025
Adrodd i: ***Report to:***	Health Board - Public
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	The Health Board completes the Funded Nursing Care fee setting process on an annual basis, this is based on National discussions and recommendations.
Argymhellion: ***Recommendations:***	This paper sets out the recommendation by the Executive team to the Board to approve the interim uplift for Funded Nursing Care The Health Board is asked to:- • **APPROVE** 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. • **APPROVE** 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.
Arweinydd Gweithredol: ***Executive Lead:***	Chris Stockport Executive Director Transformation and Planning
Awdur yr Adroddiad: ***Report Author:***	Jane Trowman – Assistant Director for Care Homes and CHC Commissioning (Acting) William Jones - Senior Financial Advisor – Continuing Healthcare

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*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	delivery of existing mechanisms/objectives	*existing mechanisms / objectives*	*existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Building an effective organisation – Value and sustainability (CHC & FNC)
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Compliance with the Continuing NHS Healthcare Framework
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?***	EqIA is not required
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?***	SEIA is not required
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 main risks are that the Interim FNC rate may be higher than the final rate agreed and the gap between the Welsh and English rates is growing
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The impact of implementing this interim uplift for the Health Board has been assessed as £0.276m for 2024/25
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Welsh Government requirement to meet the Real Living Wage for commissioned packages of care
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The recommendation is based on national discussions and has been supported by Welsh Government. This paper and recommendation have been considered by the Executive Team
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:***	Care home Fees CRR23-40

(or links to the Corporate Risk Register)	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Communication to Providers and Local Authorities will be issued subject to Board Decision, funding backdated to 1st April 2024	
Rhestr o Atodiadau: ***List of Appendices:*** None	

Situation and Background

The purpose of this report is to seek approval for an Interim All Wales 2024/25 Funded Nursing Care (FNC) rate to be paid to providers whilst agenda for change pay negotiations continue.

FNC is the term used to describe the NHS funding of Registered Nursing (RN) time in care homes for those residents assessed as requiring nursing supervision and input into their care.

The rate is set annually by HBs working together to ensure a consistent rate is applied across Wales. The rate is calculated using the Inflation Uplift Mechanism (IUM) which is made up of two components:

- an identified amount of RN time
- continence products.

The RN component is calculated using Agenda for Change Band 5 and is uplifted annually in line with the NHS Pay Award. The continence component is uplifted annually in line with the CPI as reported at January of each year.

It is anticipated that arriving at an agreed A4C pay settlement for 2024/25 will be difficult with staff side organisations indicating they will not participate in the Independent Pay Review Body process, this will inevitably lead to delays in a pay settlement being agreed by Welsh Government.

Health Boards have been encouraged by Welsh Government to ensure that Care Providers are not disadvantaged by delays in agreeing fees for the sector.

On the 7th March, NHS England published the FNC rate that will be paid within NHS England, the process for agreeing FNC rates in NHS England is different to NHS Wales. NHS England request evidence submissions from providers, which NHS England then review and set a National Fee Rate within England that NHS organisations must adhere to. For 2024/25, NHS England has increased the fee rate by 7.4% to £235.88 per week.

Assessment & Analysis

The Inflationary Uplift Mechanism (IUM) is a method of uplifting historic rates to reflect current prices and inflationary pressures within the sector. The mechanism has been used for a number of years and was not challenged at the judicial review in 2016, it is therefore recommended that the IUM is retained as the basis for applying inflation to the FNC fee rate.

The mechanism recognises the 2 components of FNC:

- Funding of Registered Nursing time, this has been calculated as 9.24 hrs of RN time per resident per week.
- Funding for incontinence products

As the 2024/25 Agenda For Change pay award is still being negotiated, and there is anticipated to be significant delays in agreeing a settlement.

At the All Wales Deputy Director of Finance meeting on the 19th February 2024, it was agreed that a recommendation to Health Boards that the Registered Nursing element is uplifted by 3% pending finalisation of pay negotiations. The NHS contribution weekly fee rate per FNC resident is recommended to be £213.18.

The table below summarises the proposed new 2024/25 Interim Rate for FNC (Per resident per week):

	NHS Component of FNC	Social Care RN Component	Total FNC
2023/24	£ 206.95	£ 8.37	£ 215.32
Uplift	£ 6.23	£ 0.25	£ 6.48
2024/25 interim	**£ 213.18**	**£ 8.62**	**£ 221.80**

Each Health Board will need to individually approve the recommended interim FNC rate via its normal governance processes reflecting individual organisation's scheme of delegation for approval of FNC fee rates and communicate the changes to each Local Authority.
The proposed uplift remains within the financial plan.

Financial and Contractual Implications

Financial Summary:

FNC Interim Uplift (All Wales recommendation)
The table below summarises the proposed new 2024/25 Interim Rate for FNC (Per resident per week):

	NHS Component of FNC £	**Social Care RN Component £**	**Total FNC**
2023/24	206.95	8.37	215.32
Uplift	6.23	0.25	6.48
2024/25 interim	**213.18**	**8.62**	**221.80**

The impact of implementing this interim uplift for the Health Board has been assessed as £0.276m for 2024/25 for the FNC element.

Risk Analysis

The 2024/25 recommended uplift equates to a 3.01% overall uplift to FNC rate, this compared to 7.4% uplift in NHS England. The differential of FNC fee rates between NHS Wales and NHS England is growing, which could result in potential disputes or challenges by Providers or Local Authorities.

There is a risk that the final pay settlement may result in a lower uplift than that included in this interim rate. Welsh Government have indicated that Health Boards should not seek recovery from providers if an interim rate has been agreed which is higher than a revised calculation following final pay agreements.

Recommendations
The Health Board is asked to:- • **APPROVE** 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. • **APPROVE** 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.

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, 30 May 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 • Joint Commissioning Committee (JCC) briefings from the meeting held in April 2024
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 30th March 2024; and • **NOTE** the briefings from the Joint Commissioning Meeting held in April 2024; and • **AGREE** to the proposal regarding the circulation of minutes outside of the Board meeting.
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: ***Assurance level:***	Arwyddocaol *Significant*	Derbyniol *Acceptable*	Rhannol *Partial*	Dim Sicrwydd *No Assurance*
	☐	☒	☐	☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This is 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)***	
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)	CRR-16 – Leadership/Special Measures

Links to BAF risks: *(or links to the Corporate Risk Register)*	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* – **JCC Briefings from the JCC meetings held in April 2024**	

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 Chairs 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
196	Ysbyty Gwynedd – Emergency Department (ED) Refurbishment & Extension	Finance and Performance (F&P) Committee 22/08/2019	07/05/2024	684
197	Ysbyty Glan Clwyd (YGC) Ward 6 Refurbishment	Welsh Government (WG) Funding FBC Approval Letter 13/03/19 / F&P Committee 22/08/2019	07/05/2024	685
198	Enlli Ward - Phase 2	Health Board Leadership Team (HBLT) 18/01/2023 & Health Board (HB) 26/01/2023	07/05/2024	686
199	YGC - Imaging Schemes - Enabling Works	HBLT 18/01/2023 & HB 26/01/2023	07/05/2024	687
200	YG - Imaging Scheme Enabling Works	HBLT 18/01/2023 & HB 26/01/2023	07/05/2024	688
201	Wrexham Maelor Hospital - Imaging Scheme Enabling Works	HBLT 18/01/2023 & HB 26/01/2023	07/05/2024	689
202	Wrexham Maelor Hospital - Imaging Schemes Enabling Works	HBLT 18/01/2023 & HB 26/01/2023	07/05/2024	690
203	Licence to occupy Parc Menai D2	HBLT 18/01/2023 & HB 26/01/2023	08/05/2024	691

4) Summary of Business discussed in the Private session of the Health Board on 30th March 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 30th March 2024:

- **NHS All Wales Capital Prioritisation**
  The Board approved the submission to Welsh Government
- **Royal Alexandra Business Case**
  A full commercially sensitive options appraisal was presented by the Chief Executive noting that the full business case was approved in the public board meeting.
- **Electronic Health Record**
  Strategic Outline Case – the Chief Digital and Information Officer presented the outline case which was approved by the Board.

- **Electronic Prescribing and Medicines Administration Programme**
  Full Business Case was approved by the Board.
- **Sensitive Quality matters**
  An update on key sensitive quality matters was provided.
- **Maggie's Contract**
  The Board agreed the approach as outlined by the Interim Executive Director of Finance
- **Corporate Risk Register**
  The risk around digital security and protection was noted along with the mitigations and actions.

5) Annual Business Cycle

At each meeting, the Board will receive a copy of its business cycle, which outlines the business planned for each meeting. The current Annual Plan of Board business is quite complex and therefore work is underway to simplify this along with the committee cycles, it is proposed that these will be finalised by the next board meeting.

The key strategic items for the Board Meeting at the end of July include:

- Vascular
- Unscheduled Care

6) Joint Commissioning Committee meetings held in April 2024

Betsi Cadwaladr University Health Board has Joint Committee arrangements with other Health Boards and NHS organisations for Specialised Services and Emergency Ambulance Services.

- Welsh Health Specialised Services Committee (WHSSC)
- Emergency Ambulance Services Committee (EASC)

The purpose of the report attached as **Appendix 1** is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Joint Committees of the Board. It is proposed for future that minutes of meetings will be circulated to Members of the Board as soon as they are available and will be reported formally through this report.

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

JOINT COMMISSIONING COMMITTEE (JCC)
EXTRAORDINRY MEETING BRIEFING – 9 APRIL 2024

The Joint Commissioning Committee (JCC) held an inaugural extraordinary public meeting on 9 April 2024. The next public meeting will take place on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The Chair welcomed members and the newly appointed Lay Members to the newly established JCC.

The papers for the meeting can be accessed using the link below: Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Joint Commissioning Committee Standing Orders (inc Scheme of Delegation) & Standing Financial Instructions (inc Financial authorisation matrix)

Members received a report requesting that the JCC approve the JCC Standing Orders (including the scheme of delegation) & the Standing Financial Instructions (SFI's) (including the financial authorisation matrix.

Members noted that guidance on the handling of interests had been developed, that the memorandum of agreement between the 7 Health Boards (HBs) will be established; and that the hosting agreement between the host body CTMHB and the 6 HBs will be established to outline the accountability arrangements and resulting responsibilities of the Host Body, the JCC and its team.

Members (1) **Noted** the establishment of the NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024, as directed by Welsh Ministers, (2) **Noted** that the JCC has superseded the Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) with effect from 1 April 2024, (3) **Noted** the development of the JCC's governance framework, as a key component of the Health Board's governance framework, (4) **Approved** the Standing Orders and Scheme of Delegation and Reservation of Powers for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 18 March 2024, (5) **Approved** the Standing Financial Instructions for the NHS Wales Joint Commissioning Committee, as issued by the Minister for Health and Social Services on 19 March 2024, (6) **Approved** the financial authorisation matrix; and (7) **Noted** the JCCs accountability map for information.

2. Interim Operating Model Framework for the NHS Wales Joint Commissioning Committee (JCC)

Members received a report requesting that the JCC note the transitional plan for Quarter 1 to enable the JCC to transact business when it went live on 1 April 2024. The plan incorporates the transitional plan developed by Welsh Government and the actions required to ensure stability and business continuity of the functions to be delivered.

Members **noted** the report.

GIG CYMRU NHS WALES | Cyd-bwyllgor Comisiynu Joint Commissioning Committee

JOINT COMMISSIONING COMMITTEE (JCC)
MEETING BRIEFING – 23 APRIL 2024

The Joint Commissioning Committee (JCC) held its latest public meeting on 23 April 2024. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the JCC.

The papers for the meeting can be accessed using the link below:
Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Minutes of Previous Meetings

The minutes of the Emergency Ambulance Services Committee (EASC) and the Welsh Health Specialised Services Committee (WHSSC) meetings held on the 19 March 2024 were **approved** as a true and accurate record of the meetings. The minutes of the Joint Commissioning Committee (JCC) meeting held on 9 April 2024 were **approved** as a true and accurate record of the meeting.

2. Chairs Report

Members received the Chair's Report and **noted**:

- **The update from the new Chair of the JCC -** the inaugural JCC meeting on 9 April 2024 received and approved the governance framework for the new JCC after it had been approved by the 7 x Health Boards (HBs) in March 2024, and the overwhelming first impression was of an organisation in good heart and in good shape, notwithstanding the significant challenges and complexities of combining the different organisations into one new national NHS sub committee,
- **JCC Induction Programme –** an update on introductory meetings with key personnel and partners and the local induction session attended and the forthcoming NHS Wales Induction programme for new Independent Members (IMs),
- **Chair's Action WHSSC – Approval of the WHSSC Legacy Statement** – the Chairs action taken by the Chair of WHSSC on 25 March 2024 to approve the WHSSC Legacy Statement as part of the work to support the establishment of the new NHS Wales Joint Commissioning Committee (JCC) from 1 April 2024 in accordance with the NHS Wales Joint Commissioning Committee (Wales) Regulations 2024 was ratified; and
- **Key Meetings attended.**

Members (1) **noted** the report; and (2) **ratified** the WHSSC Chairs action taken on 25 march 2024 to approve the WHSSC legacy statement.

3. Interim Chief Commissioners Report

Members received the interim Chief Commissioners Report and **noted** the following updates:

- **New Interim Chief Commissioner** - an update on the interim 6 month appointment of Chief Commissioner, meetings held with key partners, staff and stakeholders to build relationships and the warm welcome received from everyone; and
- **NHS Wales Joint Commissioning Committee Implementation -** The programme of work to establish the new NHS Wales JCC came to fruition on 1 April 2024. The final Welsh Government Oversight Board meeting is being held on 30 April 2024 to complete the programme. JCC members received the transitional plan for Quarter 1 2024-2025 at its meeting on 9 April 2024 which incorporated the transitional plan developed by Welsh Government and the actions required to ensure the stability and business continuity of the functions to be delivered.

Members **noted** the report.

4. Emergency Medical Retrieval and Transfer Service (EMRTS Service Review

Members received a report presenting the Joint Commissioning Committee (JCC) with recommendations of the Emergency Medical Retrieval and Transfer Service (EMRTS) Service Review which has been ongoing since November 2022 and overseen by the Emergency Ambulance Services Committee (EASC) up until 31 March 2024 which had responsibility for commissioning these services prior to the establishment of the Joint Commissioning Committee (JCC) on 1 April 2024.

The Committee gave thanks to stakeholders for their patience during the time taken to ensure the work could be carried out robustly, and were especially grateful for the way in which the Charity and EMRTS had supported and contributed to the Review in what had been challenging circumstances for them given the uncertainty affecting their people and business planning.

The Committee expressed gratitude to Llais, the national citizens voice body for Wales, who advised on the engagement as well as NHS Wales colleagues to have helped deliver the all Wales engagement with citizens.

Members noted that since taking up appointment the Chair and the interim Chief Commissioner felt it was important to listen to a variety of concerns and had been proactive in meeting with key stakeholders and had been struck by the passion and high regard that is held for the Wales

Air Ambulance Charity and the clinical teams of EMRTS, which had been acknowledged throughout the Review.

Members noted that the report presenting the recommendations of the EMRTS Service Review had been considered individually by each of the 7 x Health Board (HBs) in Wales between 20 March and 11 April, and they gave consideration to the following recommendations:

Recommendation 1 – **EMRTS Service Model.** The Committee approves the recommended service model for EMRTS including the consolidation of the Emergency Medical Retrieval and Transfer Services currently operating at Welshpool and Caernarfon bases into a single site in North Wales (Option A) as it best meets the objectives of the EMRTS Service Review,

Recommendation 2 – **Implementation.** To enable delivery of the agreed service model, the Committee requests that the Charity secures an appropriately located operational base in line with the agreed service model (as per the final recommendations of the Review),

Recommendation 3 – Implementation. The Committee approves that a joint plan is developed by EMRTS and the Charity, that maintains service provision across Wales during the transition to a new base and develop a comprehensive implementation plan for the agreed service model. This plan will be reflected in the Committee's future commissioning arrangements with EMRTS and the Charity,

Recommendation 4 – Additional service provision. The Committee approves the development of a commissioning proposal for bespoke road based enhanced and / or critical care services in rural and remote areas to enhance the core service model. It is recommended that the Ambulance and 111 Commissioning Team establish a Task and Finish Group to further refine and develop the approach and to deliver a detailed implementation plan by the end of September 2024. The Group will work in partnership with HBs and Llais and other key stakeholders and report to the JCC in October 2024. Following conclusion of this work, and agreement of the way forward, the implementation plan will be updated,

Recommendation 5 – **Lessons Learned.** The Committee supports a Lessons Learned exercise of the review and engagement process to help inform the future work of the JCC; and

Recommendation 6 – Implementation. The Committee agrees to receive regular progress reports on achievement of the implementation plan milestones, and benefits realisation.

Members discussed the recommendations and through a majority of 5 of the 7 HBs supporting, along with the 3 Lay members and Chair the recommendations were approved. Members noted that Betsi Cadwaladr UHB and Powys tHB did not support the recommendations.

Members requested that additional detailed work be undertaken, aligned to key milestones for delivery and that there was a need to provide the public with confidence on the process and impact across Wales.

Members (1) **Noted** the risks outlined above, (2) **Noted** the risk to patients and under-utilisation levels across Wales, (3) **Noted** the national feedback provided by the Picker Institute, (4) **Noted** the localised feedback from communities surrounding Caernarfon and Welshpool bases, (5) **Noted** the representations raised by Llais and the other representations, (6) **Noted** the risks to the Charity, (7) **Noted** that communications and engagement strategies are needed from both the Charity and EMRTS to rebuild trust and confidence with rural communities specifically to ensure the future of this partnership service; and
(8) **Approved** recommendations 1 to 4 in line with the Review report and to approve recommendations 5 and 6 on implementation monitoring lessons learned on implementation monitoring lessons learned; and that a report to be brought back to May 2024 meeting outlining key milestones.

5. Legacy Statements
Members received a report presenting the legacy statements from the predecessor joint committees / teams that transitioned into the new NHS Wales Joint Commissioning Committee (JCC) on 1 April 2024 for assurance.

Members noted that JCC became operational on 1 April 2024 and in accordance with the Interim Operating Model Framework for the NHS Wales JCC for Quarter 2024-2025 received by the JCC on 9 April 2024, there was a requirement for the new JCC to receive the legacy statements from the predecessor joint committees/teams.

Members noted the legacy statements for the:

- Emergency Ambulance Services Committee (EASC)
- National Collaborative Commissioning Unit (NCCU)
- 111 Service
- Sexual Assault Referral Centre (SARC)
- Welsh Health Specialised Services Committee (WHSSC)

6. Other reports
Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee; and
- Welsh Kidney Network (WKN).

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health 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: 5th March 2024 – 5th May 2024
Adrodd i: ***Report to:***	Betsi Cadwaladr University Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday 30th May 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 the Principality. 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 the Principality.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, 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 the Principality. 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 the Principality. 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.

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

APPENDIX 1

Update of Register of Approved Clinicians in Wales Reporting Period:- 5th March 2024 – 5th May 2024	
	Approved Clinicians
Approvals and Re-approvals	9
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	1
Removed (Left Wales)	2
Retired	0
No longer Registered & Retired:	1
Transferred from AC register (to S12 Register)	0
Removed from S12 – Became AC approved	0
Approval Ended	2
Death in Service	0

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

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: 5th March 2024-5th May 2024

Approvals and Re-approvals: 9

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
Stamatakis	Robert	Swansea Bay University Health Board, The Caswell Clinic, Tondu Road, Bridgend, CF31 4LN.	6th March 2029	Yes
Aziz	Victor	Swansea Bay University Health Board, Tonna Hospital, Tonna Uchaf, Tonna, Castell Nedd, Neath, SA11 3LX.	22nd April 2029	Yes
Benson	Richard	Betsi Cadwaladr University Health Board and Powys Teaching Health Board, Erwood Ward, Bronllys Hospital, Bronllys, Brecon, LD3 0LU.	10th March 2029	Yes
Pillay	Kumarasen	Cygnet Healthcare, St Teilo House and Cygnet Brunel, Goshen Street, Rhymney, Gwent, NP22 5NF.	24th March 2029	Yes
Srinivasan	Janaki	Betsi Cadwaladr University Health Board, Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, Conwy, LL33 OHH.	1st April 2029	Yes
Slater	Harriet	Aneurin Bevan University Health Board, Newport Community Learning Disability Team, Newport Civic Centre, Godfrey Road, Newport, NP20 4UR.	14th April 2029	Yes
Brook	Jennifer	Cardiff and Vale University Health Board, Mental Health Services for Older People, University Hospital, Llandough, Penlan Road, Cardiff, CF64 2XX.	18th April 2029	Yes

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
Loo	Jiann Lin	Betsi Cadwaladr University Health Board, EIP Team, Offices 1 & 2, Daniel Owen Precinct, Mold, Flintshire, CH7 1AP.	1st May 2029	Yes
Bader	Mohamed	Aneurin Bevan University Health Board, South Caerphilly (East) Community and Inpatient Services, Old School Building, Mill Road, Caerphilly, CF83 3FD.	2nd May 2029	Yes

Approvals Reinstated/Returned to Work in Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Aziz	Victor	Swansea Bay University Health Board, Tonna Hospital, Tonna Uchaf, Tonna, Castell Nedd, Neath, SA11 3LX.	*22nd May 2024 (*later reapproved)

Removed/Left Wales: 2

Surname	First Name	Workplace	Date Approval Expires
Ahmed	Raja Adnan	Swansea Bay University Health Board, Ty Garngoch Hospital, Hospital Road, Gorseinion, Swansea, SA4 4LH.	8th September 2025
Lakshmanan	Rajkumar	Cwm Taf Morgannwg University Health Board, Mental Health Unit, Keir Hardie Health Park, Aberdare Road, Merthyr Tydfil, CF48 1BZ.	Expired: 14th April 2024

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered & Retired: 1

Surname	First Name	Workplace	Date Approval Expired
Nukalapati	Lokesh	Aneurin Bevan University Health Board, CAMHS, Ty Bryn, St Cadoc's Hospital, Caerleon, Newport, NP18 3XQ.	7th March 2024

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

Approval Ended: 2

Surname	First Name	Workplace	Date Approval Expired
Nwogwugwu	Nnamdi	Pastoral Cymru (Cardiff), Ty Catrin Independent Hospital, Dyfrig Road, Cardiff, CF5 5AD.	13th March 2024
Sikabofori	Bennet Toney	Regis Healthcare, Hillview Independent Hospital, Hillside, Ebbw Vale, NP23 5YA.	20th April 2024

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expired

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

APPENDIX 2

Update of Register of Section 12(2) Approved Doctors - Wales Reporting Period:- 5th March 2024-5th May 2024	
	Section 12(2) Approved Doctors
Approvals and Re-approvals	4
Approvals suspended	0
Approvals re-instated/ returned to work in Wales	0
Removed (Left Wales)	4
Retired	0
Registered without a licence to practise and retired	0
Transferred from AC register (to S12 Register)	0
Became AC approved	0
Approval Ended	1
Death in Service	0

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

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: 5th March 2024-5th May 2024

S12 Approvals and Re-approvals: 4

Surname	First Name	Workplace	Date Approval Expires	Chair's Action Letter
Ahmed	Amira	Cardiff and Vale University Health Board, St David's Hospital, Cowbridge Road, Cardiff, CF11 9XB.	17th March 2029	Yes
Foell	Jens	Betsi Cadwaladr University Health Board, Plas Menai Health Centre, Llanfairfechan, Conwy, LL33 0PN.	17th March 2029	Yes
Gawish	Ayman	Cardiff and Vale University Health Board, Ty Penfro Continuing Care Bungalow, Pembroke Road, Cardiff, CF5 1QQ.	26th March 2029	Yes
Ooi	Kim Chuan	Powys Teaching Health Board, Ystradgynlais Community Hospital, Glanrhyd Road, Ystradgynlais, Powys, SA9 1AU.	26th March 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): 4

Surname	First Name	Workplace	Date Approval Expires
Chougule	Amit	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Ynysmaerdy, Llantrisant, CF728XR.	25th October 2025
Naik	Kshipra	Swansea Bay University Health Board, CMHT, Tonna Hospital, Tonna Uchaf, Tonna, Neath, SA11 3LX.	22nd February 2026
Sanni	Idowu	Swansea Bay University Health Board, Taith Newydd, Glanrhyd Hospital, Swansea, CF31 4LN.	27th November 2028
Khogali	Yassir	Betsi Cadwaladr University Health Board, Ty Llywelyn, Bryn y Neuadd Hospital, Aber Road, Llanfairfechan, Conwy, LL33 0HH.	*2nd May 2029 (*pending receipt of Chair's Action Letter)

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: 0

Surname	First Name	Workplace	Date S12(2) Approval Expires

Became AC approved: 0

Surname	First Name	Workplace	Date Approval Expired

S12 Approval Ended: 0

Surname	First Name	Workplace	Date Approval Expired
Khalil	Mohamed	Independent, c/o Private Address.	30th April 2024

Death in Service: 0

Surname	First Name	Workplace	Date Approval Expires

Teitl adroddiad: ***Report title:***	Board Assurance Framework and Corporate Risk Register (as at end March 2024)
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to provide assurance summary from the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) risks. The Corporate Risk Register and Board Assurance Framework has been reviewed by the Audit Committee and the appropriate committees of the Board. • **Appendix 1-** Risk Management Dashboards • **Appendix 2-** Board Assurance Framework risks • **Appendix 3-** Corporate Risk Register **Key changes to note** (*approved by the Risk Management Group and Executive Team on 10 April 2024*): Board Assurance Framework changes: • Estates risk report based on the Annual Plan Deliverables, with a score of 20. • Leadership risk (aligned to Annual Plan Deliverables) reduction from 16 to 12 (based on achieving the milestones within the annual plan and noting the corporate risk CRR24-16 Leadership, which is a broader perspective of HB risks, to remain at a score of 16). Corporate Risk Register changes: • Safeguarding corporate risk reduced from 16 to 12; but to remain on the corporate risk register for monitoring.
Argymhellion: ***Recommendations:***	The Board is asked to : • **note** the report; • **receive** the assurance in relation to the management of risk as outlined in the Board Assurance Framework and Corporate Risk Register; • **endorse changes** highlighted around the Board Assurance Framework and realigning this to the Objectives of the Health Board, recently approved at the March Board.
Arweinydd Gweithredol: ***Executive Lead:***	Pam Wenger, Director of Corporate Governance
Awdur yr Adroddiad:	Nesta Collingridge, Head of Risk Management

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:N/A***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Links to the BAF detailed in respective CRR reports			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Health 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)***	Links to the BAF detailed in respective CRR reports			
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***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Risks approved by Executives as the lead for the risk, Risk Management Group 09/04/24 Executive Team on the 10/02/24, People & Culture 11/04/24, Quality, Safety & Experience Committee 18/04/24, Planning, Population Health & Partnership Committee 23/04/24, Performance, Finance, Information Governance Committee 30/04/2024, Audit Committee 07/05/2024, *noting endorsement from Audit Committee on the next stages of the development of the BAF realigning this to the 5 strategic objectives.*
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF paper which further links Tier 1 and CRR.
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:*** 1. Reassessment of current Board Assurance Framework risks 2. Risk Management workshop for the Board members identifying BAF risks July	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Appendix 1 - Risk Dashboards 2. Appendix 2- Board Assurance Framework Risks 3. Appendix 3- Corporate Risk Register	

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

1. PURPOSE

The purpose of this report is to provide the Board with information and assurance of the management of the significant risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

This paper provides risk updates from:

- The Board Assurance Framework
- The Corporate Risk Register

Appendix 1: Risk Dashboards and Risk Management Commentary
Appendix 2 & 3: contains detailed information from both risk registers, including controls/mitigations and action plans to address the risk. (5 Board Assurance Framework Risks /17 Corporate Risks (1 private)).

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

The current changes relating to the Board Assurance Framework relate to the following:

SP14 – Estates and Capital- increased to 20

The Health Board identified actions related to Estates and Capital within the 22/23 Annual Plan, Strategic Priority 14, where 7 actions remain incomplete and low confidence of delivery with a risk score of 20.

SP16- Board Leadership & Governance decreased from 16 to 12

The Health Board has made good progress in delivering against the Strategic Priority which related to the appointment of Independent Members and their subsequent induction. This has been evidenced through updates to the Board on Special Measures as well as recent Board Effectiveness Review and Structured Assessment Report from Audit Wales.

However, due to the gaps in the substantive appointment of Executive Directors, the CRR24-16 Leadership risk remains at a score of 16, supported by the Executive Team.

The full details of these risks are highlighted in **Appendix 2**.

3. CHANGES TO THE CORPORATE RISK REGISTER

There are 17 consolidated Corporate Risks. The full details of these risks are highlighted in **Appendix 3** and include evidence of controls in place, assurances on those controls, additional controls required and actions with due dates.

Key Highlights

The Corporate Risks Dashboard highlights the current score, target score in relation to the risk appetite. One risk has a reduced score following update and review by the services.

CRR24-03: Safeguarding – Current score reduced from 16 to 12 due to the reduction in risk of public scrutiny direct to the Health Board as a result of national steer on compliance. When this guidance is released the Health Board will need to comply with them. The full detail of this is contained in the risk report. It is recommended that the risk remains for

monitoring on the corporate risk register. See risk report for full rationale in reduction of likelihood from 4 to 3. See risk report for full rationale in reduction of likelihood from 4 to 3. *Endorsed at Quality, Safety & Experience Committee.*

For Noting

CRR24-05: 2023/24 Financial Plan - Reduction in current risk score was discussed at Executive Team and Performance, Finance and Information Governance Committee due to the improved year-end financial position but was **not** approved.

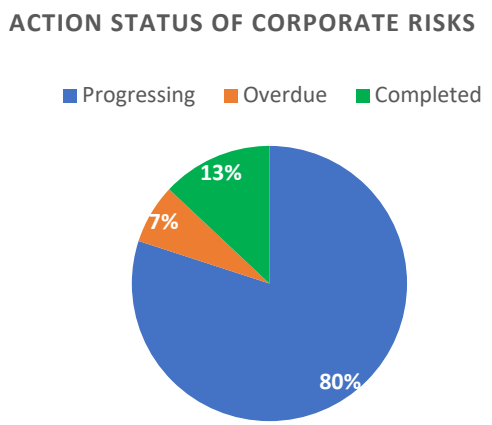
Rationale: Feedback provided around realigning this to longer term financial sustainability.

Corporate Risk Actions

Many of the risks are newly developed and therefore currently retain their initial risk scores and have a longer term outlook target date (2 year+). However, further work is required in this area to ensure the actions are the right actions in terms of risk mitigation.

Out of the 17 corporate risks, 105 actions have been developed to mitigate the risks. 13 actions have been completed, 80 actions are progressing and on track and 7 actions are overdue.

The 7 overdue actions span across 7 different corporate risks, with the ICT Failure and Cyber risk (CRR24-17) and the Planned Care risk (CRR24-11) each having 3 overdue actions. However positive assurances include 80% of actions being on track and the reduction of one score in line with target date. Positive assurance and verbal updates were provided at respective committee of overdue actions.



4. MANAGEMENT OF RISK

The Health Board has undertaken a significant amount of work to set the framework for risk management and the processes for the reporting and monitoring of risk throughout the organisation and through the board governance arrangements.

One of the key focuses for the risk management team over the next 12 months will be to work with the Executive Directors to strengthen the current arrangements with a focus on the actions and trends in relation to the management of risk to ensure that the mitigations are driving down the reduction of risk.

5. REPORTING

The current reporting of the Board Assurance Framework is at every other meeting of the Board. It is proposed that the frequency of the reporting of the Board Assurance Framework should be changed from quarterly to twice a year. The rationale for this is that the BAF should be comprised of strategic risks, which should relate directly to the achievement of the organisation's strategy (recognising that that there is currently no organisation strategy for BCUHB). The frequency of reporting will be considered at the Risk Management Development Session for the Board, which will be scheduled in June 2024.

6. BOARD ASSURANCE FRAMEWORK 2024/25

The Audit Committee held on 7th May 2024 endorsed the closure of the 23/24 BAF noting that the Board will receive an Annual Delivery Plan and therefore the Board Assurance Framework will need to be re-framed to be aligned to the Three Year Plan, and in undertaking this review, agreement on the frequency of reporting will need to be determined.

The Health Board has set out a 2024-2027 Three Year Plan, focused around five key strategic objectives:

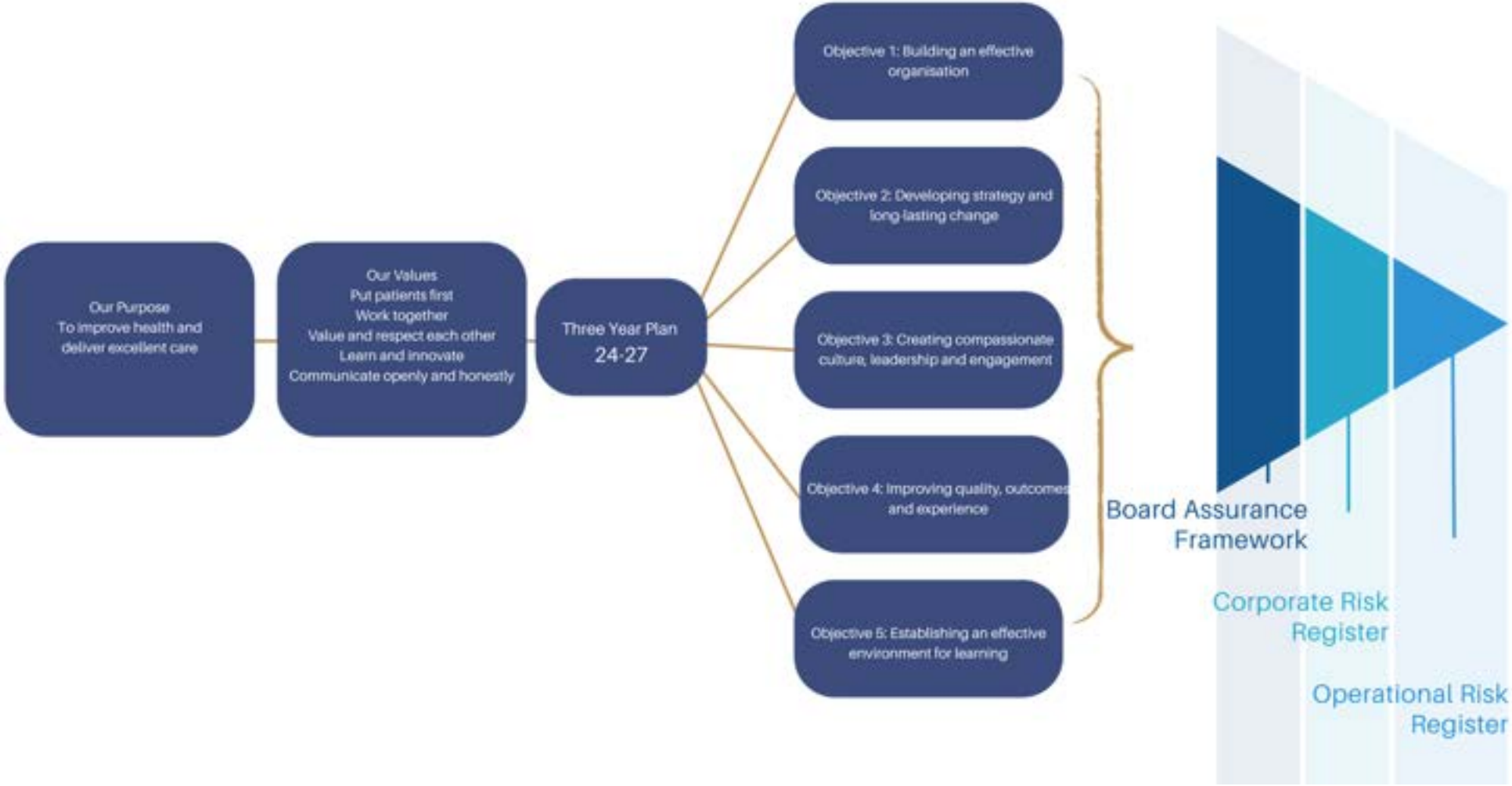
1. Building an effective organisation
2. Developing strategy and long-lasting change
3. Creating compassionate culture, leadership and engagement
4. Improving quality, outcomes and experience
5. Establishing an effective environment for learning

To ensure successful delivery of these objectives and achievement of BCUHB's overall vision, it is critical that the organisation has a robust Board Assurance Framework (BAF) in place. The BAF provides a structured approach for the Board to identify, assess and manage the principal risks that could threaten the attainment of the Health Board's strategic goals.

The outline approved at Audit Committee for developing the BAF in alignment with BCUHB's five strategic objectives is noted below:

Review the current framework to align to the Objectives	May - June
Agree set of principal risks against the Objectives	May - June
Plan session with the Board on Risk Management to agree set of principle risks and review of risk appetite	July

Health Board Strategic Objectives and Risk Relationship



DEVELOPMENT PROCESS OF BOARD ASSURANCE FRAMEWORK

01

Our Purpose

To improve health and deliver excellent care

02

Our Values

Put patients first
Work together
Value and respect each other
Learn and innovate
Communicate openly and honestly

03

24-27 Strategic Objectives

Objective 1: Building an effective organisation
Objective 2: Developing strategy and long-lasting change
Objective 3: Creating compassionate culture, leadership and engagement
Objective 4: Improving quality, outcomes and experience
Objective 5: Establishing an effective environment for learning

04

Review of Annual Plan Deliverables & Identifying BAF Risks

Engaging with the Board and Executive Team to identify the most significant risks to delivery of each strategic objective.

05

Ongoing Management and Monitoring

Assurance to Committees and Board

Appendix 1 – Board Assurance Framework and Corporate Risk Register scoring and progress

TABLE 1 – BAF Dashboard

Title	Score	Revision	Annual Plan Analysis	Risk Management Commentary
Changes to note				
Strategic Priority P14 Estates and Capital	20	↑	Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 7 actions completed, 7 Amber, 0 Red.	Risk developed by service and approved by Executive RMG 09/04/24 and ET 10/04/24.
Strategic Priority P16 Board leadership and governance	12	↓	Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q4 (23/24). 8 actions completed, 2 Amber, 0 Red.	Risk score moderated down from 16 to 12 as most actions completed.
No changes this reporting cycle				
Strategic Priority P2 Primary Care	9	↔	Overall 'Amber' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1 (24/25) and 1 priority delayed from Q4 to Q1 (24/25). 0 actions completed, 2 Amber, 2 Red.	Risk score being monitored.
Strategic Priority P3 Planned Care	9	↔	Overall 'Green' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25). 1 action completed, 0 Amber, 0 Red.	Risk score being monitored
Strategic Priority P5 Cancer	20	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q3 to Q1 (24/25). 3 actions completed, 2 Amber, 0 Red.	Delivery Confidence to be monitored, risk has been updated remains at 20.
Strategic Priority P4 Urgent and Emergency Care	0	↔	Overall 'Green' Delivery Confidence With multiple proposed delays from Q2/Q3 to Q1/Q4 (23/24). 2 actions completed, 0 Amber, 0 Red.	-
Strategic Priority P10 Children	9	↔	Overall 'Green' Delivery Confidence With 1 priority delayed from Q3 to Q3 (24/25). 0 actions completed, 0 Amber, 0 Red.	
Strategic Priority P11 Wider Delivery	12	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q2 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red.	

Title	Score	Revision	Annual Plan Analysis	Risk Management Commentary
Strategic Priority P12 Workforce	12	↔	Overall 'Green' Delivery Confidence With all on track. 4 actions completed, 0 Amber, 0 Red.	Risk score to potentially be further moderated down as all actions now completed.
Strategic Priority P13 Digital, Data and Technology	20	↔	Overall 'Amber' Delivery Confidence With multiple priorities having red or amber delivery confidence. 5 actions completed, 4 Amber, 3 Red.	Risk has been updated remains at 20.
Strategic Priority P15 Partnerships	9	↔	Overall 'Amber' Delivery Confidence With multiple priorities having amber delivery confidence. 9 actions completed, 3 Amber, 0 Red.	
Strategic Priority P17 Organisational development	12	↔	Overall 'Amber' Delivery Confidence With 1 priority delayed from Q4 to Q1 (24/25) and 1 having amber delivery confidence. 0 actions completed, 1 Amber, 1 Red.	Risk score should be reviewed and possibly may increase.
Strategic Priority P18 Quality, Innovation and Improvement	20	↓	Overall 'Green' Delivery Confidence with 1 action delayed from Q3 to Q4 (23/24). 0 actions completed, 0 amber, 0 red. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed.”	Risk score has subsequently been reduced from **25 to 20**. Reconsider impact of 5 in following iteration of report and provide rationale if remains. Change approved by Executive Team 14/02/24 and Endorsed at QSE 20/02/24

Table 2 – Corporate Risk Register Dashboard

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	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	People 4 – Seek	People & Culture Committee	Opened Dec 23. 11 actions identified, 5 completed, 2 progressing, **1 overdue and 3 new actions**. This risk is presented to the RMG and Executive Team in April for a proposed reduction in score as a result of completed actions the likelihood as reduced from a 4 to a 3, reducing the score from 16 to 12. Proposal rejected at Risk Management Group (09/04/2024) and Executive team (10/04/2024), score to remain as 16. To be further strengthened considering the recent increase in staffing T1 risks reported.
EDoN	CRR24-02	Patient Safety-Falls	5 x 4 = 20 ↔	12	Quality 3 – Open	Quality, Safety and Experience Committee	Opened Dec 23. 6 actions identified, 1 completed, 5 progressing. **Some action dates amended** from the 31/03/2024 to the 30/04/2024. Actions are on track for the April 2024 target date. However, the inherent and current risk scores are both 20, the existing controls have not reduced the risk yet. **Target date likely to change** as this risk is broadened from being operational and just around falls to being strategic and more generally patient safety focused. Work ongoing by the service to further develop the risk with the inclusion of additional patient safety risks i.e. healthcare acquired pressure ulcers, deterioration of patients etc. QSE 18/04/24 feedback-To be managed operationally and 'Patient Harm' strategic risk opened.
EDoN	CRR24-03	Safeguarding	4 x 3 = 12 ↓	8	Quality 3 – Open	Quality, Safety and Experience Committee	This risk is presented to the Risk Management Group and Executive Team in April for a proposed reduction in score but to remain as reported on CRR. See rationale within corporate risk of reduction in risk of public scrutiny due to National dependencies. QSE 18/04/24 score change endorsed.
EDoN	CRR24-04	Failure to Embed Learning	4 x 5 = 20 ↔	5	Reputational 4 – Seek	Quality, Safety and Experience Committee	Opened Dec 23, 7 actions identified, 0 completed but all progressing. The initial March 2024 **Highlighted to QSE-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.
EDoF	CRR24-05	Financial Sustainability	5 x 4 = 20 ↔	12	Financial 2 – Cautious	Performance, Finance and Information Governance Committee	Risk score has remained at 20 since opened in March 2023. 2 actions identified and progressing. This risk is presented to the Risk Management Group and Executive Team in April for a proposed reduction in score from 20 to 16 as the year-to-date deficit has improved, reducing the likelihood reduced from 5 down to 4. Proposal rejected at Risk Management Group (09/04/2024) and Executive team

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type Appetite Level	Lead Board Committee	Risk Management Commentary
							(10/04/2024), score to remain as 20. To be further strengthened to the 24/25 risk of possible deficit.
EDoF	CRR24-06	Suitability and Safety of Sites	5 x 4 = 20 ↔	12	Quality 3 – Open	Performance, Finance and Information Governance Committee	Opened March 24, 7 actions identified, 0 completed, 6 progressing, **1 overdue**. The overdue action relates to develop a Business Case Review Group. More progress is needed on the 6-facet survey, rationalisation programme and discretionary capital spend to reduce the risk in line with the 2026 target date. The backlog maintenance costs are **£348m**.
CDIO	CRR24-07	Availability and Integrity of Patient Information	5 x 4 = 20 ↔	12	Quality 3 - Open	Planning, Population Health & Partnership Committee	Opened Dec 23, 6 actions identified, 0 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. Resource requirements and system integration remain a concern to address this risk. PPHP 23/04/24 to address overdue actions prior to AC and Board.
EDoPH	CRR24-08	Population Health	5 x 4 = 20 ↔	12	Reputational 4 - Seek	Planning, Population Health & Partnership Committee	Redrafted to be more strategic Nov 2023, **No change in score**, 9 actions identified, 0 completed, 9 progressing. 2026 target date. However, the **inherent and current risk scores are both 20**, so the controls are not reducing the risk. Issues remain around securing long-term funding, partner abilities to prioritise population health, and the wider determinants of health. PPHP 23/04/24 Short term SMART actions required.
EDoO	CRR24-09	Community Care and Primary Provision	4 x 5 = 20 ↔	12	Quality 3 - Open	Quality, Safety and Experience Committee	Opened Feb 24, 5 actions identified, 1 completed, 4 progressing. Actions are on track for the 2025 target date. However, the **inherent and current risk scores are both 20**, indicating the controls are not yet reducing the risk. Timely development of a Primary Care strategy and governance model is key to reducing this risk, along with resourcing plans to address workforce and capacity gaps to reduce the **likelihood of 5**. QSE 18/04/24 -risk two be split into two.
EDoO	CRR24-10	Urgent and Emergency Care	4 x 5 = 20 ↔	12	Quality 3 - Open	Performance, Finance and Information Governance Committee	Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 6 progressing. Actions due August 2025. Challenges remain around ambulance handover delays, hospital flow, alternative pathways, and community capacity to mitigate this risk further which is further detailed in the performance reports to Board.

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoO	CRR24-11	Planned Care	5 x 4 = 20 ⟷	1	Quality / 3 - Open	Performance, Finance and Information Governance Committee	Newly developed strategic risk Feb 24, 5 actions identified, 0 completed, 2 progressing, 3 overdue. **Highlighted to PFIG- 3 overdue actions** awaiting planned care Executive workshop. Work remains to put sustainable plans in place to tackle the backlogs and avoid patient harm which is further rationalised within the details of the performance reports to Board. Target score to be revised.
EDoO	CRR24-12	Areas of Clinical Concern (encompasses ophthalmology and dermatology)	5 x 3 = 15 ⟷	12	Quality / 3 – Open	Quality, Safety and Experience Committee	Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 6 progressing. The lack of substantive medical leads and reliance on locum staffing for several fragile services is impeding progress. Focused leadership and clinical pathway work is needed to mitigate this risk.
EDoTH	CRR24-13	Timely Diagnostics	4 x 5 = 20 ⟷	5	Reputational / 4 – Seek	Quality, Safety and Experience Committee	Newly developed strategic risk Feb 24, 5 actions identified, 0 completed, 5 progressing. All actions are on track against the 2025 target date. Challenges remain around radiology staffing, ageing IT infrastructure and acting on test results and development of a Diagnostic Strategy and workforce plan required to reduce risk impact of 5.
EDoTH	CRR24-14	Harm from the Medical Devices/Equipment	4 x 4 = 16 ⟷	8	Quality / 3 – Open	Quality, Safety and Experience Committee	Newly developed strategic risk Feb 24, 6 actions identified, 0 completed, 5 progressing, **1 overdue**. The overdue action around internal communication requires focus. More progress is needed on risk-based prioritisation and securing capital funding to address the **£33m** of outdated equipment and ensure compliance with regulations.
EDoW	CRR24-15	Health and Safety	5 x 4 = 20 ⟷	8	People / 4 – Seek	People & Culture Committee	Newly developed strategic risk Feb 24, 4 actions identified, 0 completed, 4 progressing. All actions are on track against the 2024 target date. Further work is required to improve safe compliance and to strengthen the action plan.

