Bundle Health Board 26 January 2023

1.0 09:30 - 23/00 OPENING BUSINESS

1.1 09:30 - 23/01 Welcome and Apologies for Absence - Mark Polin

1.2 09:34 - 23/02 Declarations of Interest

1.3 09:35 - 23/03 Draft Minutes of the Health Board Meeting held in public on 24 November 2022 for accuracy

23 03 Health Board Minutes 24 11 22 PUBLIC.pdf

1.4 09:40 - 23/04 Action log and matters arising

20 04 Action Tracker 24 November 2022 final.docx

1.5 09:45 - 23/05 Patient Story

23 05 APPROVED - HB - Patient Story - Jan 2023.docx

1.6 10:05 - 23/06 Report of the Chairman

1.7 10:15 - 23/07 Report of the Interim Chief Executive

23 07 CEO report January cover cym.docx

23 07a CEO report - January final.docx

2.0 10:30 - 23/08 STRATEGY AND PLANNING

2.1 10:30 - 23/09 Board Assurance Framework

This report may be subject to change following QSE

23 09 - BAF cover January 2023.docx

23 09a Copy of BAF January Board 2023.pdf

2.2 10:40 - 23/10 Estates Strategy

23 10 Estates strategy HB Coversheet - v0.1 17 Jan 23.docx

23 10a Estate Strategy_Draft_v5.0 230106.pdf

23 10b Socio-economic Impact Assessment Estates Strategy v0.2.docx

23 10c Estates Strategy EqIA v0.02.docx

3.0 10:55 - 23/11 QUALITY, SAFETY AND SIGNIFICANT REPORTING

3.1 10:55 - 23/12 Unscheduled Care

23 12 Board USC report January approved NL.docx

3.2 11:05 - 23/13 Scheduled care

23 13 plannedcareboardFD_jan23 final.docx

3.3 11:15 - 23/14 Winter resilience

Paper to follow

3.4 11:25 - 23/15 Quality & Patient Safety Report

23 15 APPROVED - HB - Quality and Patient Safety Report - Jan 2023.docx

3.5 11:35 - 23/16 Vascular Report

23 16 BOARD.Vascular. Jan 2022_v3.docx

23 16 Appendix_1-Vascular_Network_Transformation_POAP-v1_0.pptx

3.6 11:45 - 23/17 Update of Register of Approved Clinicians and of Section 12(2) Doctors

23 17 All Wales AC & Section 12 Board Report FV - January 2023.docx

3.7 11:50 - 23/18 Corporate Risk register

23 18 CRR Public Sessoin 20 Jan 1501.docx

23 18a Appendix 1 - Corporate Risk Register.docx

23 18b Appendix 2 - Full List of All Corporate Risk Register Risks - reviewed 20 Jan 1508.docx

23 18c Appendix 3 - Risk Key Field Guidance V2-Final.docx

4.0 12:00 - LUNCH BREAK

4.0.1 12:30 - 23/19 GOVERNANCE

4.1 12:30 - 23/20 Targeted Intervention Report

23 20 TI Report.docx

4.2 12:40 - 23/21 Chair's Actions Report

No matters to report.

4.3.0 12:41 - 23/22 Committee and Advisory Group Chairman's Assurance Reports

4.3.1 12:41 - 23/23 Cabinet Report

23 23 FINAL_Cabinet Chair's Assurance Report_Dec 22 and Jan 23_V2.docx

4.3.2 12:51 - 23/24 Audit Committee - 13 January

23 24 Audit Committee Chairs report 13 January.docx

4.3.3 12:56 - 23/25 Performance, Finance and Information Governance Committee - 22 December 2022

23 25 Chair's Assurance Report PFIGC 22.12.22 v1.0.docx

4.3.4 13:06 - 23/26 Partnerships, People and Population Health Committee - 17 January

Including Board approval of Conwy & Denbighshire Public Services Board Well-being Plan.

23 26a HB Coversheet CD PSB well-being plan January 2023 v2.docx

23 26 Chair's Assurance Report PPPHC 17.1.23.docx

4.3.6 13:16 - 23/27 Targeted Intervention Improvement Steering Group – 21 November, 19 December 2022

23 27a Chair's Assurance Report TIIF Steering Group 21.11.22 v1.00 Final.docx

23 27b Chair's Assurance Report TIIF Steering Group 19.12.22 & 03.01.23 v1.00 Final.docx

4.3.7 13:21 - 23/28 Health Care Professionals Forum – 22 December 2022

23 28 HPF Chair's Report December 2022 v1.0 ENG.pdf

4.3.8 13:26 - 23/29 Stakeholder Reference Group – 5 December 2022

23 29 SRG Advisory Group Chairs Report to the Board 05.12.22 V1.00 Final.doc

4.3.9 13:31 - 23/30 Charitable Funds Committee - 18 October 2022

23 30 Chair assurance report CFC 18.10.22 v1.0.docx

5.0.0 13:36 - 23/31 PERFORMANCE AND DELIVERY

5.1 13:36 - 23/32 Integrated Quality & Performance Report

23 32 IQPR Report HB Cover - January 2023 (Nov Position).docx

23 32a IQPR_HB_26-01-23v2.pdf

5.2 13:46 - 23/32 Annual Plan Monitoring Report

6.0 13:56 - 23/33 PEOPLE AND RESOURCES

6.1 13:56 - 23/34 Finance Report – M8

23 34 Coversheet - Finance Report M8.docx

23 34a Finance Board Report M8.pdf

6.2 14:06 - 23/35 Savings Report

Verbal

23 35 coversheet- Savings M8 v3.docx

23 35a Board M8 Savingsv6.pdf

7.0 14:16 - 23/36 CLOSING BUSINESS

7.1 14:16 - 23/37 Review of Risks Highlighted within the meeting

7.2 14:21 - 23/38 Review of Meeting Effectiveness

7.3 14:26 - 23/39 Summary of Private Board business to be reported in public

23 39 Summary of Private Board Business 24 November 2022.docx

7.4 14:28 - 23/40 Date of Next Meeting - 30 March 2023

7.5 14:29 - 23/41 Exclusion of Press and Public

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

9.0 15:51 - CLOSE

Betsi Cadwaladr University Health Board (BCUHB)
Draft minutes of the Health Board meeting held in public
on 24 November 2022 via Zoom

Board Members Present:

Name	Title
Mark Polin	Chairman
Lucy Reid	Vice Chair
Nichola Callow	Independent Member
Cllr Cheryl Carlisle	Independent Member
John Cunliffe	Independent Member
Gareth Evans	Acting Executive Director of Therapies and Health Sciences
John Gallanders	Independent Member
Sue Green	Executive Director of Workforce and Organisational Development
Gill Harris	Interim CEO
Jacqueline Hughes	Independent Member
Cllr Medwyn Hughes	Independent Member
Dr Nick Lyons	Executive Medical Director
Molly Marcu	Board Secretary (Interim)
Richard Micklewright	Independent Member
Teresa Owen	Executive Director of Public Health
Rob Nolan	Acting Director of Finance
Chris Stockport	Executive Director Transformation and Planning
Linda Tomos	Independent Member
Angela Wood	Executive Director of Nursing and Midwifery
Jane Wild	Associate Independent Member

In Attendance:

David Seabrooke	Interim Assistant Head of Corporate Governance
Nikki Foulkes	Outsourcing And Insourcing Manager
Matthew Joyes	Acting Associate Director of Quality, Patient Safety and Experience
Andrew Kent	Head of Planned Care Improvement (interim)
Rebecca Gerrard	Director of Nursing Infection Prevention And Decontamination
Andrew Oxby	OPD Programme Support Manager
Phil Orwin	Interim Director of Regional Delivery
Steve Probert	Welsh Government – Observer
Helen Stevens-Jones	Director of Partnerships and Stakeholder Engagement
Andrew Doughton	Audit Wales – Observer

Agenda Item	Action
22/242 OPENING BUSINESS	
22/243 Welcome and Apologies The Chairman reminded the Board that they were welcome to make their contributions in either Welsh or English. **22/243.1** Apologies were received from: Fôn Roberts, Dylan Roberts, Sue Hill	
22/244 Declarations of Interest **22/244.1** There were no declarations to note.	
22/245 Draft Minutes of the Health Board and Annual General Meeting held on 29 September 2022 **22/245.1** The draft minutes of the Health Board held on 29 September 2022 were received and agreed as an accurate record. The Chairman indicated that he had added some non-material adjustments to the minutes after the agenda papers had been published. An amendment to two job titles shown in the draft was agreed. John Cunliffe confirmed that he had given his apologies to both meetings. **22/245.2** The draft minutes of the Annual General Meeting held on 29 September 2022 were received and agreed as an accurate record. The Interim Board Secretary confirmed that the responses to questions submitted to the Annual General Meeting had been provided individually. In view of recent local media coverage, a question was raised about the Health Board's financial position with Flintshire CC which would be picked-up later in the meeting.	
22/246 Matters Arising and Summary Action Log **22/246.1** The Board reviewed the action log. The following points were highlighted: 22/114.9 – Operating Model – The Chairman requested a progress update from the Acting CEO on progress 22/189.1 - Meeting effectiveness – The Chairman advised that this would be undertaken by Audit Wales; all board members would be interviewed. 22/155 - Mental Health Improvement Plan (QSE) – The Executive Director of Public Health updated on progress with the development of the plan. 22/156 Integrated Quality & Performance Report - The Chairman indicated that work to improve this report was progressing. 22/157 Annual Plan Monitoring Report – agreed to leave this action open	**GH**

22/247 Carer Story **22/247.1** The Executive Director of Nursing and Midwifery introduced the patient story, which was then presented by the Acting Associate Director of Quality, Patient Safety and Experience on video. **22/247.2** The story was a carer story told by Sue, a mother of two children with complex disabilities and who were regular visitors to Glan Clywd. The story concerned the availability of Changing Places rooms, hoists/instructions for use, baths on the children's ward, cleanliness of facilities and use by staff and of hydrotherapy facilities. A hydrotherapy pool had been lost in a previous site refurbishment. **22/247.3** Sue's story had been shared widely with senior staff. Changes had been made to cleaning schedules and access to the room addressed. Maintenance of equipment had been addressed. Glan Clywd had the only Changing Places facility in the Heath Board. **22/247.4** The Chairman requested the Acting Director of Finance to get in touch with Independent Member John Gallanders about the position on hydrotherapy. It was noted that Sue's concerns had been picked-up quickly by PALS and the hospital site. The PALS team had followed through on some of the site issues. **22/248.5** In response to an Independent Member concern, the Executive Director of Nursing and Midwifery undertook to lead a piece of work to review the range of accessible toilet and changing facilities provided at the acute hospital sites. **22/248.6** It was resolved that the patient story be received. The Acting Associate Director of Quality, Patient Safety and Experience would pass on the Board's thanks to Sue for sharing her story.	**RN** **AW** **MJ**
22/248 Chairman's Assurance Report The Chairman noted that Gill Harris had stepped into the role of Interim Chief Executive and Nick Lyons as Acting Deputy CEO following the departure of Jo Whitehead.	
22/249 Interim Chief Executive's Report **22/249.1** The Board received the report of the Interim Chief Executive. The Interim Chief Executive highlighted the work in relation to preparing for the introduction of Duty of Candour in April. **22/249.2** She thanked staff for providing support to asylum seekers dispersed to north Wales earlier in November. Screening and care had been offered by a multi-disciplinary team.	

22/249.3 The risk around potential industrial action by the Royal College of Nursing in the UK was highlighted and work was underway to plan and mitigate in line with national guidance. RCN action was mandated and was expected before Christmas and a ballot result was expected from UNISON next week. **22/249.4** In relation to CIW registration, it was noted that this would be required if the Health Board wished to provide services in this area in support of discharge. **22/249.5** The Interim Chief Executive and Linda Tomos would discuss the work around provision of health care in rural localities. **22/249.6** Finally, the success of staff in national and Health Board local awards ceremonies was highlighted, and thanks were given to all those involved in organising.	**GH/LT**
22/250 STRATEGY AND PLANNING	
22/251 Proposals for the Transformation of Informatics into Digital, Data and Technology (DDAT) – people, process and technology **22/251.1** The Board received a report presenting the conclusions of the discovery work undertaken by the Chief Digital and Information Officer in relation to the Health Board's Digital Data and Technology capabilities. The Chairman invited the Executive Director Transformation and Planning to introduce the report. **22/251.2** Benchmarking indicated that the Health Board was under-invested in this area. There were nearly 400 separate systems managed. The pandemic and recent cyber-attacks on healthcare systems had further shown the importance of this area. The PPPH Committee had seen the report and supported the transformation approach; acquiring the specialist skills needed would be a challenge needing further discussion. **22/251.3** The report called for new investment of £1.7m recurrent and the Executive Director Transformation and Planning stated that in order to find this the Health Board would have to dis-invest in other areas. The request would be considered via the IMTP process. It was confirmed that the bid was for future funding. Some ongoing work in 2022/23 was funded by DHCW. **22/251.4** The Independent Member lead for this area expressed his support for the report and its proposals which would support transformation and information and decision-making for patients. He asked that the Chief Digital and Information Officer provide further information about the approach to revenue and capital funding and the possible harm caused to patients by lack of digital information – the benefits realisation associated with this case informed on this. Digital/Data elements needed to be included as part of business cases – a number co-dependencies were considered and digital would be factored in.	**DR/CS** **CS**

22/251.5 It was confirmed that work was ongoing on other proposals going into the wider financial prioritisation process. The Chairman added that Health Boards could be facing a real terms cut in funding in 2023/24 which could result in some difficult choices. He requested that other options be put forward and it was noted that further alternatives were being developed. **22/251.6** The Board acknowledged that to begin mitigating the risks presented in the BAF, the transformation of Informatics into DDAT proposals would require additional revenue of £1,657,035. This was to bring in the necessary skills and capabilities required for the basic delivery of DDAT and ensure benefits are realised on future projects in line with the Heath Board's strategies. **22/251.7** It was recognised that this proposal will be considered alongside other IMTP submissions and bids. In addition, the Board was asked to acknowledge the exponential increase in the consumption and complexity of DDAT over the last three years and increased cyber security risks, as well as the need for more frequent refresh and upgrade cycles of the entirety of the DDAT estate. This required significant capital and revenue investment.	
22/252 - QUALITY, SAFETY AND SIGNIFICANT REPORTING	
22.253 Unscheduled Care Assurance Report **22/253.1** The Board received a report from the Interim Chief Executive setting out assurance to the Health Board with the progress of the planned care programme in line with the Welsh Government's programme to modernise these services and decrease waiting lists. Further analysis would be completed in December. The "red bag" initiative with care homes was highlighted. She undertook to provide further information about the effect on diagnostic services, including whether test requests could be reduced. **22/253.2** The Chairman invited the Interim Director of Regional Delivery to introduce the report. The Director emphasised the work around Goal 2 of the Six Goals; with new facilities were going live in coming days at Wrexham. He highlighted a summit with the ambulance service on handovers. A range of factors accounted for performance challenges. **22/253.3** In relation to a question on the admission rate it was noted that this was middle of the pack, comparatively and varied slightly between sites. It tended to increase when sites were under pressure. Category 4 and 5 cases would be streamed to an urgent treatment centre, being a more appropriate setting. **22/253.4** The Executive Medical Director stated that the plan was clinically owned. He reflected that the relationship with Stoke in England remained positive. **22/253.5** The completion of recruitment referred to actions agreed as part of a specific business case for additional investment. Gaps continued to arise due to	**GH/PO**

normal turnover. The success of recruitment was enhanced by being able to describe a clear and up to date model of care. **22/253.6** The Interim Director of Regional Delivery confirmed that all sites were using the metrics and dashboard to support monitoring. There was willingness to learn and adopt measures and actions that worked. The Chairman asked about the effect of the measures and activities being reported; it was noted that demand continued but also the urgent treatment centre at Wrexham was four weeks behind. **22/253.7** The Board received the report	
22/254 Planned care assurance report **22/254.1** The Board received a report providing assurance on the progress of the Planned Care (PC) programme in line with Welsh Government's programme to modernise PC services and decrease waiting lists. The Chairman invited the Interim Director of Regional Delivery to introduce the report. He highlighted an improvement in long waiters and improvement in patient-initiated follow-up in particular specialties, which were described. Andrew Oxby undertook to provide further information about the impact on follow-up lists. Progress was being made on the Abergele and Llandudno schemes. **22/254.2** The Chairman welcomed Andrew Kent, Andrew Oxby and Nikki Foulkes to add to the presentation of the report. Re-start, recovery and sustainability aspects were described; there was a major transformation of planned care intended to reduce the Covid backlog and bring in new ways of working. **22/254.3** Outpatients was an early focus. Monitoring was in place and a 30% reduction had been achieved August to November and the aim was 52% by 31 December. Treat in turn had been put in place to manage outpatient lists appropriately. **22/254.4** In terms of the pace of the regional treatment centre development to 2027, Andrew Kent described the steps now required including OBC/FBC and public engagement. Meanwhile additional provision was being added where possible. **22/254.5** Therapy services were being used to support patients and further bids to extend schemes were being progressed. The Chairman requested that the IQPR charts clearly showed forecasts and trajectories. In terms of theatre development, a business case was being presented in December. The Llandudno option was being progressed; there were a number of issues in the layout of the Abergele site. **22/254.6** In terms of Opthalmology and eye care improvement, there was a focus on secondary care to raise throughput starting in January. Simple procedures were being outsourced.	**AO**

22/254.7 The Board received the report.	
22.255 Winter Plan Assurance report **22.255.1** The Board received a report from the Interim Chief Executive setting out assurance to the Health Board on the development of the Winter Plan. The Interim Director of Regional Delivery informed the Board that, led by the Acting Deputy Chief Executive, the Executive was developing the detailed plan and roadmap in relation to anticipated winter pressures. Feedback from the PPPH Committee had been taken on board and the final version would be agreed in early December. **22.255.2** The Acting Deputy CEO added that the Executive was proceeding with actions ahead of the Wales guidance, looking to provide adequate staffing, minimising emergency department attendances and admissions. The threshold with the EPRR or full-scale emergency approach was being defined. **22.255.3** The current situation around mask wearing for staff was highlighted. The information provided to staff on where to access the vaccine would be reviewed. The role of the 111 service to direct people to the most appropriate service was highlighted. **22.255.4** The Acting Deputy CEO in response to a question said there was more discussion about Community Connections. The winter plans for local authorities had been exchanged, but not so far approved by them. There was confidence about plans to open inpatient beds, but staffing remained a risk. The Workforce and OD directorate were positively engaged. **22.255.5** The Acting Deputy CEO described the work, including on cost, on beds for patients who were medically fit for discharge. The Chairman requested that in the event of any significant deviation from what was described that the Executive update the Board.	**PO**
22.256 Patient Safety Report **22.256.1** The Board received a report from the Executive Director of Nursing & Midwifery with information and analysis on significant quality and patient safety issues arising during the prior two month period, alongside longer-term trend data, and information on the improvements underway. **22.256.2** Following the Chair's assurance report from the Quality, Safety and Experience Committee presented at the 29 September Board, work was underway to strengthen the information provided to the Committee. The Committee had planned a Deep Dive on surgical safety and the WHO checklist. She highlighted other improvements made to this report. **22.256.3** Work to reduce backlogs of complaints and incidents was underway. Improvements around learning from complaints were being made and the turnaround where written responses were required. Monitoring was via peer visits, a new ward accreditation scheme and a new organisational learning forum	

which would feed into clinical audit. The Executive Director of Nursing & Midwifery undertook to ensure any significant issues arising from regulators would be reported to Board members in a timely way. **22.256.4** The following principal points were highlighted: • Main incident themes were inpatient falls and pressure ulcers and recognition of deteriorating patients • Four never events reported this year, relating to surgical safety • One Section 28 notice had been received outside the current reporting period • Real time patient feedback continued to be expanded **22.256.5** In relation to a question about record-keeping, the Executive Director of Nursing & Midwifery said the approach was to support staff, provide training and set clear expectations. A multi-disciplinary approach to this was being taken. The Welsh Care Record was being implemented. **22.256.6** She confirmed that the process and final checking of information requested of the Health Board was being reviewed and improved.	
22.257 Vascular Report **22.257.1** The Board received a report from the Executive Medical Director updating on progress to secure the ongoing sustainability of the vascular surgical services following escalation measures put in place and ongoing in response to concerns raised by the Vascular Quality Review Panel (VQRP) in July 2022, which were reported to the previous Board meeting. The full report was now expected in January. The HIW review was expected to be published in March. **22.257.2** The Executive Medical Director highlighted the report on the rate of amputations and more information would come to the QSE Committee. The Health Board's submission NVR (National Vascular Registry) was considered to be accurate, but more analysis and validation was required. The definitions of major and minor would be clarified. The Executive Medical Director acknowledged that each amputation was a tragedy for the patient. **22.257.3** Work continued with Stoke-on-Trent. The Gold arrangements managing surgical rotas had been stood down following progress with stabilising the staffing. It was noted that vascular services had been brought into the Surgery and Anaesthetic Quadrant which addressed the issue of a clinical lead. **22.257.4** Work to understand patient experience was ongoing. **22.257.5** The Board received the report and supported the continuing work to ensure sustainability of safe and effective vascular services. The following main points were noted:	**NL**

• the actions which remain in place following the VQRP concerns including the vascular improvement plan (VIP). • that Health Inspectorate Wales (HIW) will review the service in December 2022. • that clinical outcomes for patients undergoing amputation are in line with peer units. • the National Vascular Registry published its 2022 report on November 10th and that BCUHB mortality rates remain within the confidence limits. • that clinical pathway development has started for patients with ischemic lower limbs. • the outcome of the vascular renal access peer review. • the issue of a Prevention of Future Deaths (PFD) report from His Majesty's Coroner (HMC). • that an incident previously categorised as a never event has been downgraded.	
22.258 Infection Prevention and Control **22.258.1** The Board received a report from the Executive Director of Nursing & Midwifery and the Chairman welcomed Rebecca Gerrard to speak to the report: **22.258.2** The following principal points were noted: • there are currently two Tier 1 infection prevention risks on the risk register. • COVID has continued to dominate the work of the IP team, but contacts no longer have to be tested and isolated and a reduced isolation time supported by LFT testing has enabled closed bays and wards to open more quickly, resulting in enhanced patient flow. • Visiting continues as pre-pandemic however, masks have been re-introduced across the Health Board. Isolating symptomatic and positive patients continues to be a challenge resulting in ongoing outbreaks and bed closures, especially when cohort wards are not available. • Safe Clean Care Harm Free Programme and progress with current campaigns; including the campaign to 'Be Proud of Our Place' with the launch of the 5S methodology, 'clear the clutter' and 'dump the junk'. • Estates and Facilities Infection Prevention Developments including 'forensic search' and ATP testing using the latest technology to highlight areas contaminated with body fluids, and an Air Purification trial taking place on Hebog ward in YG. • Decontamination; a strategic review of the decontamination of medical devices was carried out by the Shared Services Partnership in August and highlighted a number of concerns related to infrastructure, equipment and environment that will require significant investment over the next 10 years to modernise and meet national guidance. • Appropriate use of Antibiotics; BCUHB are on target for WG Improvement Goal to achieve a minimum 25% reduction in antimicrobial usage in the community; at end of 21/22 total reduction was 38.6%	

22.258.3 The Chairman observed that the charts showed the Health Board was running close to its trajectories. It was noted that appropriate measures were in place to tackle outbreaks although there were often not enough side rooms to effect timely isolation where required. **22.258.4** In terms of hospital cleaning responsibilities, these were split between nursing and estates staff and there had been staffing issues across both. Progress had been made in reviewing the effectiveness of deep cleans**.** There was a bid to put in place a dedicated deep clean team. **22.258.4** It was agreed there would be a follow-up report to QSE. The Chairman requested that a walk-round be arranged for him.	**AW/RG**
22.260 Nurse staffing **22.260.1** The Board received a report from the Executive Director of Nursing & Midwifery under the Nurse Staffing Levels (Wales) Act 2016, detailing the respective nurse staffing levels for each individual ward pertaining to sections 25B to 25E of the Act and meeting the *"duty to calculate and take steps to maintain nurse staffing levels".* **22.260.2** The Executive Director of Nursing & Midwifery informed the Board that the process and the check and challenge have been improved. She expressed confidence in the Health Board's ability to recruit the required staff. She agreed to include more in the report about the skills required. **22.260.3** The Board received the report and the assurance in relation to the organisation 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.	**AW**
22.261 Primary Care Report **22.261.1** The Board received a report from the Executive Director of Integrated Clinical Services providing an overview of the services and highlighting work to develop a Primary Care plan/ strategy that is aligned to the strategic and clinical approach of the Health Board, and which seeks to provide a clear framework for delivering quality care closer to home. **2.261.2** The Chairman invited the Executive Medical Director to introduce the report. The development of the dental academy was highlighted. There was increased demand on primary care which was being monitored. **22.261.3** In relation to a question about actions to address pressures**;** it was agreed to take this matter outside the meeting. The different measurement of Managed and GMS practices would be clarified.	

22.261.4 There had been an issue with community pharmacies providing newly discharged patients with blister packs causing delays. The Executive Medical Director would discuss this outside the meeting. **22.261.5** There was some opportunity to resume face to face consultation. The Executive Medical Director undertook to provide an update on the escalation levels. The Board noted: 1. The growing demand for primary care services, and the impact this is having on sustainability 2. The actions being taken together with primary care contractors and clusters, to manage this demand and best meet the needs of the people of north Wales 3. To agree to a separate update report on Accelerated Cluster Development being brought to the Board at a later date	**NL** **NL**
22/262 Director of Public Health Annual Report – Mental Health and Wellbeing **22/262.1** The Board received the report from the Executive Director of Public Health. **22/262.3** The introduction covered the following as support factors for mental well-being: **Being in good physical health** – Being active is the most protective life course action we can take for good mental health and wellbeing. **Safe environment for family and friends, now and in the future** – Being part of a safe, nurturing neighbourhood is essential for mental wellbeing. Sadly, there are differences in mental wellbeing between affluent, deprived and disadvantaged communities. These are driven by the quality of schools, jobs, housing and neighbourhood. **Being part of and supported by a community** – Strong family and community connections and networks are essential for building self-esteem and confidence to build social relationships that help reduce anxiety and stress. **Being free of financial stress and being financially secure** – Wealth, or the lack of it, has a profound impact on mental wellbeing across all stages of life. Poverty causes stress, anxiety and poor health, and it reduces happiness, wellbeing and shortens lives. **22/262.3** The Executive Director of Public Health reflected on the effect of Covid on people's mental well-being. She thanked the third sector for their contributions. The purpose of the report was to generate debate about what could be done to improve mental well-being.	

22/262.4 Board members welcomed the report. The report would be taken out into the community through a range of means.	
22/263 Update of Register of Approved Clinicians and of Section 12(2) Doctors **22/263.1** The report from the Executive Medical Director detailed an update of the Register of Approved Clinicians (All Wales) and Update of Register of Section 12(2) Approved Doctors for Wales. **22/263.2** The Board ratified the updates for this period 25th August– 4th November 2022.	
22/264 GOVERNANCE	
22.265 - Targeted Intervention Report **22.265.1** The Board received the report from the Interim Chief Executive, which was addressed by the Acting Deputy CEO who reminded the Board that progress to level 3 was challenging. **22.265.2** The Welsh Government placed the Health Board into Target Intervention in March 2021. Through this process BCUHB evidences sustainable changes and improvements to Welsh Government. The Health Board's Executive and Senior Teams are committed to improve the services and to exit the intervention when this can be evidenced. **22.265.3** The Targeted Intervention framework is based upon a maturity matrix for 6 domain areas. Every six months the Board is required to make a self-assessment of progress and to set a target for the following six months. The report outlined the process to establish a self-assessment position for BCUHB for November 2022 and a target position. **22.265.4** The Board had received comprehensive details of all the maturity matrices, evidence submitted and current progress at the Board Workshop on 13 October 2022. The Workshop asked that the TI Steering Group moderate the self-assessment scores. The Board approved the self-assessments shown below.	

Domain	Board Agreed Target for November 2022 (at May 2022 Board)	Recommended Maturity Matrices point prior to Board Workshop and TI Steering Group Moderation	Recommended Reference Point for November 2022. (Moderated at October TI Steering Group)	Recommended Target for May 2023. (Moderated at October TI Steering Group)	Recommended Target to achieve by November 2023 (Moderated at October TI Steering Group)
All ages Mental Health	3	2	2	2	3
Strategy & Planning	3	2	2	2	3
Leadership	2	2	2	2	3
Engagement	4	2	2	3	3
Performance	N/A	2	1	1	2
Ysbyty Glan Clwyd	N/A	1	1	2	2

22.266 Chair's Actions Report

There were no matters to report.

22/267 Committee and Advisory Group Chair's Assurance Reports

22/267.1 The Board received reports and escalations from the following meetings:

Cabinet
Performance, Finance & Information Governance Committee
Partnerships, People and Population Health
Local Partnership Forum
Mental Health Capacity and Compliance Committee
Targeted Intervention Improvement Steering Group
Quality, Safety & Experience Committee

The Chairman invited the leads from these meetings to highlight significant points to the Board:

22.267 - Cabinet Report

The report from the Cabinet encompassed 5 meetings that had taken place in July and August 2022. The principal themes related to vascular targeted intervention and make it safe (paediatrics).

22.268 - Performance, Finance & Information Governance Committee – 27 October

The discussions around the financial position and recovery were highlighted.

22/269 Partnerships, People and Population Health – 13 September and 8 November

The planned Board Workshop on 15 December was highlighted.

22/270 Local Partnership Forum – 11 October

Noted.

22/271 Mental Health Capacity and Compliance Committee – 4 November

Noted.

22.272 Quality, Safety and Experience Committee (QSE) – 1 November

The Chair confirmed that a response had been received to the Committee's report to the 29 September Board.

22.273 Targeted Intervention Steering Group – 22 September and 24 October

Noted.

PERFORMANCE AND DELIVERY

22/274 Integrated Quality & Performance Report

22.274.1 The Board received the report from the Executive Director of Finance. It was noted that a range of performance matters had been discussed already today.

22.274.2 The report highlighted the following matters of concern:

- Patients waiting more than 8 weeks for a specified diagnostic continues to increase from 7,389 (Aug 2021) to 9,464 (September 2022)
- Number of patients waiting over 52 weeks for a new outpatient appointment has started to slowly increase from 23,076 (Jan 2022) to 26,515 (August 2022)
- Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% has increased from 55,286 (Aug 2021) to 61,488 (September 2022)
- Number of patients waiting more than 36 weeks for referral to treatment has increased from 55,295 (Aug 2021) to 64,871 (July 2022) but looks to be stabilising with 64,788 reported for September 2022
- Agency spend as a percentage of the total pay bill had increased from 4.8% (Aug 2021) to 7.2% (July 2022) but is starting to fall at 6.5% in September 2022

22/275 Annual Plan Monitoring Report

22/275.1 The Board received the report from the Executive Director of Finance. It was noted that 49 schemes were monitored, 24 were on track, 19 off-track and mitigated; 6 programmes were on hold/not progressing.

22/275.2 It was agreed that further improvements to the report to provide better and information assurance for independent members as to progress. The Chairman suggested that the Director of Executive Director Transformation and Planning meet with committee chairs to re-launch the report for 2023/24. **22/275.3** The Chairman reflected on progress with stroke services. On Radiology, he was concerned about addressing wait times. The Director agreed to pick this up in the next report on Planned Care.	**CS** **PO**
PEOPLE AND RESOURCES	
22.276 - Finance Report - month 6 and 22.277 Savings and Recovery Report **22.276.1** The Board received the reports from the Director of Finance and the Chairman took them together. The Chairman invited the Acting Director of Finance to introduce the reports. **22.276.2** The M6 report confirmed that the cumulative position for the year is a deficit against plan of £3.2m. The Health Board was forecasting a £10m deficit by the end of the financial year. The Executive Team has set up a Financial Recovery Group in order to oversee improvements in the financial position and a financial recovery plan. **22.276.3** Savings delivered in the 6 months to September 2022 was £8.6m against a plan of £9.2m, a shortfall of £0.6m. Non-recurrent savings delivered were £3.4m. The savings forecast is £15.2m, which is £19.8m behind the target of £35m for the year. **22.276.4** The Acting Director of Finance highlighted the inflationary and volume pressures arising from Continuing Health Care (CHC), prescribing and medically fit for discharge. The recovery plan mitigations resulted in the current forecast. There was £8m of slippage on Welsh Government funding – any decision to recover this would affect the Health Board's position. The Health Board would need to request strategic cash support from the Welsh Government in relation to its forecast deficit position. **22.276.5** Additional support around prescribing pressures had been requested as part of an all Wales initiative. The Recovery Plan mitigations submitted by the Integrated Healthcare Communities were being validated by the Executives. This would be considered by PFIG. **22.276.6** In relation to the Health Board's position with local authority creditors reported in local media for Flintshire CC, the Acting Director of Finance described the way that CHC packages were managed. He confirmed there was regular dialogue with local authority partners. A member briefing had been requested on this matter. **22.276.7** In terms of the assumptions on the deficit, there was scheme-by-scheme evidence which was continually being tested in conjunction with operational leads. On agency spend, the reported position was deteriorating; the	

PFIG Committee would be receiving further analysis in relation to pre-covid. The release of the annual leave accrual would entail a return to pre covid rule about annual leave carry over. **22.276.8** The Finance Department would present the options to the Executive if it became necessary to make choices that might impinge on quality. There would be very careful scrutiny of any such ideas. The Interim Chief Executive stressed that the approach remained focused on efficiency gains. **22.276.9** The current profile was for £10m deficit at year end. However to comply with the three year rule the aspiration was to break even. It was noted that the Finance Department continued to provide senior presence and capacity supporting the IHCs and a central costing service. **22.276.10** Differences between detailed figures shown on pages 6 and 10 of the report were due to differences in how income was recorded. The Acting Director of Finance undertook to provide a reconciliation in this regard. **22.276.11** There was joint working with the transformation team in relation to the savings plan to re-balance transformational and transactional savings. The Board noted the reports.	**RN**
CLOSING BUSINESS	
22.278 Items to Refer to Committees The savings and recovery position would remain escalated until after the next PFIG meeting. **22.258 Infection Prevention and Control –** Report to QSE on cleaning	**AW**
22/279.1 Review of Risks Highlighted within the Meeting There was nothing to note.	
22/280 Summary of Private Board Business to be reported in Public The report was noted.	
22/281 Date of Next Board Meeting • 26 January 2023	
22/282 Exclusion of Press and Public **22/282.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be	

prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
Actions from Health Board 26.5.22						
1	Chief Executive Acting Chief Executive	**22/114.9 – Operating Model** Clarification around board expectations • to receive reports on progress on the implementation and any significant changes should be highlighted. • to receive a recruitment and selection timeline that moved the Operating Model forward • that when colleagues left the organisation their cover arrangements were shared with partners. • as permanent recruitment took place, the Remuneration and Terms of Service Committee will monitor the number of interim appointments in the structure • Executive Portfolios be finalised and reported to the Remuneration and Terms of Service	July and September 2022 Board Meetings	Update on implementation given at 4.8.22 board ref: 22/154	**29 September 2022 –** Chairman emphasized final bullet-point of action **24 November 2022 -** Could the Board have an update on progress	

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
	Vice Chair, Chair of PFIG and Deputy CEO/Executive Director of Integrated Clinical Services	Committee and clarity around the Executive Director of Therapies & Health Sciences position be provided. • that as the Operating Model moved forward, the culture and expectations of leaders would witness change. • that the structures below the higher tiers to be shared with the Board as these were clarified. **• expect to be clear on the governance, performance and assurance framework and the timing for implementation and that the Vice Chair, Chair of PFIG and Deputy CEO/Executive Director of Integrated Clinical Services would progress this outside of the meeting.**		**Update 17/01/23 :** The Vice Chair, Chair of PFIG and Interim CEO have met to progress this issue. An update report has been provided on the governance arrangements being implemented for the Operating Model and further reports will be provided to the Board and Committees as part of ongoing business	**Propose closure**	

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
Actions from Health Board 4.8.22						
2	Board Secretary	**21.189.1 Review of Meeting Effectiveness** Reflect and follow up comments regarding duplication in some papers already having been through the Committee structure and being presented to Board in the same format when perhaps a summary would have sufficed. There were also comments made that information in some papers was out of date by the time it reached Board.	29.9.22 Continue to discuss through the board development program. Actions in place for September /October round of committees	Review progress on this at the next Committee Effectiveness Group (Executive Board Development scheduled for 15/6/22) This meeting has been postponed and will be arranged as soon as possible 4.8.22 – action kept open	**Update 24/11/22 :** Audit Wales are undertaking review exercise.	
3	Board Secretary	**22/151** **2022/23 Board Assurance Framework** (i) Review the overall provision of the BAF in the board papers (ii) off-line discussion about the range of risks and associated assurance	5 September 2022	26.1.23 - The revised BAF will be presented to the meeting on 26th January meeting	Closed	

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
5	Executive Director of Finance	**22/157 Annual Plan Monitoring Report** Address concerns about the depth of information provided	29 September Board	**Update 19/1/23 :** This action will now be progressed as detailed under item 25 below	Closed and transferred to item 25 below	
Actions from 29 September public meeting						
7	Executive Director of Finance / Board Secretary	**22.209 - Decarbonisation Plan** Progress update to Board	Early 2023	**Update 10/1/23 :** This paper is scheduled to come to the Board in March		
Actions from 24 November 2022 Public Meeting						
9	Interim Chief Executive	New operating model Could the Board have an update on progress	January 2023	**Update 19/1/23 :** A briefing will be shared before the January Board meeting to reflect the most recent appointments	Propose closure	
10	Acting Director of Therapies and Health Sciences	**22/247 Patient / Staff Story** Respond outside the meeting to the concerns raised around changing facilities and the therapy pool.	January 2023	**Update 10/1/23 :** briefing note circulated regarding hydrotherapy pool provision		

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
11	Executive Director of Nursing	Review the range of toilet and changing facilities provided at the acute hospitals	March 2023	This is underway and will be reported at the March meeting.		
		Digital, Data and Technology (DDAT)				
12	Executive Director Transformation, Strategic Planning, and Commissioning	Identify digital implications on the Business Case pro forma	January 2023	**Update 13/12/22** – This has been added to the next iteration of the proforma.	Closed	
13		Update in the workshop the details around funding options.	22 December	Funding issues explored as part of IMTP workshop		
		22/254 Planned care assurance report				
14	Interim Director of Regional Delivery	Return with the number on follow-up appointments saved	January 2023	**Update 11/1/23 :** Information on appointments saved has been circulated	Closed	
15	Finance Director – Commissioning and Strategic	Ensure the graphs in the IQPR are giving the accurate information	January 2023	Work continues to consolidate and align Board level reports, to include the latest		

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
	Financial Planning	building in trajectories and forecasts.		agreed trajectories and forecasts.		
16	Interim Chief Executive Executive Medical Director Interim Director of Regional Delivery	**22/255 Winter Plan Assurance report** To share an update on the MFD Ensure that information on staff vaccines is clear with Gold control when discussions complete. Will pick up point about user of 111 via PPPH	January 2023 January 2023 January 2023	**Update 19/1/23 :** An update has been circulated Staff vaccination updated regularly provided into GOLD from programme reports Follow up at PPH	Closed	
17	Executive Director of Nursing	**22/258 Infection Prevention and Control** Report back to QSE on cleaning standards	January 2023	**Update 10/1/23** – a presentation will be given to QSE at its January meeting	Closed	
		22/259 Nurse Staffing				

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
18	Executive Director of Nursing	Review staffing skill mix around the patient at the next PPPH Committee	January 2023	**Update 10/1/23 :** A report will be presented to the March meeting of the Committee		
		22/260 Primary Care				
19		Sustainability for GMS particularly around the financial pressures and what support is available	January 2023	**Update 10/1/23 :** Enhanced services for the bank holiday and 8 weeks of winter pressures have been offered		
20	Executive Medical Director	A further update on managed practices to be received.	January 2023	**Update 16/1/23** : A briefing note has been circulated to Board members	Closed	
21		Update outside of the meeting which surgery the paper is referring to	January 2023	The paper referred to the Ruabon Practice which is part of the South Wrexham Cluster		
		22/274 Integrated Quality & Performance Report				
22	Finance Director – Commissioning and Strategic	Check if page 8 refers all of the primary care centres.	January 2023	**Update 19/1/23 :** Page 8 of the report referred to East only, however reports now include all UPCCs		

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
23	Financial Planning	Update on Oncology and staffing to be circulated outside the meeting.	January 2023	An update on staffing has been circulated	Closed	
24		Review the data given that the targets were for 12 months and we are nearly at the end of 12 months.	January 2023	The data and targets are reviewed regularly and updated as appropriate. The Cohort 1, (outpatients over 52 weeks) trajectory has now been extended to 31.03.23		
		22/275 Annual Plan Monitoring Report				
25	Executive Director Transformation, Strategic Planning, and Commissioning	CS & SH's teams to meet with the committee Chairs to discuss the population of the APMR.	January 2023	**Update 10/1/23** – Meeting arranged for 19th January with Committee Chairs. Further update to be given at the meeting		
26	Interim Director of Regional Delivery	to pick up the point on stroke in the next planned care report	January 2023			
		22/276 Finance Report – M6				

Ref	Lead Executive / Member	Minute reference and agreed action	Original Timescale	Update (date)	Action status	RAG status P Complete G On track A Slippage on delivery R Delivery not on track
27	Finance Director – Commissioning and Strategic	A briefing paper will be received at PFIG on outstanding payments	January 2023	**Update 19/1/23 :** Work undertaken in November and December has reduced the debt by £1.7m. A report will be provided to the next PFIG Committee meeting.		
28	Financial Planning	Include assumptions in the risk table.	January 2023	Risk tables in Health Board reports and the WG Monitoring Return now include the assumptions		
29		Provide RM a reconciliation between the two tables around income.	January 2023	Information shared with RM		

Teitl adroddiad: ***Report title:***	Patient Story			
Adrodd i: ***Report to:***	Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Click here to enter a date.			
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:***	The Board is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

In line with best practice, a patient or carer story is presented to the Board to bring the voice of the people we serve directly into the meeting, but it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

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

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

Betsi Cadwaladr University Health Board
Jack's Story

A video story told by Jack will be played at the meeting.

Overview of Patient Story

Jack is twelve years old and has had a fear of needles since he was four following a negative hospital experience.

Jack did not have his bloods taken for over a year due to COVID and so when he received an appointment to come in for his bloods, he was anxious and worried about what it would be like and how it would go. During his appointment, Jack became overwhelmed and worked up to the point where he did not want to go ahead with having his bloods taken.

The Health Care Support Worker, Ffion, was very understanding and empathetic and told Jack that he could come back the following day instead. Jack has said that thanks to Ffion's support and understanding he was able to think positively and returned the next day to have his bloods taken.

Jack advised that the next time he needs them done, he will not be as worried or overthink it.

Key Themes

Key themes emerging from the patient story include:

- First and lasting impressions
- Safe, supportive and healing environment
- Understanding and involvement in care

Summary of Learning and Improvement

Jack's Story is the first young person's digital patient story the Health Board has captured. The impact of Jack's story has highlighted the importance of listening to the experience of young patients.

Jack's positive experience has been shared with the Children's Outpatient Department, Paediatric Services at Ysbyty Glan Clwyd and CAMHS, who will be using his story to support staff training in a health care setting.

Jack's story is in the process of being translated for publication on the Health Board website and social media as a campaign to encourage young people to share their feedback in relation to Health Board services. This will mean that Jack's story can provide reassurance

or encouragement to any children who are having their bloods taken or are anxious about impending blood tests or procedures.

The patient story shows staff putting Jack at the centre of decisions made which supports interpersonal skills such as patience, communication and empathy. It also demonstrates staff ability to incorporate their own knowledge and experience to support Jack to overcome his anxieties and fear of needles. The Health Care Support Worker's empathy and understanding towards Jack helped him feel at ease and supported.

Following the story, the Health Board will also be looking to expand its involvement in the Harvey's Gang initiative currently in place at YGC laboratories. The aim of this work is to improve patient experience with cases similar to Jack's story, by allowing young people to be junior scientists and follow a sample to understand the laboratory processing.

There are several formats of Patient Reported Experience Measures (PREMS) within Children's Services, which include the 'High Five Low Five' initiative at Ysbyty Glan Clwyd where they have created a High Five, Low Five form to gather patient experience feedback from children about the care they received in an innovative and easy to use way. Young people can share their thoughts about their care using a 'High Five' to tell the ward what was good and a 'Low Five' for improvement. The Health Board have children's patient experience surveys covering ages 4-11 years and 11+ years. These surveys are being rolled out across Paediatric Departments in North Wales on the patient and carer experience iPads that have been allocated to each clinical area.

The Patient and Carer Champions initiative has staff representation from Children's Services, both clinical and non-clinical. A Patient and Carer Champion is someone who is passionate about patient care. Patient and Carer Champions work closely with the Patient and Carer Experience Team by sharing information and engaging in patient feedback collection. Patient and Carer Champions are a point of contact to improve engagement between the team and clinical services. The Patient and Carer Experience Team are working with these champions to increase the number of children's patent experience feedback surveys received to support service improvement and learning from young people's experiences.

The Patient and Carer Experience Team will share this feedback across Health Board departments.

The Patient and Carer Experience Team extend their gratitude and appreciation to Jack for sharing his story.

Teitl yr adroddiad: ***Report title:***	Adroddiad y Prif Weithredwr Chief Executive's Report
Adrodd i: ***Report to:***	Bwrdd Iechyd Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	26ain Ionawr 2023 26th January 2023
Crynodeb Gweithredol: ***Executive Summary:***	Mae'r adroddiad hwn yn darparu diweddariad i Aelodau'r Bwrdd ar faterion allweddol o fewn y sefydliad, gwaith allanol gyda phartneriaid a gwasanaethau a gydnabyddir drwy enwebiadau a gwobrau. Mae'r materion yn cynnwys: • Pwyllgor Gwasanaethau Ambiwlans Brys (EASC) – Ambiwlans Awyr • Cyfarfod Tîm Gweithredol ar y Cyd ag Iechyd a Gofal Digidol Cymru (DHCW) • Memorandwm Cyd-ddealltwriaeth gyda Gwasanaethau Ambiwlans Cymru – 111 pwyswch 2 • Isgyfeirio Gwasanaethau Pobl Ifanc Gogledd Cymru (NWAS) gan WHSSC– CAMHS • Gweithredu Diwydiannol • Pwysau'r gaeaf • Gwasanaethau Fasgwlaidd • Cydnabyddiaeth i Ysbytai sy'n Ymwybodol o Gyn-filwyr This report provides an update for Board Members on key issues within the organisation, external work with partners and services recognised through nominations and awards. Topics include : • Emergency Ambulance Services Committee (EASC) – Air Ambulance • Joint Executive Team Meeting with Digital Health and Care Wales (DHCW) • Memorandum of Understand with the Welsh Ambulance Service – 111 press 2 • WHSSC de-escalation of North Wales Adolescent Services (NWAS) - CAMHS • Industrial Action • Winter pressures • Vascular Services • Recognition for Veteran Aware Hospitals
Argymhellion: ***Recommendations:***	Bod y Bwrdd yn nodi cynnwys yr adroddiad. That the Board notes the content of the report.
Arweinydd Gweithredol:	Prif Weithredwr Dros Dro Interim Chief Executive

Executive Lead:				
Awdur yr Adroddiad: ***Report Author:***	Prif Weithredwr Dros Dro Interim Chief Executive			
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):***	Mae'r cyfarfodydd yn ymdrin ag amrywiaeth o flaenoriaethau strategol. Meetings cover a range of strategic priorities.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Nid oes unrhyw oblygiadau penodol yn deillio o'r adroddiad hwn. There are no specific implications arising from this report.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Amherthnasol ar hyn o bryd. 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?***	Amherthnasol ar hyn o bryd. 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)***	Mae'r materion a godir yn dylanwadu ar draws ystod o risgiau. 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***	Nid oes unrhyw oblygiadau penodol yn deillio o'r adroddiad hwn. 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***	Nid oes unrhyw oblygiadau penodol yn deillio o'r adroddiad hwn. 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***	Amherthnasol. Not applicable.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risgiau Corfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Mae'r materion a godir yn dylanwadu ar draws ystod o risgiau. 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)***	Amherthnasol. Not applicable.
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Amherthnasol i'r adroddiad hwn. Not applicable to this report.	
Rhestr o Atodiadau: ***List of Appendices:***	

Health Board – 26th January 2023

Report Title: Chief Executive's report

Situation

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

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

Background

This report provides an update for Board Members on issues affecting the organisation, external work with partners and services recognised through nominations and awards.

There are specific papers on the Health Board meeting agenda which address other priority issues and therefore these issues are not referred to in this report.

Assessment and Analysis

External / Partnership Activities

Emergency Ambulance Services Committee (EASC) – Air Ambulance

Previous reports have referenced the work ongoing through EASC to undertake a strategic review of the Air Ambulance Service's operations with a view to maximising the use of the charity's assets in order to reach as many patients as possible. As part of this review a proposal emerged that the Welshpool base be merged with the North Wales base to form a single North Wales resource.

At the November 2022 meeting of the Emergency Ambulance Services Committee (EASC), members received a proposal from the Emergency Medical Retrieval and Transfer Services (EMRTS) and the Wales Air Ambulance Charity Trust (WAACT) that outlined an opportunity to develop the service in a way that they believed would lead to a better service for the population of Wales.

Given the initial reception and subsequent correspondence and engagement with the public and politicians in response to the proposal earlier in the year, EASC members agreed that insufficient work had been done to explain how the service currently operates and the challenges that exist within the current operating model. They asked for additional scrutiny to be undertaken regarding a number of issues and as a consequence, the EASC team undertook to carry out the analysis afresh.

This which was presented at the December meeting and EASC members noted the high level overview of the service and the variation in service delivery from the existing bases. They agreed that the issues highlighted needed further exploration and that an option appraisal process should be developed. Work is now underway to prepare a pre-consultation phase across all Health Boards. Each Health Board is supporting this work and our Engagement Team will work with the EASC team to ensure that local engagement activities are robust. This pre-consultation engagement is expected to get underway early in 2023 and further updates, including a timetable for future activities be brought to the Board as soon as this is available.

Joint Executive Team Meeting with Digital Health and Care Wales (DHCW)

A joint Executive Team meeting was held with Digital Health and Care Wales (DHCW) on the 14th December. This provided an opportunity for an update on our respective organisation's priorities, risks and issues and the joint working that is progressing between us to address these.

Key issues discussed were as follows:

- The investment in Digital, Data and Technology (DDaT) functions was recognised as critical to delivering key strategic objectives for NHS Wales and the Health Board. Investment of resources in DDaT in Wales was noted as less than that in NHS England as a comparator. It was agreed that we will work with DHCW and other Health Boards to collectively make the case for increased investment in DDaT aimed at bringing NHS Wales in line with other countries.

- DHCW colleagues indicated their support for the current BCU proposals for the transformation of the Digital, Data and Technology operating model and the service itself, as a necessary foundation for any future successful digitally enabled change. It was recognised that the cost of £1.7m, as presented to the Board in November, to bring in much needed capabilities and skills to make this happen was a significant challenge in the current financial environment. DHCW colleagues offered to support the Health Board in making this transition.

- DHCW colleagues recognised that the Health Board has been proactive in taking the National Lead on progressing some important initiatives such the Digital Healthcare Maturity Assessments work across Wales, which will support the strategic case for investment.

- BCU Executive Team raised concerns regarding the increasing delivery costs being charged to the Health Board associated with both the increased use of existing national systems and the deployment of new solutions (e.g. Welsh Nursing Care Record, Microsoft Contract, WPAS etc), where central project delivery funds from Welsh Government have come to an end. The Chief Digital Information Officer and his team are to work with DHCW to understand the breakdown of these costs in detail, to ensure value for money and to provide constructive challenge regarding the efficiency of DHCW. DHCW colleagues welcomed this approach and meetings will be organised in February to progress this work.

- The challenges of recruiting staff to work in DDaT were recognised by both parties and it was agreed that DHCW and BCU will have a joint presence on the Maes at the Eisteddfod in Pen Llyn to share information and seek to attract new employees into careers in DDaT in the NHS.

Memorandum of Understanding with the Welsh Ambulance Service – 111 press 2

Health Boards across Wales have been working with the Welsh Ambulance Service to establish a new mental health service linked with NHS 111. This service provides an option to “press 2” to access mental health advice, support and signposting services.

The effective operation of this service relies upon collaboration between WAST, who operate the 111 service and local mental health services who will provide the clinical assessment and response for people accessing this service. The responsibilities of each organisation are set out in a national Memorandum of Understanding (MOU) which has been agreed by the Interim Chief Executive on behalf of the Board. The MOU describes the following key shared objectives to be delivered by parties under the MOU:

- To implement a new service model that will link services delivered by NHS 111 Press 2 option with Local Health Board Mental Health Services.
- To provide timely access to robust assessment, intervention and/or signposting for anyone with a self-defined mental health need in Wales
- To provide timely access to information and advice for professionals on behalf of people who have a mental health need

As indicated, access to the service will be accessed via 111 and the response model is shown in the diagram below:

The service in North Wales is expected to go live on 24th January 2023 and its impact will be monitored jointly by the Health Board and WAST.

WHSSC de-escalation of North Wales Adolescent Services (NWAS) CAMHS

On 3rd January the Health Board received confirmation from the Welsh Health Specialised Services Commission (WHSSC) that the North Wales Adolescent Service was being removed from its escalation process due to significant progress made in service improvement. The letter received from WHSSC summarises the progress made as follows:

" I am writing to confirm that NWAS is no longer being managed through the WHSSC escalation process because of the excellent and sustained progress made in the unit. The changes put in by the whole team to achieve this cannot be underestimated, they have implemented a new clinical leadership model, continued to integrate working with the Community Intensive Team, Community psychiatrists and General Paediatric Teams to deliver a more holistic and resilient service model. There has been an innovative approach to nursing recruitment and skill mix and now the unit is able to look after almost all patients within North Wales avoiding distressing far distant placements for families and children. "

This positive improvement is a result of the sustained effort of our clinical and support staff across the service and our thanks are extended to them for their professionalism and commitment to supporting young people in North Wales.

Internal Activities

Industrial Action

The Board will be aware that the NHS nationally has been impacted by strike action from nurses who are members of the RCN and also from GMB members within the ambulance service.

Industrial action took place on 15th and 20th December involving nursing staff and on 21st December involving ambulance service staff. Within the Health Board there was extensive preparation for these days of action with Tactical Control Centres established to co-ordinate services and staffing deployment on the day.

Every effort has been made to minimise the impact on service delivery, with urgent care prioritised. Discussions with the RCN regarding derogation of services were conducted in a professional and respectful manner enabling agreements to be reached which respected the position of each party and supported patient safety. Likewise, the conduct of staff, whether involved in the industrial action or not was professional and respectful of others.

Despite all efforts there was an impact on some planned care services during the industrial action as summarised in the table below:

	15/12/2022	20/12/2022	21/12/2022	11/1/2023
Cancelled Outpatient appointments	396	815	212	6
Cancelled Theatre procedures	57	69	39	1

With regard to the ambulance service action on 21st December and 11th January, there was a significant downturn in call volumes to WAST following extensive public communication in advance, however self-presentations were higher than usual. Across North Wales a focus was placed on releasing ambulances quickly at the Emergency Departments, enabling the available capacity to be deployed to respond to demand in the community. Significant reductions in turnaround times and lost hours were achieved. Overall presentations to the Emergency Departments remained consistent with volumes in previous years, but with a decrease in those conveyed by ambulance between 48 and 53 patients per site.

There are a number of further days of industrial action anticipated during January. WAST have advised that on the 19th and 23rd there will be action by UNITE members. This has the

potential to have a greater impact on services than was seen either in December or on the 11th January. Further notifications of action will be reported to the Board as they are known.

Winter pressures

Like many organisations across the NHS, in recent weeks the Health Board has been operating under extreme pressure, right through from primary care and community services to our district general hospitals. A lack of available beds in our hospitals is currently leading to unprecedented ambulance delays across the Health Board and we are working closely with Local Authority colleagues to support medically fit patients to be discharged from hospital.

The demand on services right across the health system in recent weeks has been unprecedented due to a combination of winter viruses, parents seeking help due to concerns about Strep A and injuries associated with the cold weather. This has meant extremely long waits for patients to be seen, particularly at our hospital Emergency Departments.

As a result of these extreme pressures it has been necessary for the Health Board to declare two Business Continuity Incidents over the Christmas and New Year period. The first of these was on Monday 19th of December and the second was on January 2nd. In both instances the incident was stood down after two days of intensive work.

In response to these incidents, the difficult decision was taken to postpone all but the most urgent procedures in our hospitals. We acknowledge that this has impacted upon a number of patients who were due to receive planned care, however action was necessary to enable staff to focus on those with emergency and urgent care needs. Procedures and appointments will be re-scheduled at the earliest opportunity.

We are currently seeing a very high volume of patients being admitted to our hospitals with flu and COVID-19, which represents about 17 per cent of inpatients, as well as an increase in the most seriously injured or unwell patients needing emergency care. Coupled with this, there remain challenges in discharging patients from hospital to suitable accommodation or care services, and patients who are medically fit to discharge currently represent about 15 per cent of our inpatient population. We are working closely with our Local Authority and community partners to explore all possible ways to create more capacity to enable people to leave hospital when they are medically fit to do so, thereby freeing up capacity to allow timely admission for those awaiting emergency and urgent care.

This unprecedented demand, coupled with the impact of industrial action as described above, has placed severe strain on staff across health and care services in hospital and community settings. We are extremely grateful to all who have displayed such

professionalism and flexibility, doing what was needed to keep essential services running throughout this difficult period.

Vascular Services

We are currently awaiting receipt of the final report of the vascular quality review panel prior to the March public Board meeting.

Following receipt of the report, we will engage with patients, families and our staff to share its contents and address the issues it raises. We will publish the Report along with our formal response and any associated action plans.

We are also expecting formal written feedback from Healthcare Inspectorate Wales (HIW) following their visit to the vascular service in December 2022. At the time of the visit there were no immediate safety concerns raised by HIW or recommendations made. The Report will provide a detailed assessment of HIW's findings and we will develop a plan to respond to any recommendations made.

In addition, we are expecting the outcome of a workforce sustainability review which was commissioned by the Health Board to help inform our strategic decision making regarding the service. Taken together, these three reports will provide significant evidence for the Board to consider in making decisions regarding the delivery of an effective vascular surgery service in North Wales.

Recognition for Veteran Aware Hospitals

National Veteran leads have congratulated Betsi Cadwaladr University Health Board for its commitment to improving NHS care for the Armed Forces Community (AFC) across North Wales.

The Health Board's three acute hospitals Wrexham Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd recently received accreditation as Veteran Aware hospitals. This recognises work to raise veteran awareness, identify veterans being referred for treatment, and striving to improve the recruitment and retention of veterans across the Health Board's workforce.

In December, the Commissioner for Wales Colonel Phillips visited Wrexham Maelor Hospital to showcase the support available to the AFC, and he raised the hospital's new Veteran Aware flag, commending it for being the first in Wales to achieve accreditation with the Veteran Covenant Healthcare Alliance (VCHA).

The VCHA is a group of NHS providers, including acute, mental health, community, and ambulance Trusts, who have agreed to be exemplars of the best care for, and support to, the AFC, be they Regular, Reserves, Veterans, spouses or dependants, and the bereaved.

Participating Healthcare providers volunteer to develop, share and drive the implementation of best practice that will improve care for the AFC, in line with the commitments set out in the Armed Forces Covenant.

The Health Board's Armed Forces Lead, Army Veteran Zoe Roberts was acknowledged by the VCHA for her dedication to the hard work, having submitted evidence of a "very high standard" to achieve the Veteran Aware accreditation for Health Board's acute hospitals

Earlier this year the Health Board successfully launched the North Wales Veterans Healthcare Collaborative (NWVHC), to ensure that the AFC across North Wales are not disadvantaged in the care they receive, and where possible, that they receive personalised care and improved patient outcomes.

Recommendation

That the Board notes the content of the report.

Report title:	2022/23 Board Assurance Framework			
Report to:	Board of Directors			
Date of Meeting:	Tuesday, 17 January 2023			
Executive Summary:	The purpose of this report is to enable the Board of Directors to review and monitor the updated BAF risks which have most recently been scrutinised at the People, Partnerships and Population Committee on the 17th of January 2022. This iteration incorporates an update on risks which have increased in rating in light of the heightened winter pressures and business continuity critical incidents.			
Recommendations:	The Board is asked to: • Note and receive the BAF risks and their associated mitigations • Note the three risks that are now outside the risk appetite of the Health Board in relation to unscheduled care, planned care and the delivery of the savings plan			
Executive Lead:	Board Secretary			
Report Author:	Molly Marcu, Interim Board Secretary			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

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

The BAF includes the risks deemed most significant to the delivery of the strategic objectives of the Health Board. Of those risks, some are outside of the risk appetite /and have significant gaps in controls and assurance
In this iteration, risks that have increased in target rating are:

Risk 1.3: Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience
(from 16 to 20)

Risk 1.5: Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm
(from 16 to 20)

Risk 2.7: Failure to achieve 2022/23 savings target of £35m, resulting in a breach of our statutory financial duty

(12 to 16)

All three of the risks are incorporated within the Board agenda in further detail.