Lead	Ref	Risk Title	Current Score (Likelihood x Impact)	Risk Target Score	Appetite Main Risk Type / Appetite Level	Lead Board Committee	Risk Management Commentary
EDoW	CRR24-16	Leadership/ Special Measures	4 x 4 = 16 ↔	8	Regulatory / 3 - Open	People & Culture Committee	Opened Dec 23. 7 actions identified, 3 completed, **1 overdue and 3 new actions**. This risk is presented to the RMG and Executive Team in April for a proposed reduction in score as a result of completed actions the likelihood as reduced from a 4 to a 3, reducing the score from 16 to 12. Proposal rejected at Risk Management Group (09/04/2024) and Executive team (10/04/2024), score to remain as 16. P&C 11/04/24 feedback-To be further strengthened beyond scope of the Board and to reflect the risk of gap in substantive Executive Team
CDIO	CRR24-17	ICT Failure and Cyber	4 x 5 = 20 ↔	15	Reputational / 4 - Seek	Planning, Population Health & Partnership Committee	Opened Feb 24, 7 actions identified, 2 completed, 5 progressing. Target score of 15 not in line with appetite. The main barriers are around securing investment for infrastructure and additional specialist posts to maintain security. 'Dependent on funding' noted on target date, 2025, (further treatments to be identified). PPHP 23/04/24 to address overdue actions prior to AC and Board.

Key:

Committee	
Performance, Finance and Information Governance Committee	PFIGC
Quality, Safety and Experience Committee	QSE
People & Culture Committee	PCC
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 Public Health	EDoPH
Executive Director of Operations	EDoO
Executive Director of Therapies and Allied Health Professions	EDoTH

Trend
No trend/Score remains the same ↔
Increased ↑
Decreased ↓

Appendix 1 – Board Assurance Framework

BAF SP5	**Executive:** Executive Director of Operations		**Date Opened:** October 2023
	Committee: Quality, Safety and Experience Committee		**Date Last Reviewed:** 14/05/2024
	Strategic Priority: **Cancer**	**Link to CRR:** Special Measures	**Last Date Reviewed at Committee:** 18/04/24
			Target Risk Date:

There is a risk of failing to achieve the aims and actions outlined in the cancer strategic priority plan such as maintain access standards, further develop and implement the Cancer Strategic Plan for North Wales and implement immediate targeted actions to improve access in diagnostics and key specialities.

Mitigations/Controls in place	**Gaps in Controls**	**Current Risk Score**
1. Roadmap for Cancer Services in North Wales developed by North Wales Cancer Partnership Board highlighting key challenges and resulting strategic aims for cancer for the next 5 years – presented to Executive Team Feb 2024 2. Workstreams underway as part of Special Measures programme to support vulnerable services, including dermatology & plastics, urology and oncology 3. New services to improve cancer pathways in place via investment from the Performance Fund Suspected Cancer Pathway (SCP) allocation, including straight to test lung and neck lump pathways, rapid diagnosis clinics, additional breast cancer capacity and increase in tracking teams 4. Pathway reviews commenced to assess compliance with national optimal pathways for cancer and identify areas of improvement; prostate and colorectal reviews completed with breast and gynaecology underway 5. Service improvement work underway to implement streamlined pathways in dermatology, lung, gynaecology, colorectal and prostate cancer 6. Patients on suspected cancer pathway tracked and delays escalated; suspected cancer patients prioritised within available capacity	1. Cancer Partnership Board funding not secured – proposal to fund via Performance Fund SCP allocation rejected by Recurrent Investments Group for Assurance process April 2024. 2. Lack of operational plans to implement vision set out in the Roadmap for Cancer Services for North Wales; in particular no agreed model for services likely to require reconfiguration across IHCs including potentially colorectal, dermatology, urology, breast 3. Lack of medical workforce in vulnerable services in particular urology, dermatology, oncology, gastroenterology and some specialist radiology posts 4. Service improvements funded via Performance Fund at risk as rejected by RIGA process April 2024 5. New services developed from Performance Fund allocation at risk due to non-recurrent nature of RIGA approvals – in year vacancies can only be filled fixed term making them unlikely to be filled, leading to service closures 6. Lack of new funding to implement service expansion in line with demand, and further service improvements identified via pathway review work	Impact: 4 Likelihood: 5 Score: 20 Movement since last Qtr: Roadmap for cancer services in north Wales completed But worsening position as funding for Cancer Partnership Board and service improvement posts rejected by RIGA process and agreed services at risk due to RIGA approvals only being to end of March. Lack of funding leaves overall score at 20

Actions and Due Date	
1. Review funding options for Cancer Partnership Board and service improvement posts to lead the implementation of the Roadmap for cancer services for North Wales	**June 2024**
2. Review long-term funding options for services established as part of the Suspected Cancer Pathway allocation from the Performance fund	**June 2024**
3. Complete work to secure vulnerable services as part of special measures programme.	**TBD**
4. Identify funding for increased capacity to reduce current backlog of patients still active over day 62 on a suspected cancer pathway, in particular within dermatology and urology	**June 2024**

Lines of Assurance			Overall Assessment
1	**2**	**3**	Service improvements funded via Performance Fund allocation vulnerable due to RIGA (recurrent investments group for assurance) as funding allocated recurrently in 2021 withdrawn or made non-recurrent. Likelihood of 5 remains, impact 4 due to **non-compliance with national** suspected cancer **pathway** due to current pressures within the dermatology service.
Strategy (Roadmap) monitored at North Wales Cancer Partnership Board Performance monitored at weekly corporate access meeting and local IHC performance meetings	Reporting line for North Wales Cancer Partnership Board to be confirmed Risk Management Group	External scrutiny and support from Welsh Government and Wales Cancer Network.	

BAF Digital, Data & Technology	**Executive:** Director of Digital (Chief Digital Information Officer (CDIO))		**Date Opened:** July 2022
	Committee: Partnerships, People and Population Health Committee		**Date Last Reviewed:** 14 May 2024
	Strategic Priority: P13	**Link to CRR:** Availability and Integrity of Patient Information	**Last Date Reviewed at Committee:** 23/04/2024
			Target Risk Date: May 2025

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.

Mitigations/Controls in place	**Gaps in Controls**	**Current Risk Score**		
		Impact	Likelihood	Score
1. Minimal controls in place with the introduction of rigour and governance to the commissioning of new Digital, Data and Technology project requests through a Project and Portfolio Management function that will ensure prioritisation, impact assessment in terms of deliverability, best use of technology, interoperability, longevity and value for money. This includes insisting that for all new projects the business change element and service design aspect up front which includes the users is built in. 2. Where possible the Health Board will bring in the necessary expertise from external service providers that the Health Board do not currently possess. 3. To set the expectations with the Health Board and Welsh Government on the inability to effectively architect and deliver Digital, Data and Technology projects and realise benefits in line with the strategy of the Health Board.	1. Funding currently not secured to implement the new operating model recurrently. 2. Unable to deliver new models of care with local and national strategies. 3. No clear technology plan, future blueprints or architectural considerations with due regards for the whole. 4. No single integrated digital health care record to address the fragmented care record concerns to deliver the special measures framework requirements. 5. Unable to replace or decommission obsolesce systems due to no funding to manage replacement or consider new ways of working. 6, Significant gaps in workforce in specific patient records and IT areas, which is resulting in decreased support for the Health Board which will impact on patient care.	4	5	20
		Movement since last Quarter: Increased likelihood from 4 to 5 since August 2023. NB. The tolerate score for this risk is 16 which is a high level of tolerance for the risk due to an inability to fund necessary resources.		

Actions and Due Date

Action Detail	**Due Date**
1. Costed proposals (£1.7m recurrent) and plans have been produced, validated and presented to Partnerships, People and Population Health Committee and Board for the implementation of a new operating model for Digital, Data and Technology which requires new capabilities and capacity to effectively deliver. This includes new functions for: Intelligence and Insight, Digital Project Management Office, Architecture Software engineering, service design and clinical change. These proposals were dependent on funding £500K of which was provided by the Health Board with due regards to other priorities for investment.	April 2023 – Completed with non-recurrent funding
2. Alternative plans to be developed within the current funding constraints that will have a small but positive impact over time.	April 2024 – Completed with non-recurrent funding
3. Commission external service providers to fill the gaps in capabilities and skills to support the delivery of objectives and special measures requirements.	August 2024

Lines of Assurance			**Overall Assessment**
1	**2**	**3**	**Next steps:**
1. Digital, Data and Technology Objectives and Operating Plan	1. Regular Assurance Reporting to Chief Digital Information Officer and Executive Team as well as Risk Management Group.	1. Internal Audit	

reviewed quarterly by Digital Senior Leadership Team. 2. Benchmarking the service against external assessments, e.g. Gartner Group IT Score. 3. National Cyber Security Centre. 4. Cyber Essentials+ 5. Information Governance Toolkit. 6. Access to external service providers to support in critical areas. 7. Government Digital Service Digital, Data and Technology roles.			The Board previously agreed a high risk tolerance score of 16, which may need to be reviewed. Risk has increased in likelihood due to significant financial pressures and Health Board and the inability to recruit to crucial roles. With the recent conclusion and investment decisions in support of the RIGA 2 process, recruitment of the necessary skills and capabilities will prove extremely problematic due to the non-recurring nature of funding allocated. Further to discussions between the Director of Finance and Chief Digital and Information Officer, it has been agreed that contracts will be progressed via Procurement with external service providers which will augment existing skills and capabilities. Proposal to delay the target due date for a further 3 months to allow procurement of external service providers to support the mitigation of the risk.

BAF SP14	**Executive:** Executive Director of Finance		**Date Opened:** 04/01/2024
	Committee: Performance, Finance and Information Governance Committee		**Date Last Reviewed:** 28/02/2024
	Strategic Priority: P14 Estates & Capital	**Link to CRR: 24-06** Suitability and Safety of sites	**Committee:** 30/04/24
			Target Risk Date: 31/03/2035 (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 of failing to deliver and provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.

Mitigations / Controls	Gaps in Controls	Current Risk Score		
		Impact	Likelihood	Score
1. Estates risk reviews to determine know high risk issues, review current mitigation and align capital funding request. 2. Current capital plan has been risk assessed to ensure they address known high risk within capital financial limits. 3. Pan BCUHB Operational Estates risk group has been formed to review and assess all infrastructure risks and develop an action plan. 4. Estates Funding Advisory Board (EFAB) funding allocated by Welsh Government to focus on key themes – MHLD, Fire, Decarbonisation and Infrastructure.	1. Capital Programme to be focused on addressing highest risk issues to the Health Board. All capital request will be aligned to Datix risk register and funding will be determined by the executive team to ensure highest risk issues are resolved. The capital programme will align with findings of the 6 facet survey and focus on compliance, engineering infrastructure and building fabric / environment. The current estimated backlog maintenance costs associated with the Health Board is in the region of £350M. 2. Inadequate resources and multiple constraints including finance, resulting in significant shortfall in capital funding to make an adequate impact on risk reduction. 3. Unable to quantify the extent of the issue due to the lack on a 6 facet survey data. 4.CRR 24-06 Suitability and Safety of Sites – Currently an open Corporate Risk for the Health Board with a current risk score of 20.	5	4	20

Actions and Due Date	
Action Detail	**Due Date**
1. Capital Programme to be focused on addressing highest risk issues to the Health Board. All capital request will be aligned to Datix risk register and funding will be determined by the exec team to ensure highest risk issues are resolved. **– Action –** Exec to review capital allocation and confirm funding aligns with the risk appetite of the Health Board.	31st March 2024
2. Unable to quantify the extent of the issue due to the lack on a 6 facet survey data. **– Action –** Plan already in place and providing exec approve revenue funding to support the programme, Operational Estates will commence with a 5 year programme of survey works across the Health Board.	31st March 2029
3. Significant shortfall in capital funding to make an adequate impact on risk reduction. **– Action –** Development and submission of Business Cases to Welsh Government to resolve major infrastructure issues and reduce the Health Board's Backlog Maintenance in line with the Estates Strategy.	31st March 2035

Lines of Assurance			Overall Assessment
1	**2**	**3**	Three actions due end of March 2024, Committee to be provided with progress update and if risk can subsequently be reduced. Significant investment is required to enable the Health Board to reduce the risk score and current backlog maintenance. The current estimated backlog maintenance costs associated with the Health Board is in the region of £350m.
1. CPMT Existing groups in operation within the Health Board where capital prioritise are reported: a. Capital Planning Management Team b. Capital Investment Group c. Performance Finance Information Governance d. Exec's group 2. Existing groups in operation within the Health Board where environmental issues and safety are escalated: a. Strategic Occupational Health and Safety Group b. Strategic Infection Prevention Group	1. Risk Management Group 2. Executive Team 3. Performance, Finance and Information Governance Committee	1. Internal Audit 2. NHS Wales Shared Services Partnership – Specialist Estates Services	

BAF Board leadership & governance	**Executive:** Director of Corporate Governance		**Date Opened:** 19 October 2023
	Committee: People & Culture Committee		**Date Last Reviewed:** 25/03/24
	Strategic Priority: SP16	**Link to CRR:** Leadership/Special Measures **Link to Tier 1's:** 4480/3969	**Last Date Reviewed at Committee:** 11/04/2024 **Target Risk Date:** May 2024

There is a risk of failing to effectively strengthen the Board arrangements following special measures and implement critical governance, accountability, planning, and performance improvements.

Mitigations	**Gaps in Controls**	**Current Risk Score**
1. The development and agreement of the Special Measures "**Governance and board effectiveness domain"** deliverables and milestones that give clarity on what needs to be delivered by when. This includes development of Board Development and Board Induction products to support Board arrangements. This is detailed in the action section. 2. Close working with Welsh Government on the recruitment of new Board members through the public appointment process. 3. Comprehensive response to the Board Effectiveness Review by Audit Wales that aligns to the Special Measures approach. 4. Structured Assessment Report, Wales Audit Office	1. The implementation of the review of the OBS is reliant upon following the organisational change policy and this will impact timescales for that part of the improvements 2. The appointment of some Executive appointments is reliant on the timely review of the Exec Portfolio review	Impact: 4 Likelihood: 3 Score: 12 Movement N/A Revised score Impact 4 remains and likelihood reduced from 4 to 3 March 2024 in line with Target

Actions and Due Date

	Target Date	
SM Ref no C1-1.3: Implement phase 1 induction for all Board members	Nov-23	Completed
SM Ref no C1-1.4: Develop phase 1 Board development programme	Dec-23	Completed
SM Ref no C1-1.5: All committees with assigned IMs operational, including ToR, Corp Calendar and Workplans	Mar-24	Completed

SM ref no C1-1.6: Design Risk management framework and commence implementation	Dec-23	Completed
SM ref no C1-1.7: Permanent Chair/IM/CEO/Exec recruitment – dependent on Exec Portfolio Review and Senior HR Cases	Mar-24	Exec recruitment commenced
SM ref no C2-1.8: OBS team – implement interim and design permanent structure	Sept- 24	Underway
SM ref no C2-1.9: Policy management and implementation/audit approach agreed	Oct-23	Completed
Feedback from Audit Wales follow up review – December 2023	Dec-23	Completed
Scrutiny of progress through Audit Committee	November 2023, January 2024 and March 2025	Completed
Assurance on progress through Board	November 2023, January 2024 and March 2026	Completed

Lines of Assurance			Overall Assessment
1	**2**	**3**	Most actions completed.
Special Measures meeting and assurances to committees on 90 day plan. OBS Team Meetings.	Director of Corporate Governance providing recommendations and progress updates through the Executive Team meetings	Internal Audit	

BAF SP18	**Executive:** Executive Director of Nursing and Midwifery		**Date Opened:** 19/10/2023
	Committee: QSE		**Date Last Reviewed:** February 2024
	Strategic Priority: SP18 Quality, Innovation and Improvement	**Link to CRR:** Failure to Embed Learning	**Last Date Reviewed at Committee:** 18/04/2024
			Target Risk Date: April 2024

There is a risk of failing to effectively strengthen governance arrangements following special measures and implement robust quality governance, improve organisational learning, and improve the handling of incidents, inquests, claims, mortality reviews and complaints.

Mitigations/Controls in place	Gaps in Controls	Current Risk Score		
		Impact	Likelihood	Score
Putting Things Right and clinical review processes and monitoring 1. Risk management processes 2. Audit programmes & monitoring arrangements 3. Patient and carer feedback and involvement processes 4. Senior sign-off process for National Reportable Incidents (NRIs) and Complaints 5. Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems 6. Clinical staff recruitment, induction, mandatory and professional training, registration & re-validation 7. Defined nurse staffing levels for all wards & departments as per Nurse Staffing Act 8. Ward accreditation schemes and ward manager/matron checks/audits. 9. Tracking of regulatory action plans 10. Internal Reviews against External National Reports 11. Getting it Right First Time (GIRFT), localised deep dives, reports and action plans 12. HIW, Ombudsman, Coroner NHS Wales Exec and WG engagement Meetings	1. Need to develop a Quality Management System (QMS) setting out an integrated approach to Quality Planning, Control, Assurance and Improvement 2. Need for clarity on quality leadership, structures and accountabilities 3. Need to review the quality governance framework of meetings and reporting 4. Need to develop a quality learning framework, aligned to the overall learning organisation programme 5. Need to review Putting Things Right and clinical review processes and monitoring 6. Need for resolution of outstanding overdue positions for incidents, complaints, claims, mortality reviews and inquests	5	4	20
		Movement since last Qtr: Score moderated from 25 to 20. 6 actions remain underway and on track for delivery at the end of Q4 at which time the risk score will be reviewed		

Actions and Due Date

Action Detail	Due Date
1. 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.	March 2024
2. Best practice guidance will be issued to IHCs and Regional Divisions to support effective local quality governance arrangements.	March 2024
3. 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.	December 2023
4. 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.	March 2024

5. The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed.			March 2024
6. The new Quality Strategy will be developed through a co-design process.			March 2024
7. 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.			March 2024
Lines of Defence			**Overall Assessment**
1	**2**	**3**	Target date revised from March to April 2024. Impact of 5 to be reviewed in following report.
1. Service and IHC Quality Groups 2. Putting Things Right and clinical review processes and monitoring 3. Ward accreditation schemes and ward manager/matron checks/audits 4. Organisational Learning Forum 5. Quality systems – RLDatix, Greatix, Civica Experience and AMAT	1. Quality, Safety and Experience Committee oversight of quality issues 2. Quality reporting to Board 3. Executive performance reviews with IHCs 4. Clinical audit 5. Patient and Carer Experience Group and oversight/assurance reporting 6. Patient Safety Group and oversight/assurance reporting 7. Clinical Effectiveness Group and oversight/assurance reporting 8. Regulatory Assurance Group and oversight/assurance reporting 9. 7. Annual Quality Report, Annual Putting Things Right Report and Annual Duty of Candour Report	1. Internal audit 2. HSE inspections 3. HIW/CIW inspections 4. PSOW investigations 5. WG performance monitoring and assurance 6. Welsh Government Reviews 7. Royal College Reviews	

Appendix 3 - Full Corporate Risk Register Detailed Information

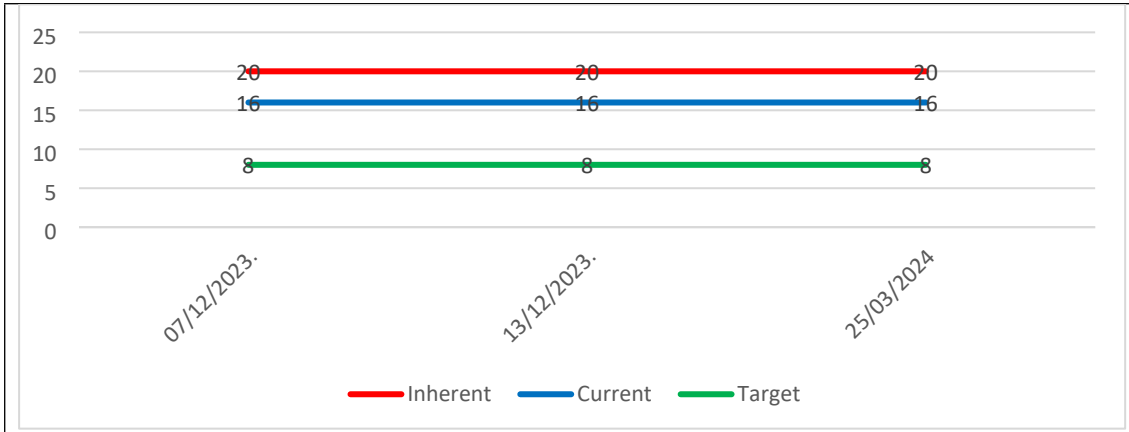
CRR 24-01	**Risk Title:** People, Culture and Wellbeing		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 11/04/24
Date Last Reviewed: 25/04/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP12	**Target Risk Date:** 30/09/2024

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 to 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. Current BCU Flexible working policy has been updated and is 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	**1st** – eg. Local Assurances: 1. Organisational Development Steering Group 2. People Services Senior Leadership Team **3.** **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team oversight 3. People & Culture Committee 4. Progress towards the People Service agenda is reported through the People & Culture Committee chaired by the CEO and reported to the Board. **3rd** – eg.External Assurances: 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.

Actions	Due Date	Progression Analysis
Education and Learning Committee is being established as a control measure	31.07.24	New action
NHS Staff Survey action plan to be developed and implemented across 24/25	30.06.24	New action
Scoping and methodology proposal for the wider review of the 2022 Operating Model restructure agreed via an appropriate Executive governance process following appropriate engagement. Proposal shared at OD Steering group. Process of gathering feedback underway in April and May 2024.	30/05/2024	Revised Date (overdue)
Findings from the wider review of the 2022 Operating Model restructure presented via an appropriate Executive governance process and next steps agreed	15/06/2024	Revised Date (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
Measure employee engagement: Proposal on a broad range of mechanisms to do this other than just the staff survey presented via an appropriate Executive governance process. Proposal was presented at OD Steering Group on 04/03/2024.	29/02/2024	Complete
Formal Culture Change Plan and accompanying Comms and Engagement plan presented via an appropriate Executive governance process. Proposal was presented and agreed at the OD Steering Group on 04/03/2024. Resources to deliver the plan still need to be agreed.	29/02/2024	Complete
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. Top level data has been received. The final local picture of the NHS survey will not be received until May 24.	29/02/2024	Complete
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	30/04/2024	Revised Date (Progressing)
Staff facing version of the Learning Organisation Framework developed for use in work-based learning contexts. This will enable improvements in a wide range of organisational outcomes, such as quality, access, experience. Version 1 of staff-facing LOF finished and ready for testing with colleagues in MHLD, as well as with critical friends and colleagues in our 'community of practice' too.	29/02/2024	Complete
The Recruiting Well, Joining Well, Leaving Well Programme is being developed to ensure we recruit, support and retain a skilled motivated workforce	TBC	New action

	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%.

CRR 24-02	**Risk Title:** Patient Safety - Falls		**Date Opened:** 01/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 18/04/24
Date Last Reviewed: 28/02/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 30/04/2024

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.

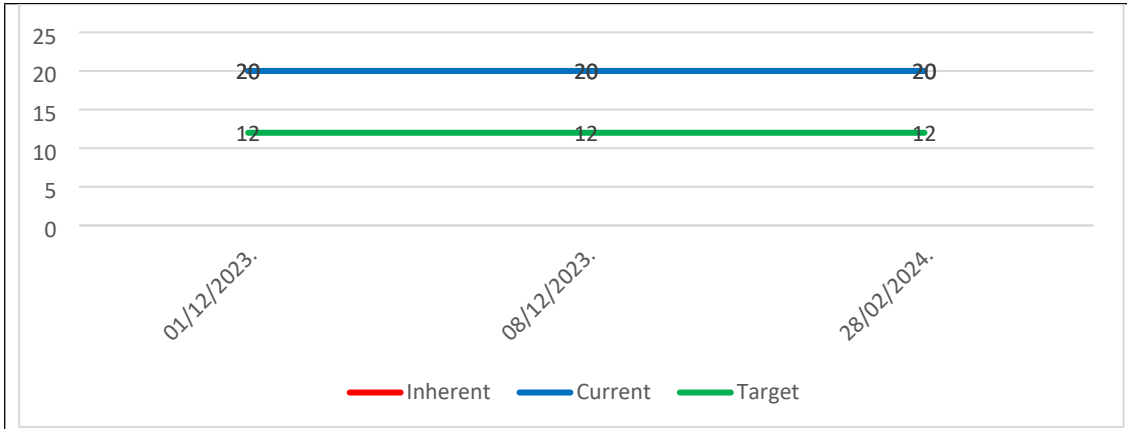
Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1.Mandatory E learning modules (1a and 1b) for Falls Prevention launched and monitoring in place for completion via the Strategic Inpatient Falls Group. Health Board compliance currently 1a 93.83%, 1b 94.55%. 2. Manual Handling 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. Local Assurances: 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/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. Quality, Safety and Experience Committee **3rd** – eg.External Assurances:	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.

7. Temporary staffing team have ensured Nurse Agencies have access to BCUHB e-learning packages and are encouraged to complete	1. Internal Audit 2. HSE 3. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 4. WG performance monitoring and assurance 5. Welsh Government Reviews	

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.	30/04/2024	Progressing
Capacity within the Manual Handling training team to be optimised with focused recruitment drive for Band 6 posts (x3) supported by workforce	30/04/2024	Progressing
Manual Handling corporate team to progress contract arrangements for external training facilities to support capacity	30/04/2024	Progressing
Outcome of peer review pilot to be evaluated	30/04/2024	Progressing
Future enhancement to the Welsh Nursing Care Record on an all-Wales basis.	30/04/2024	Progressing

	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



N.B. Inherent and Current score lines stacked as both are 20.

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:** 18/04/2024
Date Last Reviewed: 26/02/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2025

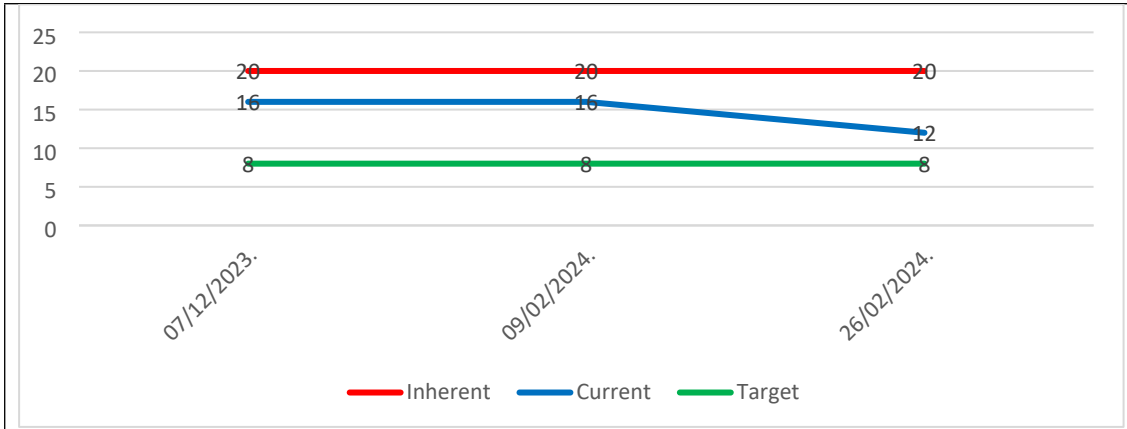
There is a risk that BCU may fail in its statutory duties to protect **vulnerable** groups from harm. This could be caused by gaps in **safeguarding governance**, **insufficient** workforce **training** and engagement, complexity of legal frameworks, and lack of resources to manage growing demand. The 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 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).	**1st** – eg. Local Assurances: **1.** Safeguarding SLT **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 1. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: 1. Internal Audit 2. Mental Capacity Act training compliance and the DoLS backlog is monitored and reported into Welsh Government. 3. This risks are regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Board. 4. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of legislation.	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. 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. .

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.		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 April 2024	30/04/2024	Progressing
National development and implementation of Single Unified Safeguarding Review SUSR training has been approved by WG. BCUHB attending February 2024. Welsh Government delay until Sept 2024.	31/03/2025	Progressing
Implementation and monitoring of the 'Workforce Safeguarding Responsibilities SoP, Approved at SGPG being shared at QDG during February 2024. Progressing through internal governance.	31/03/2024	Completed
North Wales Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications, multi-agency discussions ongoing.	30/06/2024	Progressing
Development of a DoLS/CoP DoL Standard Operating Protocol (SoP), almost complete.	31/05/2024	Progressing
CNO is undertaking a safeguarding audit of provision which will provide a benchmark for consideration, dependent on CNO.	30/03/2024	Progressing
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	31/05/2024	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

Safeguarding legislation adherence continues to be progressed and a priority and controls are in place to address risk, in collaboration with national partners. While full compliance is taking longer than desired due to dependencies nationally and outside the control of the Health Board, the team have confidence in robust controls to manage risks in the interim while awaiting further national guidance. Actions to date have positioned us well, and the team remain committed to achieving full alignment as soon as the required national guidance and legislation are available. While there remain to be some gaps in controls and full completion of actions this will be continue to be progressed and managed operationally by the team. The likelihood of public scrutiny is reduced to a 3.

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:** 18/04/2024
Date Last Reviewed: 14/03/2024	**Director Lead:** Executive Director of Nursing and Midwifery	**Link to BAF**: SP18 **-** Quality, Innovation and Improvement	**Target Risk Date:** 30/06/2024

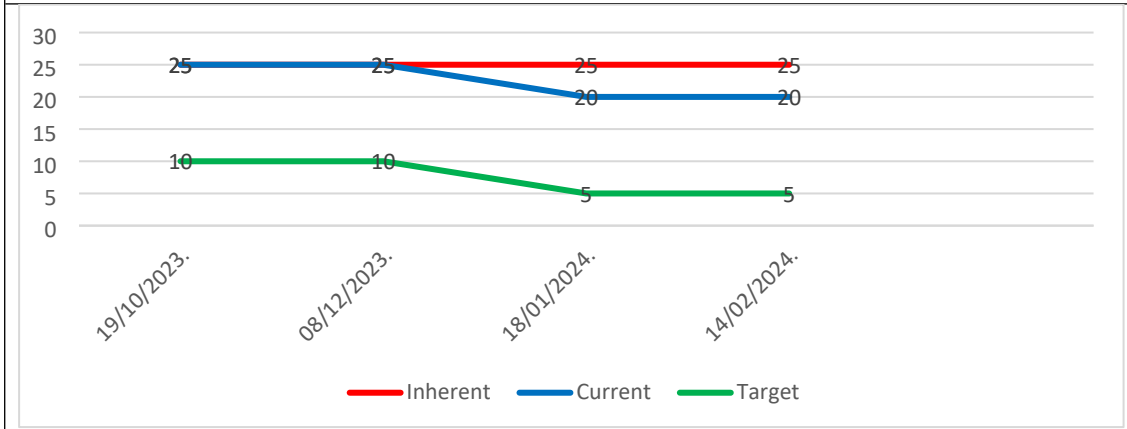
There is a risk that the Health Board could fail to meet requirements for **timely review and learning** from mortality cases, claims, inspections, incidents and complaints. This could be caused by insufficient resources, lack of unified processes, outdated IT systems, duplication of effort, and overreliance 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. Local Assurances: 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** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. Executive performance reviews with IHCs	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	4. Quality, Safety and Experience Committee oversight of quality issues **3rd** – e.g. External Assurances: 1. Internal Audit 2. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 3. WG performance monitoring and assurance 4. Welsh Government Reviews 5. 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	30/06/2024	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	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 – it is hoped to launch the Dashboard in April 2024	30/04/2024	Date Revised from December 2023
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. Update - This was due end of March – the aim is still to have a working test launched for April 2024	30/04/2024	Date Revised from March 2024
The approach to quality assurance will be reviewed and refreshed and a new regulatory procedure and quality assurance procedure will be developed	30/06/2024	Date Revised

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		from March 2024
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.	31/05/2024	Date Revised from March 2024
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	Date Revised from March 2024



	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

CRR 24-05	**Risk Title:** 2023/24 Financial Plan		**Date Opened:** 13/03/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 30/04/2024
Date Last Reviewed: 13/03/2024	**Director Lead:** Executive Director of Finance	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2024

Failure to achieve the Annual Plan for 2023/24 (£134.2m deficit), due to non-delivery of planned level of financial improvement

The financial plan for 2023-24 has identified a forecast deficit of £134.2m. This includes a target for financial improvement of £38.7m, which is based on the following:

- Disinvestment identified £13.5m
- Savings Target £25.2m (Stretch Target £30m)

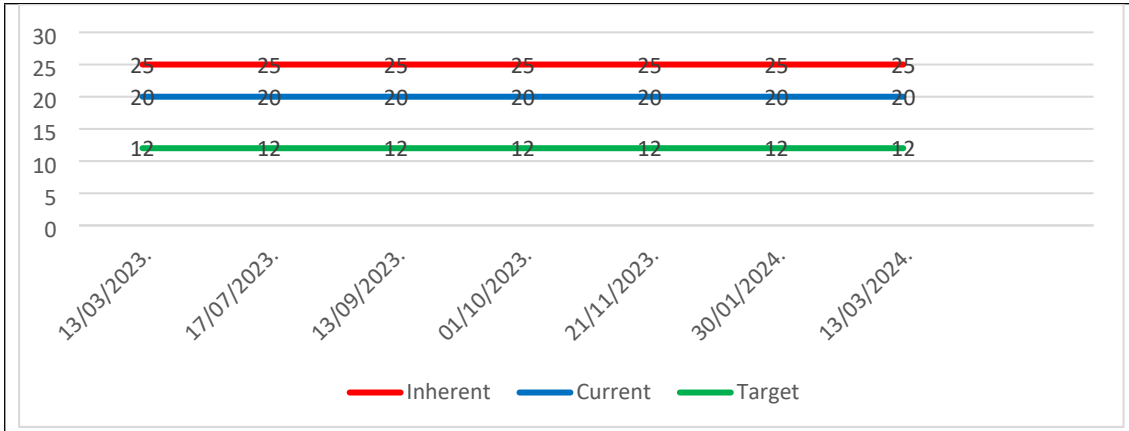
Failure to deliver the target for financial improvement could adversely impact on the achievement of the financial plan and increase the deficit.

Mitigations/Controls in place	Lines of Assurances	Additional Controls required
1. Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions has been agreed to meet at senior leadership team SLT and performance to be challenged at EDIPG. 2. Cross cutting themes with Executive leadership have also been agreed to support IHC/other delivery. 3. Introduction of the Recurrent Investment Group Assurance (RIGA) to assess the £100m Annual Plan investment (Phase 1). 4. Introduction of the Establish Control Group to review all requests for A&C posts and all Band 7+ posts (Non-Patient Facing) and to obtain Executive approval before advertising and reduction of Interim Corporate Staff from 52 to 7. 5. Internal reporting by Department on a monthly basis including review of overspends and forecasts.	**1st** – eg. Local Assurances: 1. CEO led Divisional Performance Management of Directors at IPEDG and individual performance reviews 2. Control Total Actions and Monitoring of Progress 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/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. Performance, Finance and Information Governance Committee /Audit Committee 4. Board Committee **3rd** – eg .External Assurances:	1. Welsh Government (WG) expectation to achieve a control total deficit of £20m. Delivery of control target may result in the £82m previous WG funding support plus the new 23/24 £76m investment, becoming recurrent funding in 2024/25.

6. Financial reporting to Welsh Government on a monthly basis, with the MMR. 7. Financial (including Savings and Finance Special Measures Action Plan) oversight arrangements in place through the Performance, Finance and Information Governance Committee (PFIG) 8. Regular communication with Welsh Government regarding £82m strategic funding with regards to making this recurrent rather than non-recurrent. 9. Additional £101m (£76m conditionally recurrent) provided by Welsh Government, reducing the deficit from £134m to £33m at Month 7. 10. Standing Financial Instructions updated to reflect the model issued by Welsh Government and Scheme of Reservation and Delegation (SoRD) strengthened	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 and submission of a Finance: Special Measures Action Plan	

Actions	**Due Date**	**Progression Analysis**
Recurrent Investment Group Assurance (RIGA) to assess the £42m Investments Plan (Phase 2).	31/03/2024	Progressing
Application of Control Totals to Divisions to reduce expenditure by 2% between November and March 2024 Month 11 - Year to date deficit above plan significantly reduced – now only requires a £2.7m surplus to be posted in the final month of March to achieve the £33m outturn position. Further opportunities are currently being considered which will reduce the outturn to c £27m by year end. Whilst this does not achieve the control total of £20m deficit set by WG, it demonstrates progress and is an improvement against the original planned outturn. Month 11 - The Health Board is forecast to deliver £34.3m Savings, £9.4m Accountancy Gains and generate additional Income of £0.6m, totalling £44.2m and therefore exceeding the target (£25.2m) and the stretch target (£30.9m). Of these forecast savings £21.3m is identified as recurring, with a full year effect of £27.6m	31/03/2024	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

Year to date deficit above plan significantly reduced – now only requires a £2.7m surplus to be posted in the final month of March to achieve the £33m outturn position

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:** PFIG 30/04/24
Date Last Reviewed: 28/02/2024	**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).

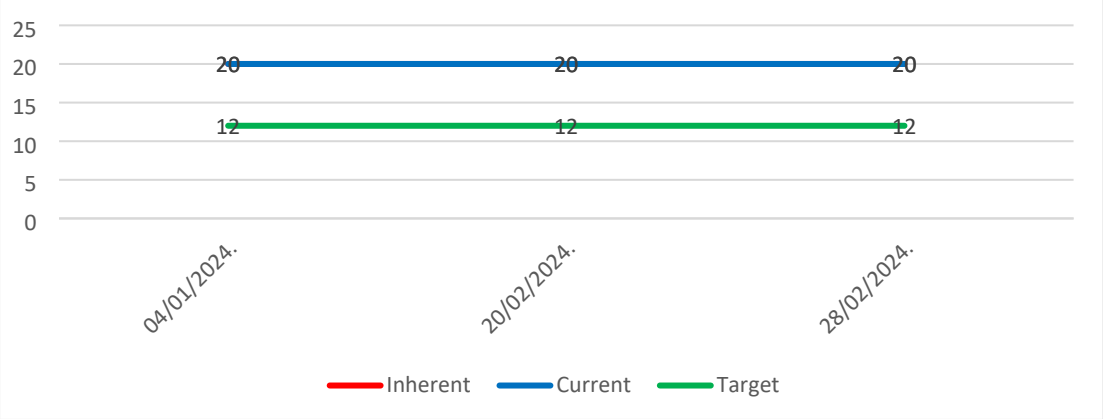
There is a risk that the suitability and safety of the estates and infrastructure across BCU could severely impact on service delivery, staff and patient safety. This could be caused by aging and unsuitable buildings, backlog maintenance issues, non-compliance with regulations, inadequate space capacity, 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	**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 Existing groups in operation within the Health Board where environmental issues and safety are escalated: 3. Strategic Occupational Health and Safety Group **4.** Strategic Infection Prevention Group **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. 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

concerns regarding the funding available to effectively manage the condition of the estate and ensure safety of patients and staff. 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	3. 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.	much capital investment is provided to 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.	29/02/2024	Overdue
Completion of Welsh Government Prioritisation exercise	31/03/2024	Progressing
Undertake action to deliver an Health Board Estates Rationalisation Programme	31/03/2024	Progressing
Agreed protocol for use of Annual Discretionary Slippage to be put in place	31/03/2024	Progressing
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	4	3	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.

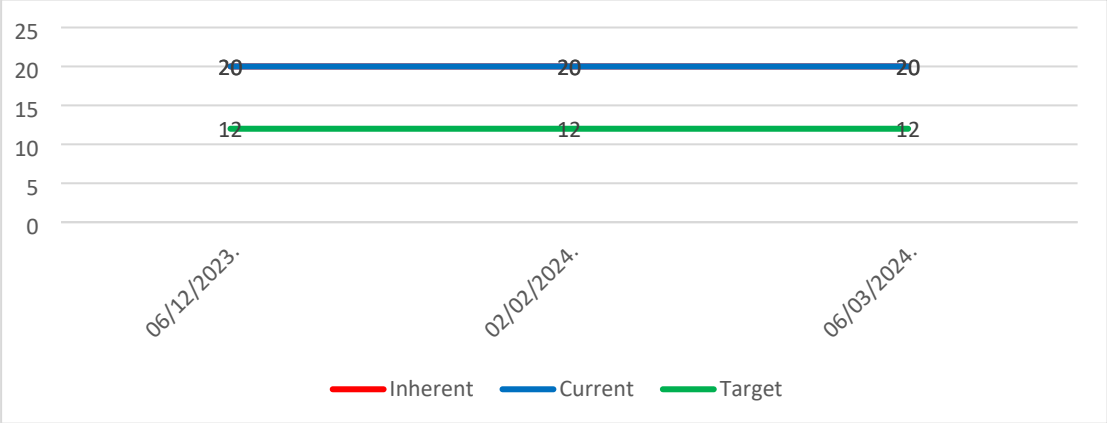
CRR 24-07	**Risk Title:** Availability and Integrity of Patient Information		**Date Opened:** 06/12/2023
	Assuring Committee: Planning, Population Health & Partnership Committee		**Date Last Committee Review:** 23/04/2024
Date Last Reviewed: 25/04/2024	**Director Lead:** Chief Digital and Information 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 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 as a potential document repository.	**1st** – eg. Local Assurances: 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/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team meeting 3. Partnerships, People and Population Health Committee **3rd** – eg.External Assurances: 1. Internal Audit Annual Information Governance Compliance Audit. 2. Information Commissioners Office Audit.	1. Establish and implement the governance arrangements for overall management of the Electronic Health Record. This will be captured as part of the full business case requirement. 2. Lack of current system capabilities systems to integrate into the fuller Electronic Health Record. Full optimisation programme underway to review all current systems interoperability and functionality. 3. Availability of current paper records within digital environment. Full 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 underway with the Senior Information Risk Owner and Caldicott Guardian.

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)	30/12/2024	Progressing
Seeking approval and funding for the Strategic outline case for Electronic Health Record	31/12/2024	Progressing

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	31/03/2025	Progressing
Undertake a review of all current systems to ensure these can be integrated into an Electronic Health Record	30/04/2025	Progressing
Accelerating the business case, approvals, procurement and implementation of an Electronic Patient Record for Mental Health (minimum 2-year project)	30/04/2025	Progressing



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.

CRR 24-08	**Risk Title:** Population Health		**Date Opened:** 01/11/2023
	Assuring Committee: Partnerships, People and Population Health Committee		**Date Last Committee Review:** 23/04/2024
Date Last Reviewed: 18/03/2024	**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.

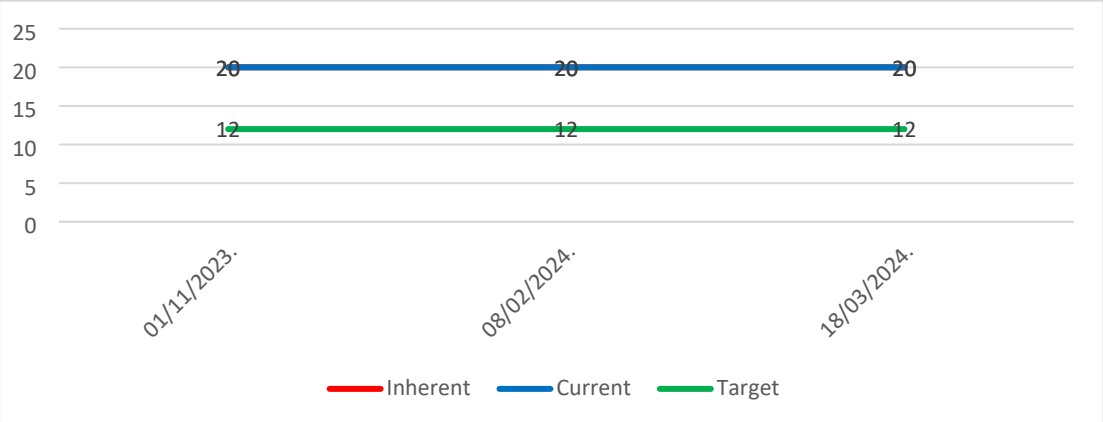
Population health improvement and protection may also be impacted by population behaviours and beliefs, modifiable risk factors, wider determinants of health (eg Housing, Education, Employment), the local demographics, the living environment, food production and consumption, local planning, socio-economic 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 such as: Hepatitis, Measles, Mumps, Rubella, HIV, E-Coli, sexually transmitted infections. 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 (meets monthly) provides strategic direction. 2. Planning, Population Health and Partnership Committee has oversight and receives regular reports. 3. Welsh Government provides oversight of grant funded activity supporting prevention and early years. 4. The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Public Health Team. **The Deputy Director of Public Health is currently Acting Executive Director of Public Health. 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.	**1st** – eg. Local Assurances: 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. 3. The Public Health Team support population needs analysis and provide professional expertise to support the development of Health Board and partner plans. 4. Prevention is embedded in the Living Healthier, Staying Well Strategy and a 'life-course' approach is promoted. **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Health Board progress is reported to Regional Partnership Board and PPPH Committee. 2. A 'Whole System Approach' is being implemented across a number of key priority areas	1. In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. 2. The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increasing the activities required. 3. It is acknowledged that this is a long term risk which cannot be mitigated and fully evidenced within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches)

7. Health Protection Team work in partnership with Local Authorities to provide expertise and management of risks and issues.	3. Annual development of Public Health work plan to reflect current and emerging need. 4. The Health Protection Team have established funding in 24/25 Health Board allocation. **3rd** – eg.External Assurances: 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. Grant funding (Welsh Government, Public Health Wales, Arts Council for Wales) has been secured for 24/25 for a number of small projects	which support the strongest evidence base for success. 4. Investment in prevention at the levels required within the health board through investment of core funding. 5. Partners within geographic area ability to commit resources at required levels to population health and prevention activity due to financial and capacity constraints 6. Response to the demographic profile and the current and forecast prevalence of chronic conditions and their effect on demand. 7. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 8. The current cost of living crisis will adversely affect those most at risk. 9. The current financial position of the Health Board and its partners will impact on investment and delivery of programmes which support this work. 10. The current position of the Health Board within escalatory measures and associated short term focus to meet ministerial and special measures priority actions may reduce focus on longer term priority work aimed at prevention and early intervention. 11. The availability of data and intelligence to support strategic focus at the local level and subsequent planning is not available. 12. The Deputy Director of Public Health post is currently vacant as the post holder is Acting Executive Director of Public Health.

Actions	Due Date	Progression Analysis
Infant Feeding Strategy 2019 (current refresh underway to 2025)	31/12/2024	Progressing
Tobacco Control Legislation (including Smoke Free Sites) / Welsh Government Tobacco Control Plan	31/03/2026	Progressing
All Wales Weight Management Pathway 2021	31/03/2026	Progressing
Health Care Public Health Programme (also linked to Special Measures Plans and chronic disease pathways)	31/03/2026	Progressing
Together for Mental Health Strategy (local / national)	31/03/2026	Progressing
Well North Wales targeted partner programmes	31/03/2026	Progressing
Health Board Annual Plan / 3 year milestones and associated activity	31/03/2026	Progressing
Working in partnership across BCUHB, PHW and LA to reduce the risk associated with infectious diseases	31/03/2026	Progressing
Immunisation Strategy 2023-2026	31/03/2026	Progressing



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

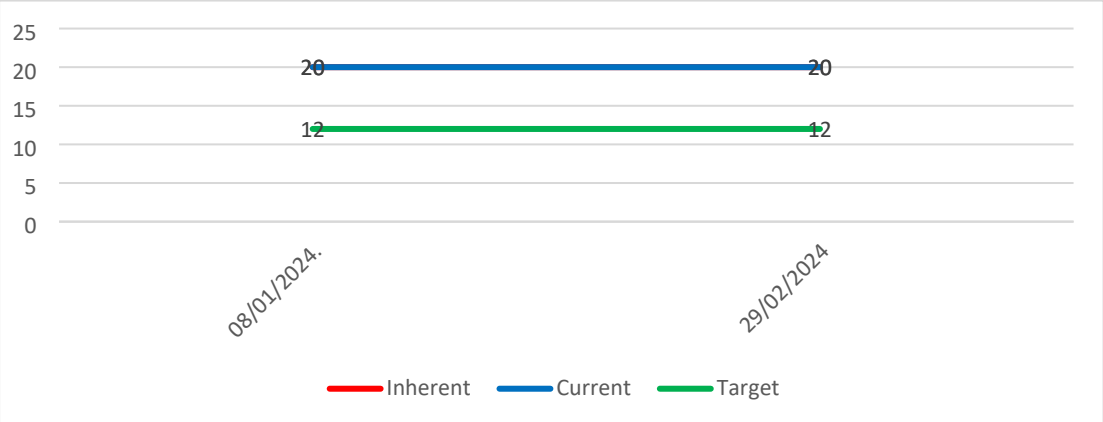
The population health of North Wales is worsening and has significant impact on demand for services and potentially on the wider community due to the loss of people from the workforce, and through the subsequent economic impacts on our communities through loss of involvement. Worsening health outcomes, 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

CRR 24-09	**Risk Title: Primary and Community Care services**		**Date Opened:** 08/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 30/04/24
Date Last Reviewed: 29/02/2024	**Director Lead:** Executive Director of Operations (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 and community care services. This may be due to challenges stem from various factors including staffing shortages, recruitment and retention issues, inadequate resources, limited prevention services, and funding constraints exacerbated by population growth and transient demographics. Moreover, deficiencies in strategic planning, data management, and information sharing further compound these challenges. The ramifications are wide-ranging, impacting the sustainability of primary care professions, patient access, timely diagnosis, and appropriate healthcare utilisation. This results 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	**1st** – eg. Local Assurances: 1. Primary Care Quality and Delivery Group 2. Primary Care Panel **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. Quality, Safety and Experience Committee **3rd** – eg. External Assurances: 1. Internal Audit 2. Regulatory inspections and investigations – HSE, HIW, CIW, PSOW 3. WG performance monitoring and assurance 4. Welsh Government Reviews 5. Royal College Reviews	1. Greater Health Board oversight of Primary Care issues and risks. 2. Strategy and resources to support introduction of new roles, ways of working and models of service delivery. 3. Improved governance structures, process and procedures. 4. Equity of resource to support primary care transformation, management and governance.

Actions	Due Date	Progression Analysis
Primary Care Board established	30/05/2024	Progressing
Primary Care strategic plan	31/03/2025	Progressing
Escalation and sustainability implementation	30/06/2024	Progressing
Health Board Managed Practices – recommendations for improved governance report	31/01/2024	Completed
Focused on implementation of recommendations	30/06/2024	Progressing



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.

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:** 30/04/24
Date Last Reviewed: 22/03/2024	**Director Lead:** Executive Director of Operations (Executive Director Therapies & Health Science)	**Link to BAF**: N/A	**Target Risk Date:** 30/03/2025

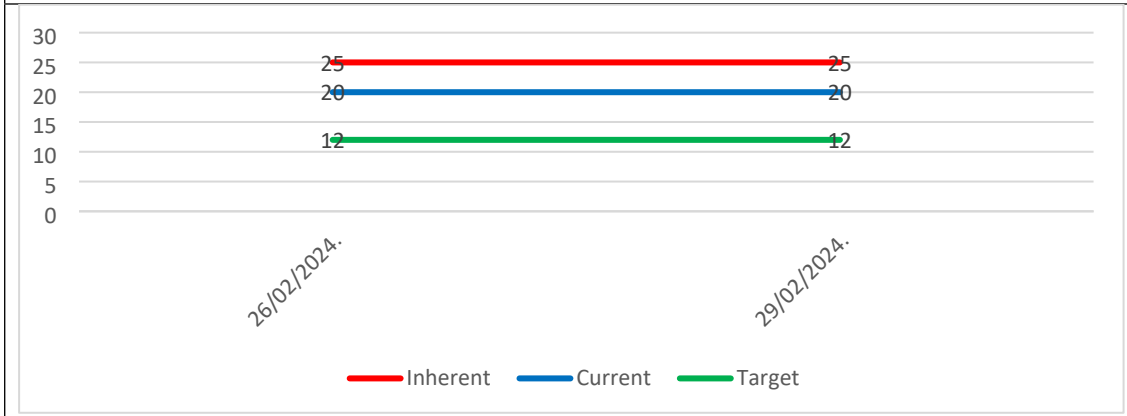
There is a risk of mortality in relation to **critically ill** patients being seen in a **timely** manner through unscheduled **care** routes. This may be caused by delayed dispatching of ambulances, ambulance queues at emergency departments, Out of Hours access and EDs and UTCs being at capacity. This 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.	**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 the 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

Care Home risk and escalation plans to support care home capacity with community team's support. 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	**2nd** – eg. Risk/Compliance/Committee Assurances:: 1. Risk Management Group 2. Executive Team oversight 3. Regular reporting to Performance, Finance and Information Governance Committee. **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.Internal Audit	management resulting in inability to drive system change. 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**
Transformational development of urgent care system (6 Goals) including developing 1000 beds and focus on ministerial priorities	31/03/2024	Progressing
Review of Complex Care arrangements in place to improve system improvements and to reduce delays	30/04/2024	Progressing
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	Progressing
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	Progressing
BCUHB agreement on IHC to trial the Continuous flow model and implement prior to August 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



	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 (2020-2023)

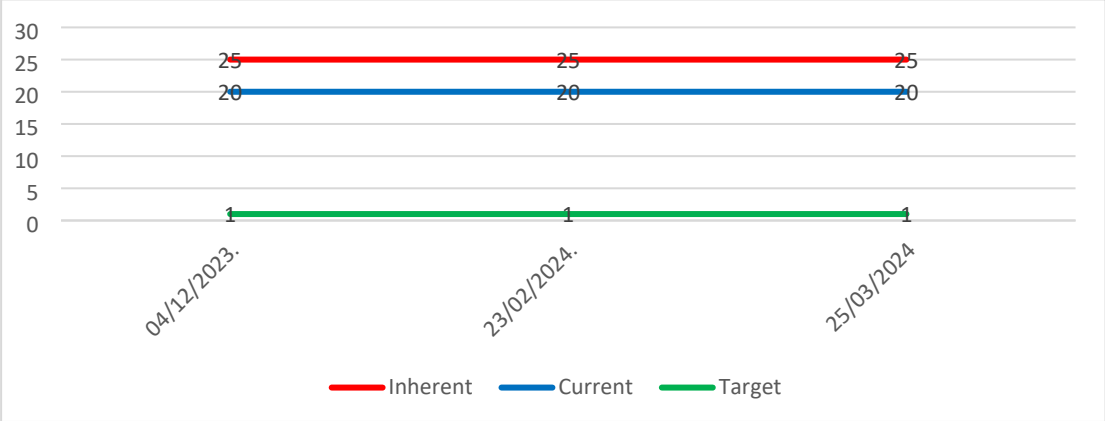
CRR 24-11	**Risk Title:** Planned Care		**Date Opened:** 04/12/2023
	Assuring Committee: Performance, Finance and Information Governance Committee		**Date Last Committee Review:** 30/04/24
Date Last Reviewed: 25/03/2024	**Director Lead:** Executive Director of Operations (Executive Medical Director)	**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 4. Risk Management Group 5. Executive Team **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Performance, Finance and Information Governance Committee **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	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.

	5.Internal Audit	

Actions	Due Date	Progression Analysis
Recruitment to the Llandudno/ Abergele business case (orthopaedic site). Funding not released, action overdue.	31/03/2024	Overdue
Approval of the application of sustainability funds and authority to deploy in line with Plan	31/03/2024	Overdue
Senior Responsible Officer for Planned Care Board	31/03/2024	Overdue
Recruiting to programmes of work in order to support successful delivery	31/05/2024	Progressing
Board Development session on planned care	31/12/2024	Progressing



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	1	1	1
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.

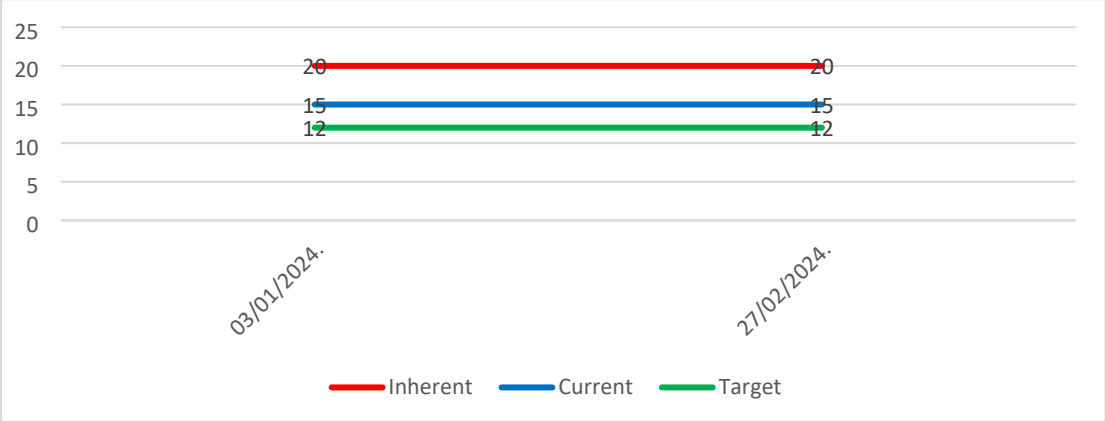
CRR 24-12	**Risk Title:** Clinical Areas of Concern		**Date Opened:** 15/12/2023
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 18/04/2024
Date Last Reviewed: 25/03/2024	**Director Lead:** Executive Medical Director/ Executive Director of Operations	**Link 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/Committee Assurances:** 1. Risk Management Group 2. Executive Team Meeting 3. Quality, Safety and Experience Committee / Performance, Finance Committee **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 (ie eye record system) and National Programmes (ie Robotics)	01/07/2024	Progressing
Ongoing recruitment for substantive medical leadership roles.	01/01/2025	Progressing

Recruitment efforts including substantive, locum and agency staff.	01/01/2025	Progressing
SLAs to be signed off through governance structures	01/08/2024	Progressing
Clinical pathway events	30/07/2024	Progressing
Non-clinical and clinical validation exercises	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.

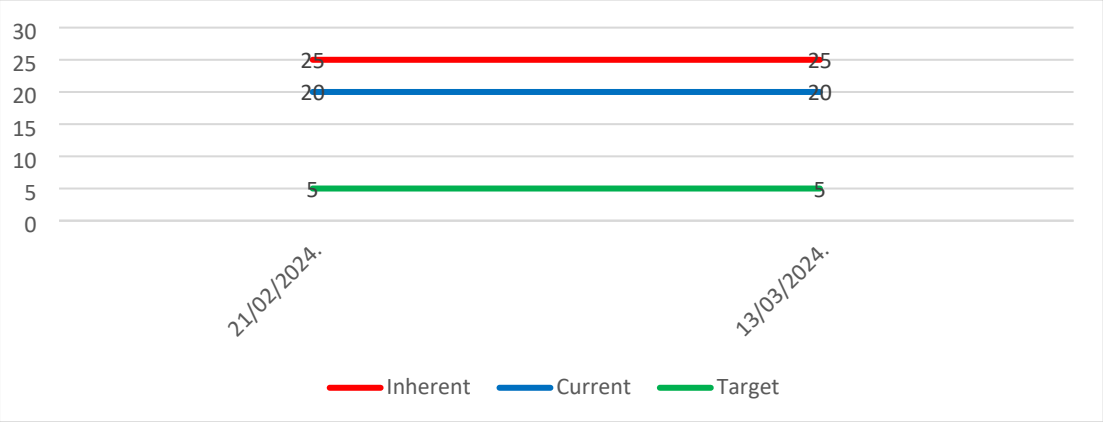
- Ophthalmology R1 seen within 25% over their clinical due date - NHS Wales Performance Framework 2024-25 Target improve to 95%
- Cancer 62 Days - NHS Wales Performance Framework 2024-25 Target improvement trajectory to 80% by 31.03.2026

CRR 24-13	**Risk Title:** Timely Diagnostics		**Date Opened:** 21/02/2024
	Assuring Committee: Quality, Safety and Experience Committee		**Date Last Committee Review:** 18/04/2024
Date Last Reviewed: 13/03/2024	**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. Local Assurances: 1. Local deployment board and wider programme team stood up with collaborative working with Pathology and DDAT. **2nd** – eg. Risk/Compliance/Committee Assurances: 2. Risk Management Group 3. Executive Team 4. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: 1. Internal Audit **1.** RISP being monitored via National and BCU implementation boards	1. Replacement of Radiology Informatics System (RISP) – implementation underway 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

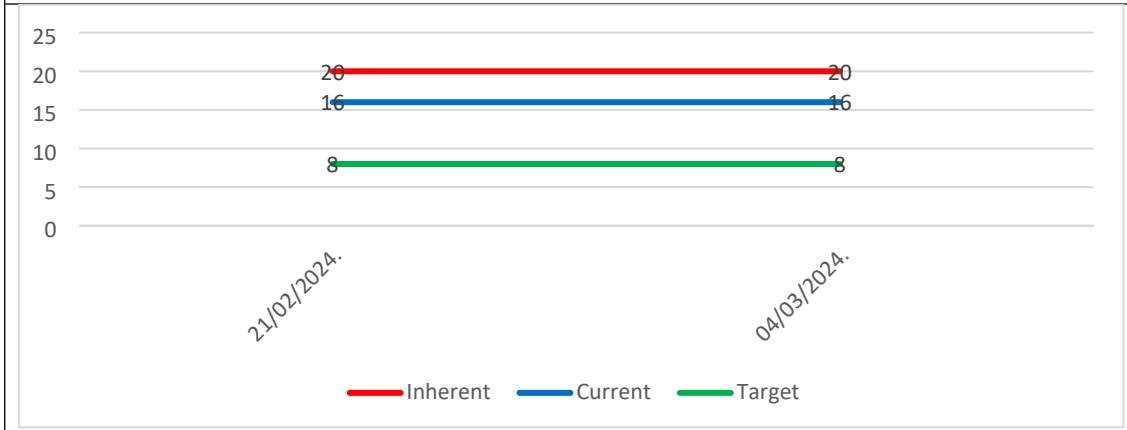
	largest. Endoscopy capacity at most risk as the insourcing into Wrexham stopped as of 1st April 2024.

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:** 18/04/2024
Date Last Reviewed: 04/03/2024	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Link to BAF**: N/A	**Target Risk Date:** 31/03/2024 (review point)

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 and issues; utilisation, performance, maintenance; repair and calibration history. 7. Audits on majority of affected equipment in line with regulatory compliance completed.	**1st** – eg. Local Assurances: 1. Medical Devices Oversight Group 2. Capital Programme Management Team 3. Capital Investment Group **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. Quality, Safety and Experience Committee **3rd** – eg.External Assurances: 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 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	Progressing
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 it's safety and will consider compliance	31/03/2024	Progressing
Review medical devices capital replacement to ensure all services have a medical devises replacement programme in place	31/03/2024	Progressing
Medical Devices strategy	31/03/2024	Progressing
Recruitment to medical devices team	31/03/2024	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.

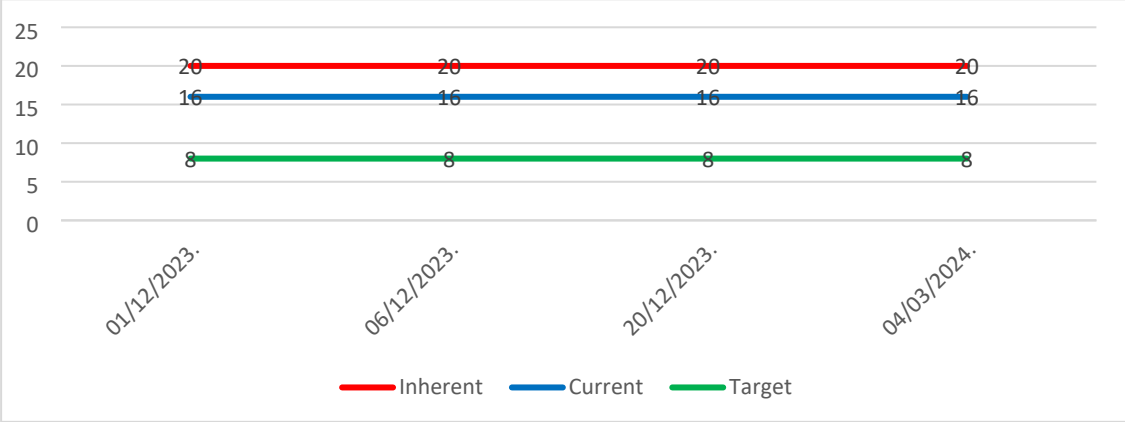
CRR24-15	**Risk Title:** Health and Safety		**Date Opened:** 01/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 11/04/2024
Date Last Reviewed: 04/03/2024	**Director Lead:** Deputy Director of People	**Link to BAF**: N/A	**Target Risk Date:** 31/12/2024

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. Falls are closely monitored by H&S advisors to review under RIDDOR reporting requirements	**1st** – eg. Local Assurances: 1. Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to People Committee 2. 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/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. People & Culture Committee **3rd** – eg.External Assurances: 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. New role of Director of Environment to be recruited to reporting to CEO, which will review Estate business cases 4. 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. 5. The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health resulting in. prosecution. 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	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



	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.

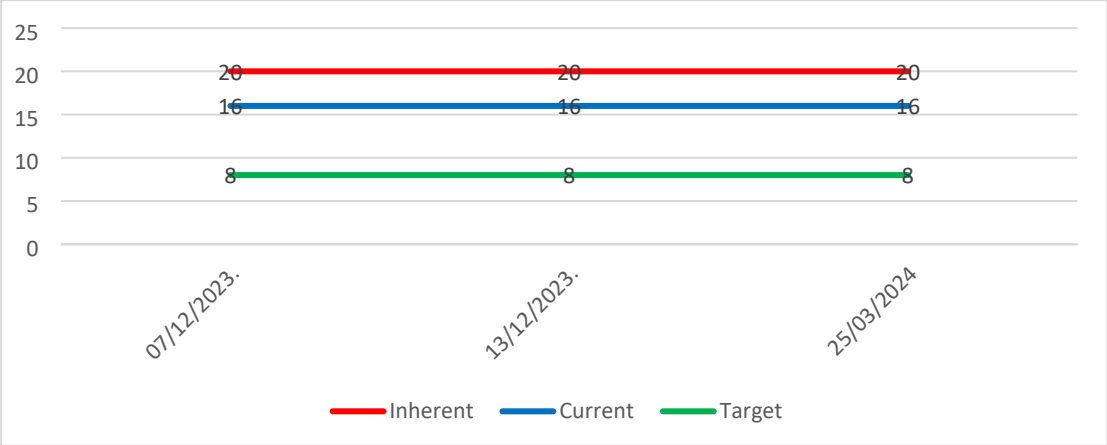
CRR 24-16	**Risk Title:** Leadership/Special Measures		**Date Opened:** 07/12/2023
	Assuring Committee: People & Culture Committee		**Date Last Committee Review:** 11/04/2024
Date Last Reviewed: 25/04/2024	**Director Lead:** Deputy Director of Workforce	**Link to BAF**: SP17	**Target Risk Date:** 30/09/2024

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	**1st** – eg. Local Assurances: 1. Organisational Development Steering Group 2. Local Integrated Health Communities & Pan Services People & Culture Committees **2nd** – eg. Risk/Compliance/Committee Assurances: 1. Risk Management Group 2. Executive Team Meeting 3. People Committee to the Board and through the CEO report to the Board. **3rd** – eg.External Assurances: 1.Internal Audit 2.Welsh Government JET meetings	1. Integrated Leadership Development Framework 2. New 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 5. Fully resourced Culture Change programme

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	31/01/2024	Complete

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.		
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	Overdue
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
OD Steering Group established. To date, the OD Steering Group have met on two occasions - 05/02/2024 and 04/03/2024.	30/12/2023	Completed
Draft Integrated Leadership Development Framework in place (forms part of special measures monitoring)	TBC	New action
Draft OD plan in development (forms part of special measures monitoring)	TBC	New Action
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	TBC	New action



	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.

Teitl adroddiad: ***Report title:***	Improving Quality Report – May 2024
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	30th May 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.
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:***	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* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***
There is confidence in the data provided in the report however, the 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 – May 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 data and exception reporting is provided in the Integrated Performance and Quality Report to the Board.

The report is structured, for ease, around quality governance (covering assurance, regulation, healthcare law and improvement) and the three high level domains of quality: patient safety, patient experience and clinical effectiveness.

QUALITY GOVERNANCE

Inquests

During March and April 2024, the Health Board received 2 Regulation 28 Prevention of Future Death Reports. A summary of the issues raised by the Coroner are listed as follows:

1. East – the current bleep system did not enable information to be conveyed electronically and that this in turn created a risk of misunderstanding as to work requirements and hence impacted upon prioritisation of tasks and therefore potential delay.

2. East – there is inadequate knowledge of the use of the Adult Critical Care Service (ACCTS) and its operation across the whole of the Health Board, including clinical site managers as well as clinicians and nursing staff.

These Notices are being reviewed and responses drafted – the Health Board has 56 days to respond and is therefore within time for all Notices. All Notices are allocated to a lead within the relevant service, with responses scrutinised and approved by the Executive Medical Director.

A bi-weekly Inquest Oversight Panel was established in autumn to provide executive support to ensuring deadlines were achieved. 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.

The Health Board shares the concerns raised by HM Senior Coroners regarding investigation timeliness, quality and evidence of learning. This concern is reflected in the very high number of notices issued by coroners. In response, a review of the investigation process is underway commissioned by the CEO and a new integrated policy for investigating incidents, complaints and mortality is due to be completed for the Board meeting in July. A project is also underway to provide assurance of investigation quality, learning and supporting evidence for previously completed investigations.

A presentation on the learning from Regulation of 28 Prevention of Future Deaths was shared at the Regulatory Assurance Group in April 2024.

Training sessions have been arranged in May 2024, facilitated by one of our leading Barristers, on the best approach to formulating a 'Lessons Learned Statement'. The objective of the lessons learned statement is to provide a chronological summary of actions taken, referencing key policies, improvements and learning in a witness statement to be signed off at senior leadership level. This can be used successfully to provide assurance to the Coroner and family that lessons have been learned and implemented in order to reduce future deaths.

The Health Board continues to meet with the two Senior Coroners to ensure good working practices.

Claims

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 25. 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.

Regulation

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.

HIW published its report following the inspection of the Community Mental Health team based at Nant Y Glyn. An improvement plan in response to the findings has been developed.

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).

There are no CIW issues for reporting to the Board.

The **Health and Safety Executive (HSE)** is the national independent regulator for health and safety. In Wales, the HSE enforce regulations including those that relate to the protection of patients.

There are no HSE issues for reporting to the Board.

Ombudsman

The Health Board currently has two draft Public Interest Reports under consideration. These reports, when finalised, will be shared via the QSE Committee papers including details of the improvement plans developed in response.

Learning

The Organisational Learning Forum (OLF) continues to receive regular presentations identifying opportunities for organisational learning and reflection. These presentations have included more recently learning from inquests, learning from medication errors and a recent presentation highlighted the learning from investigation report writing standards. The learning from medication errors has in particular included the importance of learning from human factors and its importance to integrate into patient safety reviews.

Further organisational learning has been disseminated across the organisation with regards to the safe administration of transdermal patches utilising the 7 minute briefing. This framework for staff briefing has been endorsed by the OLF as its evidence base suggests that seven minutes is an ideal time span in which to concentrate and learn.

Standards of practice for patient transplants and learning has also been disseminated across the organisation utilising 7 Principles endorsed by the OLF and supported with audit for evaluation.

The meeting has supported the ongoing development of an Organisational Learning Framework receiving reflections from the staff engagement event and supporting its plans to engage with service users in its further development.

The Health Board has received more than 1000 submissions through GREAT-ix – the new 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 NHS. 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 and will be launched this month as a pilot. This portal will provide a single, digital organisation-wide repository for learning to be captured, analysed and cascaded.

The new Quality Informatics Portal/Quality Dashboard also continues in development. This suite of dashboards will provide a single, organisation-wide resource for accessing quality information. This portal will also be launched this month.

Quality Management

Work continued to develop the Quality Management System (QMS) Framework ahead of Board submission in May 2024, building on the workshops at the Board, Executive Team and Senior Leadership Team.

Research into best practice is underway by contacting and visiting NHS organisations across the UK, alongside support from Improvement Cymru, the IHI and the NHS Wales Executive Quality Team.

A QMS Working Group is in place with representatives from all key specialist functions and a rapid design workshop took place in April 2024 with clinical and corporate leaders to support the development.

The QMS Framework is submitted to May 2024 Board for consideration and approval.

Improved access to Perinatal Mental Health resources

Approximately 1 in 4 women in the United Kingdom face perinatal mental health difficulties. In preparation for Maternal Mental Health Awareness Week, Perinatal Midwives, Health Visitors, and the Local Public Health Team have joined forces to create a dedicated Perinatal Mental Health section on BetsiNet

The section features a themed padlet that offers various resources such as leaflets and webpages for staff exploration.

These resources are consolidated for easy access by Health Board staff, serving as a central hub for accessing valuable materials themed on perinatal. This initiative aims to support staff in fostering meaningful conversations among families that are experiencing perinatal mental health challenges, which may arise from conception and up to a year after giving birth.

Additionally, a section has been incorporated to provide information on all upcoming perinatal health training events for staff, including some online training that can be completed at staff's own convenience.

PATIENT SAFETY

Nationally Reportable Incidents (NRI)

The NRIs occurring can be themed as follows:

- Grade 3 or above healthcare acquired pressure ulcer (HAPU)
- Inpatient falls

In the immediate period, other main themes of the learning from closed incidents were related to infection prevention, the need to follow correct checking processes to prevent never events and appropriate monitoring of follow up and/or investigations for patients care and treatment.

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 Health Board desktop review for the HSE Notice of Contravention improvement plan with each IHC took place with the aim to review progress and support against the actions within the overarching improvement plan.

Serious Violence Duty

The Serious Violence Duty (SVD) was introduced as part of the Police Crime Sentencing and Courts Act 2022, the SVD requires specified authorities to work together to prevent and reduce serious violence in their local area. This SVD is supported by national guidance, finalised in December 2022. The guidance includes a chapter specifically on delivery in Wales due to its unique Partnership and delivery context. In this strategy, partners in North Wales have set out how they intend to meet the SVD.

The Health Board is one of the specified Authorities "with a duty to identify, reduce and prevent serious violence in our communities". Other specified Authorities include, North Wales Police, Local Authorities, Fire and Rescue, Probation, Youth Services and Education.

The Safeguarding and Public Protection Team has been fully engaged with this agenda, attending all meetings, workshops and providing data as requested. The aim of this work is not to create additional services, but to establish what is already in place, to work collaboratively and coproduce when development opportunities occur. There has already been significant progress made towards meeting the Duty requirements in North Wales.

Specific actions for the Health Board were to ensure that data was provided to inform the strategic needs assessment in relation to serious violence within Emergency Departments which has resulted

in a Datix development request which was presented and accepted by the Quality Systems Group for progression to the National Development Team. This will mean that when violence has occurred staff will be able to select the weapon involved, using a drop-down list. This will enable the Health Board to monitor themes and provide accurate data.

Single Unified Safeguarding Assessment (SUSR)

Led by the Welsh Government (WG), the SUSR is an example of how, through collaboration and co-production across political, organisational, and geographical boundaries, organisations will tackle a complex problem and deliver a shared response. Almost 200 stakeholders were engaged in the design and delivery of the SUSR, all of whom have put the person who has been harmed, their families and communities first.

The SUSR lays out a framework for how Regional Safeguarding Boards should work with Community Safety Partnerships and other partnerships in the area such as Public Service Boards and Regional Partnership Boards to protect people from harm - sharing lessons and ensuring we work together to secure the wellbeing of every person in Wales.

This process will simplify the review landscape in Wales by combining Adult Practice Review, Child Practice Review, Mental Health Homicide Review, Domestic Homicide Review and Offensive Weapon Homicide Review processes. The SUSR will be launched in April 2024. Health Board staff have been part of the national training pilot with a full training programme due to be delivered locally from April.

Infection Prevention and Control

The Health Board is currently above trajectory for all key performance organisms, however when compared to the other acute hospital provider health boards, performance it has the lowest rate for MRSA bloodstream infections and the 2nd lowest for MSSA. The Health Board are slightly above average for C. difficile and 4th highest in Wales but are reporting less cases than for the same time period last year.

Gram-negative bloodstream infections are above average for all Wales, being 3rd for Klebsiella and 4th highest for E. coli and Pseudomonas; with the Pseudomonas infection rate being lower than the previous year. Gram negative infections are commonly associated with the urinary tract, so Integrated Health Communities (IHC) have established working groups to specifically look at reducing catheter associated urinary tract infections (CAUTI). A full audit of urinary catheter practice was carried out in January highlighting some improvements since the last audit in April but further work is required to reduce the CAUTI rate.

The Infection Prevention Team and IHC's continue to liaise to:

- Ensure learning from post infection reviews is cascaded and improvement monitored through local infection prevention groups reporting up to the strategic infection prevention group.
- Deliver a robust audit programme of practices associated with the key infections and feedback performance data to enable improvement.
- Increase awareness through the new campaign "HABITS" launched in February to further engage our staff, patients and public. March will focus on 'H': Hand hygiene.

Isolating all patients with an infection into a side room remains an ongoing challenge particularly in Wrexham Maelor Hospital where the number of side rooms is very low and very few are ensuite. The Infection Prevention team support clinical staff to prioritise those who are greatest risk and there is a detailed 'Isolation Risk Matrix' to support this.

Nosocomial COVID-19 Programme

Funding for the project ceased at the end of March 2024 and the Health Board completed all investigations.

PATIENT EXPERIENCE

Complaints

The Chief Executive has escalated the issue of complaints performance, bringing together key leads across the organisation to focus on improving the timeliness of responses to queries and formal complaints. The work that has ensued is showing positive progress and further detail of this will be provided at the next Board meeting.

During March to April 2024, the Health Board received 502 complaints, 394 of these were managed under Putting Things Right, and an additional 108 were resolved as Early Resolutions.

The majority of the complaints related to secondary care services. The top themes remain 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 395 overdue complaints in total 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 Complaints Team have adopted a targeted approach to complaint management to ensure that new complaints are closed within the 30-working day timeframe, streamlining the approvals process, ensuring that those due to becoming overdue are prioritised to ensure that deadlines are met.

The closure rate within 30 working days has improved from 39.5% to 42.93%, this is evident following the increased scrutiny by the Directors of the IHC to promote early resolution and closure to complaints.

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 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. In the reporting period

19 patient information leaflets were reviewed by the Readers Panel. Examples of patient information leaflets reviewed include:

- See on Symptoms – information for patients and carers
- Patient Initiative Follow Up (PIFU) - information for patients and carers
- Blood Taking Service – patient information leaflet (East)
- Guide to wrapped bathing for babies

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.

The Patient and Carer Experience Department are improving the way it communicates with patients and families 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 April 2024, the Patient and Carer Experience Department commenced 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 patients and families and will enable the department to monitor quality control. The telephone line will also have a survey at the end, allowing callers to provide us with feedback on their call experience. In line with the improvement made to the PALS website and telephony the PALS service opening hours from April 2024 changed to Monday, Tuesday, Thursday and Friday 10 am – 4pm and on Wednesday 9 am – 12.30pm. The change in operating hours enables PALS Officers to increase face to face patient experience activity, being more visible on wards and across community hospitals capturing and learning from patient and carer experiences.

CLINICAL EFFECTIVENESS

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

National clinical audits (Tier 1) are aimed at measuring and benchmarking the improvement of healthcare services in Wales. Tier 2 audits, which 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.

Within the Clinical Effectiveness Department in order to capture relevant information, Service Assessment of Compliance forms are sent to all services participating in Tier 1 National Clinical Audits and Outcome Reviews, to complete with regard to the recommendations made in the published reports for the mandatory National Audit/Review.

Over the last year, these forms have been reviewed, monitored and adjusted to make sure the correct information is requested to enable a detailed response to be provided. Where national findings reveal common issues identified from the audits, and where national healthcare is generally falling below the required audit standards, there is a requirement to provide an action plan to address how these will be managed and a realistic timeframe provided.

The Audit Management and Tracking (AMaT) system is now being used to monitor compliance with NICE guidance. The Clinical Effectiveness Team are working to support departments with guidance

and training, where needed and any overdue guidance is escalated back through the Strategic Clinical Effectiveness Group (SCEG) when necessary.

The mortality review process will be extended further from April. New legislation commencing then mandates that all of community/primary care deaths, along with secondary care deaths, will now be reviewed through the Medical Examiner Service.

The mortality review process is currently being reviewed to ensure that Medical Examiner Scrutiny Reviews received by the Health Board are effectively triangulated with concerns, complaints, and any ongoing investigations to ensure that these processes are being fully informed.

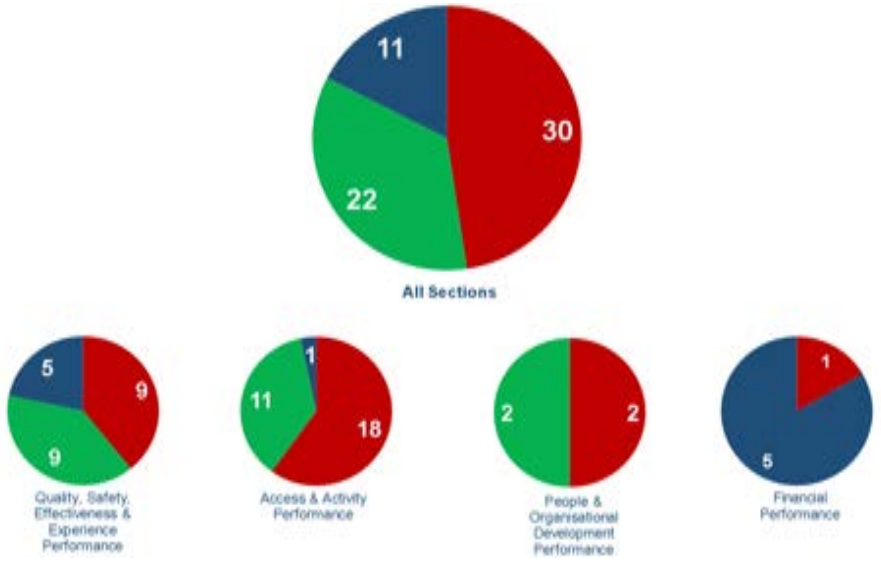
CONCLUSION

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 Coroners continue to raise concerns in a number of areas, these areas are under review and have actions being undertaken.
- A number of Regulation 28 Notices have been received by the Coroner.
- The number of overdue complaints remains unacceptably high, with an impact on patients and has an impact on the closure target compliance.
- A review of the investigation process is underway commissioned by the CEO and a new integrated policy for investigating incidents, complaints and mortality is due to be completed for the Board meeting in July

The Health Board is asked to note the report.

Teitl adroddiad: ***Report title:***	Integrated Performance Report, Month 12 2023/24
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to Month 12, 2023/24. 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 Welsh Government (WG), Health Education and Improvement Wales (HEIW) 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). 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 Committees of the Health Board, whilst enabling oversight of the current reported metrics. The key performance indicators utilised are the nationally required metrics, a key enhancement to the reporting moving forwards will be for the following; • Development of local metrics that give greater insight into understanding current performance (through Executive forums & Committees). • Greater ownership by Committees of the measures then 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 accountability review structures and escalation / de-escalation mechanisms.
Argymhellion:	The Health Board is asked to:

Recommendations:	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 2023-24.			
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 ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators within our IPR will directly/ 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 Interim 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 is working 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 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 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.

The Integrated Performance Report will undergo further development through the remainder of 2024-25 to reflect the new NHS Wales Performance Framework 2024-25.

In addition, the Performance Directorate is working with executive colleagues via the Executive Delivery Integrated Performance Group, on the development of a suite of locally defined measures that once ratified, will be included in the Integrated Performance Reports in due course.

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

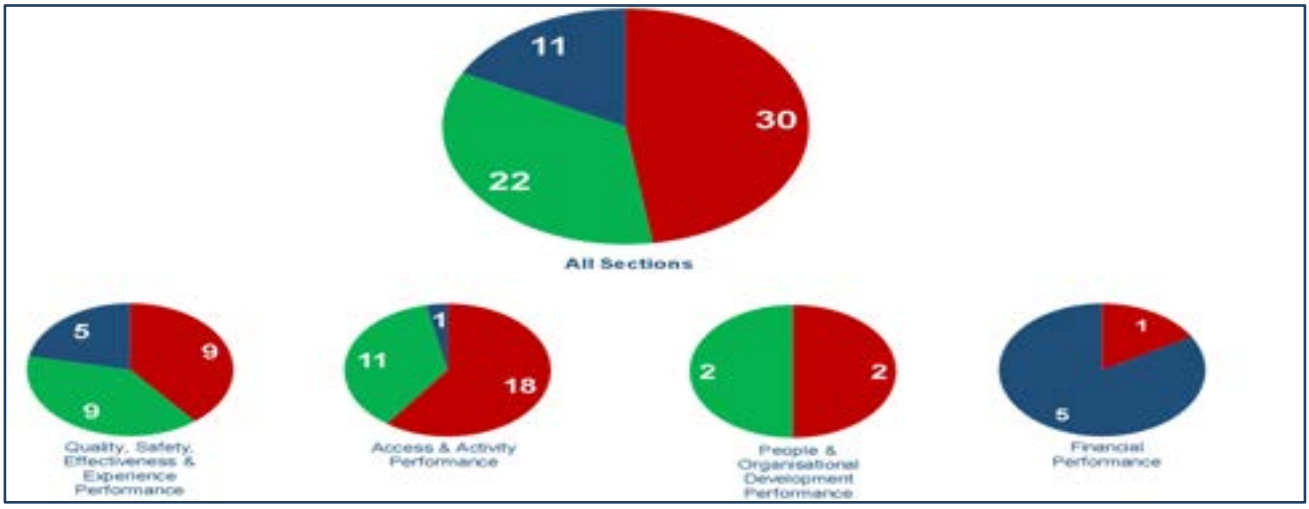
The Performance Directorate continues to develop and refine the performance report for the Health Board, the key aim being to enable focus to be placed upon areas of high performance or those metrics requiring improvement, with the 'Integrated Performance Report' including a section summarising the areas 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.

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.

2. Overall Summary



Of the measures from the NHS Wales Performance Framework included in the report, 22 are on target, 30 are off target and eleven are on a cumulative basis or locally defined. 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:-

National Reportable Incidents & Complaints have been targeted to improvement in performance against compliance with National Reportable Incidents (NRIs) and Complaints backlogs via the Integrated Performance Executive Delivery Group (IPEDG). The Integrated Healthcare 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 monitoring of trajectories.

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. This is attributed to staff vacancies and absence experienced across the Health Boards. Working with People & Organisational Development (P&OD) Directorate to address recruitment and retention issues. Coding Assurance Lead role will support development of new trainees as they progress. Working with Welsh Patient Administration System (WPAS) Operational Steering Group to improve availability of electronic records to enable some remote working opportunities starting with theatre operation sheets. Five trainee coders will commence in post mid July 2024.

3.2 People & Organisational Development

(Corporate Risk 24-01 People, Culture and Wellbeing)
(Corporate Risk 24-1 Leadership / Special Measures)

The key areas highlighted centre upon:-

Turnover rates of nursing and midwifery staff remains consistent at 1.6% since December 2023. Sickness absence has increased at 6.4% (compared to 6.2% reported previously) 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 continues to fall.

3.3 Access & Activity Performance

The key areas highlighted centre upon:-

This is the greatest number of measures contained within the report, with the 30 measures within this section requiring oversight through Performance, Finance and Information Governance Committee (PFIGC), noting BCUHB is achieving the target for 11 and not achieving the target rate for 18 of the measures.

3.3.1 Adult Mental Health Measures Performance

Overall BCUHB performance has continued to improve or sustain performance above the 85% target rate, with East performing very well, however West and Centre could further enhance performance within this area.

3.3.2 Children's & Adolescent Mental Health Services (CAMHS) and Neurodevelopment

Performance against the measures remains below trajectory. The steady improvement over three consecutive months for Part 1a has not continued into November. Part 1b performance continues to deteriorate. The service continues to have good performance with regards the specialist Children and Adolescent Mental Health Service (CAMHS) first appointment within 28 days measure.

Neurodevelopment waiting times continue to deteriorate and remain a concern, with a decline in performance within the national footprint.

3.3.3 Urgent & Emergency Care Performance

(Corporate Risk 24-10 Urgent and Emergency Care)

After remaining consistent around the 69% mark in quarter 3 of 2023-24, quarter 4 has seen performance reduce to 63.2% for patients experiencing waits over 4 hours in our Emergency Departments. Patients experiencing waits of over 12 hours continues to increase at 3,342 and remains an area of focus for the service.

Ambulance handover delays of an hour or more has improved, with 1,986 the lowest reported position since September 2023. The number of patients delayed over 4 hours in an ambulance has also improved from a high of 907 in January 2024 to 734 in February, and 651 in March 2024.

Delayed pathways of care remain a key concern for the Health Board as the number is increasing with over 347 patients experiencing delays in their pathway and no significant change seen since April 2023.

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 has improved, significantly at the end of March 2024 at 64.5% (heading towards Welsh Government targeted levels) comparing favourably to 55.2% reported previously. Whilst, concerns remain regarding the position with dermatology and urology, endorsement of recent business cases to support (in particular Dermatology) will look to mitigate these risks and improve performance in future reporting periods.

The number of patients waiting over 8 weeks for a diagnostic test now resides at c6,500 and a significant improvement over the 10,000, breaches reported a year ago. The use of Planned Care resources will further improve this reported position as we seek to achieve Welsh Government targeted improvements by December 2024.

The number of patients experiencing waits over 14 weeks for therapy interventions continues to increase and with 4,574 patients waiting in March (2,102 reported in quarter 1 of 2023-24). Main pressures in Physiotherapy include high number of vacancies, accommodation capacity in Central and East and increased demand.

The number of patients waiting over 52 weeks for a new outpatient appointment is now 18,412 (12,000 in April 2023). However, the recruitment to the Outpatients validation and booking team is expected to offer improvements as we move through the 2024/25 financial year.

In regards to patients waiting for elective care, there has been a substantial amount of work undertaken to place focus upon longer waits, with continuous reductions in the number of patients waiting, 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, even with small increases over January's reported position through winter.

The targeted use of Planned Care Funds combined with 'treat in turn' methodology is targeting patients over 156 weeks, with the intention to remove all over 156 week waits by September 2024.

The number of patients experiencing a delay of over 100% of their waiting time for a follow up outpatient appointment continues to decrease at 87,690, compared to 87,859 and 91,334 reported in for January 2024 and November 2023 respectively. Planned Care resources are to be targeted on validation, which is expected to materially reduce this number upon conclusion of the review.

3.3.5 Summary

The Health Board has faced many challenges during the 2023/24 financial year, the level of delayed pathways of care compounding system flow pressures and medical outliers driving increased use of agency and affected upon capacity to service elective care, with increased use of temporary workforce driving potential quality and performance impacts.

The Health Board also had key areas of challenge, centred upon:-

- Impact of Junior Doctor strike action
- Patient flow (emergency departments and delays to discharge)
- Achievement of cancer standards (Dermatology)
- Ambulance handover times and performance

However, the Health Board are targeting use of Planned Care Funds, with the intention of eradication of over 156 week waits by September 2024 and improvements in 104 week waiters, also substantially improving 8 weeks to diagnostic. With further targeted interventions within outpatients (new and follow up) seeking to improve waiting times for patients. In addition, adult mental health assessment is an area performing well in relation to the 85% assessment criteria.

3.4 Financial Performance (Month 12 2023-24 and Month 1 2024-25?)

(Corporate Risk 24-05 Financial Sustainability)

The 2023/24 performance against initial plan and control total is as articulated below;

Description	£m's	£m's
Deficit Plan		**134**
Conditionally Recurrent		(75)
Underlying deficit contribution	(34)	
Inflationary uplift	(41)	
Non-Recurrent		(26)
Inflationary uplift	(17)	
Energy	(10)	
Original deficit (inch year allocation)		**33**
Health Board (10% improvement)		(13)
REVISED CONTROL TOTAL		**20**

The 2023/24 financial year initial plan was a £134m deficit, with in year financial pressures;

- Additional capacity, Continuing Healthcare, Prescribing & Secondary Care Drugs.

Control measures implemented have targeted (and realised savings) in the following areas;

- Temporary workforce (Nursing & Medical), Establishment Control, Investments endorsed revisited (RIGA), Non-pay & Balance sheet mitigations.

Measures achieved an improved outturn to original plan of a £24.3m deficit, though not the £20m deficit control total

Description	April £m	May £m	Jun £m	Jul £m	Aug £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
Original Plan (post £101m Welsh Government Allocation)													33.0
Variance	1.0	2.9	5.4	5.6	5.5	3.3	1.2	0.8	(6.3)	(4.3)	(9.7)	(14.1)	(8.7)
Actual Deficit													**24.3**
Control total													20.0
Shortfall (surplus) to control total													4.3

The Health Board has attained an outturn (subject to Audit review) that totals a £24m deficit and in moving towards the control total (an improvement over 2023/24 plan) this enables conditionally recurrent resource received in 2023/24 (as part of the £101m in year allocation) to now be modelled as recurrent as we move into the 2024/25 financial year.

The 2024/25 financial performance month 1 has built on receipt of this conditionally recurrent funding, the reported position being;

Ref	Description	Amount £m's	Additional information
1	Actual deficit	4.3	The adverse deficit is largely driven through savings non-achievement and out of area mental health placements.
2	Plan (£19.7m deficit Plan)	1.6	
3	Adverse variance	2.7	

The Health Board will require a significant focus to be placed upon savings delivery (Value & Sustainability initiatives) in order to deliver the 2024/25 financial plans, with a £48m target to be reviewed and closely monitored for achievement through the Integrated Performance – Executive Delivery Group, reporting onwards to the Performance, Finance and Information Governance Committee (PFIG)

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. A separate report is to be shared on Welsh Government revised targeted performance in these areas, and the measures the Health Board are to enact in order to enhance delivery.

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 March 2024 (Finance to April 2024)

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Integrated Performance Report

Reporting Period: to 31.03.2024

Presented to **Health Board**

Thursday, 30th May 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 6 **never events** reported in 2023/24 with no new never events reported in March 2024.
- **Clinical coding compliance** remains a significant risk that is likely attributed to staff absence: work is underway to review this and a paper pertaining to solutions is being presented to the Health Board in due course.
- **NRIs**: During 2023/24 there were 321 NRIs. 26 remain open 90 days or more at the end of March 2024. **(Corporate Risk 24-04 Failure to Embed Learning)**
- **Complaints**: There were 2,502 complaints during 2023/24. 50% of the overall complaints are from Clinical treatment/Assessment. The sub category of Delay / Lack of treatment has risen significantly due to insourcing based complaints.