Link to Strategic Objective(s):	ALL
Regulatory and legal implications	Alignment to regulatory requirements associated with delivery of patient care as well as a safe working environment under the Health and Safety at Work Act
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below**	**Y**
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	(summarise risks here and provide further detail) (crynodeb o'r risgiau a rhagor o fanylion yma)
Financial implications as a result of implementing the recommendations	Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	Feedback received from Executive Directors, Board
Links to BAF risks: (or links to the Corporate Risk Register)	All
Reason for submission of report to confidential board (where relevant)	Not applicable Amherthnasol
Next Steps: • The BAF continues to be subject to a further in-depth review in order to ensure that the risks and mitigations are robust	
List of Appendices: 2022/23 Board Assurance Framework Appendix 1	

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK - January 2023

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score (impact x likelihood)	Current Risk Score (impact x likelihood	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
Strategic Aim 1: Improve physical, emotional and mental health and well-being for all/ Improve the safety and quality of all services													
1.1	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Failure to consistently provide safe provision of care to patients at YGC, resulting in significant harm to patients, poor patient experience and a high number of complaints and claims, as well as a loss of public confidence	Implementation of YGC improvement plan Journey to Excellence implementation	Vascular Steering Group, Vascular Quality panel, Quality Safety, Experience Committee, Cabinet oversight of YGC Improvement Plan	Health Inspectorate wales review of YGC ED in March , May and November 2022, Royal College Surgeons review of vascular services Internal audit review of YGC Governance in 2021, HIW review of YGC in November 2022	YGC improvement plan is in the process of being implemented, therefore sustained improvements require some time in order for effectiveness to be embedded. YGC ED and Vascular services are highlighted as services requiring significant improvement	All external assurance review of the YGC ED highlight gaps in compliance assurance, specifically: Health Inspectorate wales review of YGC ED, Royal College Surgeons review of vascular services	20 (4x5)	20 (4x5)	16 (4x4)	continue implementation of YGC improvement and Journey to Excellence plan	ongoing
1.2	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety , resulting in a deterioration of care and harm to patients and service users	Six Goals improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	Quality, Safety and Experience Committee oversight	Health Inspectorate wales review of YGC ED in March and May 2022, Royal College Surgeons review of vascular services Internal audit review of YGC Governance in 2021, HIW review of YGC in November 2022	Limited assurance on embedding HIW requirements in relation to the March and May 2022 inspections	The vascular service and ED are rated as 'requiring significant improvement' by HIW in March and May 2022 respectively YGC site was officially entered into the Targeted intervention framework as of June 2022	20 (4x5)	20 (4x5)	16 (4x4)	Implementation of HIW Action plan	
1.3	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience	Six Goals improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Performance, Finance & Performance. Governance Committee	Board, Performance, Finance and Information Governance and People, Partnerships and Population Health Committee oversight	none identified	Unscheduled care performance continues to be challenged, impacted by capacity and flow through hospitals, and a high number of medically fit for discharge patients. Delays to ambulance handover continue, resulting in poor experience and increased clinical risk across the system. Performance against 4 hour target has deteriorated to 55%	None identified	20 (4x5)	20 (4x5)	20 (4x5)	i) Working with IHC teams to support initiatives for UEC trajectory improvement in line with the 6 Goal Programme. ii) Support Welsh Government funding opportunities for high-risk patients iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise. v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative vi) Continue to drive technology support for the programme. vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR planning team.	
1.4	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee and Performance, Finance and Information Governance Committee	Risk of a consistent failure to meet performance targets, resulting in an adverse impact on patient experience and quality of care, as well as a loss in public confidence	Clinical harm reviews, management of overdue follow-up appointments, implementation of clinical prioritisation process. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 post P2 Breach. Harm review process. Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually	Performance assurance reports to QSE, PFIG and Board	none identified	Substantial challenges remain in delivering elective outpatient activity. There is a gap between capacity and demand in a number of specialties , which has widened since the pandemic	to be confirmed	20 (4x5)	20 (4x5)	16 (4x4)	ii) Support Welsh Government funding opportunities for high-risk patients – work also ongoing within each IHC to identify high risk patients in line with Goal 1 to co-ordinate planning for individuals at risk.	TBC

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK - January 2023

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score (impact x likelihood)	Current Risk Score (impact x likelihood	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
1.5	Executive Director of Integrated Health Care	Quality, Safety and Experience Committee	Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm	Streamlining the processes through efficiencies, Creating additional capacity to see long waiting patients specifically around insourcing and outsourcing . Insourcing contract being finalised. Implementing and embedding schemes such as SOS and PIFU in order to ensure patients are seen within appropriate timescales, without exposing to clinical harm	Enhanced monthly meetings to focus solely on planned care performance chaired by the Director of Performance, with assurance feeding through to Performance, Finance and Information Governance Committee. revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Performance, Finance and Information Governance Committee. Introduction of further validation staff in Q3/4 non recurring complete. Review of validation techniques and validation SOP completed; now ready for deployment and adoption.	Audit Wales' review of planned care across North Wales, due to be presented to the Audit Committee in September 2022 Waiting list Limited assurance audit opinion internal audit report	Gaps in control were identified in the risk stratification process as part of the waiting list internal audit review	Adverse variation in Planned care performance	20 (4x5)	20 (4x5)	20 (4x5)	iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. Stakeholder meetings are almost complete and contracts being prepared. This is within Goal 2 (24/7 signposting for U&EC) – This is goal 1	
1.6	Executive Director of Public Health	Quality, Safety and Experience Committee	Risk of instability of the Mental Health leadership model due to unstable temporary staffing arrangements and high turnover of staff resulting in poor performance, a lack of assurance and governance, and ineffective service delivery.	Delivery of mental health improvement plan Interim senior management is currently in place alongside other key posts; Interim Director, Interim Director of Nursing, Interim Deputy Director and Interim Director of Operations. Each lead specific programmes and will further support and develop leadership, governance and management.] .Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team. Ongoing s are regularly reviewed by the Executive Director to ensure the model is effective in discharging its roles and responsibilities. Implementation of the Mental Health Strategy in a consistent manner across the Health Board		CHC review of Mental Health services Independent serious incident review	Mental Health improvement plan is still under development and therefore requires embedding	None identified	15 (5X3)	15 (5X3)	12 (4x3)	iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise.	
1.7	Executive Director of Public Health	Quality, Safety and Experience Committee	There is a risk to the safe and effective delivery of Mental Health services, leading to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.	Delivery of mental health improvement plan Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	Quality, Safety and Experience Committee oversight rtnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local	CHC review of Mental Health services	Mental Health improvement plan is still under development and therefore requires embedding	None identified	16 (4x4)	16 (4x4)	16 (4x4)	v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative	
2. Strategic Objective:	**Target our resources to people who have the greatest needs and reduce inequalities**											vi) Continue to drive technology support for the programme	
2.1	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health Committee	Failure to attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could adversely impact on the Board's ability to deliver safe and sustainable services.	Establishment Control Policy and system in place. Implementation of Roster management Policy. Implementation of Recruitment Policy. Review of Vacancy control process underway to establish a system for proactive recruitment against key staff groups/roles. Implementation of People strategy and plan 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. Workforce Service Review programme commissioned and commenced. Implementation of Safe Employment Policy	Partnerships, People and Population Health Committee oversight. Monthly monitoring by People Executive Delivery Group	Pipeline reports produced monthly for review and action by managers across the organisation	National shortages in certain roles	Staff turnover rates	16 (4x4)	16 (4x4)	12 (4x3)	vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR planning team.	
2.3	Executive Director of Finance	Performance, Finance and Information Governance Committee	Failure to meet financial targets once Strategic Support funding ceases, resulting in an inability to meet the break even statutory duty	Transformation Team in place to assist the operational staff to deliver services in a different way Regular reports to PFIG to monitor progress on transformation	BCUHB IMTP incorporates a clear programme of work over the 3 years.	Internal audit review of savings plan to commence in quarter 3	None identified	Adverse variation in financial performance	16 (4x4)	16 (4x4)	12 (4x3)	currently under review	
2.4	Executive Director of Transformation	Performance, Finance and Information Governance Committee	Failure to deliver an approved integrated medium term plan incorporating service, workforce, financial balance and delivery of key performance targets to Welsh Government (to ensure statutory duties are met) resulting in a regulatory audit opinion	Planning cycle established with outline BCUHB Planning schedule/overall approach for 2022/2025 - plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Partnerships, People & Population Health Committee.	Performance, Finance and Information Governance Committee oversight	none identified	2022/2025 IMTP not accepted by the Welsh Government	None identified	16 (4x4)	16 (4x4)	12 (4x3)	currently under review	

BETSI CADWALADAR UNIVERSITY HEALTH BOARD													
2022/23 BOARD ASSURANCE FRAMEWORK - January 2023													
Risk Number	**Responsible Director**	**Assurance Committee**	**Principal Risk**	**Controls in place to manage risk (mitigation)**	**Internal assurances**	**External Assurances on controls**	**Gaps in control (where the controls are not working or further controls required)**	**Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)**	**Initial Risk Score (impact x likelihood)**	**Current Risk Score (impact x likelihood**	**Tolerable Risk Score (target by year end)**	**Action plan description**	**Action plan due date**
2.5	Chief Digital Information Officer	Partnerships, People and Population Health Committee	There is a risk that we won't achieve our strategic and operational objectives caused by having inadequate arrangements for the identification, commissioning and delivery of Digital, Data and Technology enabled change. –This will lead to an inability to deliver new models of care in line with National and Local Strategies which results in a significant future degradation in patient safety, quality of care, public confidence, financial controls and reputation.	No controls yet in place subject to actions being delivered by newly appointed CDIO reviewing the current operating model and developing proposals and plans for its transformation into a minimum viable Digital, Data and Technology operation for the Health Board.	Annual Plan delivery assurance report to PPPH Committee	Benchmarking the service against external assessments. e.g. Gartner Group IT Score. NCSC. Cyber Essentials+ IG Toolkit Government Digital Service DDAT roles and possibly SFIA assessments.	Implementation of new DDAT operating model and structure including investment in skills and capabilities.	Plans, finance and resourcing not in place.	16 (4x4)	16 (4x4)	12 (4x3)	currently under review	
2.6	Chief Digital Information Officer	Partnerships, People and Population Health Committee	There is a risk that we are unable to maintain the minimum level of service to our patients and population caused by having inadequate digital applications, infrastructure, security and resources that may result in major ICT failures or cyber attack. This will lead to compromised – safety and quality of care, reduced public confidence, reputational damage and, finance and regulatory non-compliance.	Cyber Security controls: Cyber Assessment Framework with Welsh Government. Monitoring tools to flag anomalies. Antivirus/Anti Ransomware software.	Annual Plan delivery assurance report to PPPH Committee	External expert independent review and assessment of the current environment.	Implementation of three-year Essential Services Programme to address the issues identified.	Plans, finance and resourcing not in place.	16 (4x4)	16 (4x4)	12 (4x3)	Develop and implement proposals for new operating model and its associated resource requirements and financial case once confirmation of IMTP received. This will include new functions for: Intelligence and insight, Digital PMO, Architecture Software engineering, Service design and clinical change , Governance arrangements	Commence Apr 2023
2.7	Executive Director of Finance	Performance, Finance and Information Governance Committee	Failure to achieve 2022/23 savings target of £35m, resulting in a breach of our statutory financial duty	Transformation Team in place to assist the operational staff to deliver services in a different way Regular reports to PFIG to monitor progress on transformation and transactional savings targets	Month 4 financial report highlighted the identification of £30m worth of schemes	Internal audit review of savings plan	Lack of a risk based Transformational plan A Transformational plan will take time to implement.	Projected deficit position as at month 8 reflects a £10m year end deficit	16 (4x4)	16 (4x4)	16 (4x4)	A recovery plan is under development, and will be monitored via the Finance and Transformation Executive Group, and onto PFIG	
3. Strategic Objective: . Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being													
3.1	Executive Director of Finance	Partnerships, People and Population Health Committee	Failure to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.	Annual Capital Programme in place, based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee. 1.Development for business case for key projects identified in key strategies.	Performance, Finance and Information Governance Committee oversight of capital programme delivery	none identified	Delays in the completion of the new Estates Strategy and its consequent alignment to enabling strategies such as the clinical services strategy and quality improvement strategy	None identified	16 (4x4)	16 (4x4)	12 (4x3)	Implementation of capital programme and estates strategy	
3.2	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health Committee	Failure to implement and embed learning from experience in order to improve services, resulting in poor staff morale and a lack of trust and confidence in senior management, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board. This could be caused by a lack of clear mechanisms for raising concerns at any and every level.	Implementation of Speak out Safely Guardians report directly to CEO, with an independent board member to support and scrutinise Guardians' role Implementation of Raising Concerns Policy Implementation of SOP which includes agreed role outlines for Guardians, Speak out Safely Champions and independent member and terms of reference for MDT	Partnerships, People and Population Health Committee oversight.	none identified	Health inspectorate Wales review of YGC ED , highlighting concerns from staff about raising concerns arrangements	None identified	16 (4x4)	16 (4x4)	12 (4x3)	Implementation of people strategy and associated plan on staff engagement	

BETSI CADWALADAR UNIVERSITY HEALTH BOARD

2022/23 BOARD ASSURANCE FRAMEWORK - January 2023

Risk Number	Responsible Director	Assurance Committee	Principal Risk	Controls in place to manage risk (mitigation)	Internal assurances	External Assurances on controls	Gaps in control (where the controls are not working or further controls required)	Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained)	Initial Risk Score (impact x likelihood)	Current Risk Score (impact x likelihood	Tolerable Risk Score (target by year end)	Action plan description	Action plan due date
3.3	Executive Director of Integrated Health Care	Partnerships, People and Population Health Committee	Risk of significant delays to access to Primary Care Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital, resulting in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.	Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care. Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services. Primary Care Transformation Fund in place across the clusters to support local innovation in addressing planned care backlog in primary care	Partnerships, People and Population Health Committee oversight.		Primary care capacity remains a significant area of concern with: 213 GPs anticipated to retire in North Wales in next 5 years Number of practices identified as being 'at risk' of handing back contract Managed Practice costs pressures (circa £2.79m)		16 (4x4)	16 (4x4)	16 (4x4)	currently under review	
3.4	Executive Director of Public Health	Partnerships, People and Population Health Committee	Failure to effectively promote wellbeing and reduce health inequalities across the North Wales population, due to service model restrictions, resulting in demand exceeding capacity	Health Improvement & Reducing Inequalities Group (HIRIG) provides strategic direction and monitors delivery of the Population Health Services. Health Board commitment to establishing priority services including: Programme management and recruitment to posts. Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place. Fully integrated Smoking Cessation Service Delivery of Immunisation strategy (2018-2022) Delivery of Infant Feeding Strategy (2019-2022)	HIRIG provide reports nationally regarding expenditure and performance. regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact. Recent appointments of Consultants in Public Health have increased expertise and support across the region [3, one part time] Population Needs Assessment	1) Embed Public Health Outcomes approach into local planning through local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales. 3) Population Needs Assessment will provide local analysis for informing plans			15 (5X3)	15 (5X3)	12 (4x3)	Embed BCUHB North Wales population health priorities within its operational and strategic plans.	Dec-23
4. Strategic Objective: 3.1.6. Respect people and their dignity , and learn from their experiences												Implement programme and performance management	
4.1	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	Significant risk of avoidable harm to patients and staff, due to a failure by the Health Board provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation	Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group. Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE. Lessons Learnt analysis from COVID reported to Executive Team, through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures. Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire. RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews in excess of 820 RIDDOR investigations have been undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200+ site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. Robust fit testing programme now in place and the business case for the fit testing co-ordination team has been approved for two years. There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team.	Health and Safer Executive investigative reviews carried out in the 2021/22 period	There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3) Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. 4) Manual handling training compliance is currently at 50% there are insufficient trainers to train all new staff (approximately 800) at this time. We have appropriate premises and are advertising to increase capacity within the Team. 5) The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health. This may result in a prosecution against BCHB by the HSE under Section 3 of HASWA and fines in excess of £1m.	Notice of contravention issued to Health Board following an incident , may result in prosection	20 (4x5)	20 (4x5)	16 (4x4)	A clear strategy and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely has been implemented and Leading Safely Modules for Senior Leadership to be implemented. 3) Business case for secuirty provision approval process underway	Dec-22

1	2	3	4	5
Insignificant	**Minor**	**Moderate**	**Major**	**Extreme**
No effect	External standards being met. Minor impact on achieving objectives	Adverse effect on delivery of secondary objective	Major adverse effect on delivery of key objective. Affects Care Quality Commission rating.	Does not meet key objectives. Prevents achievement of a significant amount of external standards
No harm/near miss	Any patient safety incident requiring extra observation or minor treatment and causes minimal harm.	Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm.	Any patient safety incident that appears to have resulted in permanent harm.	Any patient safety incident that directly resulted in one or more deaths.
Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	Lost time injury or RIDDOR /Agency reportable > 3 days absence	Fractures, amputation, extensive injury or long term incapacity/ RIDDOR reportable	Death or major permanent incapacity
Loss / interruption more than 1 hour	Loss / interruption more than 8 hours	Loss / interruption more than 1 day	Loss / interruption more than 1 week	Permanent loss of service or facility
local management tolerance level	Loss less than 0.25% of budgeted operating income	Loss less than 0.5% of budgeted operating income. Improvement notice	Loss less than 1% of budgeted operating income. Significant claim. Prosecution or Prohibition Notice	Loss more than 1% of budgeted operating income. Multiple claims.
Minor non-compliance with internal standards	Single failure to meet internal standards or follow protocol	Repeated failures to meet internal standards or follow protocols	Failure to meet national standards. Failure to comply with IR(ME)R	Gross failure to meet professional standards
Rumours	Local media – Short term. Minor effect on staff morale	Local media – Long term. Significant effect on staff morale	National Media less than 3 days. Major loss of confidence in organisation.	National media more than 3 days. MP Concern (Questions in House). Severe loss of public confidence.

1	2	3	4	5
Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Less than 1%	1 – 5%	6 – 20%	21 – 50%	Greater than 50%
Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

	Consequence (C)			
1	2	3	4	5
Insignificant	Minor	Moderate	Major	Extreme
1	2	3	4	5
2	4	6	8	10
3	6	9	12	15
4	8	12	16	20
5	10	15	20	25

Teitl adroddiad: ***Report title:***	Estate Strategy		
Adrodd i: ***Report to:***	Health Board		
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023		
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to brief the Board on the development of the Estate Strategy. The Estate Strategy responds to Living Healthier, Staying Well and the Clinical Services Strategy. It is part of a suite of enabling strategies, including People, Digital and Finance, and provides the vision and framework for the future development and utilisation of our estate and how we will work with partners to maximise the benefits of our collective property portfolios. It promotes a future estate that is fit for purpose and provides a safe and effective environment that meets the clinical and business needs of the Health Board. It offers the opportunity to eliminate high, significant and moderate backlog maintenance risks over the longer term. The strategy provides the basis and structure for the prioritisation of often competing investment requirements. The strategy is for the long term, 10 years, but its implementation will align with the Health Boards planning cycle. It will be subject to regular review and must be flexible to respond to the changing needs and priorities of the Health Board. In taking forward this strategy we will continue to engage with staff, communities and stakeholders and, if significant changes are proposed, will undertake formal consultation when appropriate.		
Argymhellion: ***Recommendations:***	The Board is asked to approve the estate strategy.		
Arweinydd Gweithredol: ***Executive Lead:***	Stephen Webster, Interim Executive Director of Finance		
Awdur yr Adroddiad: ***Report Author:***	Rod Taylor, Director of Estates Neil Bradshaw, Assistant Director of Finance – Capital Supported by Lexica		
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 strategy has been subject to broad engagement including two Health Board workshops				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The strategy is an enabling strategy to support the delivery of the objectives of Living Healthier, Staying Well and the Clinical Services Strategy.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The strategy will assist the Health Board in meeting its statutory and mandatory estate requirements.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *Y* An EqIA has been completed in support of the strategy. It should also be noted that as individual priorities are progressed they will be subject to an equality impact assessment as appropriate.			
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?***	Y - As above			
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 is as risk that failure to provide a safe and compliant built environment will adversely impact on the Health Board's ability to implement safe and sustainable services could result in avoidable harm to patients, staff, public, reputational damage and litigation. (BAF 3.1)			

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The potential investment is significant. But the strategy is for the long term (10+ years) and the Health Board will seek alternative funding sources where appropriate and economical. Investment priorities will be subject to an appropriate business case for formal approval in accordance with the Health Board's Standing Financial Instructions.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	In developing this draft strategy engagement with key stakeholders included: Health Board Partnership, People and Population Health Committee Health Board Leadership Team Capital Investment Group Clinical Senate IHCs and regional services Primary care Patient safety and experience Health, safety and equality Operational Estates Community Health Council
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	**Board Assurance Framework** BAF 21-14 Pandemic exposure BAF 21-09, Infection prevention control 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 21-17, 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
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Implementation of the strategy aligned to the Integrated Medium Term Plan cycle.	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Draft Estate Strategy	

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

Betsi Cadwaladr
Estate Strategy

DRAFT Final Report v5.0

6th January 2023

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Foreword

This document sets out BCUHB's Estate Strategy to 2033. The strategy has been developed between October - December 2022, building upon the previous (2019) estate strategy and includes the most recent data submitted to the Welsh Government via the Estates and Facilities Performance Management System (EFPMS) and published in October 2022.

The estate strategy has been developed to align with current BCUHB strategies including Living Healthier, Staying Well, Clinical Services Strategy, Digital Strategy, People Strategy and Plan, and the Decarbonisation Action Plan. Development of the strategy has included engagement with key stakeholders and regular reporting via forums including BCUHB's Capital Investment Group, Health Board Leadership Team, Clinical Senate, Board, and Community Health Council workshops.

Since the previous estate strategy was completed in Feb 2019 the COVID-19 pandemic has had a significant impact upon the Board's estate, particularly in terms of capacity, suitability and shifts to digital, which is reflected in the analyses and recommendations below.

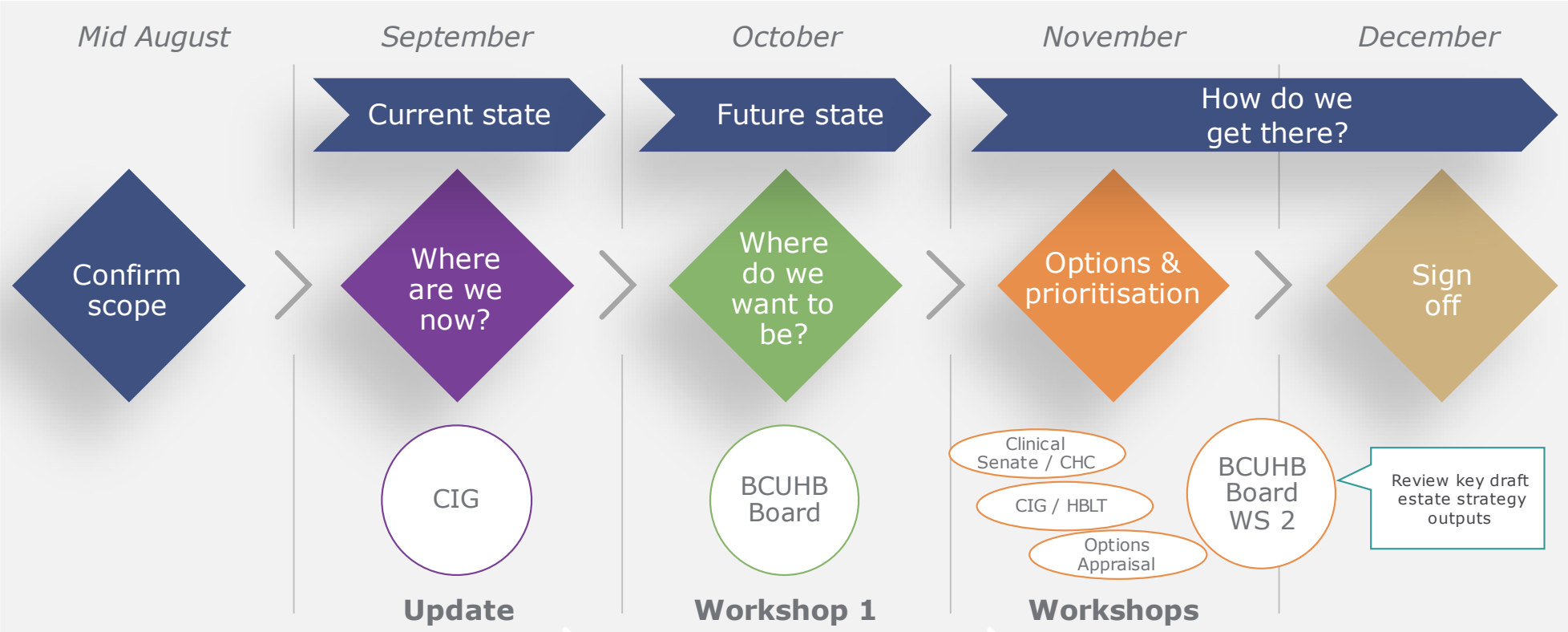
The document is structured to reflect national guidance and to answer the three key questions – Where are we now?, Where do we want to be ?, How do we get there?

The estate strategy will be continually reviewed to ensure alignment with the Integrated Medium Term Plan cycle.

1.0 Introduction

1.1 Background and Context

This Estate Strategy provides a refresh of the 2019 Betsi Cadwaladr University Health Board (BCUHB) Estate Strategy. It was developed over a four month period from September to December 2022 using the traditional 'Where, Where, How' approach (summarised below). Key tasks undertaken during the three phases include desk top review of key strategy and estates information, quantitative and qualitative analysis of existing available estate data and information, and stakeholder engagement via interviews and workshops (please refer to Appendix 1).



2.0 Current State (Where Are We now?)

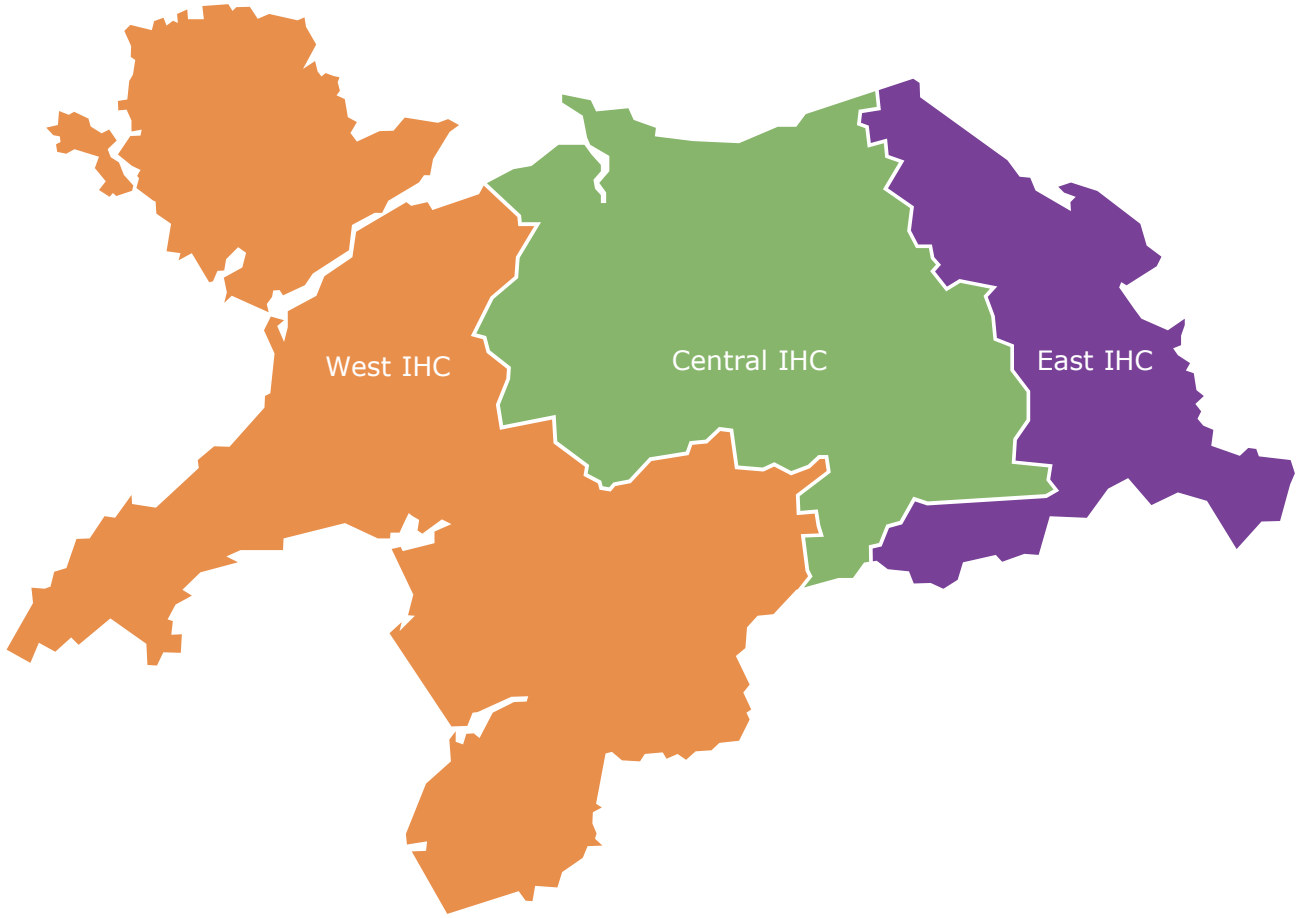
2.1 Existing Estate Overview

BCUHB currently has one of the largest property portfolios in Wales; services are delivered from c.238 properties (a total of c.420,000 m2) with a value of £569m[1] and an annual running cost of £73m[2] in 21/22.

Existing Estate Profile and Localities

Our services are delivered from, and our staff are based at a total of 238 properties (including GP owned, third party developer and private landlord primary care premises). The accommodation also hosts staff and services from other organisations including local authority and third sector.

A detailed breakdown of location and function of our estate across the three Integrated Health Communities (IHCs) is provided in Appendix 2.



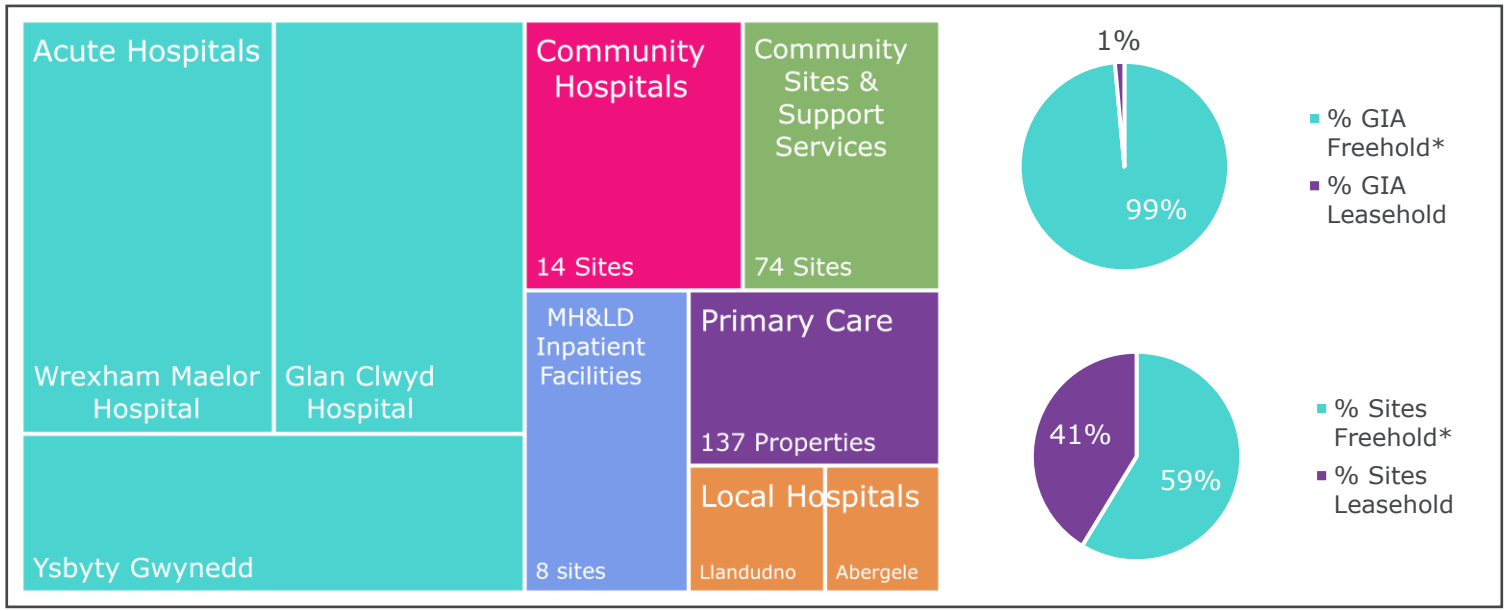
[1]Total freehold buildings, external works and land value as of 31/3/22; [2]Estates and facilities pay and non-pay costs

2.2 Existing Estate Type and Age Profile

Our estate comprises a range of property types, from acute hospitals to primary care facilities. Circa 45% of the estate is greater than 40 years old, compared to a Wales average of 49%. The majority of estate, by total Gross Internal Area (GIA) m^2, is freehold.

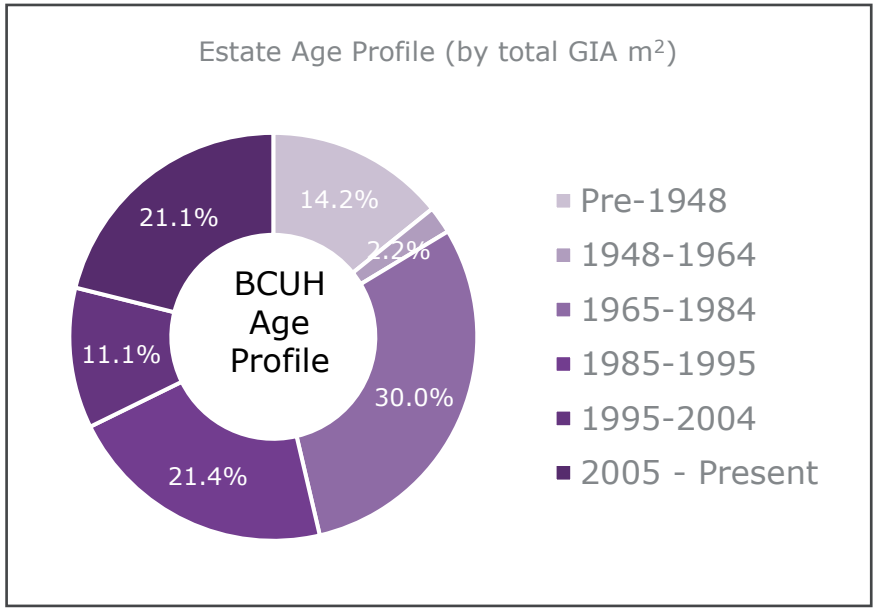
Existing Estate Type†

Our estate comprises a range of owned and leased property types. The breakdown, by number of properties and by total GIA m^2, is provided below.



Existing Estate Age Profile†

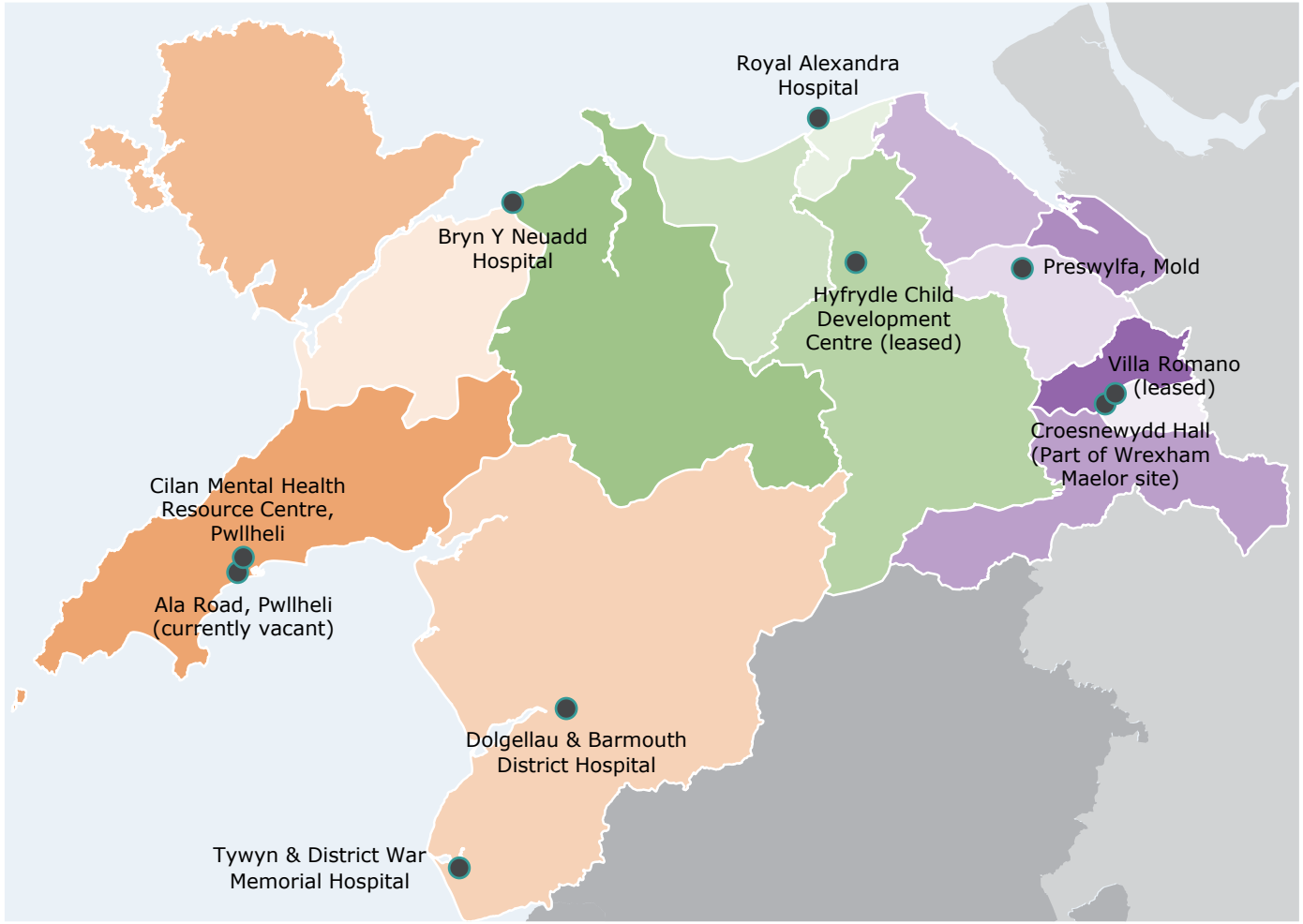
The age range of our estate, which varies widely from the 1813 Denbigh Infirmary to the Flint Health Centre, is summarised below.



†Data from Estates and Facilities Performance Management System (EFPMS) 2021/22 and Welsh Government Review of Primary Care Facilities - Primary Care Premises Database
*Data from Asset register, using Gross Internal Area (GIA) m^2 from EFPMS 2021/22 for sites where available. NHS Wales values exclude Welsh Ambulance Service NHS Trust.

2.3 Existing Estate - Listed Buildings/Sites

Our estate portfolio contains a number of Grade II listed historic building and grounds (shown below) which, in their own right, add a number of additional challenges regarding their listings and essential maintenance obligations.



West Integrated Health Community	
1	Bryn Y Neuadd Hospital
2	Ala Road, Pwllheli (currently vacant)
3	Cilan Penlan, Pwllheli
4	Dolgellau / Barmouth District Hospital
5	Tywyn District War Memorial Hospital

Central Integrated Health Community	
1	Royal Alexandra Hospital
2	Hyfrydle, Denbighshire (Leased)

East Integrated Health Community	
1	Croesnewydd Hall (Wrexham Maelor site)
2	Villa Romano (Leased)
3	Preswylfa, Mold

2.4 Estate Condition and Performance

At aggregate level for all estate*, our estate falls short of both national targets and NHS Wales average values for all estate condition and performance indicators, except space utilisation.

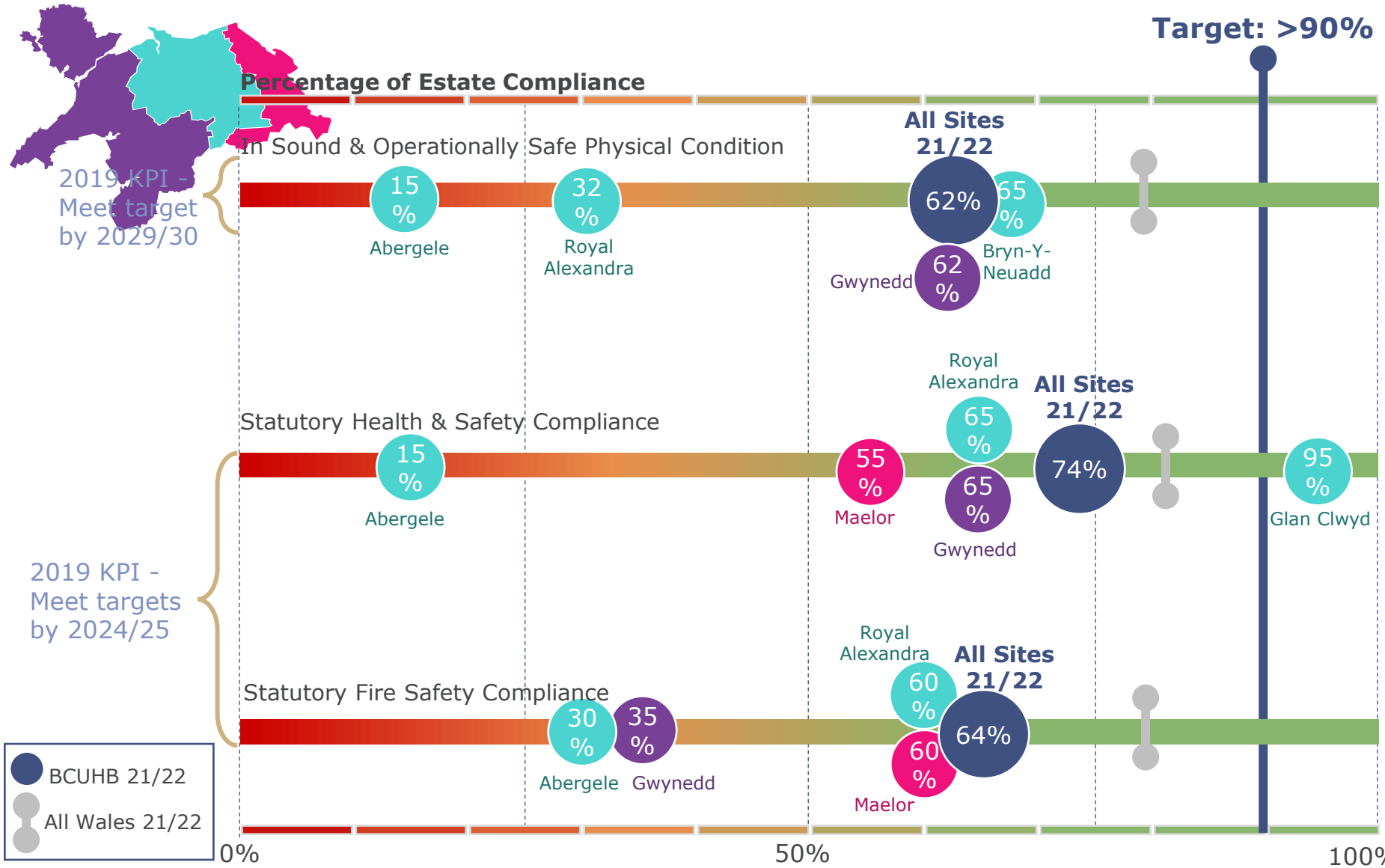
National Indicators for Evaluation

Estate condition and performance is evaluated against the standard indicators (defined by NHS Wales) opposite. Our estate currently falls short of all national targets except space utilisation. BCUHB estate also falls short of NHS Wales average values for all condition and performance indicators except space utilisation. In the 2019 Estate Strategy, compared to NHS Wales average values, our estate performed less well for all indicators except functional suitability. Since 2018/19, BCUHB estate condition and performance has reduced across all indicators except space utilisation.

Indicator	Definition	BCUHB 21-22*	Wales Average 21-22
Physical Condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deteriorations.	62%	78%
Statutory Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	74%	80%
Fire Safety Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements.	64%	78%
Functional Suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes needed.	74%	81%
Space Utilisation**	A minimum of 90% of the estate should be fully used.	93%	93%
Energy Performance	The estate should consume no more than 410 kWh/m^2.	455 kWh/m^2	383 kWh/m^2

*Data for 98 sites from EFPMS 2021/22, including 3 acute sites, 8 mental health inpatient facilities and 15 community hospitals. Excludes significant proportion of primary care properties. NHS Wales values exclude Welsh Ambulance Service NHS Trust.
**Space utilisation based on EFPMS definition of unutilised space: 'Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.'

2.4.1 Overview - Physical Condition and Compliance (All Properties[1])



Physical Condition[2]: Only 62% of our estate is condition B or above (sound, operationally safe), compared to the national target of 90% and the NHS Wales average value of 78%.

Statutory Health & Safety[2]: Against a national target of 90%, only 74% of our estate complies with statutory requirements; the NHS Wales average value is 80%.

Statutory Fire Safety[2]: 64% of our estate complies with statutory fire requirements, compared to the national target of 90% and the NHS Wales average of 78%

On average, physical condition and statutory compliance of the estate has got worse since the 2019 Estate Strategy. In particular, the Abergele Hospital, Maelor Hospital, Royal Alexandra Hospital, and Ysbyty Gwynedd sites are in poor condition with low levels of compliance.

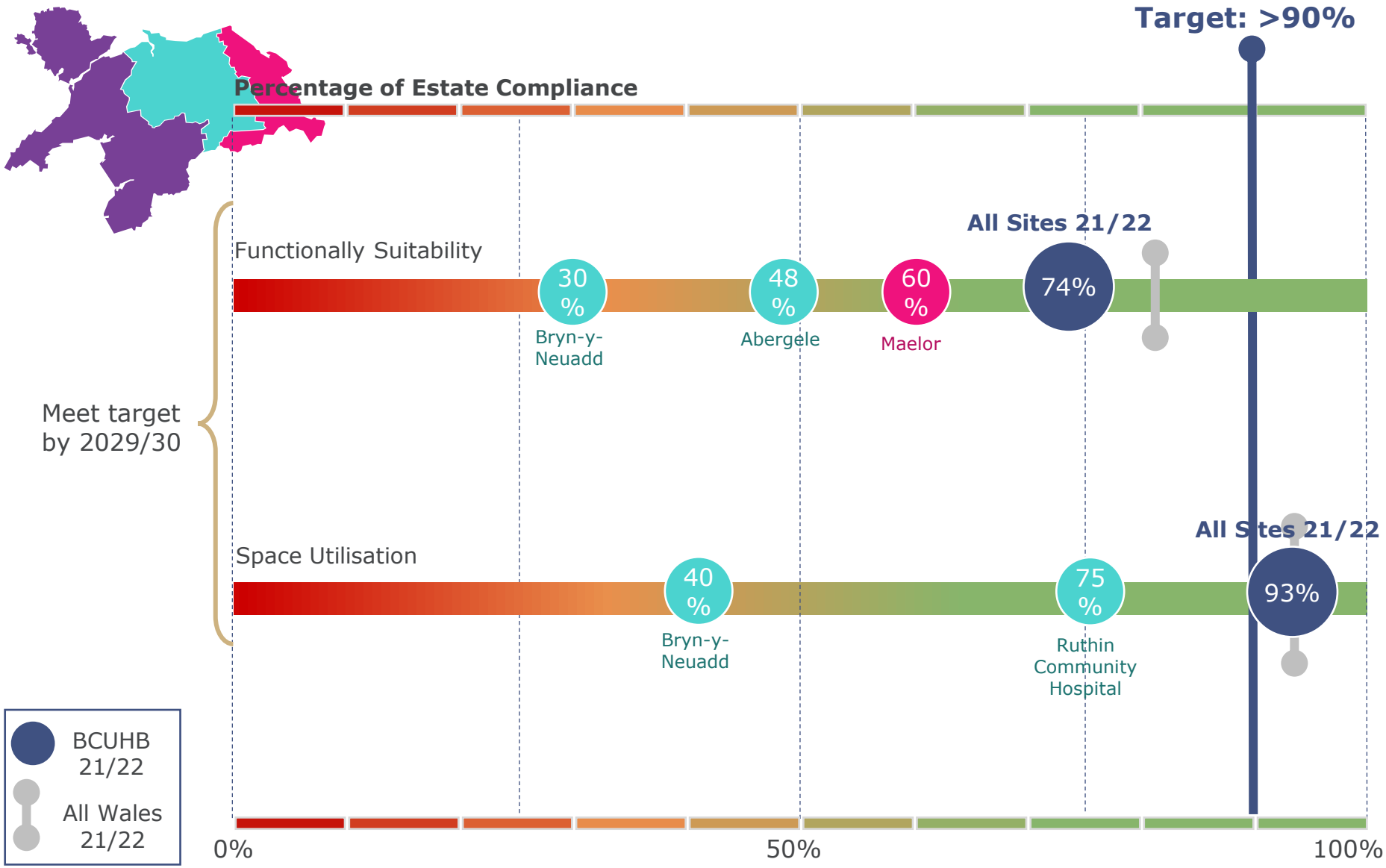
The planned Ysbyty Gwynedd Compliance Programme (currently at Programme Business Case stage on the BCUHB Capital Programme) will address key fire safety issues (compartmentation, evacuation and early warnings). BCUHB is also currently undertaking some fire precaution works through EFABS 2 All Wales funding.

Note, EFPMS currently reports that 20% of Wrexham Maelor Hospital occupied floor area is in sound and operationally safe condition. However, this value is known to be incorrect and realistically is closer to 55%.

[1] Excludes significant proportion of primary care properties. Values are per occupied floor area (OFA). NHS Wales values exclude Welsh Ambulance Service Trust.

[2]Physical condition and statutory compliance definitions are provided in Appendix 3.

2.4.2 Overview - Functional Suitability and Space Utilisation (All Properties[1])



Functional suitability[2]: 74% of our estate is considered to be functionally suitable, compared to the national target of 90% and the NHS Wales average value of 81%.

On average, there has been a reduction in the functional suitability of our estate (from 85% to 74%) since the 2019 Estate Strategy. In particular, Bryn-Y-Neuadd, Abergele and Wrexham Maelor estate all have low levels of functional suitability.

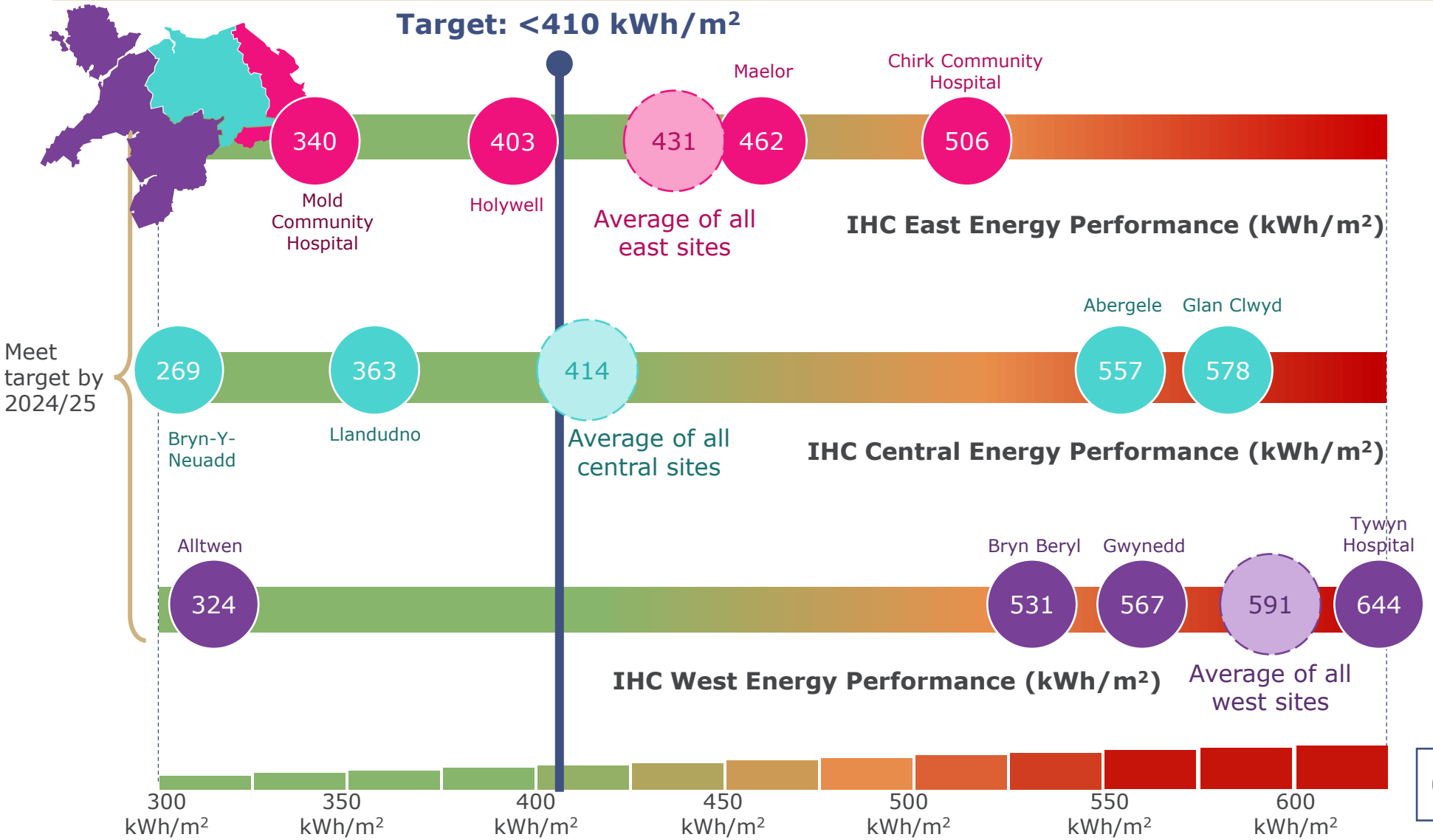
Space Utilisation[2]: 93% of our estate is utilised, compared to the national target of 90% and the NHS Wales average value of 93%.

Since the 2019 Estate Strategy, utilisation of the estate has increased (from 88% to 93%). However, this indicator does not identify whether space is being used at the required level of efficiency.

[2]Functional suitability and space utilisation definitions are provided in Appendix 3.

[1] Excludes significant proportion of primary care properties. Note that these values are per occupied floor area. NHS Wales values exclude Welsh Ambulance Service Trust.

2.4.3 Overview - Energy Performance (All Properties*)



Energy Performance : This indicator examines the total fossil and renewable non-fossil energy (electricity, gas, oil) consumed per occupied floor area.

IHC East & ICH Central: Average energy performance across sites is 431 kWh/m² and 414 kWh/m², respectively, both slightly above the national target of 410 kWh/m²; the NHS Wales average value is 383 kWh/m². Abergele Hospital has poor energy performance. Energy demand is higher at Glan Clwyd Hospital due to the high energy requirements of on site technical equipment e.g. linacs, which necessitate significant increases in plant, cooling systems, and modern ventilation systems with associated engineering.

IHC West: Average energy performance across sites is 591 kWh/m², significantly higher than the national target. Tywyn Hospital and Ysbyty Gwynedd have particularly poor energy performance.

Specific Site

Average for region

*kWh from BCUHB Utilities 2021 - 2022 report for each region. Occupied floor areas from EFPMS 2021/22. Excludes significant proportion of primary care properties.
Note that values are based on occupied floor area. NHS Wales values exclude Welsh Ambulance Service Trust.

2.5 Estate Overview

BCUHB
c.238 properties in BCUHB portfolio

c.420,000 m^2
Total size of the Betsi Cadwaladr estate (GIA)

19,200
staff employed

Total Building & Engineering Maintenance Cost per OFA
£49/m^2
(EFPMS*)

32%
built in last 27 years
(EFPMS*)

14%
built pre-1948
(EFPMS*)

£1.61bn
capital investment by 2031/32

176,000 tCO_2e
carbon footprint
(decarbonisation strategy)

£240m
Risk adjusted backlog
(EFPMS*)

3
Acute Sites
- Wrexham Maelor Hospital
- Glan Clwyd Hospital
- Ysbyty Gwynedd

8 Mental Health & Learning Disabilities inpatient facilities

16 community & local hospitals

74 community facilities

137
GP Practices

*EFPMS 21/22 data excludes significant proportion of primary care properties. Note that these values are per occupied floor area (OFA)
**Significant increase in backlog maintenance costs due to infrastructure risks at Ysbyty Gwynedd and Wrexham Maelor Hospital

BCUHB currently has one of the largest property portfolios in Wales. The estate comprises circa 238 properties with a total GIA of c.420,000 m^2.

The current estate comprises a mix of property types, from acute hospitals to primary care centres.

A significant proportion of the estate (c.45%) is greater than 40 years old.

The estate has a total backlog maintenance cost of £348m and a total risk adjusted backlog of £240m. Backlog costs have increased significantly since the 2019 Estate Strategy (from £142m to £348m)**.

Section 2.5 provides high level estate diagnostic infographics for each of the key property types within the BCUHB estate portfolio.

2.5.1 Acute Hospitals- Estate Condition and Performance

3 Acute Sites*

Total Area (GIA)

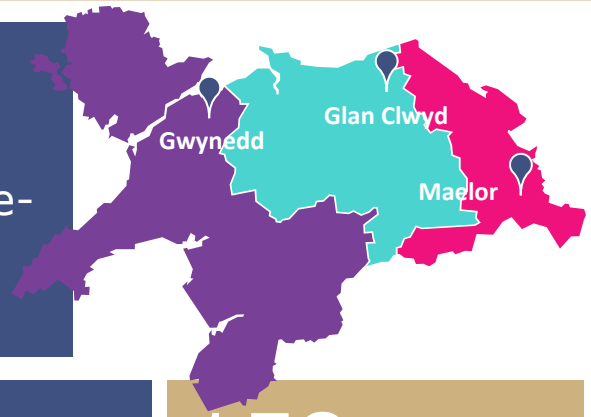
240,000m^2

34%

built in last 27 years

5%

built pre-1948



42% of OFA in condition C + D

40% of space does not meet Statutory Fire Safety compliance

25% of space is not functionally suitable

158 kWh/m^2 Total electrical energy consumed per OFA

£254,500,000 Total backlog

28% of space does not meet statutory Health & Safety compliance

97% of space is utilised

512 kWh/m^2 Fossil & renewable non-fossil energy consumed per OFA

*All data for Glan Clwyd Hospital, Ysbyty Gwynedd & Wrexham Maelor Hospital from EFPMS 21/22. Includes Heddfan, Ablett & Hergest Units. Note that these values are per occupied floor area (OFA)

The three acute hospitals comprise c.37% of the total estate GIA m^2.

Circa 66% of the acute estate is greater than 27 years old.

Only 58% of the acute hospital estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

A significant proportion of the estate does not meet statutory compliance requirements.

Acute backlog (c.£255m) accounts for c.73% of total estate backlog. Risk-adjusted acute backlog is c.£182m.

While c.97% of the acute space is utilised, 25% of this space is not functionally suitable.

The energy performance of the acute hospital estate falls short of the 410 kWh/m^2 national target.

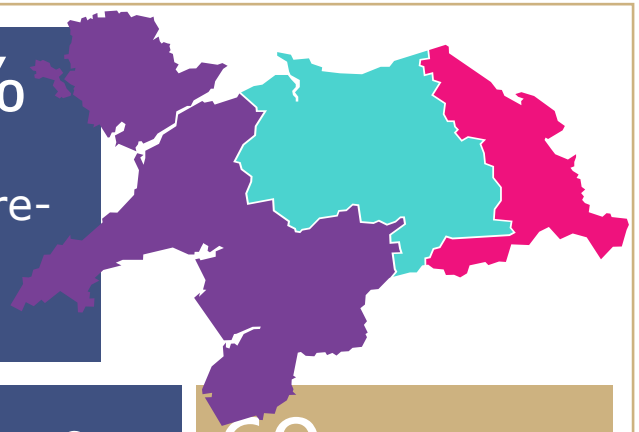
2.5.2 Mental Health & Learning Disabilities - Estate Condition and Performance

8
MH&LD Inpatient Facilities*

Total Area (GIA)*
31,900m²

18%
built in last 27 years

35%
built pre-1948



30% of OFA in condition C + D*

24% of space does not meet Statutory Fire Safety compliance

55% of space is not functionally suitable

69 kWh/m²
Total electrical energy consumed per OFA

£29,000,000
Total backlog

25% of space does not meet statutory Health & Safety compliance

54% of space is utilised

280 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*8 MH&LD Inpatient Units in total (3 on acute sites). Information above from EFPMS 2122 data for the following 5 facilities: Bryn Hesketh, Bryn-Y-Neuadd Hospital, Coed Celyn, Cefni Hospital, Tan-Y-Castell. Note that these values are per occupied floor area (OFA)

Mental health and Learning Disability (MH&LD) services are provided from 8 inpatient facilities, three of which are located on the acute hospital sites. EFPMS data for these 3 MH&LD sites is amalgamated with acute facility data. The information opposite relates specifically to the 5 MH&LD inpatient facilities not located on acute sites.

MH&LD properties comprise c.8% of the total estate GIA m². Circa 82% of the MH&LD estate is older than 27 years.

70% of the MH&LD estate is condition B or above (sound, operationally safe), compared to the national target of 90%. A significant proportion of the estate does not meet statutory compliance. Backlog (£29m) accounts for c.8% of total estate backlog. Risk-adjusted backlog is c.£22.4m.

The energy performance of the MH&LD estate exceeds the national target of 410 kWh/m².

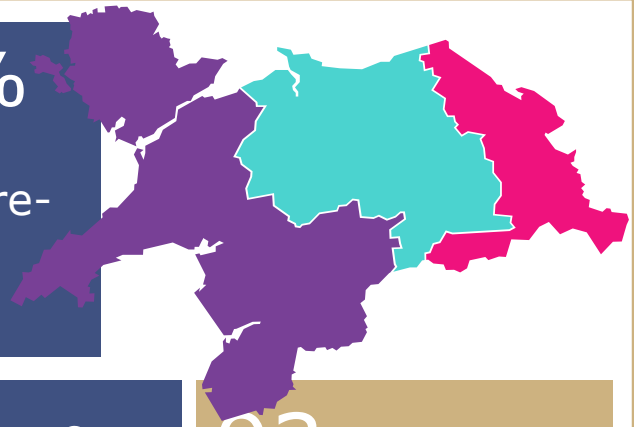
2.5.3 Community and Local Hospitals - Estate Condition and Performance

16
Community and Local Hospitals*

Total Area (GIA)
73,200m²

38%
built in last 27 years

32%
built pre-1948



30% of OFA in condition C + D

30% of space does not meet Statutory Fire Safety compliance

20% of space is not functionally suitable

93 kWh/m²
Total electrical energy consumed per OFA

£40,100,000
Total backlog

27% of space does not meet statutory Health & Safety compliance

94% of space is utilised

411 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*All data for 16 community and local hospitals from EFPMS 21/22. Note that these values are per occupied floor area (OFA). Properties included within this analysis are detailed in Appendix 4.

The 16 community and local hospitals comprise c.17% of the total estate GIA m².

Circa 62% of the estate is greater than 27 years old.

70% of the community and local hospital estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

Circa 30% of the estate does not meet statutory compliance requirements.

Community and local hospital backlog (c.£40m) accounts for c.12% of total estate backlog. Risk-adjusted acute backlog is c.£22m.

While c.94% of community and local hospital space is utilised, 20% of this space is not functionally suitable.

The energy performance of the community and local hospital estate is just short of the national target of 410 kWh/m².

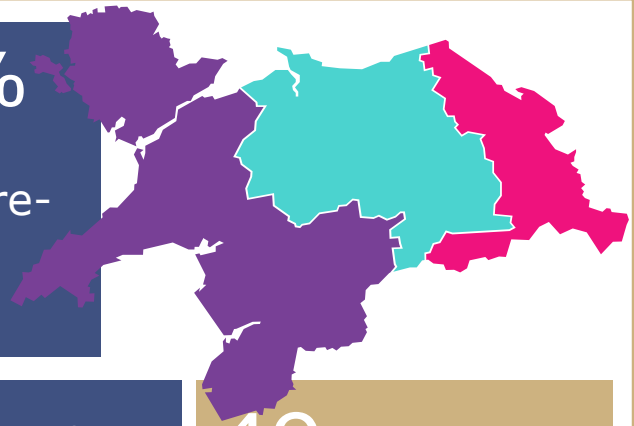
2.5.4 Community Facilities - Estate Condition and Performance

74
Community Sites*

Total Area (GIA)
44,000m²

17%
built in last 27 years

27%
built pre-1948



31% of OFA in condition C + D

28% of space does not meet Statutory Fire Safety compliance

22% of space is not functionally suitable

49 kWh/m²
Total electrical energy consumed per OFA

£24,800,000
Total backlog

£14,200,000
Risk Adjusted Backlog

16% of space does not meet statutory Health & Safety compliance

79% of space is utilised

292 kWh/m²
Fossil & renewable non-fossil energy consumed per OFA

*Data for 74 community facilities in aggregated in EFPMS 21/22data. Note that these values are per occupied floor area (OFA). Properties included within this analysis are detailed in Appendix 4. Note, the Royal Alexandra Hospital is included within this analysis.

The 74 community facilities comprise c.10% of the total estate GIA m².

Circa 83% of the estate is greater than 27 years old.

69% of the community facilities estate is condition B or above (sound, operationally safe), compared to the national target of 90%.

The estate falls below national targets for statutory compliance.

Community facilities backlog (c.£25m) accounts for c.7% of total estate backlog. Risk-adjusted acute backlog is c.£14m.

While c.79% of the community facilities estate is utilised, 22% of this space is not functionally suitable.

The energy performance of the community facilities estate is significantly better than the national target of 410 kWh/m².

2.5.5 Primary Care - Estate Condition and Performance

A complete recent data set for primary care estate condition and performance is currently not available to inform this estate strategy.

As a significant proportion of BCUHB area primary care properties are not reported on for EFPMS data returns, an accurate assessment of current primary care estate condition and performance is not available via EFPMS. The most recent assessment of 173 BCUHB primary care facilities (the vast majority of which are owned and managed by private providers) was undertaken by Lambert Smith Hampton in 2016. Summary findings on the physical condition, equality/DDA compliance, space utilisation and functional suitability of primary care properties are presented opposite. As there is no reason to assume that the overall condition of the estate has changed significantly since 2016, this assessment is considered to still provide a reasonable representation of condition and performance of the primary care estate. It is also assumed that those properties that were the most expensive in 2016 remain as so.

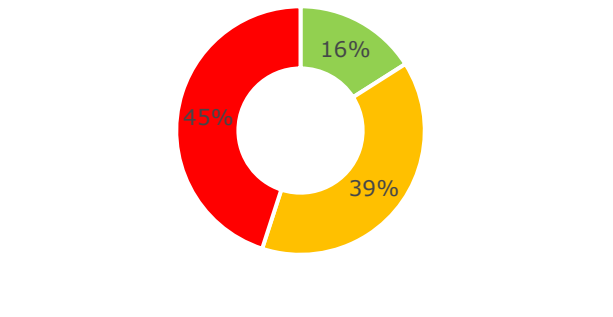
Physical Condition: In 2016, total required backlog maintenance across the whole estate was c.£4.5m (excluding VAT) and 45% of the primary care estate was rated as poor/unacceptable. Based on PUBSEC indices forecasts (to 4Q 2022), current backlog costs across the whole estate are estimated at c.£6.8m (excluding VAT).

Equality Act / DDA compliance: In 2016, it was estimated that c.£3.2m of work would be required for reasonable modifications to primary care properties to ensure compliance with Equality Act/DDA. Across the whole estate, more Equality Act/DDA compliance issues were identified in comparison to physical space and functionality issues. Based on PUBSEC indices forecasts (to 4Q 2022), current costs for reasonable modifications to primary care properties to ensure compliance with Equality Act/DDA are estimated at c.£4.8m (excluding VAT).

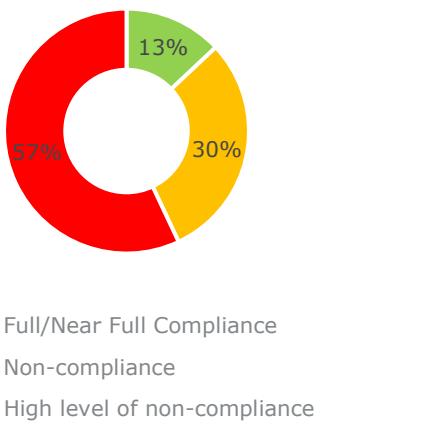
Space utilisation: In 2016, only 10% of primary care space was under utilised (typically, space within the more recently constructed properties designed to include future expansion space). This figure is likely to have reduced due to the impact of the COVID pandemic on additional space requirements within primary care properties.

Functional suitability: In 2016, 25% of properties had a poor/unacceptable level of functional suitability (generally correlating to either overcrowded or old properties).

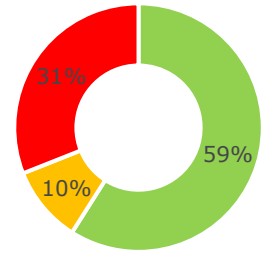
*Physical Condition – Summary



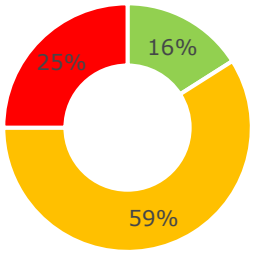
Equality Act (DDA) Compliance - Summary



Space Utilisation – Summary



Functional Suitability - Summary



*Physical condition ratings based on the following backlog maintenance costs per m^2: A – Excellent (<£15/m^2); B – Good (£15-70/m^2); C – Poor/Unacceptable (>£70/m^2)

Based on PUBSEC indices forecasts (to 4Q 2022), current backlog maintenance costs per m^2 are estimated as follows: A – Excellent (<£23/m^2); B – Good (£23-105/m^2); C – Poor/Unacceptable (>£105/m^2)

2.5.5 Primary Care - Estate Condition and Performance

Survey work is currently in progress to provide an updated primary care estate data set across Wales.

The Future for Primary Care Premises in Wales

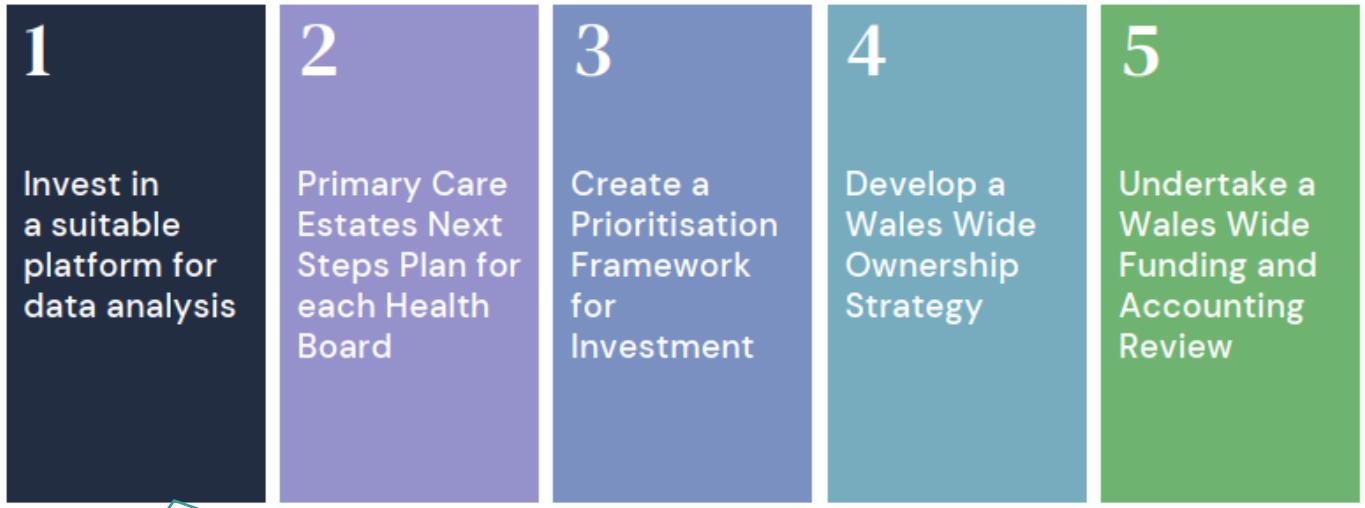
Welsh Government recently (Aug 2021) published the vision for primary care services and premises in Wales (Case for Change: Future for Primary Care Premises in Wales).

This document sets out a roadmap to improvement for primary care estate in Wales. Key steps are listed below:

- Invest in a suitable platform for data analysis
- Develop a primary care estate next steps plan
- Create a prioritisation framework for investment
- Develop a Wales wide ownership strategy
- Undertake a Wales wide funding an accounting review

Currently, significant gaps exist in primary care estate data (planning, condition, performance, ownership / leasing / licensing details) across Wales. Lack of data impacts on the ability to generate informed investment decisions.

To address this issue, a survey of all primary care premises in Wales is being undertaken. Examples of key estate metrics being collected are shown opposite. When available, this information will be used to inform and update our estate strategy.



2.6 Estate Backlog Maintenance Costs

Our estate has a total backlog maintenance cost of £348m and a total risk adjusted backlog of £240m. Approximately 73% of total backlog relates to the 3 acute hospitals. Total backlog costs have increased significantly since the 2019 Estate Strategy (from £142m to £348m).

Backlog Maintenance

Backlog 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 is £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.

Profile of BCUHB 2021/22 Backlog Maintenance Costs (£m)

Property Type	Total backlog	High Risk	Significant Risk	Moderate Risk	Low Risk	Risk Adjusted
All Properties	*£348.79*	*£91.81*	*£142.50*	*£68.66*	*£45.42*	*£239.96*
Acute Hospitals*	£254.51	£64.42	£113.42	£45.21	£31.46	£181.49
Mental Health Inpatient*	£28.97	£16.22	£6.38	£4.48	£2.42	£22.41
Community & Local Hospitals*	£40.12	£5.84	£15.07	£12.10	£7.12	£21.82
Community Facilities*	£24.78	£5.33	£8.15	£6.88	£4.43	£14.23
Primary Care†	£0.41					

*All data from EFPMS 21/22.
†Data from Welsh Government Review of Primary Care Facilities - Primary Care Premises Database for 75/137 properties

2.7 Estate Revenue Costs

Our estate has an annual key estate cost of c.£34.7m. Since the 2019 Estate Strategy, annual estate costs have increased by 54% from £22.6m to £34.7m. Our key estate cost/m^2 of c£94 is above the NHS Wales average of c.£66/m^2.

Estate Revenue Costs

The table opposite provides a summary of the 2020/21 aggregated BCUHB annual estate costs compared to NHS Wales average costs. Our key total estate cost in 21/22 was c.£34.7m, of which approximately 70% relates to the 3 major acute hospitals, 20% to community hospitals, community facilities and corporate estate.

Since the 2019 Estate Strategy, annual estate costs have increased by 54% from £22.6m to £34.7m. Our key estate cost/m^2 of c£94 is above the NHS Wales average of c.£66/m^2. Factors influencing our increasing estate costs and higher costs/m^2 (compared to the NHS Wales average) are as follows:

- The age, scale and geographic spread of our estate across North Wales represents significantly more risk; the ageing estate profile requires more maintenance
- We are investing more revenue on estates due to the deteriorating condition of the estate
- We are spending more on the estate to make it more compliant
- Due to the COVID pandemic, there is an increased focus on compliance and environmental improvement.

2021/22 Key Estate Costs*	BCUHB Cost (£m)	BCUHB (£/m^2)	NHS Wales Average (£/m^2)
Estate Costs			
Building and engineering[1]	£18.10M	£48.79	£28.48
Total energy	£13.16M	£35.48	£29.96
Water	£1.37M	£3.69	£2.04
Sewage	£0.83M	£2.25	£1.77
Waste	£1.28M	£3.46	£3.29

*All data from EFPMS 2021/22. NHS Wales values exclude Welsh Ambulance Service NHS Trust. Definitions as per EFPMS. Excludes significant proportion of primary care properties.

[1]Building and engineering costs defined as *total pay and non-pay costs for the provision of building and engineering maintenance services, to maintain the whole of the building fabric sanitary ware, drainage, engineering infrastructure, systems and plants, etc. both internally and externally to the buildings. Includes labour and materials costs for all directly employed and contract staff. Includes all capital investment costs that have been expensed in support of the maintenance function but excludes all capital modernisation works involving adaptations improvements, and alterations included items that will be redefined as revenue to captain the final accounts.*

2.8 Stakeholder Engagement - Summary Priorities Statement

Engagement with stakeholders across BCUHB to understand current key estate issues revealed the requirement to address a number of immediate priorities (summarised below).

Current State – Stakeholder Engagement

Engagement with stakeholders from the following key groups was undertaken, either via structured interviews or workshops, to understand key current estate issues and priorities to inform development of the future estate vision.

Integrated Health Communities and clinical leads

- Ysbyty Gwynedd
- Glan Clwyd Hospital
- Wrexham Maelor Hospital
- Community Dental Services
- Primary and Community Care
- Mental Health and Learning Disabilities
- Midwifery and Women's Services
- Cancer and Diagnostics and Clinical support
- Patient Safety and Experience

Corporate and external

- Board
- Health Board Leadership Team
- Capital Investment Group
- Clinical Senate
- Community Health Council

Estates

- Health, safety, and equality
- Operational estates
- Property and asset management

Summary Priorities - Immediate issues

Maintenance, quality and safety issues
Significant concerns exist regarding the quality of both acute and community estate

Space utilisation
There is a common perception of underuse on a number of sites which will require targeted validation

Capacity
Capacity constraints exist across acute and community sites. Re-purposing the space released post-RTCs should reduce pressure in the acute hospitals

Approach to workspace
Recognising post-COVID changes to working practices (including a greater level of working from home), a flexible approach is expected

Flexibility
Given financial constraints and other complexity, flexibility and senior support is required to address some of the most critical immediate issues

2.9 Key Estate Risks and Challenges

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.

Evaluation of key BCUHB estate condition and performance indicators (as per 2021/22 EFPMS data) can be summarised as follows:

Physical Condition: Only 62% of BCUHB estate is condition B or above (sound, operationally safe), compared to the national target of 90%; the NHS Wales average value is 78%.

Statutory Health & Safety: Against a national target of 90%, only 74% of BCUHB estate complies with statutory requirements; the NHS Wales average value is 80%.

Statutory Fire Safety: 64% of BCUHB estate complies with statutory fire requirements, compared to the national target of 90% and the NHS Wales average of 78%

On average, physical condition and statutory compliance of the estate has got worse since the 2019 Estate Strategy. In particular, the Abergele Hospital, Wrexham Maelor Hospital, Royal Alexandra Hospital, and Ysbyty Gwynedd sites are in poor condition with low levels of compliance.

Functional suitability: 74% of BCUHB estate is considered to be functionally suitable, compared to the national target of 90% and the NHS Wales average value of 81%.

On average, there has been a reduction in the functional suitability of BCUHB estate (from 85% to 74%) since the 2019 Estate Strategy. In particular, Bryn Y Neuadd Hospital, Abergele Hospital and Wrexham Maelor Hospital estate all have low levels of functional suitability.

Space Utilisation*: 93% of the BCUHB estate is utilised, compared to the national target of 90% and the NHS Wales average value of 93%. Since the 2019 Estate Strategy, utilisation of the estate has increased (from 88% to 93%). However, this indicator does not identify whether space is being used at the required level of efficiency.

Energy Performance: This indicator examines the total fossil and renewable non-fossil energy (electricity, gas, oil) consumed per occupied floor area.

IHC East & ICH Central: Average energy performance across sites is 431 kWh/m^2 and 414 kWh/m^2, respectively, both slightly above the national target of 410 kWh/m^2; the NHS Wales average value is 383 kWh/m^2. Glan Clwyd Hospital and Abergele Hospital have poor energy performance.

IHC West: Average energy performance across sites is 591 kWh/m^2, significantly higher than the national target. Tywyn Hospital and Ysbyty Gwynedd have particularly poor energy performance.

*Space utilisation based on EFPMS definition of unutilised space: 'Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.'

2.9 Key Estate Risks and Challenges

The major risks presented by our current estate may be summarised as follows:

Ysbyty Gwynedd (YG)

- The highest backlog maintenance in the property portfolio
- The age and resilience of the engineering infrastructure
- A significant percentage of occupied floor area is condition C/D, not compliant with statutory requirements, and not functionally suitable
- The design and layout of YG presents infection prevention and control risks, and does not comply with current guidance or support efficient working and new models of care
- The planned YG Compliance Programme (currently at Programme Business Case stage on the BCUHB Capital Programme) will address key infrastructure and fire safety issues (compartmentation, evacuation and early warnings) and focus on the following areas:
    - Fire packages
    - Evacuation packages
    - Low voltage infrastructure
    - Heating and ventilation
    - Medical gases and distribution pipework
    - Water systems
    - Building fabric
- BCUHB is also currently undertaking some fire precaution works through EFABS 2 All Wales funding

Wrexham Maelor Hospital (WMH)

- The second highest backlog maintenance in the estate
- The age and resilience of the engineering infrastructure
- 80% of occupied floor area is condition C/D, with high percentages not compliant with statutory requirements, and not functionally suitable
- The design and layout of WMH presents infection prevention and control risks, and does not comply with current guidance or support efficient working and new models of care
- The WMH Continuity Programme (currently at Full Business Case stage on the BCUHB Capital Programme) will address key infrastructure issues and focus on the following areas:
    - Completion of the existing HV Ring Main
    - New Intake and Phase 1 electrical sub stations

2.9 Key Estate Risks and Challenges

- Replacement of obsolete fire alarm panels
- Oxygen accessible pipework
- Heating and domestic hot and cold water to the former "EMS" area
- Replacement of critical damaged fire door sets across the site
- Replacement of vacuum plant to Nucleus phases 1&2; replacement of medical air plant to Nucleus Phase 2
- Address the red risks as identified within the fire survey

Glan Clwyd Hospital

- Backlog maintenance of c.£37m
- The Glan Clwyd Hospital compliance and electrical capacity project (currently on the BCUHB Capital Programme) will address key infrastructure issues focused on upgrading electrical infrastructure

Abergele Hospital

- Backlog maintenance of c.£15.5m; 80% of occupied floor area is condition C/D, with similar amounts of floor area not complaint with statutory requirements, and not functionally suitable
- 10% of occupied floor area is unutilised

Royal Alexandra Hospital (RAH)

- The age, design and physical condition of the building and engineering infrastructure
- Backlog maintenance of c.£15.3m
- 68% of occupied floor area is condition C/D, with 35-40% of occupied floor area not complaint with statutory requirements
- The RAH development project (currently at Full Business Case stage on the BCUHB Capital Programme) will address key infrastructure and statutory issues

Bryn Y Neuadd Hospital

- The age, design and physical condition of the building and engineering infrastructure
- Backlog maintenance of c.£27.7m
- 35% of occupied floor area is condition C/D, with moderate levels of statutory non-compliance
- 70% of occupied floor area is not functionally suitable, with 60% of area being underutilised
- 40% (c.10,800m^2) of the site GIA m^2 is unoccupied

2.9 Key Estate Risks and Challenges

The design and layout of the **Hergest Unit, Ablett Unit, Cefni Hospital and Bryn Hesketh Hospital** are not considered fit for purpose and do not support new models of Mental Health care (Hergest Unit and Ablett Unit redevelopment schemes are on the current BCUHB capital programme); this will particularly impact on the following:

- Provision of an appropriate physical environment for Mental Health and Learning Disabilities services
- Service user privacy and dignity, experience, behaviours and security
- Compliance with Royal College of Psychiatrists guidance

The age, design and physical condition of the building and engineering infrastructure of:

- Colwyn Bay Hospital
- Denbigh Hospital
- Eryri Hospital
- Ruthin Hospital

The design and engineering infrastructure of **Dolgellau Hospital.**

Space limitations within community properties may prevent colocation of large teams and impact on model of care delivery.

Insufficient provision of space for training purposes; lack of accommodation for people in training.

Net Zero Risks and Challenges

- Heat decarbonisation: To comply with NHS and Welsh Government targets, fossil fuelled boilers and CHP approaching end of life, such as at Glan Clwyd Hospital and the CHP plant at Ysbyty Gwynedd, must be identified and option appraisals conducted to switch to clean heat
- Transport: Progress on EV rollout across the estate, with 30% of lease cars electric, and 20x EV charging points having been installed at the Wrexham Maelor Hospital site, could be challenged by growing demand for charging on site
- Renewables: NHS Wales target to maintain 100% REGO backed electricity supply, could become difficult on the BCUHB estate given inflationary pressures in energy markets that are expected to continue into 2023/24
- Clinical emissions: NHS Wales ambition to use methods to minimise gas wastage and technologies to capture expelled medical gases has been identified as a significant concern by the clinical team at BCUHB

3.0 Future State (Where Do We Want To Be?)

3.1 Strategic Challenges

Operating in a complex and diverse environment, BCUHB faces a number of key strategic challenges as summarised below.

External Environment

- Health and wellbeing of the population is determined by a number of complex factors
- BCUHB has relatively little direct influence over these factors
- Increased partnership working required to focus collective resources on maximising health and wellbeing gain for population

Population Need

- Ageing of the population set to continue
- Increasing incidence of long term conditions / complex health needs
- More people living with dementia and mental health conditions
- Uneven distribution of health benefits across the geographical areas and groups of North Wales

Geography

- North Wales is a large geographical region (c.50% rural)
- More densely populated areas follow the northern coast and English border
- Complex mix of care needs and circumstances that differ between communities

People

- BCUHB employs c.19,200 staff over 167 locations
- High vacancy rate
- Need greater capability and capacity in digital skills
- Primary Care workforce development is a priority
- Vital to ensure BCUHB can recruit and retain a well trained, motived, and sustainable workforce

Finance

- Underlying funding deficit in both capital and revenue
- BCUHB is reporting a potential 2022/23 year end deficit, in common with all Health Boards
- BCUHB is instigating a recovery plan that seeks to strike a balance between performance, quality and cost

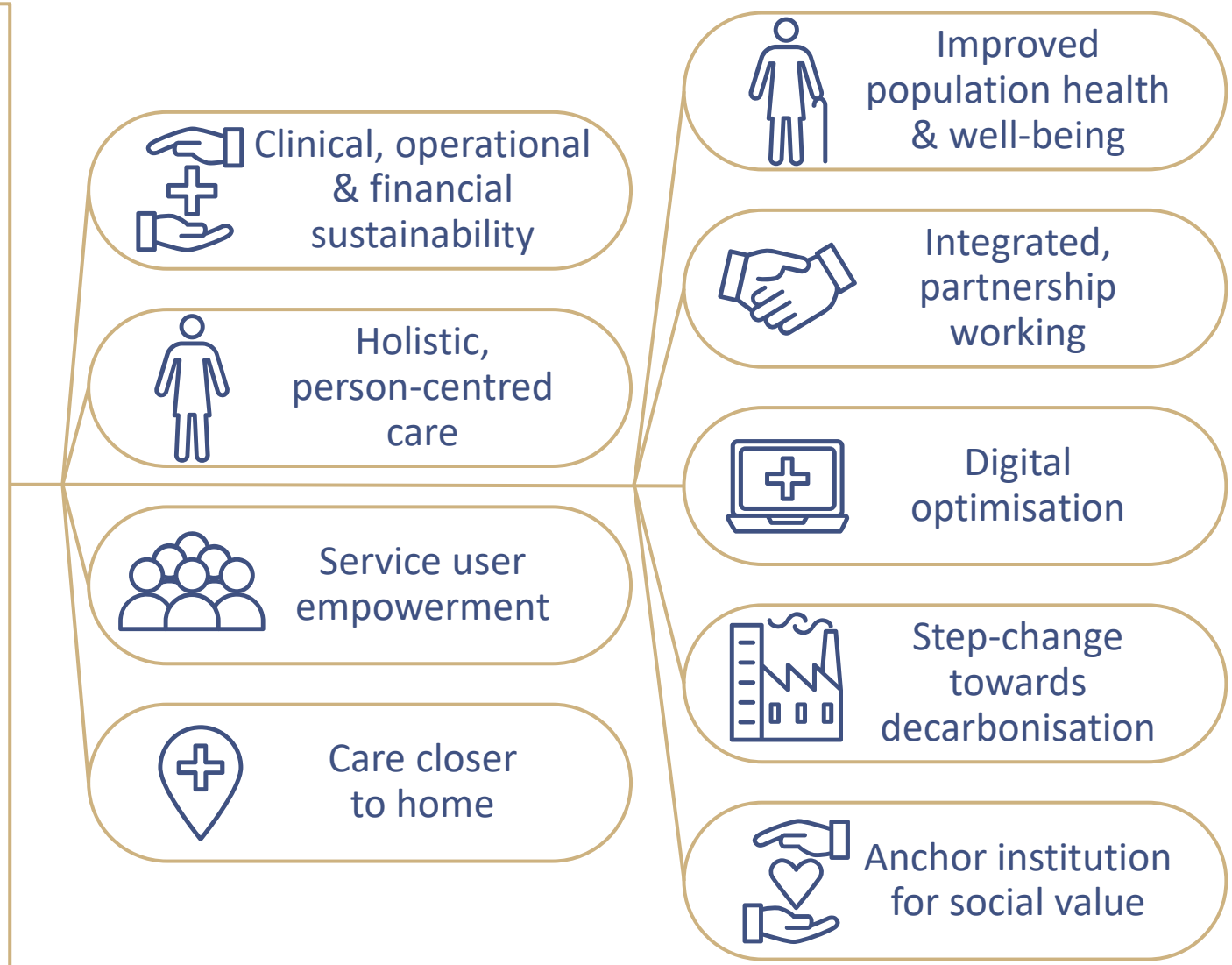
3.2 Strategic Context

In March 2018, BCUHB approved its long term strategy, Living Healthier, Staying Well, which outlines the vision for health, wellbeing and healthcare over the next ten years.

Living Healthier, Staying Well underpins the strategic framework for our future estate that will be designed to support health and wellbeing, primary and community services through a network of wellbeing centres. This network will be supported by three acute hospital campuses providing acute and specialist care together with key support services (clinical and non-clinical).

Through targeted development, repurposing, reconfiguration and rationalisation the property portfolio will be aligned to support the 14 clusters and three acute hospital campuses, with estate capacity and size reflecting the shift in care closer to home and new models of working. The future estate will support the development of regional facilities providing centres of clinical excellence and support services to all of North Wales and will be designed to be sustainable, reduce environmental impact and to support the wider economic, social and cultural wellbeing of North Wales.

The BCUHB Clinical Services Strategy (June 2022) sets out the future direction and strategic intentions for clinical services in North Wales. It provides a 'blue print' for large-scale service redesign and in conjunction with Living Healthier, Staying Well will guide implementation of the estate strategy.



3.3 Strategic Service and Business Objectives Informing Estate Need

The impact of BCUHB's vision, strategic objectives, major programmes and transformation priorities on future key estate requirements is summarised below.

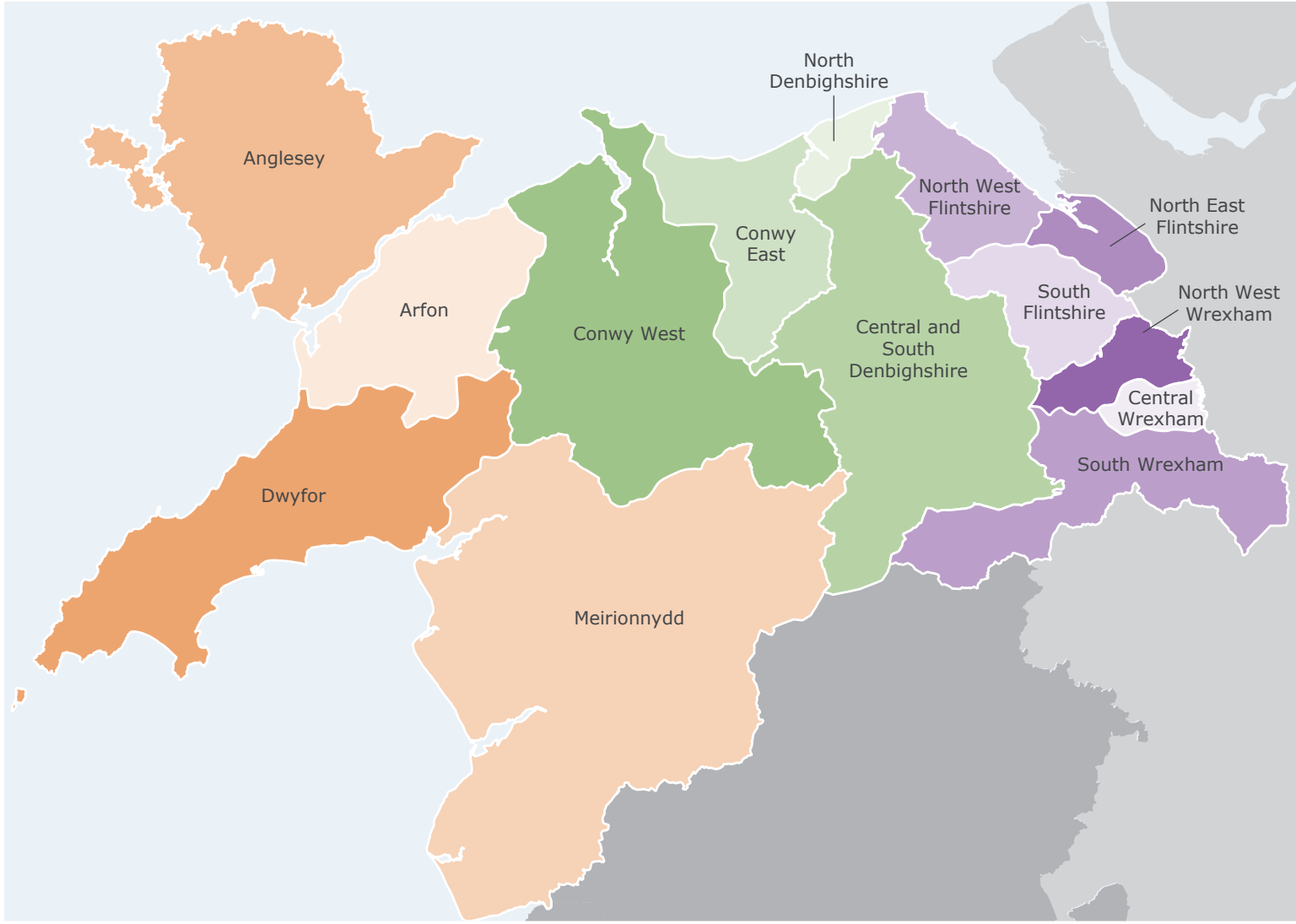
Vision/ ambition	Lead the way on integrated care, supporting health improvement for the population now and in the future						
Strategic objectives	Improve health and wellbeing for all and reduce health inequalities	Support children to have the best start in life	Work in partnership to design and deliver excellent care closer to home	Support, train and develop our staff to excel	Improve the safety and quality of all services	Respect individuals and maintain dignity and care	Listen to and learn from the experiences of individuals
Overlapping major programmes	Improving health and reducing inequalities		Care closer to home		Excellent hospital care		
Transformation priorities	• Healthy lifestyles • Protection and prevention • Resilient communities, tackling inequalities		• Secondary prevention and early intervention • Health and Social Care working together in local communities • Access to care in an emergency		• Sustainable planned care • Unscheduled care • Specialist and complex care		
	Impact on current and future estate						
Key estate requirements	Examine how we use current facilities	Share facilities with other services and organisations when possible	Develop Health and Wellbeing Centres	Improve facilities so mothers have a positive birth experience	Modernise hospitals and other facilities as required	Dispose of premises that are expensive to run or do not support models of care	Ensure buildings are more eco-friendly

3.4 Opportunities - Context

The long term strategy, Living Healthier, Staying Well, outlines the vision for health, wellbeing and healthcare over a 10 year period from 2018 and defines future models of care delivery for BCUHB.

Across the three Integrated Healthcare Communities, 14 clusters, broadly coterminous with local authorities and based on a population of c.50,000, will form the footprint through which Care Closer to Home services are delivered. Within each cluster local community resource teams, GPs and mental health services will work together with local authority and the third sector partners offering a range of advice, assessment and treatment services.

To support enhancement of services within communities, there will be further development of networks of Health and Wellbeing Hubs and Primary Care Centres. Primary care facilities incorporating primary care, community services and partner organisation services will be supported by Health and Wellbeing Hubs providing a wider range of services typically incorporating urgent care (minor injuries), ambulatory consultations and treatment, and inpatient activity.



3.5 Opportunities - Detail

Key high level opportunities informing our strategic estate framework fall within the following broad categories: new models of care, integrated partnership working, repatriation/growth of activity, managing demand and maximising utilisation, new business models and alternative funding routes. Further specific detail on these opportunities is provided below.

DIGITAL

Model of Care

- Care Closer to Home service provision: 14 clusters based on population of c.50,000
- Partnership working facilitated by network of local health and wellbeing hubs and primary care centres
- Acute sites: relocation of services to RTCs / community; vacate space to accommodate service growth e.g. ED
- Reconfigure services to develop Centres of Excellence or ensure sustainability
- Medical and Health Sciences School

DIGITAL

Working with Partners

- Models of care promote an integrated approach with local authority and third sector partners
- Community resource teams faciliate co - location of key services to patients
- Partnership working to develop integrated solutions optimising use of collective property assets

DIGITAL

Repatriation and Growth

- Some specialist services currently provided to BCUHB population by providers outside North Wales
- Opportunity to repatriate services where safe and economical
- Services such as continuing healthcare, low secure mental health, rehabilitation
- RTCs: increase and protect planned capacity

DIGITAL

Managing Demand; Maximising Utilisation

- New models of care to reduce reliance on acute hospital services
- Promoting health and wellbeing se lf management
- Enhancing community services
- Proactive referral management
- Alternative models of acute care follow up
- Promoting centres of excellence for specialist services
- Unlocking capacity through extended working

DIGITAL

New Business Models

- Regional solutions for support services (clinical and non - clinical) to improve service quality and reduce duplication of assets
- Further agile working implementation to reduce office accommodation
- Strategic partnership development for delivery of residences and some non-clinical support services
- Reduce reliance of leased accommodation

DIGITAL

Alternative Funding

- Seek alternative sources of funding outside Welsh Govt capital allocation
- Capital grants
- Invest to Save
- Third party partnership arrangements including Mutual Investment Model, 3rd party development of community facilities, joint venture arrangements
- Long term viability of models subject to revenue affordability

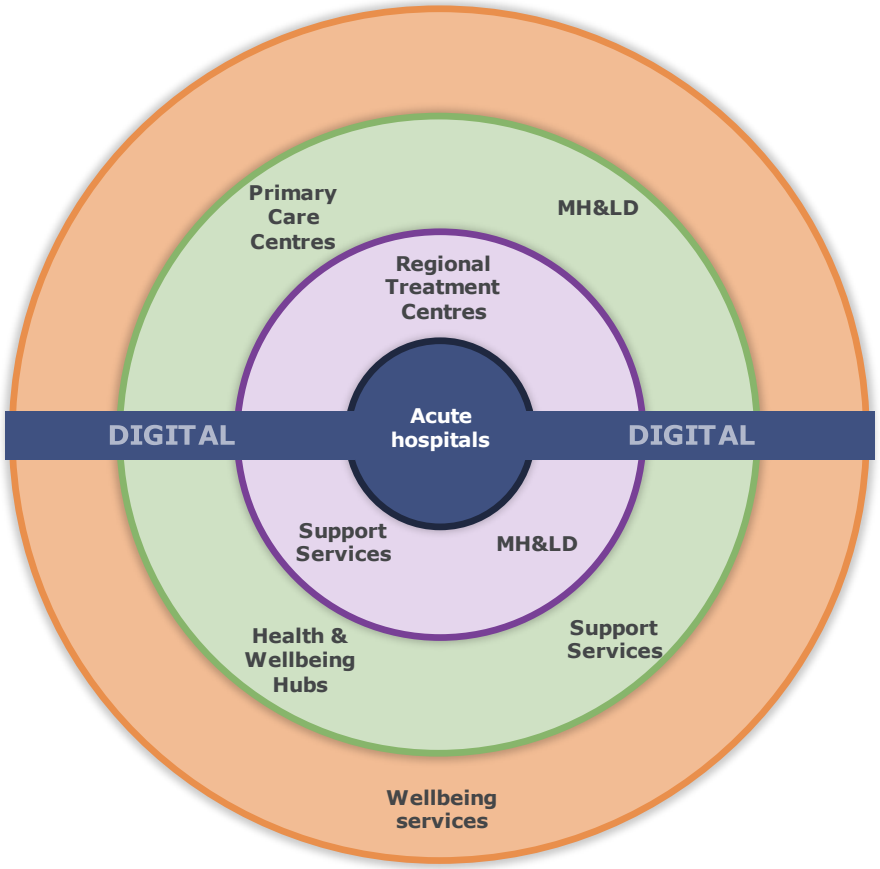
3.6 Vision for the Future Estate

Living Healthier, Staying Well defines the ambition for delivery of BCUHB health and care services that provide the strategic framework for our future estate. This vision, framework and detail regarding specific services and property types for delivery of services is summarised below. Additional detail is provided in the following pages.

Summary of Vision for Future Estate

- Estate that is fit for purpose; provides a safe and effective environment for patients, carers, visitors and staff
- The estate is aligned to clinical and enabling strategies and supports transformation plans
- The efficiency of the estate is improved through appropriate utilisation and investment
- Duplication is eradicated to enable release of assets for direct patient care or disposal
- Assets are employed effectively to deliver value for money
- An agile estate that is able to respond to new growth requirements of services
- Estate that enables a step-change towards decarbonisation and net zero targets

Strategic Framework for Future Estate



Wellbeing services : delivered in a range of public and commercial settings, and at home; focus on improving health and reducing inequalities

Primary care centres: A network of primary care facilities to enhance the existing portfolio of primary care centres and health centres

Health and Wellbeing hubs : Each geographical care cluster supported by at least one Health and Wellbeing hub

Mental Health, Learning Disabilities and Substance Misuse services : Community services colocated with community resource teams; additional accommodation required for inpatient, rehabilitation, specialist support and interventional services.

Regional Treatment Centres : Provide outpatient appointments, diagnostic tests and day surgery.

Excellent hospital care : Commitment to provide acute hospital care from three hospital campuses (Wrexham Maelor, Glan Clwyd, Ysbyty Gwynedd)

Support services estate : Including offices, training and academic centres, residences, medical records storage, HSDU, laundry, workshops and call centre.

3.6 Vision for the Future Estate

3.6.1 Improving Health and Reducing Inequalities

Services focused on supporting health and wellbeing and reducing inequalities will be delivered in a range of settings to facilitate ease of public access. Locations for delivery may include:

- Public community facilities, such as sports and fitness centres, community halls, and libraries
- Commercial premises such as pharmacies, supermarkets, health stores, theatres/cinemas
- Health facilities (including primary care and general dental services)
- Local authority and third sector properties

3.6.2 Care Closer to Home

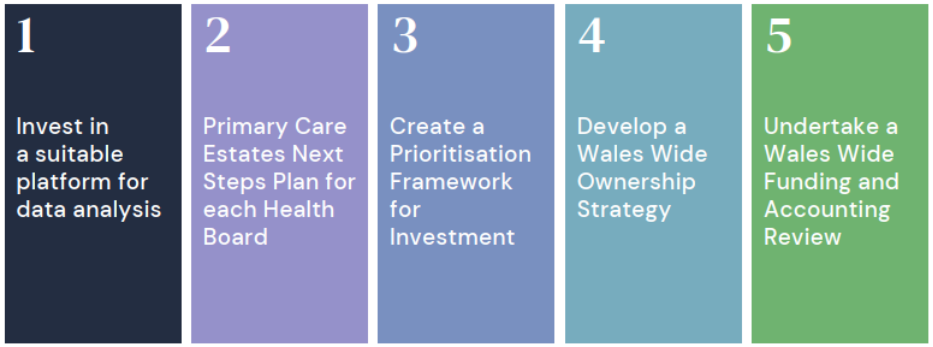
The future network of community facilities required to deliver primary care, community, and mental health, learning disability and substance misuse services will be developed to align with the 14 clusters across the three integrated health communities, meet population needs and consider the impact of geographical factors such as location, transportation links and travel times.

Health and Wellbeing Hubs

It is expected that each of the 14 clusters will be supported by at least one Health and Wellbeing Hub. This network of hubs will build upon the existing portfolio of community and local hospitals and Health and Wellbeing Centres. Health and Wellbeing Hubs may be delivered via use of existing properties, by reconfiguration of existing facilities or development of new properties.

Primary Care Centres

Welsh Government recently (Aug 2021) published the vision for primary care services and premises in Wales (Case for Change: Future for Primary Care Premises in Wales). This document sets out a roadmap to improvement for primary care estate in Wales. Key steps are listed below:



Key stages in this roadmap for all Health Boards focus on development of a next steps plan for primary care and creation of a prioritisation framework for investment.

The BCUHB clinical strategy for primary care is currently emerging. While the focus on Accelerated Cluster Development and delivery of place-based care within clusters is currently at the early stages, there are some notable examples of where BUCHB has begun to move forwards with the vision.

3.6 Vision for the Future Estate

As described within Living Healthier, Staying Well, the proposed network of primary care facilities will build upon the existing portfolio of primary care centres and health centres and will provide access points to health and wellbeing services in primary care settings. Primary Care Centres may be delivered by using existing properties, by reconfiguring existing facilities or by development of new properties. There should also be a drive to deliver primary care services from appropriate non-healthcare (e.g. town centre) premises.

Options for delivery of the primary care centre vision must ensure the provision of sufficient accommodation within facilities to enable delivery of effective and efficient education and training requirements. This will require further evaluation of preferred approaches for education and training (e.g. face to face vs virtual) and alignment with existing primary care space capacity and utilisation (likely to require investigation via the use of room occupancy software).

Delivery of the Care Closer to Home vision via Primary Care Centres and Health and Wellbeing Hubs should also consider the possibility of extended working to maximise asset utilisation and reduce capital investment.

BCUHB will continue to seek Welsh Government funding for the delivery of primary care services via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF).

The Board will also continue to seek opportunities to access Welsh Government improvement grants to support improvement of the condition, functional suitability, performance and sustainability of non-BCUHB primary care estate, subject to value for money assessments.

3.6.3 Mental Health, Learning Disabilities and Substance Misuse

The BCUHB Mental Health Strategy (2017) outlines a vision to support prevention, early intervention, support of service users within the community and a reduction in acute admissions.

Inpatient care will continue to be focused on the three acute sites together with facilities providing secure/rehabilitation services, learning disability units, and Child and Adolescent Mental Health Services facilities.

Community services may be delivered from existing facilities or from Health and Wellbeing Hubs to normalise/destigmatise attendance and enhance service user experience. Community Mental Health Teams will be co-located with the wider community resource teams with some additional accommodation required for specialist support and interventional services.

Similarly, primary care mental health teams will deliver services from primary care premises.

3.6 Vision for the Future Estate

3.6.4 Excellent Hospital Care

There is a commitment to provide acute hospital care from the three hospital campuses at Ysbyty Gwynedd, Glan Clwyd Hospital and Wrexham Maelor Hospital.

There are plans for investment on all three acute sites, especially Wrexham Maelor Hospital and Ysbyty Gwynedd.

Relocation of activity to Regional Treatment Centres (RTCs), and potential relocation/consolidation of services across the three acute hospitals (to develop Centres of Excellence or ensure sustainability) present opportunities to vacate space on acute sites to accommodate growing services.

Administration space requirements on acute sites will be aligned with BCUHB's agile working policy and support the Welsh Government's target for 30% of the Welsh workforce to work remotely supported by technology and smart working processes. This will enable rationalisation of existing administration space and consolidation on acute sites or relocation off-site if essential functional relationships are not required (e.g. some corporate administration). Vacated administration space on acute sites may be used to accommodate growing clinical services or new care models.

3.6.5 Regional Treatment Centres

To increase and protect planned capacity, RTCs will provide outpatient appointments, diagnostic tests and day surgery.

Relocation of activity from the acute hospital sites to RTCs will vacate space on the acute sites to accommodate key service growth e.g. Emergency Department, Same Day Emergency Care, ambulatory care, GP out of hours, and facilitate compliance.

In addition, plans are being developed to expand capacity for orthopaedics under a separate initiative.

3.6.6 Support Services

BCUHB currently provides important clinical and non clinical support services from a range of freehold and leasehold properties. These services include:

- Administration (office space)
- Education and Training (Academic/Training centres)
- Staff/student accommodation (residences)
- Medical records (storage)
- Sterilisation and decontamination (Hospital Sterilisation and Decontamination Unit)
- Workshops
- Call centre

The future support services estate will be built upon strategic hubs, providing regional solutions whilst supporting local delivery e.g. centralised decontamination, regional administration hubs supporting IHCs (aligned with BCUHB's agile working policy and the Welsh Government's target for 30% of the Welsh workforce to work remotely).

This focus will reduce the current reliance on leased accommodation, eradicate duplication and rationalise the current owned assets to facilitate a more sustainable estate.

3.6 Vision for the Future Estate

3.6.7 Net Zero and Carbon Reduction

The Welsh Government has put sustainable development high on the agenda and, in 2021, announced their ambition of achieving net zero carbon status within the public sector by 2030. BCUHB has accordingly produced a decarbonisation plan aligned with NHS targets for emissions reduction, and this estates strategy triggers additional priorities that will support BCUHB to move 'beyond carbon'. Key priorities in terms of deliverables, outcomes and governance with the aim of future-proofing, greening and decarbonising our estate, are as follows:

Priority	Reduce carbon footprint	Ensure inclusive design	Address local economic inequality	Support sustainable transport	Compliance and best practice	Net zero estate	Resilience
Objective	2040 and 2045 net zero	Ensure inclusive design through the participation of local communities	Optimise local procurement and labour to support the local economy	Improved access for patients, staff and visitors	Comply with statutory regulations and best practice guidance	BREEAM standard of "very good" as a minimum	Reduced climate risk
KPI	Carbon emissions equivalent (CO_2e)	Compliance: Environment Act (Wales) 2016; Well-being of Future Generations (Wales) Act 2015	PM2.5, PM10 and nitrogen dioxide	Ratio of journeys-single occupancy against active/public/ sustainable	Organisational compliance risk score	Carbon emissions equivalent (CO_2e)	Exposure rating
Mechanism	Decarbonisation Plan	Accessibility audit	Clean Air Hospital Framework	Green Travel Plan	EMS	Heat Decarbonisation Plan	Climate Change Adaptation Plan

3.6 Vision for the Future Estate

3.6.8 Climate Adaptation

Whilst the mitigation of BCUHB's carbon footprint is vital to achieve Wales's ambition of a net zero Welsh public sector by 2030, it is also imperative to consider the risk that the physical effects of climate change pose to our future estate.

To account for future risk, a climate adaptation analysis has been run across our estate using Cervest's EarthScan climate intelligence interface. The software incorporates global and regional climate models, including the Coupled Model Intercomparison Project (CMIP6) and the Coordinated Regional Downscaling Experiment (CORDEX), to produce accurate future projections of physical climate risks over historical observational baselines.

The physical climate risks modelled across the BCUHB estate include heat stress, extreme precipitation, drought, extreme wind, flooding and wildfire.

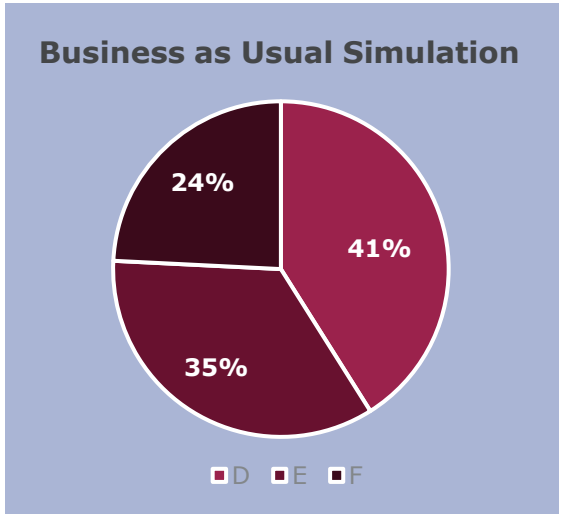
The EarthScan interface allows for the manipulation of climate modelling parameters. In line with the UK's net zero target of 2050, the BCUHB analysis has been tailored to model climate risk for the year of 2050 across two differing climate scenarios:

1) Business as Usual (no-policy highest emitting climate scenario)
2) Paris Aligned (<2˚C global warming with best efforts to limit to 1.5˚C)

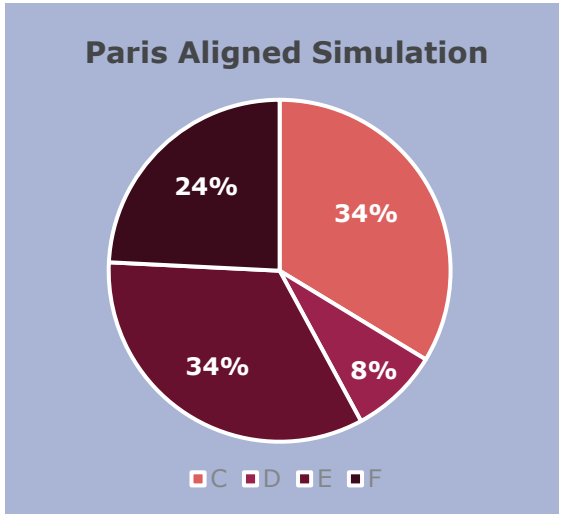
The climate risks generated for each building are quantified via a numerical scope that corresponds to a graded rating. Ratings provide a quick and clear indication of climate related risk, to reveal vulnerabilities and identify opportunities.

Cervest Rating	Cervest Score	Description
A	833-999	Excellent: very low climate-related risk
B	667-832	Good: low climate-related risk
C	501-666	Moderate: medium climate-related risk
D	334-500	Poor: high climate-related risk
E	167-333	Very poor: very high climate-related risk
F	0-166	Extremely poor: extremely high climate related risk

The graphs below display the combined physical risk rating across the two modelled scenarios. This rating is the result of the synthesis of all projected physical climate risks to facilitate comparison of building assets across multiple modelled climate risks. Addressing risks identified will be part of the site specific analysis.



Combined physical risk rating of BCUHB estate under BAU scenario



Combined physical risk rating of BCUHB estate under Paris aligned scenario

4.0 How Do We Get There?

4.1 Summary Priorities Statement

Engagement with stakeholders across BCUHB revealed a number of common themes around strategic ambitions for the estate.

Future State - Stakeholder Engagement

Engagement with stakeholders from the following key groups was undertaken, either via structured interviews or workshops, to understand key priorities to inform development of the future estate vision.

Integrated Health Communities and clinical leads

- Ysbyty Gwynedd
- Glan Clwyd Hospital
- Wrexham Maelor Hospital
- Community Dental Services
- Primary and Community Care
- Mental Health and Learning Disabilities
- Midwifery and Women's Services
- Cancer and Diagnostics and Clinical support
- Patient Safety and Experience

Corporate and external

- Board
- Health Board Leadership Team
- Capital Investment Group
- Clinical Senate
- Community Health Council

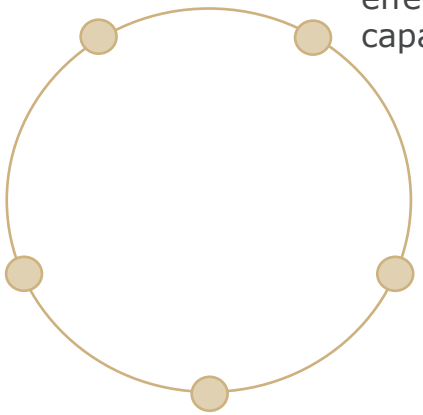
Estates

- Health, safety, and equality
- Operational estates
- Property and asset management

Balancing Strategic Ambitions

New space for growth
A legacy of underestimating the estates impact of new or expanded services reported by respondents

Service interdependencies
Desire for co-locations limited by cost effectiveness and capacity



Financing
Extremely tight capital and revenue funding will initially constrain realisation of our ambition in the short term

Fixed points
3 DGH model will remain with opportunities for consolidation and off-site transfers

New models of care
The recently formed IHCs face the challenge of balancing system-wide objectives with legitimate local variation

4.2 Initial Agreed Priorities

The proposed development of the estate to support BCUHB's suite of enabling strategies provides the opportunity to repurpose, reconfigure and rationalise the current estate portfolio.

This estate strategy proposes repurposing and reconfiguring some existing community facilities, and providing new build facilities where required, to deliver the Health & Wellbeing Hub and Primary Care Centre infrastructure to support Care Closer to Home.

Particular focus should be given to the identified high risk properties, including addressing the issues on the Wrexham Maelor and Ysbyty Gwynedd acutes sites. Consideration must also be given to the roles of Abergele Hospital and Bryn Y Neuadd Hospital sites, within the context of the key strategies of BCUHB and the Welsh Government, as both hospital sites are not sustainable in their current forms.

The Full Business Case for the new North Denbighshire Community Hospital, planned to be built next to the replaced existing Royal Alexandra Hospital, was submitted to Welsh Government in March 2021 (approval decision is currently pending). This remains a priority project for BCUHB.

From 2019/20 to 2021/22, the size (GIA m2) of our property portfolio size has decreased by 8% (from 456,000 m^2 to 420,000 m^2) against a target reduction of 5%. This estate strategy suggests further opportunity to consolidate the estate, particularly to a smaller number of key strategic sites and rationalised support services such as administration.

To better understand this opportunity, there is a requirement to revisit the key targets for reduction in property portfolio size and estate revenue costs and undertake supporting detailed analysis and projections.

Based on recent reductions in the property portfolio, and subject to engagement and, when appropriate, formal consultation, there may be further opportunity for BCUHB to reduce the estate portfolio size against a confirmed target emerging from deep dive analysis. This would reduce some of the current estate risks and release resources to support the reconfigured estate and alternative funding models.

Initial pipeline of priorities identified by BCUHB

The following schemes have been identified by BCUHB as priorities on the capital programme, with business cases currently in progress or completed:

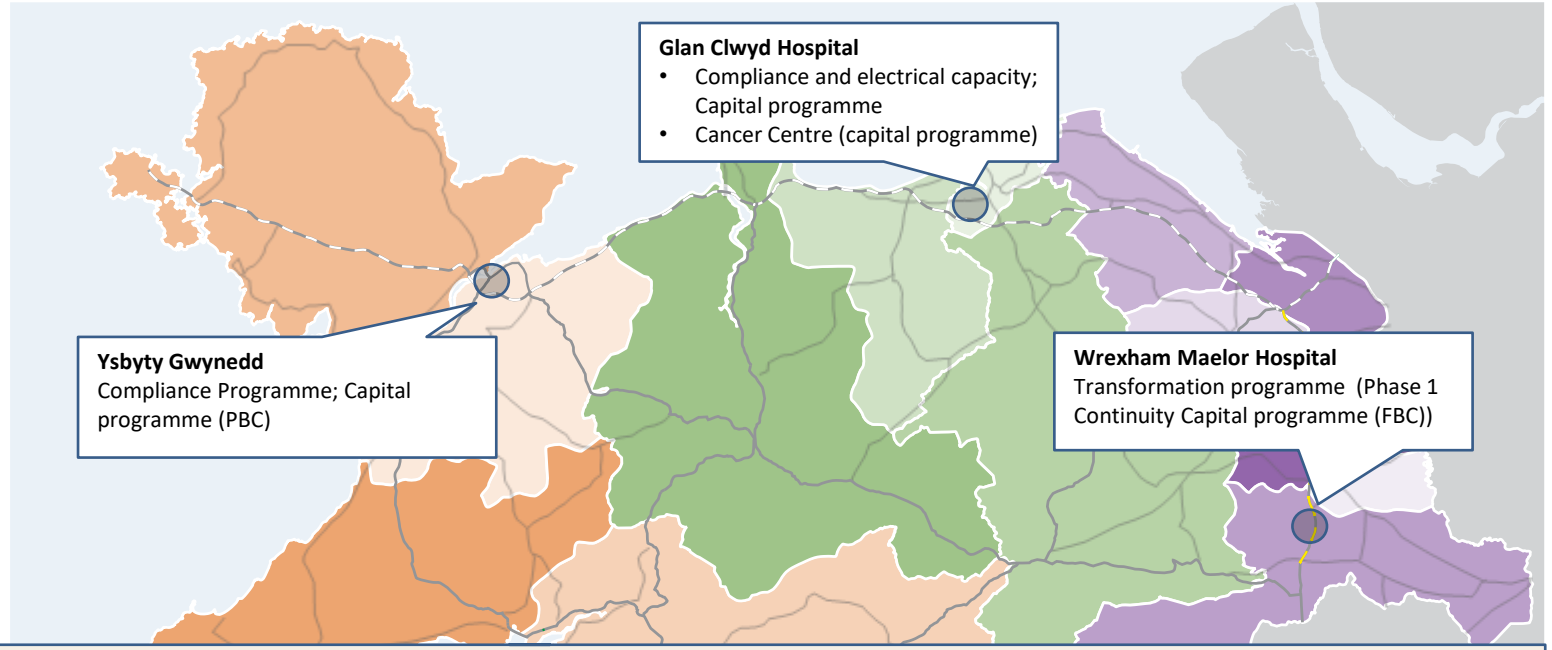
- Wrexham Maelor Hospital infrastructure continuity programme (Phase 1 of transformation programme)
- Ysbyty Gwynedd fire compliance programme
- Regional Treatment Centre programme and expanded orthopaedics capacity
- Royal Alexandra Hospital development project
- Replacement of the Ablett Unit at Glan Clwyd Hospital
- Medical and Health Sciences School

The estate strategy will be subject to regular review aligned with the IMTP cycle and will identify any changes in estate priorities.

Identified additional estate opportunities are detailed in section 4.3. These, and others, will be subject to further evaluation and development aligned to the estate vision.