People & Organisational Development Performance

- **PADR** rate improved in year but remains 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 being developed for the organisation.
- **Sickness absence rate** stayed below 6.5% for all of 23/24 to date, in line with ongoing staff wellbeing work aim is to maintain this through the rest of 23/24.
- At 1.6%, 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.
- At 3.3%, 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.**(Corporate Risk 24-01 People, Culture and Wellbeing) (Corporate Risk 24-1 Leadership/Special Measures)**

Access & Activity Performance

- **RTT**: Number of patients waiting over 156 weeks has reduced by 51% during the financial year **(Corporate Risk 24-11 Planned Care)**
- **Cancer:** In 2023/24 43,000 urgent suspected cancer referrals. The majority of these patients will not have cancer, but all need to be seen and diagnosed quickly. 5,300 people were diagnosed with cancer and treated. **(CR 24-11)**
- **Diagnostics waits over 8 weeks:** Number of pathways waiting 8 weeks for specific diagnostic has decreased by 25% in year. With 6,504 patients currently waiting. **(Corporate Risk 24-13 Timely Diagnostics)**
- **Pathways of Care Delays:** The position has not improved and the number of patients experiencing delays to their Pathways of Care remains a concern with an average 335 per month. Increased acuity resulting in delays to clinician assessment on lower triage category of patients is becoming a concern.
- **Ambulance handover waits:** The number of ambulance patient handover over 4 hours is reported at 651 **(Corporate Risk 24-10 Urgent and Emergency Care)**

Description	£m's	£m's
Deficit Plan		**134**
Conditionally Recurrent		(75)
Underlying deficit contribution	(34)	
Inflationary uplift	(41)	
Non-Recurrent		(26)
Inflationary uplift	(17)	
Energy	(10)	
Original deficit (inch year allocation)		**33**
Health Board (10% improvement)		(13)
REVISED CONTROL TOTAL		**20**

The 2023/24 financial year initial plan was a £134m deficit, with in year financial pressures;

- Additional capacity, Continuing Healthcare, Prescribing & Secondary Care Drugs.

Control measures implemented have targeted (and realised savings) in the following areas;

- Temporary workforce (Nursing & Medical), Establishment Control, Investments endorsed revisited (RIGA), Non-pay & Balance sheet mitigations.

Measures achieved an improved outturn to original plan of a £24.3m deficit, though not the £20m deficit control total

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Original Plan (post £101m Welsh Government Allocation)													33.0
Variance	1.0	2.9	5.4	5.6	5.5	3.3	1.2	0.8	(6.3)	(4.3)	(9.7)	(14.1)	(8.7)
Actual Deficit													**24.3**
Control total													20.0
Shortfall (surplus) to control total													4.3

Produced on behalf of the **Health Board** by the **Performance Directorate**

Our Quality: Escalated Performance Measures

New Never Events – No new Never events were reported in March of 2024. However, there were 6 never events reported in 2023/24. Rapid Learning Panels were being arranged and full investigations are underway. Learning will be reported via the Improving Quality Report to Board.

Measure	WG Target	Internal Target	Position	Wales Rank
Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	30.9%	8th of 8 (at Oct 23)

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. Working with People & Organisational Development to address recruitment and retention issues. Exploring potential of a Coding Assurance Lead to oversee a training programme and reduce the training burden on qualified coders.

National Reportable incidents (NRIs) that remain open 90 days of more

Measure	WG Target	Internal Target	Position	Wales Rank
Number of National Reportable incidents that remain open 90 days or more	Decreasing trend	TBC	26	6th of 10 (at Mar 24)

Clinical treatment/Assessment
Communication Issues (including Language)
Attitude and Behaviour
Medication
Appointments
Patient Care
Discharge Issues
Access (to Services)
Confidentiality
Referral

50% of the overall complaints are from clinical treatment / Assessment. The sub category of Delay / Lack of treatment has risen significantly due to insourcing based complaints.

During 2023/24 there were 321 NRIs. 26 remain open 90 days or more at the end of March 2024. The Patent 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. Themes included: Delay in referral, admission or treatment. Investigation reporting error. Unexpected death or self harm of patient under or recently under mental health services . Correct preparation of portable oxygen cylinder. Maternity adverse occurrence. Healthcare acquired Grade 3 pressure ulcer. Patient fall with harm. Healthcare acquired infection. PRUDIC – child brought to ED.

Access & Activity: Escalated Performance Measures

Planned Care

- The number of patients waiting over 156 weeks has reduced considerably during the financial year. Winter pressures and industrial action have impacted the delivery of planned care with USC position absorbing capacity to see extreme waits in Dermatology. Clinical support in Orthodontics and gastroenterology is also affecting ability to reduce extreme waits in these specialties.

- Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion is at 64.5%.

- Number of pathways waiting 8 weeks for specific diagnostic has decreased by 25% in year. With 6,504 patients currently waiting.

- There has been a 100% increase in the number of patients waiting over 14 weeks for therapy since April 2023

CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
24-11	PFIG	Over 156 weeks all stages	N/A	TBC	1621	#N/A
24-11	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%)	70.0%	64.5%	3rd of 6 (at Feb 24)
24-13	PFIG	Number of pathways waiting 8 weeks for specific diagnostic	Decreasing trend (to 0)	2500	6504	5th of 7 (at Feb 24)
24-11	PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (including audiology)	Decreasing trend (to 0)	0	4574	7th of 7 (at Feb 24)

(Corporate Risk 24-11 Planned Care & Corporate Risk 24-12 Areas of Clinical Concern

Access & Activity: Escalated Performance Measures

Urgent & Emergency Care

Pathways of Care Delays: The overall position across north Wales has not improved and the number of patients experiencing delays to their Pathways of Care (Delayed Discharges) remains a concern. An average of 335 per month over the year. Main reason for delays are linked to high POCDs alongside increased acuity resulting in delays to clinician assessment on lower triage category of patients.

CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
	PFIG	Number of Pathways of Care Delayed discharges	Decreasing trend	TBC	347	8st of 8 (at Mar 24)

The number of **ambulance patient handover over 4 hours** is reported at 651, a slight change to what was reported at PFIG, due to validation of breaches. Slight improvement has been noted in Central and West. (Corporate Risk 24-10 Urgent and Emergency Care)

CRR Ref	Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
24-10	PFIG	Number of ambulance patient handovers over 4 hour	0	372	651	

People & OD: Escalated Performance Measures

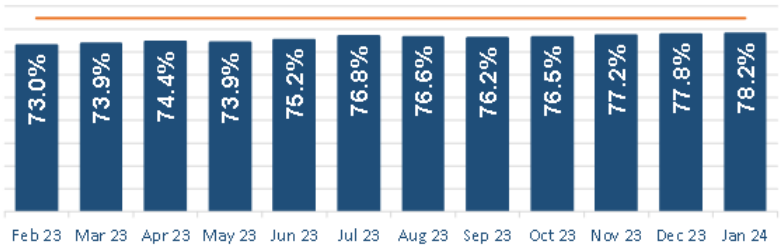
- **PADR** rate has improved in year but has remained under the WG target of 85%. This work feeds into the ongoing culture work and will be reported as part of the new culture dashboard being developed for the organisation.

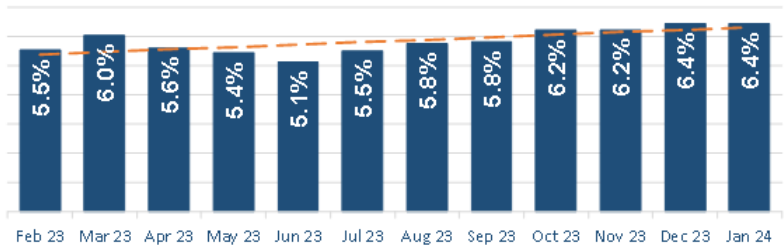
- **Sickness absence** rate stayed below 6.5% for all of 2023/24, in line with ongoing staff wellbeing work.

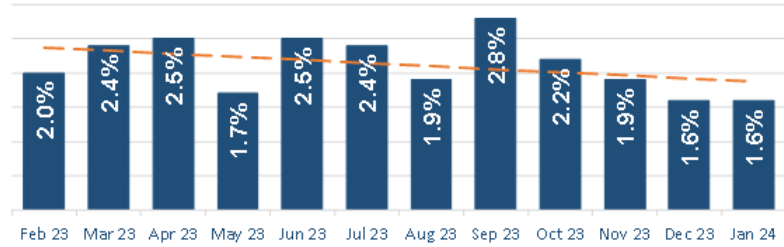
- At 1.6%, 3rd best performing in Wales as at latest benchmarking, **Turnover rate** for nursing aligned with the national and local retention work put in place with a dedicated retention lead coming on-board for the organisation funded by HEIW

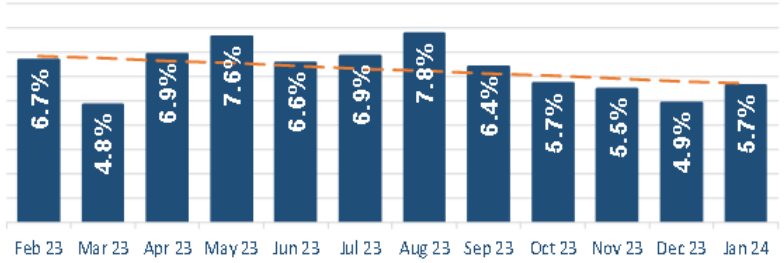
- At 3.3%, focus on off-contract **agency reduction** demonstrating consistent improvement. Ongoing work taking place around the Welsh Health Circular for agency spend reduction and the Value and Sustainability workforce programme.

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	78.2%	3rd of 13 (at Nov 23)
PFIG	Percentage of sickness absence rate of staff	Decreasing trend	TBC	6.4%	6th of 12 (at Nov 23)
PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Decreasing trend against 2019/20	TBC	1.6%	3rd of 11 (at Oct 23)
PFIG	Agency spend as a percentage of total pay bill	Decreasing trend	TBC	5.7%	10th of 12 (at Nov 23)









Finance: Escalated Performance Measures

Description	£m's	£m's
Deficit Plan		**134**
Conditionally Recurrent		(75)
Underlying deficit contribution	(34)	
Inflationary uplift	(41)	
Non-Recurrent		(26)
Inflationary uplift	(17)	
Energy	(10)	
Original deficit (inch year allocation)		**33**
Health Board (10% improvement)		(13)
REVISED CONTROL TOTAL		**20**

The 2023/24 financial year initial plan was a £134m deficit, with in year financial pressures;

- Additional capacity, Continuing Healthcare, Prescribing & Secondary Care Drugs.

Control measures implemented have targeted (and realised savings) in the following areas;

- Temporary workforce (Nursing & Medical), Establishment Control, Investments endorsed revisited (RIGA), Non-pay & Balance sheet mitigations.

Measures achieved an improved outturn to original plan of a £24.3m deficit, though not the £20m deficit control total

Description	April £m	May £m	Jun £m	Jul £m	Aug £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
Original Plan (post £101m Welsh Government Allocation)													33.0
Variance	1.0	2.9	5.4	5.6	5.5	3.3	1.2	0.8	(6.3)	(4.3)	(9.7)	(14.1)	(8.7)
Actual Deficit													**24.3**
Control total													20.0
Shortfall (surplus) to control total													4.3

Ref	Description (YTD – Month 1)	April £m's	Additional information
1	Actual deficit	4.3	The adverse deficit is largely driven through savings non-achievement and out of area mental health placements.
2	Plan (£19.7m deficit Plan)	1.6	
3	Adverse variance	2.7	

In 2024/25 the Health Board will require a significant focus be placed upon savings delivery (Value & Sustainability initiatives) in order to deliver the 2024/25 financial plans, with a £48m target to be reviewed and closely monitored for achievement through the Integrated Performance – Executive Delivery Group, progress reported through to the Performance, Finance and Information Governance Committee (PFIG)

2023/24 Outturn (subject to Audit)

The Health Board has attained an outturn (subject to Audit review) that totals a £24m deficit and (in moving towards the control total) an improvement over 2023/24 plan. This enables conditionally recurrent resource received in 2023/24 (as part of the £101m in year allocation) to now be modelled as recurrent as we move into the 2024/25 financial year.

2024/25 Month 1 reported position

The 2024/25 financial performance at month 1 has built on receipt of this conditionally recurrent funding, the reported position being a £4.6m deficit (a £2.6m adverse variance).

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About the Integrated Performance Report

Produced on behalf of the **Health Board** by the
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NHS Wales Performance Framework 2023-24

The NHS Performance Framework is a key measurement tool for "A Healthier Wales" outcomes, the 2023/24 revision now consists of 53 quantitative measures of which 9 are Ministerial Priorities and require Health Board submitted improvement trajectories. A further 11 qualitative measures are also currently included of which assurance is sought bi-annually by Welsh Government

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.

The IPF is undergoing phased implementation across the Health Board with core integration by Q4 2023/24 and to run as business as usual from 1st April 2024.

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

Performance is monitored against our Annual Plan but is RAG rated against the Welsh Government targets.

Green

Green = On track
A stable, sustained or improving position that is consistently on or above the **Welsh Government Target** for at least 3 or more consecutive months

Amber

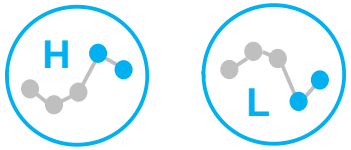
Amber = Early Warning or Off Track and in Exception – Short summary provided
On or above **Welsh Government Target,** but a deteriorating position of 3 or more consecutive months or inconsistently above/on/below the **Welsh Government Target**

Red

Red = Off Track and in Escalation
Consistently below **Welsh Government Target** and below **BCU submitted improvement trajectories – Detailed Exception report provided**

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

Variance			Assurance*		
					
Common cause. No significant change	Special cause for positive change or lower pressure due to Higher (**H**) or Lower (**L**) values	Special cause for negative change or higher pressure due to Higher (**H**) or Lower (**L**) values	Variance indicates inconsistent performance (not achieving, achieving or passing the target rate)	Variance indicates consistent positive (**P**) performance (achieving or surpassing the target on a regular and consistent basis)	Variance indicates consistent negative (**N**) performance (not achieving the target on a regular or consistent basis)

How to interpret variance results

- Variance results show the trends in performance over time
- Trends either show **special cause** variance or **common cause variance**
- **Blue Icons** indicate **positive** special cause variance
- **Orange Icons** indicate **negative** special cause variance **requiring action**
- **Grey Icons** indicate **no significant change**

How to interpret assurance results

- Assurance results demonstrate the likelihood of achieving a target and is based upon the trends over time
- **Blue Icons** indicate an expectation **to** consistently achieve the target
- **Orange Icons** indicate an expectation **not to** consistently achieve the target
- **Grey Icons** indicate an expectation for **inconsistent** performance, sometimes the target will be achieved and sometimes it will not be achieved.

* Assurance based upon observations of the data as presented in the SPC charts only.

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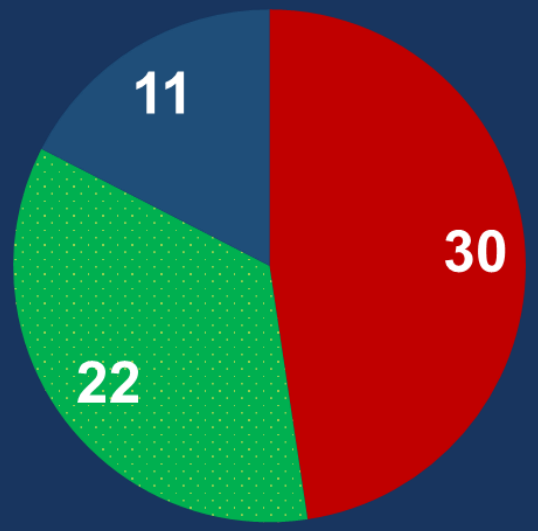
Integrated Performance Report



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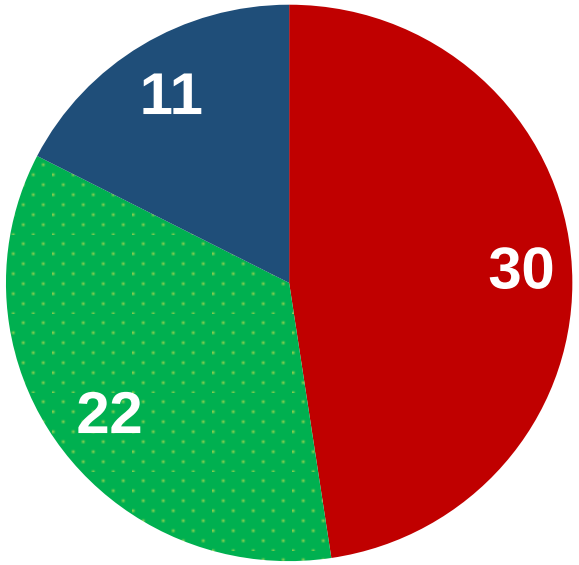
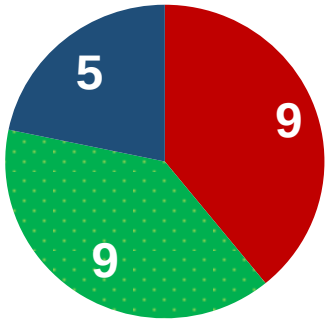
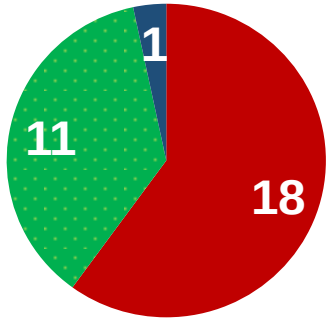
Summary of Performance to Month 12



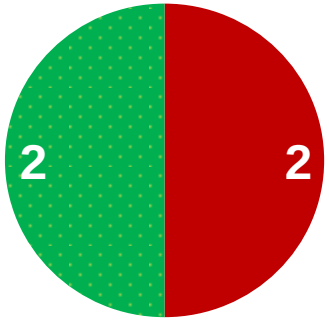
All Sections



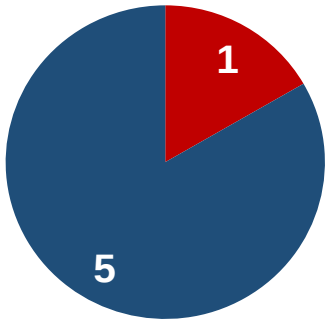
Quality, Safety, Effectiveness & Experience Performance



Access & Activity Performance



People & Organisational Development Performance



Financial Performance

NHS Wales Performance Dashboard- part 1

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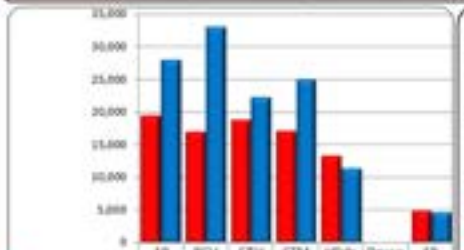
PERFORMANCE DASHBOARD

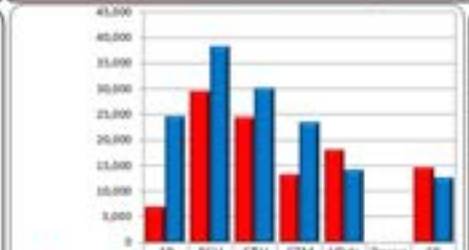
Number of patients waiting more than 36 weeks for a new outpatient appointment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-24 - profile	19,463	17,045	18,791	17,156	13,387	0	4,893
Mar-24 - actual	28,002	33,155	22,296	25,074	13,464	91	4,739

- In Mar-24, HDda and SB achieved their trajectories for the number of patients waiting over 36 weeks for a new outpatient appointment.
- HDda and Powys saw a reduction in Mar-24 when compared to the previous month.
- At an all Wales level, the number of patients waiting over 36 weeks for a new outpatient appointment has increased in Mar-24 when compared to the previous month by 4,657 to 124,821, a 3.9% increase.
- Powys had the lowest number of patients waiting over 36 weeks for a new outpatient appointment in Mar-24 at 91, BCU had the highest number of waits at 33,155 (26.6% of the total).

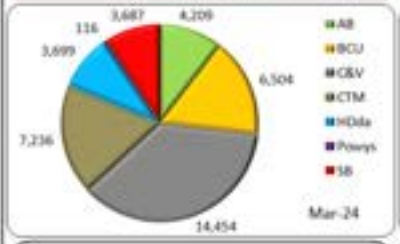
Number of patients waiting more than 52 weeks for referral to treatment



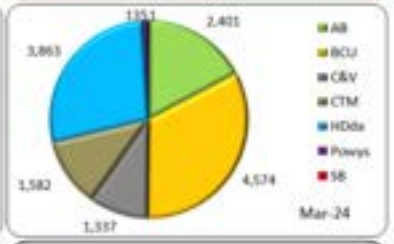
	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-24 - profile	7,173	29,544	24,500	13,366	18,188	0	14,785
Mar-24 - actual	24,730	38,251	30,084	23,518	14,274	24	12,786

- In Mar-24, HDda and SB achieved their trajectories for the number of patients waiting over 52 weeks for referral to treatment.
- CTM, HDda, Powys and SB have all seen a reduction in Mar-24 when compared to the previous month.
- At an all Wales level, the number of over 52 week referral to treatment waits has increased in Mar-24 when compared to the previous month by 2,732 to 143,667, a 1.9% reduction.
- Powys had the lowest number of patients waiting over 52 weeks for referral to treatment in Mar-24 at 24, BCU had the highest number of waits at 38,251 (26.6% of the total).

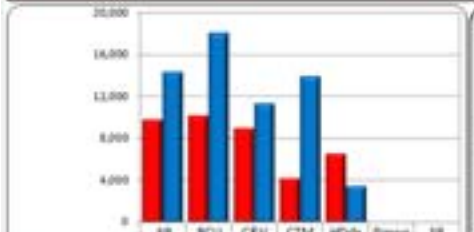
Number of patients waiting more than 8 weeks for a specified diagnostic



Number of patients waiting more than 14 weeks for a specified therapy (including audiology)



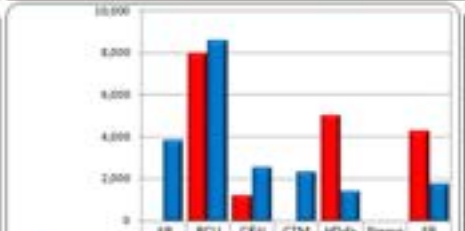
Number of patients waiting more than 52 weeks for a new outpatient appointment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-24 - profile	9,802	10,175	8,999	4,187	6,532	0	0
Mar-24 - actual	14,342	18,061	11,304	13,914	3,479	0	0

- In Mar-24, HDda, Powys and SB achieved their trajectory for the number of patients waiting over 52 weeks for a new outpatient appointment.
- C&V, CTM, HDda and Powys all saw a reduction in Mar-24 compared to the previous month.
- At an all Wales level, the number of over 52 week new outpatient waits has increased in Mar-24 when compared to the previous month by 1,135 to 61,100, a 1.9% increase.
- SB have had no over 52 week new outpatient waits since Oct-23, BCU had the highest number of waits at 18,061 (29.6% of the total).

Number of patients waiting more than 104 weeks for referral to treatment



	AB	BCU	C&V	CTM	HDda	Powys	SB
Mar-24 - profile	0	7,978	1,263	0	5,014	0	4,313
Mar-24 - actual	3,862	8,568	2,578	2,364	1,458	1	1,805

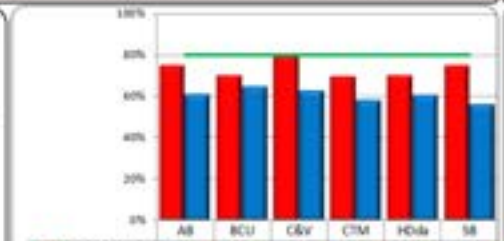
- In Mar-24, HDda and SB achieved their trajectories for the number of patients waiting over 104 weeks for referral to treatment.
- All HBs, except BCU and Powys, have seen a reduction in Mar-24 when compared to the previous month.
- At an all Wales level, the number of over 104 week referral to treatment waits has reduced in Mar-24 when compared to the previous month by 2,344 to 20,836, a 10.2% reduction.
- Powys had the lowest number of patients waiting over 104 weeks for referral to treatment in Mar-24 at 1, BCU had the highest number of waits at 8,568

- In Mar-24, no HB achieved the target of an improvement trajectory towards a national target of zero by 31 March 2024 for the number of patients waiting over 8 weeks for a specified diagnostic.
- AB did not provide an 8 week diagnostic trajectory.
- All HBs, except BCU and C&V, saw a reduction in Mar-24 when compared to the previous month.
- At an all Wales level, the number of over 8 week waits for specific diagnostics has reduced in Mar-24 when compared to the previous month by 2,175 to 39,905, a 5.2% reduction.
- Powys had the lowest number of over 8 week waits for specific diagnostics in Mar-24 at 116, C&V had the highest at 14,454 (36.2% of the total).

- In Mar-24 no HB achieved the target of an improvement trajectory towards a national target of zero by 31 March 2024 for the number of patients waiting over 14 weeks for a specified therapy.
- CTM did not provide a 14 week therapy trajectory.
- C&V, Powys and SB all saw a reduction in Mar-24 when compared to the previous month.
- At an all Wales level, the number of over 14 week waits for specific therapies increased in Mar-24 when compared to the previous month by 1,134 to 11,891, an 8.9% increase.
- SB had the lowest number of over 14 week waits for specific therapies in Mar-24 at 1, BCU had the highest at 4,574 (32.9% of the total).

% of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route)

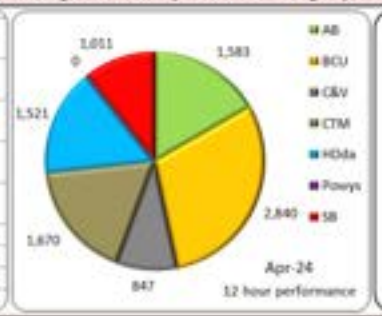
- In Mar-24, none of the HBs achieved their trajectory for the percentage of patients starting 1st definitive cancer treatment within 62 days.
- All HBs saw an improvement in performance in Mar-24 when compared to the previous month.
- At all Wales level, the percentage of patients starting 1st definitive treatment within 62 days has seen an improvement in performance in Mar-24 when compared to the previous month of 7.1 percentage points to 60.5%.
- The best performing HB in Mar-24 was BCU with performance at 64.5%, SB had the lowest performance at 55.9%.



	AB	BCU	C&V	CTM	HDda	SB
Mar-24 - profile	75%	70%	80%	70%	70%	75%
Mar-24 - actual	61%	64%	62%	58%	60%	56%
2026 Target	80%	80%	80%	80%	80%	80%

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%



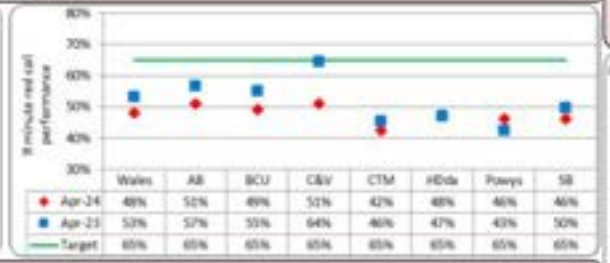
- In Apr-24 BCU, CTM, Powys and SB achieved the target of an improvement compared to the same month in the previous year, towards the national target of 95% for the percentage of patients who spent less than 4 hours in A&E.
- All HBs saw an improvement in performance in Apr-24 when compared to the previous month.
- At all Wales level, the percentage of patients who spent less than 4 hours in A&E has seen an improvement in performance in Apr-24 when compared to the previous month of 2.6 percentage points to 70.3%.
- The best performing HB in Apr-24 (exc. Powys) was SB 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 national target of zero for the number of patients who spent more than 12 hours in A&E.
- 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

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

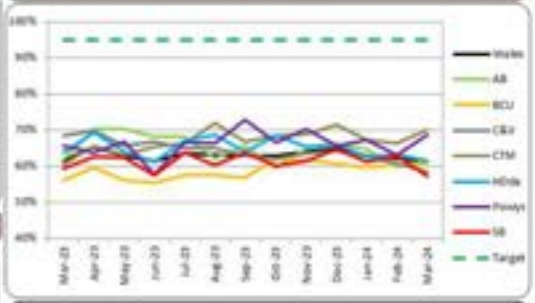
Number of ambulance patient handovers over 1 hour and % of emergency responses to red calls arriving within 8 minutes

- C&V had the lowest number of over 1 hour handovers in Apr-24 with 331 over 1 hour handovers, BCU had the highest at 2,192 (35.8% of the total).
- Over the last 12 months, AB, C&V and SB saw an improvement trend in performance.
- In Apr-24, no HB achieved the 65% target for the percentage of emergency responses to red calls within 8 minutes.
- C&V were the best performing HB in Apr-24 with performance at 51%, CTM were the lowest with performance at 42.4%.
- Over the last 12 months all HBs saw a deterioration trend in performance. HDda and Powys saw an improvement in performance in Apr-24 when compared to the previous month.



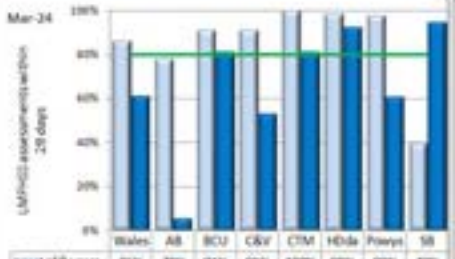
	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
Apr-24	48%	51%	49%	51%	42%	48%	46%	46%
Apr-23	53%	57%	55%	64%	46%	47%	43%	50%
Target	65%	65%	65%	65%	65%	65%	65%	65%

% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

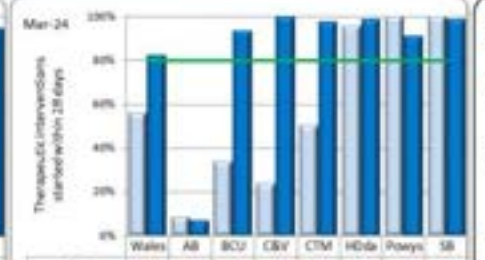


- In Mar-24 no HB achieved the 95% target for the percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date.
- The best performing HB in Mar-24 was CTM with performance at 70%, SB were the lowest performing HB with performance at 57.3%.
- In Mar-24, AB, CTM and Powys 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.

Mental Health Part 1 - % of LPMHSS assessments and therapeutic interventions within 28 days



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	86%	78%	91%	91%	100%	98%	98%	40%
>=18 years	61%	6%	81%	53%	81%	92%	61%	95%
Target	80%	80%	80%	80%	80%	80%	80%	80%



	Wales	AB	BCU	C&V	CTM	HDda	Powys	SB
<18 years	56%	9%	34%	24%	51%	96%	100%	100%
>=18 years	82%	7%	93%	100%	98%	99%	91%	99%
Target	80%	80%	80%	80%	80%	80%	80%	80%

<18 years

- In Mar-24, all HBs, except AB and SB, achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was CTM at 100%, SB had the lowest performance at 40%. Over the last 12 months, all HBs, except Powys, saw an improvement trend in performance.
- In Mar-24, HDda, Powys and SB achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HBs were Powys and SB at 100%, AB had the lowest performance at 8.6%. Over the last 12 months, all HBs, except BCU, saw an improvement trend in performance.

>=18 years

- In Mar-24, BCU, CTM, HDda and SB all achieved the 80% target for % of LMPHSS assessments undertaken within 28 days of a referral. The best performing HB was SB at 94.5%, AB had the lowest performance at 5.8%. Over the last 12 months, all HBs, except AB and C&V, saw an improvement trend in performance.
- In Mar-24, all HBs, except AB, achieved the 80% target for % of therapeutic interventions started within 28 days of an LPMHSS assessment. The best performing HB was C&V at 100%, AB had the lowest performance at 7%. Over the last 12 months, BCU, C&V, CTM and SB all saw improvement trend in performance.

- Note: AB are still validating their data from Apr-23 due to moving to a new IT system so data may be revised in future months.

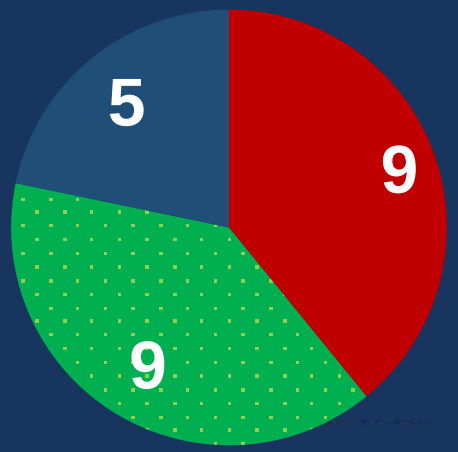
Health Care Acquired Infections - HCAIs (provisional data)

- For eColi, only AB have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, HDda had the highest rate of eColi at 100.49 per 100,000 population compared to AB who had the lowest rate at 59.35 per 100,000 population.
- For S.aureus, none of the HBs have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, SB had the highest rate of S.aureus at 36.77 per 100,000 population compared to AB who had the lowest rate at 21.85 per 100,000 population.
- For C.difficile, only C&V have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, SB had the highest rate of C.difficile at 65.20 per 100,000 population compared to C&V who had the lowest rate at 22.35 per 100,000 population.
- For Klebsiella, none of the HBs have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, BCU had the highest number of cases of Klebsiella at 156 compared to SB who had the lowest number at 94.
- For Aeruginosa, all HBs, except BCU and HDda, have provisionally achieved the 2023/24 cumulative target. In the Apr-23 to Mar-24 period, BCU had the highest number of cases of Aeruginosa at 32 compared to C&V who had the lowest number at 18.

Section 1

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

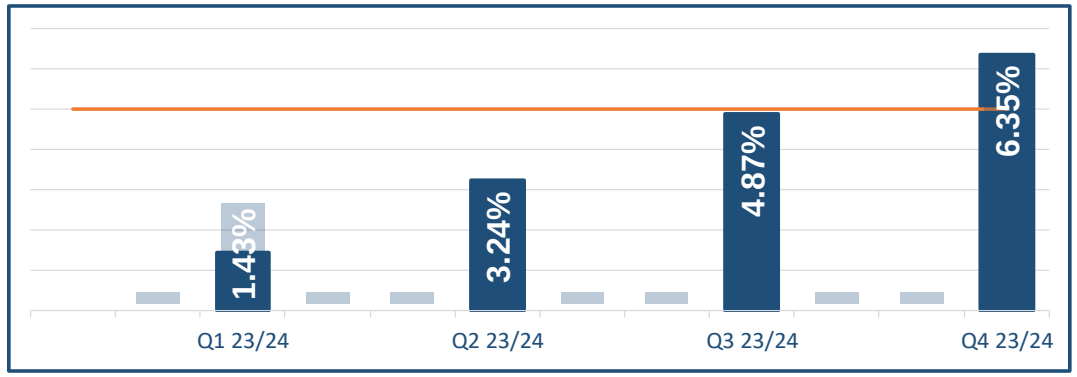
Quality, Safety, Effectiveness and Experience Performance

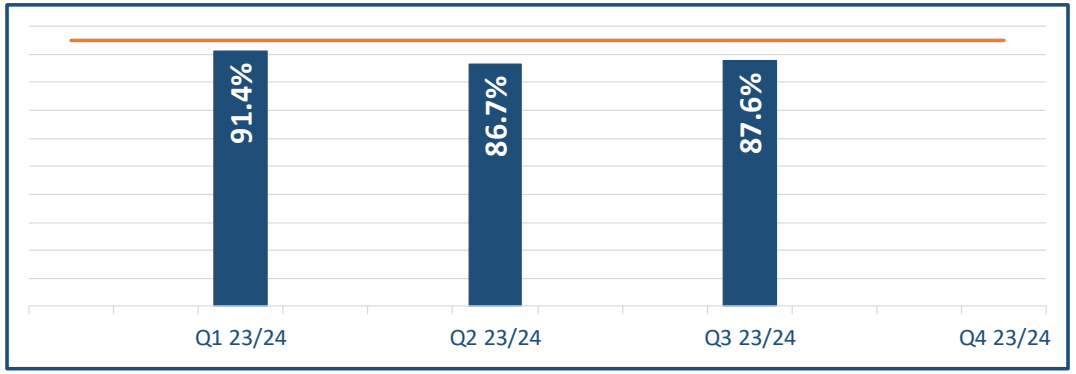


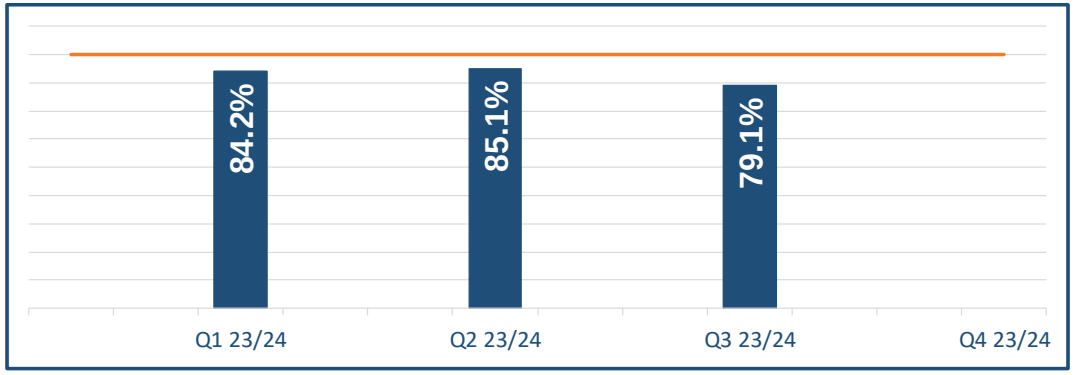
Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

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 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	87.6%	2nd of 7 (at Dec 23)
QSE	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	90%	TBC	79.1%	5th of 7 (at Jun 23)

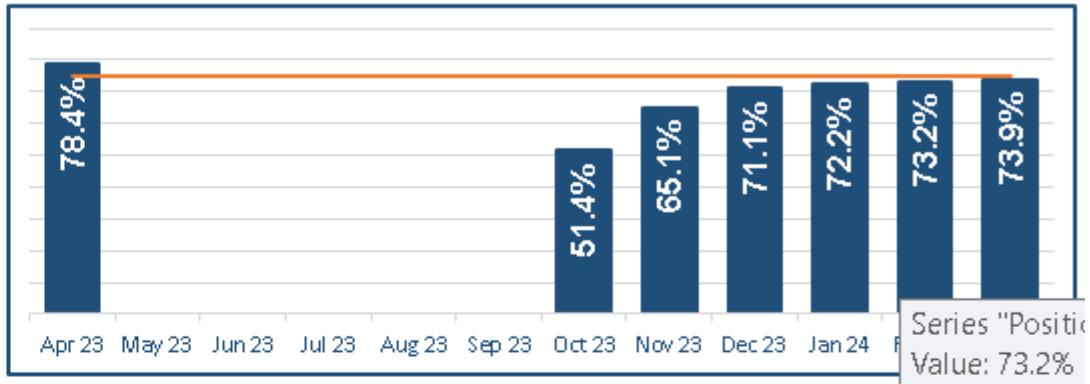


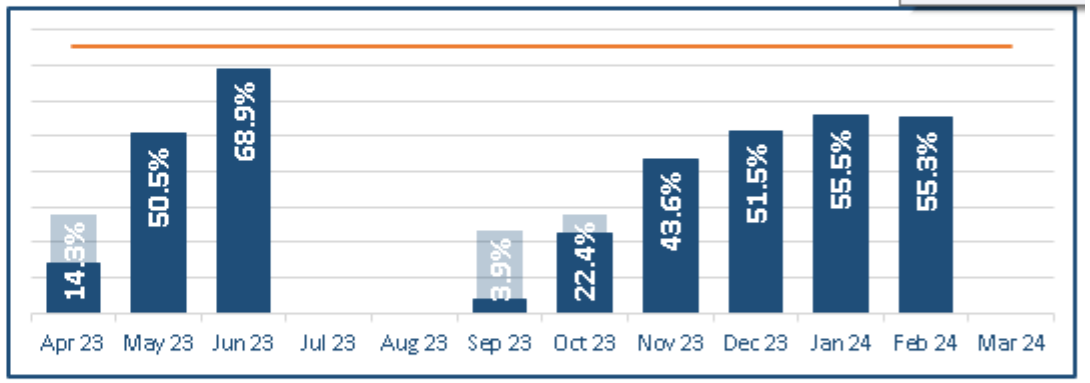


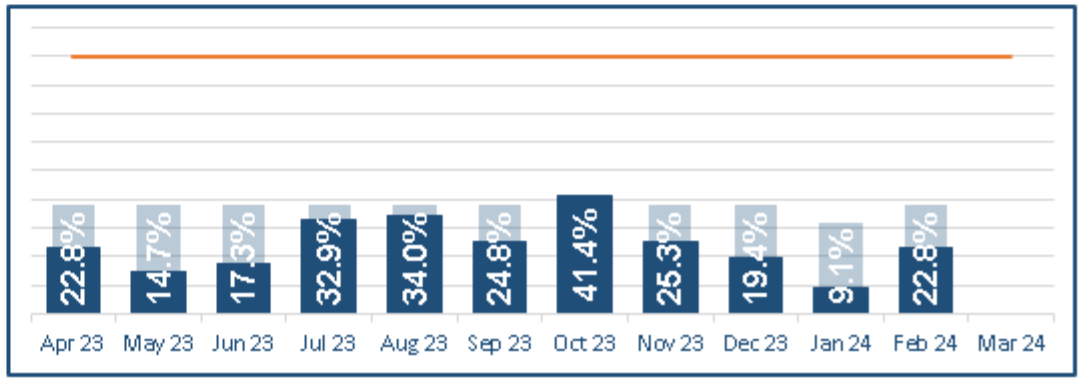


Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
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	55.3%	3rd of 7 (at Feb 24)
QSE	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	90%	TBC	22.8%	4th of 7 (at Jan 24)



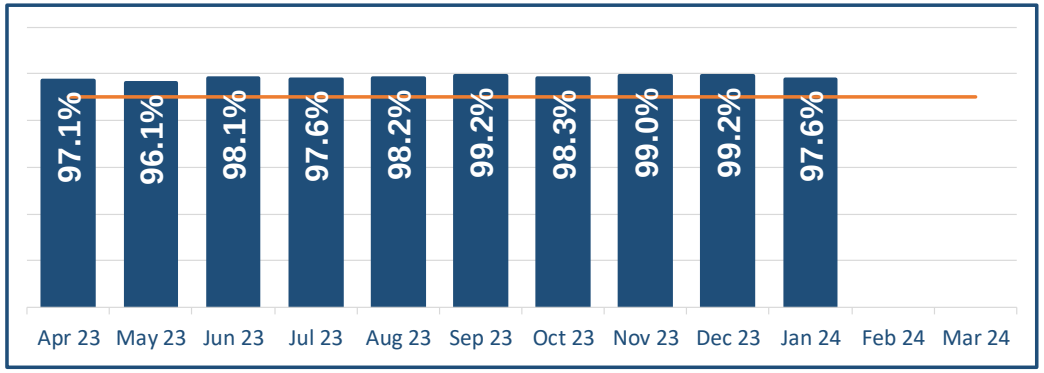


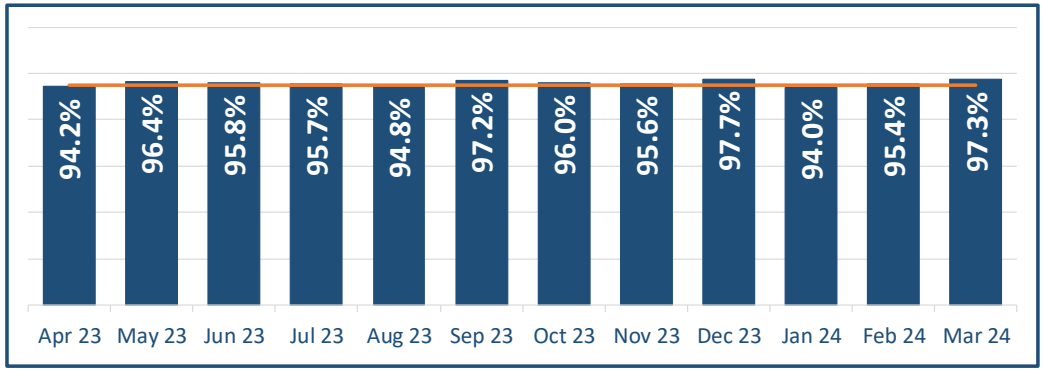


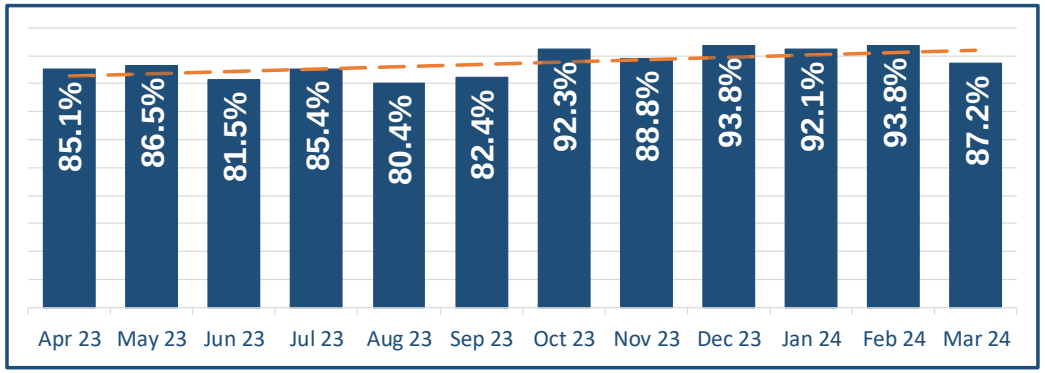
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	90%	TBC	97.6%	1st of 7 (at Jan 24)
QSE	Percentage of eligible newborn babies who have a conclusive bloodspot screening result by day 17 of life	95%	TBC	97.3%	5th of 7 (at Feb 24)
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	87.2%	3rd of 7 (at Dec 23)