4.3 Opportunities – Acute Sites

Following engagement with key BCUHB stakeholder leads, and review of options previously identified for the BCUHB 2019 Estate Strategy, estate strategy opportunities relating to acute hospital sites were identified (shown opposite and described below). These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan. As a result of the estate response to clinical strategy implementation, there may be opportunities to repurpose, reconfigure or rationalise our estate. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



Opportunities Applicable To All Acute Sites

Regional Treatment Centres

- To increase and protect planned capacity, Regional Treatment Centres (RTCs) will provide outpatient appointments, diagnostic tests and day surgery
- Relocation of activity from the acute hospital sites to RTCs will vacate space on the acute sites to accommodate key service growth e.g. Emergency Department, Same Day Emergency Care, ambulatory care, GP out of hours and facilitate compliance
- Plans are being developed to expand capacity for orthopaedics under a separate initiative

Relocate/consolidate services across North Wales (acutes)

- Potential relocation/consolidation of services across the three acute hospitals (to develop Centres of Excellence or ensure sustainability) presents opportunities to vacate space on acute sites to accommodate growing services

Administration space

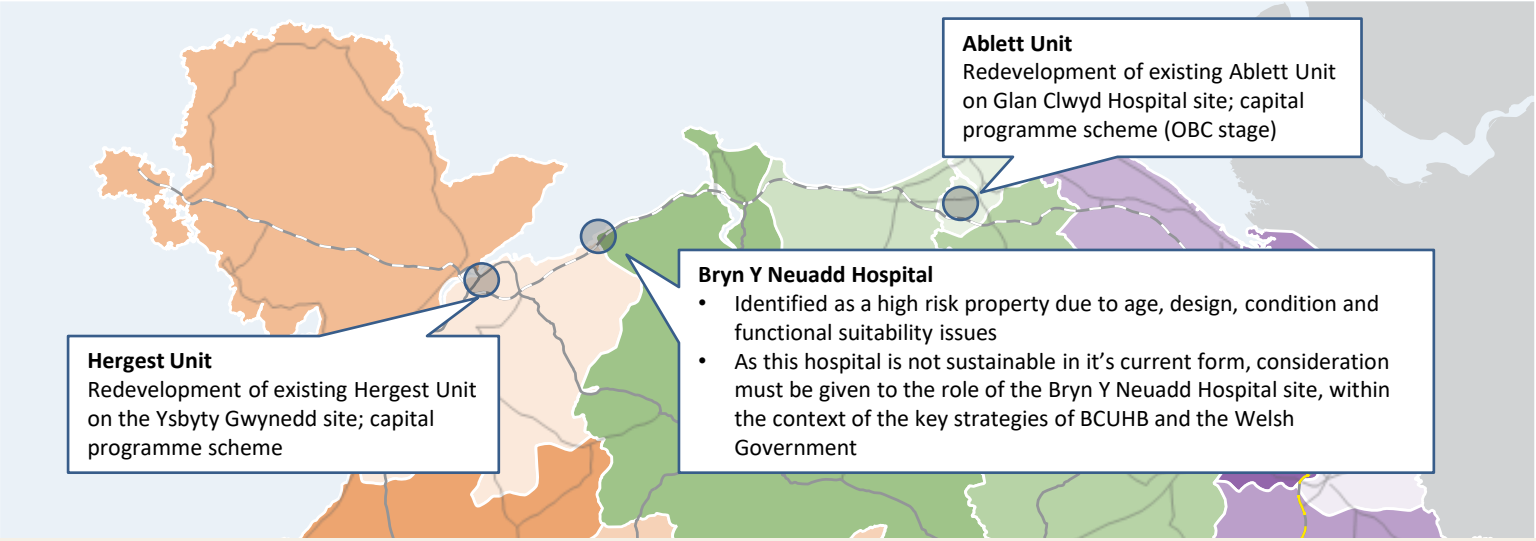
- Administration space requirements on acute sites will be aligned with BCUHB's agile working policy and support the Welsh Government's target for 30% of the Welsh workforce to work remotely supported by technology and smart working processes. This will enable rationalisation of existing administration space and consolidation on acute sites or relocation off-site (potentially to corporate administration hubs) if essential functional relationships are not required (e.g. some corporate administration)
- Vacated space may be used to accommodate growing clinical services / new care models

4.4 Opportunities – Mental Health & Learning Disabilities

Mental Health & Learning Disabilities

Following engagement with key BCUHB stakeholder leads, and review of options previously identified for our 2019 Estate Strategy, estate strategy opportunities relating to mental health and learning disability properties were identified (shown opposite and described below). These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to repurpose, reconfigure or rationalise our estate. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



Opportunities Required for Current Issues

- **Space utilisation:** there is currently a lack of effective information to understand how well allocated space is being used e.g. Bryn Y Neuadd Hospital
- **Capacity issues in community facilities**: opportunities exist to optimise use of space, repurpose/reconfigure, and relocate teams and services to provide better colocation of staff and services
- **Current service provision gaps** e.g. perinatal mental health service, adult eating disorder clinic
- **Repatriation:** service users are still being sent out of area, specifically in terms of secure units (no provision for women in Wales at all); continuing healthcare patients with complex needs often have to be sent out of area (long term placements)
- **Estate gaps:** there is insufficient estate to establish equitable services (as per Royal College guidelines); require additional rented accommodation to deliver services
- **Older Person's inpatient capacity:** recent reduction in beds due to changing model for managing care; likely future capacity constraints due to ageing population (potentially more of an issue in west IHC)
- **Adult inpatient capacity Wrexham**: current inpatient capacity constraints
- **Inappropriate mixing of patient cohorts:** recent Health Inspector review; mixing older persons and adult 18+; appropriate segregation required

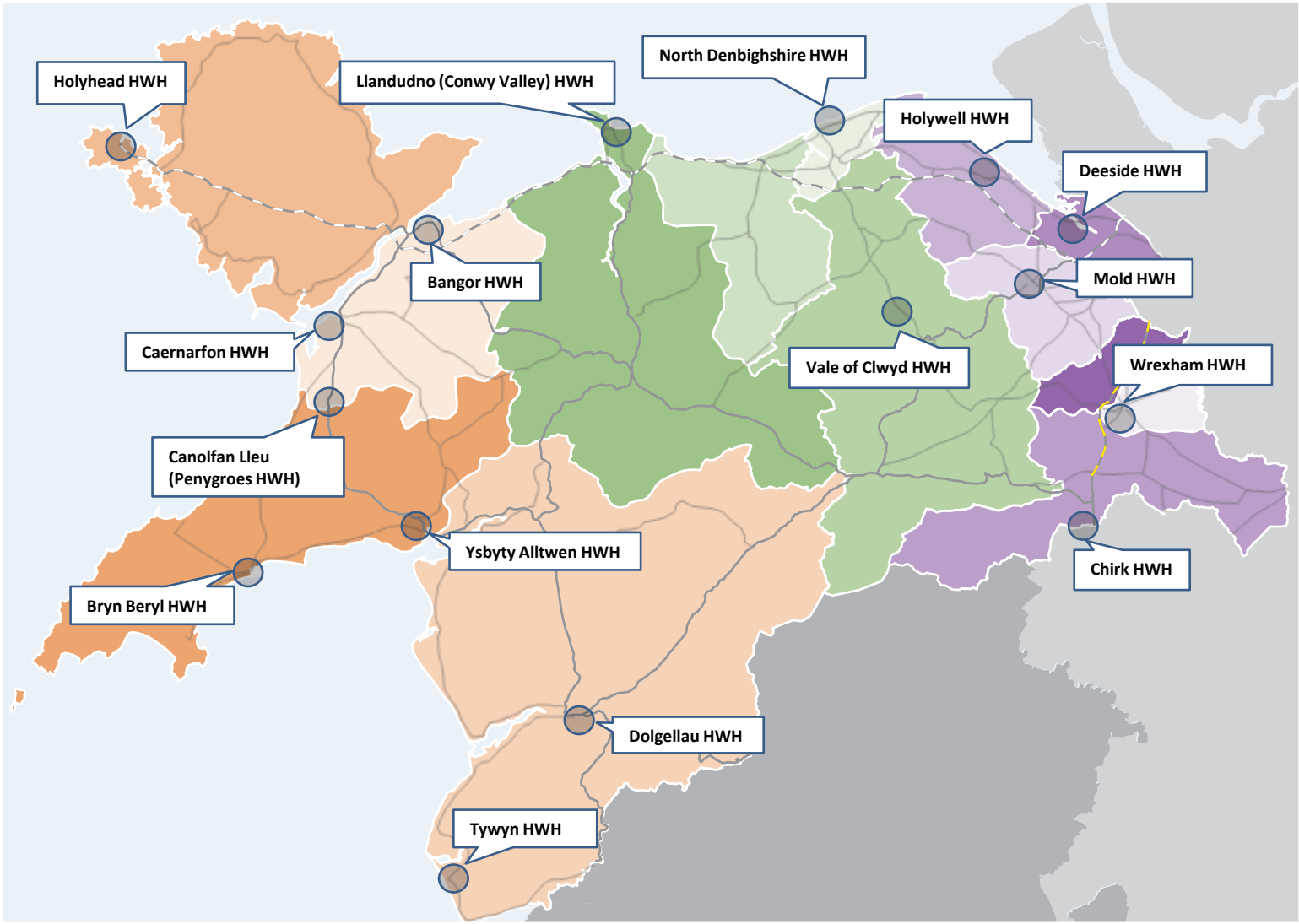
4.5 Opportunities - Health and Wellbeing Hubs

Health and Wellbeing Hubs

Following engagement with stakeholder leads from the three Integrated Health Communities, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Health and Wellbeing Hubs were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



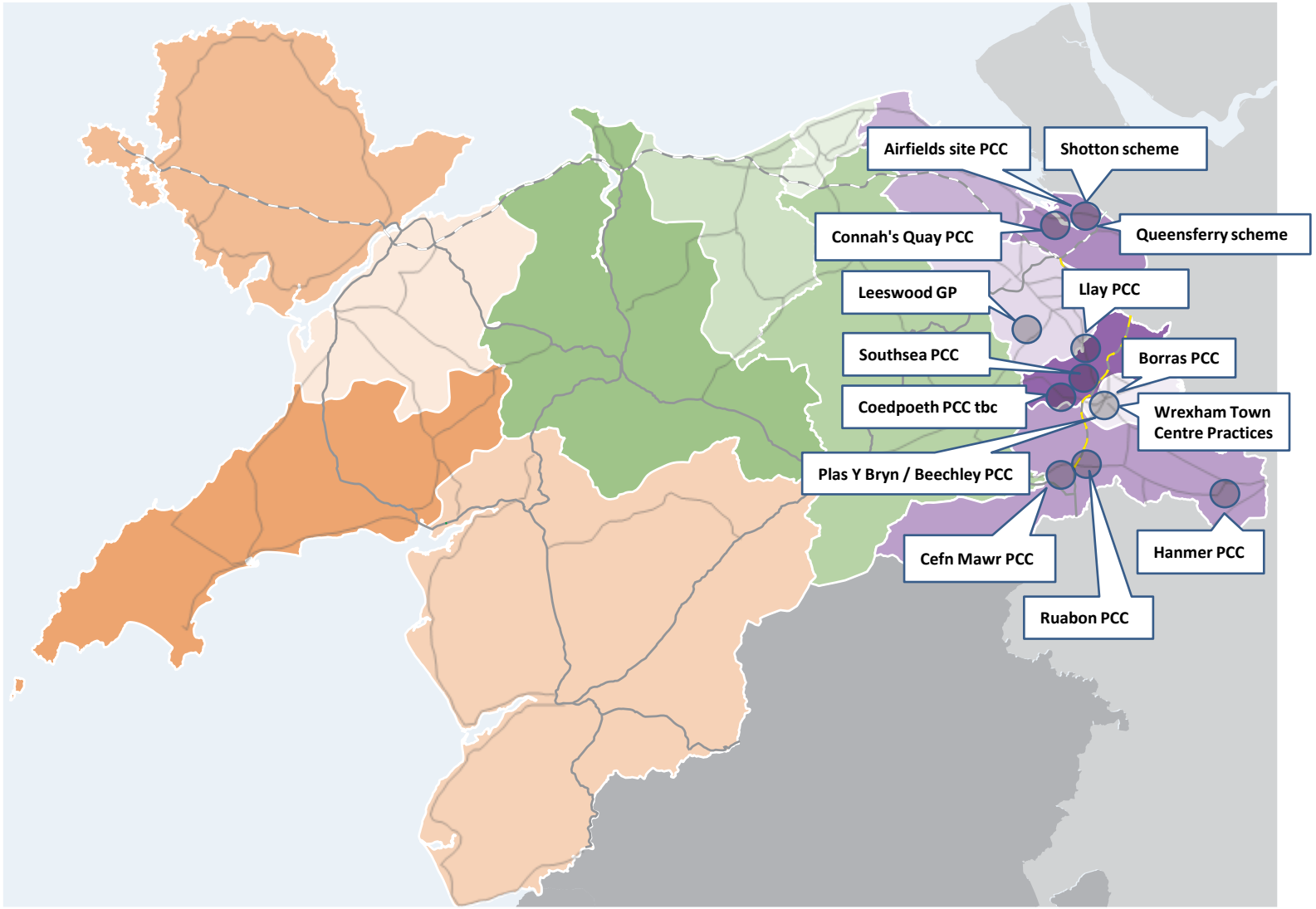
4.6 Opportunities - Primary Care Centres (East)

Primary Care Centres – East IHC

Following engagement with stakeholder leads from the East Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



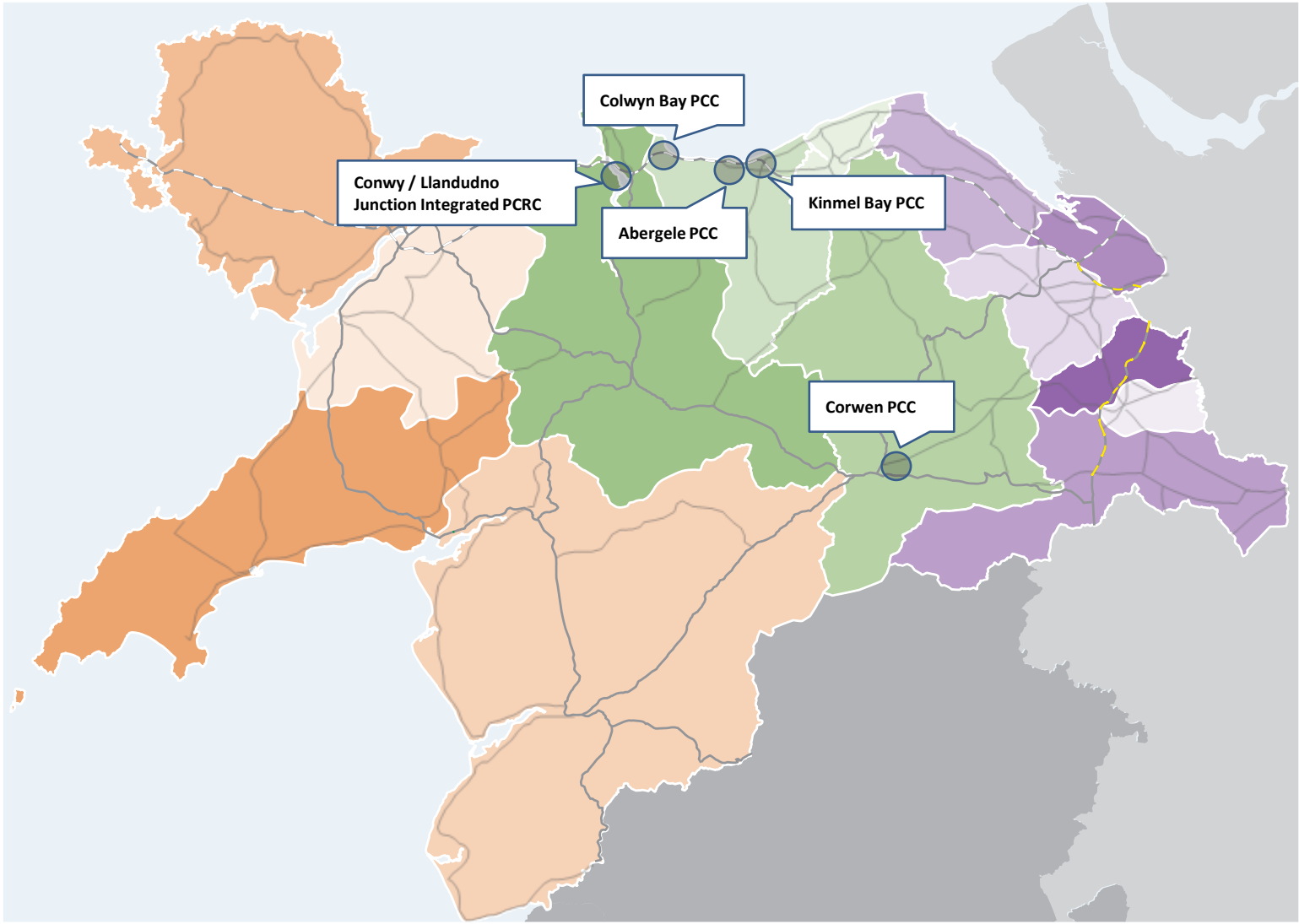
4.7 Opportunities - Primary Care Centres (Central)

Primary Care Centres – Central IHC

Following engagement with stakeholder leads from the Central Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



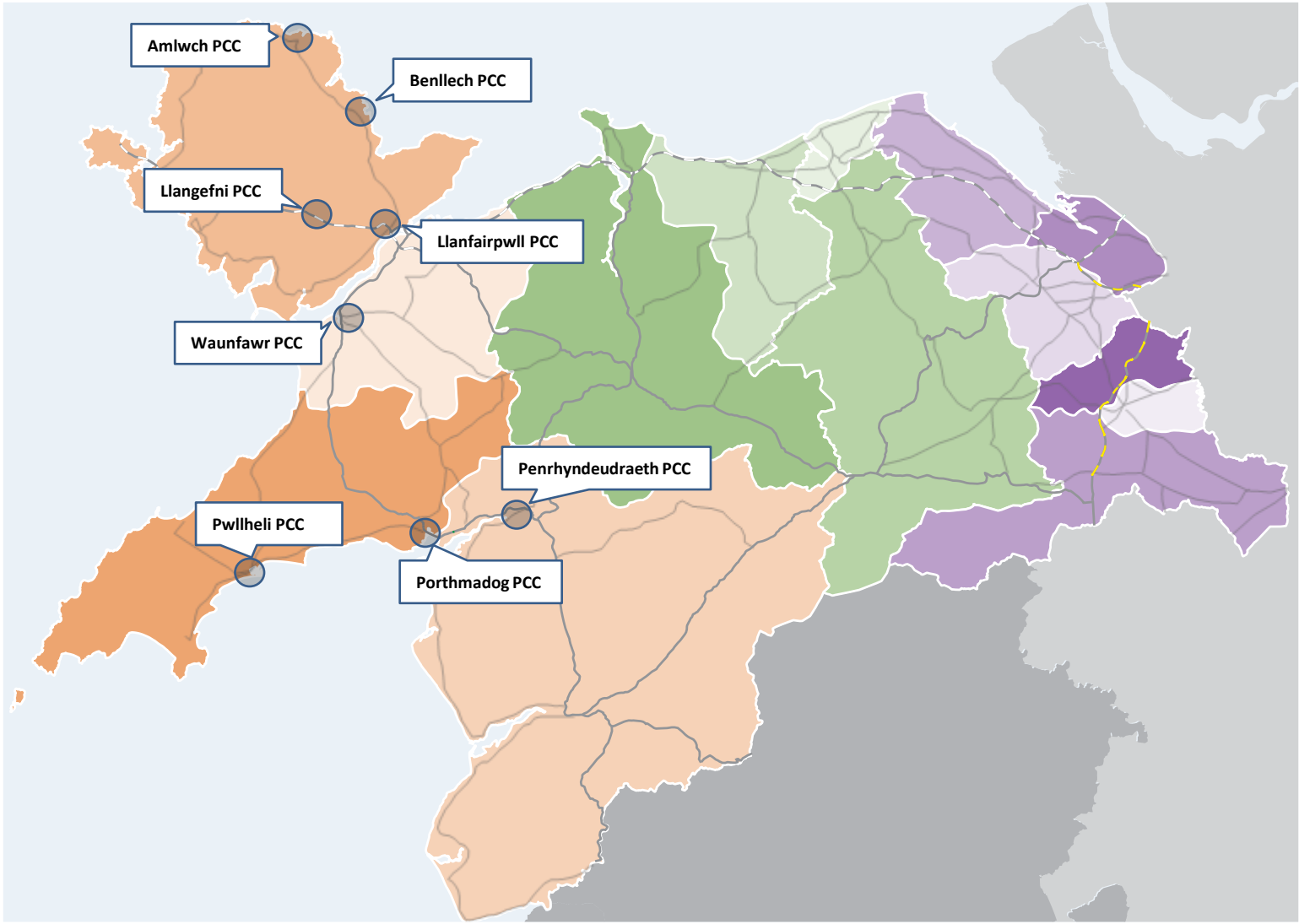
4.8 Opportunities - Primary Care Centres (West)

Primary Care Centres – West IHC

Following engagement with stakeholder leads from the West Integrated Health Community, and review of options previously identified for the BCUHB 2019 Estate Strategy, opportunities to enable delivery of the network of Primary Care Centres were identified (shown opposite).

These opportunities will require further investigation and discussion with key BCUHB stakeholders to confirm project options to be evaluated and prioritised for the capital investment plan.

As a result of the estate response to clinical strategy implementation, there may be opportunities to dispose of a number of BCUHB properties. As discussed in section 4.13, as the priority areas identified within this estate strategy are taken forward, we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements. In some areas these changes may require formal consultation.



4.9 Delivering the vision

Prioritisation

- Financial criteria
- Non-financial criteria
- Banding methodology

Targeted deep dive analysis

For example:

- Utilisation, access
- Equality Impact Assessment
- Socio-Economic Impact Assessment

Collaborative delivery

- Integrated partnership approach (e.g. Health and Wellbeing Hubs)
- RPB Integrated care fund priorities
- BCUHB residence JV

Managing delivery

- Prioritised project pipeline
- Business case process
- Project Boards / Working groups
- Iterative implementation of strategy

April 2023 to April 2033

Strategy Alignment

- National
- BCUHB: Clinical, Digital, Workforce, Agile, Net Zero

Continued engagement and consultation

- Stakeholders, staff, communities
- Further develop estate requirements and implementation plans
- Formal consultation may be required

Repurpose, Reconfigure Rationalise

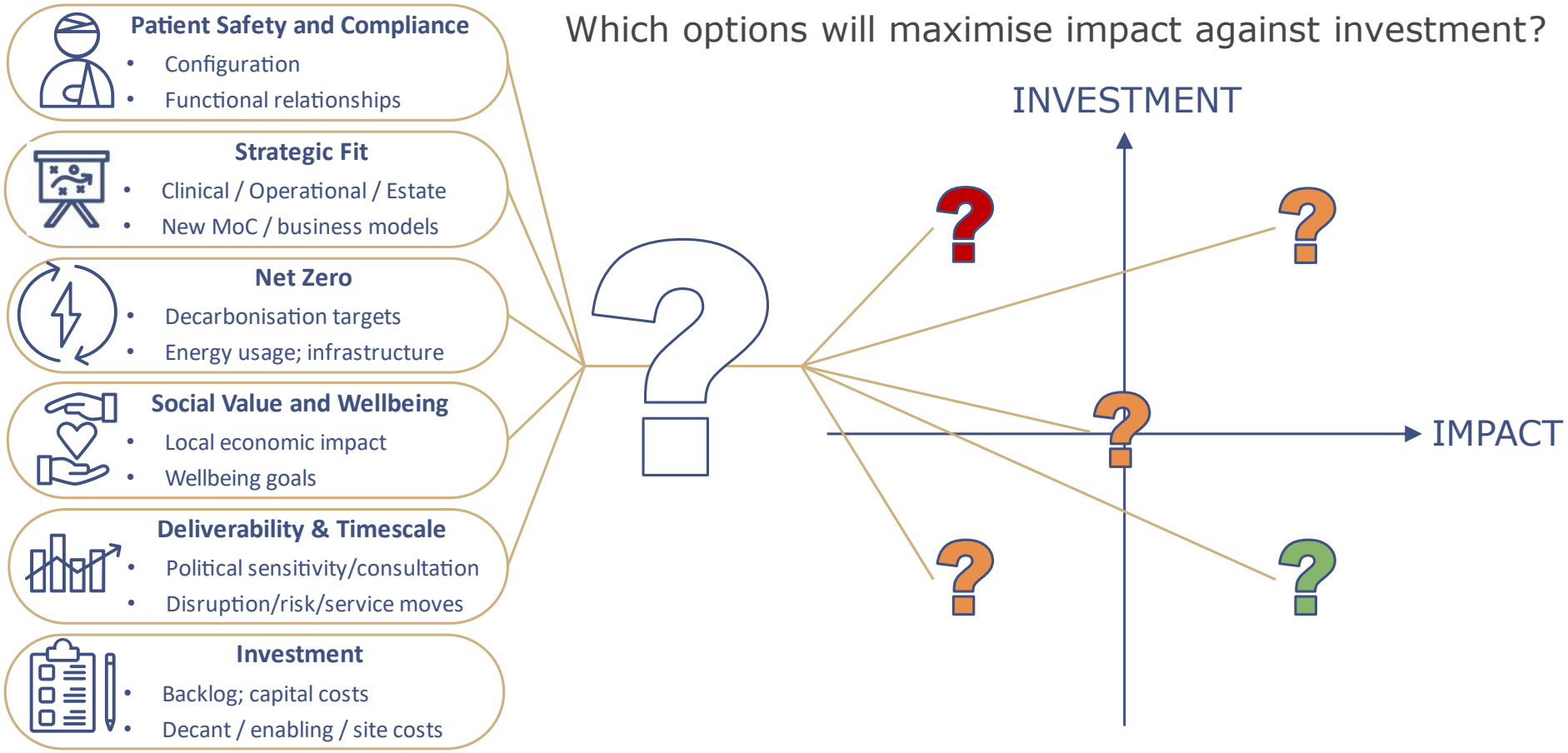
- In response to BCUHB strategies
- Improve patient pathways
- Contribute to net zero

Measuring success

- Monitoring of KPIs
- Improvement dashboard
- Review targets/strategy and update

4.10 Prioritisation and Impact: Evaluation Criteria

To determine future investment requirements and changes to the estate, evaluation and prioritisation of projects must be undertaken on an iterative basis to ensure alignment with key criteria and underpinning enabling strategies. The evaluation criteria summarised below have been agreed for use by the Board. These criteria will be applied to evaluate and determine the priority order of future projects to inform the BCUHB capital investment programme and project implementation plans.



4.11 Strategy Alignment

This Estate Strategy forms a vital component of a suite of BCUHB enabling strategies that both support key NHS Wales Strategies and BCUHB's Living Healthier, Staying Well vision and inform BCUHB transformation programmes and delivery plans (summarised below). The BCUHB enabling strategies are interdependent and must be complementary to ensure successful delivery. BCUHB strategies will require regular updating. Prioritisation of infrastructure projects should be aligned with the key suite of BCUHB strategies.

Key Strategies	Living Healthier, Staying Well; A Healthier Wales; Pan Wales Digital Strategy; NHS Wales Decarbonisation SDP						
Strategic Objectives	Improve health and wellbeing for all and reduce health inequalities	Support children to have the best start in life	Work in partnership to design and deliver excellent care closer to home	Support, train and develop our staff to excel	Improve the safety and quality of all services	Respect individuals and maintain dignity and care	Listen to and learn from the experiences of individuals
Overlapping Major Programmes	Improving health and reducing inequalities		Care closer to home		Excellent hospital care		
Key Enabling Strategies	BCUHB Clinical Services Strategy • Quality improvement and patient experience	BCUHB People Strategy & Plan • Whole health, care and support systems workforce	Our Digital Future • Digital roadmap for health in North Wales	BCUHB Decarbonisation Action Plan • Reduce carbon emissions	BCUHB Estates Strategy • Infrastructure to support delivery of BCUHB strategies		
Transformation Programmes	Three year Service Transformation Programmes (Integrated Medium Term Plans)						
Overlapping Major Programmes	Underpinning Divisional/Service Delivery Plans						

4.12 Targeted Deep Dive Analysis

Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options. Targeted deep dive analysis may include as appropriate on a project by project basis:

- Demand and capacity modelling (clinical activity and administrative activity) to determine future capacity requirements
- Space utilisation studies to identify baseline capacity surplus/shortfall, support demand and capacity modelling, and inform options
- Site feasibility studies to understand the range of options
- Analyses to support patient/service user/staff access and travel times to specific properties and locations
- Impact of new models of care and site locations on staffing models and requirements
- Equality Impact Assessment for estate options
- Socio-Economic Impact Assessment for estate options

4.13 Continued Engagement and Consultation

This estate strategy has been developed in response to BCUHB's 10 year strategy to improve health, well-being and healthcare in North Wales. Living Healthier, Staying Well was subject to significant engagement and co-produced with partners and communities across North Wales. The foundations of this strategy have therefore been built on the priorities determined by the population of North Wales.

Also, this estate strategy forms a key component of a suite of BCUHB enabling strategies which are interdependent and complementary to successful delivery.

As we take forward the priority areas identified within this estate strategy we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements and co-produce associated detailed implementation plans. It is clear that our estate must change if it is to be sustainable, viable and support the implementation of Living Healthier, Staying Well. In some areas these changes may require formal consultation.

4.14 Collaborative Delivery

Further partnership working between health, local authority and third sector partners to deliver integrated community services, together with new business models for non-clinical services, present opportunities for partners to develop integrated solutions, share collective property assets and promote joint developments.

The identification, evaluation and prioritisation of opportunities to promote collaborative delivery will form part of an iterative process.

These new models of delivery will require formal contractual agreements between each party to ensure clarity of responsibility, liability (financial and non-financial) and governance. Where such agreements impact upon BCUHB's accounting regime, for example joint ventures, formal support will also be required from Welsh Government.

4.15 Managing Delivery

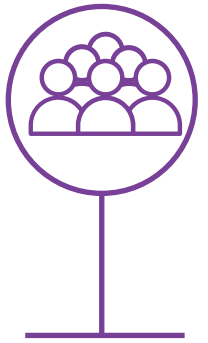
Following evaluation and prioritisation of projects, an agreed prioritised investment pipeline will be defined within BCUHB's Integrated Medium Term Plan.

All projects will be subject to the development of appropriate business cases for formal approval in accordance with the Board's Standing Financial Instructions. Business cases will establish the benefits to be realised and define the quality, cost and time parameters.

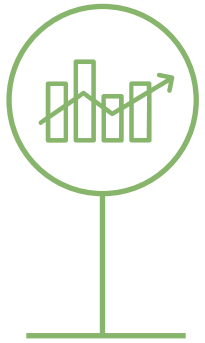
Projects will be required to comply with BCUHB policy and procedures for managing capital projects. Discrete project boards will be established to deliver the agreed projects. Each project board will be led by a Project Director, under the overall leadership of a Senior Responsible Owner, with a clear responsibility to ensure that the project is delivered within the agreed parameters and realises the expected benefits.

Implementation of the estate strategy will be an iterative process which must be flexible and able to respond to the changing needs, priorities and financial challenges of the BCUHB.

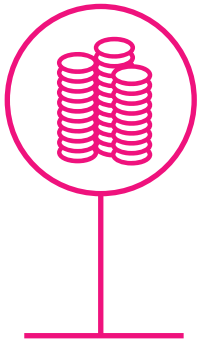
Leadership



People and capability



Data driven decisions



Investment

4.16 Measuring Success

Estate Strategy Implementation

The existing BCUHB Capital Investment Group (CIG) will advise the BCUHB Board and other key groups on the development and implementation of the estate strategy and ensure that property assets occupied by BCUHB services are utilised, managed and developed optimally and align with BCUHB service and business needs and available resources.

Monitoring of Key Performance Indicators

Key performance indicators (KPIs) have been established to monitor the delivery and success of the estate strategy. The estate strategy should target delivery of the KPIs shown opposite.

Improvement Dashboard and Performance Management Arrangements

The most efficient and effective way to ensure that focus is maintained on delivering the improvement expected is by embedding the measures within routine performance management arrangements. Within BCUHB, mechanisms already exist for appraising performance and testing progress against targets. Benefits from capital and revenue projects should be assimilated into this process.

Regular Review and Update

The estate strategy will be reviewed and updated to align with Integrated Medium Term Plan timescales.

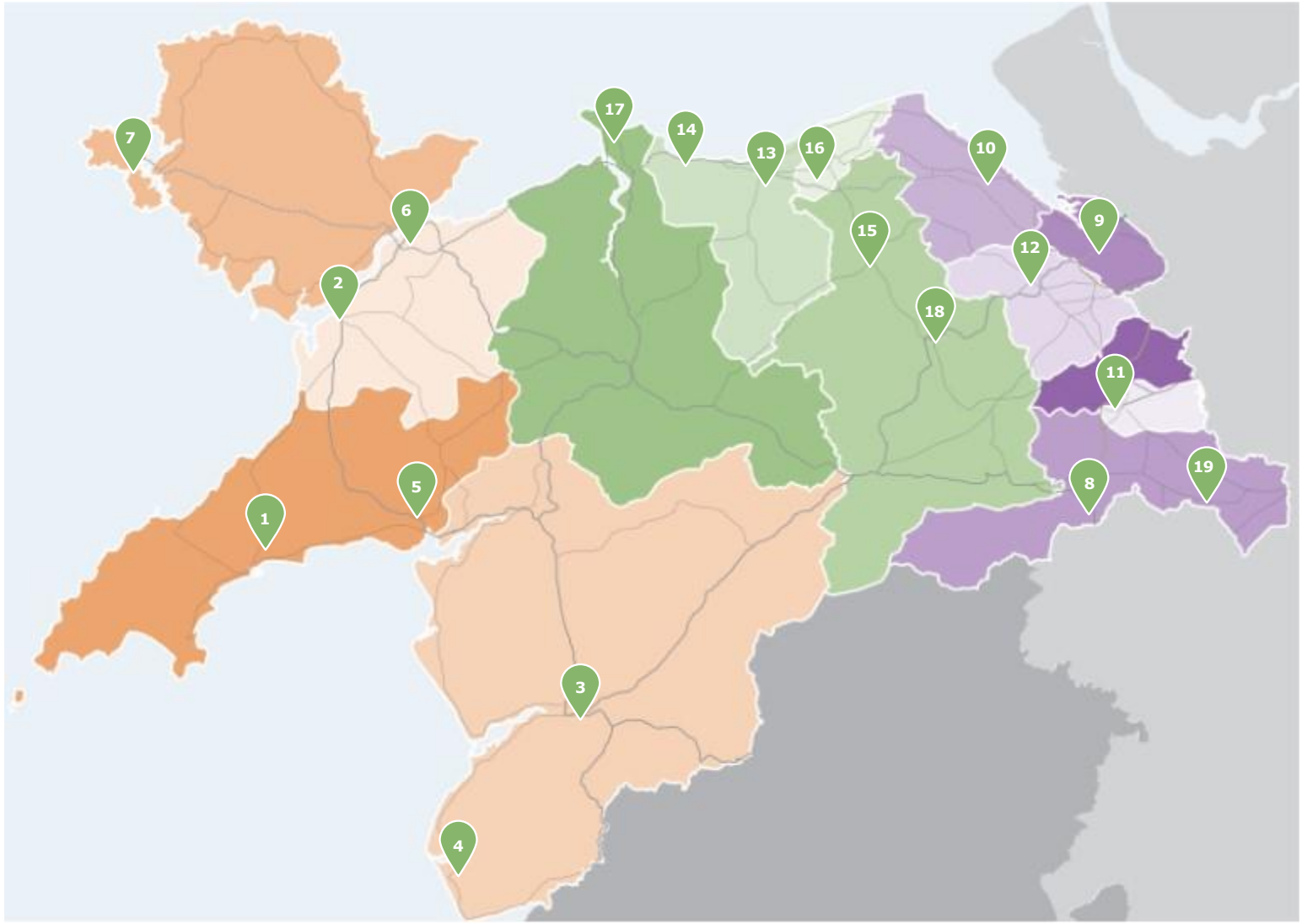
Indicator	Definition	Target
Revenue cost	Reduction in estate revenue cost	3% per IMTP cycle
Property portfolio	Planned reduction in property portfolio	5% per IMTP cycle
Statutory Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Fire Safety Compliance	A minimum of 90% of the estate should comply with relevant statutory requirements	Meet national target within 10 years
Energy Performance	The estate should consume no more than 410 kWh/m^2	Meet national target within 10 years
Backlog maintenance (BLM)	• 90% reduction in high risk BLM • 75% reduction in significant risk BLM • 70% reduction in risk adjusted BLM	Meet target within 10 years
Physical condition	A minimum of 90% of the estate should be sound, operationally safe and exhibit only minor deterioration	Meet national target within 10 years
Functional Suitability	A minimum of 90% of the estate should meet clinical and business operational requirements with only minor changes needed	Meet national target within 10 years
Space Utilisation	A minimum of 90% of the estate should be fully used	Meet national target within 10 years

Appendix 1 – Stakeholders Engaged

- Alison Kemp - Associate Director Community and Primary Care Central IHC
- Alyson Constantine - Director of Operations, Central IHC
- Andrea Williams - Head of Informatics Programmes, Assurance, and Improvement
- Anita Pierce - Deputy Medical Director Mental Health & Learning Disabilities
- Arwel Hughes - Head of Operational Estates
- Barry Williams - Hospital Director, Ysbyty Gwynedd
- Carolyn Owen - Assistant Director of Patient and Carer Experience
- Chris Lindop - Head of Planning and Performance, Mental Health, and Learning Disabilities
- Clive Ball - Head of Property Services Cardiff
- David Fletcher - Divisional General Manger, Diagnostics and Clinical Support
- Eleri Roberts - Associate Director, Community, West IHC
- Gemma Nosworthy - Primary Care Academy Manager
- Geraint Roberts - Divisional General Manager, Cancer
- Hazel Davies - Hospital Director, Wrexham Maelor Hospital
- Ian Donnelly - Director of Operations, East IHC
- Jo Flannery - Senior Health Planning Manager
- Jodie Berrington - Primary Care West
- John Thomas - Head of ICT Digital Services
- Laura Vernon - Deputy Divisional General Manager- Cancer
- Liz Davis - General Manger Midwifery and Women's Services
- Martin Woodcock - Senior Property and Asset Manager
- Neil Rogers - Director of Operations, West IHC
- Paul Andrews - Hospital Director, Glan Clwyd Hospital
- Paul Bowker - Principal Programme Manager, North Wales Community Dental Services
- Paul Clarke - Head of Facilities Management
- Peter Bohan - Associate Director of Health, Safety and Equality
- Rachel Wright - Patient and Carer Experience Lead
- Rachael Page - Associate Director Primary Care, East IHC
- Rod Taylor - Director of Estates and Facilities
- Shaun Taylor - Planning and Commissioning Manger
- Wyn Thomas - Associate Director, Primary Care, West IHC
- BCUHB Capital Investment Group
- BCUHB Leadership Team
- BCUHB Board
- BCUHB Clinical Senate
- BCUHB Community Health Council

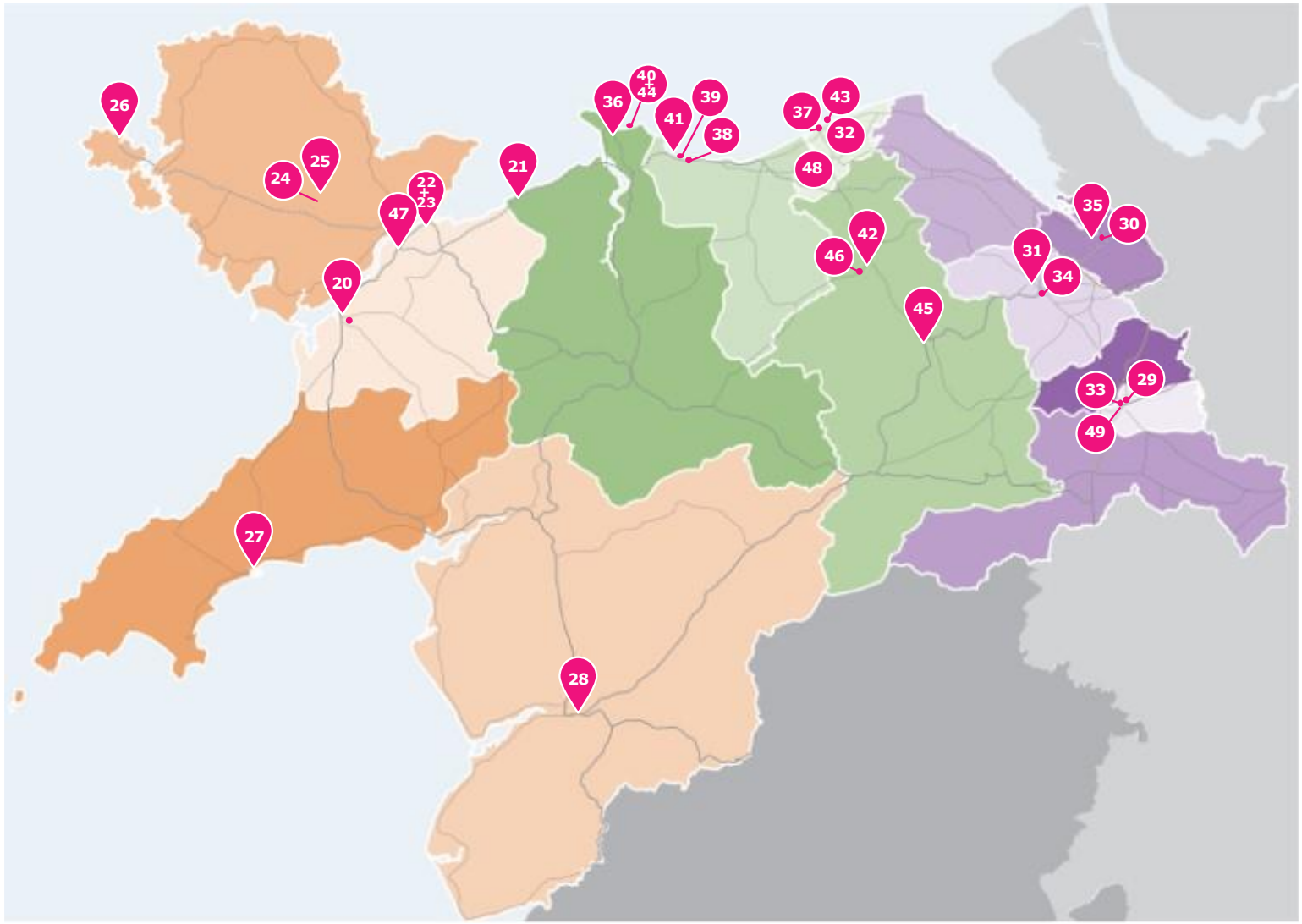
Appendix 2 – BCUHB Estate Locality Maps

BCUHB Estate Locality Map - Hospitals



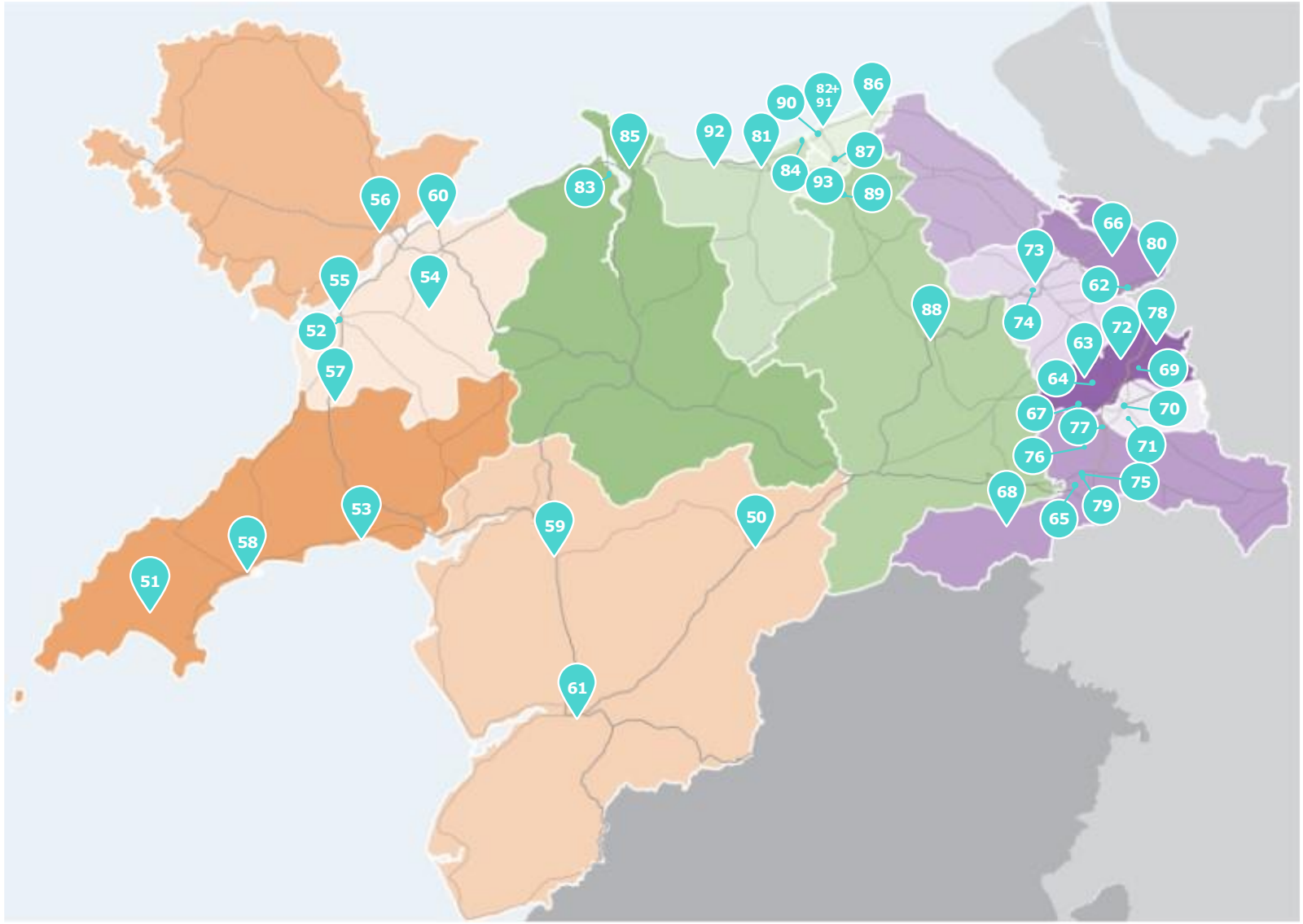
1	Bryn Beryl Hospital
2	Eryri Hospital & Bodfan, Caernarfon (Rehabilitation)
3	Dolgellau & Barmouth District Hospital
4	Tywyn & District War Memorial Hospital
5	Ysbyty Alltwen
6	Ysbyty Gwynedd
7	Ysbyty Penrhos Stanley
8	Chirk Community Hospital
9	Deeside Community Hospital
10	Holywell Community Hospital
11	Wrexham Maelor Hospital
12	Mold Community Hospital
13	Abergele Hospital
14	Colwyn Bay Community Hospital
15	Denbigh Community Hospital & Clinic
16	Glan Clwyd Hospital
17	Llandudno Hospital
18	Ruthin Community Hospital
19	Penley Rehabilitation Hospital (Rehabilitation)

BCUHB Estate Locality Map - Mental Health & Learning Disabilities



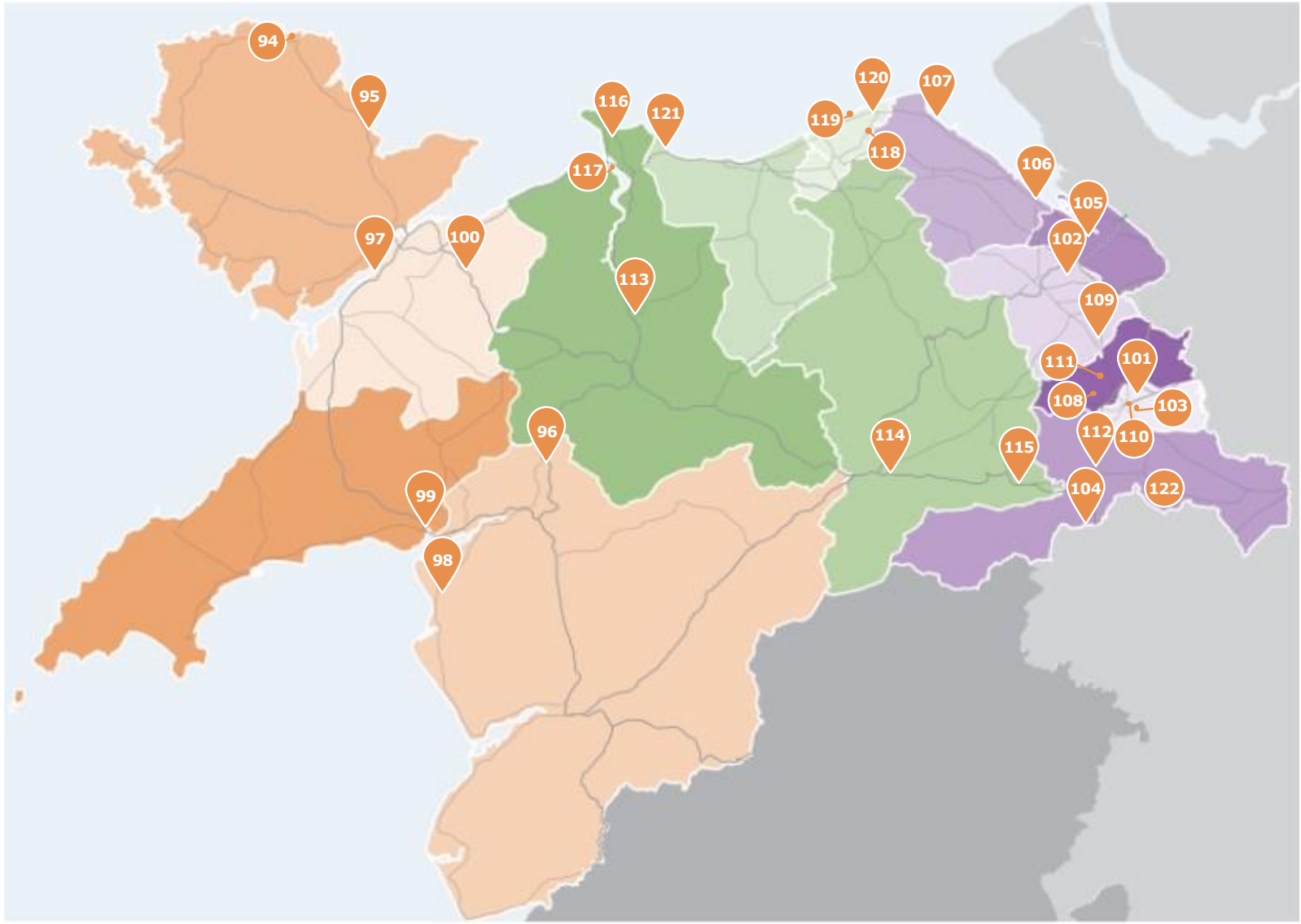
20	Bron Y Castell (Substance Misuse Service)
21	Bryn Y Neuadd Hospital (Rehabilitation/LD/secure)
22	Child Development Centre, Bangor (CAMHS)
23	Talarfon Child Development Services, Bangor (CAMHS)
24	Cefni Hospital
25	Isgraig Clinic, Llangefni (Substance Misuse Service)
26	Craig Hyfryd, Holyhead (Mental Health Resource Centre)
27	Cilan Mental Health Resource Centre, Pwllheli
28	Plas Brith Health Centre (Mental Health Resource Centre)
29	Coed Celyn & Swn Y Coed Wrexham (Rehabilitation)
30	Deeside Counselling Centre, Shotton (Substance Misuse Service)
31	Mold Mental Health Resource Centre
32	Glan Traeth, Rhyl (Memory Service)
33	The Elms, Wrexham (Substance Misuse Service)
34	Unit 14 Mold (Mental Health Resource Centre)
35	Wepre House, Connahs Quay (Mental Health Resource Centre)
36	Bodnant, Llandudno (Community Mental Health Team Unit)
37	5&7 Brighton Road, Rhyl (Substance Misuse Service)
38	Bryn Hesketh, Colwyn Bay (Older People's IP and Day Unit)
39	Colwyn Bay Mental Health Resource Centre
40	Conwy Child Development Centre, Llandudno
41	Dawn Centre, Colwyn Bay (Substance Misuse Service)
42	Dyffryn Clwyd CMHT, Denbigh
43	Hafod, Rhyl (Community Mental Health Team Unit)
44	Roslin Mental Health Resource Centre, Llandudno
45	Tan–Y–Castell Mental Health Unit, Ruthin (Rehabilitation)
46	Treferian Mental Health Day Centre, Denbigh
47	Hergest Unit (on Ysbyty Gwynedd site)
48	Ablett Unit (on Glan Clwyd Hospital site)
49	Heddfan Unit (on Wrexham Maelor Hospital site)

BCUHB Estate Locality Map - Health Clinics



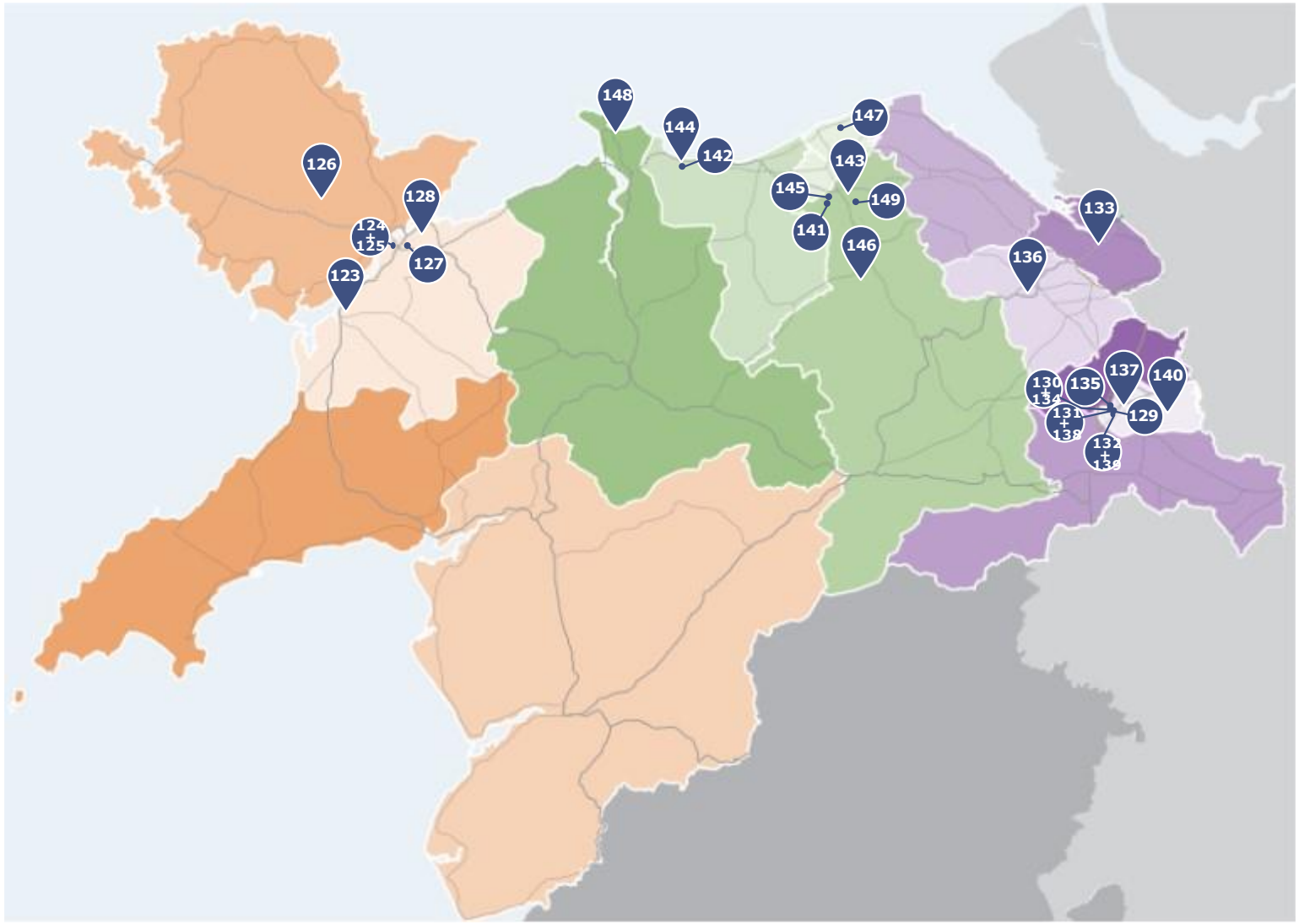
50	Bala Health Centre
51	Botwnnog Health Centre
52	Bron Hendre Health Clinic
53	Criccieth Health Centre
54	Deiniolen Health Clinic
55	Hafan Iechyd Surgery
56	Llanfairpwll Health Centre
57	Penygroes Health Clinic
58	Pwllheli Health Clinic
59	Trawsfynnydd Health Centre
60	Ty Cegin, Bangor (Flying Start)
61	Y Lawnt Health Clinic
62	Broughton Clinic
63	Brymbo Health Clinic
64	Brynteg Clinic Southsea
65	Cefn Mawr Clinic
66	Mancot Clinic, Catherine Gladstone House
67	Coedpoeth Clinic
68	Glyn Ceiriog Clinic
69	Gresford Health Centre
70	Grove Road Health Centre
71	Beechley Medical Centre
72	Llay Health Centre
73	Mold Clinic
74	Mold Primary Care Centre
75	Plas Madoc Acrefair
76	Rhosllannerchrugog Health Centre
77	Rhostyllen Clinic
78	Rossett Clinic
79	Ruabon Clinic
80	Saltney Clinic
81	Abergele Clinic
82	Fforddlas Clinic
83	Gyffin Surgery
84	Kinmel Bay Clinic
85	Maes Derw Clinic
86	Prestatyn Clinic
87	Rhuddlan Clinic
88	Ruthin Clinic
89	St. Asaph Health Centre
90	West Rhyl Primary Care Centre
91	Royal Alexandra Hospital
92	Child Health Clinic Colwyn Bay (Child Services)
93	Community Dental Centre, Glan Clwyd Hospital)

BCUHB Estate Locality Map - Primary Care Centres



94	Amlwch Primary Care Centre
95	Benllech Primary Care Centre
96	Blaenau Ffestiniog Health Centre
97	Felinheli Primary Care Centre
98	Harlech Primary Care Centre
99	Porthmadog Health Centre
100	Yr Hen Orsaf Medical Centre
101	Borras Park Surgery, Wrexham
102	Buckley Medical Centre
103	Caia Park Primary Care Centre
104	Castle Health Centre, Chirk
105	Connah's Quay Primary Care Centre
106	Flint Health & Wellbeing Centre
107	Ffynongroyw Primary Care Centre
108	Forge Road Surgery
109	Hope Health Centre
110	Hillcrest Medical Centre
111	Pen Y Maes Clinic, Summerhill
112	Ruabon Medical Centre
113	Canolfan Crwst Primary Care Centre
114	Corwen Health Centre
115	Llangollen Health Centre
116	Llys Dyfrig Primary Care Centre, Llandudno
117	Llys Meddyg Conwy Primary Care Centre
118	Meliden Primary Care Centre
119	Seabank Primary Care Centre
120	Ty Nant Primary Care Centre
121	West End Medical Centre
122	Overton Primary Care Resource Centre

BCUHB Estate Locality Map - Other Property Types



123	Erylodon Caenarfon (Administrative Services)
124	Intec, Unit 10, Parc Menai Bangor (Administrative Services)
125	Intec, Unit 11, Parc Menai Bangor (Administrative Services)
126	Mon Sector Offices (Administrative Services)
127	Mountain View, Bangor (Occupational Health)
128	Plumbing Centre, Bangor (Covid 19 Vaccination Centre)
129	ALAC Centre, Wrexham (Artificial Limb / Appliance Centre)
130	Berwyn House, Wrexham (Education & Training)
131	Cambrian House, Wrexham (Education & Training)
132	Block B, Clwydian House, Wrexham (Administrative Services)
133	Deeside Enterprise Centre, Shotton (Administrative Services)
134	Gwenfro Wrexham Technology Park (Administrative Services)
135	Plas Gororau, Wrexham (Multipurpose Building)
136	Preswylfa, Mold (Administrative Services)
137	Villa Romano, Wrexham (Administrative Services)
138	Wrexham Hospital Sterilisation and Decontamination Unit (HSDU)
139	Wrexham Medical Institute (Education & Training)
140	Dutton Road Dental Unit, Wrexham (Workshop/Storage)
141	87 Bowen Court, St Asaph (Administrative Services)
142	Brain Injury Service Unit, Colwyn Bay (Brain Injury Service)
143	Carlton Court, St Asaph (Administrative Services)
144	Eirias Park Health Precinct (Joint Care Administrative Services)
145	72 Fford William Morgan, St Asaph (Administrative Services)
146	Hyfrydle, Denbigh (Child Development Centre)
147	Oasis Dental Centre, Rhyl (Dental Centre)
148	Sector House, Llandudno (Covid 19 Vaccination Centre)
149	St Kentigerns Hospice, St Asaph (Hospice)

Appendix 3 – Key Definitions*

- **Backlog maintenance cost:** is the cost to bring estate assets that are below condition B in terms of their physical condition and/or compliance with mandatory fire safety requirements and statutory safety legislation up to condition B
- **Physical condition rankings**
  - A - As new and can be expected to perform adequately to its full normal life
  - B - Sound, operationally safe and exhibits only minor deterioration
  - B(C) - Currently as B but will fall below B within five year
  - C - Operational but major repair or replacement is currently needed to bring up to condition B
  - D - Operationally unsound and in imminent danger of breakdown
  - X - Supplementary rating added to C or D to indicate that it is impossible to improve without replacement
- **Mandatory fire safety requirements / statutory safety legislation rankings**
  - A - Complies fully with current mandatory fire safety requirements and statutory safety legislation
  - B - Complies with all necessary mandatory fire safety requirements and statutory safety legislation with minor deviations of a non-serious nature
  - B(C) - Currently as B but will fall below B within five years as a consequence of unabated deterioration or knowledge of impending mandatory fire safety requirements or statutory safety legislation
  - C - Contravention of one or more mandatory fire safety requirements and statutory safety legislation, which falls short of B
  - D - Dangerously below conditions A and B
- **Risk categories**
  - **Low risk elements** can be addressed through agreed maintenance programmes or included in the later years of an estate strategy
  - **Moderate risk elements** should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. These items require expenditure planning for the medium term
  - **Significant risk elements** require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety
  - **High risk elements** must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution
- **Risk-adjusted backlog:** Backlog costs and associated risk rankings are combined to produce a risk-adjusted backlog figure for comparative purposes and as a driver for the eradication of high-risk sub-elements and buildings with short remaining lives

$$\text{Risk-adjusted backlog (£)} = \frac{\text{Non-critical backlog}}{\text{Remaining life of building/block}} + \text{Safety-critical backlog}$$

  - Non-critical backlog (£) = Total backlog cost relating to low and moderate risk sub-elements for the building/block
  - Safety-critical backlog (£) = Total backlog cost relating to significant and high risk sub-elements for the building/block

*As per 'A risk-based methodology for establishing and managing backlog' NHS England (https://www.england.nhs.uk/publication/a-risk-based-methodology-for-establishing-and-managing-backlog)

Appendix 3 – Key Definitions*

- **Gross internal site floor area:** Total internal floor area of all buildings including temporary buildings or premises or part therein, occupied or non-occupied, which constitute the site operated by the NHS Organisation and is either owned by the NHS Organisation or is defined within the terms of a lease, Service Level Agreement, or tenancy agreement. Includes embedded education and training facilities, university accommodation and areas temporarily in the possession of building contractors. Excludes any leased-out areas. This figure should be the sum of the occupied and non-occupied floor areas.
- **Occupied floor area:** Total internal floor area of all buildings or premises or part therein which are in operational use and required for the purpose of delivering the function/activities of the NHS Organisation (i.e. occupied by the NHS Organisation), and either owned by the NHS Organisation or defined within the terms of a lease, license, Service Level Agreement or tenancy agreement. Include leased-in areas, industrial process areas, embedded education and training facilities and university accommodation which are occupied. Measured as for the Gross Internal Floor Area, inclusive of plant rooms, and circulation spaces, but excluding areas which are not required for operational purposes (i.e. non-occupied areas and not in use). The total of the non-occupied floor area and occupied floor area should equal the gross internal floor area. Excludes leased-out and licensed-out areas. PLEASE NOTE FROM 2013/14 EXCLUDES MULTI-STOREY CAR PARKS
- **Unoccupied floor area:** Total internal floor area of all buildings or premises or part therein, which are not used by the NHS Organisation for the purpose of delivering the function/activities of the NHS Organisation (i.e. non-occupied area) but are in the ownership of the NHS Organisation or within the terms of a lease, license, Service Level Agreement or tenancy agreement. Includes unoccupied embedded education and training facilities, university accommodation and areas temporarily in the possession of building contractors. Measured as for the Gross Internal Floor Area, inclusive of any associated plant rooms, and circulation spaces, or part therein, which are directly related to the nonoccupied area(s). The total of the non-occupied floor area and occupied floor area should equal the gross internal floor area. Excludes leased-out and licensed-out areas.
- **Not functionally suitable:** Percentage of occupied floor area that is below Estatecode Condition B for functional suitability (i.e. below an acceptable standard, or unacceptable in its present condition, or so below standard that nothing but a total rebuild will suffice).
- **Un-utilised space:** Percentage of occupied floor area where space utilisation is classified as being either "empty" or "under-used" as defined in Estatecode and Developing an Estate Strategy documents.

*As per 'Estates & Facilities Performance Management System: Data Definitions and Completion Notes (2020 / 2021); Welsh Government

Appendix 4 – Properties included in community estates diagnostic

Community and Local Hospitals - Estate Condition and Performance

Section 2.5.3 provides and overview of community and local hospital estate condition and performance (based on EFPMS 2021/22 data). The following 16 community and local hospitals are included within this analysis.

Abergele Hospital, Bryn Beryl Hospital, Eryri Hospital, Penley Hospital, Deeside Community Hospital, Colwyn Bay Community Hospital, Chirk Community Hospital, Denbigh Community Hospital, Dolgellau & Barmouth District Hospital, Holywell Community Hospital, Llandudno General Hospital, Mold Community Hospital, Ruthin Community Hospital, Tywyn & District War Memorial Hospital, Ysbyty Alltwen, Ysbyty Penrhos Stanley

Community Facilities - Estate Condition and Performance

Section 2.5.4 provides and overview of the condition and performance of community facilities (based on EFPMS 2021/22 data). The following 74 community facilities are included within this analysis.

5 & 7 Brighton Road, Abergele Clinic, Alder House, Bodnant, Maes Du Road, Blaenau Ffestiniog Pcc, Bala Health Clinic, Bowen Court, Unit 87, Bron Hendre, Broughton Clinic, Brymbo Health Clinic, Brynteg Clinic (Southsea), Caia Park Pcc, Catherine Gladstone House, Cefn Mawr Clinic, Child & Adolescent Mh, Talarfon, Child Development Centre, Ymca Holyhead, Coedpoeth Clinic, Corwen Health Clinic, Deiniolen Health Clinic, Deeside Counselling Centre, Criccieth Health Clinic, Denbigh Stores, Drug & Alcohol, High Street, Rhyl, Dyffryn Clwyd Cmht, Denbigh Clinic, Eryldon, Fforddlas Clinic, Flint Pcrc, Glyn Ceiriog Clinic, Gresford Health Clinic, Grove Road Dental Clinic, Hafan Iechyd (Clinic Section), Hightown Medical Centre, Hyfrydle, Llanfairpwll Health Clinic, Kinmel Bay Clinic, Iscraig (Substance Misuse), Llangollen Health Clinic, Bishops Walk, River Lodge, Llay Health Clinic, Maes Derw Clinic, Llandudno, Mhrc Cilan, Mhrc Craig Hyfryd, Mhrc Plas Brith, Mold Clinic, Mold Mhrc (Pwll Glas), Occupational Health Dept, Mountain View, Overton Pcrc, Pen Y Maes Clinic, Summerhill, Penygroes Health Clinic, Preswylfa, Prestatyn Clinic, Plas Madoc, Acrefair, 51-52 Bodlyn, Rhosllanerchrugog Health Clinic, Rhostyllen Clinic, Rhuddlan Clinic, Roslin Mhrc, Rossett Clinic, Royal Alexandra Hospital, Ruabon Clinic, Ruthin Clinic, Saltney Clinic, St Asaph Health Clinic, Swn Y Coed, The Elms, Unit 14, Mold, Treferian Mh Day Centre, Trawsfynydd Health Clinic, Villa Romano, Wepre House, West End Medical Centre, Rysseldene, Wrexham Hsdu, Y Lawnt Health Clinic, Ysgol Gogarth, Llandudno, Hafod Mhrc, Pwllheli Health Clinic


GIG
CYMRU
NHS
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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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

SOCIO ECONOMIC IMPACT ASSESSMENT TEMPLATE

For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

Public health data is available here North Wales Population Health Directory. If you require support with interpreting public health data please contact the Betsi Cadwaladr Public Health Team.

Further support in applying this process is available from Strategy and Planning colleagues, the Equality Team and your Equality Delivery Group representative. An intranet resource page to guide you through the process has been set up here Betsi Cadwaladr University Health Board | Socio-economic Duty (wales.nhs.uk)

This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

Policy / Strategy / Proposal/Procedure Title	Estate Strategy
Lead Manager	Executive Director of Finance and Performance
Approval Committee	PPPH, PFIG & HB
Date form completed	09/01/2023
What are the aims and objectives of the policy/strategy/proposal?	The Estate Strategy responds to Living Healthier, Staying Well and the Clinical Services Strategy. It is part of a suite of enabling strategies, including People, Digital and Finance, and provides the vision and framework for the future development and utilisation of our estate and how we will work with partners to maximise the benefits of our collective property portfolios. It promotes a future estate that is fit for purpose and provides a safe and effective environment that meets the clinical and business needs of the Health Board. It offers the opportunity to eliminate high, significant and moderate backlog maintenance risks over the longer term.

	The strategy provides the basis and structure for the prioritisation of often competing investment requirements. The strategy is for the long term, 10 years, but its implementation will align with the Health Boards planning cycle. It will be subject to regular review and must be flexible to respond to the changing needs and priorities of the Health Board. In taking forward this strategy we will continue to engage with staff, communities and stakeholders and, if significant changes are proposed, will undertake formal consultation when appropriate.

STAGE 1: PLANNING						
Is the decision a strategic decision? See definition	YES	Please provide a brief explanation for your answer	This is a strategic judgement.			
Have you identified key stakeholders groups? Please detail below	YES	**Can you identify relevant communities of interest?** See guidance Please detail below	Yes	**Can you identify relevant communities of place?** See guidance Please detail below	Yes	
North Wales Community Health Council Regional Leadership Group Stakeholder Reference Group Community Health Council Service and Full Council Equality and Human Rights Strategic Forum North Wales Cancer Network Regional Partnership Board and each of the Public Services Boards Health and Wellbeing Networks Equality Stakeholder Group (BCHUB)		• Communities experiencing socio-economic deprivation • People experiencing long term health conditions including long Covid and unpaid Carers. • People experiencing Homelessness • Gypsy and Traveller community • People with protected characteristics who have been disproportionately impacted by Covid – including Black, Asian and ethnic minorities, and disabled people • Veterans (armed forces community)		• Rural communities • Areas of high levels of deprivation (as identified on WIMD) Tourist hot spot areas		

STAGE 2: EVIDENCE	
What evidence have you considered about socio-economic disadvantage and inequalities of outcome in relation to this decision?	When the LHSW strategy was first devised the Socio Economic Duty was not in place, however a range of information relevant to reducing inequalities of outcome was collated back in 2017 that evidenced socio-economic disadvantage was considered. This has been considered in the refresh of Living Healthier Staying Well, to which this Estates Strategy is aligned. **Evidence included during 2018 work:** **Wales wide:** Is Wales Fairer? The Equality and Human Rights Commission (EHRC) 2015 identified a number of key equality and human rights challenges for Wales. Evidence suggests that inequality damages the economy and society as a whole. Everyone is affected whether or not we experience discrimination in our daily lives. In assessing whether Wales is fairer the EHRC have found that compared to five years ago: • There are a few improvements, for example, a reduction in hostility towards lesbian, gay and bisexual people • In areas of life such as education and employment significant inequalities remain between different groups of people. • Young people are significantly worse off in many ways including income, employment, poverty, housing and access to mental health services **Gypsy Traveller Groups:** The Welsh Government framework, "Travelling to a Better Health"[1], seeks to ensure the needs of gypsies and travellers are assessed, planned and implemented in a more strategic way. Through this framework access to services for gypsies and travellers in Wales is being developed and improved. It is necessary to recognise the cultural differences which have often led to the social exclusion of these groups and ensure these communities are heard in service delivery.

[1] travelling-to-better-health.pdf (gov.wales)

The literature suggests that Gypsy and Travellers, especially Gypsy and Traveller children, experience equality of outcomes, examples of health inequality include:

- Life expectancy lower in Gypsy and Traveller population – lower in men compared to women
- Greater risk of poor outcomes during pregnancy and giving birth (during the perinatal period)
- Lower rates of uptake of national vaccination and screening programmes
- Issues with registrations with Primary Care services and some experience reluctance to engage with health services due to a range of factors including fear of discrimination and prejudice
- Poorer levels of dental health
- Health staff - low levels of cultural understanding of Gypsy and Traveller community

There are multiple barriers experienced by this group:

- Knowledge of health services and how these can be accessed
- Low incomes
- Living arrangements and transience
- Literacy levels
- Health literacy

Evidence considered within review work 2021:

In addition to direct engagement work, reports which include the experiences of different groups should also inform this review. Key reports and summary information in relation to Covid impacts and socio economic duty includes:

Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19. Report commissioned by Disability Equality Forum of the Welsh Government[2].

- Significant impact from Covid 19 for disabled people across Wales – with 68% of Covid 19 deaths among disabled people

[2] Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19 [HTML] | GOV.WALES

	• Impacts of Covid 19 on disabled people due to mix of factors including social factors including discrimination, poor housing, poverty, employment status, institutionalisation, lack of PPE, poor and patchy services, inaccessible and confusing public information and personal circumstances, significantly contributed to this figure • During the pandemic many disabled people encountered new barriers to travel, restricting mobility and increasing isolation • disabled people's access to on-going medical treatment and health services were severely disrupted, leading in some cases to a serious deterioration in pre-existing conditions (for example sight impairments), or even death • Disproportionate negative effect of the pandemic on disabled people's mental health and well-being. More research and better data are needed to understand the complex relationship between social factors, COVID-19 infections, mental well-being and disability in Wales • Disabled people are more likely to experience relative income poverty and live in more economically-deprived areas in Wales, than non-disabled people. Nationally, disabled people have disproportionately fallen behind with household bills during the pandemic, because of their disadvantaged position in the labour market, poor housing and increased costs associated with being disabled. • Serious problems with UK Government support to different groups of disabled people during the pandemic. The Self-isolation Support Scheme (SISS), the Self-Employment Income Support Scheme (SEISS), the continued uplift in Universal Credit (UC) and sick pay provisions are four areas. Issue with sick pay provision during the pandemic • There is a significant shortage of accessible and appropriate housing available to disabled people in Wales, who are currently concentrated in the rented sector. The correlation between poor quality housing and poor health outcomes has been established (Marmot, 2020) • The poor pre-pandemic position of disabled people in the labour market also suggests that a pandemic-related recession will have a disproportionately negative impact on disabled people's employment. Disabled people are over-represented in insecure and low paid jobs and many opt for self-employment or freelance roles because they can provide increased opportunities to accommodate an impairment • We anticipate an increase in demand for information on workplace rehabilitation and reasonable adjustments as workspaces reopen, given what we already know about the long-term impact of COVID-19 on physical and mental health on the wider population

	• Vital role played by Disabled People's Organisations (DPOs) and voluntary and community organisations during the pandemic. An army of, often unpaid volunteers, tried to fill the gap left by the withdrawal of many statutory services, to disabled people • disabled people have been physically and practically excluded during the pandemic and psychologically and emotionally marginalised in everyday public spaces and life • The pandemic highlighted the important role of accurate and accessible information and communications, including the role of traditional media and social media. Including the normalising the use of British Sign Language (BSL) • Best practice guidance for local authorities and health boards/ services in Wales on public accessibility needs to be a priority … establishing a working group with DPOs for this purpose • 37% of children who lived in a household with a disabled person were in relative income poverty[3], compared with 24% of children who lived in households where no-one was disabled. • 31% of working-age adults who lived in a household with a disabled person were in relative income poverty, compared with 18% of those who lived in a household where no-one was disabled. • A report by Citizens Advice (2020) found 1 in 6 disabled people (16%) have fallen behind with their bills during the pandemic, compared to fewer than 1 in 10 non-disabled people (7%), suggesting pre-existing inequalities and levels of poverty have been further exacerbated • Recommendations from the report in relation to SED/LHSW: o Welsh Government establish priority criteria to ensure disabled people to receive timely diagnosis and medical evidence that are pre-requisites for accessing key areas of day-to-day living for example, benefits, shopping, work, reasonable adjustments, social support o Welsh Government adopt a more nuanced patient-centred approach to the provision of mental health services, to establish a better dialogue about patient needs and preferences and mental health service delivery o Priority be given to recruiting and training more people to work in mental health services in Wales, by making it a focus of careers advice/ workshops in educational settings and offering 'golden handcuffs' arrangements, with funded training packages available to those who commit to working in the field in Wales for x number of years

[3] A person is defined as living in relative income poverty if he, or she, is living in a household where the total household income from all sources is less than 60% of the average UK household income (as given by the median).

- In relation to socio economic duty, report recommends Welsh Government issue clear guidance to local authorities and health boards on best practice, including meaningful co-production. Welsh Government need also to ensure that local and pan-Wales mechanisms are in place to enable citizens to challenge impact assessments and decision-making, in line with the Wellbeing for Future Generations Act

Race Equality Action Plan: An Anti-racist Wales[4] (draft)

This draft plan is due to be finalised and published in early 2022. The vision is for an anti racist Wales by the year 2030. The high level goals for health include:

- Leadership & accountability: to ensure that NHS Wales is anti-racist, with zero tolerance of any form of discrimination or inequality for employees or service users
- Workforce: to ensure that the NHS Wales workforce reflects the population it serves; and staff work in safe, inclusive environments that enables them to reach their full potential
- Data & Intelligence: to ensure that health data in relation to race, ethnicity and intersectional disadvantage is actively collected, understood and used to drive and inform continued improvements in services
- Access: to ensure public health messages to improve uptake and access to health services are developed through dialogue and in partnership; individuals are supported where necessary in order to access health care
- Tackling health inequalities: To ensure disease and condition specific delivery plans and strategies include actions to address the evident health inequalities experienced by some Black, Asian and Minority Ethnic people

[4] 41912 An Anti-Racist Wales - Race Equality Action Plan for Wales (gov.wales)

Coronavirus (COVID-19) and the Black, Asian and minority ethnic population in Wales[5]

This report summarises the impact of Covid 19 on Black, Asian and minority ethnic groups[6] in Wales. The report highlights that:

- Covid19 has a disproportionate adverse impact on minority ethnic people.
- People who are Black, Asian and ethnic minority are at higher risk of ill health and have higher mortality rates compared to people of same age in the general population
- People who are Black, Asian and ethnic minority are more likely to experience socio economic disadvantage through:
    - Poorer housing and overcrowding
    - Employment – lower skilled work and job security
    - More likely to be living in relative income poverty
    - More likely to live within most deprived areas – based on Welsh Index of Multiple Deprivation

This report will have relevance for future planning of services in post Covid recovery with considerations for both communities and our workforce, in ensuring that services are culturally sensitive.

Wales faces unprecedented 'triple challenge' to health and wellbeing report[7]. Published 1st October 2021 by Public Health Wales

This reports on the compounding impacts of Brexit, Covid 19 and climate change across multiple determinants of health. These will need to be viewed in synergy, cumulatively and not through a singular lens. Summary of the report highlights:

- Key determinants affected include for example, mental well-being, food insecurity, health behaviours, environmental policy and regulations, employment and working conditions
- Population groups potentially affected include for example, those in rural communities, fishers and farmers, those on low incomes and children and young people

[5] Coronavirus (COVID-19) and the Black, Asian and Minority Ethnic (BAME) population in Wales (gov.wales)

- Climate change is a common theme in COVID-19 and Brexit literature. Both challenges present ways to tackle climate change directly and indirectly, for example improving air quality in Wales
- There is an opportunity to strengthen public health messaging around health behaviours with the increased profile of public health and environmental issues related to Brexit, COVID-19 and climate change for example, diet and nutrition; food insecurity and waste
- Brexit and the pandemic can present opportunities for the future, for example to support a 'green industrial revolution', 'green jobs' and more employment to create a fairer, more sustainable Welsh economy and 'Economy of wellbeing'

Most people affected by the triple challenge:

Babies, children and young people	Farmers, Fishers and agricultural sector workers
Older people	Critical workers, including health and social care workers, and delivery and HGV drivers
Those on low incomes / unemployed	Minority ethnic groups
Geographical areas, including those in rural or coastal areas, tourist areas or port towns	Migrants and their families
Those with existing health conditions and needs	Single parent families

How coronavirus has affected equality and human rights report[8] by the Equality and Human Rights Commission October 2021

[6] This also includes Gypsy or Irish Travellers

[7] https://phw.nhs.wales/publications/publications1/rising-to-the-triple-challenge-of-brexit-covid-19-and-climate-change-for-health-well-being-and-equity-in-wales/

[8] How coronavirus has affected equality and human rights | Equality and Human Rights Commission (equalityhumanrights.com)

	This report highlights that the negative impact of the pandemic has been more severe for some groups than others. In summary: • Report shows that the negative impact has been more severe for some groups than others • Impact on employment, underemployment[9] and unemployment leading to poverty • The groups most likely to be affected by the expected rise in poverty include young people, ethnic minorities, and disabled people, who are already closest to the poverty line • Young people have experienced significant interruption to their education, which threatens previous gains in attainment levels. Differences in support for remote learning during the pandemic threaten to widen inequalities for those who already perform less well than their peers, particularly boys, Black pupils, some Gypsy, Roma and Traveller pupils, pupils who need support in education, and those who are socio-economically disadvantaged • Older people, ethnic minorities and some disabled people, particularly those in care homes, have been disproportionately impacted by the pandemic. Care home residents accounted for 34% of COVID-19 related deaths in Wales. Report also notes some reluctance to access health care services due to fear of contracting Covid 19, leading to delays in care. • The increased demand for social care has threatened the financial resilience of the sector, potentially impacting its users and workers. This has led to an increased reliance on unpaid carers, who are more likely to be women • There has been a rise in reported domestic abuse and we have concerns about the ability of survivors to access justice • Impact on social care sector – staff faced higher risk of Covid, staff shortages and stressful work conditions • Impact of Covid 19 related to increase of domestic abuse. Increases in the prevalence of domestic abuse in this period will particularly affect people who share certain protected characteristics o Domestic abuse disproportionately affects women. In 2018/19 1.6 million women and 786,000 men in England and Wales experienced domestic abuse (cited within EHRC: ONS, 2019a). o Domestic abuse has a disproportionate impact on younger and disabled people (cited within EHRC:ONS, 2019b; Scottish Government, 2019) o available data show that LGBT people in England and Wales and people of Mixed Ethnicity in England are also disproportionately affected

[9] *Underemployment* occurs when a worker takes a job that doesn't reflect their skillset or financial requirements

	The evidence base outlined above has been analysed and incorporated in to the development and refresh of Living Healthier Staying Well and associated strategies, including the Estates Strategy.
Have you engaged with those affected by the Policy / Strategy Proposal / Policy?	Previous extensive engagement work was undertaken during the development of the LHSW strategy in 2017/2018. Relevant engagement to the socio economic duty are summarised in the sections below. Refresh engagement took place during 2021[10]which included general engagement with: • Presentations to the Stakeholder Reference Group, • Presentations to the Community Health Council Service and Full Council • Presentation at the Regional Leadership Group • Presentation to Equality and Human Rights Strategic Forum • North Wales Cancer Network • Information and opportunities to feedback to both the Regional Partnership Board and each of the Public Services Boards at the launch of the programme • Health and Wellbeing Networks Refresh engagement with targeted engagement with: • Virtual LHSW Q&A Sessions (30 people) • Fresher's Fair – Wrexham • (West Area) Engagement Practitioners Forum (42 people) • (East Area) Engagement Practitioners Forum (25 people) • Chinese Association lunch (60 people) • Diabetes Q&A event (24) • Palliative Care Q & A event (22) Engagement varied from providing general information such as signposting to information about the strategy and the online survey, to more considered and deliberative sessions with groups and stakeholders. The key engagement tool and source of feedback however was through the online public

[10] Extract taken from draft Living Healthier Living Well Refresh Engagement Findings November 2021 Report

	survey. This was promoted on the Health Boards website, social media, namely Facebook and Twitter and shared widely with public, third and community sector networks and groups. In total 312 people completed the survey. Monitoring data was collated from responses of which align to protected characteristics and area (Local Authority) area in which people live. Further details are contained within the Engagement Findings Report November 2021.
What engagement with people living with socio economic disadvantage will be / has been undertaken?	**Feedback from North Wales Public Sector Stakeholder Equality Meetings: 2015** Key themes summarised: • Adopting a Human Rights Approach • People who experience significant health inequalities – Homelessness and vulnerable people • Improving mental health services taking account cultural needs and children / young people • Collaboration between health board, and public health • Role of primary care in improving access to services • Equality issues – communication formats and language needs, carers needs, needs of people with learning impairments, needs of transgender people • Use of digital technologies • Accumulative impacts of wider policies – e.g. carers and pension age • Levels of awareness of health campaigns and information about accessing services **Engagement with people with an interest in Black, Asian, Minority Ethnic health inequalities** (for 2018 strategy work): Themes based on evidence and policy 'James Y. Nazroo. Morbidity and mortality data. • The overall theme of this was generally poorer health across Black, Asian and minority ethnic groups, with Bangladeshi people having the poorest health, followed by Pakistani, Black Caribbean, Indian and Chinese people. This is due to a complex range of reasons, of which includes socio-economic inequalities, including experiences of racism and discrimination.

	Engagement with minority ethnic elders[11] (for 2018 strategy work): • Ethnic minority elders are more likely to suffer discrimination in accessing services or gaining employment. Also access issues relating to language barriers and isolation impacting on mental health and wellbeing. **Engagement with people with an interest in sexual orientation including Stonewall Cymru and Celtic Pride staff network** (for 2018 strategy work): • Evidence collated from Stonewall publication' Unhealthy Attitudes[12] • Issues relating to discrimination experienced by LGBTQ+ community in relation to accessing health services and engaging with services **Engagement with people with an interest in equality issues for older people** (for 2018 strategy work): • Social isolation • Timely access to services • Better coordination between social care and health needed • Better support for unpaid Carers • Services to support people to stay independent in their own homes as long as possible **Engagement with people with interest in sensory loss** (for 2018 strategy work): Engagement took place with individuals which raised the following themes: • All Wales Standards for Accessible Communication and Information for People with Sensory Loss was introduced in 2013.[13]

[11] The Minority Ethnic Elders Advocacy Project (MEEA) is an all Wales project funded by the Big Lottery fund in partnership with equality councils including the North Wales Regional Equality Network (NWREN)

[12] Unhealthy Attitudes (stonewall.org.uk)

[13] The purpose of the Standards is to ensure that the communication and information needs of people with a sensory loss are met when accessing healthcare services. Effective and appropriate communication is fundamental to ensuring services are delivered in ways that promote dignity and respect. The evidence also demonstrates that ineffective communication is a patient safety issue and can result in poorer health outcomes.

- Accessing communication support for service users via the Welsh Interpretation &Translation Service (WITS)
- IT systems for flagging communication needs
- Environment and signage
- Improved accessibility

Engagement with people with interest in gender health inequalities (for 2018 strategy work):
Engagement took place with individuals which raised the following themes:

- Response of public sector organisations to legislation: Violence against Women, Domestic Abuse and Sexual Violence (Wales) 2015
- The Fair Treatment for the Women of Wales support group based in North Wales have raised issues expressed by women in the region suffering with endometriosis

Engagement with people with interest in young people (for 2018 strategy work):
Engagement took place with individuals through the Denbighshire CAMHS team via "an evening with" session with Denbighshire Youth Council which raised the following key theme:

- Low level mental health and support in schools.

Engagement with people with an interest with other groups of interest (for 2018 strategy work):
Wide engagement took place with individuals, Health Visitors and other health professionals who represented the interests of groups of interest. Themes included:

- Dental health in children and young people
- Domestic violence
- Alcoholism
- Mental health – significant positive outcomes from community outreach work
- Concern with levels of self-harm and suicide

Refresh engagement work 2021:

- 312 respondents, from all counties of North Wales, with the highest responses from Conwy and Flintshire

- A spread of ages amongst respondents, but the majority aged between 45 – 64
- Vast majority (79%) of respondents identified as female
- 32% identified themselves as Health Board employees

Key themes summarised from 2021 refresh work: (taken from draft engagement report November 2021)

A number of the goals were highlighted as more important by respondents, some identifying more than one:

- Improving physical, emotional and mental health and well-being for all was felt to be most important (45.0% identified this)
- Listening to people and learning from their experiences (44.7%)
- Improving the quality and safety of all services (36.2%)
- Working in partnership to support people – individuals, families, carers, communities – to achieve their own well-being (30.9%)
- All goals are equally important (44.0%)
- Improving access and waiting times – across secondary, primary care and in relation to diagnostics
- Balance of use of technology for appointments

A wide range of additional comments were made identifying improving access and waiting times, communication, workforce and staff welfare, leadership and development as areas to address**.**

Other themes raised within the responses:

- Just over 40% thought the Health Board had been at least somewhat effective in improving the health and well-being of our residents – although the pandemic was identified as a factor limiting effectiveness
- 74% thought that improving health and reducing inequalities was the right approach

	• 66% agreed or strongly agreed that local services should be supported to meet people's needs in the right way and at the right time – with many comments regarding access. • 80% agreed or strongly agreed with the aim of getting support quicker for more serious needs. There were many concerns regarding current waiting times. • More than half said they would be willing to travel further to get treatment sooner, or more specialised care. There was clear acknowledgement that travel would depend on circumstances, and that travelling further would have a much greater impact on specific groups. • Just over a third of respondents felt the Health Board has delivered on its commitment to promote equality and human rights, with a quarter disagreeing or strongly disagreeing. • There was a high number of comments however indicating concerns, particularly in relation to access to services, the need to make reasonable adjustments and to improve outcomes for all. • Clarify and simplify the aims of the Health Board and connect throughout the organisation • Need to reconfirm our commitment to improving outcomes and experience for the people of north Wales • Strengthen the commitment to partnership working, ensuring this is core to the Health Board's functions • Support for care closer to home; and three acute hospitals each having a 24/7 emergency department and supporting services • Equality (and health inequalities, exacerbated by the pandemic); also socio-economic factors • Acting in the best interests for the environment, and sustainability for future generations • Ensure there is sufficient focus on equality and human rights in the strategy and the organisational plans take this forward • Workforce – staff welfare, recruitment and retention. Support for staff from overseas • Improvement of mental health support – including crisis support • Improving communication with patients - between hospital, primary care and community services and departments. Improve mechanisms for listening and engagement both internally and with stakeholders and further development of the Welsh language provision • Leadership & development: It was suggested that the Health Board might work differently and more collaboratively with best performing organisations and that managers should be seen to lead by example.

How has / will this influence your work/guided your policy/proposal, or changed your recommendations?	This evidence based will continue to be reviewed and issues raised considered in each decision stage of the Estate Strategy development and delivery. The Estates Strategy will also be reviewed by the EQIA/SEIA scrutiny group.

Stage 3: ASSESSMENT AND IMPROVEMENT

What are the main socio economic impacts of the proposal?
Consider evidence from both research and any engagement already carried out.
Who is being affected? Refer to the North Wales Population Health Directory
Are some communities of interest or communities of place more affected by disadvantage than others?

The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain these areas include:

- Education
- Work
- Living standards
- Health
- Justice and personal security
- Participation

It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regards to each of these areas, evidence is provided below and issues for consideration suggested.

Education	**In Practice**	**Evidence considered:**
A literature review by the Centre for Research in Early Childhood (CREC) finds that evidence they examined indicates that in the UK, especially, parents' socio-economic status continues to be the primary predictor of which children prosper in adult life. They report that the magnitude of early childhood inequality in the UK is well-documented; some	Overall school children in Wales attain scores in reading, science and mathematics below those in England, Scotland and most other developed countries. Since schools closed during lockdown, children from better-off families have been spending 30 per cent more time on home learning than poorer children	**Educational attainment:** Table showing variation of educational attainment for adults 18-64 years for males and females for year ending 31 Dec 2020[14] **Literacy rates:** Information from National Literacy Trust: 1 in 8 (12% / 216,000 people) adults in Wales lack basic literacy skills[15].

	No qualifications (1)	Qualified to NQF level 2 or above (2)	Qualified to NQF level 3 or above (3)	Qualified to NQF level 4 or above (4)
Isle of Anglesey	5.3	84	67	43.1
Gwynedd	6	83.2	64.4	39.6
Conwy	8.3	80.5	60.3	38.3
Denbighshire	7.6	77.5	59	38.7
Flintshire	8.6	77.2	54.5	33.2
Wrexham	9.6	77.8	57.1	35.7
North Wales	7.8	79.6	59.5	37.3
Wales	7.3	80.9	62.3	41.4

[14] Highest qualification level of working age adults by region and local authority (gov.wales) Notes on table:

1. Persons who reported holding no qualifications
2. Persons who are qualified to at least NQF level 2 and includes persons qualified to a higher level
3. Persons who are qualified to at least NQF level 3 and includes persons qualified to a higher level
4. Persons who are qualified to at least NQF level 4 and includes persons qualified to a higher level

[15] Adult literacy | National Literacy Trust. (further information on adult skills are contained in a report - National Survey of Adult Skills in Wales 2010

estimates suggest that half the attainment gaps for pupils are already present at the start of primary school. Using Millennium Cohort study data, this research shows large gaps exist in the UK for vocabulary tests between children aged 4 and 5 from families with middle incomes and those from families with lowest fifth of incomes.

Data for Wales also shows pupils eligible for free school meals and children in care have poorer educational outcomes in schools on average with the gap widening as pupils get older.

How does your proposal take account of the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have or have had access to training opportunities and qualifications?

Think about how careers support at BCUHB and with partners, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.

Special Education Needs:

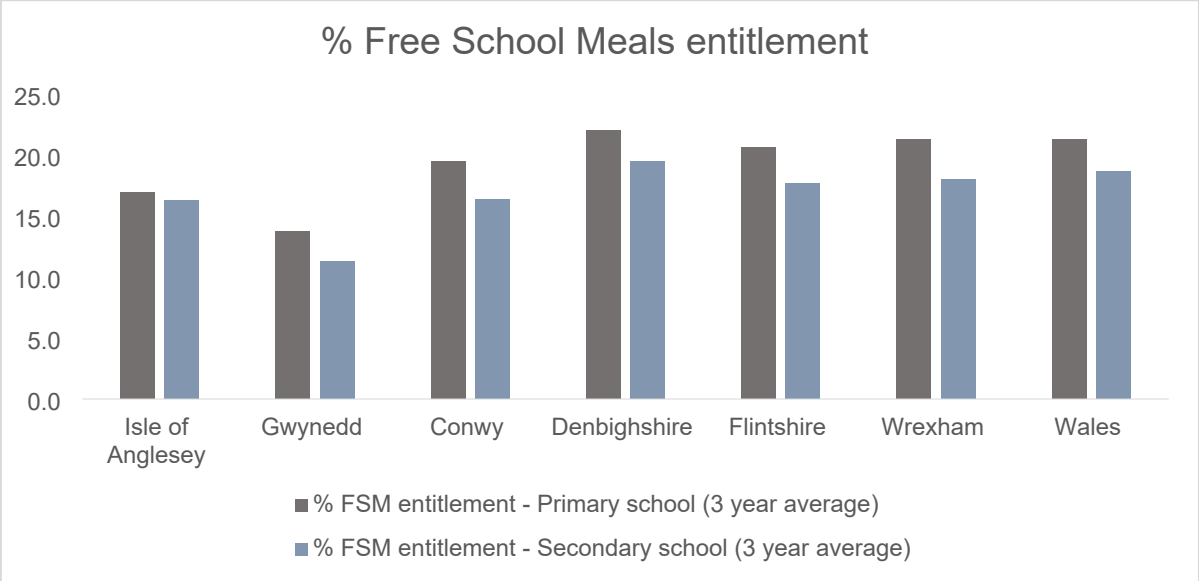
Table showing Special educational needs data for Primary school age:

Primary School age %	Special educational needs - School Action (Primary age)	Special educational needs - School Action Plus (Primary age)	Special educational needs - Statemented (Primary age)
Wales	11.1	7.5	2.0
Isle of Anglesey	14.0	7.1	1.7
Gwynedd	8.8	10.4	1.5
Conwy	9.3	12.7	0.6
Denbighshire	8.9	11.2	1.0
Flintshire	11.9	5.6	2.3
Wrexham	8.3	5.0	2.8

Table showing Special educational needs data for Secondary school age:

Secondary school age %	Special educational needs - School Action	Special educational needs - School Action Plus	Special educational needs - Statemented
Wales	12.0	7.3	2.4
Isle of Anglesey	18.5	8.7	2.9
Gwynedd	9.2	9.4	2.3
Conwy	10.6	11.8	1.1
Denbighshire	9.5	8.8	1.8
Flintshire	11.6	3.8	2.4
Wrexham	8.0	4.5	2.6

Children entitlement for free school meals[16]



Narrative on education:

- There is variation across North Wales for those qualifications and no qualifications
- The % of residents with no qualifications are in Wrexham (9.6%), Flintshire (8.6%) and Conwy (8.3%)
- The rate of those with qualifications level 4 and above are generally lower across North Wales compared to Wales – with the exception of Isle of Anglesey which is slightly higher (43.1% compared to 41.4%)
- Approximately 12% of adults in Wales have poor literacy skills
- For entitlement to free school meals (FSM) there is variation across the North Wales area, with highest rates within Denbighshire and Wrexham. Denbighshire has higher rates compared to the Wales rate.

[16] Data based on school census January 2021. Source: Pupil Level Annual School Census summary data by local authority (pupils aged 5 to 15 in primary, middle or secondary schools) (gov.wales)

		• In terms of special educational needs for primary school age, there is variation across North Wales for the % on school action. The % of children with a statement is generally lower than the Welsh rate with the exception of Wrexham and Flintshire • In terms of special educational needs for secondary school age, there is significant variation across North Wales for the % on school action. The % of children with a statement is variable compared to the Welsh rate. The areas with higher rates (compared to Wales rate) are the Isle of Anglesey and Wrexham • Rates of English as an additional language is generally higher within primary school age children compared to secondary age. Across North Wales areas, the rate of English as an additional language is generally lower than the Wales rate (both age groups) with the exception of Wrexham • School population data of % Black, Asian and minority ethnic groups how a significantly lower representation across North Wales areas with the exception of Wrexham. This generally mirrors the data of English as an additional language **Assessment summary for Education:** The above information links to the Estates Strategy in the following ways: Options for delivery of the primary care centre vision must ensure the provision of sufficient accommodation within facilities to enable delivery of effective and efficient education and training requirements. This will require further evaluation of preferred approaches for education and training (e.g. face to face vs virtual) and alignment with existing primary care space capacity and utilisation (likely to require investigation via the use of room occupancy software). The context about our population in terms of education will help understand the communication needs of different groups and keeping communities informed on any proposed change to the strategy and future progress. This will take account of literacy levels and have information in accessible formats.

		BCUHB is an anchor institution across North Wales and links in with schools, colleges and Universities in its area. It is also a significant employer in the area providing opportunities for employment, apprenticeships and training for different health occupations. BCUHB currently provides important clinical and non clinical support services from a range of freehold and leasehold properties. These services include: • Administration (office space) • Education and Training (Academic/Training centres) • Staff/student accommodation (residences) • Medical records (storage) • Sterilisation and decontamination (Hospital Sterilisation and Decontamination Unit) • Workshops • Call centre The future support services estate will be built upon strategic hubs, providing regional solutions whilst supporting local delivery e.g. centralised decontamination, regional administration hubs supporting IHCs (aligned with BCUHB's agile working policy and the Welsh Government's target for 30% of the Welsh workforce to work remotely). This focus will reduce the current reliance on leased accommodation, eradicate duplication and rationalise the current owned assets to facilitate a more sustainable estate.
Health There is a clear social gradient in terms of health outcomes as documented by the Marmot Review	**In Practice** How does your proposal take account of the expected health outcomes of the	**Evidence:** **Population info[17]:** North Wales has a resident population of 699,500 persons, living across an area of approximately 2,500 square miles. The region is defined by coastland; rural areas,

[17] Locality Needs Assessment Draft 11February2021

(2010 and 2020 update). It makes it clear that health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources (i.e. the social determinants of health). Indeed, data for Wales shows that adults and children living in the poorest areas are having poorer health outcomes. Adults living in the most deprived areas of Wales have lower life expectancies than those living in the least deprived areas. There is reasonable evidence that people in poverty or living in deprived neighbourhoods have a higher risk of	local population? What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors. What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?	particularly in the North West; and more urban areas in the North East. Many rural areas have experienced migration patterns that have resulted in ageing populations with increasing health and social care needs. The East Area has the highest number of residents in the BCUHB region and has the youngest population. The Central Area has the largest proportion of residents aged 65 years and over and 85 years and over. **Aged 0 to 15 / Aged 16 to 64 / Aged 65 and over / Aged 85 and over** **Betsi Cadwaladr UHB: 18 / 59 / 23 / 3** Isle of Anglesey: 17 / 57 / 26 / 3 Gwynedd: 17 / 61 / 23 / 3 **West Area: 17 / 59 / 24 / 3** Conwy: 11 / 37 / 18 / 3 Denbighshire: 18 / 58 / 24 / 3 **Central Area: 17 / 57 / 26 / 4** Flintshire: 19 / 60 / 21 / 2 Wrexham: 19 / 61 / 20 / 3 **East Area: 19 / 60 / 21 / 2** Source: StatsWales Betsi Cadwaladr UHB has an increasing and ageing population. The population is expected to increase to 734,700 by 2036.

addiction and mental illness and it's also known that many patients struggle financially and socially.

Table 1:

Population projections by age group, count and percentage change since 2011, Betsi Cadwaladr UHB, 2011-2036

		2011	2016	2021	2026	2031	2036
Under 16							
Estimated population		123,300	124,600	128,300	125,900	121,900	118,300
Population change since 2011	Count	-	1,300	5,000	2,700	-1,400	-5,000
	%	-	1.1	4.1	2.2	-1.1	-4.0
16 to 64							
Estimated population		425,700	418,900	416,100	415,100	410,200	406,200
Population change since 2011	Count	-	-6,800	-9,600	-10,600	-15,500	-19,500
	%	-	-1.6	-2.2	-2.5	-3.6	-4.6
65 to 84							
Estimated population		120,900	136,400	144,300	152,400	160,300	163,000
Population change since 2011	Count	-	15,600	23,500	31,500	39,500	42,100
	%	-	12.9	19.4	26.1	32.7	34.8
85 and over							
Estimated population		18,600	21,300	24,900	30,100	37,800	47,300
Population change since 2011	Count	-	2,800	6,300	11,500	19,300	28,700
	%	-	14.9	34.1	62.0	103.6	154.4
All ages							
Estimated population		688,400	701,300	713,700	723,500	730,300	734,700
Population change since 2011	Count	-	12,900	25,300	35,100	41,900	46,300
	%	-	1.9	3.7	5.1	6.1	6.7

Produced by Public Health Wales Observatory, using 2011-based population projections (WG)
Numbers have been calculated using unrounded data, then rounded to the nearest 100.

The percentage of the population aged 85 years and over is expected to increase by 154% between 2011 and 2036.

Population Density:
The East Area is the most densely populated Area in the BCUHB region with around 355 persons per square kilometre in Flintshire compared to 49 km^2 in Gwynedd.

Population density (persons per square kilometre) Wales and North Wales unitary authorities, 2019

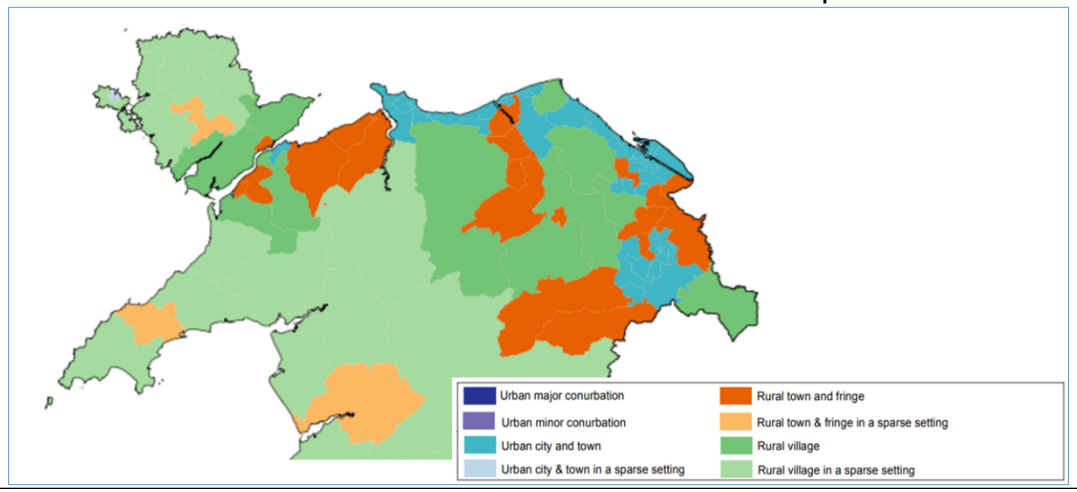
	Km^2
Wales	152.0
Isle of Anglesey	98.4
Gwynedd	49.1
Conwy	104.1
Denbighshire	114.4
Flintshire	355.0
Wrexham	269.9

Source: StatsWales (WG)

Rurality

Rural-Urban Classification for Middle Layer Super Output Areas (MSOAs), North Wales, 2011

Source: Office for National Statistics licensed under the Open Government Licence v.3.0



Ethnicity:

Ethnicity by area and ethnic group, Wales, Betsi Cadwaladr UHB Areas & unitary authorities, 31st March 2020

	White	Black, Asian and minority ethnic	Percentage of people who are Black, Asian and minority ethnic
Wales	2,929,600	186,600	6
Betsi Cadwaladr UHB	679,600	17,800	2.6
Isle of Anglesey	69,500	*	*
Gwynedd	118,400	4,400	3.6
West Area	**187,900**	**4,400**	**2.3**
Conwy	111,000	3,700	3.3
Denbighshire	90,900	4,200	4.4
Central Area	**201,900**	**7,900**	**3.9**
Flintshire	153,800	2,500	1.6
Wrexham	136,000	3,000	2.2
East Area	**289,800**	**5,550**	**1.9**

Source: StatsWales (WG)

Morbidity and mortality data have identified a number of inequalities across ethnic groups as described in the Living Healthier, Staying Well: Equality Information paper. This includes health inequalities experienced by vulnerable groups including Gypsy, Roma and Travelling communities.

Evidence tells us that specific groups may be at greater risk of certain health conditions (such as diabetes, stroke, and coronary heart disease.) The impact of the strategy programmes

will need to be monitored and evaluated to ensure that the needs of specific groups are being addressed and improved outcomes delivered.

Gypsy, Roma and Traveller communities

local authority: county / unitary (prior to April 2015)	All usual residents		White: Gypsy or Irish Traveller	
	number	%	number	%
Conwy	115,228	100.0	65	0.1
Denbighshire	93,734	100.0	34	0.0
Flintshire	152,506	100.0	95	0.1
Gwynedd	121,874	100.0	153	0.1
Isle of Anglesey	69,751	100.0	65	0.1
Wrexham	134,844	100.0	104	0.1

Source: Nomis - Official Labour Market Statistics - Nomis - Official Labour Market Statistics (nomisweb.co.uk)

Census data from 2011 indicates there are over 500 people from GRT backgrounds.

There are 22 authorised Traveller sites across the Health Board area. [18]

Life expectancy

Life expectancy is an estimate of the average number of years that newborn babies could expect to live, assuming that current mortality rates for the area in which they were born applied throughout their lives.

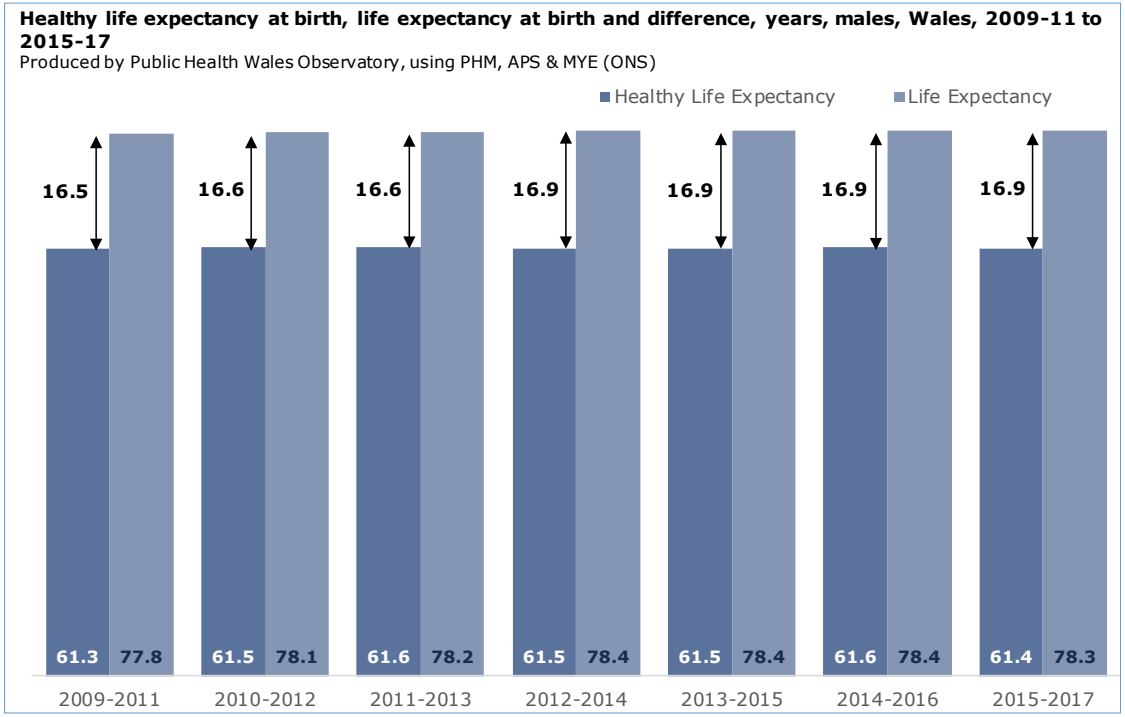
	Male	Female	Gender gap
UK	79.2 years	82.9 years	3.7 years
Wales	78.3 years	82.2 years	3.9 years

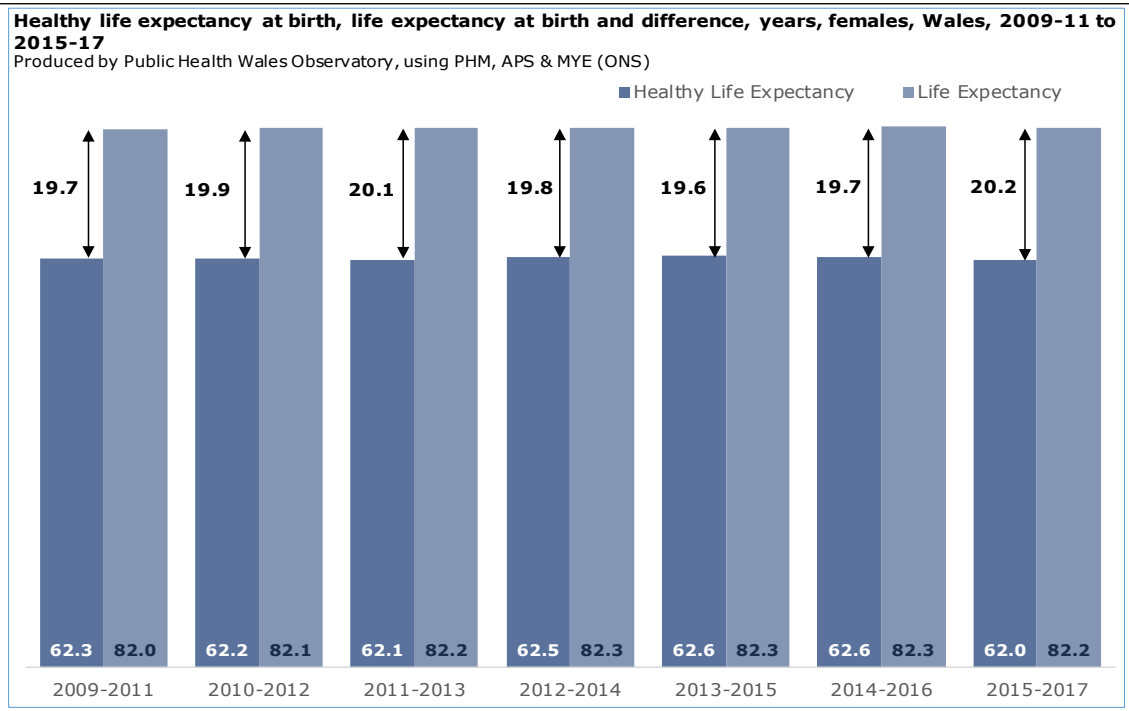
2017 latest data set available

[18] Number of sites by authorisation and local authority (gov.wales)

Life expectancy – Local Authority areas 2018-2020:

	Males	Females
Isle of Anglesey	79.27	82.87
Gwynedd	79.51	83.1
Conwy	78.36	83.05
Denbighshire	78.27	81.13
Flintshire	79.21	82.17
Wrexham	78.32	81.33
Wales	78.29	82.09





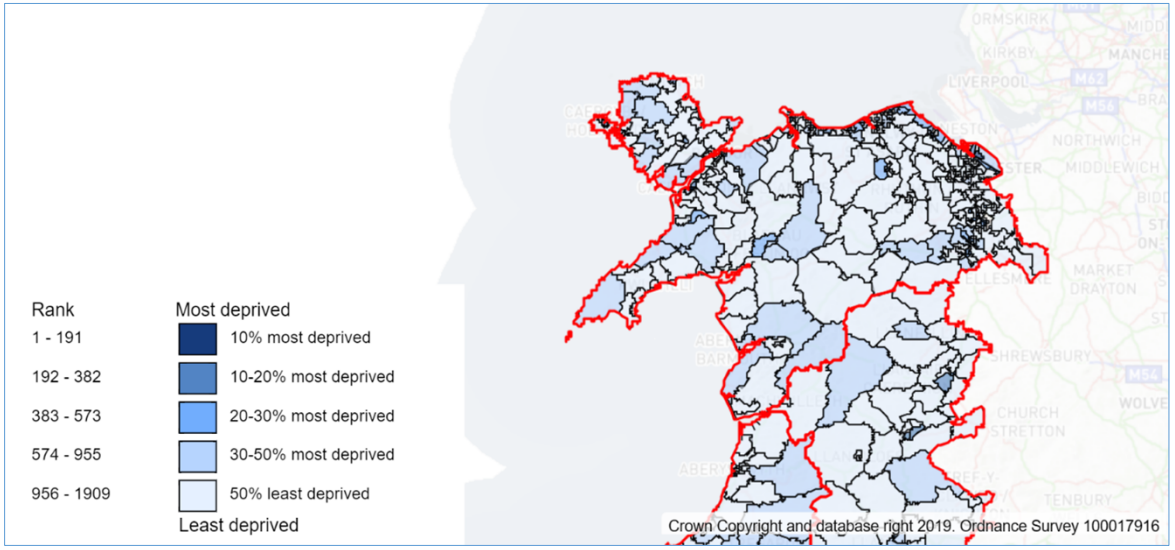
- Across reach local authority area, there are differences between male and female life expectancy – with females having higher life expectancy
- There is variation across the local authorities areas, of which Wrexham has the lowest life expectancy
- There will be life expectancy differences within each local authority area – linked to deprivation

Audit work for Maternity services[19] across Wales highlights significant inequalities of outcomes in terms of perinatal health and deprivation across the measures for Apgar score and breast milk at first feed measures.

[19] Ref 308 Inequalities Sprint Audit Report 2021_FINAL.pdf (maternityaudit.org.uk)

		Assessment summary for Health: As described within Living Healthier, Staying Well, the proposed network of primary care facilities will build upon the existing portfolio of primary care centres and health centres and will provide access points to health and wellbeing services in primary care settings. Primary Care Centres may be delivered by using existing properties, by reconfiguring existing facilities or by development of new properties. There should also be a drive to deliver primary care services from appropriate non-healthcare (e.g. town centre) premises. Options for delivery of the primary care centre vision must ensure the provision of sufficient accommodation within facilities to enable delivery of effective and efficient education and training requirements. This will require further evaluation of preferred approaches for education and training (e.g. face to face vs virtual) and alignment with existing primary care space capacity and utilisation (likely to require investigation via the use of room occupancy software). Delivery of the Care Closer to Home vision via Primary Care Centres and Health and Wellbeing Hubs should also consider the possibility of extended working to maximise asset utilisation and reduce capital investment. BCUHB will continue to seek Welsh Government funding for the delivery of primary care services via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF). The Board will also continue to seek opportunities to access Welsh Government improvement grants to support improvement of the condition, functional suitability, performance and sustainability of non-BCUHB primary care estate, subject to value for money assessments. **3.6.3 Mental Health, Learning Disabilities and Substance Misuse** The BCUHB Mental Health Strategy (2017) outlines a vision to support prevention, early intervention, support of service users within the community and a reduction in acute admissions. Inpatient care will continue to be focused on the three acute sites together with facilities providing secure/rehabilitation services, learning disability

		units, and Child and Adolescent Mental Health Services facilities. Community services may be delivered from existing facilities or from Health and Wellbeing Hubs to normalise/destigmatise attendance and enhance service user experience. Community Mental Health Teams will be co-located with the wider community resource teams with some additional accommodation required for specialist support and interventional services. Similarly, primary care mental health teams will deliver services from primary care premises. There is a commitment to provide acute hospital care from the three hospital campuses at Ysbyty Gwynedd, Glan Clwyd Hospital and Wrexham Maelor Hospital. There are plans for investment on all three acute sites, especially Wrexham Maelor Hospital and Ysbyty Gwynedd. Relocation of activity to Regional Treatment Centres (RTCs), and potential relocation/consolidation of services across the three acute hospitals (to develop Centres of Excellence or ensure sustainability) present opportunities to vacate space on acute sites to accommodate growing services. Administration space requirements on acute sites will be aligned with BCUHB's agile working policy and support the Welsh Government's target for 30% of the Welsh workforce to work remotely supported by technology and smart working processes. This will enable rationalisation of existing administration space and consolidation on acute sites or relocation off-site if essential functional relationships are not required (e.g. some corporate administration). Vacated administration space on acute sites may be used to accommodate growing clinical services or new care models. **3.6.5 Regional Treatment Centres** To increase and protect planned capacity, RTCs will provide outpatient appointments, diagnostic tests and day surgery. Relocation of activity from the acute hospital sites to RTCs will vacate space on the acute sites to accommodate key service growth e.g. Emergency Department, Same Day Emergency Care, ambulatory care, GP out of hours, and facilitate compliance. In addition, plans are being developed to expand capacity for orthopaedics

		under a separate initiative.
Living standards 3% of all people in Wales were living in relative income poverty between 2016-17 and 2018-19. This figure has remained relatively stable for the past 16 time periods. At 23%, the figure is slightly lower than last year's. Children were the age group most likely to be in relative income poverty (at 28%) and this has been true for some time. 11% of children living in Wales between 2016-17 and 2018-19 were in material deprivation and low income households.	**In Practice** How does your proposal take account of the impact of poverty and deprivation? Can you identify which groups are disproportionately impacted by poverty e.g. disabled people? Think about the UK-wide reforms to social security and the impact on the poorest in society, particularly women, disabled people, ethnic minorities and lone parents in Wales.How have the needs of people with caring responsibilities been considered? What is	**Evidence:** **Deprivation data for Health Board area:** The Welsh Index of Multiple Deprivation (WIMD) [20]defines deprivation as the "lack of access to opportunities and resources which we might expect in our society". Deprivation is measured in relation to other areas and based on eight factors including income, health, education and housing. **Deprivation – Health Board level[21]**  Deprivation data is 2019 data. Supporting narrative for WIMD data:

[20] Welsh Index of Multiple Deprivation | GOV.WALES
[21] Source: WIMD - Explore (gov.wales)

	the incidence of rough sleeping and levels of homelessness? Twice as many people expect their financial situation to get worse as those who expect it to get better, with this rising to three times in the bottom income quintile, and more than three times for single parents. Think about the availability and accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces.	• There is variation across the geographical areas within the Health Board area – see Local Authority area data (section 3.2) • Across all of Wales, there are 191(from 1,909) Lower Super Output Areas (LSOA) which are within the most 10% most deprived • The Health Board area contains 423 Lower Super Output Areas (LSOA) • Of the 423 LSOA's, 23 fall within 0-10% most deprived • Of the 423 LSOA's, 48 fall within 0-20% most deprived • Of the 423 LSOA's, 83 fall within 0-30% most deprived • Of the 423 LSOA's, 122 fall within 0-40% most deprived • Of the 423 LSOA's, 162 fall within 0-50% most deprived **Child Poverty** Table showing % of children living in relative poverty [22]

		2014-15 to 2016-17	2015-16 to 2017-18	2016-17 to 2018-19	2017-18 to 2019-20
All households		28	29	28	31
All households	One child	29	28	27	25
	Two children	27	24	19	24
	Three or more children	28	39	44	46

Data area: Wales level.

[22] Source: Children in relative income poverty by number of children in the household (gov.wales)

As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?

Percentage data for child poverty is at Wales level, shows that relative poverty has increased overall for all households, with significant increase over time for households with three of more children

Pensioners and poverty

Table showing % of Pensioners living in relative poverty cross referenced with disability[23] (as defined by the Equality Act)

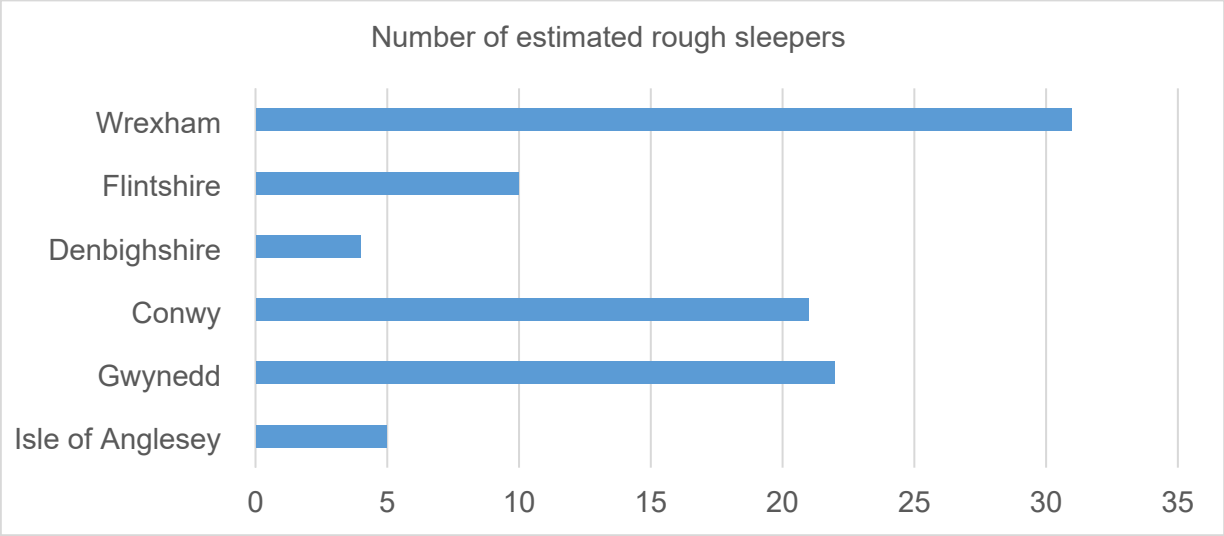
		2013-14 to 2015-16	2014-15 to 2016-17	2015-16 to 2017-18	2016-17 to 2018-19	2017-18 to 2019-20
All households		18	20	19	19	18
	No-one disabled within the family	18	22	22	22	19
	Someone disabled within the family	18	18	18	17	17

Percentage data for pensioner poverty is at Wales level, shows 18% of all households with pensioners live in poverty. There is no significant difference between those within households where there is someone with a disability or not

Rough sleepers

Local Authority data 2019/20[24]: rough sleepers data

[23] Source: Pensioners in relative income poverty by whether there is disability in the family (Equality Act definition) (gov.wales)
*data is not disclosive or sufficiently robust for publication



- The number of rough sleepers, reduced during the last 18 months following interventions of councils during the pandemic. Estimated rough sleepers for 2019/20 are 93 people. There is variation of where these are located, with highest number in Wrexham, Gwynedd and Conwy
- Local Authority data on households termed as homeless under section 75 (of the Housing Act) shows some variation across the Health Board area
- There were 498 households classed as Households unintentionally homeless and in priority need
- Highest rates of homelessness under section 75 which were above the Welsh rate were within Denbighshire, and Conwy Local Authority areas

Car Ownership[25]:

[24] Source: Rough Sleepers by local authority (gov.wales)

[25] Source: 2010 census data: NOMIS - Official Labour Market Statistics - Nomis - Official Labour Market Statistics (nomisweb.co.uk)

- 20% of households across the Health Board area do not have a car
- Car ownership lowest in Wrexham, Conwy and Gwynedd areas
- 25,040 households across North Wales over the age of 65 do not have access to a car

Assessment summary for Health:
A range of information has been included within this section that informs the refreshed LHSW strategy.

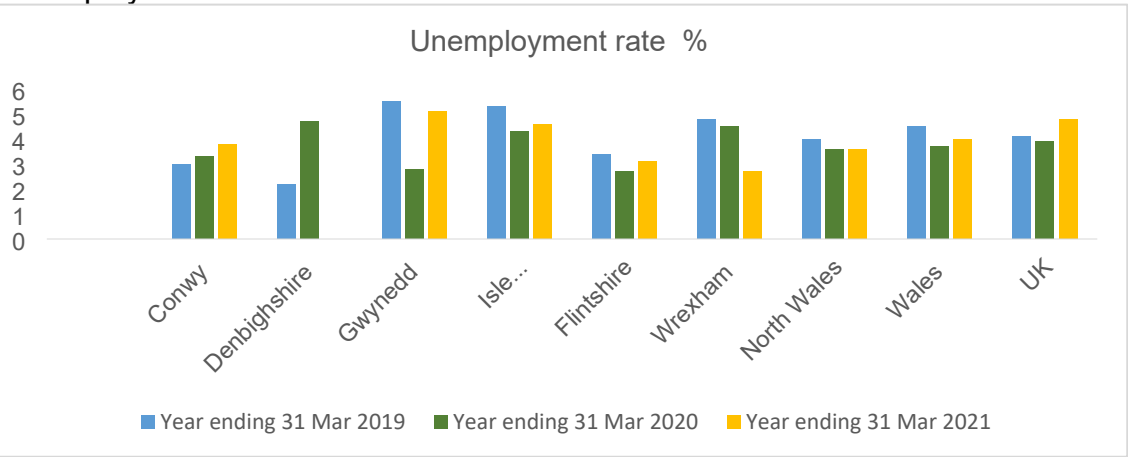
The engagement work and information on deprivation highlights variation across the health board area in terms of poverty and deprivation. Deprivation is seen as a significant determinant of health outcomes and the strategy has a key role in meeting the future health needs of its population.