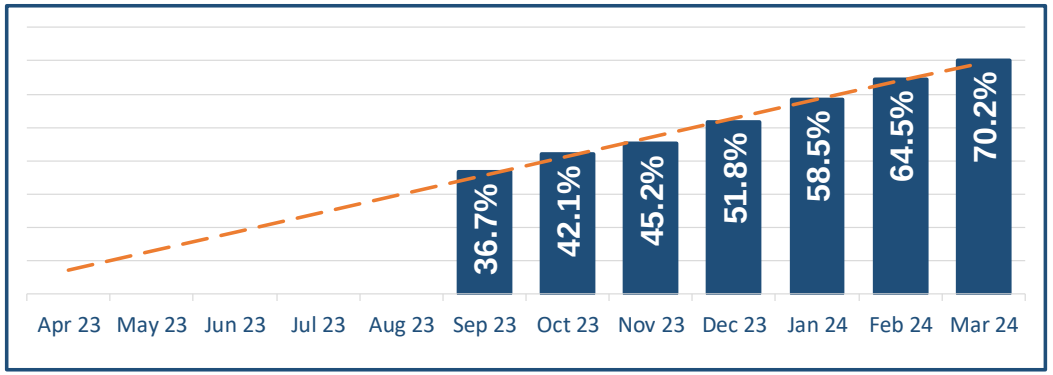


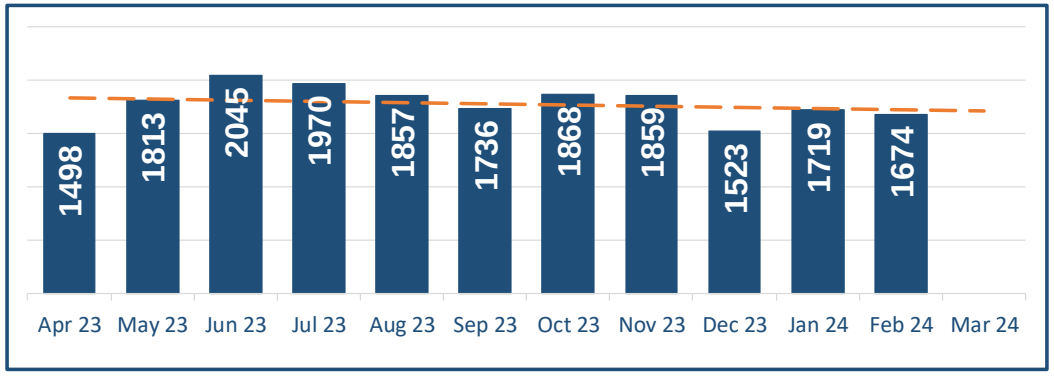


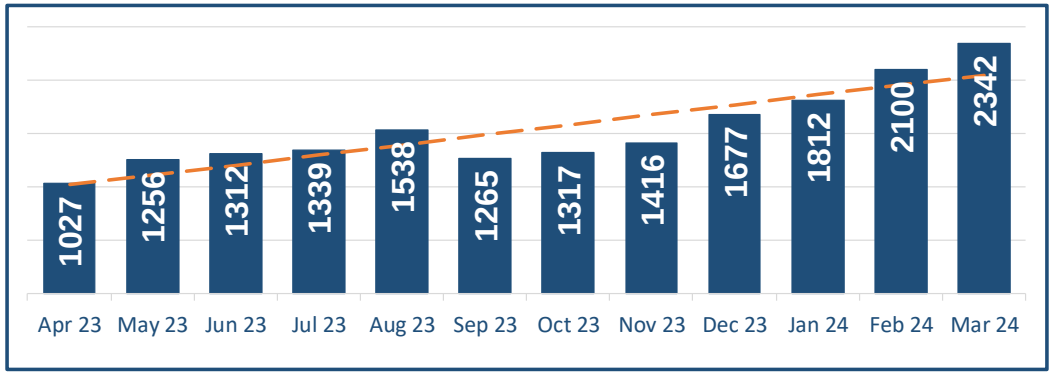


Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Increas-ing trend (to 100%)	TBC	70.2%	6th of 7 (at Mar 24)
PFIG	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Decreas-ing trend	TBC	1674	7th of 7 (at Feb 24)
PFIG	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Mth to mth increase (2022/23 to 2023/24)	TBC	2342	1st of 7 (at Feb 24)







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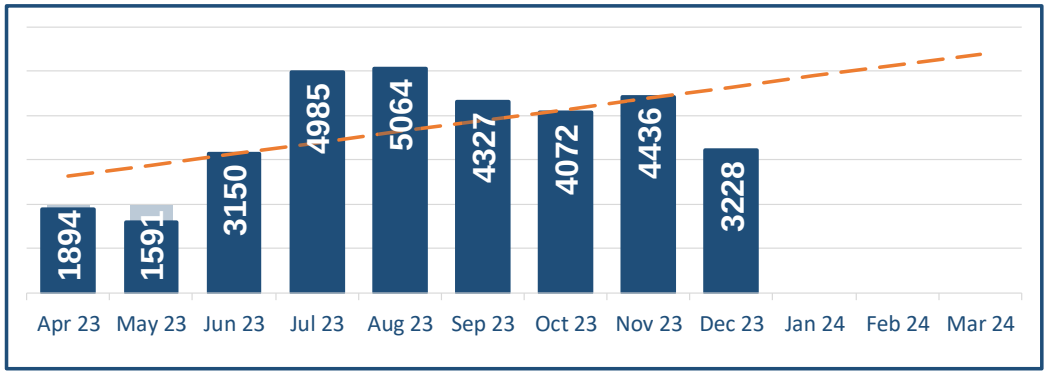
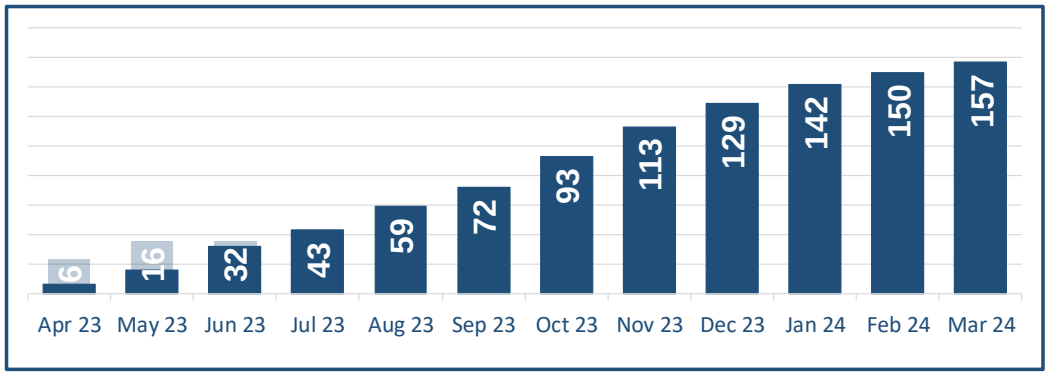
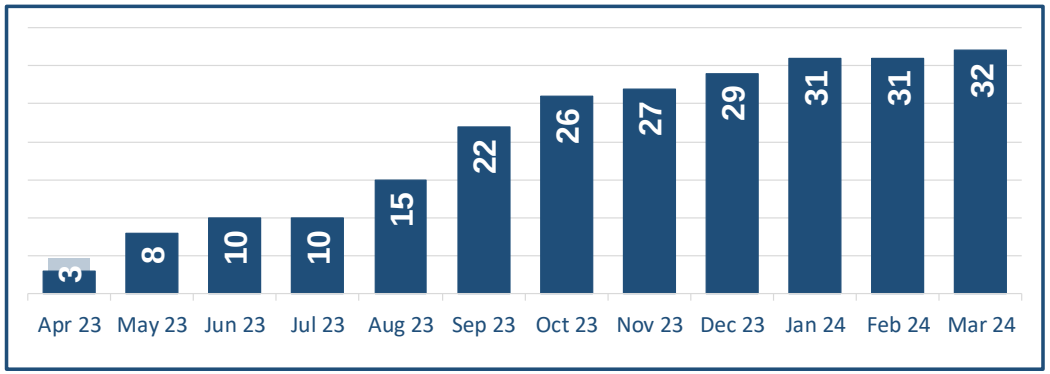
Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Number of service user feedback experience responses completed and recorded on CIVICA	Increas-ing trend	TBC	3228	2nd of 10 (at Dec 23)
QSE	The cumulative number of laboratory confirmed Klebsiella in reporting month	Not avail-able	TBC	157	6th of 6 (at Mar 24)
QSE	The cumulative number of laboratory confirmed Pseudomonas Aeruginosa in reporting month	Not avail-able	TBC	32	6th of 6 (at Mar 24)







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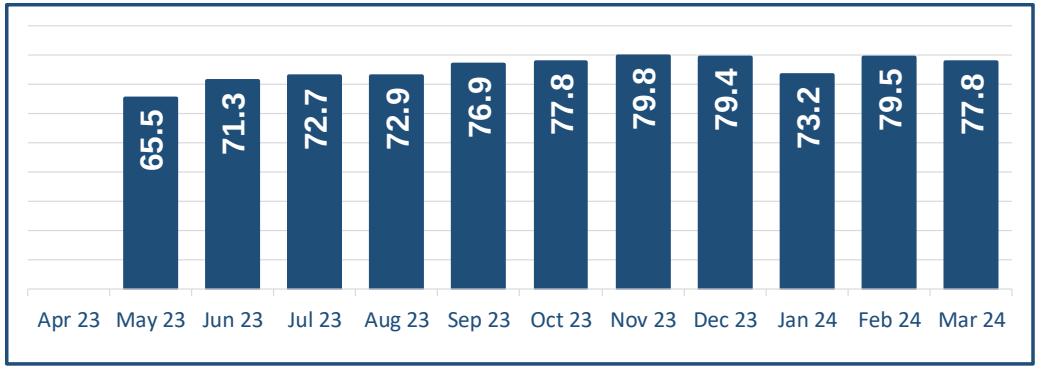
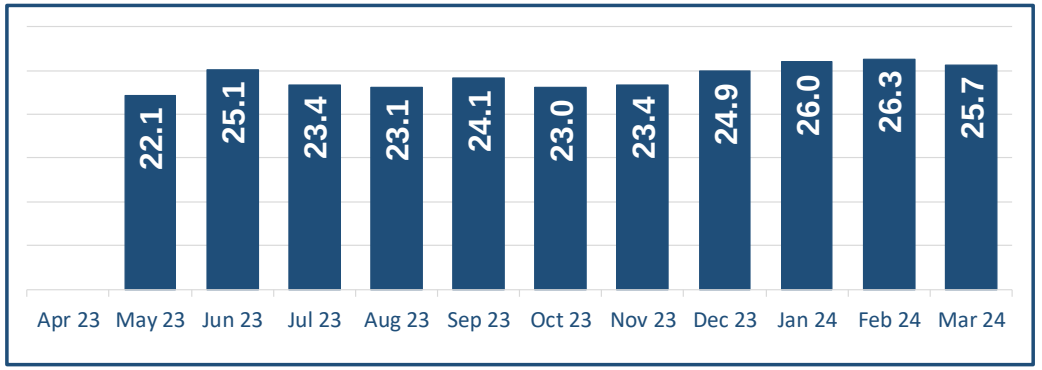
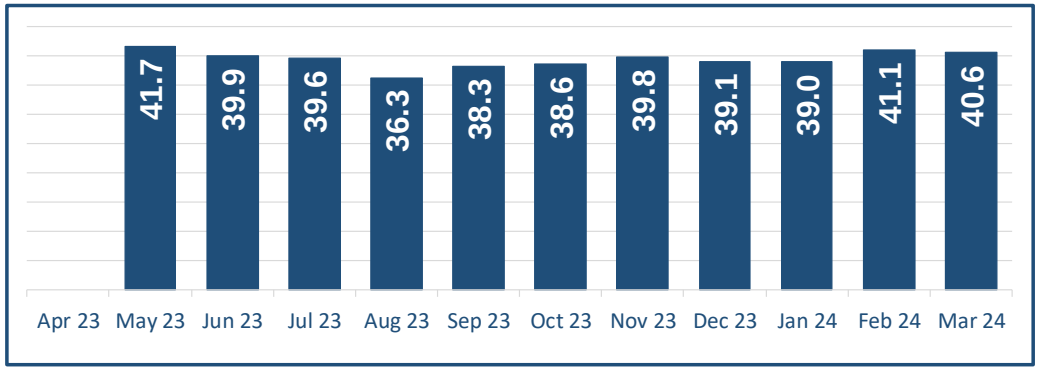
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	The cumulative rate of laboratory confirmed E.coli bacteraemias cases per 100,000 population	Not available	TBC	77.8	4th of 6 (at Mar 24)
QSE	The cumulative rate of laboratory confirmed S. Aureus Bacteraemia (MRSA and MSSA) cases per 100,000 of the population	Not available	TBC	25.7	2nd of 6 (at Mar 24)
QSE	The cumulative rate of laboratory confirmed C.difficile cases per 100,000 of the population	Not available	TBC	40.6	4th of 6 (at Mar 24)



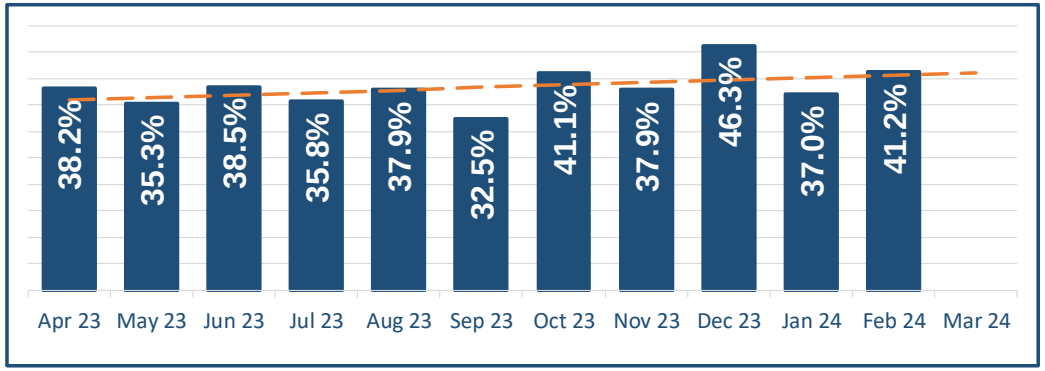


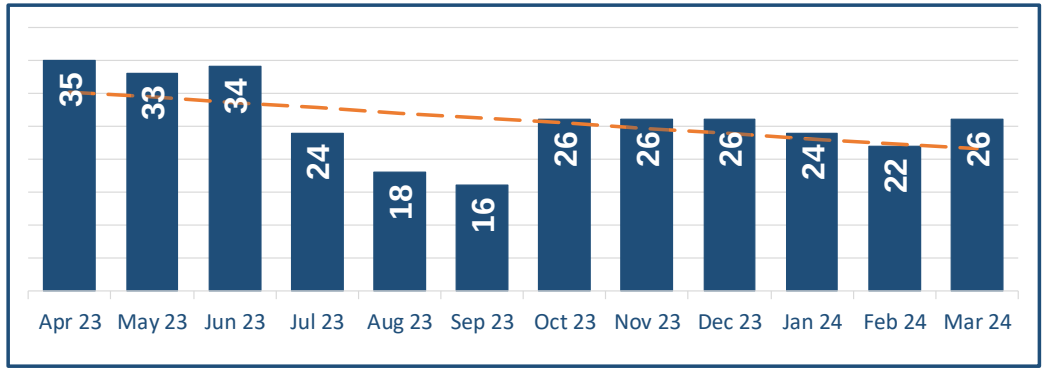


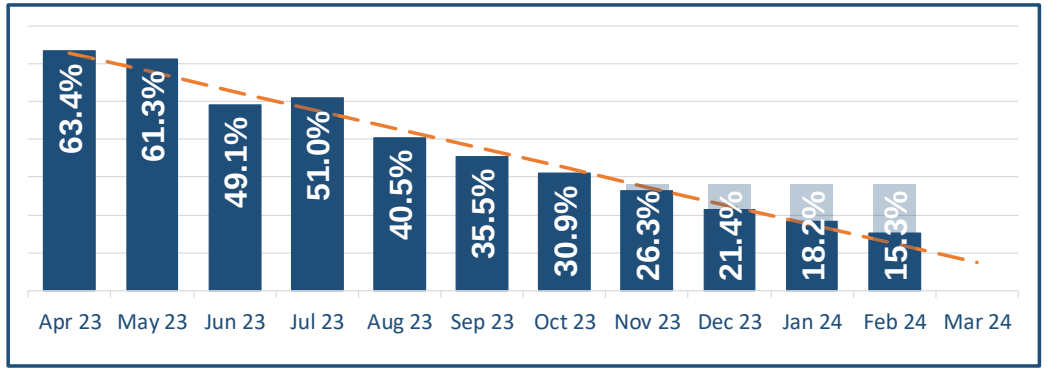
* Wales Ranking may differ as may refer to previous month

Quality: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
QSE	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Mth to mth reduction (2022/23 to 2023/24)	TBC	41.2%	6th of 6 (at Mar 24)
QSE	Number of National Reportable incidents that remain open 90 days or more	Decreasing trend	TBC	26	6th of 10 (at Mar 24)
QSE	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Increasing trend (to 95%)	TBC	15.3%	8th of 8 (at Jan 24)

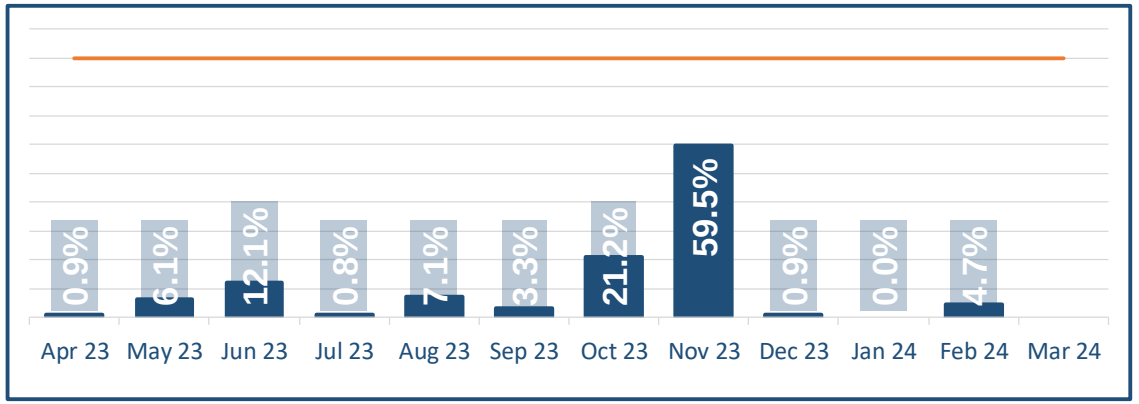


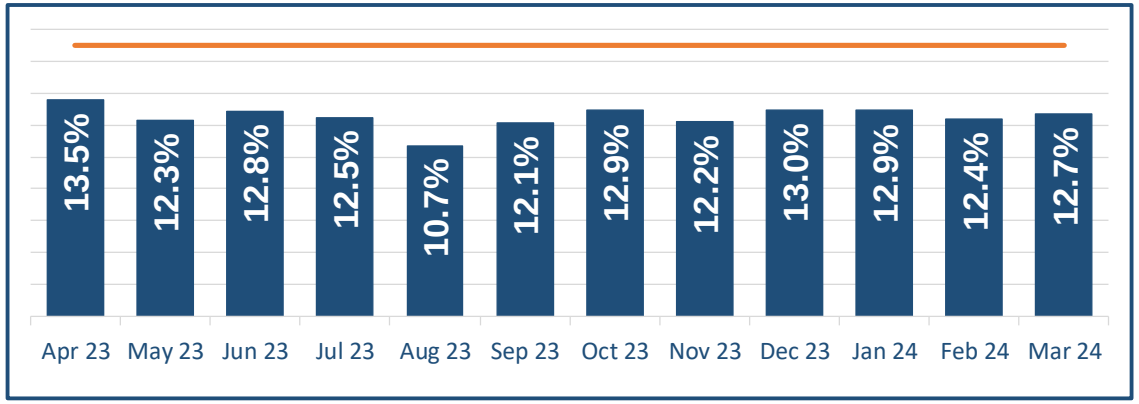




Quality: Performance

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	4.7%	8th of 8 (at Feb 24)
QSE	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	>17%	TBC	12.7%	6th of 7 (at Feb 24)

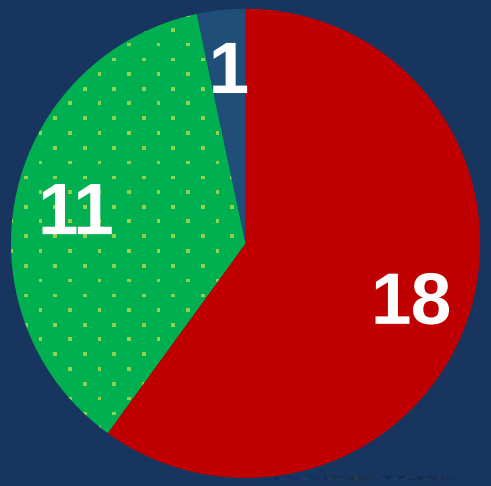




Section 2

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

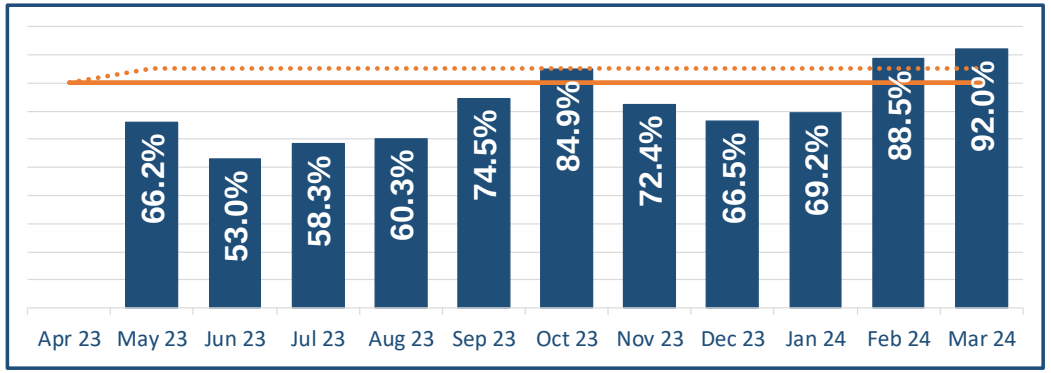
Access and Activity Performance

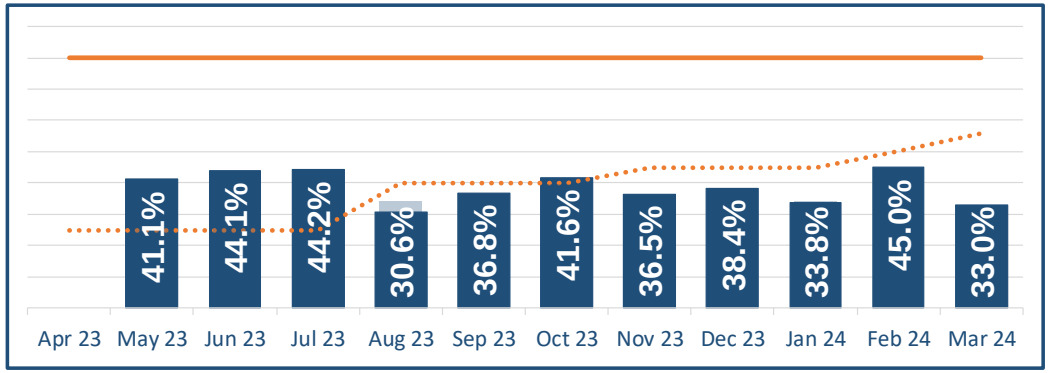


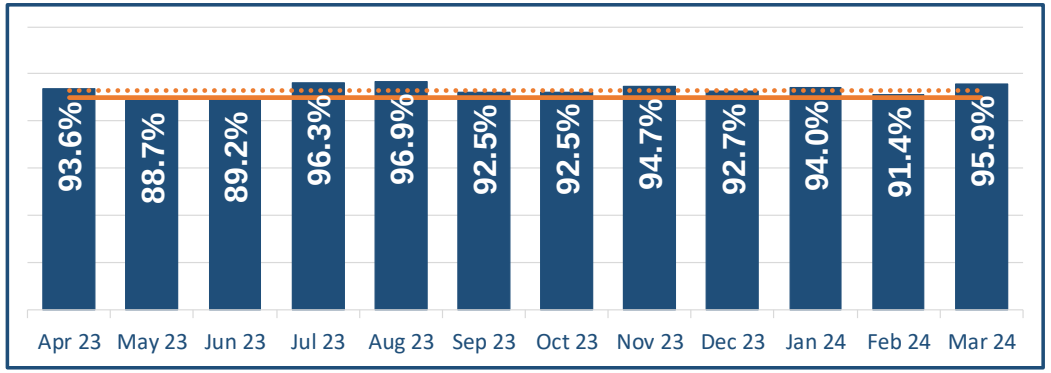
Produced on behalf of the **Health Board** by the
Performance Directorate in partnership with our **Health Board Directors**

Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
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%	85.0%	92.0%	5th of 7 (at Feb 24)
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%	56.0%	33.0%	5th of 7 (at Feb 24)
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%	93.0%	95.9%	4th of 7 (at Feb 24)



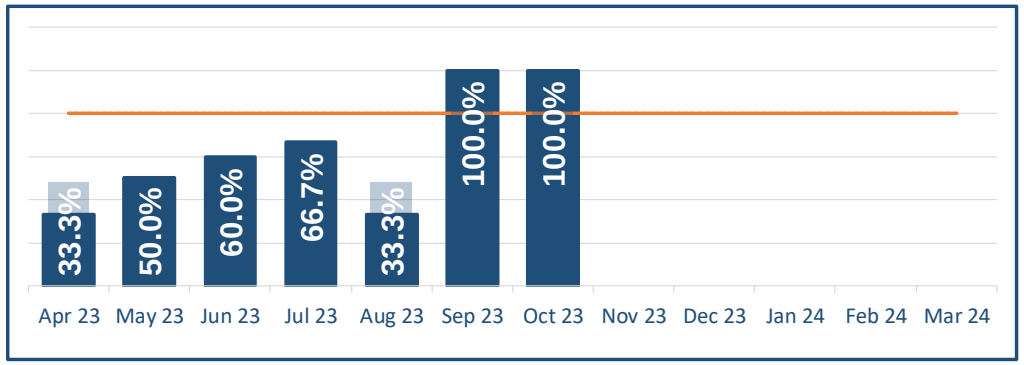


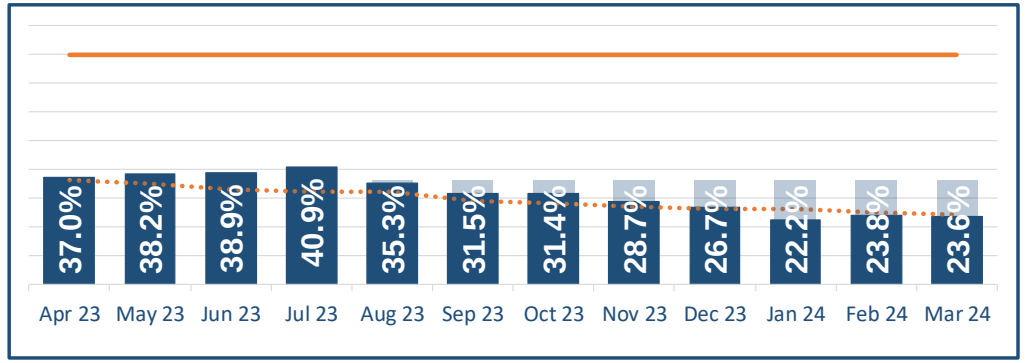


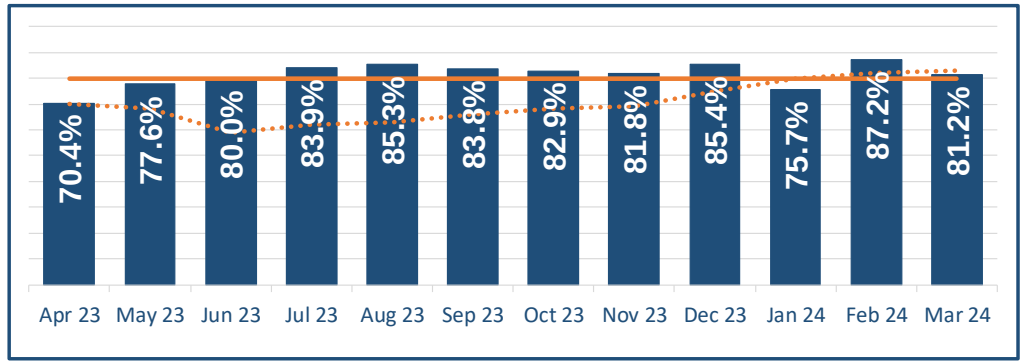
* Wales Ranking may differ as may refer to previous month

Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	80%	80.0%	100.0%	1st of 6 (at Oct 23)
PFIG	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	24.0%	23.6%	5th of 7 (at Feb 24)
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%	83.0%	81.2%	4th of 7 (at Feb 24)

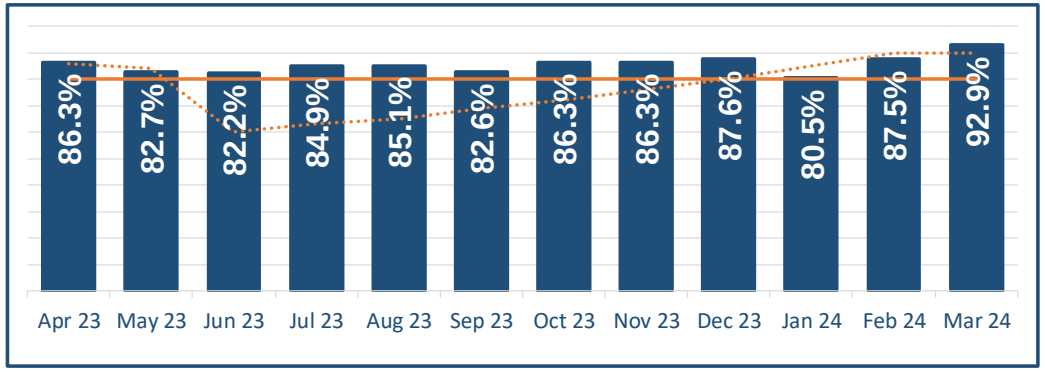


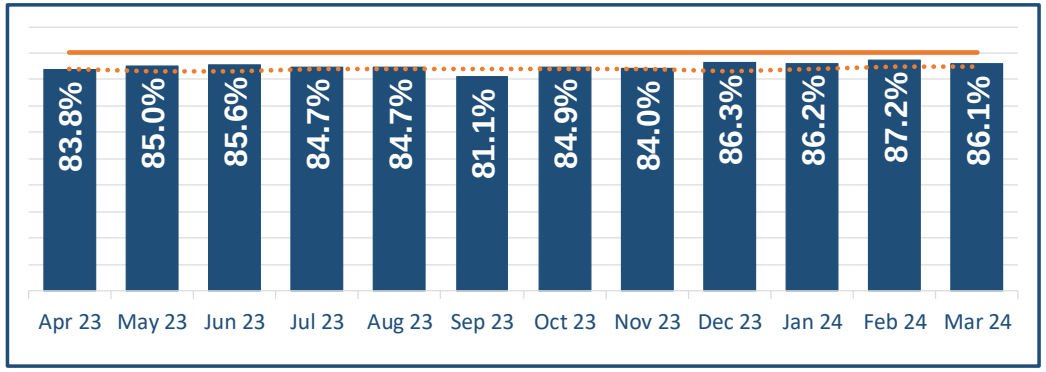


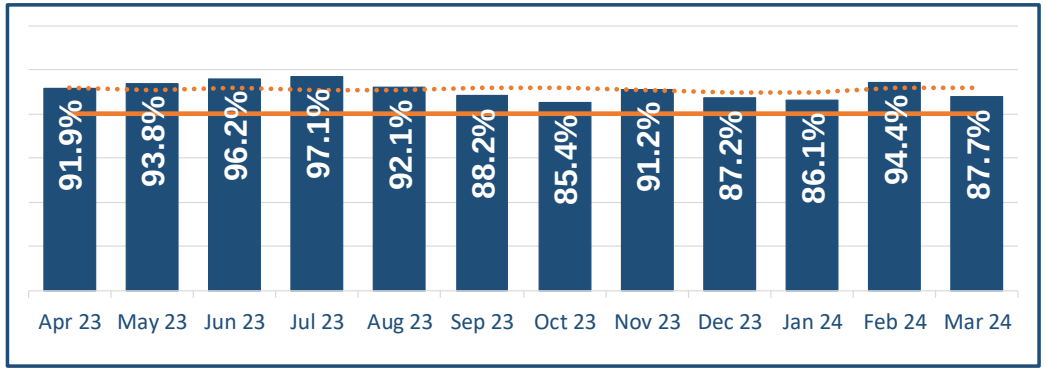


Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
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%	90.0%	92.9%	6th of 7 (at Feb 24)
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%	85.0%	86.1%	4th of 7 (at Feb 24)
PFIG	Percentage of patients waiting less than 26 weeks to start a psychological therapy in specialist Adult Mental Health BCU Level	80%	92.0%	87.7%	1st of 7 (at Feb 24)

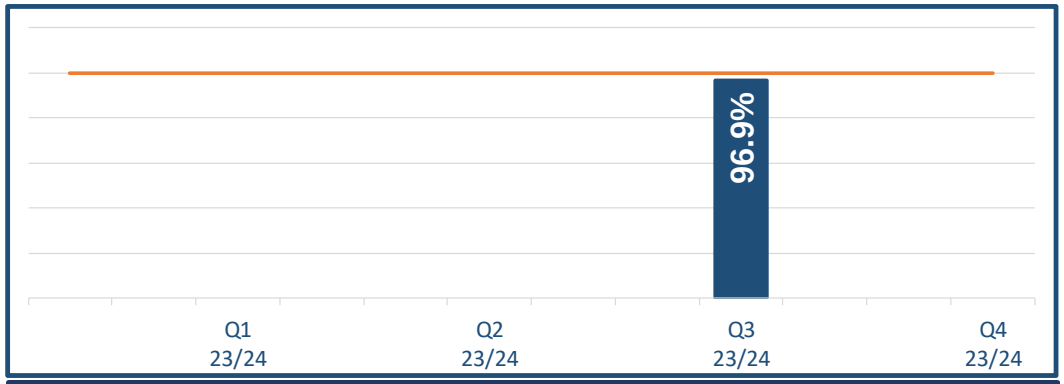


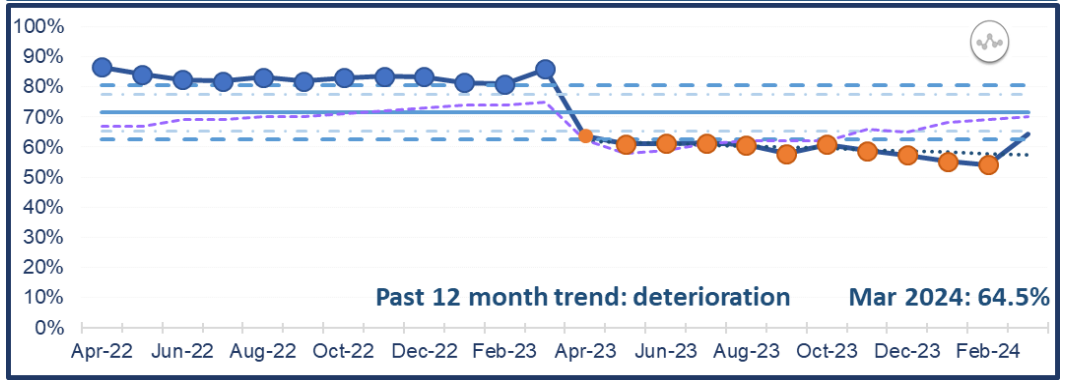


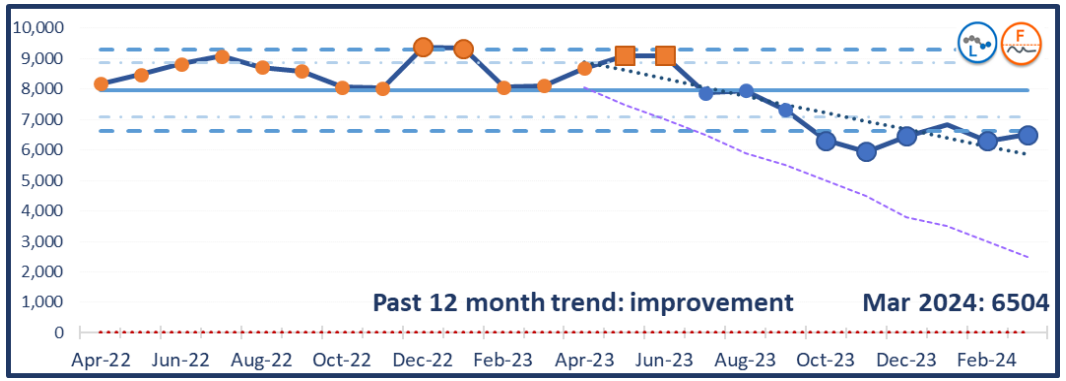


Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	TBC	96.9%	6th of 7 (at Mar 23)
PFIG	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Increas-ing trend (to 80%)	70.0%	64.5%	3rd of 6 (at Feb 24)
PFIG	Number of pathways waiting 8 weeks for specific diagnostic	Decreas-ing trend (to 0)	2500	6504	5th of 7 (at Feb 24)

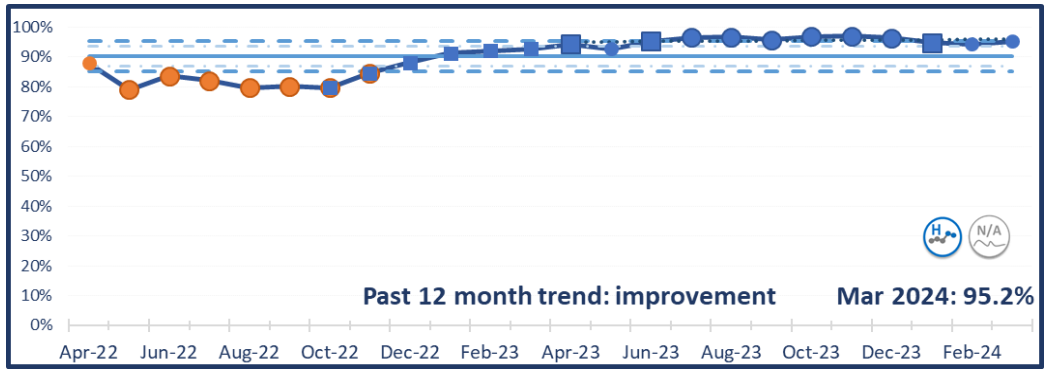


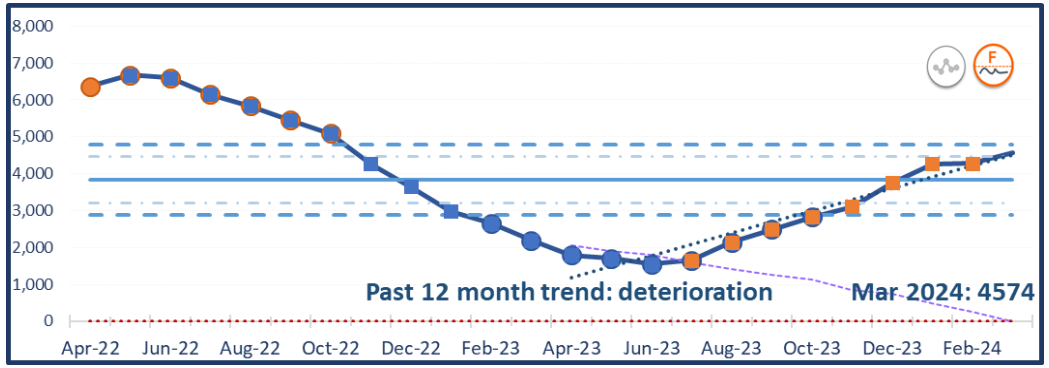


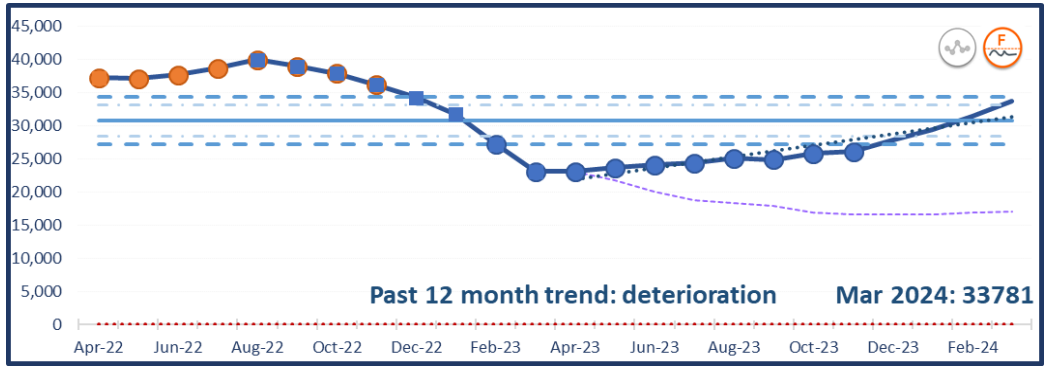


Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
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)	Increas-ing trend	TBC	95.2%	2nd of 7 (at Feb 24)
PFIG	Number of patients (all ages) waiting more than 14 weeks for a specified therapy (including audiology)	Decreas-ing trend (to 0)	0	4574	7th of 7 (at Feb 24)
PFIG	Number of patients waiting more than 36 weeks for a new outpatient appointment	Decreas-ing trend (to 0)	17041	33781	7th of 7 (at Feb 24)







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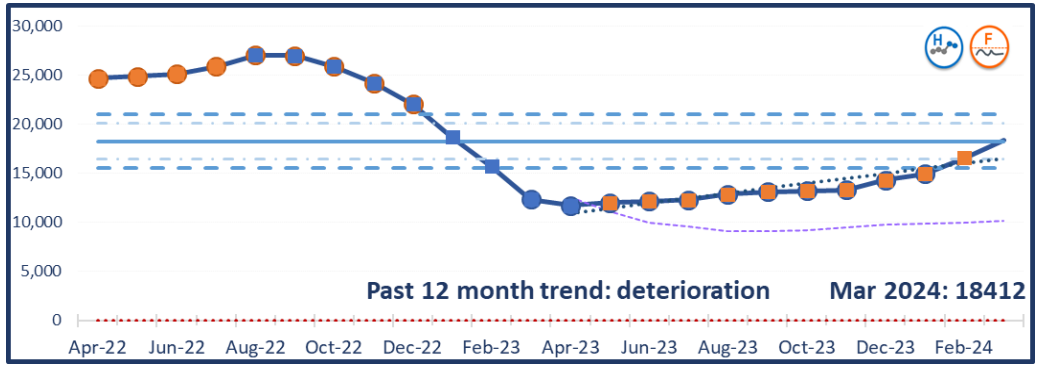
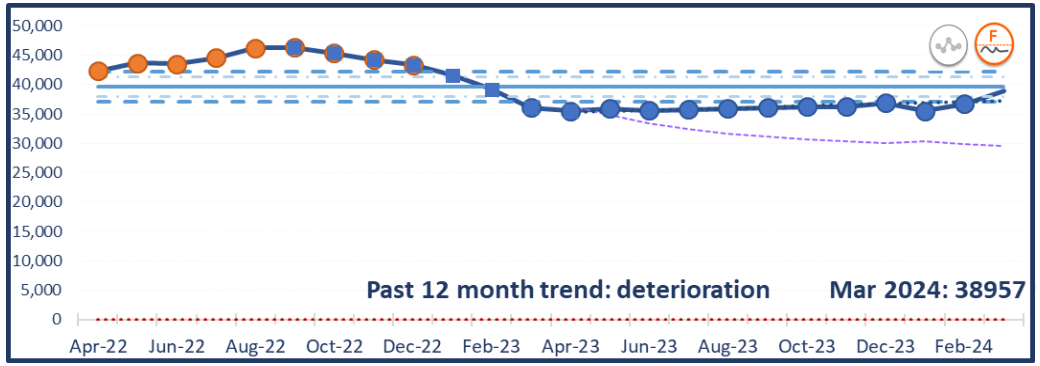
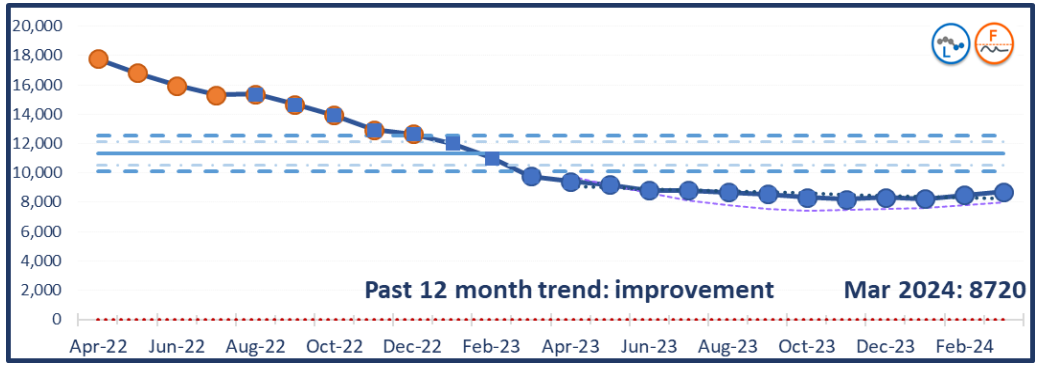
* Wales Ranking may differ as may refer to previous month

Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Number of patients waiting over 52 weeks for a new outpatient appointment	Decreasing trend (to 0)	10175	18412	7th of 7 (at Feb 24)
PFIG	Number of patients waiting more than 52 weeks for referral to treatment	Decreasing trend (to 0)	29544	38957	7th of 7 (at Feb 24)
PFIG	Number of patients waiting more than 104 weeks for referral to treatment	Decreasing trend (to 0)	7978	8720	7th of 7 (at Feb 24)







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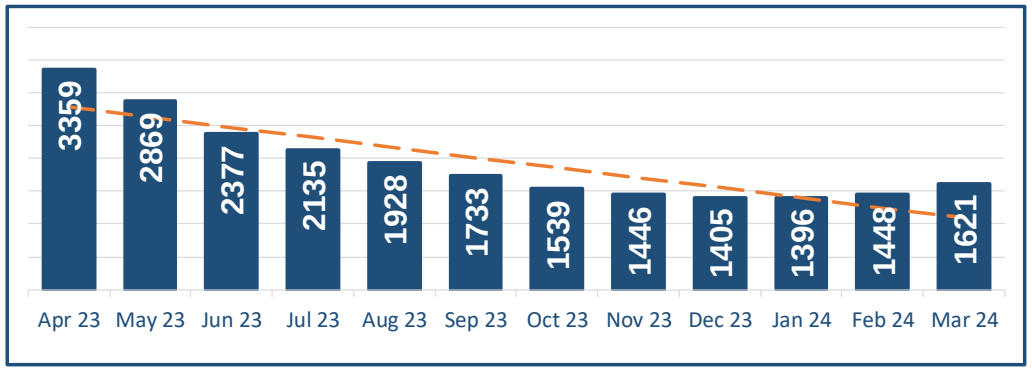
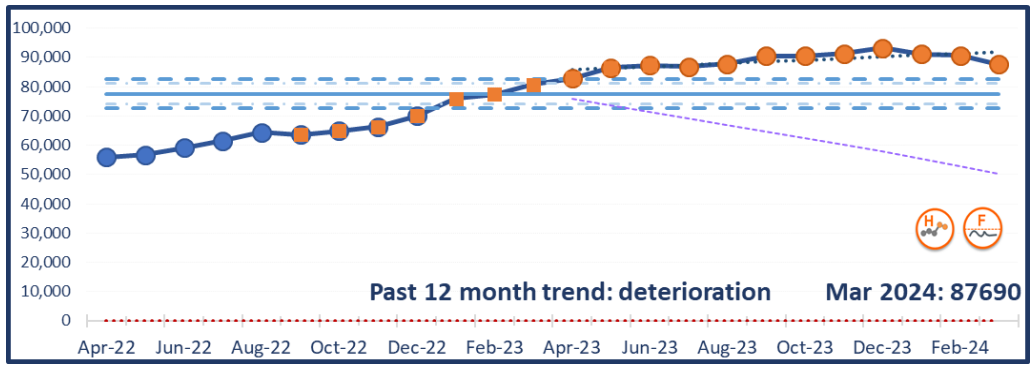
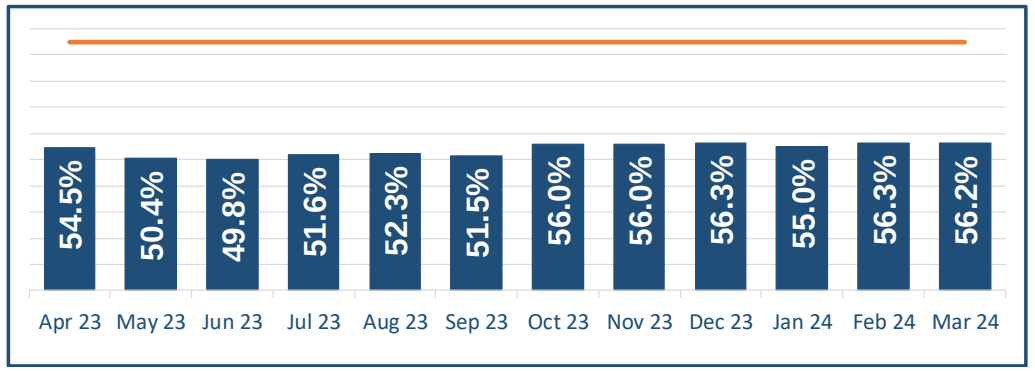
Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Over 156 weeks all stages	N/A	TBC	1621	
PFIG	Number of patients waiting for a follow up outpatient appointment who are delayed by over 100%	Decreas-ing trend (to 0)	50371	87690	7th of 7 (at Feb 24)
PFIG	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	95%	TBC	56.2%	5th of 7 (at Mar 24)

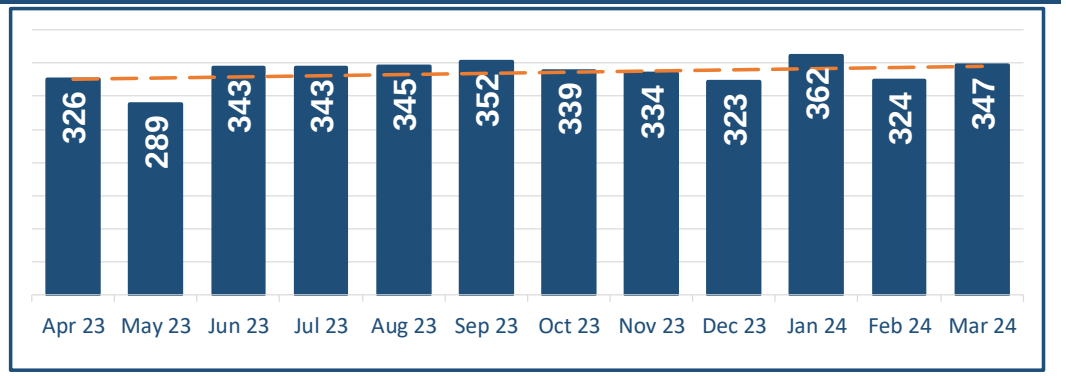


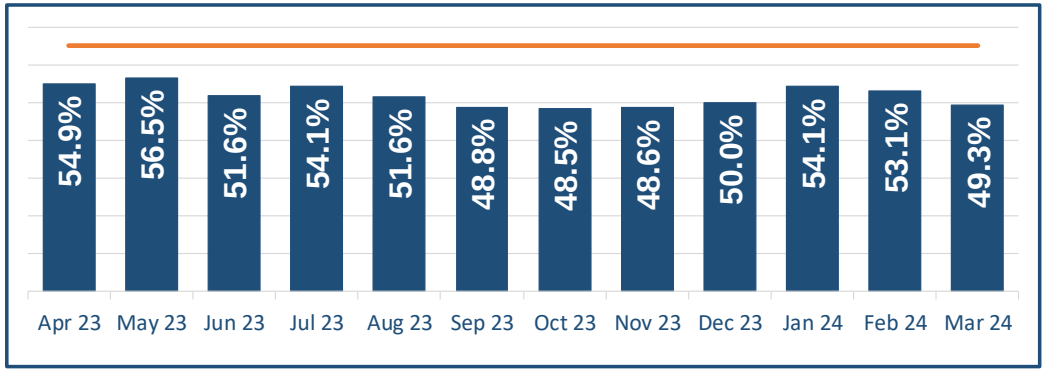


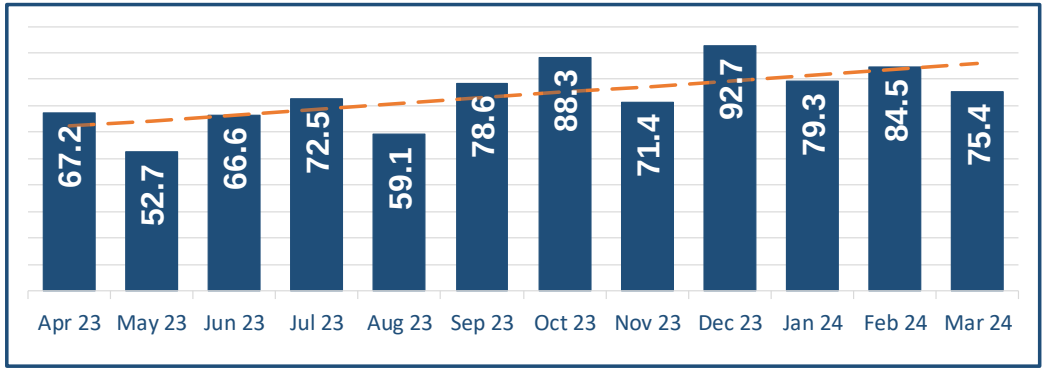


Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Number of Pathways of Care Delayed discharges	Decreas-ing trend	TBC	347	8st of 8 (at Mar 24)
PFIG	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	TBC	49.3%	4th of 7 (at Mar 24)
PFIG	Median emergency response time to amber calls	Decreas-ing trend	TBC	75.4	3rd of 7 (at Mar 24)







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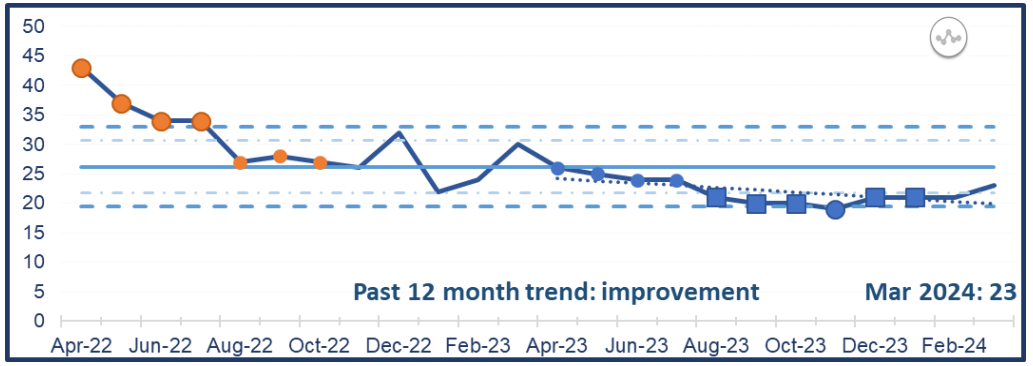
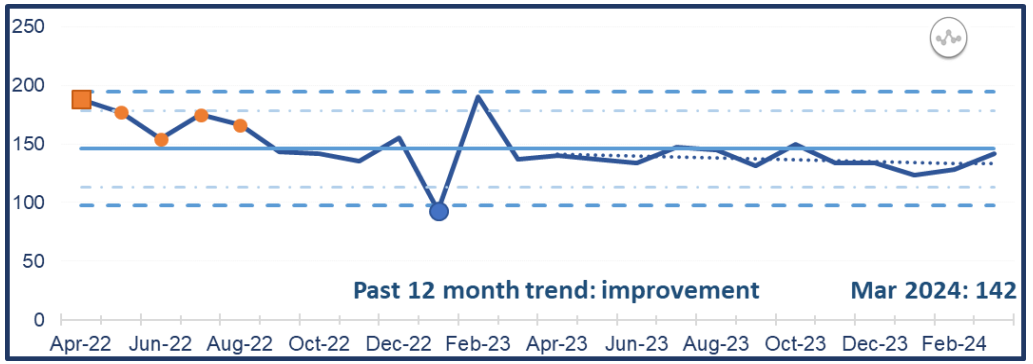
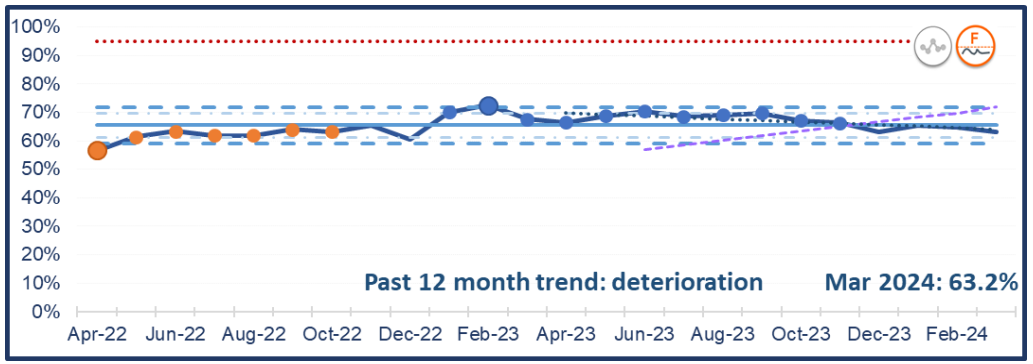
Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
PFIG	Median time from arrival at an emergency department to triage by a clinician	Decreas-ing trend	TBC	23.0	4th of 6 (at Mar 24)
PFIG	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	Decreas-ing trend	TBC	142.0	5th of 6 (at Mar 24)
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	Mth to mth increase (2022/23 to 2023/24)	72.0%	63.2%	7th of 7 (at Mar 24)

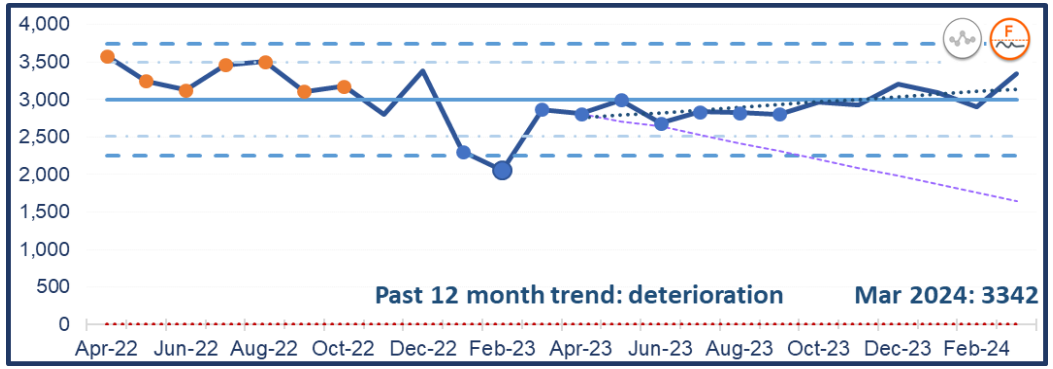


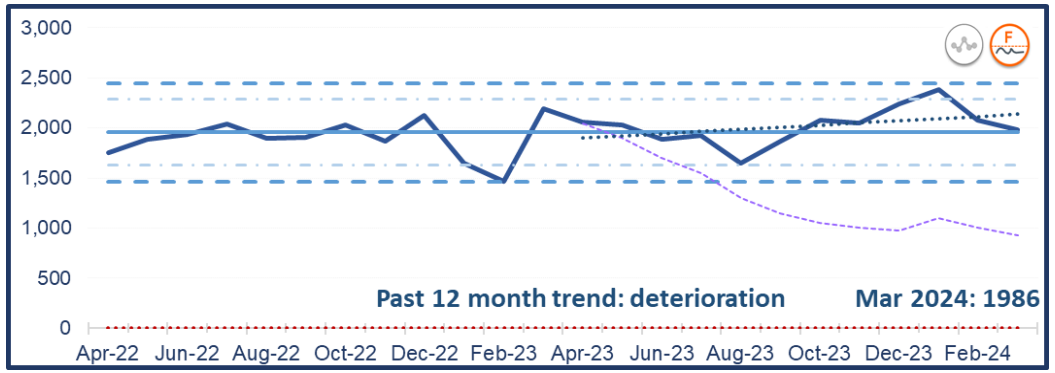


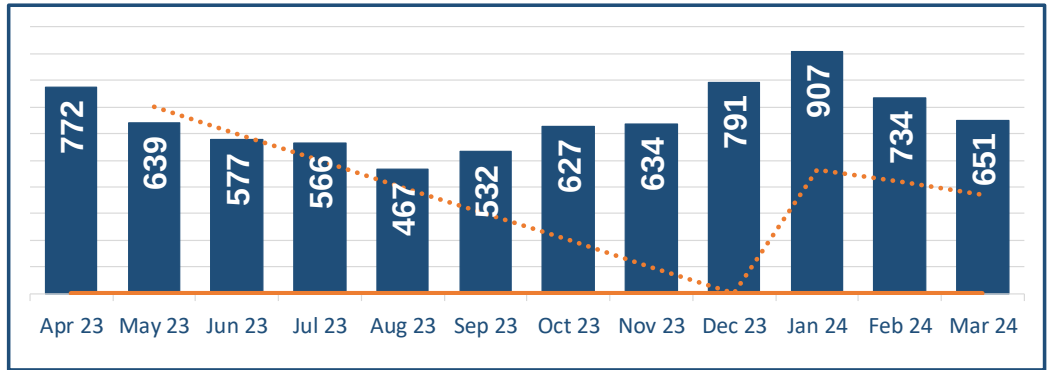


Our Access & Activity: Performance

Cmt	Measure	WG Target	Internal Target	Position	Wales Rank
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	Decreasing trend (to 0)	1650	3342	7th of 7 (at Mar 24)
PFIG	Number of ambulance patient handovers over 1 hour	Decreasing trend (to 0)	925	1986	6th of 6 (at Mar 24)
PFIG	Number of ambulance patient handovers over 4 hour	0	372	651	

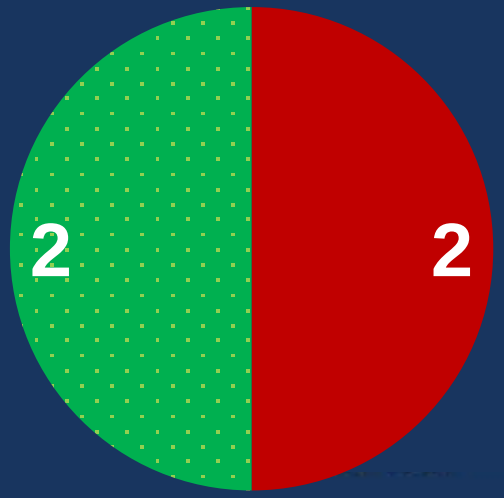






Section 3

People and Organisational Development Performance



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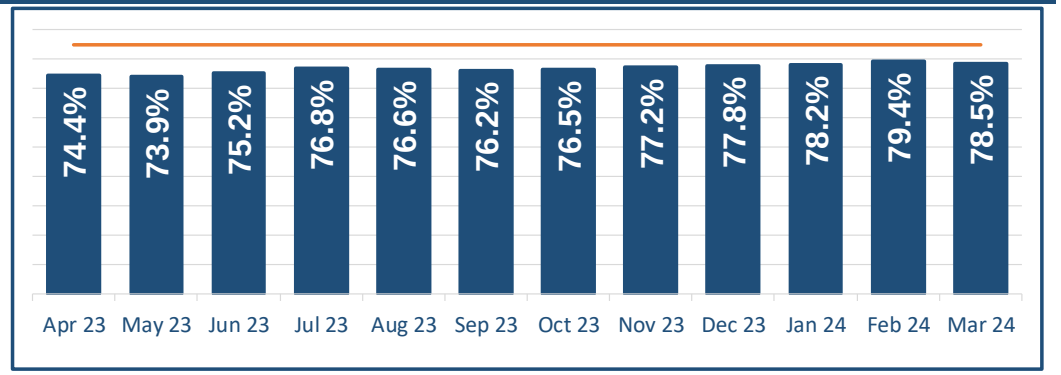
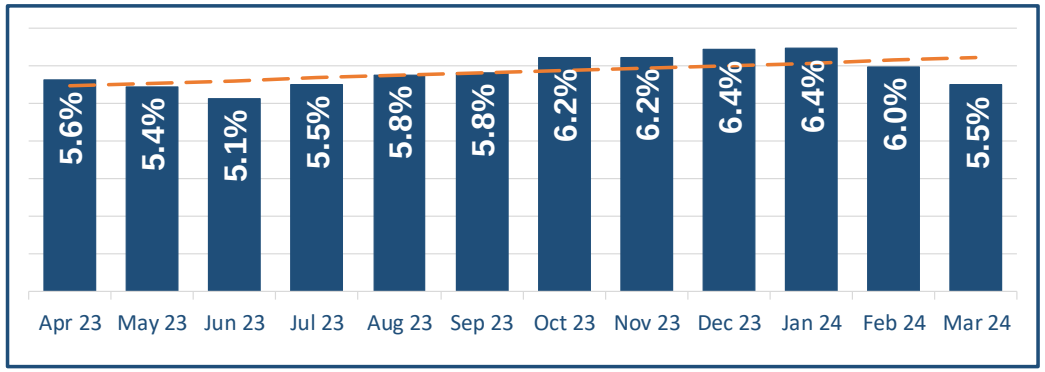
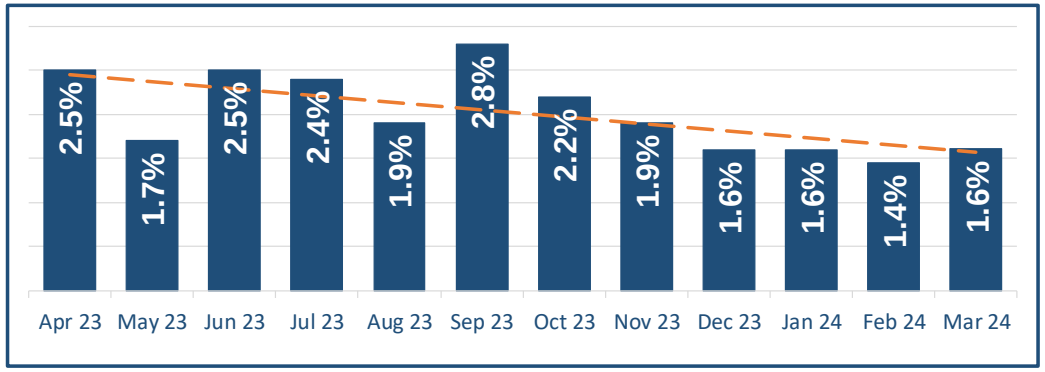
Our People: Performance

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	78.5%	3rd of 13 (at Jan 24)
PFIG	Percentage of sickness absence rate of staff	Decreas-ing trend	TBC	5.5%	6th of 12 (at Jan 24)
PFIG	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Decreas-ing trend against 2019/20	TBC	1.6%	3rd of 11 (at Nov 23)







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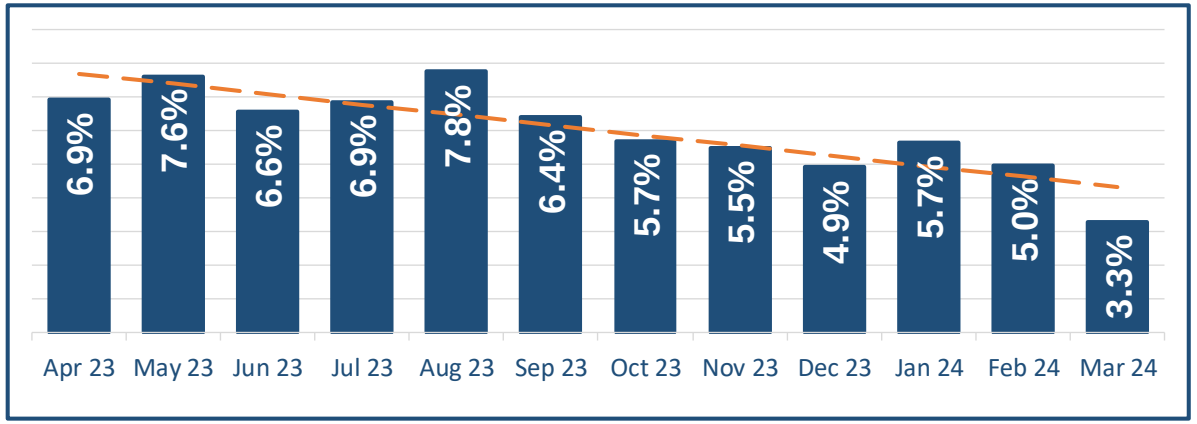
Our People: Performance

Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank*
PFIG	Agency spend as a percentage of total pay bill	Decreas-ing trend	TBC	3.3%	10th of 12 (at Jan 24)



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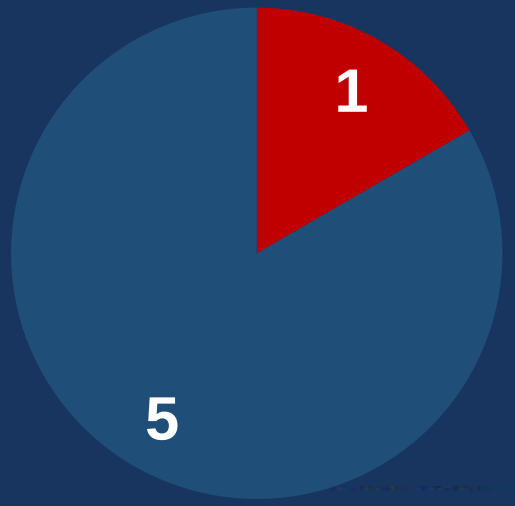
Section 4

Financial Performance



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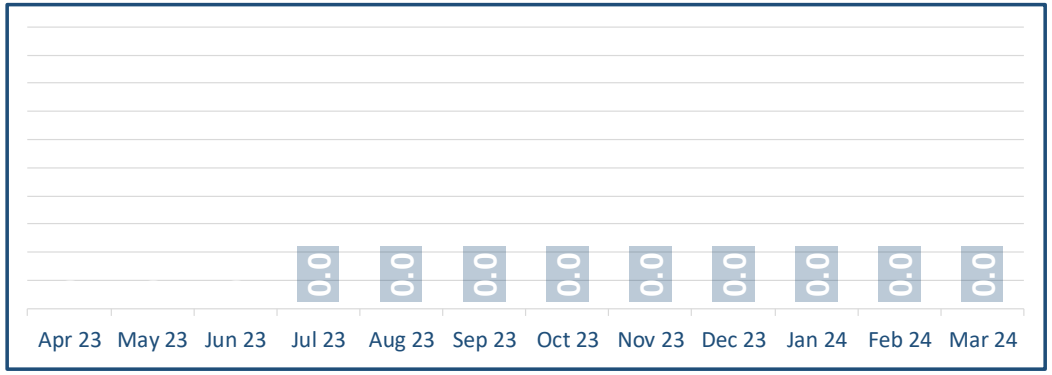
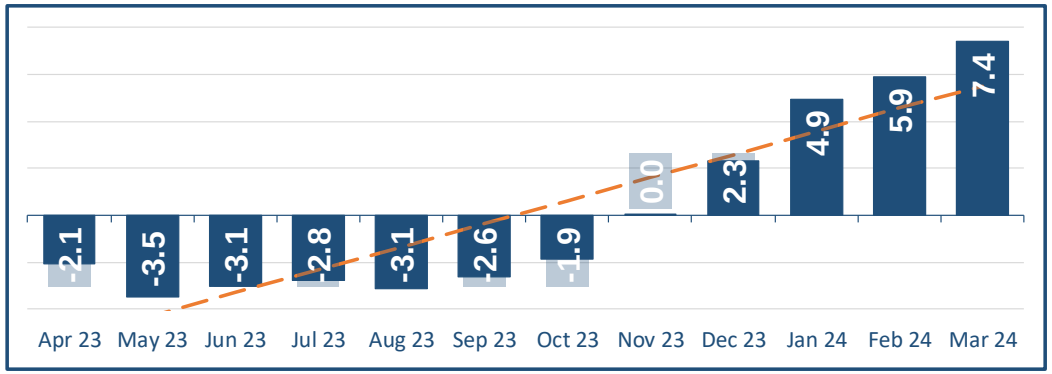
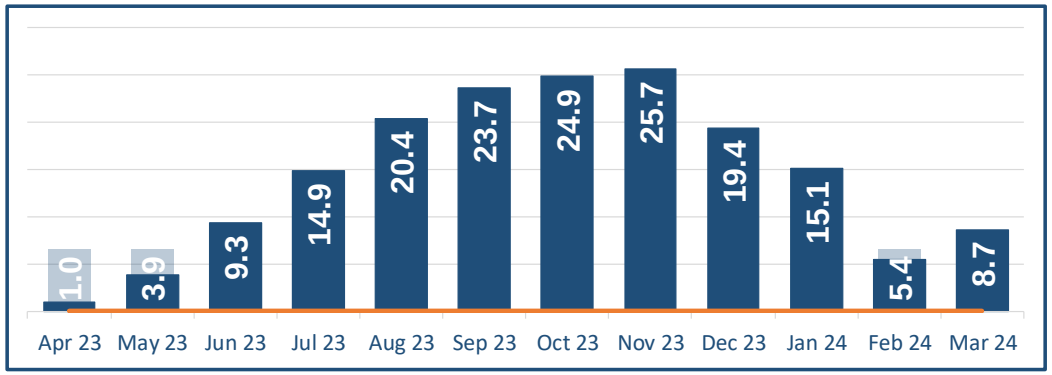
Finance: Performance

Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
PFIG	Forecast outturn (£million)	N/A	TBC	0.0	
PFIG	Year to date savings delivery against target (£million)	N/A	TBC	7.4	
PFIG	Year to date deficit against plan (£million)	N/A	TBC	8.7	

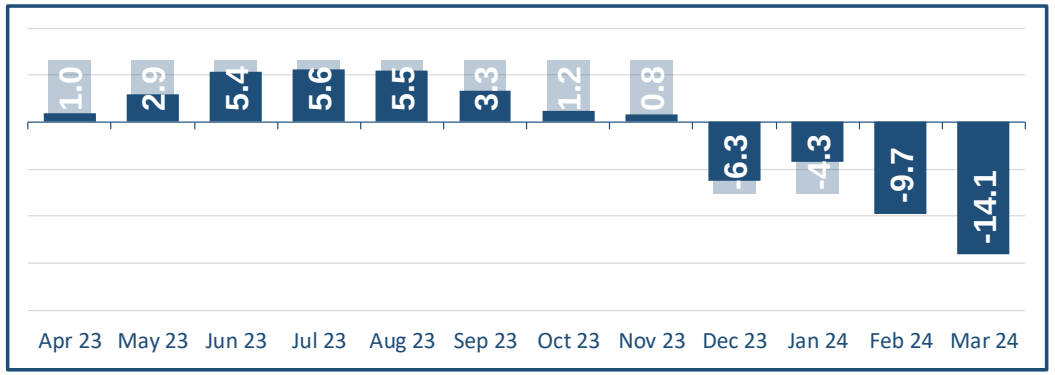


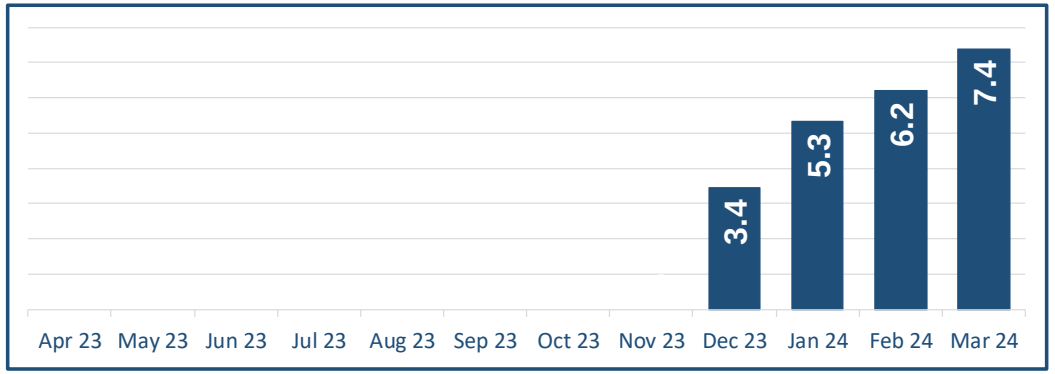


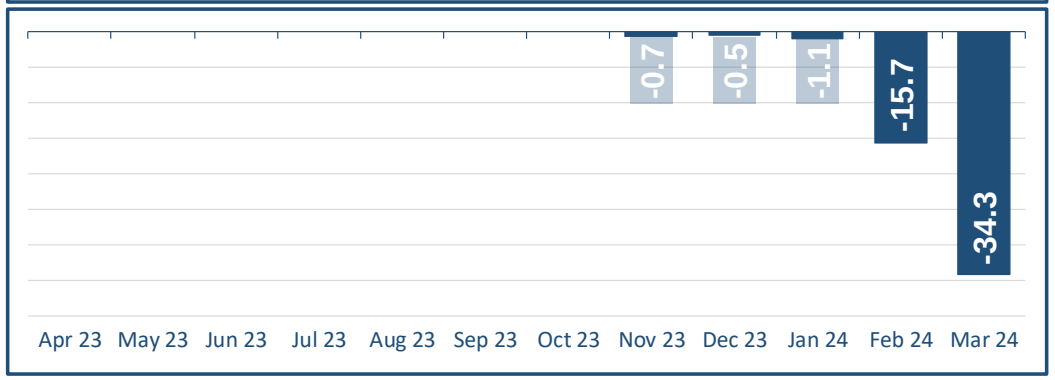


Finance: Agency

Cmt	Measure	WG Target	Internal Target	BCU Position	Wales Rank
PFIG	In month variance to plan (£million)	N/A	TBC	-14.1	
PFIG	Forecast savings delivery against target (£million)	N/A	TBC	7.4	
PFIG	In year capital expenditure against plan (£million)	N/A	TBC	-34.3	







Finance: Agency

BCU Wide and Divisional Positions (Red = overspend against plan)					
Forecast outturn of £33m, actual outturn £24.3m	Q1 to Q3 £m	January £m	February £m	March £m	Outturn £m
West IHC	(11.3)	(1.0)	(0.9)	(1.7)	(14.8)
Central IHC	(16.0)	(1.0)	(1.1)	(1.5)	(19.5)
East IHC	(9.7)	(1.1)	0.4	(3.8)	(14.2)
Womens	0.4	0.0	0.1	0.2	0.7
MH & LD	(5.5)	(0.9)	(1.4)	(0.9)	(8.7)
Commissioning Contracts	2.3	0.4	(1.3)	0.8	2.1
ICD Primary Care	1.2	1.3	0.1	1.4	4.0
ICD Regional Services	(1.7)	0.0	(0.3)	(0.8)	(2.8)
Support Functions & Other Budgets	20.9	6.6	14.1	20.4	62.0
BCU Wide	**(19.4)**	**4.3**	**9.7**	**14.1**	**8.7**

Savings Scheme Pipeline	Green		Green (Proc)		Green		Variance Green
	R	NR	R	NR	Total	Target	to Target
Centre	3,424	75	141	45	3,685	7,950	46%
East	4,393	420	154	50	5,017	8,070	62%
West	3,485	1,093	110	31	4,720	6,046	78%
MHLD	3,355	0	5	8	3,368	3,267	103%
Womens	915	10	5	4	935	915	102%
Cancer	1,537	6	4	7	1,554	755	206%
Diagnostics	108	37	341	25	511	1,015	50%
Corporate	374	2,692	83	2,648	5,798	2,495	232%
Primary Care	114		15	4	133	154	86%
Provider Income					0	267	0%
Procurement (VAT)					0	-5,734	
Budget Reducing Savings	**17,705**	**4,335**	**858**	**2,823**	**25,722**	**25,200**	**102%**

The actual savings delivered exceeded the plan of £25.7m, and totalled £36.0m, of which £21.9m related to recurring savings, and these savings have a full year effect of £26.3m.

Finance: Agency

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*TYPE*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	508	484	421	370	319	185	181	291	94	204	128	-1	3,184	3,184
2	Medical & Dental	1,967	2,431	2,890	2,357	2,308	1,982	2,213	1,866	1,389	1,973	1,515	1,783	24,674	24,674
3	Nursing & Midwifery Registered	2,536	3,068	3,125	3,314	3,742	3,155	2,496	2,279	2,493	2,509	2,250	2,306	33,273	33,273
4	Prof Scientific & Technical	16	24	-11	27	-2	20	20	-15	11	10	11	17	128	128
5	Additional Clinical Services	54	80	43	-4	25	30	21	8	16	19	20	21	333	333
6	Allied Health Professionals	655	616	471	729	534	414	423	454	351	461	398	158	5,664	5,664
7	Healthcare Scientists	19	20	15	11	16	3	10	5	5	20	13	24	161	161
8	Estates & Ancillary	15	-2	18	6	73	-52	1	6	16	6	-4	16	99	99
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	5,771	6,721	6,972	6,810	7,015	5,737	5,365	4,894	4,375	5,202	4,331	4,324	67,517	67,517
11	Agency/Locum (premium) % of pay	6.90%	7.60%	6.60%	6.90%	7.80%	6.40%	5.70%	5.50%	4.90%	5.70%	5.00%	3.30%	5.90%	5.90%

Additional Information

Introduction to Integrated Performance Report (IPR)

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.

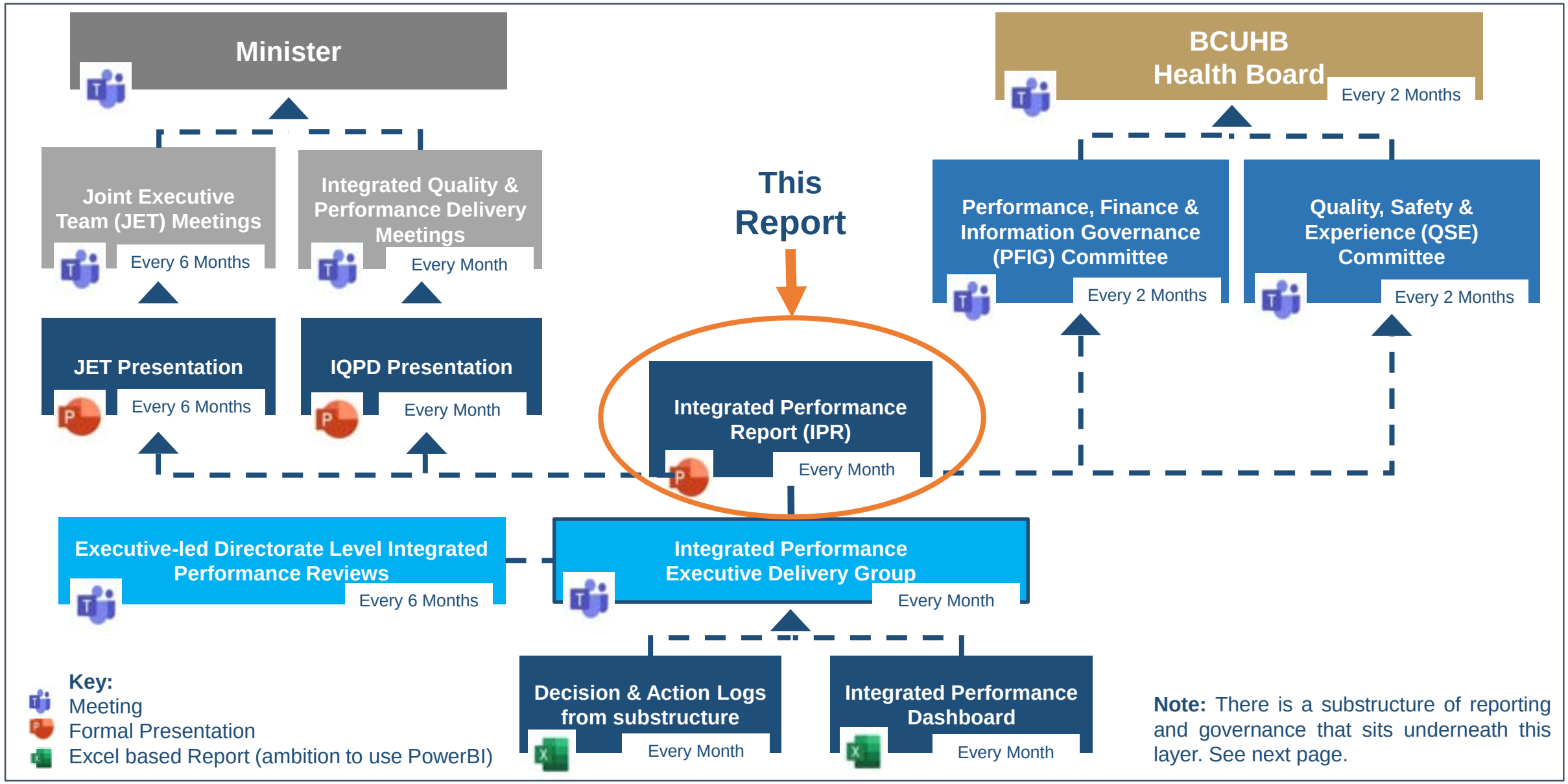
The Integrated Performance Framework sits within a "triumvirate" together with the Integrated Planning Framework and the Risk Management Framework (also ratified at Health Board on the 28th September 2023). This triumvirate of frameworks will encompass the planning, safe delivery and monitoring of the 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

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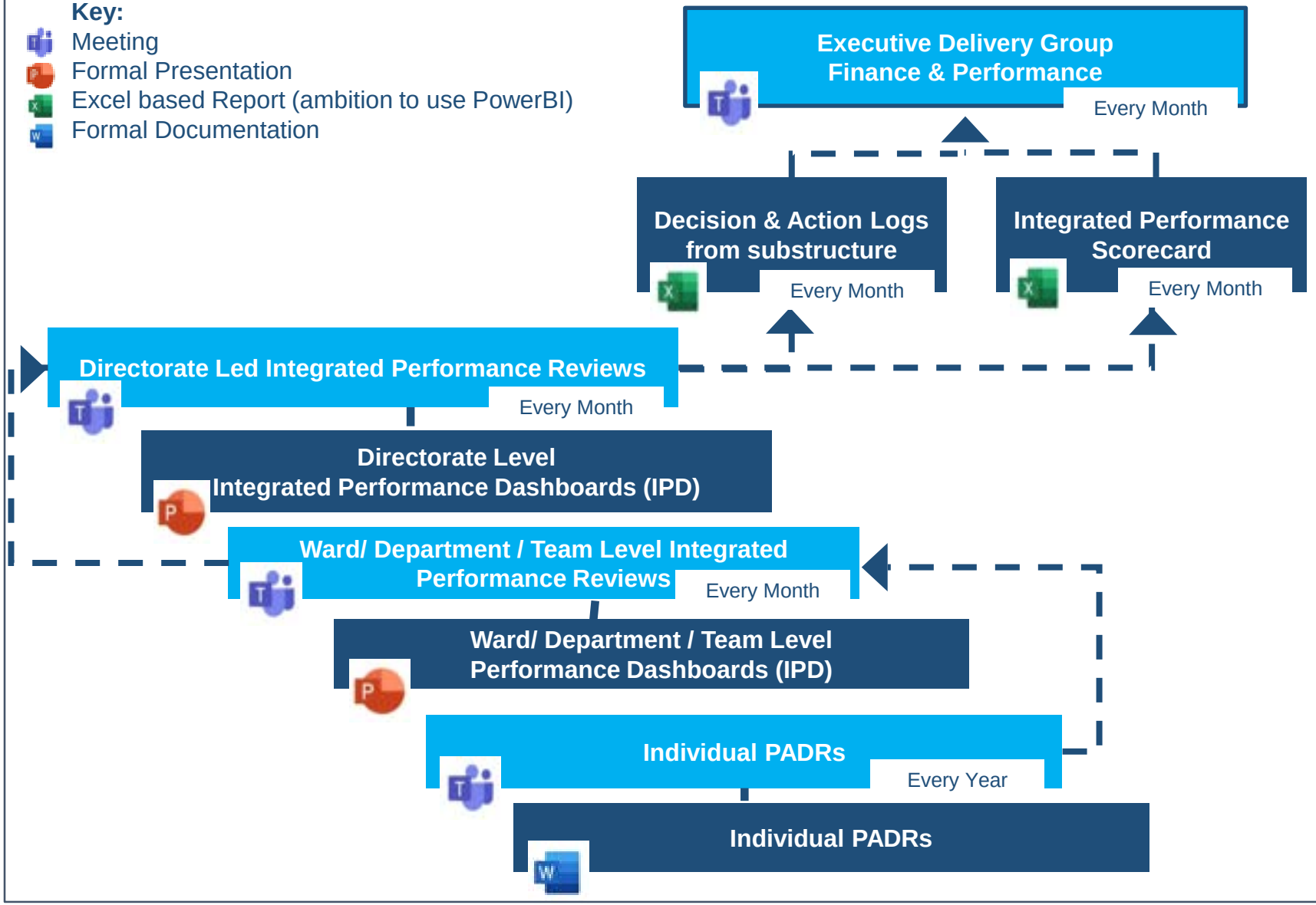
Key:
- Meeting
- Formal Presentation
- Excel based Report (ambition to use PowerBI)
- Formal Documentation



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

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.

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

Our Partners

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

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Teitl adroddiad: ***Report title:***	**2023-24 Financial Outturn 2023/24**
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 30 May 2024
Crynodeb Gweithredol: ***Executive Summary:***	This report provides a briefing on the draft unaudited financial performance of the Health Board as at the end of March 2024 and includes an update on delivery of the approved capital programme and savings delivery against target. The report also contains high level financial performance for month one of the 2024/25 financial year (April 2024).

Finance Report

The full year, draft unaudited financial position of the Health Board is reporting a deficit of £24.3m, with the in-month position reporting a surplus of £11.4m. The end of year financial position is subject to the closure and submission of the final accounts for 2023/24 and the subsequent audit by Audit Wales.

The Health Board has delivered an £8.7m surplus against the planned forecast deficit of £33.0m, making significant progress towards delivering the £20m deficit control.

It is encouraging to report that the Health Board has delivered a materially improved outturn deficit of £24.3m. The improvement is reflective of the focus placed upon savings attainment and additional control environment, endorsed by the Executive Team and approved by the Board that was introduced during 2023/24 in response to the deteriorating in-year position.

As the Health Board has made significant progress towards delivering the £20m deficit control total, WG have 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.

The improvement within the financial position from the Month 11 forecast deficit of £33.0m down to a £24.3m deficit reported at Month 12 includes the benefits from Welsh Government funding for inflation in early March 2024 of £5.7m and retention of Covid slippage funding of c.£1.4m. The below table summarises monthly variance against plan:

	April £m	May £m	Jun £m	Jul £m	Aug £m	Sept £m	Oct £m	Nov £m	Dec £m	Jan £m	Feb £m	Mar £m	Total £m
Monthly Deficit / (Surplus) above Plan	1.0	2.9	5.4	5.6	5.5	3.3	1.2	0.8	-6.3	-4.3	-9.7	-14.1	-8.7

The monthly improvement from August 2023 reflects the improvements articulated earlier, with key elements centring upon savings performance, additional focus on cost controls implemented within the Health Board, and in the months of December 2023 through to March 2024 the release of Balance Sheet Provisions to offset related expenditure (as disclosed was the intention during the year) and realisation of Accountancy Gains.

A focus placed upon identification and delivery of savings targeted by the Health Board, in conjunction with Controls implemented such as the Establishment Control Group (ECG), Revenue Investments Group for Assurance (RIGA), Medical & Nursing enhanced temporary workforce controls / escalations and the impact of additional controls predominantly in relation to the non-pay subjective requisitions review.

It is of note that these initiatives continue to have clinical backing and continue to be assessed to ensure they do not impact upon patient safety.

All of the measures deployed have contributed to the reduction within the in-month and year to date cost pressures. This has resulted in the movement back to planned levels of performance at close of the financial year, an overall improvement compared to Plan of £8.7m. This performance is a substantial improvement over initial forecasts, delivery securing recurrent investment within the Health Board as we move into the 2024/25 financial year.

Capital Programme 2023/24

The finance report articulates performance within the Capital Programme which consists of Discretionary funding plus specific funding for Major Projects. An additional £6m of Welsh Government funding, from All Wales Capital Slippage, was provided to the Health Board during Quarter 4. This has been utilised on the projects approved by the Board.

The approved Capital Resource Limit (CRL) for 2023/24 is £34.511m (including IFRS16 funding of £4.491m). Total 23/24 expenditure is £34.3m against a plan of £34.5m, with an underspend of £0.2m being reported.

Savings Report 2023/24

The Health Board's financial plan required a target of £25.2m savings to be delivered, with a full year stretch savings target of £30.9m.

The Health Board has delivered £36.0m savings and £10.7m Accountancy Gains, totalling £46.7m and therefore exceeded the stretch target. Of these savings, £21.9m is identified as recurring, with a full year effect of £26.2m.

In-month Accountancy Gains of £1.3m have been reported in Continuing Health Care (CHC) bringing the total to £10.7m at Month 12, with Establishment Control Group savings of c£2.7m reflecting decisions made by the group.

This represents a substantial improvement over savings performance attained within the initial quarter of the 2023/24 financial year.

2024/25 Financial Performance – Month 1 (April 2024)

Whilst the extended closedown of the 2023/24 financial year results in delays in production of the new financial year's performance, this report reflects on the delivery for month 1 at a summary level, as denoted within the below table;

Ref	Description	Amount £m's	Additional information
1	Actual deficit	4.3	The adverse deficit is largely driven through savings non-achievement and out of area mental health placements.
2	Plan (£19.7m deficit Plan)	1.6	
3	Adverse variance	2.7	

The Health Board will require a significant focus be placed upon savings delivery (Value & Sustainability initiatives) in order to deliver the 2024/25 financial plans, with a £48m target to be reviewed and closely monitored for achievement through the Integrated Performance – Executive Delivery Group, oversight provided by the Performance, Finance and Information Governance Committee (PFIG) a committee of the Health Board.

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: ***Report Author:***

Andrea Hughes, Interim Finance Director – Operational Finance
Michelle Jones, Head of Financial Reporting
Daniel Eyre, Head of Capital Development

Pwrpas yr adroddiad: ***Purpose of report:***

I'w Nodi *For Noting*	I Benderfynu arno *For Decision*	Am sicrwydd *For Assurance*
☒	☐	☒

Lefel sicrwydd: ***Assurance level:***

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

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

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

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF – Financial Stability Current risks and mitigations are shown in Appendix A, Slide 13. From a capital perspective, the Health 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:***	**Appendix A & B** **BAF risks** BAF - Financial Stability

(or links to the Corporate Risk Register)	**Corporate Risk Register:** CRR23-49, Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget. CRR23-51, Risk of failure to achieve the initial financial plan for 2023/24. This risk has being updated to reflect the revised financial plan. CRR23-52, WG cash funding for 2023/24. **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 - 2023/24 Finance Report (Revenue, Capital and Savings) - Month 12	

Finance Report
March 2024 – M12
(Draft - Subject to Audit)

Russell Caldicott
Interim Executive Finance Director

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

Summary of Key Numbers (Draft Subject to Audit)

Month 12 Position

In Month:

£11.4m favourable

£14.1m in-month surplus against in-month planed deficit of £2.7m

(Draft subject to Audit)

2023/24 Position

Full Year:

£24.3m adverse position

£8.7m surplus against 23/24 full year planned deficit of £33.0m (below the £20m deficit control total issued by Welsh Government)

(Draft subject to Audit)

Divisional Performance Month 12

West IHC	£14.8m adverse
Central IHC	£19.5m adverse
East IHC	£14.2m adverse
Womens	£0.7m favourable
MH & LD	£8.7m adverse
Commissioning Contracts	£2.1m favourable
ICD Primary Care	£4m favourable
ICD Regional Services	£2.8m adverse
Support Functions	£4.1m favourable
Other Budgets	£57.9m favourable

Savings

In-month: £3.6m against target of £2.1m

£1.5m favourable

Savings Delivered

Full Year: £36m (including non budget reducing schemes, but excluding Accountancy Gains) against a target of £25.2m

£10.8m favourable

COVID-19 Impact

£12.8m cost Full Year

£14.2m Funding Received.