The different layers of multiple disadvantage faced by different groups can be described as 'intersectional disadvantage'. This can often impact on access to services, of which barriers faced are often complex and multi-factored. Issues in direct relation to socio economic deprivation often are centred on the cost of travel / ease of travel. During the pandemic, there may be additional economic burdens on families / people due to risk of employment, furlough and loss of earning due to ill health or requirement to self-isolate. Financial stresses can also lead to poorer mental health and the pressures of increased living costs may acerbate this.

The LHSW strategy (2018 version) includes actions in relation to poverty:

- Providing care closer to home
    - support local services to work together better
    - build on the resources we have
    - look at ways to use community hospitals and other places as well-being centres
    - work with local people to make the right plans for their area
    - support carers more

		○ support GP practices better ○ develop Community Resource Teams that work with specialists to support patients in their community ○ use technology better including information and advice apps ○ develop new ways to identify and support people who have higher risks to their health ○ link into other service plans Two of the priorities stated in the Estate Strategy are: - **Address local economic inequality** - **Support sustainable transport.** These priorities include commitments to optimize local procurement and labour to support the local economy and improving access for patients staff and visitors, both key objectives in reducing health inequality. Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options. Targeted deep dive analysis may include as appropriate on a project by project basis: • Demand and capacity modelling (clinical activity and administrative activity) to determine future capacity requirements • Space utilisation studies to identify baseline capacity surplus/shortfall, support demand and capacity modelling, and inform options • Site feasibility studies to understand the range of options • Analyses to support patient/service user/staff access and travel times to specific properties and locations • Impact of new models of care and site locations on staffing models and requirements. These will be analysed from a socio-economic perspective.

Work	**In Practice**	**Evidence considered:**
When considering all children in Wales, the likelihood of being in relative income poverty is much greater, and the gap is increasing for those living in a workless household compared to living in a working household (where at least one of the adults was in work).	As one of the largest employers in Wales BCUHB provides numerous opportunities for people to access work, the Step into Work programme is a great example. Think about how careers support including apprenticeships and volunteer work placements can be promoted to support those who are furthest from the job market, those who are in households where no one is in employment, young people who are not in employment or training and other seldom-heard groups.	**Work – Health Board level [26]** **Employment** Employment rate (population aged 16-64) 75.9% Unemployment rate (population aged 16 and over) 3.9% Economic inactivity rate (excl. students) (population aged 16-64) 17.9% Source: Annual Population Survey, Office for National Statistics. Data relates to year ending 30 September 2019 Unemployment data sets for each area[27]: 

[26] Source: Summary statistics for North Wales region: 2020 (gov.wales)
[27] Source: ILO unemployment rates by Welsh local areas and year (gov.wales)

	Think about people in terms of their income and employment status, consider the impact on the availability and accessibility of work, paid and unpaid employment, wage levels, job security and working conditions. What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, workless, and people who are unable to work due to ill-health. Consider people living in work poverty. During the pandemic lower earners are three times as likely to	Employment rate across North Wales generally in line with the Wales rate with some variations within Local Authority areas. **Narrative:** • Employment levels comparatively high compared to Welsh data • There is some variation across areas with highest unemployment rates within Gwynedd and Anglesey • There is some variation across employment rates with highest employment in Flintshire and Conwy • Wales data on gender pay gap show gap is 4.3% **Work vacancies:** The North Wales Regional Skills Partnership reported [28] the impacts of Covid 19 on employment and skills. Reporting noted that tourism and hospitality sector saw largest increase in vacancies (sept 2019 to April 2021) and certain roles continue to be hard to fill – such as jobs in health, care and support worker roles. **Carers:** There were approximately 5.8 million people providing unpaid care in England and Wales in 2011, representing just over one tenth of the population. The absolute number of unpaid carers has grown by 600,000 since 2001; the largest growth was in the highest unpaid care category, fifty or more hours per week. Table showing number of Unpaid Carers (2011 Census)

[28] Download.aspx (rspnorth.wales)

have lost their job or been furloughed as high earners.

How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage? As part of your proposal what are the opportunities to increase employment opportunities for people who experience socio-economic disadvantage?

local authority: county / unitary (prior to April 2015)	All categories: Provision of unpaid care	Provides no unpaid care	Provides 1 to 19 hours unpaid care a week	Provides 20 to 49 hours unpaid care a week	Provides 50 or more hours unpaid care a week
Conwy	115,228	101,623	7,813	1,814	3,978
Denbighshire	93,734	82,103	6,470	1,765	3,396
Flintshire	152,506	134,863	10,680	2,487	4,476
Gwynedd	121,874	109,431	7,266	1,680	3,497
Isle of Anglesey	69,751	61,709	4,677	1,180	2,185
Wrexham	134,844	119,696	8,853	2,247	4,048
North Wales	687,937	609,425	45,759	11,173	21,580

Source: Nomis - Official Labour Market Statistics - Nomis - Official Labour Market Statistics (nomisweb.co.uk)

This group have been included in this assessment due to the socio economic disadvantage that many unpaid carers face. The Locked Out Report[29] notes that carers have been negatively impacted by the pandemic in terms of health needs, lack of information on support and financial support.

Carers UK [30] report increased burden on unpaid carers during the pandemic and increased financial pressures. The UK wide report notes that 1.2 million carers were already in poverty (pre Covid) with 38% of carers surveyed feeling worried about their financial situation. Rising living costs, job insecurity and level of carers allowance are cited reasons for these worries.

Veterans:

[29] Locked out: liberating disabled people's lives and rights in Wales beyond COVID-19 | GOV.WALES
[30] Caring_behind_closed_doors_April20_pages_web_final.pdf (carersuk.org)

		This group have been included within this assessment due to socio economic disadvantage faced and significant proportion of the population that are veterans. This group are commonly referred to as the 'ex Service community'.
		
		Welsh Government report – Giving and Receiving [31](2016) notes:
		
		• In Wales there are estimated to be 385,000 members of the Armed Forces community, this equates to 12% of the population
		• There is a requirement to demonstrate commitment to the Armed Forces Covenant[32]
		• Armed forces personnel may face particular health needs arising from their service. Some may face significant health needs due to injury and experience of conflict
		• Veterans often face challenges in adjusting to civilian life – including
		  ○ finding employment,
		  ○ gaining new skills and qualifications,
		  ○ navigating the benefits system, and
		  ○ finding housing
		
		The Royal British Legion report 2014[33] notes significant health needs.
		
		There are a range of different support organisations across North Wales that provide support services to veterans.
		
		The Health Board employs around 18,000 people and is a significant employer for the area. We report our workforce data[34] – in accordance with the specific duty as part of the Public Sector Equality Duty.

[31] giving-and-receiving.pdf (gov.wales)
[32] About - Armed Forces Covenant
[33] A UK household survey of the ex-Service community (rblcdn.co.uk)
[34] https://bcuhb.nhs.wales/use-of-site/publication-scheme/class-five-our-policies-and-procedures/equality-and-human-rights/equality-and-human-rights/statutory-employment-reports-2019-20-commentary/annual-equality-report-2020-21/

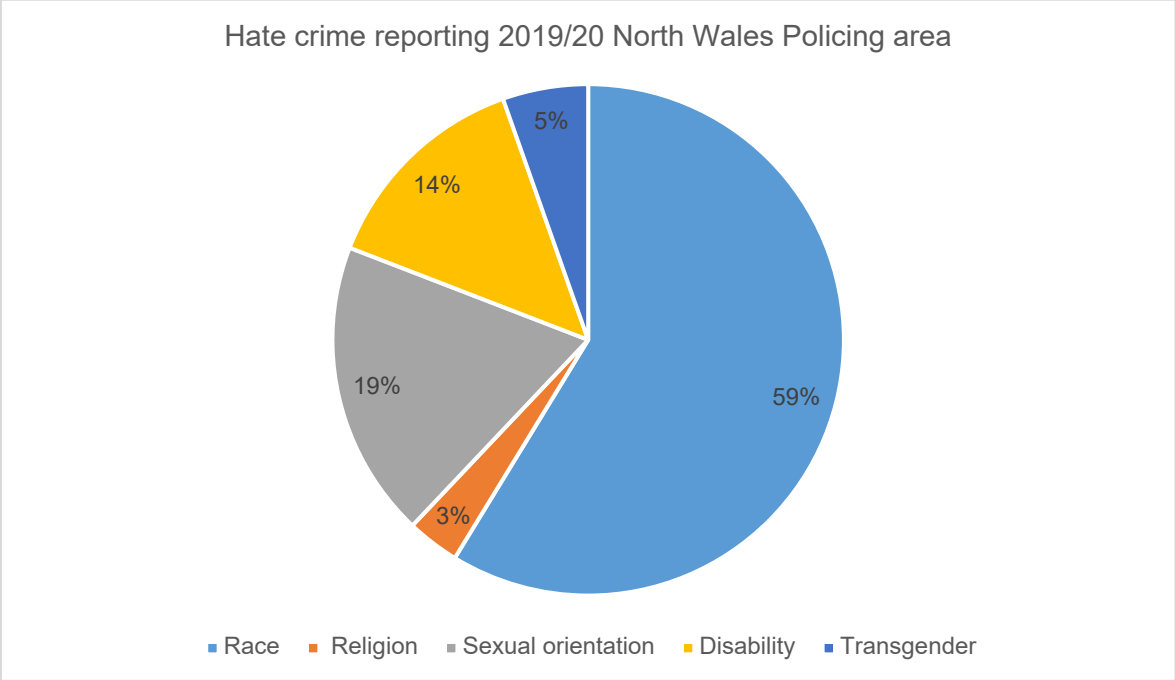
		The Health Board also provides a range of volunteering opportunities across the whole health board. There are approximately 330 “Robin” volunteers who volunteer across the hospitals. The Heath Board also run a Step into Work Programme, We work in partnership with social enterprises to offer placements for groups including workless households, long-term unemployed, communities for work projects, in work poverty, Agoriad, Remploy, MONCF, North Wales Regional Equalities Network (NWREN), Not in Education (NEETS), Employment or Training, Go Wales, Higher Education Students (HE) and Further Education Students (FE). Our programme has helped over 200 participants secure a role in the Health Board including Health Care Assistants, Domestic, Porters, Catering, administration and laboratories. Workforce recruitment and retention is a key factor in delivery of future services to meet the needs of our communities. **Assessment support for work:** We know that unemployment is a key factor leading to socio-economic deprivation and a wider determinant of health. The above links to the aims of the LHSW aims to: • Improve physical, emotional and mental health and well-being for all • Target our resources to people who have the greatest needs and reduce inequalities • Support children to have the best start in life • Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being . As we take forward the priority areas identified within this estate strategy we will continue to engage withstaff, communities and stakeholders to further develop the future estate requirements and co-produce associated detailed implementation plans. It is clear that our estate must change if it is to be sustainable, viable and support the implementation of Living Healthier, Staying Well.

Justice and personal security The National Survey for Wales (2018-19) shows that people who were not in material deprivation were found to be more likely to feel safe in their local area, compared with those who were in material deprivation. Research by the University of Bristol shows that, notwithstanding some significant methodological limitations, existing analyses in the UK and internationally have consistently found vulnerability to domestic violence and abuse to be associated with low	**In Practice** How does your proposal take account of local crime rates and exposure to crime? What are the hate crime statistics? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control. How can your proposal promote and protect people's	**Evidence:** **Feeling safe:** Data (Wales level data) available on feeling safe[35] April 2018 to March 2019 highlights the following factors / predictors in feeling unsafe in their local area: • Females in local green areas after dark • Females, experiencing deprivation - most likely to feel unsafe at home after dark • Females most likely to feel unsafe when travelling by public transport after dark • Older people experiencing deprivation most likely to feel unsafe travelling by car **Domestic abuse:** • Crime Survey for England and Wales[1] (CSEW) year ending March 2020, an estimated 5.5% of adults aged 16 to 74 years (2.3 million people) experienced domestic abuse in the last year. 69% of victims were women. • Welsh Women's Aid reported 87% (June 2020 survey) increased demand for online support with other survey reporting the pandemic rules was being used by perpetrators to control and put abuse victims at risk[1] • Demand for support services increased during the pandemic (2020) • Aspects of Covid restrictions were used to exert further domestic abuse and control over victims **Hate Crime:** Table of reported hate crimes 2019/20 for Wales Police areas:

[35] Feeling safe in a local area (National Survey for Wales): April 2018 to March 2019 | GOV.WALES
What factors are linked to people feeling safe in their local area? (gov.wales)

income, economic strain, and benefit receipt. This association is underpinned by a complex set of relationships and interdependencies.	rights and increase their access to justice and personal security?	

Police Force Area	Race	Total Religion	Sexual orientation	Disability	Trans-gender	Total number of motivating factors	Total number of offences
Wales	**3,052**	**150**	**884**	**504**	**173**	**4,763**	**4,654**
Dyfed-Powys	439	34	108	84	20	685	685
Gwent	437	6	141	73	26	683	677
North Wales	706	40	226	165	65	1,202	1,144
South Wales	1,470	70	409	182	62	2,193	2,148



Further detailed information on hate crime statistics and trends is found at: Hate crime, England and Wales, 2020 to 2021 - GOV.UK (www.gov.uk)

Assessment summary for justice and personal security:

The above evidence / information links to the aims of the LHSW aims to:

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

		• Improve the safety and quality of all services • Respect people and their dignity • Listen to people and learn from their experiences Detailed impact assessments of the strategy will include an analysis of the above.

Participation
 	
The National Survey for Wales (NSW) shows that in 2018-19, 87% of households had access to the internet. Household internet access varies by WIMD levels of area deprivation. In 2018-19, 92% of households in the least deprived areas had internet access, compared to 83% of households in the most deprived areas. The NSW also shows households in social housing were less likely to have internet
	In Practice
	
	How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal?
	
	Covid-19 has shone a spotlight on a digital divide and highlights the effects of digital exclusion on those in poverty, with some feeling isolated and forgotten about.
		Evidence:
		
		Accessing information on health and wellbeing
		April 2019 to March 2020 data from National Survey for Wales:
		• 84% of people said that they can access the right information, advice and support both when they are ill and to help them to lead a healthy lifestyle.[36]
		• People saying they can access the right health and well-being information are more likely to have one or a combination of the following characteristics:
		  ○ being aged 16 to 24
		  ○ being in good health
		  ○ attending or taking part in arts and cultural events
		  ○ not being lonely
		
		Digital Exclusion (data poverty):
		77% of internet users have visited at least one public service website in the past 12 months.[37]
		
		People who visit public sector websites are more likely to have one or a combination of the following characteristics:
		
		• being aged 16 to 49
		• being educated to degree level or above
		• using the internet at least several times a day

[36] Wales level: Accessing information on health and wellbeing (National Survey for Wales): April 2019 to March 2020 | GOV.WALES

[37] (National Survey for Wales): April 2019 to March 2020. Internet skills and online public sector services (National Survey for Wales): April 2019 to March 2020 | GOV.WALES

access (75% of such households) than those in private rented (90%) or owner occupied (89%) accommodation. Those in employment were more likely to have internet access at home (96%) than those who were unemployed (84%) or economically inactive (78%).	Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities. How can your proposal increase participation for people who experience socio-economic disadvantage?	• being female • being employed • being white (Welsh, English, British etc.) National Survey for Wales. They show older people, disabled people, those living in social housing and the economically inactive & unemployed as those most likely to be digitally excluded. 10% of the population of Wales are not online and 27% of those who do use the internet lack at least one of the five basic digital skills[38]: 1. Handling information and content 2. Communicating 3. Transacting 4. Problem solving 5. Being safe and legal online Older people, people with disabilities and people with a limiting long term health condition are less likely to be online, these are more likely to need health and social care support. Research carried out with Gypsy and Traveller communities in 2018[39] notes high levels of digital exclusion within these communities, with 20% never had used the internet, with 50% not feeling confident in using technology. Access issues highlights that 38% (33% if housed) have a household internet connection. **Loneliness / social isolation:** Evidence within the report 'Who is lonely in Wales? | WCPP' [40] contains information on who feels most lonely. In summary, the following groups feel most lonely:

[38] Digital Strategy - Betsi Cadwaladr University Health Board (nhs.wales)
[39] Digital-Inclusion-in-Gypsy-and-Traveller-communities-FINAL-1.pdf (gypsy-traveller.org)
[40] Who is lonely in Wales? | WCPP (Additional data on protected characteristics available within the report).

- Younger age groups (less than 65 years)
- Men have higher levels of social isolation, whereas women have higher levels of emotional loneliness
- Those with w a long term illness or disability and in poorer health are lonelier than those without
- People who are single, separated and divorced are lonelier than those who are married or in a civil partnership
- People who are LGBT are lonelier than heterosexual people
- People who are from Black, Asian and Ethnic minority groups are more lonely compared to white British
- Single parent households report the highest levels of loneliness
- Those with higher levels of education report higher levels of social loneliness

Related information for loneliness:

Around 44,000 people aged 65 years and over live alone in BCUHB, around 15% of the population.[41]

	One person household: Aged 65 and over		One person household: Other	
	Number	*Percent*	*Number*	*Percent*
Wales		13.7		17.1
Betsi Cadwaladr UH	**43,932**	**14.9**	**48,809**	**16.5**
Isle of Anglesey	4,802	15.7	5,086	16.6
Gwynedd	8,701	16.6	9,847	18.8
West Area	**13,503**	**16.3**	**14,933**	**18.0**
Conwy	8,748	17.1	8,549	16.7
Denbighshire	6,147	15.2	6,567	16.2
Central Area	**14,895**	**16.2**	**15,116**	**16.5**
Flintshire	8,200	12.9	9,277	14.5
Wrexham	7,334	12.9	9,483	16.6
East Area	**15,534**	**12.9**	**18,760**	**15.5**

Source: Census 2011 (ONS)

[41] Locality Needs Assessment Draft 11 February 2021

		Information on visiting population – due to tourism: North Wales area is a popular area for tourism – with significant numbers visiting the area for holidays as well as day trips. During 2019, there was 30 million visitors to North Wales[42]. Visitors to the area has some seasonal variation with higher peaks during summer holidays. The number of visitors also has an impact on our services, especially in geographical holiday hot spots. Regardless of status of being a visitor, the health board provides health care and access to unplanned care. This includes emergency attendances and attendances to minor injury units / walk in provision. **Co-production:** Co-production is is one of the main principles of the Social Services and Well-being (Wales) Act 2014. It means working with and involving individuals, their family, friends and carers to make sure their care and support is the best it can be.[43]

[42] North Wales Visitor Numbers Reaches An All-Time High (businessnewswales.com)
[43] Co-production | Information and Learning Hub (socialcare.wales)

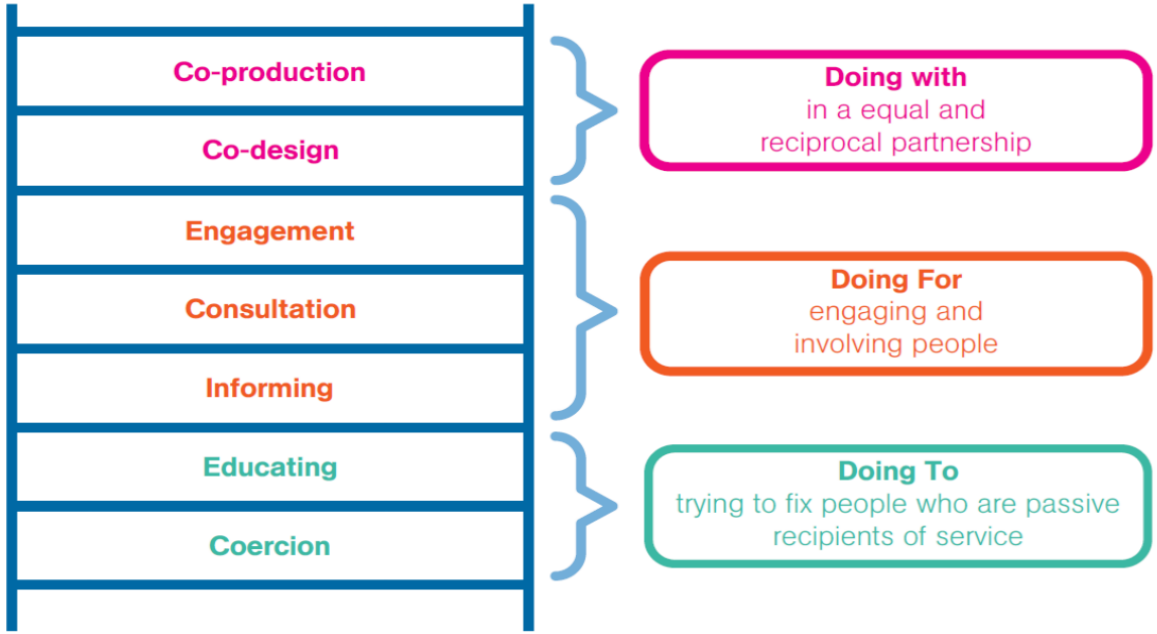


Figure: Arnstein / NEF

The Locked Out Report recommends the co-production of a Patient Charter for Wales that includes diverse groups and gives patients more rights and power.

Assessment summary for participation:

The refreshed LHSW strategy and previous work has carried out engagement with the public, stakeholder groups and workforce.

The above evidence / information within this section links to the aims of the LHSW aims to:

- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities

		• Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being • Listen to people and learn from their experiences The strategy includes direct links to reducing social isolation - making the most of our partnership working to promote wellbeing – to design and build better community-based solutions to address issues like loneliness and isolation. The priorities within the strategy included improving access to primary care – which is difficult for some people depending on where they live and also in light of changes to how services have been delivered due to the pandemic. The strategy also recognises that information about services needs to tell people what is available, including self-care. Information needs to be available in different formats as not everyone has access to digital methods of communication. This is recognised within both communities and our communications / engagement within our workforce. In meeting future health needs, there is recognition that groups / individuals which most need health services are least likely to receive it. This is referred to as the 'Inverse Care Law'[44]. The reasons for this may be complex and link to a range of factors, of which are linked to inequalities. Detailed impact assessments of the strategy will include an analysis of the above.

[44] Inverse care law | The King's Fund (kingsfund.org.uk)

What actions will you undertake to minimise any adverse impacts identified during this Socio Economic Duty Impact Assessment?			
Impacts Identified	**Mitigating Action to be Taken**	**Action Owner**	**Monitoring Arrangements**
Detailed Impact solution handling will be reviewed as elements of the strategy reach maturity.			

STAGE 4: STRATEGIC DECISION MAKERS		
Who signed-off this SED Impact Assessment	**Signatory** As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.	
	Board or Sub Committee:	
Approval and Review	**Approval Date:**	
	Review Date:	

Appendix 3

Type of Decision Includes but is not limited to:	**Equality Impact Assessment Required**	**Socio Economic Duty Impact Assessment Required**
Strategic policy development.Strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions	x	x
Health Board Wide Plans.Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)	x	x
Business Case/Capital Involvement/Options Appraisal required	x	x
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)	x	x
Changes to and development of public services Closure of Services	x	x
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services	x	x
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities	x	x
Directorate Financial Planning	x	x
Divisional policies and procedures affecting staff	x	
New policies, procedures or practices that affect service delivery	x	
Large Scale Public Events	x	
Major procurement and commissioning decisions	x	x
Local implementation of National Strategy/Plans/Legislation (e.g. vaccination programme)	x	x

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

For:	Estates Strategy
Date form completed:	09/01/2023

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Estates Strategy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This document sets out BCUHB's Estate Strategy to 2033. The strategy has been developed between October -December 2022, building upon the previous (2019) estate strategy and includes the most recent data submitted to the Welsh Government via the Estates and Facilities Performance Management System (EFPMS) and published in October 2022. The estate strategy has been developed to align with current BCUHB strategies including Living Healthier, Staying Well, Clinical Services Strategy, Digital Strategy, People Strategy and Plan, and the Decarbonisation Action Plan. Development of the strategy has included engagement with key stakeholders and regular reporting via forums including BCUHB's Capital Investment Group, Health Board Leadership Team, Clinical Senate, Board, and Community Health Council workshops. Since the previous estate strategy was completed in Feb 2019 the COVID-19 pandemic has had a significant impact upon the Board's estate, particularly in terms of capacity, suitability and shifts to digital, which is reflected in the analyses and recommendations below. The document is structured to reflect national guidance and to answer the three key questions – Where are we now?, Where do we want to be ?, How do we get there? The estate strategy will be continually reviewed to ensure alignment with the Integrated Medium Term Plancycle. Our services are delivered from, and our staff are based at a total of 238 properties (including GP owned, third party developer and private landlord primary care premises). The accommodation also hosts staff and services from other organisations including local authority and third sector. At aggregate level for all estate*, our estate falls short of both national targets and NHS Wales average values for all estate condition and performance indicators, except space utilisation. Estate condition and performance is evaluated against the standard indicators (defined by NHS Wales) opposite. Our estate currently falls short of all national targets except space utilisation.

Part A Form 1: Preparation

		BCUHB estate also falls short of NHS Wales average values for all condition and performance indicators except space utilisation. In the 2019 Estate Strategy, compared to NHS Wales average values, our estate performed less well for all indicators except functional suitability. Since 2018/19, BCUHB estate condition and performance has reduced across all indicators except space utilisation. Our estate portfolio contains a number of Grade II listed historic building and grounds (shown below) which, in their own right, add a number of additional challenges regarding their listings and essential maintenance obligations. Our estate comprises a range of property types, from acute hospitals to primary care facilities. Circa 45% of the estate is greater than 40 years old, compared to a Wales average of 49%. The majority of estate, by total Gross Internal Area (GIA) m2, is freehold. Initial pipeline of priorities identified by BCUHB.The following schemes have been identified by BCUHB as priorities on the capital programme, with business cases currently in progress or completed: • Wrexham Maelor Hospital infrastructure continuity programme • Ysbyty Gwynedd fire compliance programme • Regional Treatment Centre programme and expanded orthopaedics capacity • Royal Alexandra Hospital development project • Replacement of the Ablett Unit at Glan Clwyd Hospital • Medical and Health Sciences School The estate strategy will be subject to regular review aligned with the IMTP cycle and will identify any changes in estate priorities. Identified additional estate opportunities are detailed in section 4.3. These, and others, will be subject to further evaluation and development aligned to the estate vision.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	The Executive Director for Finance and Performance.

Part A Form 1: Preparation

4.	Is the Policy related to, or influenced by, other Policies or areas of work?	This Estate Strategy forms a vital component of a suite of BCUHB enabling strategies that both support key NHS Wales Strategies and BCUHB's Living Healthier, Staying Well vision and inform BCUHB transformation programmes and delivery plans (summarised below). The BCUHB enabling strategies are interdependent and must be complementary to ensure successful delivery. BCUHB strategies will require regular updating. Prioritisation of infrastructure projects should be aligned with the key suite of BCUHB strategies. 
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The Estates Strategy will be reviewed by relevant stakeholder groups via the EQIA/SEIA scrutiny group. Detailed Impact solution handling will be reviewed as elements of the strategy reach maturity.
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Further detailed information and analysis may be required to inform projects and enable better evaluation and prioritisation of estate options. Targeted deep dive analysis may include as appropriate on a project by project basis: • Demand and capacity modelling (clinical activity and

		administrative activity) to determine future capacity requirements • Space utilisation studies to identify baseline capacity surplus/shortfall, support demand and capacity modelling, and inform options • Site feasibility studies to understand the range of options • Analyses to support patient/service user/staff access and travel times to specific properties and locations • Impact of new models of care and site locations on staffing models and requirements • Equality Impact Assessment for estate options • Socio-Economic Impact Assessment for estate options
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	**3.6.1 Improving Health and Reducing Inequalities** Services focused on supporting health and wellbeing and reducing inequalities will be delivered in a range of settings to facilitate ease of public access. Locations for delivery may include: • Public community facilities, such as sports and fitness centres, community halls, and libraries • Commercial premises such as pharmacies, supermarkets, health stores, theatres/cinemas • Health facilities (including primary care and general dental services) • Local authority and third sector properties As described within Living Healthier, Staying Well, the proposed network of primary care facilities will build upon the existing portfolio of primary care centres and health centres and will provide access points to health and wellbeing services in primary care settings. Primary Care Centres may be delivered by using existing properties, by reconfiguring existing facilities or by development of new properties. There should also be a drive to deliver primary care services from appropriate non-healthcare (e.g. town centre) premises. Options for delivery of the primary care centre vision must ensure the provision of sufficient accommodation within facilities to enable delivery of effective and efficient education and training requirements. This will require

		further evaluation of preferred approaches for education and training (e.g. face to face vs virtual) and alignment with existing primary care space capacity and utilisation (likely to require investigation via the use of room occupancy software). Delivery of the Care Closer to Home vision via Primary Care Centres and Health and Wellbeing Hubs should also consider the possibility of extended working to maximise asset utilisation and reduce capital investment. BCUHB will continue to seek Welsh Government funding for the delivery of primary care services via the Health and Social Care Integration and Rebalancing Capital Fund (IRCF). The Board will also continue to seek opportunities to access Welsh Government improvement grants to support improvement of the condition, functional suitability, performance and sustainability of non-BCUHB primary care estate, subject to value for money assessments.

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

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

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

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

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

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

Part A

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

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	x		x		Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit. There are current capacity constraints due to ageing population (potentially more of an issue in west IHC)	Consideration to be given to stakeholder involvement in decisions that affect them.
Disability (think about different types of impairment and health	x		x		Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations	Consideration to be given to stakeholder involvement in decisions that affect them.

conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)					and standards are met through an accessibility and inclusion audit. Disability: Mental Health: There are currently capacity issues in community facilities: • Current service provision gaps e.g. perinatal mental health service, adult eating disorder clinic service users are still being sent out of area, specifically in terms of secure units (no provision for women in Wales at all); continuing healthcare patients with complex needs often have to be sent out of area (long term placements) • Estate gaps: there is insufficient estate to establish equitable services (as per Royal College guidelines); require additionalrented accommodation to deliver services • Older Person's inpatient capacity: recent reduction in beds due to changing model for managing care; likely future **Inappropriate mixing of patient cohorts:** recent Health Inspector review highlighted mixing older persons and adult 18+;appropriate segregation required	Opportunities exist to optimise use of space, repurpose/reconfigure, and relocate teams and services to provide better colocation of staff and services and relocate teams and services to provide better colocation of staff and services The strategy is an opportunity to repatriate patients, who can receive care closer to home. The strategy will explore opportunities to facilitate the appropriate segregation of patients by age cohort.
Gender Reassignment (sometimes referred to as					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations	Consideration to be given to stakeholder involvement in decisions that affect them.

'Gender Identity' or transgender)					and standards are met through an accessibility and inclusion audit.	
Pregnancy and maternity					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit.	Consideration to be given to stakeholder involvement in decisions that affect them.
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit.	Consideration to be given to stakeholder involvement in decisions that affect them.
Religion, belief and non-belief					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations	Consideration to be given to stakeholder involvement in decisions that affect them.

					and standards are met through an accessibility and inclusion audit.	
Sex (men and women)					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit.	Consideration to be given to stakeholder involvement in decisions that affect them.
Sexual orientation (Lesbian, Gay and Bisexual)					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit.	Consideration to be given to stakeholder involvement in decisions that affect them.
Marriage and civil Partnership (Marital status)					Ensuring inclusive design is a stated priority of the Estates Strategy. We have stated the objective to ensure inclusive design through the participation of local communities and we will ensure that all appropriate statutory expectations and standards are met through an accessibility and inclusion audit.	Consideration to be given to stakeholder involvement in decisions that affect them.

Part A

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

Low-income households					Please see socio-economic impact assessment	

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

Human Rights:

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

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	x					

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

Welsh Language:

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

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

Part A Form 4: Record of Engagement and Consultation

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Engagement with stakeholders from the following key groups was undertaken, either via structured interviews or workshops, to understand key priorities to inform development of the future estate vision. **Integrated Health Communities and clinical leads** • Ysbyty Gwynedd • Glan Clwyd Hospital • Wrexham Maelor Hospital • Community Dental Services • Primary and Community Care • Mental Health and Learning Disabilities • Midwifery and Women's Services • Cancer and Diagnostics and Clinical support • Patient Safety and Experience **Corporate and external** • Board • Health Board Leadership Team • Capital Investment Group • Clinical Senate • Community Health Council **Estates** • Health, safety, and equality • Operational estates • Property and asset management This estate strategy has been developed in response to BCUHB's 10 year strategy to improve health, well-being and healthcare in North Wales. Living Healthier, Staying Well was subject to significant engagement and coproduced with partners and communities across North

Part A Form 4: Record of Engagement and Consultation

	Wales. The foundations of this strategy have therefore been built on the priorities determined by the population of North Wales. Also, this estate strategy forms a key component of a suite of BCUHB enabling strategies which are interdependent and complementary to successful delivery. As we take forward the priority areas identified within this estate strategy we will continue to engage with staff, communities and stakeholders to further develop the future estate requirements and co-produce associated detailed implementation plans. It is clear that our estate must change if it is to be sustainable, viable and support the implementation of Living Healthier, Staying Well. In some areas these changes may require formal consultation.
Have any themes emerged? Describe them here.	Accessibility is a key theme: any updating or building of existing or new estate represents an opportunity to improve the accessibility of our estate. We aim to be a fully inclusive service and in order to fulfil our long term goals of reducing health inequality it is vital that our estate is fully inclusive. Information and communication of people's rights is also key. All opportunities to state and evidence our commitment to equality and inclusion across all protected characteristics will be used.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	Accessibility and inclusivity will be key drivers of all estates programmes and will be key criteria in decision making, scoring and risk management. Consideration will be given to the use of accessibility audits and engagement with the Equality Stakeholder Group. Citizens Voice, Centre for Sign Sight and Sound and Autistic UK.

Part A Form 4: Record of Engagement and Consultation

	To future proof this strategy it will be reviewed for alignment with the expected Welsh Government Disability Rights Action Plan and the current Code of Practice for Autism.

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Estates Strategy

2. Brief Aims and Objectives: (Copy from Form 1)	This document sets out BCUHB's Estate Strategy to 2033. The strategy has been developed between October - December 2022, building upon the previous (2019) estate strategy and includes the most recent data submitted to the Welsh Government via the Estates and Facilities Performance Management System (EFPMS) and published in October 2022. The estate strategy has been developed to align with current BCUHB strategies including Living Healthier, Staying Well, Clinical Services Strategy, Digital Strategy, People Strategy and Plan, and the Decarbonisation Action Plan. Development of the strategy has included engagement with key stakeholders and regular reporting via forums including BCUHB's Capital Investment Group, Health Board Leadership Team, Clinical Senate, Board, and Community Health Council workshops. Since the previous estate strategy was completed in Feb 2019 the COVID-19 pandemic has had a significant impact upon the Board's estate, particularly in terms of capacity, suitability and shifts to digital, which is reflected in the analyses and recommendations below. The document is structured to reflect national guidance and to answer the three key questions – Where are we now?, Where do we want to be ?, How do we get there? The estate strategy will be continually reviewed to ensure alignment with the Integrated Medium Term Plan cycle.

From your assessment findings (Forms 2 and 3):

Part B Form 5: Summary of Key Findings and Actions

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes x	No

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any	Yes	x
	Record Details:	

Part B Form 5: Summary of Key Findings and Actions

identified minor negative impact?		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No
	How is it being monitored?	Monitoring arrangements will be delivered through the Capital Investment Group.
	Who is responsible?	Chair of CIG – Executive Director of Finance and Performance.
	What information is being used?	E.g. will you be using existing reports, data etc. or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	EQIA will be reviewed at the same time as the programmed Estates Strategy review.

7. Where will your policy or proposal be forwarded for approval?	CIG

Part B Form 5: Summary of Key Findings and Actions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Stephen Doore	Equality and Inclusion Manager, BCUHB
	Rod Taylor	Director of Estates, BCUHB
	Ian Howard	Assistant Director, Strategic and Business Analysis, BCUHB
Senior sign off prior to committee approval:	Neil Bradshaw	Assistant Director of Finance – Capital, BCUHB
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Accessibility and inclusivity will be key drivers of all estates programmes and will be key criteria in decision making, scoring and risk management. Consideration will be given to the use of accessibility audits and engagement with the Equality Stakeholder Group. Citizens Voice, Centre for Sign Sight and Sound and Autistic UK. To future proof this strategy it will be reviewed for alignment with the expected Welsh Government Disability Rights Action Plan and the current Code of Practice for Autism. Consideration to be given to stakeholder involvement in audit relevant to each protected characteristic.	Programme Lead	When proposal reaches planning maturity.

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Not applicable		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	Not applicable		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Not applicable		

Teitl adroddiad: ***Report title:***	Unscheduled Care Update			
Adrodd i: ***Report to:***	BCUHB Health Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	Scheduled agenda update in relation to the unscheduled care plan in line with the Six goals for Urgent and Emergency care 2021-2026. The paper sets out an update from the previous 6 months for unscheduled care and identifies areas of progression over the next 6 months for assurance.			
Argymhellion: ***Recommendations:***	The Board is asked to note the update provided on the actions being taken within the Unscheduled Care improvement programme and plans for winter.			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons – Executive Medical Director.			
Awdur yr Adroddiad: ***Report Author:***	Geraint Farr – (Interim) Associate Director For Emergency Care. Medwyn Jones – Six Goals Programme Board Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Six Goals for Urgent and Emergency care 2021-2026 A Healthier Wales 2018			
Goblygiadau rheoleiddio a lleol:	Health and Safety Executive			

Regulatory and legal implications:	Quality and Safety Executive
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo ***Y****/N* 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 ben undertaken?***	Do/Naddo ***Y****/N* 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)***	The following risks are associated with USC • Risk 3873 - Access to timely care in Emergency departments. • Risk 2896 – Crowding in Emergency Departments. • Risk 4486 – WAST Ambulance delays and access to time critical transfers. The BAF also includes risks relating to safe provision and standards of care and effectively managing demand within Unscheduled care Services.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Additional funding of £2.9 Million to support the implementation of the Six Goals for Urgent and Emergency Care by 2026.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Six Goals Programme director has been appointed. Additional clinical / Nursing sessions to support implementation
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Discussed and reviewed by Executive Medical Director as part of the Six Goals for Urgent and Emergency Care board.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	1.2 - Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users 1.3 - Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Amherthnasol

Reason for submission of report to confidential board (where relevant)	Not applicable NA
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau/*List of Appendices:*	

Appendix 1: Four & Twelve hour performance and Average Length of Stay
Appendix 2: No: Medically fit for Discharge (MFD) patients within acute and community hospitals across NW by D2RA pathway
Appendix 3: Ambulance performance
Appendix 4: Revised Discharge to Recover & Assess Pathways
Appendix 5: SAFER principles of patient flow
Appendix 6: Red to Green principles of patient flow
Appendix 7: Preventing deconditioning

1. Cyflwyniad / Cefndir / Introduction/Background

This report is provided to Board to provide an overview of the Unscheduled care performance including challenges and the actions identified within the 6 goals programme to Support improvements across the Unscheduled care system Across North Wales.

2. Corff yr adroddiad / *Body of report*

Unscheduled Care performance overview

Significant pressures in unscheduled care continue across Wales with a worsening position nationally for the Emergency Department (ED) performance across 4 hour, 12 hour and Ambulance handovers hour delays. There are ongoing challenges in the ability to discharge the number of Medically fit for Discharge (MFFD) patients which continues to impact on flow across the unscheduled care system that is also impacting on Planned care services.

Industrial action by Royal College of Nursing members and staff working for Welsh Ambulance Service Trust (WAST) has provided additional pressures but also led to deployment of winter plans and escalation.

Increased unscheduled care demand over the Christmas and New Year bank holidays resulted in use of the plans and declaration of an internal critical incident.

The number of attendances remains static but over recent weeks there has been a sharp increase in the acuity of those attending EDs, with a notable increase in frailty

patients who are experiencing prolonged delays at home awaiting an ambulance response due to the inability to release ambulances from sites.

Infection prevention issues continue to fluctuate with bed closures across BCUHB, and areas closed due to risk of increased infection. This has not only reduced flow, but also reduced ability to safely discharge patients who are positive for an infectious condition.
Some of the contributing factors for the current Unscheduled care performance are as follows:

i) There have been periods of escalation into Business Continuity Planning due to demand and capacity over the previous weeks. This has been because of sheer demand, lack of flow and extended periods of ambulance delays with harm occurring in the community.

ii) Increased primary care demand due to acuity of patients presenting for consultation, has resulted in an increase in referrals for hospital assessment / admission. Due to delays in ambulances attending calls which are held at sites, this has resulted in patients arriving at the hospital sites later on in the day, leading to further delays in assessments, and then requiring admission via ED. Furthermore, due to pressure faced by Welsh Ambulance Service they are seeing an increase in demand for HCP calls for admission but due to multiple factors they are not arriving on scene until early evening / overnight.

iii) The increase in ambulance delays as a result of the inability to offload patients upon arrival to hospital sites, also results in patients self-presenting at EDs, including those who could have been routinely assessed and discharged on scene by ambulance crews, that wouldn't have been conveyed to ED. Furthermore, patients with more serious conditions and have a higher acuity are self-presenting to EDs due to the inability for an ambulance to attend.

iv) Due to the constant demand 24/7, there is now a growing picture of delays during the out of hours periods due to capacity within the three Integrated Health Communities (IHCs) and an increase in patient moves beds on wards during the out of hours period. Currently the data shows more moves out from EDs during the out of hours period against the in-hours period. The implications around out of hours moves are multiple, for example, patients are subsequently not seen by speciality team due to reduced staffing out of hours and resulting in longer delays for investigations/assessments that may support the patient journey and prevent un-necessary admissions to beds.

The numbers of patients who are medically fit for Discharge and are delayed within a hospital bed remains consistently high across the acute and community hospitals, with 1/3 of the health board beds being occupied by patients awaiting discharge, which heavily impacts on flow and performance. Due to social care challenges to recruit into vacant posts within the current social economic position, there are conflicting recruitment campaigns ongoing for the same staff that is heavily influencing the ability to recruit. This has most recently been highlighted at the Health and Social Services Group (HSSG) and addressed nationally to support equal approach to recruitment

utilising joint recruitment campaigns, equality around pay to support an equal rate for the same role either Social care or NHS.

Performance Metrics:

BCUHB 4 hour performance

The 4 Hour performance for each acute site (Appendix 1) continues to remain affected by multiple factors with patient flow being the main contributory factor. This is now evident in the 4-hour performance for those discharged from the emergency department which is currently reporting at 55%.

A review of the Single Integrated Clinician Assessment tool (SICAT) is due to take place January – February 2023 in support of increasing capacity to assist with signposting in line with Goal 2 of the 6 Goals Programme for Urgent & Emergency Care. Alongside that, access to Physician Triage Assessment System (PTAS) is being supported to allow Nurse specialists across each Integrated Health Community (IHC) to review calls on the stack that can be supported closer to home (Goals 1 and 2 of the 6 goals programme). This in turn should support a reduction of ambulance arrivals and also reduce attendances to the emergency departments.

Urgent Primary care centres (UPCCs) / Urgent treatment centres (UTCs) are established in East and West, with ongoing discussions around increasing capacity to pull those primary care suitable patients from the emergency departments to create capacity, but also support access to the UPCC teams to SDEC to further speciality assessments. The UPCC model in the Central IHC is a cluster based model, within Denbighshire County, compared to the 'hub and spoke' model within East and West IHCs.

A validated 4-hour performance dashboard is now in place to identify the variance in performance for unvalidated data against validated data.

BCUHB 12 hour performance

The 12-hour performance (Appendix 1) shows a constant trend across BCUHB of increasing 12-hour delays for all 3 Emergency Departments. Time to clinical assessment has deteriorated resulting in a delay in decision-making, The Royal College of Emergency Medicine (2021) highlighted evidence which demonstrates that the higher the occupancy is within EDs there is a clear correlation with admission rates. As aforementioned, there has been a notable increase in the acuity of those being admitted over previous weeks, resulting in patients requiring admission to speciality wards, which have limited beds. This has also been impacted by the limitations imposed due to infectious conditions. Performance data is being developed which has the ability of using the 'Symphony' software tool to capture decision to admit (DTA) data, and whilst this is not a recordable metric within Wales it provides a valuable tool to support improving flow. The development of this function is being reviewed within the 6 Goals programme to support efficiencies in speciality clerking of patients and timely transfer of patients to specialty ward or SDEC (Same Day Emergency Care service).

Ambulance Performance
Ambulance demand remains constant with a noticeable peak in arrivals during the evenings and early hours. There has been a marked increase in lost hours over the previous months, with periods of delays approaching 24hrs (Appendix 2).

Local schemes were put in place to support the industrial action (IA) in December and January that supported a substantial reduction in lost hours that had a positive outcome. Following on from that there will be a site management / Emergency department workshop to identify what can be done as business as usual following on from the IA. The element that supports the additional work highlights the need to identify real estate to support formal ambulance handover areas at each site with appropriate staffing to support the area 24/7.

A task and finish group is established with support from the National Collaborative Commissioning Unit (NCCU) to develop an urgent improvement programme utilising current services, that will report into the national Ambulance commissioning group along with local delivery unit (DU) meetings that will support Goal 4 of the six goals programme for urgent and emergency care which focuses on rapid response in a crisis and reducing ambulance delays.

National feedback has been provided in relation to the immediate release process that impacts on lost hours along with the clinical safety plan (CSP) that impacts on self-presenters but also the ability for Intelligence conveyances that is having a negative effect on the patient journey. The ask to the NCCU is to support a wider review that encompasses the whole NHS picture rather than solely focus on ED.

Average Length of Stay (LOS) >21 days
Average length of stay >21 days remains consistent over recent months, which correlates with the MFD coding (see Appendix 3) for patients who are delayed on the current Discharge to Recover and Assess (D2RA) pathways. This data excludes those delays that are awaiting social worker assessment or internal delays.

There is a requirement for reviewing patients that are delayed due to internal delays with a clear mechanism for escalation for support as pan BCU that at the beginning of January equated up to 145 patients that are within our gift to discharge. These are being identified at Board rounds with a clear plan to reduce the internal delay and if not possible to escalate to the relevant management team for support. Furthermore the implementation of the Optimal Hospital Flow framework will focus on the embedding of patient flow initiatives including ‘SAFER’ principles that aim to deliver efficiencies across the system, which is described in more detail below.

<u>6 Goals Programme Update</u>
The Unscheduled Care programme within BCU is being progressed in conjunction with the Welsh Government 6 Goals Programme for improving Urgent and Emergency Care, with a scheduled plan to support all Six goals of the programme. The 6 Goals programme of work is being led by the recently appointed Programme Director (Medwyn Jones) working with Dr Chris Subbe and Dr Jim McGuigan, Deputy Executive Medical Director as the Senior Clinical Leads for the programme, and also supported by Geraint Farr as the acting Associate Director for Urgent & Emergency Care pan-BCUHB. There is a clinical lead for Same Day Emergency Care services (SDEC) and

data analysts also supporting the programme. Executive leads have been identified for the 6 goals as follows; Goals 1 & 2, Gareth Evans, Executive Director of Therapies & Health Sciences; Goals 3 & 4, Angela Wood, Executive Director of Nursing & Midwifery; Goals 5 & 6, Dr Nick Lyons, Executive Medical Director.

The refreshed BCUHB 6 Goals Programme Group has been established with Terms of Reference, agreed membership and meetings in place which will be chaired by Dr Nick Lyons (Medical Executive Director). Reporting framework and accountability within IHC teams and associated stakeholders are being agreed and finalised.

The 6 Goals programme team are focusing on immediate action plans to support a number of high impact interventions that aim to deliver improvements in both patient and staff experience as well as organisation performance. There will also be an emphasis on developing wider projects with the programme to support the medium and long-term aspirations for Urgent and Emergency Care over the coming years. This includes but is not limited to:

i) Working with IHC teams to support initiatives for UEC trajectory improvement in line with the 6 Goal Programme.
ii) Support Welsh Government funding opportunities for high-risk patients – work also ongoing within each IHC to identify high risk patients in line with Goal 1 to co-ordinate planning for individuals at risk.
iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. Stakeholder meetings are almost complete and contracts being prepared. This is within Goal 2 (24/7 signposting for U&EC) – This is goal 1
iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise.
v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative
vi) Continue to drive technology support for the programme.
vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR (Emergency Preparedness Resilience and Response) planning team.

With regards to Goal 5, which focuses on optimal hospital care and discharge from the point of admission, the Minister for Health & Social Services launched the 'Optimal Hospital Patient Flow Framework' on 6th December 2022. This guidance sets out the key approaches within patient flow; Discharge to Recover & Assess (D2RA), SAFER and Red to Green (R2G), which aim to support all healthcare professionals to improve patient flow and deliver timely pathways of care. The guidance, developed through a series of national expert groups comprising of operational and managerial staff, sets out the integration of these approaches and the necessary tools required to support delivery of transformational care and safeguard against deconditioning, ensuring better outcomes and experiences for people in hospital. Appendices 1-4 describe the D2RA, SAFER and R2G principles as well as preventing deconditioning.

The guidance for all adults admitted to an acute or community hospital bed emphasises the need for discharge planning to commence from the point of admission and is based on 4 key questions around 'what matters to me', that all healthcare professionals should be able to answer for every person within their care. Patients, their families and carers must be central to all decision making and their views should always inform the answers to these 4 questions.

1. What do you think is wrong with me?
2. What is going to happen today?
3. What needs to happen to get me home and what can I do to speed things up?
4. When can I go home?

It is acknowledged that at a national level across Wales, D2RA and the fundamental elements of SAFER and Red to Green are not consistently being met, which is resulting in patients experiencing longer lengths of stay and deconditioning. The principles of these approaches have now been refined and collated to be simpler and more effective. The guidance stipulates that D2RA and SAFER principles must be custom and practice from the point of time when a decision is made to admit. R2G approach ensures that every day a person stays in a hospital bed, adds value to their care and aims to reduce a patients length of stay by highlighting 'non value' adding days and reducing avoidable delays where a patient is kept waiting for things to happen to progress their care.

Following the ministerial launch of this guidance, Health Boards are now required to develop implementation plans to roll out and embed the above principles of D2RA, SAFER, R2G and prevention of deconditioning, with a priority focus to implement the revised D2RA pathways, commencing in early 2023 with support from the Delivery Unit (DU) including supporting resource materials (posters), training and education. Draft implementation plans will be developed and submitted to the DU by the end January 2023 for review.

Delayed Pathways of Care reporting

A pilot has commenced for the 3 months from November 2022 to January 2023, to reintroduce the national census reporting of the former delayed transfers of care (DTOC), which was stood down in early 2020 due to the pandemic. The reporting process has been refined with delay codes amended to align with the revised D2RA pathways, which are to be implemented across BCUHB in the New Year. This reporting process is a ministerial priority.

BCUHB and the 6 NW Local Authorities are working together to ensure accurate data is inputted and validated and to address any issues or challenges during this pilot period. The process will be fully implemented and go live from February 2023 onwards and the next phase of the reporting process going forwards will require integrated action plans to be developed to identify themes trends to inform what gaps within services require funding and support to be developed. It is expected that these

action plans will be reviewed through Health Board Unscheduled Care (6 goals) groups and also at Regional Partnership Boards.

Increased Community Capacity (1000 beds campaign – across Wales)
In line with the national 1000 beds campaign work is continuing locally in partnership with the 6 Local Authorities across North Wales to progress a number of schemes identified to increase capacity over the winter months. A total of 18 schemes are in place currently with trajectories that aim to deliver 221 additional beds or placements out of the required 243 target set for North Wales. Of the 18 schemes, 7 are amber where they are not currently on trajectory and 11 are green. Key challenges to delivery of the schemes is around recruitment of additional staff. Further pipeline schemes are also being worked in each County through for additional capacity to achieve the 243 and learning is being shared between IHCs and counties of successes.

Current highlights from the schemes include;

- recruitment of micro-providers in Denbighshire to support increased provision of domiciliary care in the county;
- significant overseas recruitment within a care agency in Wrexham which to date has reduced the number of hours of packages of care awaiting in the County.
- Peripatetic service in Conwy set up to respond to urgent demand for provision of short to medium term personal care and support to individuals within their own homes, working closely with the reablement team to pick up new packages of care in the County and support hospital discharges.
- The Tuag Adref (Homeward Bound) and District Nursing service in the West IHC is supporting with the provision of a number of packages of care where the Local Authorities have confirmed they are unable to provide the PoC within the required timeframe. Recruitment process has successfully appointed additional Health Care Support workers to Tuag Adref and the service is also in the process of becoming registered as Domiciliary care provider with Care Inspectorate Wales (CIW).

Work is ongoing to commission targeted care home placements to provide specialist step down to recover rehabilitation beds and step-up, short-term rehabilitation support through block purchasing arrangements. Following an exercise to invite Expressions of Interest from over 300 residential and nursing care homes, responses were received from only 7 homes across North Wales totalling 35 placements. An evaluation process was undertaken of the applications received which resulted in 5 of the 7 homes being awarded contracts for a total of 21 additional placements, some of which were not suitable due to being under review by Care Inspectorate Wales or subject to escalating concerns. Further review will be undertaken once these circumstances change. It is also anticipated that further placements will be available from additional submissions from care homes, which did not submit within the deadline.

Alongside the 6 goals work stream and as part of the operational focus on the unscheduled and Emergency care framework:

- Demand Management – The electronic dashboard is now live, and being amended to the new national OPEL reporting levels. A trial this was successfully tested during the recent BCI events when on discussion with WG it was identified

nationally an inaccuracy on reporting pan Wales. The actions on escalation require embedding across BCUHB to support a constant approach of de-escalating down rather than the constant firefighting.

- ICAP (Integrated Commissioning Action Plan) is a joint piece of work with WAST/ NCCU and BCUHB to support actions associated with improving ambulance handovers. The next step in the work is to utilise the Emergency Department staff as part of the group to develop the solutions going forwards.

- Joint reviews of any Appendix B's to support joint working along the improvement programme. The process within BCUHB to review Appendix B's has been identified as the gold model and being rolled out across Wales. Since the introduction, there has been a reduction in allocations of Appendix B's. Theme and trends are now being identified as part of Goals 1,2 5 and 6 of the 6 goals programme to support care closer to home, safer discharge planning, and early escalation.

- Capacity management – Review of hospital full protocols and setting of a benchmark of acceptance ie: 90% with local escalation and demand management, 95% occupied then enactment of hospital full protocol, but need formal review process on de-escalating to identify any missed opportunities.

- Developing a 7 days discharge lounge in line with 7day NHS services, and reviewing capacity of discharge lounges to reduce restriction.

- Joint work with Local Authorities to support :
  i) Better utilisation of step down capacity;
  ii) Develop joint solutions for additional capacity e.g. NHS funded care home / step down as part of the 1000 beds programme;
  iii) To progress an integrated workforce to ensure sustainable care workforce;
  iv) Work together to improve communication and engagement.

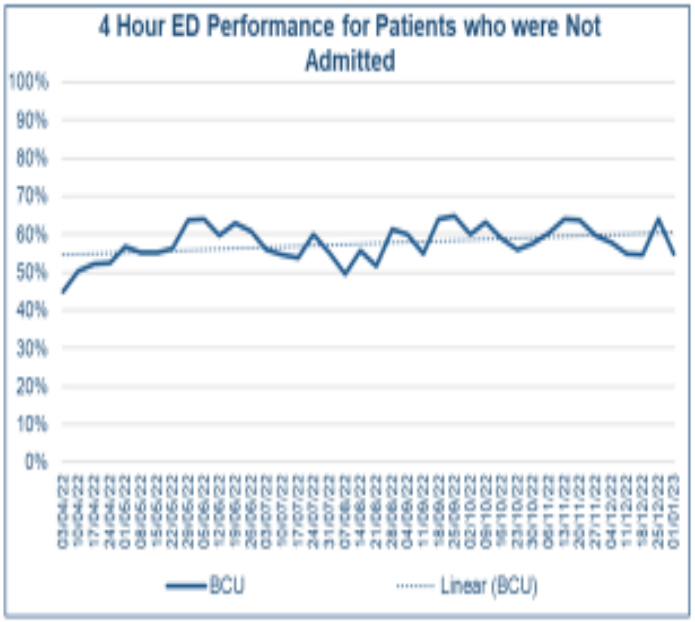
Winter plans

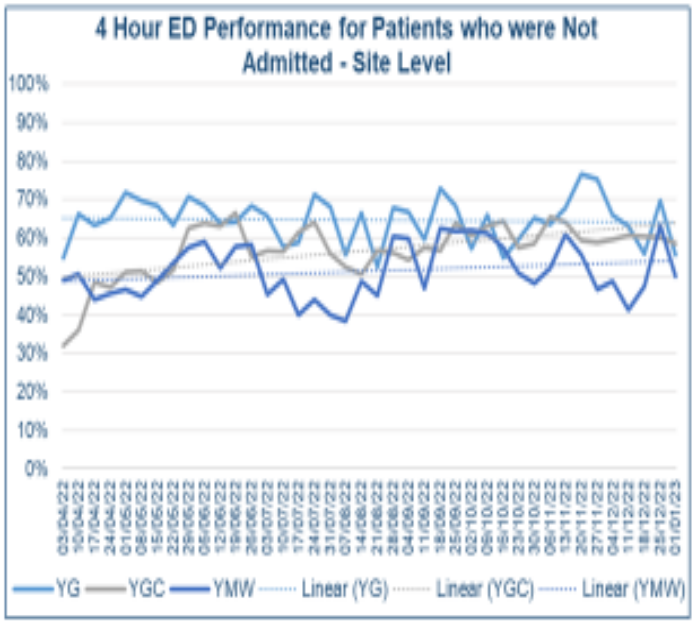
A number of proposed winter schemes have been identified by each Health Community for 2022-23 separate to IMTP bids, with an agreed joint communication between planned care/Unscheduled care and planning to prevent duplication and supporting realistic expectation that is still awaiting ratification.

Whilst we have not received any specific guidance from WG on any USC funding, it is their expectation that we do not have a separate winter plan this year and that the schemes are aligned to the USC improvement programme as part of the 6 goals programme for urgent and emergency care in conjunction with IMPT bids going forwards once funding has been confirmed then the respective IHC's can enact their plans.