£1.5m Surplus

Full Year Income

£158.5m against budget of £149.1m

£9.4m favourable

Full Year Pay

£1103.3m against budget of £1086.0m

£17.3m Adverse

Full Year Non-Pay

£1215.8m against budget of £1,199.4m

£16.4m Adverse

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 on 2023/24 financial outturn

- Draft (subject to audit) financial outturn of the Health Board is reported as a deficit of £24.3m; an £8.7m improvement against the planned forecast deficit of £33.0m. This delivery (whilst not attaining the Welsh Government control total) is predominantly due to enhanced savings performance, expenditure controls deployed during the financial year on temporary workforce (Nursing & Medical) and establishment control, planned release of balance sheet provisions and additional resources received for inflation with retention of Covid funding slippage..
- The approved Capital Resource Limit (CRL) for 2023/24 was £34.511m, including £4.491m IFRS 16 Funding (Right of Use Leases) with the total 2023/24 expenditure being £34.3m resulting in a small underspend of £0.2m and attainment of the target for the year..
- The Health Board achieved 94.5% Public Sector Payment Performance for Non NHS invoices (Best Practice 95%). Whilst slightly behind on target, this still represents good performance in year, the majority of suppliers of goods and service remunerated within 30 days of invoice (supporting cashflow within our local communities).
- The Health Board has delivered £36.0m Savings and £10.7m Accountancy Gains (which in the main relates to CHC Care Packages £5.3m and Medicines management £4.5m) therefore exceeded the stretch target. Of these savings, £21.9m has been identified as recurring, with a full year effect of £26.3m.

Key income allocations

- The Health Board received an in year allocation for 2023/24 that was conditionally recurrent moving into 2024/25 and beyond on condition that progress be made towards the control total deficit of £20m.

  As the Health Board satisfied this condition, £74.6m was issued on a recurrent basis for 2024/25 and this has been incorporated into the underlying financial position carried forward into 2024/25 (now a £178.2m deficit).

- Whilst the Health Board has secured the £82m received from Welsh Government non-recurrently in 2023/24 into 2024/25, this remains non-recurrent and is driving the underlying deficit. As such, dialogue continues to secure the £82m Strategic Support (£40m) and Performance and Transformation Funding (£42m) on a recurrent basis. This would stabilise the services currently being supported by this funding and this would further reduce the Health Board's underlying deficit financial position.

Revenue Position

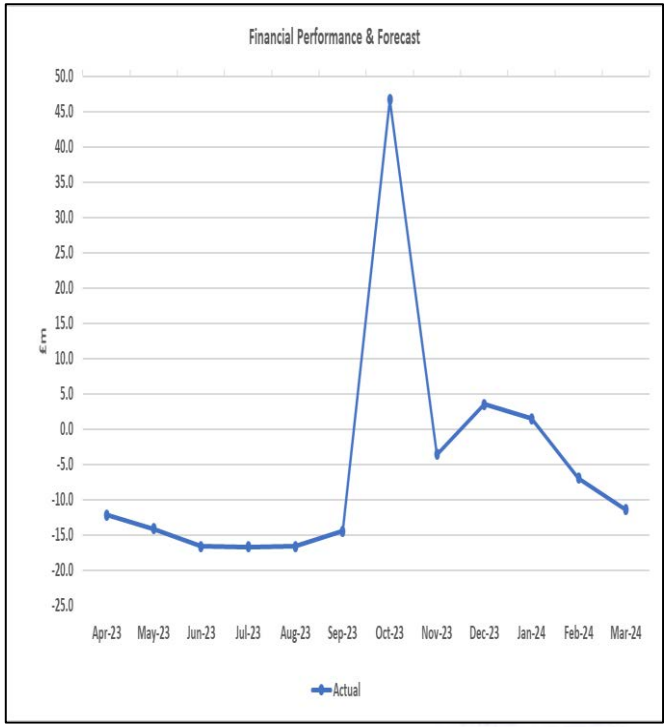
	Actual 2023-24												2023/24 Cumulative against Plan			
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Budget	Actual	Variance	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%
Revenue Resource Limit	(148.7)	(159.8)	(169.9)	(170.9)	(163.0)	(160.6)	(225.6)	(176.9)	(171.4)	(174.2)	(186.8)	(228.4)	(2,136.2)	(2,136.2)	**0.0**	0.0%
Miscellaneous Income	(12.2)	(11.9)	(13.2)	(12.3)	(12.2)	(12.3)	(13.3)	(13.4)	(13.0)	(13.6)	(14.4)	(16.6)	(149.1)	(158.5)	**-9.4**	6.3%
Health Board Pay Expenditure	81.1	85.3	102.7	96.2	88.0	86.8	91.3	86.9	86.2	89.3	84.5	125.0	1,086.0	1,103.3	**17.3**	1.6%
Non-Pay Expenditure	92.0	100.5	97.0	103.8	103.9	100.6	101.0	107.0	94.7	97.0	109.8	108.6	1,199.4	1,215.8	**16.4**	1.4%
Total Deficit / (Surplus)	**12.2**	**14.1**	**16.6**	**16.7**	**16.7**	**14.5**	**(46.6)**	**3.6**	**(3.5)**	**(1.5)**	**(7.0)**	**(11.4)**	**0.0**	**24.3**	**24.3**	
Planned Deficit	**11.2**	**11.2**	**11.2**	**11.2**	**11.2**	**11.2**	**(47.8)**	**2.8**	**2.8**	**2.8**	**2.8**	**2.7**	**33.0**	**0.0**	**33.0**	**100%**
Total Deficit / (Surplus) above Plan	**1.0**	**2.9**	**5.4**	**5.6**	**5.5**	**3.3**	**1.2**	**0.8**	**(6.3)**	**(4.3)**	**(9.7)**	**(14.1)**	**33.0**	**24.3**	**-8.7**	

- The improvement within the financial position from the Month 11 forecast deficit of £33.0m down to a £24.3m outturn deficit reported at Month 12 (subject to Audit) is predominantly due to:
  - Continuation of controls deployed throughout the Health Board for pay (establishment control and temporary workforce)
  - Implementing decisions on controlling non-pay combined with balance sheet release
  - Receipt of inflationary funding and retention of Covid slippage
  - Impact of additional controls on non-pay

- The monthly improvement on variance to plan from August 2023 reflects the overall improvement in savings performance, additional focus on cost controls implemented within the Health Board and in the months of December 2023 through to March 2024 the release of balance sheet provisions and realisation of accountancy gains.

- Controls continue, such as the Establishment Control Group (ECG), Revenue Investments Group for Assurance (RIGA) and Medical & Nursing enhanced temporary workforce controls.

- During the year, a release of the provision relating to Annual Leave, which had previously been allowable to be carried forward as a result of the Covid Pandemic, mitigated costs of applicable staff taking their accrued leave in 2023/24.



Revenue Position

- Following the Welsh Government NHS Budget review and the Health Board receiving an additional funding allocation of £101.1m in Month 7, the 2023/24 forecast outturn was revised down to a deficit of £33.0m (original deficit plan of £134.1m less the £101.1m additional allocation). The Welsh Government issued a £20.0m deficit Control Target to the Health Board.

- The Health Board received substantial resources non-recurrently, funding conditionally recurrent on moving towards the control total.

- As the Health Board has made significant progress towards delivering the £20m deficit control total, and the conditionally recurrent funding of £74.6m has been treated as recurrent in the underlying position reported in the Final Month 12 Monthly Monitoring Return.

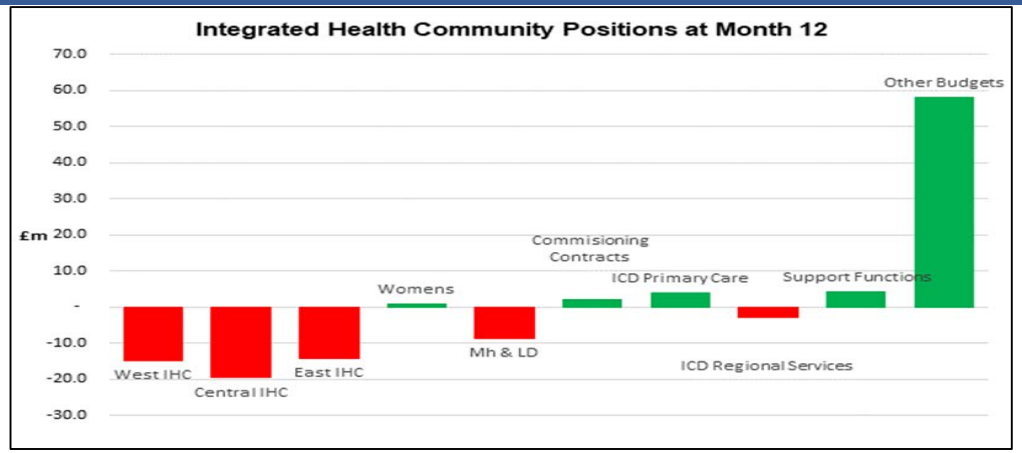
Ref	DESCRIPTION	£m's	£m's
1	**Deficit Plan**		**134.10**
2	Health Board 10% improvement		(13.41)
	Deficit Plan		120.69
3	Conditionally Recurrent Underlying deficit contribution Inflationary uplift	 (33.30) (41.30)	(74.60)
4	Non-Recurrent Inflationary uplift Energy Other	 (16.70) (9.80) 0.41	(26.09)
5	**REVISED CONTROL TOTAL**		**20.00**

A number of actions have been progressed to deliver the improvement within the financial position, from a forecast deficit of £33.0m down to a £24.3m deficit (subject to Audit) reported at Month 12:

- Recurrent Investment Group Assurance (RIGA) work commenced in early October. Phase 1 was the review of the 23/24 funded investments to assess if they were essential (i.e. unavoidable costs and patient safety), and where possible removing or reducing the investment (Three sessions 2/10, 17/10 and 1/11). The outcome of Phase 1 has been presented to and endorsed by the Executive Team and has been communicated to divisions. The Health Board moved into Phase 2 reviewing and re-prioritising the developments funded from the £42m Performance and Transformation Fund. The results have been endorsed by the Executive Team and communicated to Divisions.
- Establishment Control Group (ECG) – The EC Group meets weekly and the decisions up until end of February are now reflected in the Savings Tables. The Establishment Control Group savings are c.£2.7m reflecting decisions made up to the end of March 2024.
- Auto-cascade parameters were adjusted with no off-contract from 1/10/23 and shifts offered to on-contract agency a maximum of 7 days prior to the start of the shift. Additional controls have been put in place for Medical, Nursing & Therapies Temporary Workforce Controls.
- The Board has also endorsed control measures to undertake check and challenge on circa 70 non-pay subjective's plus an additional freeze on permanent recruitment of Band 8d & above posts for non clinical posts.
- Expenditure Control Totals were issued to Divisions in October requiring reductions in expenditure of c.2%.

Divisional Positions

	In Month				Cumulative			
	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	(208,182)	(208,182)	0	0%	(2,116,062)	(2,116,062)	0	0%
WEST INTEGRATED HEALTH COMMUNITY								
Management	1,280	114	1,166	-91%	1,273	1,107	166	-13%
West Area	16,241	16,947	(706)	-4%	196,321	200,868	(4,546)	-2%
Ysbyty Gwynedd	9,980	11,761	(1,781)	-18%	129,351	138,697	(9,346)	-7%
Facilities	910	1,260	(350)	-38%	13,537	14,627	(1,090)	-8%
Total West	28,411	30,081	(1,671)	-6%	340,482	355,298	(14,816)	-4%
CENTRAL INTEGRATED HEALTH COMMUNITY								
Management	124	43	81	-65%	1,210	1,076	134	-11%
Central Area	21,436	21,476	(40)	0%	258,023	262,373	(4,350)	-2%
Ysbyty Glan Clwyd	13,430	14,930	(1,501)	-11%	161,167	176,166	(14,999)	-9%
Facilities	1,330	1,349	(19)	-1%	16,362	16,677	(315)	-2%
Total Central	36,320	37,798	(1,478)	-4%	436,762	456,292	(19,531)	-4%
EAST INTEGRATED HEALTH COMMUNITY								
Management	738	91	647	-88%	1,042	1,055	(13)	1%
East Area	22,836	25,770	(2,935)	-13%	288,733	294,758	(6,025)	-2%
Ysbyty Wrexham Maelor	11,098	12,548	(1,450)	-13%	137,148	144,375	(7,227)	-5%
Facilities	1,181	1,252	(71)	-6%	14,483	15,459	(975)	-7%
Total East	35,853	39,661	(3,808)	-11%	441,407	455,647	(14,240)	-3%
Total Midwifery and Women's Services	4,062	3,815	246	6%	47,437	46,751	686	1%
Total Mental Health and LDS	14,685	15,629	(944)	-6%	170,620	179,331	(8,712)	-5%
Total Commisioning Contracts	26,187	25,396	791	3%	278,382	276,241	2,141	1%
INTEGRATED CLINICAL DELIVERY PRIMARY CARE								
Covid Programmes	1,832	805	1,027	56%	11,241	9,465	1,776	16%
Dental North Wales	2,794	2,495	299	11%	33,521	30,875	2,646	8%
Community Dental Services	452	535	(82)	-18%	5,576	6,377	(802)	-14%
Other Primary Care	114	(3)	117	103%	1,383	1,048	335	24%
Total Integrated Clinical Delivery Primary care	5,192	3,831	1,361	26%	51,721	47,766	3,955	8%
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES								
Provider Income	(1,852)	(1,195)	(657)	35%	(22,224)	(22,440)	215	-1%
Diagnostic and Specialist Clinical Support	6,650	6,552	98	1%	79,402	82,070	(2,668)	-3%
Cancer Services	5,391	5,641	(250)	-5%	63,879	64,256	(377)	-1%
Total Integrated Clinical Delivery	10,189	10,999	(809)	-8%	121,057	123,887	(2,830)	-2%
Total Service Support Functions	13,890	14,143	(253)	-2%	163,531	159,390	4,141	3%
Total Other Budgets	36,145	15,469	20,677	57%	97,696	39,805	57,891	59%
Total Service Support Functions and Other Bud	2,753	(11,360)	14,113		33,033	24,347	8,686	
Total	2,753	(11,360)	14,113	513%	33,033	24,347	8,686	26%



- Key movements for the cost pressure /surplus positions compared to the planned forecast deficit of £33.0m:

	In-month Cost Pressures / (Surplus) £m	Year to Date Cost Pressure/ (Surplus) £m
Pay Pressures above planned assumptions	**1.1**	12.5
Commissioning Services incl NHS & Private Providers	**(0.7)**	9.3
CHC	**1.4**	8.8
Primary Care & Secondary Care Drugs	**0.0**	8.2
Other incl the Net of Non-Pay (incorporating Control Totals) / Energy / GDS / GMS / additional other income	**(11.3)**	(7.2)
Additional Savings incl Run Rate	**(2.2)**	(10.8)
Accountancy Gains	**(1.3)**	(10.7)
Retained COVID Surplus	**(1.1)**	**(1.4)**
Total	**(14.1)**	**8.7**

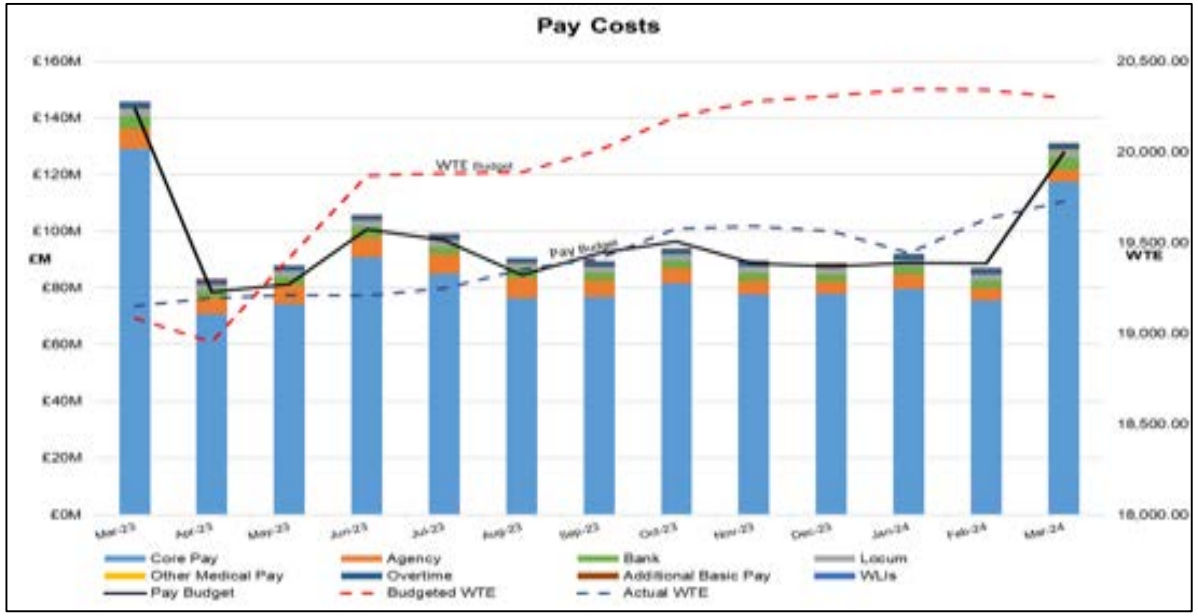
Expenditure – Pay & Non-Pay

Pay Costs	Actual 2023-24												Cumulative		
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	11.7	12.2	16.1	13.9	12.5	12.4	12.3	12.4	12.1	12.2	12.0	18.9	166.3	158.8	7.4
Medical & Dental	18.8	19.5	19.8	19.7	19.5	19.3	24.1	19.9	19.5	20.9	18.5	24.0	233.9	243.6	(9.7)
Nursing & Midwifery Registered	24.6	26.3	32.0	30.3	27.7	27.2	27.0	26.7	26.8	27.6	26.5	39.9	333.1	342.7	(9.6)
Additional Clinical Services	12.0	12.9	16.7	15.2	13.3	13.3	13.1	13.0	13.0	13.6	13.0	20.4	161.0	169.7	(8.7)
Add Prof Scientific & Technical	3.2	3.3	4.1	4.0	3.4	3.4	3.4	3.4	3.5	3.4	3.5	5.3	48.6	43.7	4.9
Allied Health Professionals	5.6	5.6	6.9	6.7	5.8	5.7	5.6	5.8	5.7	5.8	5.6	8.3	71.1	73.0	(1.9)
Healthcare Scientists	1.3	1.4	1.7	1.7	1.5	1.5	1.5	1.5	1.5	1.5	1.4	2.0	18.6	18.4	0.2
Estates & Ancillary	3.8	4.0	5.3	4.6	4.2	4.1	4.1	4.0	4.0	4.1	3.9	6.2	52.5	52.5	(0.0)
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.0	1.0	0.0
Health Board Total	**81.1**	**85.3**	**102.7**	**96.2**	**88.0**	**87.0**	**91.1**	**86.9**	**86.2**	**89.3**	**84.5**	**125.1**	**1,086.0**	**1,103.3**	**(17.3)**
Other Services (Incl. Primary Care)	2.1	2.8	3.2	3.0	2.5	2.5	2.8	2.9	2.7	2.7	2.7	5.3	26.3	35.3	(8.9)
Total Pay	**83.2**	**88.1**	**105.9**	**99.2**	**90.5**	**89.5**	**94.0**	**89.8**	**88.9**	**92.0**	**87.2**	**130.4**	**1,112.4**	**1,138.6**	**26.3**

Non-Pay Costs	Actual 2023-24												Cumulative		
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractor	18.7	18.3	18.9	19.1	18.2	19.0	18.4	19.0	20.3	19.3	23.5	20.7	233.8	233.3	0.5
Primary Care - Drugs & Appliances	9.3	10.4	11.4	11.0	12.2	10.8	10.4	10.9	9.8	10.9	11.2	12.1	122.7	130.2	(7.5)
Provider Services - Non Pay	16.0	18.4	18.4	17.1	18.8	18.7	18.9	19.8	17.2	16.7	17.9	24.4	254.3	222.5	31.8
Secondary Care - Drugs	6.5	7.6	7.9	8.1	8.4	7.7	8.1	8.3	7.4	7.6	8.2	7.1	87.7	92.9	(5.3)
Healthcare Services Provided by Other NHS Bodies	26.2	28.1	27.6	29.1	28.9	27.1	27.8	31.3	26.5	28.5	34.2	32.7	340.3	348.0	(7.8)
Continuing Care and Funded Nursing Care	10.1	10.2	10.0	12.3	11.3	10.8	10.9	11.6	10.9	8.2	9.5	9.6	126.0	125.6	0.4
Other Private & Voluntary Sector	2.1	2.1	2.2	2.4	1.6	2.1	1.5	1.6	1.4	1.4	1.7	1.4	21.5	21.5	(0.0)
Joint Financing and Other	0.2	0.1	0.3	0.3	0.3	0.2	0.2	0.3	0.3	0.2	0.2	0.3	2.7	3.1	(0.5)
Losses, Special Payments and Irrecoverable Debts	0.3	0.8	(3.6)	0.6	0.5	0.5	0.8	0.6	(2.9)	0.4	(0.3)	0.6	2.9	(1.8)	4.7
Non-pay costs	**89.5**	**96.0**	**93.1**	**100.1**	**100.3**	**97.0**	**96.9**	**103.3**	**91.0**	**93.3**	**106.1**	**108.9**	**1,191.9**	**1,175.4**	**16.4**
AME/DEL Depreciation	2.5	4.5	3.9	3.6	3.6	3.6	4.1	3.7	3.7	3.7	3.7	(0.3)	40.4	40.4	0.0
Total non-pay	**92.0**	**100.5**	**97.0**	**103.8**	**103.9**	**100.6**	**101.0**	**107.0**	**94.7**	**97.0**	**109.8**	**108.6**	**1,232.3**	**1,215.8**	**16.4**

- **Provided Services Pay:** Expenditure is £40.5m (48.0%) higher than previous month. £42.2m of the movement relates to the 6.3% employers' superannuation year end adjustment fully funded by WG.
- Agency expenditure remains in line with previous month; however overtime has increased by £0.2m.
- **Non-Pay Expenditure (excluding Depreciation)**: Month 12 total Non Pay expenditure has increased by £2.8m from previous month, of which Provider Services Non Pay is reporting an increase of £6.5m, this being predominantly due to £6.1m Local Authority payments, of which £1.4m was additional RIF (Regional Integrated Fund) Funding in M12.
- Further detail on Non-Pay expenditure movements are reported on Slide 11.

Expenditure – Pay



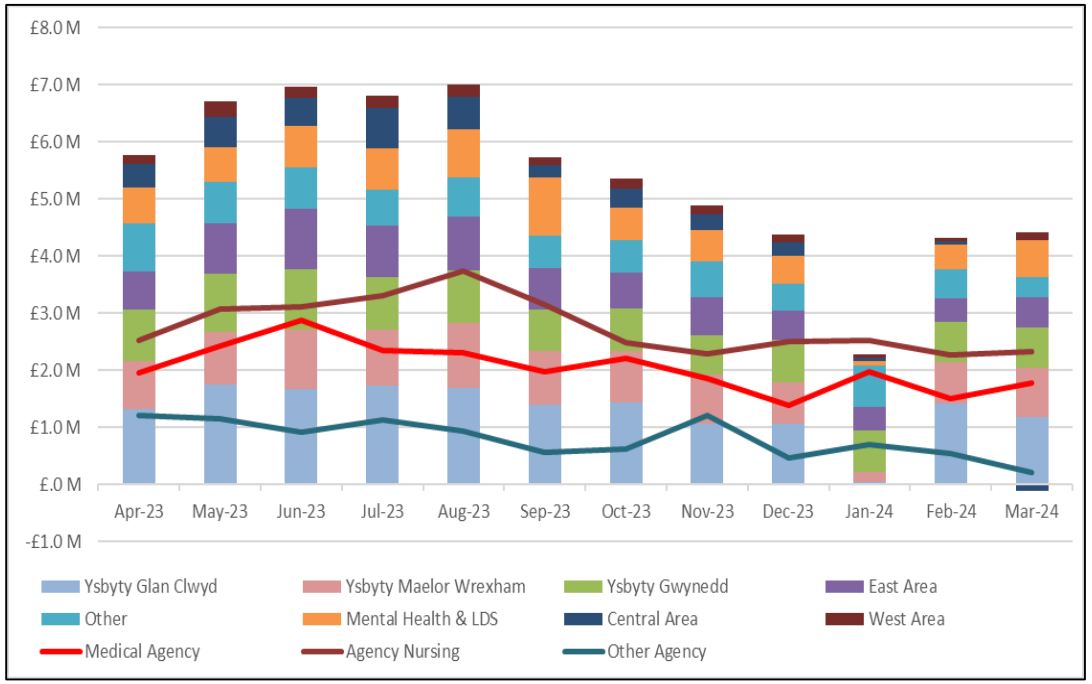
	2023-24											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Budgeted WTE	18,952	19,415	19,869	19,883	19,887	20,009	20,194	20,277	20,309	20,345	20,340	20,298
Actual WTE	19,193	19,211	19,206	19,248	19,350	19,413	19,575	19,589	19,563	19,442	19,630	19,728

Variable Pay	Actual 2023-24												Total
	M01	M02	M03	M04	M05	M06	M07	M08	M9	M10	M11	M12	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Agency	5.8	6.7	7.0	6.8	7.0	5.7	5.4	4.9	4.4	5.2	4.3	4.3	67.5
Overtime	1.1	1.2	1.1	1.3	1.1	1.2	1.3	1.3	1.1	1.4	1.5	1.7	15.4
Locum	2.2	2.4	2.6	2.6	2.3	2.0	2.0	2.4	2.3	2.4	2.2	2.6	27.8
WLIs	0.4	0.4	0.5	0.6	0.5	0.5	0.4	0.4	0.4	0.4	0.4	0.4	5.4
Bank	2.3	2.7	3.6	2.6	2.8	2.8	2.9	2.6	2.6	2.8	2.8	4.3	34.7
Other Non Core	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.7
Additional Hours	0.4	0.4	0.3	0.4	0.3	0.3	0.3	0.4	0.4	0.3	0.4	0.4	4.2
Total	**12.4**	**13.8**	**15.2**	**14.2**	**14.1**	**12.6**	**12.5**	**12.1**	**11.1**	**12.5**	**11.6**	**13.8**	**155.8**

- Actual worked in March is 19,728 WTE, an increase of 98 WTE from previous month.
- Pay expenditure has increased by £40.5m in March, of which £42.2m is the 6.3% employers' superannuation year end adjustment fully funded by WG.
- Provisions relating to Annual Leave (£8.9m) and Study Leave (£0.5m) were released into the outturn position (£3.5m of Annual Leave provision had been released in February and a further £3.5m had been estimated for March, thus the final release was 1.9m higher than estimated). This release covers additional backfill expenditure for applicable staff due to the accrued leave being taken.
- Variable Pay has increased by £2.3m in Month 12. Agency remains in line with previous month. Bank has increased by £1.5m and overtime has also increased by £0.2m. The increase in March Bank expenditure is distorted by the impact of the 6.3% year end superannuation adjustment.

Pay Costs – Agency

	23-24 Actual												Total Year to Date
	M01 £000	M02 £000	M03 £000	M04 £000	M05 £000	M06 £000	M07 £000	M08 £000	M09 £000	M10 £000	M11 £000	M12 £000	
West Area	148	281	202	206	217	139	190	155	138	92	60	169	**1,995**
Central Area	416	527	483	718	568	208	314	270	225	318	59	(102)	**4,005**
East Area	676	879	1069	899	939	709	637	665	506	569	412	541	**8,502**
Ysbyty Gwynedd	884	1024	1057	934	921	742	734	692	735	770	720	681	**9,894**
Ysbyty Glan Clwyd	1323	1757	1677	1736	1,697	1,408	1,441	1,073	1,068	1,372	1,417	1,179	**17,147**
Ysbyty Maelor Wrexham	851	922	1038	973	1,140	926	909	849	729	851	724	868	**10,779**
Mental Health & LDS	629	602	729	722	851	1,026	583	549	489	492	446	647	**7,765**
Womens	226	130	126	111	133	127	126	112	128	165	41	62	**1,486**
Other incl pan BCU Cancer Servcies and Corporate	619	600	592	512	549	452	430	528	359	572	452	281	**5,945**
Total Agency	**5,771**	**6,721**	**6,972**	**6,811**	**7,015**	**5,737**	**5,365**	**4,893**	**4,376**	**5,201**	**4,331**	**4,324**	**67,518**



- Month 12 Agency expenditure is £4.3m, representing 3.3% of total pay. Month 12 expenditure is in line with previous month spend. Total 2023/24 Agency expenditure is £67.5m, which is £0.5m less than the Agency forecast outturn of £68.0m at Month 11 and £5.2m less than the £72.7m Agency expenditure reported in 2022/23.

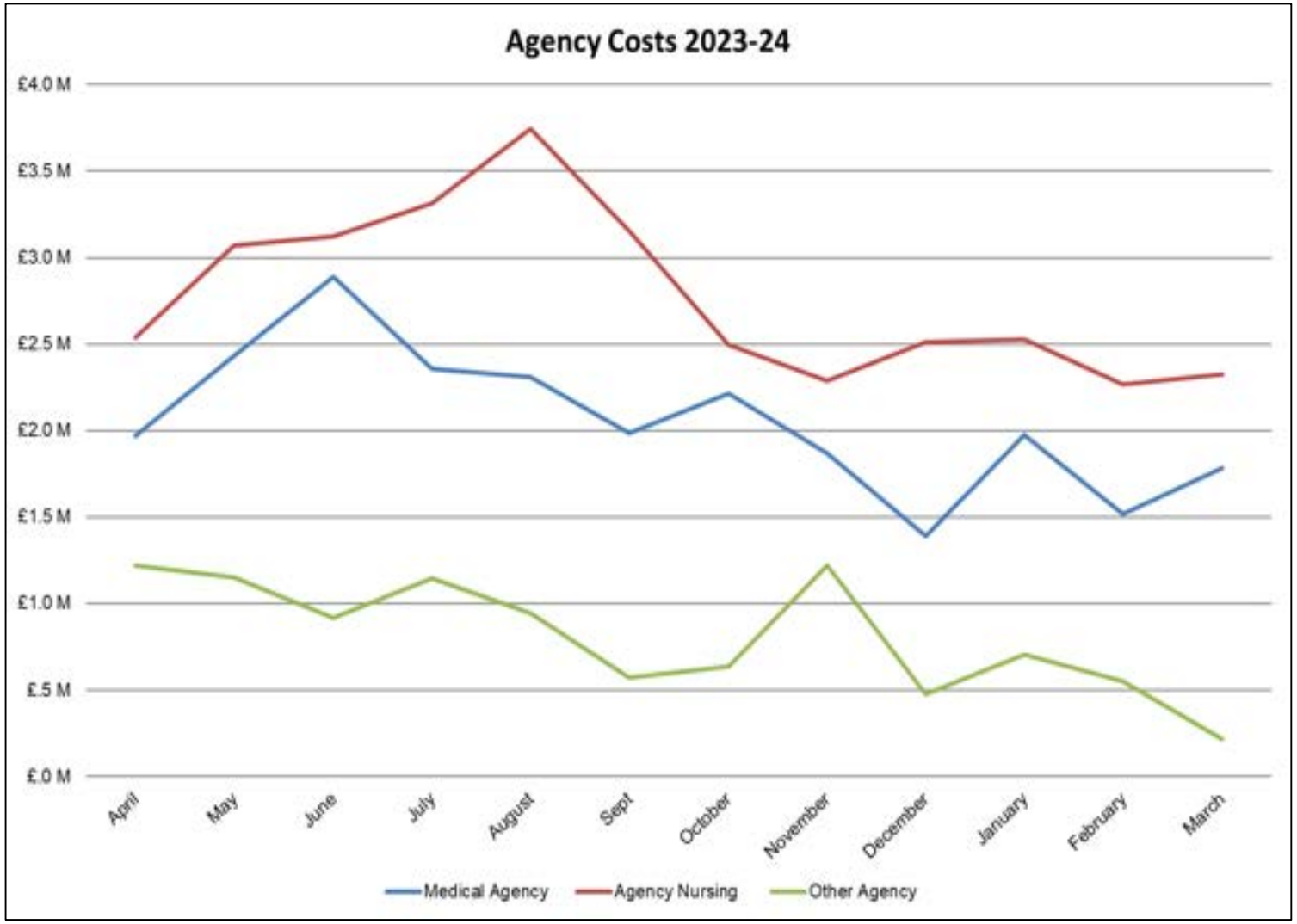
- Month 12 Medical Agency expenditure is £1.8m, an increase of £0.3m from previous month. The increase is mainly reported against Mental Health (£0.4m), East Area (£0.1m), West Area (£0.1m) and Cancer Services (£0.1m). Medical Agency is primarily used to cover vacancies. The main areas of Month 12 Medical Agency spend are Mental Health (£0.5m), Ysbyty Glan Clwyd (£0.4m), Ysbyty Gwynedd (£0.3m), East Area (£0.2m), Ysbyty Maelor Wrexham (£0.1m) and West Area (£0.1m).

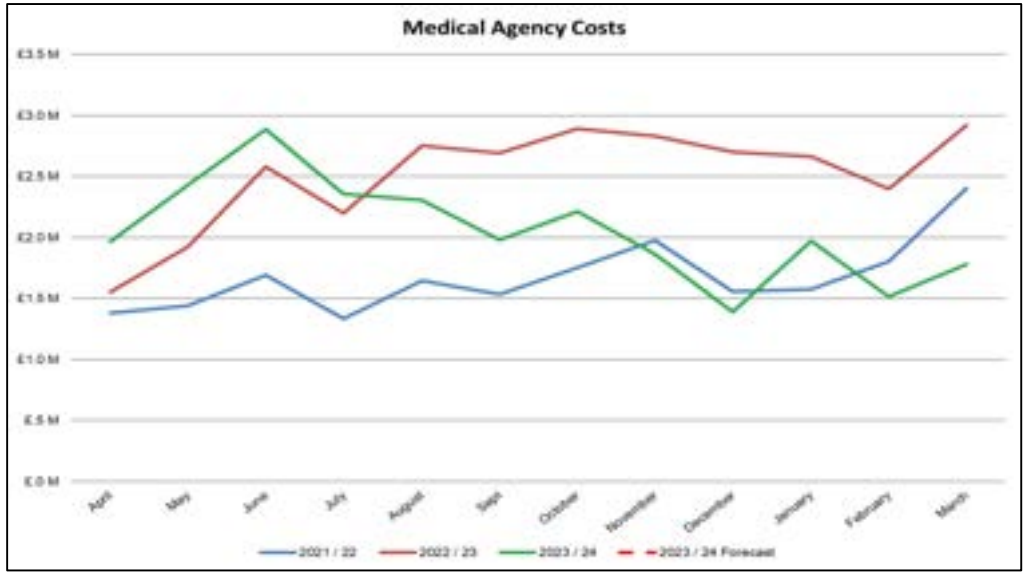
- Nurse agency costs totalled £2.3m for the month, and is in line with previous month expenditure. Agency Nursing continues to support the sustained pressures arising from unscheduled care and provides cover for a large number of vacancies in Secondary Care to ensure the Nurse Staffing Act Ward staffing levels are maintained. The use of agency nurses is particularly an issue for Ysbyty Glan Clwyd (£0.7m in month), Ysbyty Maelor Wrexham (£0.7m), Ysbyty Gwynedd (£0.4m), Mental Health (£0.2m) and East Area (£0.2m), which together account for 93.5% of March expenditure.

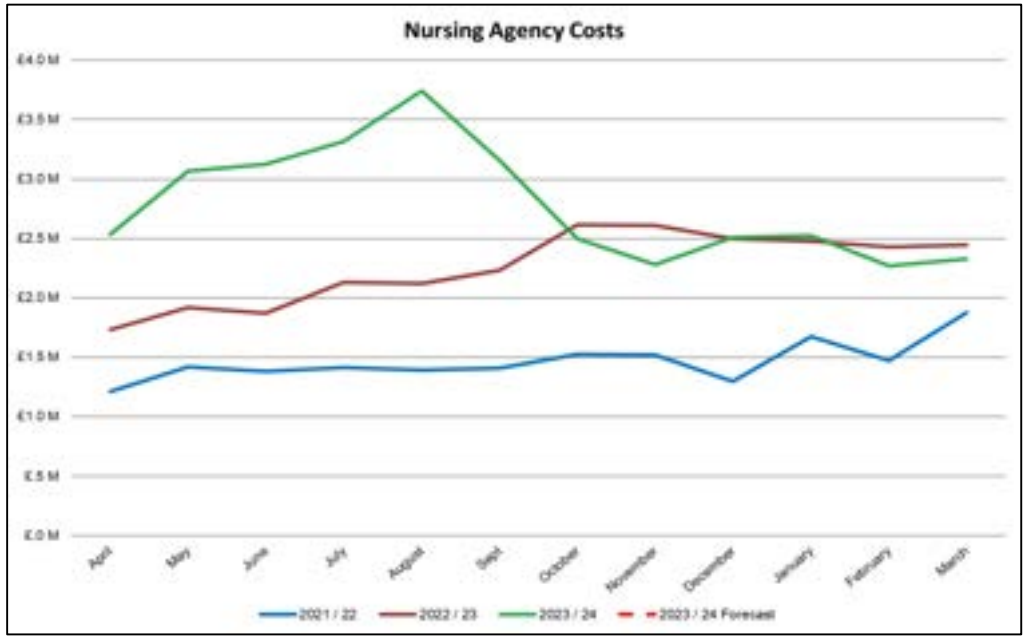
- Other agency costs totalled £0.2m in Month 12, a decrease of £0.3m from Month 11. Other Agency costs mainly consists of £0.2m Allied Health Professionals Agency expenditure.

Pay Costs – Agency

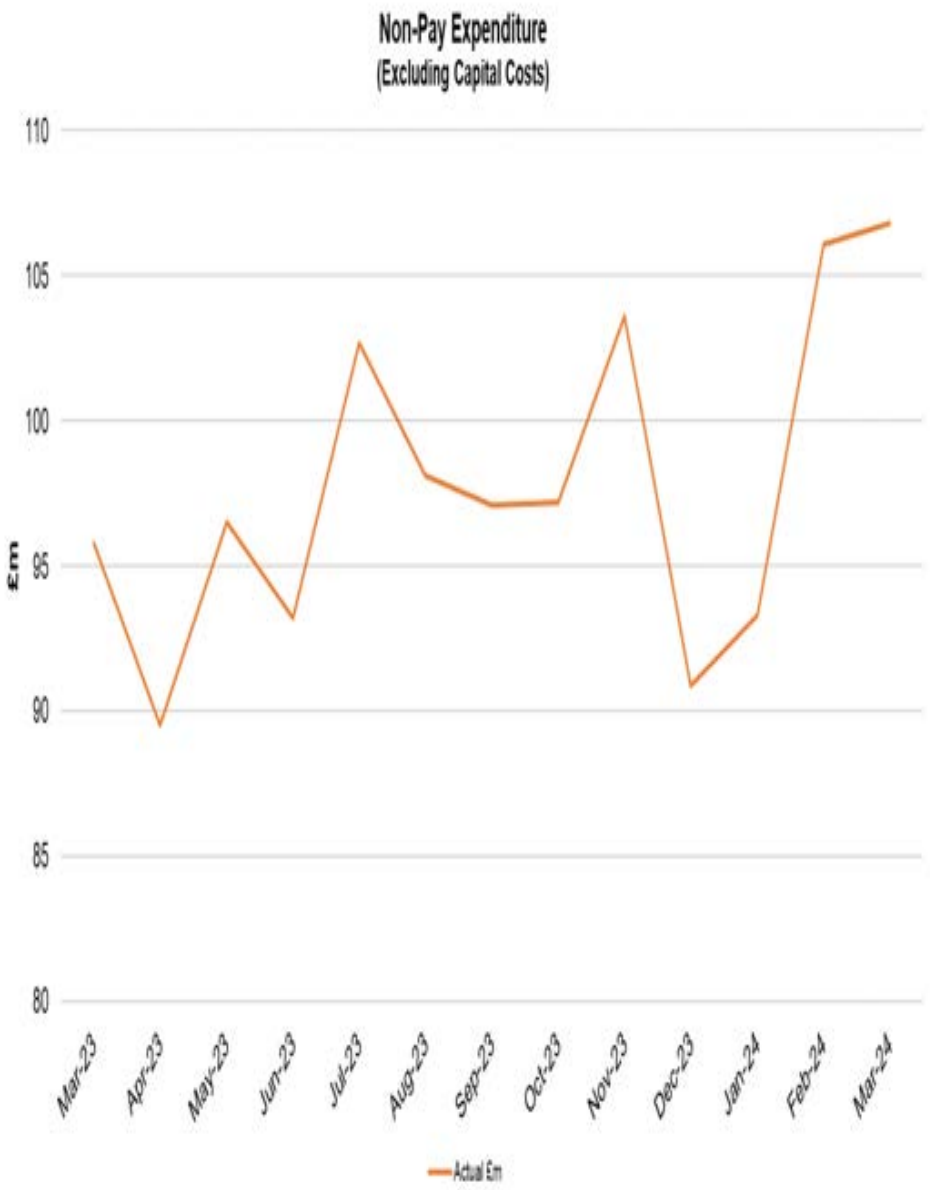
- The below graphs shows movements in both Medical & Agency Nursing costs.







Expenditure - Non Pay



- **Primary Care Contractor:** In-month expenditure is £2.8m (11.8%) less than previous month. February expenditure included the impact of the £4.4m 23/24 Global Sum Uplift. In comparing M12 expenditure against previous months average, the increase is £1.6m, of which £1.0m is the 6.3% employers' superannuation year end adjustment and £0.6m GPOOH adjustment. Cost pressures remain within Managed Practice operating expenses/Locum GP costs and cost of drugs and fees reported through GMS Dispensing. Also, Enhanced Services included some backdated claims in Month 12.

- **Primary Care Drugs:** Expenditure is £0.9m (8.1%) higher than previous month. March estimate is based on the on the HSW (Prescribing Shared Services) year-end forecast estimate for 2023-24 as this was considered the most prudent option due to the inclusion of the Easter break at the end of March. BCU's position compared to HBs across Wales shows a price growth of 6.35% against the National Welsh average of 6.21% (last month 7.11% against National Welsh average 6.86%).

- **Secondary Care Drugs:** Expenditure is £1.0m (12.8%) less than previous month, with the movement primarily being due to the £0.8m year end stock adjustment for the Pharmacy top up system.

- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £1.5m (4.3%) less than previous month, however Month 11 actual was impacted by £4.7m additional funding for Vertex, ATMP and ARRP. In comparison to previous months monthly average, the increase is £4.0m, of which £2.8m is Quarter 4 Vertex, £0.6m Genomics Programme and £0.2m WHSCC additional funding for ATMP's.

- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure is £0.1m (0.8%) higher than previous month. Following review and resolution of individual care package costs, there has been a further £1.3m Accountancy Gain in Month 12, which has been offset by CHC acuity increases.

- **Losses, Special Payments and Irrecoverable Debts:** Expenditure is £0.9m higher than previous month, thus being partly due to the £0.7m reduction reported in Month 11 following review and reduction in the provision for defence fees, clinical negligence and personal injury claims. In addition, there has also been a £0.3m bad debt provision adjustment in Month 12.

Allocations

Description	£m
Total Allocations Received	2,136.2
Total Allocations Anticipated	0
Total Welsh Government Income	**2,136.2**

COVID -19 Funding	£m
Total 23/24 COVID-19 Forecast Expenditure	14.2
Received	14.2
Anticipated	0

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). All allocations have been received. Total 2023/24 allocations received is £2,116.6m.

- Total 23/24 COVID-19 funding allocation received is £14.2m, leaving a £1.4m surplus. Welsh Government provided confirmation to NHS Wales that slippage could be retained and managed. The Health Board has recorded this slippage as an improvement in the forecast outturn, it has not been utilised to maintain the orginal planned deficit.

Impact of COVID-19

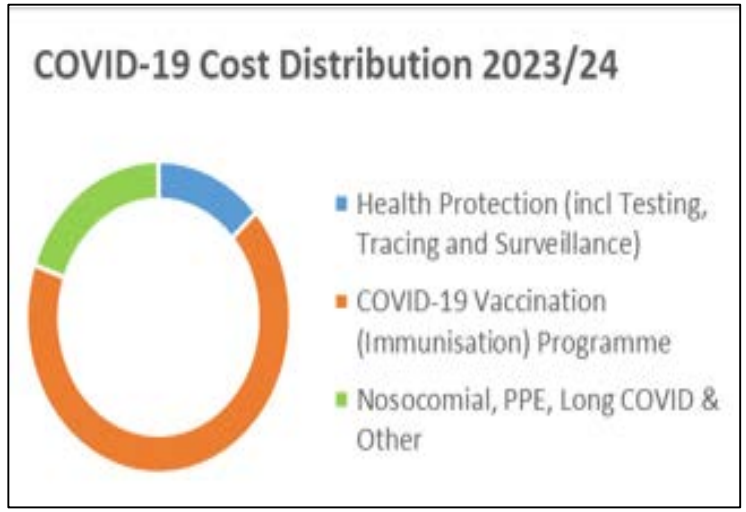
- Total 2023/24 COVID expenditure is £12.8m, which is therefore reporting a slippage of £1.4m against the £14.2m COVID-19 funding allocation. This slippage is £0.8m higher than the projected surplus of £0.6m reported at Month 11. Welsh Government provided confirmation to NHS Wales that slippage could be retained and managed. The Health Board has recorded this slippage as an improvement in the forecast outturn, it has not been utilised to support the orginal planned deficit.

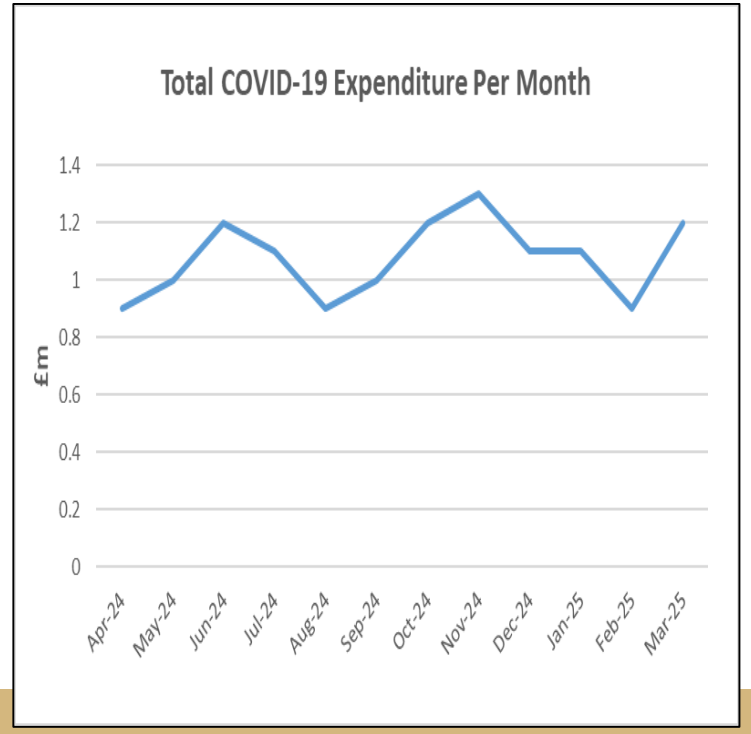
- Month 12 COVID-19 expenditure for WG funded programmes is £1.2m, an increase of £0.3m from previous month expenditure. This includes the translation of the Test, Trace and Protect Service to a new Health Protection Service, together with Mass Vaccination, PPE and Long Covid.

- Total 2023/24 Health Protection expenditure is £1.7m, which is £0.2m less than the funding allocation received.

- Total 2023/24 Mass Vaccination expenditure is £8.6m, which is £0.8m less than the £9.4m funding allocation received. This is due to less staffing costs in Mass Vaccination due to both delays in recruitment, and the impact of reduced levels of Mass Vaccination funding for 2024-25.

- Total 2023/24 PPE, Nosocomial and Long COVID expenditure is £2.5m, which is £0.4m less than the funding allocation received.





	Month 12 £m	Year to Date Expenditure £m
Health Protection (incl Testing, Tracing and Surveillance)	0.2	1.7
COVID-19 Vaccination (Immunisation) Programme	0.7	8.6
Nosocomial, PPE, Long COVID & Other	0.3	2.5
Total COVID-19 Expenditure	**1.2**	**12.8**
Welsh Gov COVID-19 Income	2.2	14.2
Impact of COVID-19 on Position	**(1.0)**	**(1.4)**

Balance Sheet

Non-Current Assets	Opening Balance Beginning of Apr-23 £'m	Closing Balance End of Mar-24 £'m	Forecast Closing Balance End of Mar-24 £'m
Property, plant and equipment	707.9	724.0	724.0
Intangible assets	1.5	1.2	1.2
Trade and other receivables	78.9	84.6	84.6
Non-Current Assets sub total	**788.3**	**809.7**	**809.7**
Current Assets			
Inventories	20.3	20.9	20.9
Trade and other receivables	77.4	107.7	107.7
Cash and cash equivalents	2.9	5.0	5.0
Non-current assets classified as held for sale	0.0	0.4	0.4
Current Assets sub total	**100.6**	**134.0**	**134.0**
TOTAL ASSETS	**888.9**	**943.7**	**943.7**
Current Liabilities			
Trade and other payables	237.8	209.6	209.6
Provisions	34.3	47.1	47.1
Current Liabilities sub total	**272.1**	**256.7**	**256.7**
NET ASSETS LESS CURRENT LIABILITIES	**616.8**	**687.1**	**687.1**
Non-Current Liabilities			
Trade and other payables	28.0	27.5	27.5
Provisions	76.7	85.9	85.9
Non-Current Liabilities sub total	**104.7**	**113.4**	**113.4**
TOTAL ASSETS EMPLOYED	**512.1**	**573.7**	**573.7**
FINANCED BY:			
Taxpayers' Equity			
General Fund	304.4	353.6	353.6
Revaluation Reserve	207.7	220.1	220.1
Total Taxpayers' Equity	**512.1**	**573.7**	**573.7**

Cash Flow Forecast

- The closing cash balance at 31st March 2024 was £5.027m, which included £2,574m cash held for revenue expenditure and £2.453m for capital projects.
- Revenue Strategic Cash Support was secured from Welsh Government of £27.0m
- Revenue and Capital Working Balance Cash Support of £41.5m and £0.2m respectively was received from Welsh Government.
- IFRS 16 Movement in Working Balances Cash support of £4.8m for Right of Use assets was also received.
-

Capital Expenditure for 2023/24

BUDGET 23/24

1) Capital Resource Limit 2023/24	**£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	11.899	
All Wales Scheme	18.121	
Total CRL	**30.02**	

CAPITAL PROGRAMME 23/24	**Initial Programme taking into account 25% reduction (£m)**	**Year to Date (£m)**	**Forecast Outturn (£m)**	**Current Over/Under Commitment (£m)**	**Comments**
Divisions	5.187	6.687	6.921	-1.521	Programme adjusted to support key priorities and ensure delivery with in planned funding and includes expenditure that relates to brokerage
Operational Estates	1.765	1.947	1.947	-0.182	Over commitment managed within programme
Medical Devices	2.306	2.872	2.851	-0.545	Over commitment managed within programme
Informatics	2.262	1.261	1.261	1.001	Under commitment to be managed within programme
All wales funding brokerage to be re-provided from discretionary	0.379	0.000	0.000	0.379	Brokerage managed within the programme
WG Discretionary Capital	**11.899**	**12.767**	**12.980**	**-0.868**	**Over commitment**

MAJOR CAPITAL SCHEMES (with in year spend)	**Programme (£m)**	**Year to Date (£m)**	**Forecast Outturn (£m)**	**Current Over/Under Commitment (£m)**	**Comments**
AOPMH YGC	1.688	2.035	2.035	-0.347	The scheme is currently in design and fees was due this financial year.
Efab	4.324	3.866	3.866	0.458	A number of schemes were delayed, the underspend will be reprovided through discretionary in the next financial year.
Nuclear Medicine	0.373	0.432	0.432	-0.059	The scheme is currently in design and fees was due this financial year.
Conwy West - Health & Well Being Hub	0.100	0.006	0.006	0.094	The scheme is in its initial stages and will continue into 2024/25. Underspend will be reprovided through discretionary in the next financial year.
Orthopaedic Hub at Llandudno	2.466	2.246	2.246	0.220	The works commenced with some delays reflected in the underspend. The funding will be reprovided in 2024/25.
Ambulance Shoreline	0.071	0.062	0.062	0.009	Works complete.
RISP	0.317	0.342	0.342	-0.025	Complete
Substance Misuse Building, Llandudno	0.154	0.157	0.157	-0.003	The scheme is in its initial stages and will continue into 2024/25.
Teledermoscopy Project	0.094	0.062	0.062	0.032	Complete
5 Glidescopes - Transfer NWSSP	0.056	0.056	0.056	0.000	Complete
Cyber Security	1.219	1.219	1.219	0.000	Complete
Emergency Department and Minor Injury Unit Improvements	0.523	0.321	0.321	0.202	Majority of works complete. Underspend will be reprovided in 2024/25.
Diagnostic Equipment	2.528	2.544	2.544	-0.016	Complete
Increased Electrical Infrastructure Capacity Fees, Ysbyty Glan Clwyd	0.321	0.196	0.196	0.125	The project is commencing in 2024/25, current design in progress. Underspend will be reprovided in 2024/25.
DPIF - WNCR Paediatrics	0.034	0.029	0.029	0.005	Complete
Digital Year End Funding - January 2024	0.427	0.427	0.427	0.000	Complete
Digital Year End Funding - February 2024	1.387	1.254	1.254	0.133	Complete. Underspend due to delay with supplier.
Year End Funding - February 2024	0.395	0.358	0.358	0.037	Complete
Diagnostic Equipment - February 2024	1.205	1.036	1.036	0.169	Project complete, however delay with supplier in regards to equipment that will only be delivered in 2024/25. Funding to be reprovided.
Year End Funding - January 2024	0.439	0.411	0.411	0.028	Complete
All Wales Capital	**18.121**	**17.059**	**17.059**	**1.062**	**Under commitment**

Total Capital Funding Available	**30.020**	**29.826**	**30.039**	**0.194**	

Savings Executive Summary

Savings Plans compared to Target

		Full Year Plan				
	Target £000	Green £000	Red £000	Pipeline £000	Total £000	Variance Green v Target £000
Recurring	25,200	18,564	-	-	18,564	(6,636)
Non Recurring		7,158	-	-	7,158	7,158
Total	**25,200**	**25,722**	**-**	**-**	**25,722**	**522**

Year to date delivery performance against target

	Target	Plan	Actual	Var to Target	Var to Plan
Recurring	25,200	18,564	21,220	(3,980)	2,657
Non Recurring		7,158	11,363	11,363	4,205
Budget Reducing Savings	**25,200**	**25,722**	**32,583**	**7,383**	**6,861**

Delivery performance against target

	Target	Plan	Actual	Var to Target	Var to Plan
Recurring	25,200	18,564	21,220	(3,980)	2,657
Non Recurring		7,158	11,363	11,363	4,205
Budget Reducing Savings	**25,200**	**25,722**	**32,583**	**7,383**	**6,861**

Additional run rate savings

£3.4m run rate savings

£36.0m total budget adjusting and run rate savings

Slide – 'Run Rate Savings Summary' provides detail

- The Health Board's Financial Plan for 2023-24, requires delivery of recurring, budget adjusting savings of **£25.2m.** An additional £5.7m 'stretch' is included in the full year cash savings target of £30.9m.
- The full year plan value of Green schemes totals **£25.7m**. The delivery against Green Savings totals **£32.6m**. Of these savings £21.2m is identified as recurring, with a full year effect of £23.7m. Run Rate (in year mitigation) Schemes total **£3.4m**, bringing the total savings to **£36.0m**
- Red risk and Pipeline schemes have been reviewed and either converted to green schemes or form part of the 24/25 opportunities pipeline.

Savings Plans against Targets

Savings Scheme Pipeline	Green		Green (Proc)		Green		
	R	NR	R	NR	Total	Target	Variance Green to Target
Centre	3,424	75	141	45	3,685	**7,950**	46%
East	4,393	420	154	50	5,017	**8,070**	62%
West	3,485	1,093	110	31	4,720	**6,046**	78%
MHLD	3,355	0	5	8	3,368	**3,267**	103%
Womens	915	10	5	4	935	**915**	102%
Cancer	1,537	6	4	7	1,554	**755**	206%
Diagnostics	108	37	341	25	511	**1,015**	50%
Corporate	374	2,692	83	2,648	5,798	**2,495**	232%
Primary Care	114		15	4	133	**154**	86%
Provider Income					0	**267**	0%
Procurement (VAT)					0	**-5,734**	
Budget Reducing Savings	**17,705**	**4,335**	**858**	**2,823**	**25,722**	**25,200**	**102%**

- At Month 12, the full year Plan value of Green schemes totals £25.7m, no change from the previous month.
- The recurring green scheme plans are £18.6m, being a £6.6m gap on the requirement of £25.2m.
- The cancer schemes have a £60K investment necessary to enable the savings to be delivered, which is not reflected in the table above.

Savings Delivery Against Target

Target

- Financial Plan requires £25.2m savings
- Additional 'stretch target' of £5.7m allocated to IHC's/Services
- Target flat phased £2.1m per month

	YTD M12			
IHC / Service Plans	Target £000	Plan* £000	Actual £000	Variance to Plan
Recurring	25,200	18,564	21,220	2,657
Non Recurring		7,158	11,363	4,205
Budget Reducing Savings	**25,200**	**25,722**	**32,583**	**6,861**

Delivered Savings

- Actual (budget releasing) savings total £32.6m, of which £21.2m is recurring, against a £25.7m plan and £25.2m Target.
- The favourable variance of actual savings to Plan totals £6.9m. This includes:
  - Procurement — £3.41m - mainly relating to non recurring contract savings
  - Apixaban Off Patent savings in Primary Care Prescribing — £0.79m
  - IHC Central CHC Programme — £0.57m
  - IHC Central IHC Bio-similar (AMD) — £0.48m
  - IHC Central Primary Care Reviews (Polypharmacy & switches) — £0.46m
  - IHC West Primary Care Reviews (Polypharmacy & switches) — £0.28m
  - IHC West CHC Programme — £0.25m
  - IHC Central Dressings — £0.22m
  - IHC East Primary Care Agency — £0.21m
  - IHC West – Pay Grip And Control — (£0.16m)
  - Womens Birth Choices scheme delayed as previously reported — (£0.25m)
  - MHLD Out of Area Placements — (£0.30m)

Figures relate to Green schemes. There are no Amber schemes. A detailed variance analysis is provided in 'Green Scheme Details' slides 1 & 2.

In Month

- Savings delivered in Month totalled **£3.6m**, of which £2.3m recurring, against a £1.9m Plan and £2.1m Target

Summary by Category

Full Year Plan (Green Schemes)

Full Year Plan by MMR Category	West Integrated Health Community £000	Central Integrated Health Community £000	East Integrated Health Community £000	MHLD £000	Womens Services £000	Diagnostic and Specialist Clinical Support £000	Cancer Services £000	Primary Care £000	Corporate £000	Total £000
Agency - Reduced usage of Agency/Locums paid at a premium	630	509	1,618	147	488					3,392
CHC and Funded Nursing Care	1,546	855	880	1,924						5,205
Commissioned Services	79			300	255					634
Medicines Management (Primary & Secondary Care)	1,237	1,678	1,702	322			1,537			6,476
Non Pay - Procurement	141	186	204	13	9	366	11	19	2,732	3,681
Non Pay - Other	282	190	401	20	183	145	6	5	3,020	4,252
Pay	804	267	213	642				109	46	2,081
Grand Total	**4,720**	**3,685**	**5,017**	**3,368**	**935**	**511**	**1,554**	**133**	**5,798**	**25,722**

Full Year Delivery (Green Schemes)

Full Year Forecast by MMR Category	West Integrated Health Community £000	Central Integrated Health Community £000	East Integrated Health Community £000	MHLD £000	Womens Services £000	Diagnostic and Specialist Clinical Support £000	Cancer Services £000	Primary Care £000	Corporate £000	Total £000
Agency - Reduced usage of Agency/Locums paid at a premium	378	509	1,929	147	488					3,450
CHC and Funded Nursing Care	1,918	1,428	1,037	1,924						6,306
Commissioned Services	87			0	0					87
Medicines Management (Primary & Secondary Care)	1,861	3,121	2,107	342			1,914			9,345
Non Pay - Procurement	53	83	68	8	12	303	3	2	6,556	7,088
Non Pay - Other	237	187	362	0	183	147	6	5	3,020	4,147
Pay	882	267	213	642				109	46	2,159
Grand Total	**5,416**	**5,594**	**5,715**	**3,063**	**683**	**450**	**1,923**	**116**	**9,622**	**32,583**

Run Rate Savings Summary

- Run rate expenditure reductions are not budget adjusting. These mitigate the additional in year cost pressures reported above the planned deficit and include actions such as the Enhanced Control Review measures.
- At Month 12 the total full year value is £3.4m, and includes a value of £2.7m for the impact of Establishment control decisions.
- Savings Delivery, combining budget releasing and non-budget releasing actions, totals £36m.
- Savings Delivery plus Accountancy Gains, totals £46.8m

Run Rate Savings	Actual Year to Date			Full Year Forecast				
£'000	Recurring	Non-Recurring	Total	Recurring	Non-Recurring	Total	Savings Plans plus Run Rate Savings plus Income	Savings Plans plus Run Rate Savings plus Accountancy Gains
ECR related 'Run Rate' savings	-	2,674	2,674	-	2,674	2,674		
Other local 'Run Rate' savings	708	20	728	708	20	728		
Cost Avoidance (non-cash)	-	-	-	-	43	43		
Total	**708**	**2,695**	**3,403**	**708**	**2,738**	**3,446**	**36,029**	**46,756**

Accountancy Gains (revised assessment of previous year provisions and accruals in the Balance Sheet) totalling £1.3m were reported at Month 12, bringing the total annual release to **£10.7m.** These mainly related to CHC Care Packages £5.3m and Medicines Management £4.5m.

Green Schemes Details (1/2)

			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 - Centre	Accommodation Rental Increase	R	14,833	12,361	-2,472	14,833	12,361	-2,472
HC - Centre	Apixaban Off Patent savings in Primary Care Prescribing	R	701,436	986,267	284,831	701,436	986,267	284,831
HC - Centre	B Braun Giving Sets Credit	NR	75,224	75,224	0	75,224	75,224	0
HC - Centre	CHC	R	855,000	1,427,813	572,813	855,000	1,427,813	572,813
HC - Centre	Dressings	R	90,000	310,417	220,417	90,000	310,417	220,417
HC - Centre	Medical Agency	R	508,950	508,950	0	508,950	508,950	0
HC - Centre	NWSSP Drug Contract implementation	R	180,208	170,941	-9,267	180,208	170,941	-9,267
HC - Centre	Polypharmacy Reviews	R	406,850	867,399	460,549	406,850	867,399	460,549
HC - Centre	Primary & Community Non Pay Efficiencies	R	99,743	99,743	0	99,743	99,743	0
HC - Centre	Primary & Community Pay Efficiencies	R	107,907	107,907	0	107,907	107,907	0
HC - Centre	Secondary Care Drugs (AMD Biosimilars)	R	300,000	785,568	485,568	300,000	785,568	485,568
HC - Centre	Therapies Pay Efficiencies	R	158,916	158,916	0	158,916	158,916	0
HC - East	Accommodation Rental Increase	R	18,900	18,900	0	18,900	18,900	0
HC - East	Agency Medical reduction ED	R	480,000	408,735	-71,265	480,000	408,735	-71,265
HC - East	Agency Medical Reduction Medicine YMW	R	150,000	158,557	8,557	150,000	158,557	8,557
HC - East	Agency Medical Reduction Surgery	NR	166,000	267,804	101,804	166,000	267,804	101,804
HC - East	Apixaban Off Patent savings in Primary Care Prescribing	R	853,224	1,173,294	320,070	853,224	1,173,294	320,070
HC - East	B Braun Giving Sets Credit	NR	74,362	74,362	0	74,362	74,362	0
HC - East	CHC Cost containment	R	600,000	600,797	797	600,000	600,797	797
HC - East	CHC Management & Trigger Tool	NR	180,000	242,817	62,817	180,000	242,817	62,817
HC - East	Childrens	R	100,000	193,446	93,446	100,000	193,446	93,446
HC - East	Dietetics non pay efficiencies	R	21,553	21,553	0	21,553	21,553	0
HC - East	ENT Disposable Scopes	R	200,000	161,003	-38,997	200,000	161,003	-38,997
HC - East	Medical Agency Reduction - Community Services	R	383,486	385,476	1,990	383,486	385,476	1,990
HC - East	Medical Agency Reduction - Primary Care - Managed Practices	R	300,000	513,351	213,351	300,000	513,351	213,351
HC - East	Medical Staffing - Agency reduction Childrens Services	R	138,039	194,602	56,563	138,039	194,602	56,563
HC - East	NWSSP Drug Contract implementation	R	83,434	122,952	39,518	83,434	122,952	39,518
HC - East	OT Non Pay efficiencies	R	4,013	4,013	0	4,013	4,013	0
HC - East	OT Pay 0.5wte Band 6	R	26,468	26,468	0	26,468	26,468	0
HC - East	Physio non pay efficiencies	R	64,484	64,484	0	64,484	64,484	0
HC - East	Podiatry Pay 1 wte Band 3	R	24,379	24,379	0	24,379	24,379	0
HC - East	Polypharmacy Review (previously GP Prescribing)	R	489,850	615,132	125,282	489,850	615,132	125,282
HC - East	Reduced costs at managed practices	R	162,573	162,573	0	162,573	162,573	0
HC - East	Secondary Care Drugs (AMD Biosimilars)	R	275,000	195,573	-79,427	275,000	195,573	-79,427
HC - East	Speech and Language non pay efficiencies	R	17,391	17,391	0	17,391	17,391	0
HC - West	Accommodation Rental Increase	R	17,418	20,277	2,859	17,418	20,277	2,859
HC - West	Apixaban Off Patent savings in Primary Care Prescribing	R	466,782	655,721	188,939	466,782	655,721	188,939
HC - West	B Braun Giving Sets Credit	NR	71,077	71,077	0	71,077	71,077	0
HC - West	BAU: Grip and control measures - pay	R	607,500	447,000	-160,500	607,500	447,000	-160,500
HC - West	Children Special Cases Review	R	150,000	159,802	9,802	150,000	159,802	9,802
HC - West	Continence Products - usage review within community	R	50,000	0	-50,000	50,000	0	-50,000
HC - West	Continuing Healthcare	R	996,320	1,248,117	251,797	996,320	1,248,117	251,797
HC - West	Continuing Healthcare - Phase 2	NR	400,000	509,585	109,585	400,000	509,585	109,585
HC - West	Enteral feeding - therapies	NR	40,000	41,798	1,798	40,000	41,798	1,798
HC - West	Grip and control measures - pay	NR	250000	250000	0	250000	250000	0

Green Schemes Details (2/2)

			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 - West	IHCW 10 GCC ED Social Worker	NR	46,992	46,992	0	46,992	46,992	0
HC - West	IHCW 19 - Pay Grip and Control - SACC Nursing	R	360,000	245,500	-114,500	360,000	245,500	-114,500
HC - West	IHCW 3 - Benefit Realisation of SICAT	R	90,000	191,000	101,000	90,000	191,000	101,000
HC - West	IHCW 5 - Grip and control measures NEPTS	R	32,400	40,311	7,911	32,400	40,311	7,911
HC - West	IHCW20 - BAU: Grip and control measures - non pay	NR	28,950	28,950	0	28,950	28,950	0
HC - West	Medicines Management - Primary Care	R	400,000	679,672	279,672	400,000	679,672	279,672
HC - West	Medicines Management - Supply Chain Projects	R	180,000	166,536	-13,464	180,000	166,536	-13,464
HC - West	NWSSP Drug Contract implementation	R	59,813	99,658	39,845	59,813	99,658	39,845
HC - West	Primary Care Rebate Schemes	NR	130,000	259,000	129,000	130,000	259,000	129,000
HC - West	Release part vacancy within COTE Medicine - N/R	NR	51,263	51,263	0	51,263	51,263	0
HC - West	Review of GP Bed payments within community hospitals	R	75,000	75,000	0	75,000	75,000	0
HC - West	Urology Robot - VAT Recovery	NR	75,000	75,000	0	75,000	75,000	0
Cancer	B Braun Giving Sets Credit	NR	6,102	6,102	0	6,102	6,102	0
Cancer	I2S - Increasing Cancer Homecare Activity - East	R	177,196	253,367	76,171	177,196	253,367	76,171
Cancer	Increasing Cancer Homecare Activity - Centre	R	101,280	98,992	-2,288	101,280	98,992	-2,288
Cancer	Increasing Cancer Homecare Activity - West	R	20,871	105,200	84,329	20,871	105,200	84,329
Cancer	Patent/Price Reduction Drugs scheme - New 23-24	R	251,468	463,417	211,949	251,468	463,417	211,949
Cancer	Patent/Price Reduction Drugs scheme -Existing	R	986,402	993,368	6,966	986,402	993,368	6,966
DSCS	B Braun Giving Sets Credit	NR	3,272	3,272	0	3,272	3,272	0
DSCS	EBME covid equipment maintenance	R	60,017	61,644	1,627	60,017	61,644	1,627
DSCS	EBME covid equipment maintenance	NR	8,076	8,657	581	8,076	8,657	581
DSCS	Linac Warranty Maintenance -Non Rec	NR	26,064	26,064	0	26,064	26,064	0
DSCS	Pathology Contracts & Batch Efficencies	R	47,531	47,531	0	47,531	47,531	0
MH&LDS	Bank, Agency & Overtime Reductions	R	642,000	642,000	1	642,000	642,000	1
MH&LDS	Drug Costs	R	322,236	342,029	19,793	322,236	342,029	19,793
MH&LDS	Patient Transport	R	20,400	0	-20,400	20,400	0	-20,400
MH&LDS	Reductions in OOA Placements	R	300,000	0	-300,000	300,000	0	-300,000
MH&LDS	RIGA Savings - MHLD	R	147,000	147,000	0	147,000	147,000	0
MH&LDS	Right Care Programme	R	1,923,809	1,923,809	-1	1,923,809	1,923,809	-1
Midw & Womens	B Braun Giving Sets Credit	NR	10,358	10,358	0	10,358	10,358	0
Midw & Womens	Birth Choices Scheme 23/24	R	254,670	0	-254,670	254,670	0	-254,670
Midw & Womens	I2S - Medical Agency: Recruitment over-establishment (Invest to Save)	R	100,797	100,797	0	100,797	100,797	0
Midw & Womens	Medical Agency: Local increase in Medical Bank rates for fixed period -	R	80,193	80,193	0	80,193	80,193	0
Midw & Womens	Medical Agency: Recruitment to substantive posts	R	307,116	307,116	-0	307,116	307,116	-0
Midw & Womens	Non Pay: Dressing (Leukomed Sorbact)	R	23,047	23,047	0	23,047	23,047	0
Midw & Womens	Non Pay: Local enhanced governance re ad-hoc expenditure	R	149,469	149,469	0	149,469	149,469	0
Corporate and Estates	B Braun Giving Sets Credit	NR	121	121	0	121	121	0
Corporate and Estates	DDaT-004 McAfee Subscription	R	41,744	41,744	0	41,744	41,744	0
Corporate and Estates	Energy Sell Back	NR	534,709	534,709	0	534,709	534,709	0
Corporate and Estates	LINC	NR	1,079,000	1,079,000	0	1,079,000	1,079,000	0
Corporate and Estates	Office of CEO	R	14,026	14,026	0	14,026	14,026	0
Corporate and Estates	Office of CEO	NR	21,920	21,920	0	21,920	21,920	0
Corporate and Estates	Pest Control across Health Board	R	66,609	66,609	0	66,609	66,609	0
Corporate and Estates	PH - Review of None Pay budgets	R	20,000	20,000	0	20,000	20,000	0
Corporate and Estates	Plas Gororau utilities	NR	451,490	451,490	0	451,490	451,490	0
Corporate and Estates	Review of Non Pay	R	132,000	132,000	0	132,000	132,000	0
Corporate and Estates	Review of pay vacancies	NR	9,909	9,909	0	9,909	9,909	0
Corporate and Estates	RIGA Savings - Finance	R	37,000	37,000	0	37,000	37,000	0
Corporate and Estates	RIGA Savings - Medical Director	R	62,500	62,500	0	62,500	62,500	0
Corporate and Estates	WICIS Project	NR	595,000	595,000	0	595,000	595,000	0
Primary Care	CDS Redesign and modernisation (non pay)	R	5,000	5,000	0	5,000	5,000	0
Primary Care	CDS Redesign and modernisation (pay)	R	109,080	109,080	0	109,080	109,080	0
Grand Total			**22,040,221**	**25,494,966**	**3,454,746**	**22,040,221**	**25,494,966**	**3,454,746**
Procurement			3,681,311	7,087,904	3,406,592	3,681,311	7,087,904	3,406,592
Total			**25,721,533**	**32,582,870**	**6,861,338**	**25,721,532**	**32,582,870**	**6,861,338**

Next Steps

	Update	Actions Required
24-25 Plan	Plans have been received which incorporate circa £5m of schemes which meet green criteria. Additionally, circa £16m of Opportunities have been included within the Pipeline including £12m from the V&S Medicines Management programme.	Focus on identifying further Opportunities from the Value & Sustainability theme approach; Exec Leads and Support Staff tasked with providing a further update to the IP-EDG by mid May. Where Opportunities have been identified, the Divisions are to assess delivery and confirm back to Exec Leads, whose support team will arrange for savings documentation to be completed and then delivery will be monitored.

2024/25 Financial Performance – Month 1 (April 2024)

Whilst the extended closedown of the 2023/24 financial year results in delays in production of the new financial years performance, this report reflects on the delivery for month 1 at a summary level, as denoted within the below table;

Ref	Description	Amount £m's	Additional information
1	Actual deficit	4.3	The adverse deficit is largely driven through savings non-achievement and out of area mental health placements.
2	Plan (£19.7m deficit Plan)	1.6	
3	Adverse variance	2.7	

The Health Board will require a significant focus be placed upon savings delivery (Value & Sustainability initiatives) in order to deliver the 2024/25 financial plans, with a £48m target to be reviewed and closely monitored for achievement through the Integrated Performance – Executive Delivery Group, oversight provided by the Performance, Finance and Information Governance Committee (PFIG) a committee of the Health Board.

Reporting Committee:	**Audit Committee**
Committee Chair:	Karen Balmer, Independent Member
Date of last meeting:	7th May 2024
Paper prepared by:	Jody Evans, Corporate Governance Officer

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the meeting held on 7th May 2024.

The Committee received the following updates and reports;

- **Update report on Internal and External Audit Recommendations –** *The Committee:*
  - Considered the proposed new processes around the introduction of External and Internal Audit Reports, along with the new closure approval process for auditor's recommendations and development of a Standard Operating Procedure.
  - Noted the current position regarding open recommendations and those proposed for closure, and limited assurance recommendations.
  - Noted the Audit recommendations proposed for closure - to be presented to Internal Audit for review.
  - Noted current positions of overdue audit recommendations.
  - Approved for closure; recommendations (January) approved by Internal Audit, and items not falling within the Audit Charter and thereby not requiring Internal Audit approval to close.

In particular, the Committee focussed on the overdue internal audit recommendations from limited and no assurance reports and agreed the focus will be on driving down the number of outstanding recommendations with a view to improvements in the systems of internal control across the Health Board. The Audit Committee will also be focussed on seeking assurance against recommendations from External Audit going forward.

- **Special Measures update** - *The Committee* noted and received acceptable assurance for:
  - The Special Measures update and its transition into the Annual Delivery Plan, in terms of reporting, and the update regarding Independent Reviews.

- **Risk Management update - Board Assurance Framework and Corporate Risk Register** - *The Committee:* noted and received assurance for:
  - The Chair's Assurance Report from the Risk Management Group held on the 10th April 2024.
  - Board Assurance Framework and Corporate Risk Register, Divisional Risk Registers, and emerging risks.
  - Endorsed changes around the Board Assurance Framework and realigningment to the objectives of the Health Board, recently approved at the March Board Meeting.
  - Supported the approach to consider the frequency on the reporting of the Board Assurance Framework as part of a Board Development Session on Risk Management.

- **Finance update and the Annual Conformance Report 2023/24 –** The Committee noted and discussed performance relating to:

- Non-compliance of Purchase orders with Standing Financial Instructions.
- The E-Waiver System Developments and Single Tender Waivers.
- Receivables and conformance with payroll procedures.
- Payables and conformance with Public Sector Payment Policy.
- The Committee approved the Losses and Special Payments Report from (January to March 2024) and the Committee approved a consequential loss of £1,519.08.

- **Annual Accounts 2023/24** - The Committee agreed on the process to discuss the draft content for the meeting scheduled for 21 May 2024.

- **Internal Audit Progress Report (1 March to 18 April 2024) –** *The Committee:*
  - Received and noted the progress report, along with details pertaining to reports issued in draft and work in progress.
  - The overdue management response was acknowledged with regard to Health & Safety and the Operating Model, the response to be circulated to the committee once issued to Internal Audit and ahead of the next meeting.
  - Noted the backlog of closures relating to audit recommendations.
  - Approved the deferment by 6 months of the Contracted patient services: Quality and Safety arrangements (follow up review), but only on the basis that this would take place in the latter part of the financial year i.e. Quarter 3/Q4.

- **External Audit Update**
  - The Audit Wales Leads provided the Committee with an update in relation to External Audit and their update on accounting and performance work.
  - The Committee noted the final reports, which provided detail into the following reviews, key findings and recommendations;
    - Structured Assessment 2023
    - Review of workforce Planning Arrangements
  - The Committee also received the Detailed Audit Plan for 2024.

- **Counter Fraud – Verbal Report (Matters for Public) –**
  - The verbal update was provided and it was again highlighted of the requirement to update the Local Counter Fraud, Bribery and Corruption Policy. The approval route was noted and it was agreed to consider the Policy for final approval at the Committee in September along with the Annual Report relating to Counter Fraud.
  - It was noted that the practice of the closure of a cases before completion with regard to ongoing fraud investigations and an employee's departure was to cease with investigations being seen through to conclusion.
  - It was agreed to provide a written report with regards to Counter Fraud to future Committee Meetings.
  - In recognition of the imminent retirement of the Head of Counter Fraud, the Chair expressed her appreciation and thanks on behalf of the Committee.

- **Items for referral to other Committees:**
  - Integrated Governance Committee – Board Assurance Framework, Corporate Risk Register items, Audit Tracker reporting, and Contracting of Patient Services review and follow up.

- **In Private Session the Committee were provided with Progress Reports in relation to:**
  - Breaches of Standing Financial Instructions (update May 2024) – The verbal report provided the update on breaches of Standing Financial Instructions (SFIs) that had been notified since the last Audit Committee on the 15th March 2024.
  - Independent Review Management Response (Contract Procurement Review) – The Committee were provided with the Management Response to the Independent Review of Contract and Procurement Management.
  - Local Counter Fraud Service – An update was provided on the progress of the Local Counter Fraud Service Operational Work and the Committee considered and approved the Annual Workplan 1 April 2024 - 31 March 2025.
  - Development of the Annual Governance Statement (AGS) for the period 2023/24 - The Committee were provided with an update on the preparations for the AGS, along with the overview of the process being undertaken for the full Annual Report and Accounts for 2023/24.

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

The Risks associated with:

- The lack of progression of the recommendations from the “no Assurance” report in May 2023. The review scheduled in 2023/24 was deferred to 2024/25 and a request to defer to further. Committee approved a deferral to later this year and for the QSE Committee to drive progress on recommendations with urgency.

- The continued delay in the management response with regard to Health & safety was concerning, the response has subsequently been circulated but an emphasis needs to be given on addressing the recommendations.

NEXT MEETING

The next meeting of the Audit Committee will be held on 18th July 2024

Reporting Committee:	**Performance, Finance and Information Governance Committee**
Committee Chair:	Gareth Williams, Independent Member/ Board Vice Chair
Date of last meeting:	30.4.24
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 meetings held between February and April 2024 at Carlton Court Boardroom :

22.2.24 The Committee

- was concerned about the delays in preparation of the Annual plan against the original timetable outlined.
- was reassured, however, that it would have an opportunity to discuss the Plan in draft
- welcomed significant progress on delivering savings within the current year, while noting that the means by which these had been delivered were not sustainable in the longer term if the Board is serious in its commitment to empowering staff at all levels to manage resources appropriately
- sought to explore the robustness of the establishment control process against budgets, given the evidence of a significant increase in the establishment in the current year and questioned whether this should be discussed further at the People and Culture (PC) Committee
- welcomed a discussion with senior leaders from the East Integrated Health Community who had presented their Finance and Performance reports; welcomed their open-ness about the many challenges with regard to financial management and performance; and noted the request from them in regard to greater support for transformation and financial management
- sought further information on the lack of progress in addressing the decreasing compliance with Access to Health Records

30.4.24 The Committee

- sought greater clarification on the appropriate roles of the PFIG Committee and the Planning, Population Health and Partnerships Committee in regard to the development of the IMTP/Annual Plan in future.
- sought to understand the relationship between the PFIG Committee and the new PC Committee in relation to the reporting of performance metrics.
- was deeply concerned with the poor level of performance against KPIs being reported, the risks to patient safety and well-being this presented and the evidence this gave of the lack of clear understanding of what was happening ‘on the ground’ by those developing the Annual Plan. The Committee was not confident the Board had the levers in place to exert real grip on all the issues.
- acknowledged that deep seated cultural and structural issues needed to be addressed in order to deliver improvements in performance sustainably into the future.

In private sessions the Committee

- considered Electronic Prescribing and Medicines Administration Programme – Full Business Case (EPMA) and supported submission to the Board for consideration
- considered Cyber risk on Corporate Risk Register
- noted Dental Contract Novations
- supported submission of the Bangor Wellbeing Centre strategic outline case to the Board
- noted the award of Llandudno Orthopaedic main tender
- noted the management responses and the actions taken to address the issues raised in the Independent Contract Procurement Review
- approved the costed project proposal for the Children and Adolescent Mental Health Service (CAMHS) Crisis hub – Alternative to admission pilot scheme

A workshop was held on 7.3.24, which other Board members joined, in order to discuss the latest draft of the annual plan and consider further amendments prior to submission to the Health Board meeting on 28.3.24.

On 21.3.24 the Committee discussed the latest revision of the Annual plan to inform the Committee Chair's final recommendations to the Board discussion at the March Board meeting. The Committee acknowledged the difficulties in correlating finances, service capacity and demand pressures and gaining the right level of ambition and realism in terms of delivery.

A Committee development session was also held on 21.3.24 to receive two outstanding Independent Reviews i.e. Planning and Contract & Procurement.

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

The need for a more detailed and in-depth focus on specific aspects of performance, in particular relating to Urgent Care and Planned Care by both the Board and the Committee.

The need to clarify some aspects of the relationship between different Committees through the forthcoming Integrated Governance Committee meeting,

NEXT MEETING

The next meeting of the Performance, Finance and Information Governance Committee will be held on 25.6.24

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

Reporting Committee:	**Quality, Safety & Experience Committee**
Committee Chair:	Caroline Turner, Independent Member
Date of last meeting:	18.04.24
Paper prepared by:	Philippa Peake-Jones, Head of Corporate Affairs

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the meeting held on 18.04.24 at Carlton Court:

- **Report of the Chair**
  The Committee received a verbal update from the incoming Chair highlighting all the activity that she had undertaken to familiarise herself with the Committee and its business and explained that a development session would be planned for the Committee as soon as possible.

- **Patient Story**
  The Committee noted a story from a patient describing the journey he had experienced while recently undergoing hip replacement surgery at Wrexham Maelor Hospital, following increased pain and inflexibility. The learning identified from the patient sharing his experience was received.

- **Quality Report**
  The Committee noted the report and understood that the report gave the Committee the narrative on organisational learning, quality improvement, the forthcoming Quality Management System, Patient Safety and information on Safeguarding and Infection Control.

- **Integrated Quality Report**
  The Committee reviewed the contents of the report and the actions included within it, the report highlighted, Quality (Safety, Effectiveness & Experience) Performance, Access & Activity Performance, People & Organisational Development Performance and Financial Performance.

- **Quality Delivery Group Chair's Report**
  The Committee noted the report, which highlighted a number of service pressures and concerns from Integrated Health Communities. It was noted that there was positive support from Workforce, Finance and Data.

- **Regulatory and Legal Report**
  The Committee considered the Ombudsman Annual Letter and Health Board response which was noted would inform the Committee's work on seeking assurance of the complaint handling process.

- **Clinical Policy**
  Noted that the "Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents" would be received at Audit Committee on the 15 May 2024 and noted the being made on updating policies

- **Nurse Staffing Act**
  Received a presentation on the Nurse Staffing Act

- **Commissioned Services Quality report**

The Committee received a verbal update on the Commissioned Services Quality report, it was highlighted that a no assurance report from Internal Audit had been received and that they would be following up. Ongoing conversations were taking place with the Executive Team to move this forward.

- **Urology Review**
  The Committee noted the Royal College of Surgeons England report and the Getting it Right First Time report. They discussed the approach taken to respond to the recommendations and noted the actions which had already been undertaken. The Committee supported the approached outlined to identify a sustainable service model and the development of an appropriate robotic resource for urology. The Committee requested a more detailed Action Plan and an update on implementation at its meeting in August, and emphasised the need for pace in implementing the Action Plan, in particular in relation to the recommendations that were deemed to be urgent by the two reports. Concern was raised by the Committee that there had not been success in appointing a clinical lead, but noted that one of the Deputy Medical Directors was leading on implementing the Action Plan.

- **Corporate Risk Register and Board Assurance Framework**
  The Committee noted and received assurance on the management of two BAF and six corporate risks of which it had oversight.

Although a Deep Dive into the East Integrated Health Community was on the agenda it was agreed that this would return to the next Committee.

In private session the Committee were provided with Progress Reports in relation to:

- **Confidential Quality Report**
  The Committee received an update on information and analysis on progress with investigation and closure of Nationally Reported Incidents (NRIs) and the key learning from those that have been closed during the reporting period, as well as information on the improvements that were underway.

- **Inquest/Learning from investigations update**
  The Executive Medical Director gave a verbal update on the review of the cases that were in the coronial pathway.

- **Insourcing**
  The Executive Medical Director gave a verbal update on insourcing contracts.

Approved minutes and papers are available on our BCUHB website: Quality, Safety and Experience Committee - Betsi Cadwaladr University Health Board (nhs.wales)

ITEMS TO BE ESCALATED TO THE BOARD

There were no items to be escalated to the Board

NEXT MEETING
The next meeting of the Quality, Safety & Experience Committee will be held on Thursday 6 June 2024

Reporting Committee:	**Planning, Population Health and Partnerships Committee**
Committee Chair:	Clare Budden, Independent Member
Date of last meeting:	23rd April 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 23rd April 2024 in the Boardroom, Carlton Court.

- **Overview of Digital, Data and Technology (DDaT) Workstreams**
  The Committee received an overview of the six digital workstreams that align to the three year plan. It was noted that there are Corporate and Board risks that relate to these workstreams, mainly linked to resource availability and organisational culture. There was discussion around improving data and the challenge of moving from data to intelligence to improve quality. It was agreed that a regular report would be presented to the Committee and the August meeting would receive a deeper dive on data issues and opportunities.

- **Partnerships, Engagement and Communications Update**
  The Committee received a report and had a good discussion around partnerships and engagement. It was agreed that a high priority must be given to developing strong and positive partnerships to enable improved collaborative working for the benefit of the residents and communities of North Wales. There is a need to specifically focus on the third and voluntary sector. It was agreed that this item would come back to the Committee once further work has been completed with proposals on next steps and future strategy. It was noted that partnership working was a key area of focus throughout many of the items discussed during the meeting. There was also a discussion around engagement with the public, the positive change which is underway/what lessons can be learnt and how this can continue to be developed.

- **Population Health Assurance Report**
  The Committee received a report highlighting the key activities from the last twelve months and our current position. There was discussion around the need for a whole system approach to public health in terms of collaboration and partnership working to build healthier communities and improve wellbeing. It was suggested that a deep dive into a specific area should be an agenda item for the next meeting and it was agreed that a report highlighting the route to improving Population Health, making reference to Primary Care and Social Prescribing should be presented to the Board.

- **Primary Care Assurance Report**
  The Primary Care Board has been established and will be a key structure for improving and developing primary care services. It was agreed that the Primary Care Board should report into the PPHP Committee, and following the initial

meetings a report will be produced to inform a Committee decision on performance information it will regularly receive and review. • **North Wales Social Prescribing Study 2024** The Committee received a report on the North Wales Social Prescribing work with recommendations on next steps to further embed this across the region. With the Committees support the paper presented to PPHP will be presented to the Regional Partnership Board for their consideration and approval.
ITEMS TO BE ESCALATED TO THE BOARD
• Population Health Update Progress Report
NEXT MEETING
The next meeting of the Committee will be held on 18th June 2024

V2.00 Final

Reporting Committee:	**People and Culture Committee**
Committee Chair:	Dyfed Jones, Independent Member
Date of last meeting:	11th April 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 11th April 2024 in the Boardroom, Carlton Court.

- **Organisation Development**
  The Committee had a detailed discussion on the organisational development approach and provided some challenge and suggestions to feed into the work being led by the OD Steering Group. It was agreed that a regular update on the progress would be provided to the Committee, which would include the development of a plan aligned with the deliverables agreed as part of the three year plan.

- **Independent Review of Key Areas of Workforce**
  The Committee received the Independent Review of Key Areas of Workforce which was completed by Geraint Evans in June 2023. It was noted that this review was not a formal Independent Review but was completed in line with Special Measures. Work is now taking place to gain clarity on the findings and ensure these are tracked through the Three Year Plan. It was agreed that an update on the Review would be provided at the Health Board on 30th May 2024.

- **Review of Workforce Planning Arrangements, BCUHB**
  The Committee received the final report including the management response on the Review of Workforce Planning Arrangements which was completed by Audit Wales and issued in March 2024. It was suggested that the Health Board currently have insufficient capacity to effectively support workforce planning therefore significant investment may be required in this area. It was agreed that the Committee would monitor the progress of the report and provide a mid-year / end of year assurance report to the Health Board.

- **Flexible Working Policy & Workforce Policies**
  The Committee noted the update on the Workforce policies including the Flexible Working policy. There was a discussion around the requirements and potential challenges of the flexible working policy. It was agreed to include flexible working as an item for the June meeting to support discussion on our current position, our future plans and how the organisation can best support staff to provide a more strategic focus on flexible working.

- **Board Assurance Framework (BAF) & Corporate Risk Register (CRR) related to Committee**
  The Committee received the Board Assurance Framework & Corporate Risk Register. In relation to the BAF the score for “P16 Board Leadership & Governance” has been reduced from 16 to 12 to reflect the progress made in relation to recruitment to the Board and establishment of Committees. In relation to

the CRR there are three risks that relate to the remit of the Committee. It was noted that all three risks scores remained the same. The Committee received an update in relation to the Health & Safety risk on the BAF register and noted that updates on key actions will be reported in future Committees.
ITEMS TO BE ESCALATED TO THE BOARD
• Independent Review of Key Areas of Workforce • Review of Workforce Planning Arrangements, BCUHB (mid-year / end of year assurance report)
NEXT MEETING
The next meeting of the Committee will be held on 13th June 2024

V2.00 Final

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

Reporting Committee:	Mental Health Legislation Committee
Committee Chair:	Gareth Williams, Board Vice Chair / Independent Member
Date of last meeting:	2 May 2024
Paper prepared by:	Gareth Williams, Vice Chair

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the meeting held on 2 May 2024 at Carlton Court:

- **Mental Health Assurance Report**
  The Committee discussed and noted the report and appendices.

- **Mental Capacity Assurance Report**
  The Committee accepted the DoLS and MCA Report and the DoLS and MCA Action Plan and noted the progress.

- **HIW Assurance Report**
  The Committee received an update on the HIW Announced Visit to Nant Y Glyn Community Mental Health and noted the report.

- **Associate Hospital Managers Update Report**
  The Committee received the Associate Hospital Managers update report

- **Report from the Power of Discharge (Associate Managers) Group**
  The Committee received and noted the Power of Discharge report

ITEMS TO BE ESCALATED TO THE BOARD

There were no items to be escalated to the Board

NEXT MEETING

Thursday 1 August 2024

Reporting Committee:	**Remuneration Committee**
Committee Chair:	Dyfed Edwards, BCUHB Chair
Date of last meeting:	22.03.24
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 meeting held in private session on March 22, 2024: • Executive and Senior Management updates, approving actions to progress where required • A report from the Chief Executive regarding Building an Effective Organisation • A report from the Chief Executive on the BCUHB Operating Model • An update on Senior Agency Interim Appointments and Extensions	
ITEMS TO BE ESCALATED TO THE BOARD	
None	
NEXT MEETING	
June 11, 2024	

V1.0

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

Reporting Committee:	**Local Partnership Forum**
Committee Chair:	Carol Shillabeer, Chief Executive
Date of last meeting:	26th February 2024
Paper prepared by:	Llinos Roberts, Executive Business Manager (Chair's Office)

KEY DECISIONS / MATTERS CONSIDERED BY THE COMMITTEE

The Board is asked to note that the following matters were discussed at the Local Partnership Forum Meeting on 26th February 2024:

- Patient's Story – Orthopaedic Patient Pathway
- Presentation and discussion on the Integrated Three Year Plan
- Organisational Development Update: Culture, Leadership and Engagement
- Workforce report February 2024
- Workforce Policies Group February 2024
- Job Evaluation Programme Report
- Codi Llais Yn Ddiogel / Speak Out Safely Verbal Update
- Equality Team Update
- Issues Raised by Trade Unions
- Quality & Performance Report
- Strategic Occupational Health and Safety Group (issues of significance)

ITEMS TO BE ESCALATED TO THE BOARD

There were none.

NEXT MEETING

The next meeting of the Local Partnership Forum will be held on 1st May 2024.