3. Goblygiadau Cyllidebol / Ariannol / Budgetary / Financial Implications
The Funding to support projects against the Welsh Government £25m for Urgent and Emergency care in line with the 4 key deliverables: Contact First, Urgent Primary Care Centres, Same Day Emergency Care models and Remote clinical support and optimising conveyance as well as funding for programme management support have had been received in the financial year 2021-2022 and will continue until 2026 in line with the programme.
4. Rheoli Risg / Risk Management
Board Assurance Framework (BAF) describes the risks that "…*the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users*" and "*Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience"* Mitigating actions to reduce harm, improve patient outcomes and better patient and staff experience across the urgent and emergency care system will be aligned with the 6 Goals Programme of improvement programme work together with improvement plans and trajectories.
5. **Goblygiadau Cydraddoldeb ac Amrywiaeth / Equality and Diversity Implications**
n/a

Emergency Department Attendances but Not Admitted, for BCU and by Site to 01.01.2023





- Overall trajectory is for improvement in performance
- Centre, and East linear trajectories are increasing
- West linear trajectory is decreasing

BCUHB ED Trajectory Submission

Date: 17/10/2022 – 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	2209	2146	2006	2173	2118	2101	2155	2096	2165	1919	1972	942
Minor ED Attendances	1087	1127	946	1016	1031	1104	1090	1168	1144	1028	1131	494
Average Time to Triage (mins)	35.0	39.6	31.5	37.5	35.8	35.4	42.4	50.1	52.4	39.3	48.4	39.3
Average Time to ED Clinician (mins)	194.7	224.2	188.5	187.9	177.4	199.2	219.0	236.3	225.4	165.6	205.3	142.2
4 Hour Performance	45.9%	48.6%	51.9%	54.7%	54.9%	51.0%	49.8%	46.9%	47.6%	54.1%	48.4%	55.0%
12 Hour Breaches	755	830	651	660	666	633	724	795	796	665	794	248
More Than 21 LoS	517	504	481	456	433	444	427	421	442	453	406	432
% Occupancy > 21 LoS	16.0%	16.0%	14.9%	14.1%	13.5%	13.9%	13.2%	13.1%	14.3%	14.6%	14.8%	16.7%
Less Than 21 LoS	2706	2645	2738	2782	2769	2758	2808	2799	2642	2660	2333	2160
% Occupancy < 21 LoS	84.0%	84.0%	85.1%	85.9%	86.5%	86.1%	86.8%	86.9%	85.7%	85.4%	85.2%	83.3%
ED Left Without Being Seen	364	452	308	286	323	303	429	489	448	287	350	142

Ysbyty Gwynedd:

BCUHB ED Trajectory Submission

Date: 17/10/2022 – 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	742	766	638	687	690	672	731	662	748	612	644	322
Minor ED Attendances	261	248	223	231	260	257	249	308	283	248	268	88
Average Time to Triage (mins)	44.1	41.9	36.9	47.9	35.6	36.6	43.0	34.8	66.1	52.0	69.6	31.6
Average Time to ED Clinician (mins)	204.5	192.3	161.6	167.1	135.5	147.5	179.3	191.1	263.4	169.8	220.0	112.9
4 Hour Performance	49.3%	54.4%	52.1%	55.1%	64.4%	60.7%	54.4%	53.5%	44.4%	54.6%	44.8%	59.8%
12 Hour Breaches	226	199	198	178	166	173	197	214	307	221	247	61
More Than 21 LoS	219	186	192	188	159	161	163	156	167	178	160	176
% Occupancy > 21 LoS	17.6%	15.7%	15.9%	16.2%	12.7%	13.1%	12.9%	12.2%	14.1%	14.5%	15.9%	17.9%
Less Than 21 LoS	1022	997	1018	974	1092	1070	1101	1125	1014	1046	846	806
% Occupancy < 21 LoS	82.4%	84.3%	84.1%	83.8%	87.3%	86.9%	87.1%	87.8%	85.9%	85.5%	84.1%	82.1%
ED Left Without Being Seen	111	116	80	61	68	43	75	121	167	85	115	31

Ysbyty Glan Clwyd:

BCUHB ED Trajectory Submission

Date 17/10/2022 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	752	738	651	745	693	723	702	738	777	692	675	309
Minor ED Attendances	448	450	393	433	414	442	407	442	414	403	492	221
Average Time to Triage (mins)	25.7	25.5	21.9	29.1	29.2	32.9	35.0	37.0	31.1	28.2	39.9	33.9
Average Time to ED Clinician (mins)	182.9	200.9	152.5	160.5	168.4	185.3	181.8	183.6	169.3	153.3	203.0	143.5
4 Hour Performance	44.4%	46.9%	51.7%	48.9%	47.1%	46.9%	46.1%	47.5%	49.5%	48.9%	45.8%	54.1%
12 Hour Breaches	306	324	243	311	302	282	283	312	274	281	375	124
More Than 21 LoS	101	105	98	101	103	114	102	100	99	99	88	85
% Occupancy > 21 LoS	10.7%	11.6%	11.1%	10.5%	11.9%	12.8%	11.5%	11.5%	11.6%	12.0%	10.6%	11.5%
Less Than 21 LoS	842	798	783	861	765	777	787	766	751	725	744	656
% Occupancy < 21 LoS	89.3%	88.4%	88.9%	89.5%	88.1%	87.2%	88.5%	88.5%	88.4%	88.0%	89.4%	88.5%
ED Left Without Being Seen	85	104	70	73	87	82	93	89	77	77	87	32

Wrexham Maelor:

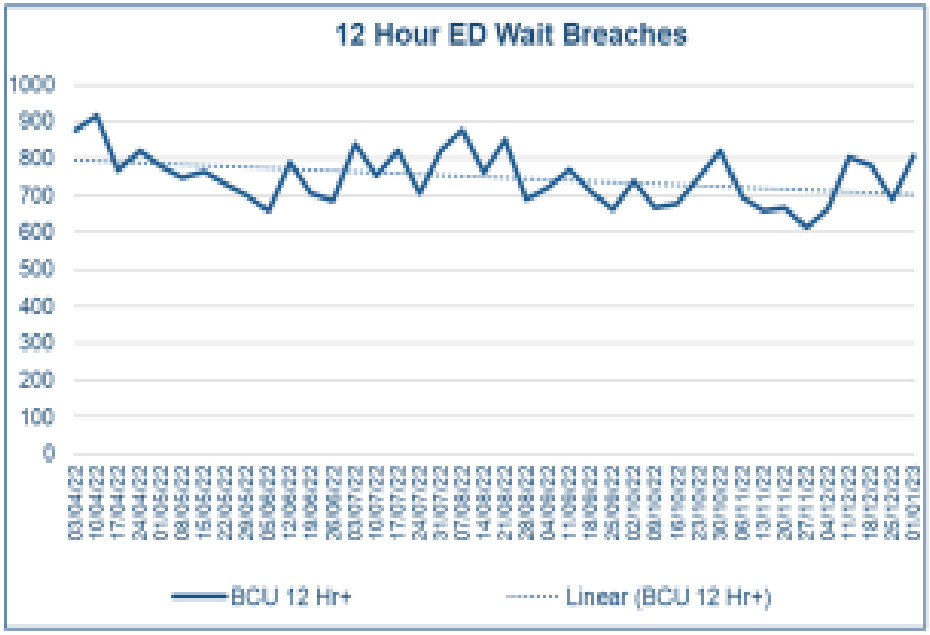
BCUHB ED Trajectory Submission

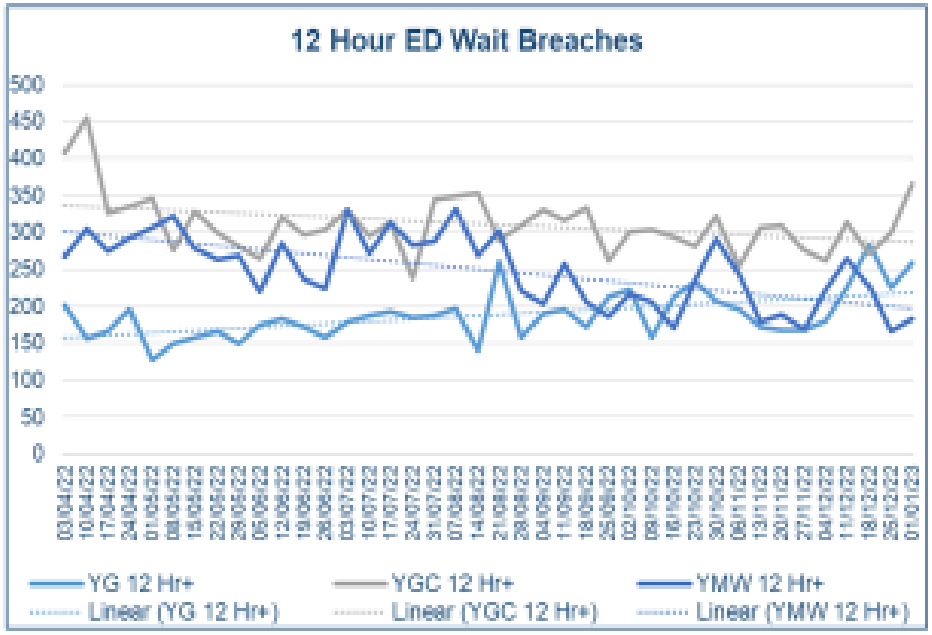
Date 17/10/2022 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	715	642	717	741	735	706	722	696	640	615	653	311
Minor ED Attendances	378	429	330	352	357	405	434	418	447	377	371	185
Average Time to Triage (mins)	36.9	52.9	36.7	37.9	42.7	36.9	49.1	77.3	62.9	40.6	39.4	51.6
Average Time to ED Clinician (mins)	199.4	286.1	254.1	240.2	227.6	263.6	298.9	345.8	255.1	176.8	194.5	165.1
4 Hour Performance	44.6%	45.1%	51.9%	60.4%	54.4%	47.1%	49.6%	40.9%	48.5%	59.2%	54.4%	52.0%
12 Hour Breaches	223	307	210	171	198	178	244	269	215	163	172	63
More Than 21 LoS	197	213	191	167	171	169	162	166	176	176	158	171
% Occupancy > 21 LoS	18.8%	19.9%	16.9%	14.9%	15.7%	15.6%	14.9%	15.4%	16.6%	16.5%	17.5%	19.6%
Less Than 21 LoS	850	857	940	952	916	915	925	911	882	891	746	702
% Occupancy < 21 LoS	81.2%	80.1%	83.1%	85.1%	84.3%	84.4%	85.1%	84.6%	83.4%	83.5%	82.5%	80.4%
ED Left Without Being Seen	168	232	158	152	168	178	261	279	204	125	148	79

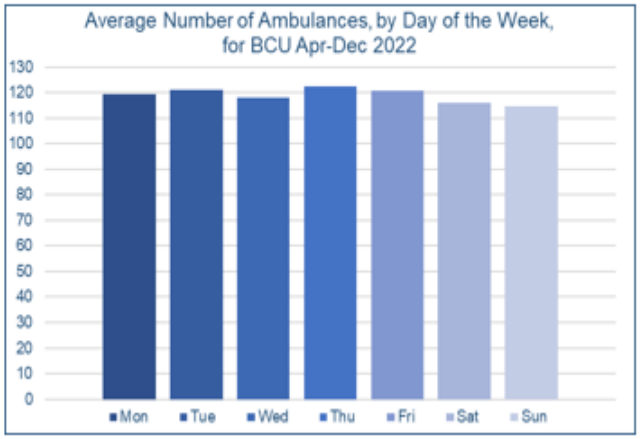
Weekly Number of 12 Hour Wait Breaches in ED, for BCU and by Site, to 01.01.2023

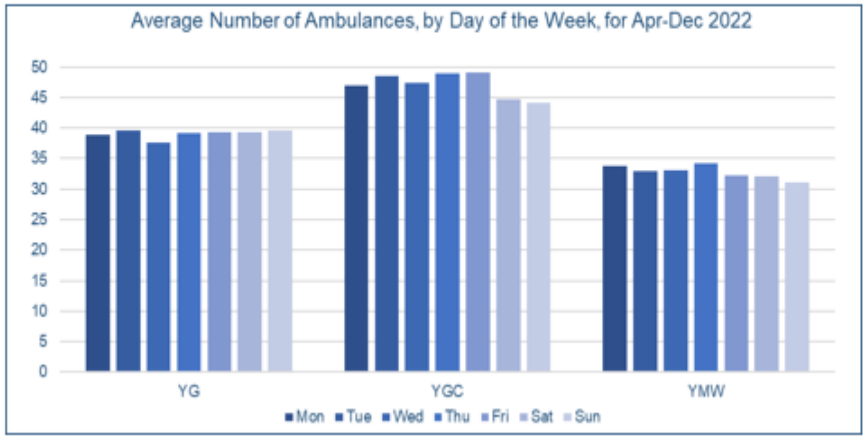




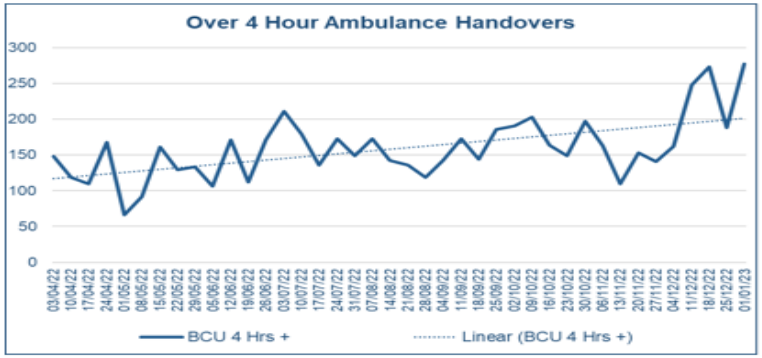
- Overall trajectory is for decreasing numbers of 12 hour wait breaches in ED (this trend is the same when breaches are observed as a proportion of total attendances)
- Centre and East linear trajectories are decreasing
- Centre has the higher number of breaches
- West linear trajectory is increasing

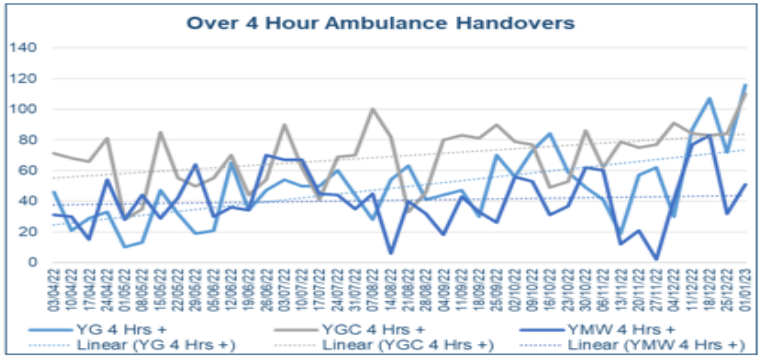
Average Number of Ambulance Conveyances by Day of Week for BCU and by Site to 31.12.2022



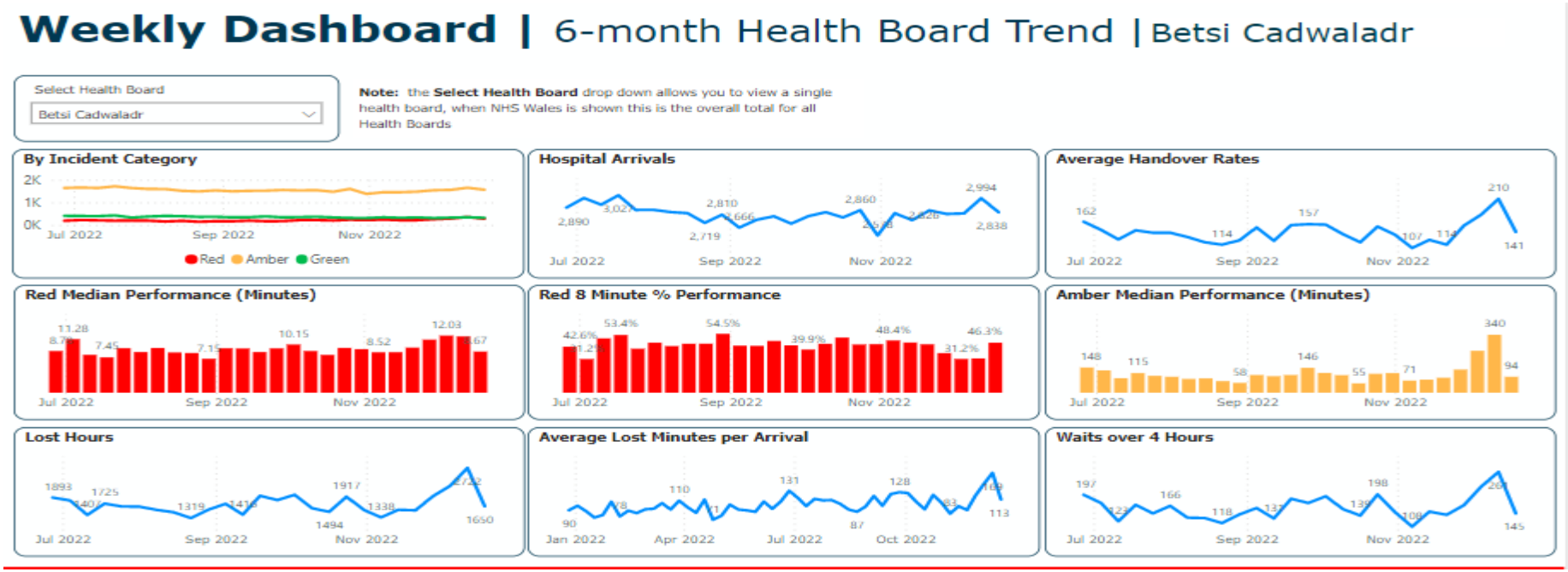


Weekly Number of Ambulance Handover Delays, Over 4 Hours, for BCU and by Site, to 01.01.2023



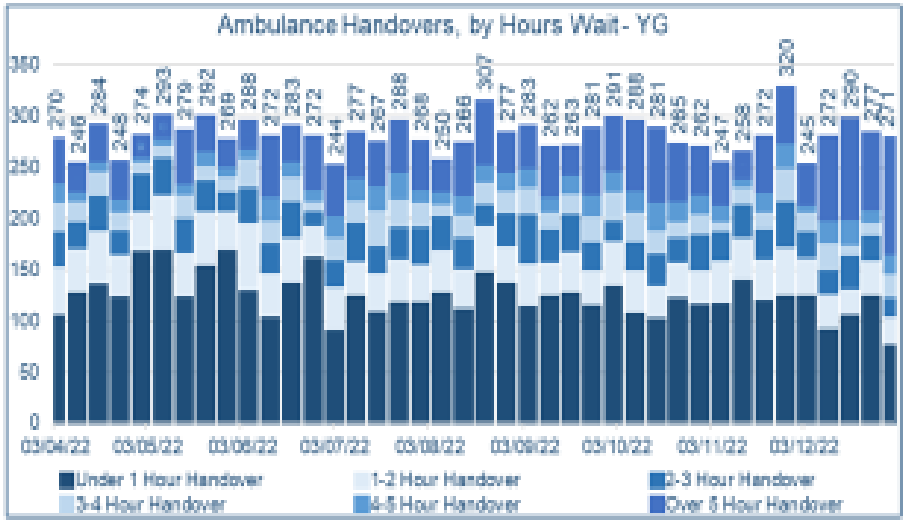


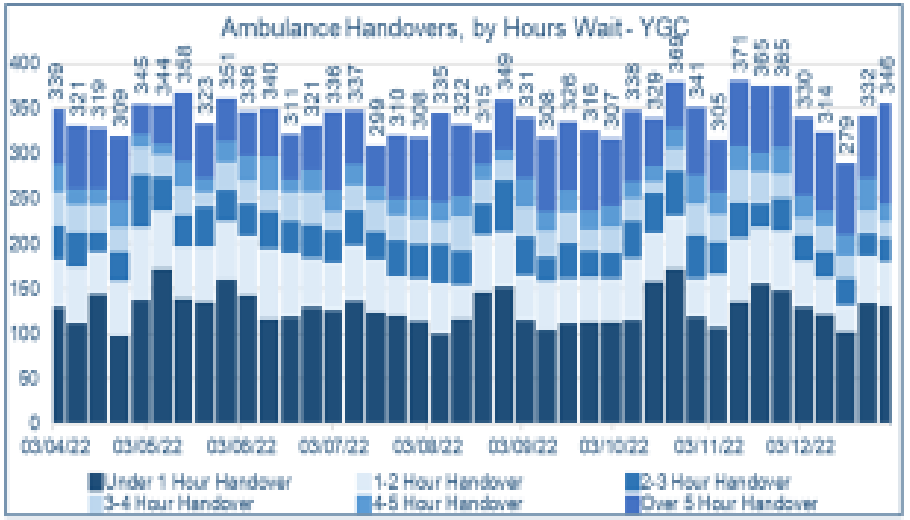
- Overall trajectory is for increasing number of ambulance handover delays of 4 hours or more
- West, Centre and East linear trajectories are all increasing
- West have the sharpest increase, with December performance affecting the trajectory quite significantly

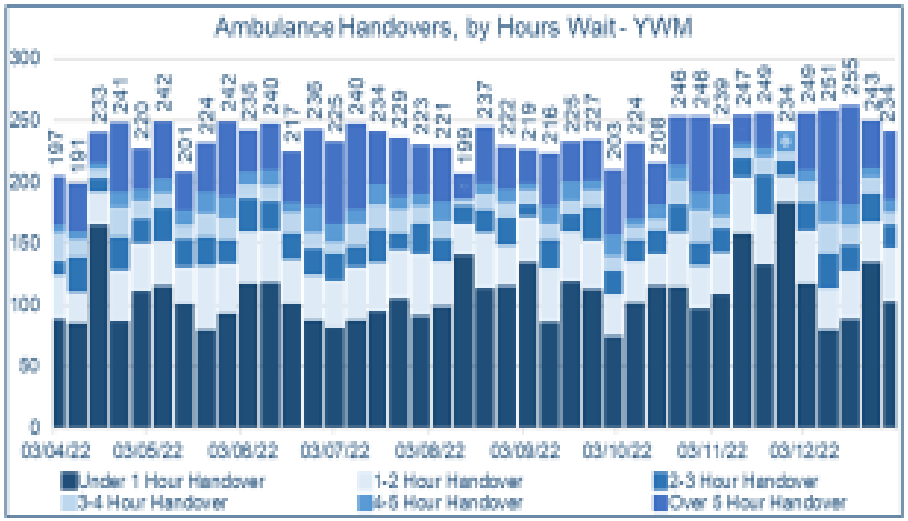


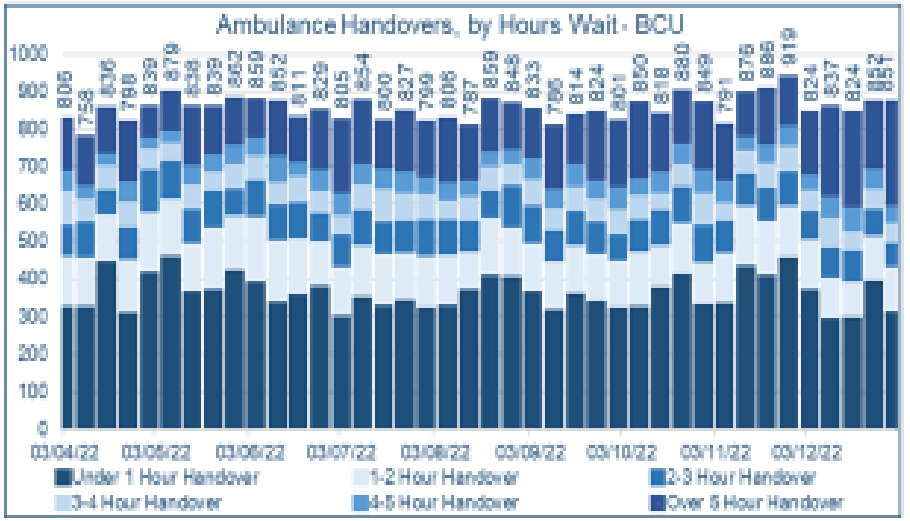
Red release BCUHB:

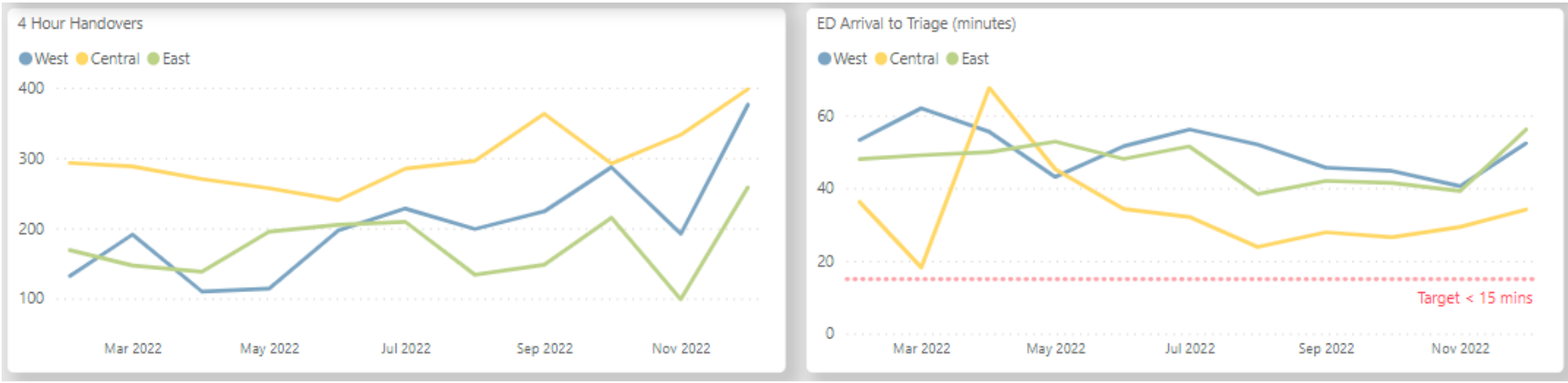
Weekly Number of Ambulance Handovers, by Handover Time, for BCU and by Site, to 01.01.2023










4 Hour Handovers
West
Central
East
400
300
200
100
Mar 2022
May 2022
Jul 2022
Sep 2022
Nov 2022
ED Arrival to Triage (minutes)
West
Central
East
60
40
20
0
Target < 15 mins
Mar 2022
May 2022
Jul 2022
Sep 2022
Nov 2022

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

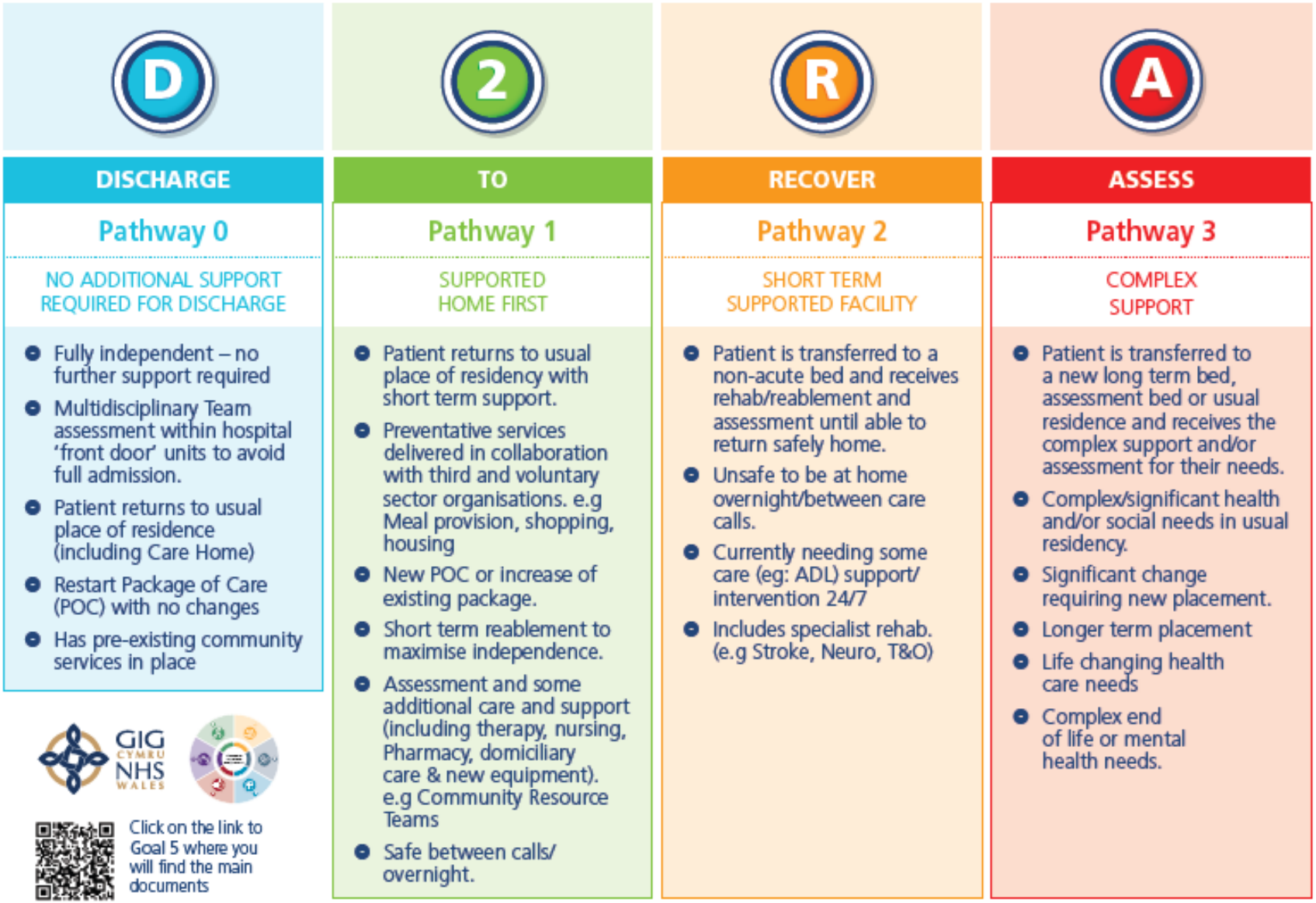
Number of Medically Fit for Discharge Patients Acute & Community Hospitals – North Wales

Date	Pathway 0 Voluntary sector support	Pathway 2 Discharge own home	Pathway 3 Discharge step down bed	Pathway 3a stepdown / step up (covid +)	Pathway 4 Existing Care Home placement	Court of Protection delays	No awtg packages of care (D2RA)	No of people awaiting permanent Care Home placement	No awaiting equipment/ adaptations	No awaiting packages of care	No of patients awaiting permanent Care Home placement	Other	Total
02/08/2022	0	30	82	0	10	4	101	60	2	9	33	2	333
09/08/2022	0	31	70	0	11	1	99	54	2	11	28	2	309
16/08/2022	0	29	70	0	10	2	99	58	3	11	36	4	322
23/08/2022	0	24	58	0	16	2	97	42	1	14	31	2	287
30/08/2022	0	22	39	0	11	3	92	41	2	17	30	1	258
06/09/2022	0	21	44	0	11	1	105	44	1	13	37	2	279
13/09/2022	0	20	50	1	11	2	97	42	0	14	33	0	270
20/09/2022	0	15	34	0	1	0	96	43	0	4	30	0	223
27/09/2022	0	28	43	0	9	0	91	37	5	13	36	2	264
04/10/2022	0	29	39	0	17	0	82	47	6	7	38	0	265
11/10/2022	1	27	31	2	5	0	100	53	4	14	28	0	265
18/10/2022	1	31	45	1	9	1	95	64	2	14	28	1	292
25/10/2022	0	25	34	2	9	0	77	69	6	8	22	4	256
01/11/2022	0	28	46	0	8	1	79	68	2	4	22	2	260
08/11/2022	0	27	27	0	8	0	87	62	2	9	18	1	241
15/11/2022	0	14	38	1	9	0	87	59	0	10	13	4	235
22/11/2022	1	20	34	0	3	0	83	59	4	12	27	1	244
29/11/2022	0	28	43	0	5	0	102	53	7	15	25	2	280
06/12/2022	0	18	38	0	7	0	103	57	3	12	24	1	263
13/12/2022	0	22	50	0	5	4	102	52	4	11	17	0	267
20/12/2022	0	17	51	0	3	2	121	44	3	8	16	1	266
03/01/2023	0	21	54	0	6	0	67	44	9	5	21	3	230

Note: Submission not required by WG Delivery Unit 27th Dec. Total MFFD reported by IHCs (un-validated) = 204 **Average MFFD Total from 02/08/22 = 269**

Source: Once weekly data submitted to Welsh Government

3


D
2
R
A
DISCHARGE
Pathway 0
NO ADDITIONAL SUPPORT REQUIRED FOR DISCHARGE
Fully independent – no further support required
Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission.
Patient returns to usual place of residence (including Care Home)
Restart Package of Care (POC) with no changes
Has pre-existing community services in place
TO
Pathway 1
SUPPORTED HOME FIRST
Patient returns to usual place of residency with short term support.
Preventative services delivered in collaboration with third and voluntary sector organisations. e.g Meal provision, shopping, housing
New POC or increase of existing package.
Short term reablement to maximise independence.
Assessment and some additional care and support (including therapy, nursing, Pharmacy, domiciliary care & new equipment). e.g Community Resource Teams
Safe between calls/ overnight.
RECOVER
Pathway 2
SHORT TERM SUPPORTED FACILITY
Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to return safely home.
Unsafe to be at home overnight/between care calls.
Currently needing some care (eg: ADL) support/ intervention 24/7
Includes specialist rehab. (e.g Stroke, Neuro, T&O)
ASSESS
Pathway 3
COMPLEX SUPPORT
Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support and/or assessment for their needs.
Complex/significant health and/or social needs in usual residency.
Significant change requiring new placement.
Longer term placement
Life changing health care needs
Complex end of life or mental health needs.
GIG CYMRU NHS WALES
Click on the link to Goal 5 where you will find the main documents

S A F E R

Is the **Right Patient,** in the **Right Place,** having the **Right Care, first time?**

SEEN

SEEN BEFORE MIDDAY

Key Staff Questions:

- Clear actions and accountability with a timeframe?
- Patient waiting for a diagnostic/ treatment? Can this happen today, if not, why not?
- Is the patient clinically optimised for discharge or transfer?
- A senior support structure in place for escalation.

AIM

WHAT MATTERS TO ME?

Key Patient Questions:

1. What do you think is wrong with me? (Diagnosis)
2. What is going to happen to me today? (Tests, interventions etc.)
3. What is needed to get me home, and is there anything I can do to help? (Clinical criteria for discharge and Recovery Plan)
4. When can I go home? (EDD) Patient, family/ carers involved in care planning.

FLOW

RIGHT BED FIRST TIME

Prepare for early morning transfer to wards

- Front door, can admission be avoided?
- All patients on correct D2RA pathway?
- Identification of patients requiring supported discharges.
- Review discharges daily
- Are tomorrow's discharges planned?
- Patients discharged at earliest opportunity – Each day a green day.

EARLY DISCHARGE

HOME FOR LUNCH/ASAP

Ward battle rhythm set?

- Prioritise patients being discharged today.
- Pharmacy to be on board round to review medications?
- Link with Family, Friends, Carers to arrange transport.
- Key/ keycode available?
- Book patient transport service if no alternative.
- Identify, clear actions and accountability with a timeframe to avoid delays

RECOVERY

WHAT MATTERS TO ME?

- Discussion with patient on recovery goals and expectations and plan updated regularly?

Can they go home?

- Stakeholder communication: Think GPs, DNs,3rd sector, Community Services, Social Workers.
- Right support for recovery? Think : AHP, social worker, carer, volunteer support.

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

SAFER ENABLERS • Get up, Get Dressed, Keep Moving • Board Rounds • Huddles • Red2Green • Discharge Lounge • Community Liaison • Integrated Hubs (Single Point of Access)

RED TO GREEN

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

A DAY OF NO VALUE

KEY QUESTIONS

1. Can the patient care or interventions received today be delivered at HOME or in a non-acute setting? **YES – It's a RED DAY**
2. If I saw the patient in an outpatient setting, would their current 'physiological status' require an emergency admission? **NO – It's a RED DAY**

- Inadequate MDT presence at the Board Round to allow firm decisions to be made.
- The care or interventions the patient is receiving today could be delivered in a non-acute setting.
- Tests and investigations have occurred but the results have not been reviewed by the Medical team and acted upon.
- A planned investigation, clinical assessment, discharge assessment or therapy intervention for today does not occur.
- Acute - The medical care plan lacks a Senior Medic approved expected date of discharge.
- Acute - The patient is a new admission and has not yet had a medical review/there is no initial diagnosis/treatment plan.
- If a patient is due for discharge today and the discharge prescription medications are not ready (Pathways of Care Delay).
- Transport delaying discharge or causing plans to fail today.

A DAY OF VALUE

- Patient progresses towards discharge
- Everything planned and requested is done
- Patient needs this bed for Acute care

- Everything that was planned for today gets done
- The patient requires acute hospital care
- The patient requires community hospital care
- The results from tests and investigation have been reviewed by the Medical team and acted upon
- The patient is receiving active interventions to get them to be discharged by tomorrow, and the discharge prescription medications are ready by the evening before the expected date of discharge.

PREVENT DECONDITIONING

"Get Up, Get Dressed and Keep Moving"

PREVENT & IDENTIFY DECONDITIONING

- Is the patient at high risk of deconditioning?
- What is the patient's level of mobility/ bladder and bowel control/ cognitive function?
- Has there been a change in the patient's mobility/ bladder and bowel control/ cognitive function?
- Has there been a conversation with the patient and family/ carers on what they can do to prevent deconditioning and why it is important?

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

PROMOTE FUNCTIONAL ACTIVITY

- Patients should be enabled and encouraged to get out of bed, sit out in a chair and mobilise everyday if clinically able to do so
- Patients should be encouraged to wash and dress themselves when possible or with as minimal assistance as required
- The clinical environments should promote functional activity and mobility (chairs at the bedside, corridors kept clear of clutter)
- Enable and encourage patients to mobilise to the toilet and/or bathroom to use the facilities
- If patients require their glasses or a walking aid to mobilise, ensure they are within easy reach
- Encourage patients to sit out for lunch

CONTINENCE MANAGEMENT

- Patients should be encouraged and supported to use toilet facilities if clinically able to do so
- The use of bedpans and commodes at the bedside should be actively discouraged to ensure patient dignity and encourage mobility
- The use of incontinence products such as pads should be discouraged for patients with bowel/ bladder control – including at night-time
- Promote and support good nutrition and hydration
- Record bowel movements and prevent, identify and manage constipation as early as possible

COGNITIVE FUNCTION

- Focus on delirium prevention
- Ensure mechanisms are in place to orientate patients to time, date and day
- Promote establishing a day and night routine in the clinical environment
- Promote activities that will provide cognitive stimulation and social interaction in clinical areas
- With the patient's permission, promote involving family, friends and carers in their care to prevent deconditioning and delirium – review visiting times to facilitate this
- Promote and support good nutrition and hydration- monitor and record intake
- Patients with an acute change in cognitive function should be screened for delirium
- Patients that are delirium positive should have a medical review and a holistic management plan in place, including a medication review and appropriate pharmacological management of delirium

DECONDITIONING STARTS WITHIN HOURS – PREVENTION IS EVERYONE'S BUSINESS

Deconditioning is a complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It results in functional losses in areas such as mental status, degree of continence and ability to accomplish activities of daily living. (Gillis et al 2005)

Teitl adroddiad: ***Report title:***	Planned Care Assurance Paper			
Adrodd i: ***Report to:***	Health Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide partial assurance to the Health Board (HB) with the progress of the Planned Care (PC) programme. The paper describes the challenges facing BCUHB (Betsi Cadwaladr University Health Board) in relation to Planned Care (PC), specifically around the considerable number of patients waiting for an outpatient appointment or a planned intervention/treatment, many of whom have been waiting more than 52 weeks and some more than 104. The origins of this precede Covid in certain specialties but the pandemic and post pandemic situation has exacerbated the position significantly. The paper also reports on the ministerial target position, where the organisation will be reporting 20,968 patients waiting over 52 weeks at the end of December 2022, against a ministerial target of zero. This performance is close to our forecast but was exacerbated by delays in the insourcing contract, which were outside our control and loss of activity due to operational pressures. The paper continues the overview of the PC programme's workstreams including the continued recovery of the backlogs within the organisation.			
Argymhellion: ***Recommendations:***	The Board is asked to note the partial assurance of the PC programme recognising that the delivery of this programme is complex and will take time in delivering the key objectives - reduction in waiting lists and transforming PC services. Partial assurance is given due to the volume of patients waiting and factors outside of our control, such as the impact of strike action and operational pressures now apparent over the quarter.			
Arweinydd Gweithredol: ***Executive Lead:***	Interim Chief Executive			
Awdur yr Adroddiad: ***Report Author:***	Co Authors: Nikki Foulkes, Acting Associate Director Planned Care/Andrew Kent, Interim Subject Matter Expert: Planned Care/Andrew Oxby, Interim Subject Matter Expert: Outpatients			
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*	

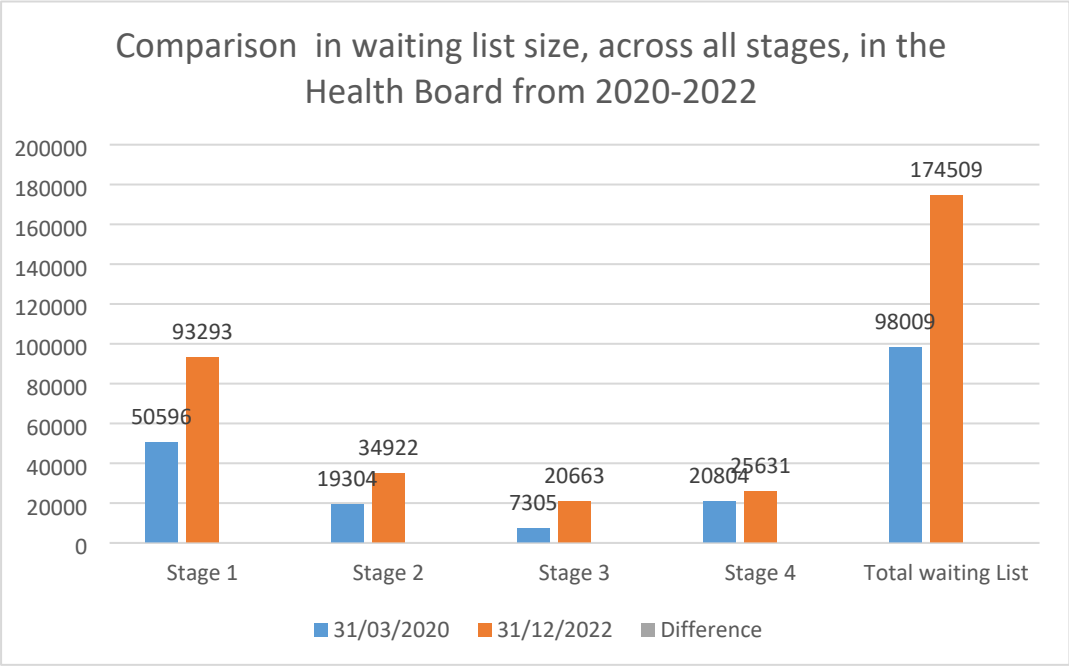
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, 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):***	This paper aligns to the Health Boards strategic goal of reducing the number of patients waiting.
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 ben 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)***	BAF Risk 1.5 - Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Please refer to detail in report.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Please refer to detail in report.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Planned Care programme is reported at the Planned Care Recovery and Transformation Group (PCRTG), Executive Delivery Group (EDG): Transformation and Performance, Finance, and Information Governance Committee (PFIGC).
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF Risk 1.5 - Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm

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*	

Planned Care Assurance Paper

Introduction/Background

The paper presented to Performance, Finance, and Information Governance Committee (PFIGC) described the challenges facing BCUHB (Betsi Cadwaladr University Health Board) in relation to Planned Care (PC). Specifically, the considerable number of patients waiting for an outpatient appointment or a planned intervention/treatment, many of whom have been waiting more than 52 weeks across all stages (43,410) and 12,667 being over 104 weeks across all stages. The origins of this precede Covid but the pandemic and post pandemic recovery has exacerbated the position significantly across all specialties, with an estimated growth of the waiting list of 76,500 across all stages. The graph below illustrates the changes in the waiting list size by stages and overall. This is due to a combination of a decrease in capacity and only partially mitigated demand. For most specialities we are not quite up to the levels of referrals that we had pre covid but that is balanced with the increase in the demand for USC/urgent pathways, possibly due to the length of time patients have been waiting.



This is an all-Wales concern with Welsh Government (WG) publishing a strategy for 'Transforming and modernising planned care and reducing waiting lists,' (April 2022). This builds upon the priorities within the NHS Planning Framework with the aim of accelerating health care recovery in the short to medium term whilst focusing on stabilising and recovering the waiting lists. It aims to do this by developing and embedding long-term transformative and innovative change.

The short-term plan included trajectories to meet the two ministerial priorities for 2022/23.

- No patient should be waiting more than 52 weeks for their first outpatient appointment (Stage 1) by the end of December 2022.
- No patient should be waiting more than 104 weeks for any stage of their pathway by the end of March 2023

Underpinning this plan is the governance framework and the four pillars of PC (Performance, Delivery, Transformation and Planning). The progress within these pillars are reported at the Planned Care Recovery and Transformation Group (PCRTG).

Strategic Implications

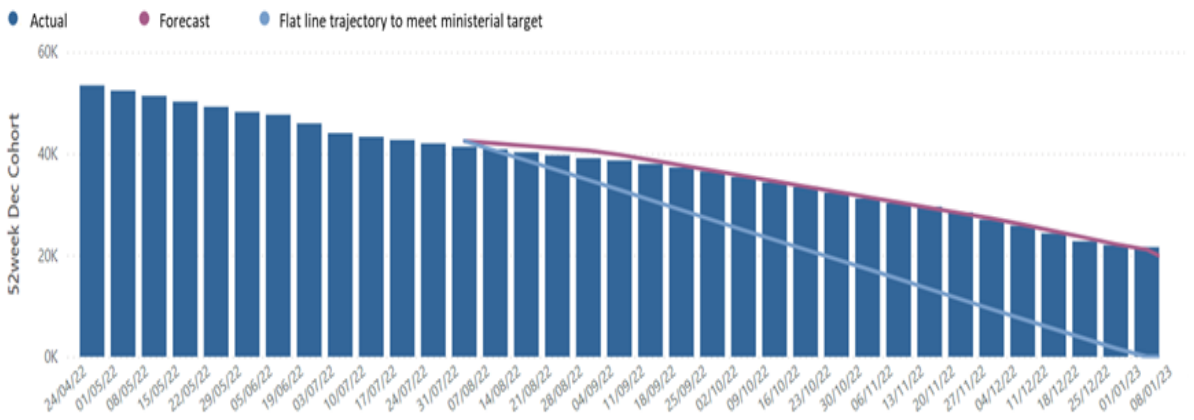
The sustained delivery of PC (and the clearance of the backlog) is a key business and safety objective for BCUHB. Delays to elective treatment are continuing to have significant impacts on the well-being of patients and their families. These impacts can be potentially life threatening, or life limiting, with all having a significant impact socially and economically. Furthermore, for those patients on waiting lists for significant periods (e.g. more than 52 weeks), deterioration in their condition is almost inevitable.

The delivery of the PC Recovery Plan is a combination of transactional (operational) and transformational initiatives. As presented at PIFGC (19th January 2023), there are three distinct but inter-dependent stages; Restart, Stabilisation with recovery, and Sustainability.

The first continues with varying degrees of completeness and is the immediate objective across the health board as work continues to get back to activity levels of 2019/20 and creating the stability which will see the waiting list plateau and begin to reduce. Ongoing sustainability of services is one of the aims of the PC transformation programme.

IMTP Trajectories against ministerial targets

As reported at PIFGC (19th January), the trajectories for the two ministerial priorities were submitted. The organisation reached an invalidated position of 20,968 over 52 week stage 1 breaches against a target of zero at the end of December 2022. The graph below shows progress towards 52-week ministerial target



Forecasts are now being prepared to understand when we will achieve this particular Ministerial target and these will be available by February of this year. The next milestone is zero over 104 week waits across all stages by March 31st. Our current position is 16,696 over 104 weeks. Based on our target profiling we are currently 8,542 patients behind where we need to be. This number has been affected by the interruption of planned care services due to operational pressures. Recovery plans from the health communities are currently being worked through in order to improve and support the delivery of this target. The next major milestone that the planned care group are now evaluating is the achievement of no over 52 week breaches across all stages by 2025. This will be a significant challenge to achieve given our current position and size of the waiting list. The PCG are looking at internal milestones to drive the organisation towards achieving this target.

Transformational Programme

The PC transformational programme continues, with the four work streams which are presented at PFIGC and Executive Delivery Group (EDG). They follow the patient's pathway from visiting their GP through their journey within secondary care before being discharged. All four-work streams are progressing with work stream leads and projects, with outpatients being the most developed.

Outpatient Work Stream

The 3-point plan is to reduce demand, improve scheduling and policy adherence leading to increased capacity.

The external validation team (HBSUK) is part of a national programme commissioned via Welsh Government. Of the total validated (37,776) for both stage one and stage four pathways, 5,379 patients have been discharged. However, not all removals can be attributed to HBSUK validation activity as some patients will have been seen, removed from the waiting list or discharged during this period.

With regard to scheduling and policy adherence, the health board has completed the move to a single booking management system, by adopting a 'fully booked' process that has been running in the West and is now accepted at Centre and East.

The single booking process has been worked through with Welsh Government [Access] policy leads. Further timelines are listed below:

- Revised BCU Access Policy – 29th April 2023
- Single PTL (Informatics) 19th May 2023
- From May 2023, BCU will have the ability to schedule patients across the HB in a standardised manner that will improve patient experience and support patient care across the HB.

GiRFT/Clinical Pathways

The Getting it Right First Time (GIRFT) programme continues with Urology, where an implementation plan is being developed through the Urology steering group. This cycle continues with General Surgery's deep dive to be rearranged following the cancellation due to strike action. Ophthalmology's review is due in quarter four. Orthopaedics, as an example, has 39 recommendations across the whole of the service, including increasing theatre utilisation at Abergele. Work to increase utilisation includes ensuring a senior manager on site during the week, a robust theatre scheduling meeting and offering fallow sessions to consultants in West and East. During January this has been successful, with some West consultants undertaking a number of theatre lists at the site. Gynaecology continue to work with the GiRFT team on implementing the recommendations made. The PC team are working on the governance structure which will ensure that progress on each of these reviews is being monitored and reported, to ensure the improvements can be delivered and sustained.

Cancer

A Cancer strategy for the health board is being developed, which is aligned with the Welsh cancer plan. This strategy is inclusive of programmes of work from prevention to end of life care. Priority areas to improve performance continue within Urology and Colorectal. The straight to test (mpMRI) continues for Urology patients and we continue the implementation of the endoscopy business case to increase capacity and reduce waits.

Additional Capacity

The additional capacity created through partnerships with Independent providers continues with outsourcing. Insourcing commenced in December 2022, however there was a 6-week delay to commencement, due to circumstances outside our control. Ysbyty Gwynedd were the first site to be mobilised in December focusing on stage one activity. The Wrexham site commenced in early January and will be followed by the Centre site later in the month. Early indications are positive with an average run rate of 230 patients being seen on each site, each weekend. The insourcing capacity, once fully mobilized, offers the potential for an average of 700 patients to be seen per weekend across North Wales. The next stage, in February, will be to introduce daycase surgery. Internal clinical engagement and pathway agreements within this partnership are being continually monitored and refined.

Llandudno business case

The RTC programme board have recognised the need to separate out orthopaedic in-patients from the RTC's, which is based on an ambulatory care model. Given the number of patients waiting for in-patient orthopaedic procedures it has been decided to pursue a case to re-furbish and increase the number of theatres at the Llandudno site and develop it for this purpose. This will reduce the lead-time in creating new capacity, which could come on stream in 2024/25, two years earlier than if it remained within the RTC development. This business case is scheduled to be concluded in January 2023.

Regional Treatment Centres (RTCs)

The RTC Programme continues to progress work across the range of its established work streams. The development of the RTC model of care (approved by the BCUHB executive team in October 2022) has provided the basis for continuation of work to progress the development, including option appraisal and wider engagement to support the phases of work required to complete a robust OBC. This now includes proposals for a process of public engagement and consultation, overseen by the Communication and Engagement work stream within the RTC Programme.

A separate update report is being circulated to members of PFIG summarising the progress of recent work responding to the recommendations of the RTC Gateway Review.

IMTP 2023/24

The demand and capacity (D&C) Confirm and Challenge meetings have concluded and the outputs from these meetings have been cross-referenced with the HR position for each specialty. A demand and capacity planning paper has been written and presented to PCRTG, with a view to being submitted to PFIG. This will include possible opportunities identified with consultant job plans.

Planned Care Strategy 2023 – 2025

Although significant plans are in place to improve BCU's PC function, work is progressing to develop a Planned Care Strategy 2023 – 2025. The outline strategy will be ready for review and comment by the end of February 2023.

Budgetary/Financial Implications

Significant funding has been made available for this financial year. Investment plans for 2022/23 have been confirmed to ensure that both current performance is maintained and additionality is achieved or procured. Much of the investment in the current financial year has been to support diagnostics, cancer and endoscopy, in either their recovery, or to create a

sustainable service. There are significant investments in Outsourcing and Insourcing, which will reduce the waiting times for our longest waiting patients. Monthly monitoring against this funding has been embedded as part of PC's governance.

Risk Management

The underlying risk score associated with the backlog of patients on the waiting list remains unchanged currently at 25, but the current score based on actions to date has been revised to 20. The various actions are designed to mitigate and reduce the risk, but it needs to be recognised that none of these will provide immediate solutions, and operational pressures may still affect progress.

Equality and Diversity Implications

The PC programme is designed to address health inequalities and facilitate the HB's socio-economic duty by streamlining process, transforming services and reducing waiting lists

Recommendation

The Board is asked to note the partial assurance of the PC programme recognising that the delivery of this programme is complex and will take time in delivering the key objectives - reduction in waiting lists and transforming PC services.

Teitl adroddiad: ***Report title:***	Quality and Patient Safety Report: October 2022 – November 2022			
Adrodd i: ***Report to:***	Public Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	26/01/2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with information and analysis on significant quality and patient safety issues arising during the prior two month period, alongside longer-term trend data, and information on the improvements underway.			
Argymhellion: ***Recommendations:***	The Health Board is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
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 strength 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 the BAF risk for quality (1.2), the Patient Safety Improvement Programme and the Quality Strategy currently being finalised.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards or safety legislation.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	BAF 1.2 – Quality
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 1.2 – Quality
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:*** Quality and Patient Safety Report	

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

Quality and Patient Safety Report to the Health Board

October 2022 – November 2022

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

Quality and Patient Safety Report October 2022 – November 2022

INTRODUCTION

Within the NHS in Wales, quality is defined in statute as having three dimensions: patient safety, clinical effectiveness and patient (and carer) experience.

This report provides the Health Board with a summary of key quality related information from the months of October and November 2022. The aim of this report is to provide the Health Board with key quality highlights at each meeting.

Detailed information relating to trends, themes, learning and improvement is provided to the Quality, Safety and Experience (QSE) Committee in the bi-monthly Patient Safety Report and triannual Patient and Carer Experience Report.

There are two sections of this report that may include incidents that affect employees and members of the public, as well as patients; these are nationally reportable incidents and liability claims. As the Quality Directorate manage these matters, they are included in this report to provide an overall view of these areas.

NATIONALLY REPORTABLE INCIDENTS (NRI)

The following definition of a nationally reportable incident applies:

"A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare."

The timescale for reporting such incidents is within seven working days.

During October and November 2022, 25 nationally reportable incidents were reported to the Delivery Unit.

Appendix 1 provides a breakdown of NRIs per health community/service.

There has been a gradual increase in reportable incidents since April 2022, with Health Community West, Ysbyty Gwynedd accounting for seven of the 25 reportable incidents in the reporting period. However, the position remains lower than the previous year. The main themes continue to be falls, healthcare acquired pressure ulcers (HAPUs) and recognition and escalation of the deteriorating patient.

In previous reports, the Health Board's position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population was provided. Unfortunately, the Delivery Unit are currently unable to provide this information.

In addition to the above mentioned nationally reportable incidents, there were 13 Early Warning Notifications (EWN) reported, eight of which were in relation to healthcare

associated infections (Clostridium difficile & Covid-19 outbreaks). The other notifications relate to incidents that may attract media attention.

At the time of writing, the total number of nationally reportable incidents open is 76 of which 38 are overdue. Appendix 2 shows the overdue position per health community/service.

Overall investigation closure rate within timeframe was 30% in October, falling to 20% in November. Weekly reports highlight the divisional performance.

Recognising the delays to full investigations, the Patient Safety Team continue to place particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.

There were 25 NRIs, for the two-month time period covered in this report. The NRIs recorded during this period can be broken down as follows

- Falls n=5
- Delay in diagnosis n=4
- Suspected suicide (patient known to mental health services) n=2
- Health Care Acquired Infection (resulting in death) n=1
- Incident of unusual circumstance n=2
- Grade 3 or above HAPUs n=7
- Delay in recognition of deteriorating patient n=4

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and further investigation and review. The learning and actions from each are recorded on the Datix Cymru incident management system.

The sharing of learning from incidents (beyond the immediate service) is achieved through clinical governance/quality meetings and networks, and through safety alerts where appropriate.

The system sharing and embedding of learning remains a risk for the organisation (and is contained on the Board Assurance Framework). Plans are in place to strengthen the extracting, sharing, and embedding of learning to include:

- A weekly ‘Harm Free Care’ Meeting
- A new “lessons learned” on a page template
- A new Monthly Patient Safety Bulletin
- A new central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process
- A new organisation-wide Learning Forum.

Themes identified from Nationally Reported Incidents (excluding Never Events)

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). Currently, the following are the identified themes:

- Recognition and escalation of deteriorating patient
- Falls
- Healthcare acquired pressure ulcers (HAPU)

These three theme areas are underpinned by a recurring issue of record keeping, that whilst not directly causal to an incident occurring is contributory to the circumstances that create unsafe conditions.

Never Events, whilst being a sub-set of Nationally Reportable Incidents, are detailed separately in a section below.

The following section provides a summary of some of the themes and the actions underway.

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=8)

There have been eight incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. Two incidents reported by East IHC, two incidents reported by West IHC and four incidents reported by Central IHC.

Appendix 3 provides a breakdown of incidents per service. There is no statistically significant change in the trend.

Sepsis continues to contribute to mortality in the Health Board. Of the approximate 700 cases referred back from the Medical Examiner Service (MES) to the Health Board, 91 included sepsis either as a direct or contributory to mortality. The Health Board has invested in Acute Intervention Teams on the three acute sites to provide direct patient care for the deteriorating patient. The AITs also provide education and support to front line staff around recognition and treatment of sick patients, with a particular focus on NEWS and the Sepsis 6 bundle

The STEAR (Sepsis Triggers, Escalation and Antibiotic Stewardship Review) group was set up in May 2022 in response to the initial Academy of Medical Royal Colleges' (AoMRC) statement. It is a BCUHB wide group with membership from front line clinicians, AIT, microbiologists and antimicrobial pharmacists. They will oversee the transition to the new risk assessment tool for sepsis. They will work with the Clinical Effectiveness Team and clinical staff to determine a new data set to measure compliance with the new tool.

The benefits of the AoMRC statement are two fold (i) the sicker patients are focused on as a priority and (ii) allows healthcare professionals more time to investigate and consider best treatment for the patient with a lower NEWS. It is estimated this stratification of risk assessment could reduce the use of broad spectrum antibiotics by up to 75%.

The time-frame for agreement and roll out of the new risk assessment tool is anticipated for end of Q4. Data collection for the new Sepsis Tier 2 audit is anticipated to commence in Q1 of 2023/24. The results of the audit will be tracked via both the Clinical Effectiveness Group and the STEAR Group which will inform any necessary improvement and / or education needs depending on results.

Falls (n=5)

Within the reporting period there were five patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is a reduction from nine in the previous period

This is broken down as follows:

IHC West (3) and IHC Central (2)

Appendix 4 provides a breakdown of incidents per service. There is no statistically significant change in the trend.

On review of learning from these incidents, there are ongoing themes that can be identified that contribute to these falls:

- Staff oversight
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells
- Reliance on alarm equipment
- No lying and standing BP taken.

Immediate actions have been undertaken for each of these incidents and these include immediate staff de-briefings, localised training and increasing of awareness through sharing incident details. The impact of this awareness raising and training is then monitored and measured through the ward accreditation process.

There were ten investigation reports relating to falls during this period that were approved following review at the Incident Learning Panel.

The Health Board Falls Strategic Group continues to meet and oversee the activity around falls improvement across the Board, setting direction and monitoring improvement trajectories and actions. A detailed update was provided to the QSE Committee in the Patient Safety Report.

Falls dashboards have been developed within the current Datix incident management system as an interim fix to support wards with access to their falls data easily. This is a temporary fix following the break in the data feed to the Health Board reporting mechanism Nursing Information Intelligence Portal (NIIP) since the implementation of the current version of Datix. It is still unclear when the national fix will be completed, the Health Board Informatics team are aware and involved in seeking a solution.

Grade 3 or above healthcare associated pressure ulcer (n=7)

Within the reporting period there were a total of 7 grade 3, grade 4 or ungradable healthcare associated pressure ulcers reported to the Delivery Unit. This is broken down as follows:

IHC East (3), IHC West (2) and IHC Central (2)

Appendix 5 provides a breakdown of incidents per service. There is no statistically significant change in the trend.

The recurring themes are:

- No evidence of increasing intentional grounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

All investigations from pressure ulcer investigations are reviewed weekly at local harms meetings. In addition, the sharing of findings at local level is reflected through the raising of awareness at safety briefs. The impact of the increased awareness is then monitored and measured through the ward accreditation process.

The second HAPU Improvement Group was held on the 25 October 2022 with the first focused collaborative meeting on the 06 October 2022. The next workshop is scheduled for 06 December where each of the IHCs and MHLD will be presenting their first PDSA findings. At the time of writing, the outcomes from these workshops were being collated to inform the overall improvement plan.

NEVER EVENTS

Never Events are defined as "*patient safety incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.*" The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

In the current financial year, April to November 2022/23, four never events have been reported, compared to seven in the same timescale in 2021/22.

Twelve Never Events were reported in 2021/22, compared to five in 2020/21 and six in the full year of 2019/20. However, two Never Events are subject to the downgrade process following completion of investigations and establishment of facts informed by external expert reviews, reducing the confirmed number of Never Events in 2021/22 to 10.

Within the current reporting period no new Never Events were reported. The primary theme (11 of 12 incidents) is surgical safety.

Appendix 6 provides a breakdown of Never Events per service.

In response, the Health Board recognised the role of human factors in the prevention and mitigation of systemic failure on patients, families, and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

The BCUHB Transformation and Improvement Directorate appointed a Quality Improvement Fellow specifically dedicated to theatres; the aim of this work is to support the teams in relation to consistently using the WHO checklist and addressing the causes of never events. The QI Fellow and designated YGC WHO Improvement Group, have undertaken observational audits and departmental surveys which directed their attention to complete review of their current WHO checklist in order to ensure relevance, eliminate duplication and waste and incorporate human factor elements into this process. The aim is to spread the work across other sites once the work at YGC has become embedded and sustained.

The presence of the QI Fellow and the engagement and drive of the WHO Improvement Group has undoubtedly renewed focus on the importance of full staff engagement and compliance with the checklist. This has yielded a number of positive quantifiable results:

- Zero WHO Checklist Datix incidents raised for 4 months (June/September 2022)
- 100% compliance with the Pre-Brief element for June/September 2022.
- 100% engagement with the Pre-Brief element for June/July 2022.
- 100% compliance with Sign In element for June/September 2022.
- 100% engagement with the Sign In element for June/September 2022.

The Time Out and Sign Out elements require further targeted testing across all teams. The recently ratified pan BCUHB LocSSIP 69 '5 Steps to Safer Surgery – The WHO Checklist' is soon to be shared across BCUHB theatres. Staff name and role boards are to be introduced within all YGC theatres imminently with this suggestion shared with East and Ophthalmic theatres.

The QSE Committee is undertaking a deep dive assurance review into this improvement work in March 2023.

PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on identifying significant national patient safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales. There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas and take immediate action. This stage 'warns' organisations of

emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Organisations are required to confirm that they have achieved compliance by the date stated.

Overdue Alerts

Reference	Title	Applicable To?	Type	Date action underway	Deadline	Notes
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	BCU-wide	Patient Safety Solution - Notice	27/05/2021	31/12/2021	Clinical policy progressing through approval process – expected to be approved on 18 Jan 2023. Deputy Executive MD now providing leadership to progress completion.

Closed Alerts

No alerts have been closed for the time period

LITIGATION

During this bi-monthly period of October and November 2022, 50 claims or potential claims were received against the Health Board. Of these, 43 related to alleged clinical negligence and 7 related to personal injury.

During the bi-monthly period, 19 claims were closed. Of these, 22 related to clinical negligence and 4 related to personal injury. The total costs for the total closed claims in this period amounted to £2,194,986.57 before reimbursement from the Welsh Risk Pool.

The following themes have been identified for this period for clinical negligence:

- Implementation of care
- Diagnosis – Including delay in diagnosis
- Treatment or procedure

As expected, the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The themes remain similar. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

The following themes have been identified for personal injury:

- Slips/trips
- Violence & Aggression

All settled claims require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool to reclaim costs.

A more detailed summary of high value cases is provided to the QSE Committee in the Patient Safety Report.

INQUESTS

HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board. The Health Board's Legal Services Team within the Quality Directorate facilitate this process and offer support to any witness by way of training and one to one support.

During the relevant time period October and November 2022, 89 new inquests or requests for information from the coroner were received from the Coroners in North Wales.

52 inquests were concluded between during October and November 2022. The inquest conclusions are in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

In the period of this report, there was one new Regulation 28 (PFD) reports issued by HM Coroner to the Health Board. This related to the pace of improvement work for intra-hospital transfers. Details of the response will be provided in the Patient Safety Report to the QSE Committee.

HEALTHCARE INSPECTORATE WALES (HIW)

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality care in mental health services.

HIW undertook an inspection of the Emergency Department, Wrexham Maelor Hospital on 8 – 10 August 2022. No immediate concerns or serious issues were raised. The Health Board await the report from HIW and in the meantime, the service are taking steps to ensure the initial verbal feedback from the inspection is shared with staff across all sites, and service improvement is commenced.

On 9 May 2022, Healthcare Inspectorate Wales (HIW) identified the Emergency Department, Ysbyty Glan Clwyd as a Service Requiring Significant Improvement (SRSI). The Quality Team are working closely with the Improvement Director at YGC in regards to

seeking assurance of action delivery from the inspections earlier in the year. The updated position was reported to the QSE Committee on 20 January 2023.

HIW conducted a further unannounced inspection of the Emergency Department at Glan Clwyd Hospital on 29 - 30 November 2022 with the intention to follow up on the areas for improvement highlighted during the previous inspection in May 2022. HIW were not assured that all risks to health and safety within department were being managed appropriately. As such, they highlighted some serious issues which required immediate action by the Health Board.

An Immediate Assurance Plan was coordinated by the Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality with input from nursing and medical leadership. HIW have since confirmed that the plan provided them with sufficient assurance and discussions between the executive team, quality team and HIW continue to take place for assurance purposes.

Despite the immediate issues raised, HIW praised the department and leadership on areas of good practice and acknowledged the current pressures on the department and Health Board.

In February 2022, HIW designated BCUHB Vascular Services as a Service Requiring Significant Improvement (SRSI). This was in response to the Royal College of Surgeons (RCOS) Clinical Record Review Report, published on 20 January 2022, which identified a number of concerns that indicated a risk to patients using the vascular service. As a consequence of the RCOS report and the SRSI designation, HIW undertook a local review during late 2022 to examine progress made by the Health Board in relation to the RCOS recommendations, and whether measures taken in addressing the RCOS recommendations are sustainable and ensure that patients receive safe care of good quality. The outcome of this review will enable HIW to consider whether the vascular service can be de-escalated as a SRSI. The fieldwork phase of the review comprised a number of different activities, including reviewing medical and data. Discussions have taken place and the fieldwork was undertaken during December 2022. The outcome is awaited.

HIW conducted an unannounced onsite inspection of Heddfan Unit, Mental Health and Learning Disability Division in November 2022. Following the inspection, HIW issued the Health Board with an Immediate Assurance Plan as during the inspection HIW found issues which posed an immediate risk to patient safety in relation to the delivery of safe and effective care which were reported to the QSE Committee 20 January 2023. The Immediate Assurance Plan was submitted to HIW on 18 November 2022, which HIW confirmed provided sufficient assurances. The Health Board now awaits the main improvement plan.

HIW conducted an unannounced onsite inspection of Bryn Hesketh, Mental Health and Learning Disabilities Division on November 1st and 2nd 2022. No immediate patient safety issues were identified during the inspection, with areas of good practice noted. The Health Board submitted the improvement plan to HIW on 19 December 2022. HIW are yet to confirm the plan has provided sufficient assurance. The improvement actions are linked to the wider improvement work underway by the service, led by the Interim Director of Mental Health and Learning Disabilities.

Complaints

During the months of October 2022 and November 2022, 432 complaints were received by the Health Board. 322 of those were complaints managed under the Putting Things Right Regulations (PTR). 110 were initially classified as Early Resolutions and 44 of these were later upgraded to being managed under the PTR as the services involved did not manage them to resolution within 2 working days as required.

The majority of the complaints related to Secondary Care Services. The themes related to clinical treatment and assessments, poor communication and waiting times. Other recurring themes were in relation to patient discharge from hospitals, prescribing and treatments not providing the expected outcomes.

At the end of November 2022, performance remained below the All Wales target of 75% for complaints closed within 30 working days. The percentage of complaints closed within the timeframe was 21%. The performance level has dropped due to the number of new complaints received during the period in addition to managing the backlog of overdue complaints. In addition, work pressures within services has compromised performance due to capacity and Covid 19 related sickness absence.

Integral to the overdue complaints recovery plan, constructive discussions have taken place with Directors of Nursing and Heads of Nursing to implement a robust plan to manage the overdue complaints. The Patient and Carer Experience Department are proactively engaging with services to establish how we can resolve enquiries at the earliest opportunity with a focus on extrapolating themes and trends identifying the services receiving the highest number of complaints. This will identify training opportunities and performance management issues. The Complaints Team are supporting the management of early resolutions which require a response within two working days. Proactive engagement and the assurance that the relevant leads within services are identified will contribute to a reduction of the number of early resolutions upgrading to being managed under PTR.

There was a decrease in the number of overdue complaints during this period, with a decrease from 487 complaints overdue at the beginning of October 2022 to 342 complaints overdue at the end of November 2022. This is a decrease of 29%. The total number of complaints open at the beginning of October was 687, and at the end of November 2022, the total number open was 515. This is a reduction of 25%. The response rate within the PTR timescale has been severely impacted due to the increasing number of complaints received across the Health Board and the impact of staffing and operational pressures.

There are no legacy cases remaining open. This involved significant proactive work across all services and dedicated support to secondary services in particular. Attendance at weekly complaints review meetings, collaborative working with the Public Service Ombudsman Wales (PSOW) Lead, attendance at weekly redress clinics and a collaborative approach supported the closure of the remaining legacy responses.

The team continue to work with services to provide accurate and detailed performance data on a weekly basis with a new complaint management approach adopted via ‘rapid resolution workshops’ to resolve the backlog of overdue complaints. In addition, the Complaints team are continuously cleansing the data to ensure that all complaints are closed where consent is not obtained after thirty days, and any complaints relating to a patient safety incident are

transferred to the incident team for investigation. The main objective is to improve performance to achieve the Welsh Government's Complaints Key Performance Indicators (KPIs) and improve patient safety and care, ensuring that action plans are implemented and positive changes are made to provide support to services with complaint resolution.

During October 100% of complaints were acknowledged within 2 working days, and during November 2022 98.51% (in accordance with the PTR timescales). The Corporate Complaints Team continue to review processes to identify opportunities to work SMART to maintain key performance indicators.

The common themes identified for the early resolutions for the period were particularly in relation to:

- Adult Community Mental Health Services – lack of communication, changes in appointments, lack of support for mental health condition(s).
- General Practice – Difficulties in obtaining regular prescribed medication and/or new medication.
- Emergency Medicine – Lengthy waits, conditions of facilities, staff attitude, lack of staff
- General Surgery – Lack of/poor communication, waiting times for surgery
- Community Dental – Difficulties accessing emergency dental care.

Redress

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state if at any time during the investigation of a complaint or patient safety incident it is considered that a qualifying liability exists or may exist, that would attract financial compensation of £25,000 or less, it must be determined whether or not an offer of redress should be made.

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate); and
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

Between October and November 2022, 20 cases were concluded which involved Redress:

- 7 offers of financial compensation as redress were made totalling £53,250;
- 1 apology only was offered as redress;
- 1 offer of financial redress was accepted totalling £5000;
- 11 were advised to pursue a clinical negligence claim, as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.

To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool (WRP) requires the Health Board to submit a Learning from Events Report

(LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation. The LFER will be considered by the WRP Committee who will approve reimbursement to the Health Board for the costs entailed in each redress case, once satisfied with the evidence of learning provided.

Public Services Ombudsman for Wales (PSOW)

Monthly meetings are scheduled with the Ombudsman's Head of Complaints Standards to promote partnership working between the Health Board and PSOW, and to discuss and share compliance data and review the Health Board's current position.

During the period under review (October and November 2022), the Ombudsman contacted the Health Board regarding 42 new concerns.

The Health Board currently has 98 Ombudsman Investigations ongoing. These figures are unprecedented and the highest numbers recorded. Across the Health Board, there are currently 32 cases within the West, 34 cases within Central and 32 cases within East.

Rather than carry out a full investigation, the Ombudsman will often ask the Health Board to agree to an early resolution proposal.

One emerging theme remains the number of cases being returned to the Health Board by the Ombudsman with instruction that they are to be re-investigated under the Putting Things Right Regulations in order to consider Redress. There are currently 13 cases under review for Redress. The Health Boards Investigation Report template has now been amended to ensure breach of duty and qualifying liability are considered where necessary.

Specialties being monitored for increased numbers of complaints being investigated by the Ombudsman are the following:

- GP Surgeries now have 12 cases being investigated by the Ombudsman;
- Mental Health have 10 cases being investigated;
- Continuing Health Care Team currently have 7 cases;
- Obstetrics & Gynaecology have 6 cases;
- Emergency Departments have 4 cases;

However, we have also seen a reduction in Ombudsman investigations in some specialities as follows:

- Urology numbers have reduced to 3 cases;
- HMP Berwyn have reduced to 2 ongoing investigations.

Detailed information on key cases investigated by the Ombudsman is included in the Patient and Carer Experience Report to the QSE Committee.

Patient Feedback

Patient feedback and listening to the voices of patients, carers and service users, is key to effective service improvement. The CIVICA real-time patient feedback system is currently being embedded across the Health Board, with implementation started in summer of 2021, and is a mechanism to support real time patient and carer feedback. The online patient feedback system supports the development and deployment of multiple surveys across multiple channels, along with standard reporting, alerting and enhanced text analytics. It signals an important milestone in providing every patient and carer with an opportunity to have their voices heard and acted upon.

From October 2022 to November 2022, 2821 patient feedback surveys were completed. Overall 89% of patients who completed the survey were satisfied and felt they were listened to. The Patient and Carer Experience Team are re-launching the Civica All Wales Feedback system with both staff and patients. This includes SMS texting to patients who have attended an outpatient appointment, have recently been discharged or attended an Emergency Department, using the All Wales Friends and Family Test (FFT) feedback survey.

From October 2022 to November 2022, PALS dealt with 1145 enquiries. Below are the top three enquiry themes:

- Communication (negative)
- Assisting Service users (negative)
- Delay in appointment (negative)

To help improve communication and staff assisting service users the Patient and Carer Experience Team are delivering a series of Patient and Carer Experience Training sessions across Integrated Health Communities. Within a two-month period, 17 training sessions were delivered to staff in the Central Integrated Health Community. The training includes effective communication, empowering staff to resolve issues locally to encourage early resolution of complaints and raising awareness of the role of PALS.

Patient and Carer feedback kiosks have been installed in the waiting areas of Minor Injury Units (MIU) across North Wales. The feedback kiosk give patients and carers the opportunity to complete an all Wales Patient Feedback Survey through Civica whilst they are waiting for treatment. In November 2022, the MIU at Llandudno Hospital received 86 feedback surveys completed through the kiosk, of which 99% of respondents who completed the survey felt they were listened to and got assistance when needed. The Patient and Carer Experience Team will continue to roll out feedback kiosks across outpatient areas and Emergency Departments across the Health Board

A Long Covid Partnership Group was established with patients playing an important role in decision making to ensure the voice of the patient is heard throughout the development of the Long Covid service. BCUHB were a finalist at the Patient Experience Network National Awards in Birmingham on the 28th September 2022 for Effective Partnership Working in Patient Centred Care award category. On the 28th October 2022, BCUHB won an NHS Wales award for Empowering People to Co-produce their Care for the Long Covid Service. This national recognition confirms the importance of patient and carer involvement in co-producing BCUHB services.

PALS are supporting the collation of patient and carer feedback for the National Audit of Dementia to find out patients with dementia experience of hospital admission. The Patient and Carer Experience Team are supporting the re-launch of the Language Choice Scheme and Butterfly Scheme across BCUHB.

A breakdown of this information is provided to services by means of a live dashboard and a monthly report. Services are encouraged to review their feedback and take action to improve.

A new Patient and Carer Feedback Framework is in development to establish a strengthened approach to listening and acting upon feedback.

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Detailed information is contained in the Patient and Carer Experience Report to the QSE Committee.

CONCLUSION

This report provides the Health Board with information and analysis on quality and patient safety matters including Nationally Reportable incidents, Never Events and HIW activity occurring in the last two months.

The key points of note are:

- The rate of Nationally Reportable Incidents (NRIs) remains constant – the main themes remain falls, healthcare acquired pressure ulcers, and the recognition and action on deteriorating patients. Improvement work for all these areas has been reinvigorated under the leadership of senior clinical staff.
- The rate of surgical safety NRIs (specifically Never Events) has reduced and whilst it is too early to draw a definitive conclusion, the learning from previous incidents and the intensive improvement work which is ongoing is likely to be making a difference.
- The number of overdue incident investigations, and consequently closure within the target timeframe is below expectation. Services report clinical and operational pressure as being the main cause. Support is being provided. The Health Board is marginally the outlier in this regard.
- One overdue Safety Alert remains. Whilst this is the best overall position in Wales, the actions required are being actively chased and have been escalated to the Executive Medical Director.
- The number of overdue complaints remains unacceptably high, with an impact on the closure target compliance. As with incidents, services report pressures as being the cause. Support is being provided to all divisions from the corporate team and a recovery plan has been developed. It is likely to take several months to address the backlog position and the risk of ongoing or greater pressure on services is a risk to success.

- The number of ongoing Ombudsman investigations is the highest to date with an emerging theme that complaints need to be re-investigated under the PTR Regulations as redress has not been considered.

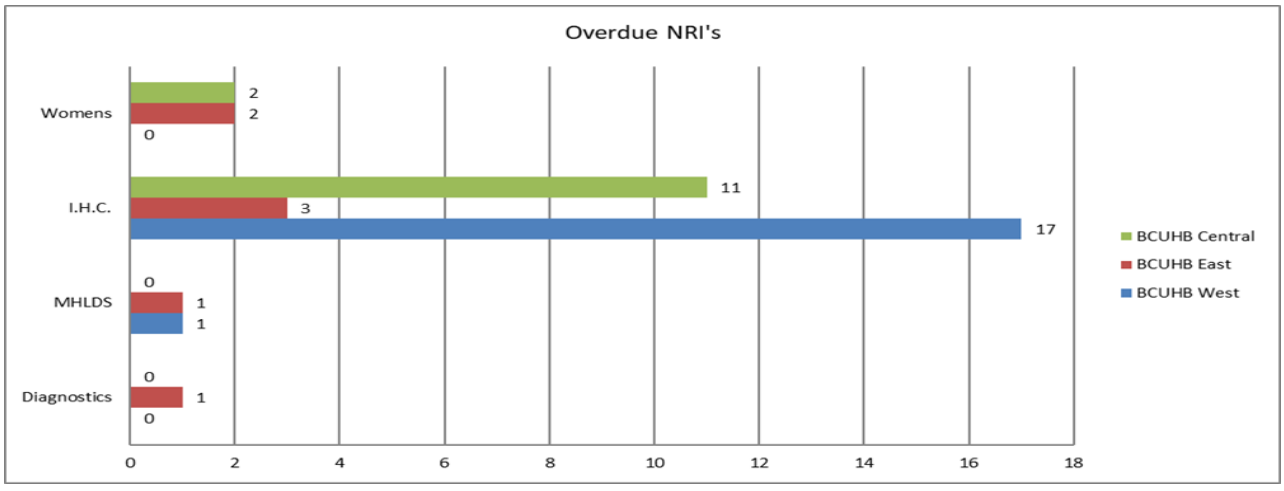
The Health Board will continue to submit more detailed information to the QSE Committee through the bi-monthly Patient Safety Report and triannual Patient and Carer Experience Report.

The Health Board is asked to note the report.

Appendix 1 – Reporting rates of NRIs

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
Health Community West: YG	2	4	1	8	0	8	1	3	0	1	3	6	1	6	44
Health Community West: Primary and Community	0	1	1	1	0	3	2	0	0	1	2	0	0	2	13
Health Community Central: YGC	2	3	3	6	8	4	5	2	6	4	3	3	3	1	53
Health Community Central: Primary and Community	0	3	0	1	3	1	0	0	1	0	0	1	2	2	14
Health Community East: WMH	0	6	4	0	0	5	0	1	1	1	2	0	3	2	25
Health Community East: Primary and Community	0	2	1	1	0	0	0	0	1	1	0	1	0	0	7
Women's and Midwifery	0	2	3	0	0	1	0	0	1	2	1	1	0	0	11
Diagnostics and Clinical Support	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Cancer Services	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Mental Health and Learning Disability	1	0	1	1	0	1	0	1	0	1	1	1	3	0	11
Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	6	21	15	18	12	23	8	8	10	11	12	13	12	13	182

Appendix 2 – Reporting rates of NRIs – Overdue position



Appendix 3 – Reporting rates of NRIs - Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	0	1	2	4	2	1	3	2	3	1	0	0	1	1	21
WHM	1	0	0	0	0	2	0	0	0	0	1	0	2	0	7
YG	1	2	0	1	0	3	1	0	0	0	2	2	0	2	14
Central Area	0	0	0	0	1	0	0	0	0	0	0	0	1	1	3
Cancer Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Womens	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2
Total	2	3	2	5	3	7	4	2	3	1	4	2	4	4	48

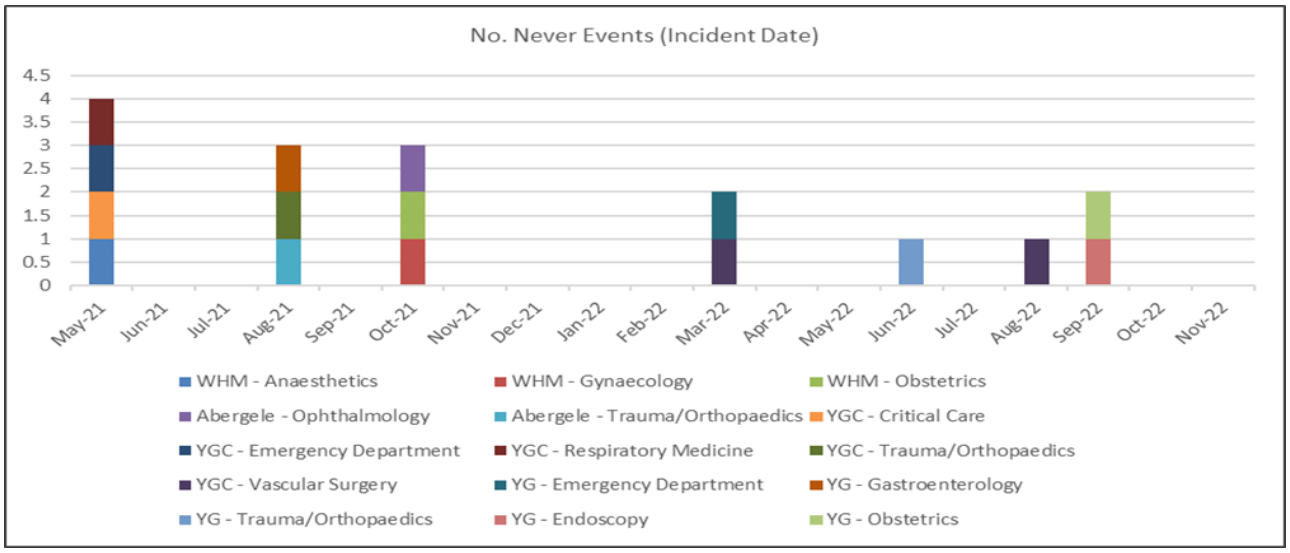
Appendix 4 – Reporting rates of NRIs – Falls

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	1	1	1	2	4	2	0	0	1	2	1	1	1	0	17
WHM	0	1	3	0	0	2	0	1	1	2	0	0	0	0	10
YG	0	0	1	7	0	2	1	3	0	0	1	1	0	3	19
Central Area	0	0	0	0	2	1	0	0	0	0	0	0	1	0	4
East Area	0	0	0	0	0	0	0	0	2	1	0	0	0	0	3
West Area	0	0	0	1	0	3	1	0	0	0	0	0	0	0	5
MHLDS	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Cancer Services	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	1	2	6	10	6	11	2	4	4	5	2	2	2	3	60

Appendix 5 – Reporting rates of NRIs – HAPU

Avoidable HAPU	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
WHM	0	5	0	0	0	1	1	0	0	1	0	0	1	2	11
YG	0	0	0	1	0	0	0	0	0	0	0	0	0	1	2
Central Area	0	2	1	1	2	0	0	1	1	0	0	1	1	1	11
East Area	0	2	0	0	0	2	0	0	0	0	0	1	0	0	5
West Area	0	1	0	1	0	0	0	0	0	0	2	0	0	1	5
Total	0	10	1	3	2	3	1	1	2	1	2	2	2	5	35

Appendix 6 – Reporting rates of NRIs – Never Events



Teitl adroddiad: **Report Title:**	Vascular Network Update
Adrodd i: **Report to:**	Public Board
Dyddiad y Cyfarfod: **Date of Meeting:**	26 January 2023
Crynodeb Gweithredol: **Executive Summary:**	The purpose of this paper is to update the Board on progress to improve the sustainability, quality and experience of vascular services. It describes the improvement work via the development of specific pathways for key conditions, and the longer-term transformation work. The paper summarises progress against the actions arising from the Royal College of Surgeons review, and the Vascular Quality Review Panel. The paper gives initial feedback on the visit by Health Inspectorate Wales in December 2022 and expands further on the findings from the National Vascular Registry (NVR) report published in 2022. The paper outlines current professional and tertiary support from NHS England and an update on consultant staffing.
Argymhellion: **Recommendations:**	The Board is asked to note: • The pilot of the new emergency ischaemic limb pathway • Progress with the development of a pathways for vascular access for renal dialysis and patients with diabetes-related foot problems • The high level transformation plan over 3-18 months for vascular services • The longer term work plan for the vascular network • The positive verbal feedback from Health Inspectorate Wales (HIW) following their review of vascular services in December 2022 • The summary findings of the NVR report • The imminent publication of the Vascular Quality Panel (VQP) report • The current professional support arrangements for the BCU vascular MDT • The improved stability of the consultant surgical workforce
Arweinydd Gweithredol: **Executive Lead:**	Dr Nick Lyons

Awdur yr Adroddiad: **Report Author:**	Jenny Farley – Vascular Network Director			
Pwrpas yr adroddiad: **Purpose of Report:**	I'w Nodi For Noting ☐	I Benderfynu arno For Decision ☐	Am sicrwydd For Assurance ☒	
Lefel sicrwydd: **Assurance Level:**	Arwyddocaol Significant ☐ Lefel uchel o hyder/tystiolaeth or 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 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 provision of safe and high-quality services is a primary duty of the Health Board.			
Goblygiadau rheoleiddio a lleol: **Regulatory and legal implications:**	None			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? **In accordance with WP7 has an EqlA been identified as necessary and undertaken?**	Not applicable – This paper does not reflect a change in service			
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 – This paper does not reflect a change in service			
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)**	CRR22-25 has been downgraded at the Corporate Risk Register Committee CRR 22-27 Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services			
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith **Financial implications as a result of implementing the recommendations**	Contingency measures and dual consultant operating and on-call have incurred a further £169K since the previous board paper.			

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith **Workforce implications as a result of implementing the recommendations**	Kendall Bluck Consulting are preparing their final report regarding staffing for the service.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori **Feedback, response, and follow-up summary following consultation**	Not applicable currently
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) **Links to BAF risks:** (or links to the Corporate Risk Register)	BAF21-02: Recovering access to timely planned care pathways
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:**	Continuation of the transformation programme
Rhestr o Atodiadau: **List of Appendices:**	Appendix 1 – Vascular Network Plan on a Page Appendix 2 – Summary of NVR report findings and recommendations

VASCULAR SERVICES UPDATE

Introduction / Background

Vascular services for the population of North Wales have been provided since 2019 through a hub and spoke model with centralisation of arterial and endovascular services at Glan Clwyd Hospital.

An invited service review by the Royal College of Surgeons (RCS) was commissioned by the Board in 2020 to review the quality of the new service. The first report was published in March 2021 and the second report in February 2022. In response to the second report, the Board convened a Vascular Quality Review Panel (VQRP) with an external chair to review specific cases. Health Inspectorate Wales visited the Health Board in December 2022, and the Welsh Aortic Aneurysm Screening Programme (WAASP) will be carrying out a quality assurance exercise early in 2023.

The improvement and clinical governance of the service has been overseen by the Vascular Steering Group (VSG) which was established in November 2021 and includes lay representatives, and Community Health Council input.

Activity and outcomes are benchmarked against other units using the National vascular Registry (NVR). NVR data is cross-referenced against Health Board activity data.

The service

The vascular network team has continued to transition to the targeted intervention approach to vascular services and the updates below set out the progress to date.

Pathways Update

Emergency Ischaemic Limb

In response to His Majesty's Coroner's Prevention of Future Death Report (PFD) in October 2022, all three acute sites are now using a unified pathway for patients who present with an ischaemic limb in an emergency which is the result of the BCUHB Vascular Network Team, WAST and the three Emergency Departments co-designing the new pathway to enable these patients to be conveyed directly to the vascular ward at the major arterial centre at Glan Clwyd Hospital from all geographical areas of North Wales.

The pathway has been in place since 1 December 2022 and will be reviewed and formally ratified at the multi-disciplinary vascular clinical governance meeting on 17 January 2023.

In order to ensure the pathway is sustainable, Plan, Do, Check, Act (PDCA) bi-weekly meetings have been established with terms of reference and an Agenda to monitor trends, capture incidents and if necessary, modify the pathway to meet unforeseen issues. These meetings will be chaired by a member of the Vascular Network Team and run for six months in the first instance.

Patients who self-present or who are unstable from a cardiovascular perspective will continue to need immediate assessment and treatment at Emergency Departments on each of the sites.

Renal Pathways

Two renal pathway mapping exercises were held between September and December 2022. The first focused on mapping the current and future pathways for fistula, the second focused on issues, risks and actions arising from the implementation of the future fistula pathway.

These have been fed into the Renal Peer Review action plan with future sessions planned to cover peritoneal dialysis (PD) Pathway and to identify the Multi-Disciplinary Team (MDT) resource requirements.

Diabetic Foot Pathway

The second Diabetic Foot summit is planned for the 13 January 2023 and will focus on the following topics:

(a) Clinical governance data from each integrated health community (IHC)

(b) Process mapping the Emergency Diabetic Foot pathways and identify the difference in services in each IHC.

(c) How the current pathways compare to the NICE guidance

(d) The design of future service within the current and planned resources

(e) Prioritisation of improvements/actions

The next summit/workshop will be planned for the end of March 2023.

Vascular Network Plan

Long term transformations

A number of transformations currently under the umbrella of the Vascular Network Team are identified as long-term and as such will be subject to six-weekly meetings. These include:

a) Suite of investigations for every patient with an abdominal aortic aneurysm (AAA)

b) Discharge planning to include all MDT members and start from admission

c) Rehabilitation

d) Patient Length of Stay

e) Hot clinics and virtual ward

The Vascular Network has produced a Plan on a Page (**Appendix 1**) to outline their **mission, vision and priorities.**

Support

Specialised vascular surgical arrangements and MDT support

All patients deemed to need abdominal aortic surgery are discussed between the BCUHB multi-disciplinary team meeting (MDT) and the MDT at the University Hospitals of the North Midlands NHS Trust (UHNM). These discussions generate additional assurance about decision making and pre-operative work-up of patients.

Liverpool University Hospitals Foundation Trust (LUHFT) continue to provide tertiary vascular surgery for the patients who need more complex interventions.

Scrutiny

Health Inspectorate Wales (HIW) visit

HIW visited BCUHB and met with representatives from vascular clinical teams, operational teams and the vascular network team on 13-15 December 2022.

The TI plan now includes all issues, regardless of where these came from. For simplicity, and for clarity when presenting to Health Inspectorate Wales (HIW), these were split out into the following TI plans:

(1) Royal College of Surgeons (RCS) – **67%** of actions now complete

(2) Vascular Quality Panel (VQP) – **76%** of actions now complete

(3) All other internally generated action – **70%** of actions now complete

Verbal feedback from the Senior Healthcare Inspector during the meeting was positive.

The HIW team acknowledged the amount of progress made. They approved the action plan format and were appreciative of the dashboard providing basic statistics. They commended the pathways for Emergency Ischaemic Limb and the process that has been put in place to monitor delivery and acknowledged the progress on renal pathways and action plan.

All evidence was sent to the Senior Healthcare Inspector.

Vascular Quality Panel Report

A draft of the Vascular Quality Panel report was received on 22nd December 2022 and it is expected that the final report will be received by the Health Board in January 2023.

National Vascular Registry report

Data from the 2022 National Vascular Registry (NVR) report confirmed activity and outcomes are broadly in line with the national average. A summary of the findings is in **Appendix 2** and the themes will be taken forward by the vascular steering group, the vascular network and the operational teams. Data entry was not complete for all fields.

Workforce Report

Kendall Bluck Consulting finalised their demand and capacity review on the 4 January 2023 with the workforce lead for the Health Board. This will be further disseminated with key stakeholders for input and discussion by the end of January 2023.

The profile of consultant medical staffing in the service has improved further with a substantive appointee due to start in May 2023.

Budgetary / Financial Implications

The process for monitoring recruitment and expenditure in line with IMTP now sits with each of the Hospital Directors, their operational, finance and HR teams. A recruitment update is provided to Vascular Steering Group on a monthly basis.

The service continues to incur cost arising from locum additional cover for dual on-call and aortic operating although this is expected to decrease now that the dual on-call arrangements have ceased.

Appendix 2: Summary of NVR report

Areas of good performance

Clinical

Within national expectations

- Mortality and case load for lower limb revascularisation
- Diabetic foot MDT clinic
- Post-operative death / stroke after carotid endarterectomy
- Delays to surgery for carotid endarterectomy
- Length of stay for abdominal aortic aneurysm (AAA) repair
- Mortality and case load for major amputation
- Above knee amputation (AKA):below knee amputation (BKA) ratio
- High proportion of patients with AAA having MDT discussion, pre-operative CT and formal anaesthetic assessment

High levels of

- Consultant presence for amputation
- Antibiotic prophylaxis given for amputation

Good organisational performance in terms of

- Consultant review within 48 hours for all admissions
- Clinic spaces for urgent assessment of critical limb ischaemia (CLI)
- Staffing numbers: Consultant surgeons; Specialist nurses; access to Healthcare of the Elderly consultants; Vascular scientists
- Number of elective operating sessions
- Dedicated endovascular lists in the Interventional Radiology suite
- Access to hybrid theatre
- Same day imaging
- Ring fenced urgent angioplasty slots
- Specialised amputee rehabilitation centre (Artificial Limb and Appliance Centre in Wrexham)

Areas for improvement

Clinical

- Increase proportion of patients undergoing revascularisation within 5 days of admission for CLI
- Further explore the mortality rate for lower limb revascularisation.
- Examine reasons for AAA mortality rate (4.4%) after elective AAA repair in context of this being within the 95% control limit but higher than national mean (1.4%)
- Consider the high proportion of Endovascular Aneurysm Repair (EVAR) to open repair for elective AAA
- Examine processes that would reduce delay to AAA repair after referral
- Examine possibilities for provision of 24/7 emergency EVAR service to increase proportion of EVAR for ruptured AAA

- Recognise that the AKA:BKA ratio is less than 1 and audit failure to heal rates in BKA
- Need to reduce delay to amputation after vascular assessment for patients requiring this procedure

Organisational

- Need diabetic foot MDT ward round
- Need specialist amputee rehabilitation team, including psychology
- Need amputee physiotherapist in arterial centre
- Need more vascular interventional radiologists
- Need data support staff for interventional radiologists for NVR
- Need allocated operating lists for vascular emergencies
- Need supervised exercise programme

Vascular Services Transformation Plan on a Page

OUR VISION

We strive to deliver clinically outstanding vascular care with kindness compassion and humanity to our patients their family carers and workforce teams

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

OUR MISSION

To be a Network that inspires our workforce and fulfils our patient expectations

OUR PRIORITIES FOR 2022-2023

- To deliver a standardised vascular and vascular diabetic foot service across all three hospital sites
- To deliver clinically led, and patient focused, transformation of the pathway processes, workforce models and culture of the vascular services
- To deliver evidenced based good patient experience regardless of the geographical location
- To ensure our workforce is designed to meet the needs of the services, and staff are supported in fulfilling their roles, responsibilities and professional development

HOW WE'LL DELIVER OUR PIORITIES

- Senior Clinicians and all key stakeholders will be involved in the planning delivery and setting the agreed standards for care for Vascular, Renal, and Diabetic Foot services
- We will use Lean methodology to process map agreed pathways across all three sites engaging all disciplines in leading the transformation required to deliver standardised care
- We will work to national standards of agreed care including those set out in NICE, the Vascular Society and Diabetes National Standards
- We will review our workforce to ensure it is fit for purpose we will engage multi-disciplinary leads and 3rd sector services in redesigning where necessary roles and focus on fully recruiting to all our vacancies

TARGET

- With all key stakeholders, we will define the pathways that need to be process mapped with the vascular, vascular diabetic foot and renal services by January 2023
- We will create a Timeline setting out the start, end date and deliverables of the transformation programme (TI) by January 2023
- We will respond with our key stakeholders to the Vascular Quality Panel's report ensuring delivery of all key recommendations within agreed timelines

- Complete Renal Vascular Pathway transformation by September 2023
- We will implement a QI project with our WAST partners to safely embed the Emergency Ischaemic Limb Pathway by June 2023 through our PDCA cycle
- Complete the transformation of one of the diabetic foot pathways by June 2023 and agree with clinical teams which other diabetic foot pathways needs to be completed by June 2024
- Agree additional pathways and priorities to be transformed within a 3, 6 and 12 month timeframe by January 2023

- We will establish internal quality indicators and implement national Key Performance Indicators to evidence improvement in patient care by March 2023
- We will evidence our transformational improvements by producing quarterly reports to all senior committees, tracking improvement against Key Performance Indicators

- We will ensure that we have appropriately trained and experienced staff in post to contribute to the delivery of the transformation of pathways
- We will review the current workforce competencies and redesign roles and responsibilities as required
- We will liaise with, and if required, develop contracts with our 3rd sectors support services to improve the wider patient experience

SUCCESS LOOKS LIKE

- Key Clinical Stakeholders are leading and participating in delivering the changes required to transform the pathways within the vascular network
- All actions and recommendations are delivered by their due dates

- The programme of process mapping will be completed
- Outcomes from the process mapping will be embedded in practice and quality assured

- The Vascular Quality Indicators will be equal to, or better than, published National Standards
- Relevant NICE guidelines will be implemented
- Patient satisfaction surveys will evidence improvement in the indicators

- A reputable vascular service with a skilled, effective and caring workforce

Cyfarfod a dyddiad: Meeting and date:	Board Meeting 26 January 2023
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	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 (All Wales) and Update of Register of Section 12(2) Approved Doctors for Wales.**
Cyfarwyddwr Cyfrifol: Responsible Director:	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.
Craffu blaenorol: Prior Scrutiny:	Not applicable
Atodiadau Appendices:	**Appendix 1:** Mental Health Act 1983 as amended by the Mental Health Act 2007:- Approved Clinician (Wales) Directions 2018. - Update of Register of Approved Clinicians for Wales. **Appendix 2:** Mental Health Act 1983 as amended by the Mental Health Act 2007:- - Update of Register of Section 12(2) Approved Doctors for Wales.

Argymhelliad/Recommendation:

The details presented to the Board in this Report is a summary of the approvals which have already received ratification for Approved Clinicians and Section 12(2) Doctor approvals across the Principality.

This report provides a governance record of compliance with legislative requirements under the Mental Health Act 1983 (as amended 2007) of the approvals and ratification process.

The Board is asked to note the report and ratify the approvals in line with the Welsh Government Guidance Mental Health Act 1983 Approval of Approved Clinicians (Wales) July 2018 for Approved Clinicians and the Section 12(2) Process and Criteria Document for S12(2) Approved Doctor approvals.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol						**N**	

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

Sefyllfa/Situation:

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

Cefndir/Background:

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

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

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

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

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

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

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

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

Asesu a Dadansoddi/Assessment & Analysis

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

Opsiynau a ystyriwyd/Options considered

This is a factual report for assurance purposes.

Goblygiadau Ariannol/Financial Implications

None

Dadansoddiad Risk/Risk Analysis

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

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

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

Cyfreithiol a Chydymffurfiaeth/Legal and Compliance

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

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

Asesiad Effaith/Impact Assessment

None.

Update of Register of Approved Clinicians and Section 12 (2) Approved Doctors for Wales 5th November 2022 – 21st December 2022		
	AC	**S12 (2)**
Approvals and Re-approvals	11	9
Approvals suspended	0	0
Approvals re-instated/ returned to work in Wales	0	1
Removed	0	0
Retired	0	0
Registered without a licence to practise and retired	0	0
Transferred from AC register (to S12 Register)	0	0
Transferred/Removed from S12 – Became AC approved	0	0
No longer working in Wales and Approval Expired	0	0
No longer working in Wales	1	2
Approval Ended	4	0
RIP	0	0

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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 for Wales

5th November 2022 – 21st December 2022

Approvals and Re-approvals: 11

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Chance	Patrick	Aneurin Bevan University Health Board, Royal Gwent Hospital, Clytha House (RAID Team), 13 Clytha Square, Newport NP20 2EF.	10th November 2027	Yes
Bigham	Lucy	Cardiff and Vale University Health Board, Pendine Community Mental Health Team, 124-126 Cowbridge Road West, Ely, Cardiff, CF5 5BT.	13th November 2027	Yes
Noblett	Joanne	Swansea Bay University Health Board, Uned Gobaith, Tonna Hospital, Tonna, SA11 3LX.	17th November 2027	Yes
Zafar	Sohail	Cygnet Health Care Limited, Cygnet Raglan House Raglan Road, Smethwick, B66 3ND.	17th November 2027	Yes
Megeri	Deepak	Cwm Taf Morgannwg University Health Board, Mental Health Unit, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, CF72 8XR.	20th November 2027	Yes
Garwood	Lynne	Cwm Taf Morgannwg University Health Board, Mental Health Unit, Princess of Wales Hospital, Bridgend, CF31 1RQ.	29th November 2027	Yes
Williamson	Kathryn	Aneurin Bevan University Health Board, Mental Health Unit, Older Adults, Ysbyty Ystrad Fawr, Ystrad Fawr Way, Ystrad Mynach, Hengoed, Caerphilly, CF82 7GP.	6th December 2027	Yes

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Skalbania	Witold	Betsi Cadwaladr University Health Board, Ysbyty Bryn y Neuadd, Aber Road, Llanfairfechan, Conwy, LL33 0HH.	12th May 2024	Yes
Medford	Frank	Cwm Taf Morgannwg University Health Board, Ynysmeurig House, Navigation Park, Abercynon, Rhondda, Cynon Taf, CF45 4SN.	12th December 2027	Yes
Jones	Richard	Hywel Dda University Health Board, Cwmseren PICU, Hafan Derwen, Parc Dewi Sant, Carmarthen, SA31 3BB.	18th December 2027	No* *pending ratification via a Chair's Action Letter
Edwards	Ruth	Hywel Dda University Health Board, Commissioning, St Brides, Hafan Derwen, St David's Park, Jobswell Rd, Carmarthen SA31 3HB.	18th December 2027	No* *pending ratification via a Chair's Action Letter

Approvals Suspended: 0

Surname	First Name	Workplace	Date Approval Expires

Approvals re-instated/or Returned to Wales: 0

Surname	First Name	Workplace	Date Approval Expires	Previous Chair's Action

Removed (Left Wales) and Approval Expired: 0

Surname	First Name	Workplace	Date Approval Expired

Retired: 0

Surname	First Name	Workplace	Date Approval Expired

No longer Registered & Retired: 0

Surname	First Name	Workplace	Date Approval Expired

Transferred from AC Register to S12 Register: 0

Surname	First Name	Workplace	Date Approval Expires

No longer working in Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Kollabathula	Indira	Betsi Cadwaladr University Health Board, South Gwynedd CMHT, Bryn Beryl Hospital, Caernarfon Road, Pwllheli, Gwynedd, LL53 6TT.	14.12.2022

Approval Ended: 4*

Surname	First Name	Workplace	Date Approval Expired
Medford	Frank *(*later reapproved)*	Cwm Taf Morgannwg University Health Board, Ynysmeurig House, Navigation Park, Abercynon, Rhondda, Cynon Taf, CF45 4SN.	13th November 2022
Davey	Isobel	Cwm Taf Morgannwg University Health Board, CAMHS Clinic, The Children's Centre, Neath Port Talbot Hospital, Baglan Way, Port Talbot ,SA12 7BX.	21st November 2022
Ferre-Vidal	Juan Claudio	Cardiff and Vale University Health Board, CAMHS Cardiff Child and Family Centre, St David's Hospital, Cowbridge Road East, Cardiff CF11 9XB.	27th November 2022
Garwood	Lynne *(*later reapproved)*	Cwm Taf Morgannwg University Health Board, Mental Health Unit Princess of Wales Hospital, Bridgend, CF31 1RQ.	5th December 2022

RIP: 0

Surname	First Name	Workplace	Date Approval Expired

APPENDIX 2

Mental Health Act 1983

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

5th November 2022 – 21st December 2022

S12 Approvals and Re-approvals: 9

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Goss	Grace	NHS Shared Services/Aneurin Bevan University Health Board, Hywel Dda Centre, Regent Way, Chepstow, NP16 5BY.	6th November 2027	Yes
Jeal	Susan	Cwm Taf Morgannwg University Health Board, Bridgend North CMHT, Maesteg Community Hospital, Neath Road, Maesteg, CF34 9PW.	18th November 2027	Yes
Kinally	Eamonn	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Mental Health Admissions Unit, Ynysmaerdy, Pontyclun, CF72 8XR.	21st November 2027	Yes
Mohanasundaram	Harisundar	Hywel Dda University Health Board, Older Adult Mental Health Service, Caebryn, Prince Philip Hospital, Bryngwyn Mawr, Dafen, Llanelli, Carmarthenshire, SA14 8QF.	22nd November 2027	Yes
Yousuf	Iqbal	Betsi Cadwaladr University Health Board, Ty Llywelyn MSU, Aber Road, Llanfairfechan, Conwy, LL33 0HH.	7th December 2027	Yes
Anjam	Muhammad	Cwm Taf Morgannwg University Health Board, Ysbyty Cwm Cynon, New Road, Mountain Ash, CF45 4BZ.	11th December 2027	Yes
Memon	Ismail	Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital Llantrisant, CF72 8XR.	12th December 2027	Yes
Jones	Stephen Neil	Aneurin Bevan University Health Board, St Julian's GP Medical Centre, 13A Stafford Road, Newport, NP19 7DQ.	17th November 2027	Yes

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Hazem	Abdul	Swansea Bay University Health Board, Area 2 CMHT Central Clinic, 21 Orchard Street, Swansea, SA1 5AT.	4th December 2027	Yes

S12 suspended: 0

Surname	First Name	Workplace	Date Approval Expires

S12 Approvals reinstated or Returned to Wales: 1

Surname	First Name	Workplace	Date Approval Expires
Cunning	Catherine	Betsi Cadwaladr University Health Board, Child and Adolescent Mental Health Service (CAMHS), Wrexham Child Health Centre, Croesnewydd Road, Wrexham, LL13 7TD.	14th November 2023

S12 Removed – Approval Expired: 0

Surname	First Name	Workplace	Date Approval Expired

Registered Without a Licence and Retired: 0

Surname	First Name	Workplace	Date Approval Expires

Transferred from AC Register & Became S12 approved: 0

Surname	First Name	Workplace	Date S12(2) Approval Expires

Transferred from S12 Register & Became AC approved: 0

Surname	First Name	Workplace	Date Approval Expired

S12 No longer working in Wales: 2

Surname	First Name	Workplace	Date Approval Expires
Patel	Neil	Powys Teaching Health Board, Older Adults Mental Health, Felindre Unit Bronllys Hospital, Powys, LD3 0LU.	22nd August 2026
Hardt	Helmut	Hywel Dda University Health Board, Hafan Hedd, Adpar, Newcastle Emlyn, SA38 9NS.	25th January 2023

S12 Approval Ended: 0

Surname	First Name	Workplace	Date Approval Expired

RIP: 0

Surname	First Name	Workplace	Date Approval Expires

Teitl adroddiad: **Report title:**	Corporate Risk Register Report		
Adrodd i: **Report to:**	Board		
Dyddiad y Cyfarfod: **Date of Meeting:**	Thursday, 26 January 2023	Agenda Item number:	-----
Crynodeb Gweithredol: **Executive Summary:**	The purpose of this standing agenda item is to provide a position of activity for the Corporate Risk Register (CRR) since the last Risk Management Group (RMG) and presents the changes that have been captured following a review and update of the risks by the various lead officers of risks on the CRR, noting the support provided by the Corporate Risk Team. Once reviewed, risks on the CRR are submitted to the relevant Executive Directors for approval and sign off prior to their inclusion and presentation to the RMG and the appropriate Board Committee thereafter for scrutiny oversight. In reviewing the CRR controls and mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Framework. The CRR enables the Board to fulfil its obligations of ensuring there are effective and comprehensive systems and processes in place to identify, understand, monitor and address current and future risks deemed high enough to negatively impact on the delivery of operational objectives, whilst evaluating the effectiveness of their controls, and monitoring associated action plans. In addition, this report gives an update of the proactive work that is being undertaken by the Risk Management Team to lever the New Operating Model Governance so as to enable a golden thread of Risk Management embedded into the BCUHB Operational Governance. Furthermore, the report evidence that this is being used to identify, assess and manage risks.		
Argymhellion: **Recommendations:**	The Board is asked to: 1. Review, scrutinise and discuss the report. 2. Gain assurance that the Health Board`s Risk Management arrangements are effective and fit for purpose.		
Arweinydd Gweithredol: **Executive Lead:**	Nick Lyons, Executive Medical Director		

Awdur yr Adroddiad: **Report Author:**	Phil Meakin, Associate Director of Governance			
Pwrpas yr adroddiad: **Purpose of report:**	For Noting ☒	For Decision ☐	For Assurance ☒	
Lefel sicrwydd: **Assurance level:**	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Improvements being put in place in the New Operating Model Guidance are improving the "golden thread" of risk management and this can be evidenced in this report.				
Cyswllt ag Amcan/Amcanion Strategol: **Link to Strategic Objective(s):**	See the individual risks for details of the related links to Strategic Objectives.			
Goblygiadau rheoleiddio a lleol: **Regulatory and legal implications**	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.			
Yn unol â WP7, a oedd 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)	See the individual risks for details of the related links to the Board Assurance Framework.			

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 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 reduced claims.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith **Workforce implications as a result of implementing the recommendations**	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori **Feedback, response, and follow up summary following consultation**	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) **Links to BAF risks:** (or links to the Corporate Risk Register)	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) **Reason for submission of report to confidential board (where relevant)**	Not applicable
Camau Nesaf: **Gweithredu argymhellion** **Next Steps:** The Risk Management Group will be meeting on the 7th February 2023, therefore an updated position of the risks will be presented during Committee meetings during the next quarter and again to the Board in July 2023.	
List of Appendices: Appendix 1 – Corporate Risk Register Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels	

Board
26th January 2023
Corporate Risk Register Report

1. Introduction/Background

1.1 The continued implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR needs to reflect the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

1.2 Since the last report the Operational Governance for key parts of the BCUHB New Operating Model has been introduced and this has given added opportunity to embed the objectives identified in paragraph 1.1 above. This report can evidence that this is having a positive impact on the identification and assessment of risks. (Para 2.9 below)

2. Corporate Risk Register Update and Risk Management Improvements Update

2.1 The Risk Management Group met on the 2nd August, 4th October and were scheduled to meet on the 6th December, however the December meeting was cancelled all RMG papers were reviewed by the HBLT in December 2023 and HBLT members were given an extended opportunity to comment by 4 January 2023. The papers were presented to the Health Board Leadership Team for approval, to review the Corporate Risk Register which included "deep dives" into the below risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint:

- CRR20-05 - Timely access to care homes.
- CRR20-06 – Informatics - Patient Records pan BCU.
- CRR21-16 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.
- CRR21-17 – The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out of hours.

2.2 Following discussion and support at the Risk Management Group during 2nd August 2022, risk CRR20-06 'Management of Patient Records' is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' (CRR22-32) has been developed, and was approved for inclusion on the Corporate Risk Register at the 4th October 2022 Risk Management Group. A second of the three proposed revised risks has further been developed and included on the Corporate Risk Register following the approval from the Health Board Leadership Team 'Risk of Lack of access to clinical and other patient data' (CRR23-33). Work remains ongoing to develop the 3rd revised risk 'Risk of poor clinical recording of patient information', which will include the transfer over of open actions from the current CRR20-06 and

result in the closure and archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'

2.3 During the Risk Management Group meeting on the 2nd August 2022, it was noted that risk CRR20-05 'Timely access to Care Homes' originally related to the pandemic but that the landscape has now changed and the controls no longer meet the description The risk is no longer effective in its current form and collaborative work with the risk team, finance, and operational leads has taken place to split and rewrite as two separate risks, one risk will focus around quality and safety, whilst the second will focus around contracting and commissioning.

2.4 During the Risk Management Group meeting on the 4th October 2022 the ophthalmology service proposed to disaggregate risk CRR20-08 'Insufficient clinical capacity to meet demand may result in permanent vision loss in some patient by the relevant clinical conditions, which will enable the risks to reflect impact on patient safety/care. Work has taken place to review and re-write the risk, with 5 new risks approved to replace the current CRR20-08.

2.5 The following risks have been escalated and incorporated onto the Corporate Risk Register:

- CRR22-25 – Risk of failure to provide full vascular services due to lack of available consultant workforce. – This risk was approved for escalation during the October 2022 Risk Management Group meeting. Following positive developments there is a proposal to de-escalate this risk to be managed at Tier 2 level as part of the December Risks Management Group paper recommendations. As this is a proposal for a de-escalation of a CRR Risk this proposal will be formally confirmed at the Quality, Safety and Experience (QSE) Committee in March 2023. The QSE Committee will be provided with the appropriate information to support the review.
- CRR22-26 – Risk of significant patient harm as a consequence of sustainability of the acute vascular service. - This risk has been approved for escalation during the October 2022 Risk Management Group meeting and following positive developments there is a proposal to de-escalate this risk to be managed at Tier 2 level as part of the December 2022 Risk Management Group paper recommendations. As this is a proposal for a de-escalation of a CRR Risk this proposal will be formally confirmed at the QSE Committee in March 2023. The QSE Committee will be provided with the appropriate information to support the review.
- Furthermore, in relation to the above two risks a new risk will be developed that encompasses a broader consideration of risk related to the Vascular services.
- CRR22-27 - Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular Services.
- CRR23-32 – Retention and Storage of Patient Records.
- CRR23-33 - Risk of Lack of access to clinical and other patient data.
- CRR23-34 - There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.

- CRR23-35 - Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.

2.6 The following risks have been incorporated onto the Health Board's risk register and following Executive approval, work continues to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model

The following risks were identified and the detailed risk description and titles are being developed at the time of writing this report:

- CRR23-36 - Cost of Living Impact on Staff and Patients.
- CRR23-37 - Targeted Intervention.
- CRR23-38 - Workforce.
- CRR23-39 - Patient Flow - Impact on Access and Quality of Care.

2.7 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting on the breadth and categories of risks recorded, in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	33	0	9	1
Tier 2 (9-12)	319	97	36	100
Tier 3 (1-8)	218	52	43	89

2.8 As mentioned in the introduction the BCUHB Risk Management Team have undertaken work to strengthen the management of risks in the Health Board. Some examples are given below:

- Following the approved Risk Management Strategy, the Risk Management Team has developed the RM02 Document ready for approval at the next RMG meeting. This is the document that provides the procedures and processes behind the Risk Management strategy.
- On-going support with risk leads to review their risks in the Integrated Health Communities (IHCs) context.
- Review of risk training records and database to identify risk handlers and managers who require refresher training.
- Targeted training for those colleagues identified by their IHC's is underway.
- The Risk Management Corporate Orientation, will now be recorded for new starters to the organisation from 1 February 2022.
- All recommendations from the NHS Wales Audit and Assurances Services Risk Audit have been actioned and signed off by Interim Chief Executive

2.9 The management of risk within the Services Governance structure has been considered in the delivery of the New Operating Model Governance. The following has been agreed and is in place from December 2022 for the three IHCs, Mental Health and Learning Disability Service and Women's Services. Cancer and diagnostic services and Primary Care services are part of a phase 2 to commence from February 2023.

- Service Leadership Teams will have Risk Management item on every Service Leadership Team Agenda and in their newly developed 4 x Service Groups Agenda. **This has now been agreed and is in place from December 2022.**
- Accountability Reviews for all Service Leadership Team accountability reviews have a Risk Management agenda item. The Associate Director of Governance will triangulate the risk information from these agendas and Risk Management Group and report to HBLT at least every two months. **This has now been agreed and has been in place from October 2022.**
- All services to attend BCUHB Risk Management Group. **This is in place from October 2022.**
- Furthermore, the Associate Director triangulates the risk reports from these sources in a report for Health Board Leadership Team to consider in-between the bi-monthly Risk Management Group meetings. As a result of this work there are risks in this report that have been recently escalated using this method. These are risks

  CRR23-36 - Cost of Living Impact on Staff and Patients.
  CRR23-37 - Targeted Intervention.
  CRR23-38 - Workforce.
  CRR23-39 - Patient Flow - Impact on Access and Quality of Care.

2.10 Work is also well underway to redesign Risk and Board Assurance Framework reports for the Board and its Committees as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments. It has now been agreed that BCUHB will pilot this on behalf of all Health Boards in Wales and this has been warmly received by the Shared Service Partnership.

2.11 At the time of writing this report, a further report was being prepared to the Quality, Safeguarding and Experience Committee on the measures being taken to more effectively highlight Clinical and Safety Risks. An update on this can be provided at the Board meeting or from phil.meakin@wales.nhs.net

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the full details of individual risks in Appendix 1.

5. Equality and Diversity Implications

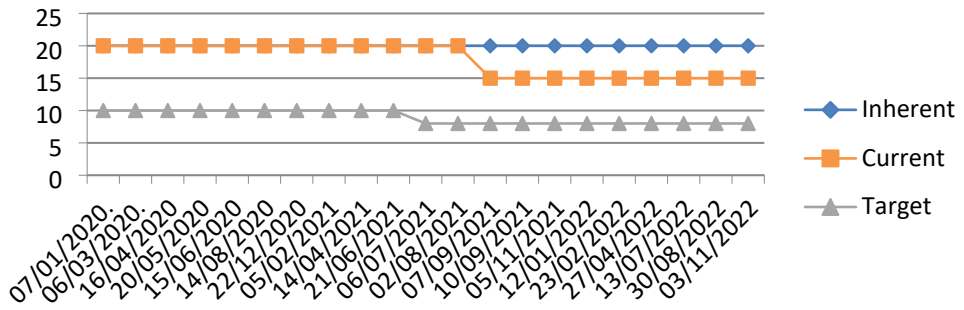
5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

5.2 Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 – Corporate Risk Register

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 November 2022
	Risk: Asbestos Management and Control	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. 2. Annual programme of re-inspection surveys undertaken. 3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available. 6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place. 8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 9. 5 year programme for the removal of high risk asbestos with monitoring at the Asbestos Group is in place with oversight at the Strategic Health and Safety Group. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. 11. Senior Estates Officer/Asbestos Management appointed and in place. Review of systems and procedures in line with the Asbestos management policy.	4. Internal Audit review undertaken against the gap analysis. 5. Self assessment completed and submitted to Welsh Government which use specialist services to review the returns for consistence and compliance.

Gaps in Controls/mitigations
Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 82%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter four in 2022/23. Whilst it was anticipated that the target score would have been met by quarter 1, staff shortages due to COVID have been experienced which have influenced the ability to achieve the target.

Progress since last submission
1. Controls in place reviewed to reflect current position. 2. Gaps in controls reviewed to reflect current position. 3. Asbestos Management Policy has been updated and revised version going for sign off at Quality, Safety and Experience Committee on the 1st November 2022. 4. Action ID 23728 - Action closed, review completed by the Senior Estates Officer/Asbestos Management with recommendations included within the report and implemented.

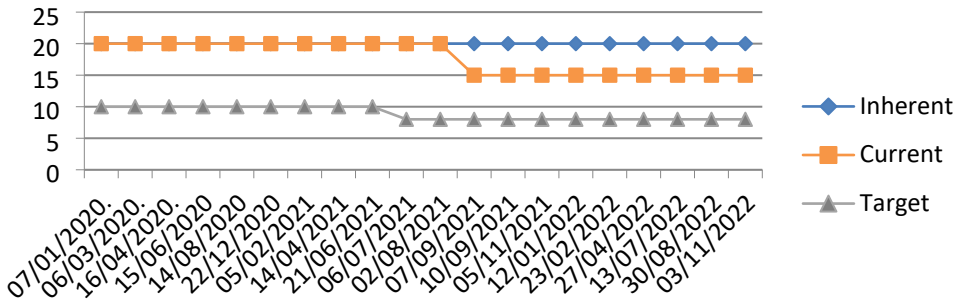
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely. This information is currently held by a third party. With the implementation of the MiCAD system, this will digitalise the information held locally by the Health Board. October 2022 progress update - Meeting held 31/10/2022 and agreed to purchase Asbestos module for MiCad, this will require investment in the MiCad management system.	On track

	23728	Implement recommendations following the review by the new Senior Estates Officer/Asbestos Management.	Hughes, Mr Arwel Hughes, Head of Operational Estates	31/03/2023	Action closed 03/11/2022 Provide assurance that the systems of controls are suitable and sufficient to meet the requirements of Asbestos Management Regulations. October 2022 progress update - Action closed, review completed by the Senior Estates Officer/Asbestos Management with recommendations included within the report and implemented.	Completed

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 November 2022
	Risk: Contractor Management and Control	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Control of Contractors Procedure in place, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 2. Induction process being delivered to new contractors, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group. 8. Approved Contractors Framework for minor works across the Health Board in place, monitored quarterly as part the Contract Performance Review.	

Gaps in Controls/mitigations
Staff resources gap due to demand versus capacity. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors. Additional to current funding has been allocated from 23/24 for additional resources.

Progress since last submission
1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been updated to include the mitigation in place. 3. Action ID 12252 – Action delayed, operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems. 4. Action ID 12256 – Action delayed, the Health Board have signed off the frameworks access agreement for the purchase of the SHE software. 5. Action ID 12257 – Action delayed, Currently a paper exercise, which present a risk of failure to follow due process within the SOP. Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP). 6. Action ID 12258 – Action delayed, operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and Health & Safety Management within Health & Safety Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to ensure compliance. November 2022 progress update - Operating model agreed, this action will need to be aligned with each IHC's	Delay

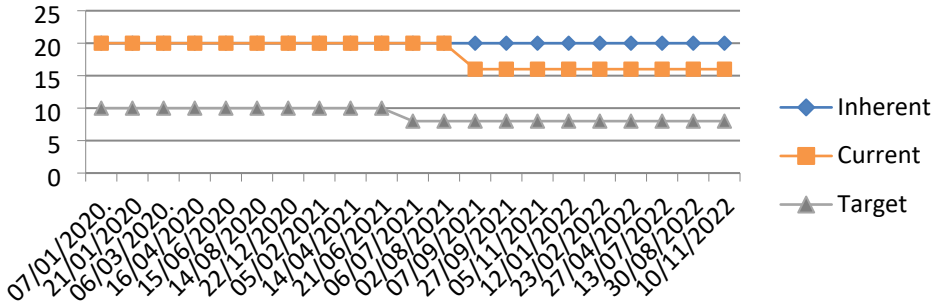
					Governance and Health and Safety Management systems.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of (SHE) - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board. November 2022 progress update - The Health Board have signed off the frameworks access agreement for the purchase of the SHE	Delay
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to	Delay

					ensure compliance with the Health Board Contractor Management Processes. November 2022 progress - Currently a paper exercise, which present a risk of failure to follow due process within the SOP. Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP).	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g.	Delay

					Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. November 2022 progress update - Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.	

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 November 2022
	Risk: Legionella Management and Control.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group, which is reported to Infection Prevention Sub-Group and Quality and Safety Committee. 2. Risk assessment undertaken by clear water, with action and issues reported to the water Safety Group. 3. High risk engineering work completed in line with Clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group. 4. Quality, Safety and Patient Experience Committee.

6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team. 8. Water Safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken. 10. Alterations to water systems are now signed off by responsible person for water safety. 11. Local Infection Prevention Groups in place with oversight of water safety.	

Gaps in Controls/mitigations
1. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case has been approved as part of the IMTP with funding agreed recurrently from April 2023, which will provide supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

Progress since last submission
1. Controls in place review to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Revised Water safety policy has been approved by the Water Safety Group and Infection Prevention Sub Group and will be submitted to the Quality, Safety and Experience Committee in November 2022. 4. As part of the appointment of the authorising engineer, targeted audits are planned for each of the 3 operational areas which commences in August 2022 with completion by end of March 2023 (outcomes from these audits will be considered for areas of improvement and mitigation should they be required). 5. As a result of concerns raised during the transition of data from the existing software model to a new model a targeted intervention with the appointed water safety contractor was required. This work is ongoing with additional resources allocated to the contract to address the issues identified, this has caused a delay, and will be recovered by 31/12/2022.

6. Standard Operating Procedure for management of little used outlets developed and approved by the water safety group and Infection Prevention Sub-Group. SOP to be presented to Strategic Occupational Health and Safety Group for approval to publish on Betsinet.
7. Action ID 12262 – Action closed as simplistic schematics of water systems are provided as part of the water safety risk assessments.
8. Action ID 12267 – Action delayed, awareness training is included within the Infection Prevention mandatory training module.
9. Action ID 19015 – Action delayed, the business case has been approved and looking at appointing to the roles.

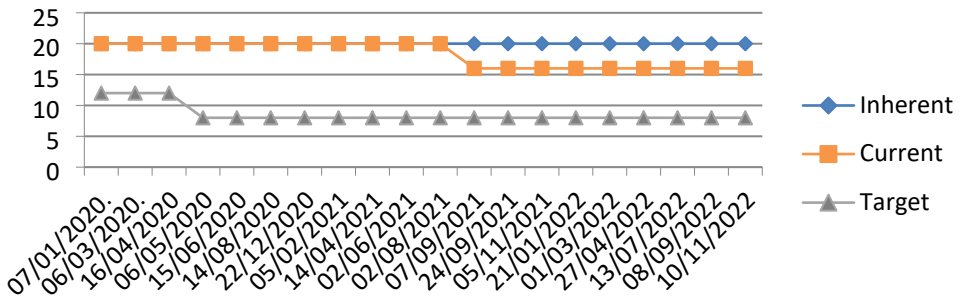
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Action closed 10/11/2022 MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which	Completed

					has been approved by the Health Board in January 2021. November 2022 progress update - Action closed, simplistic schematics of water systems are provided as part of the water safety risk assessments.	
	12267	Awareness and training programme in place to ensure all staff aware as part of Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board. November 2022 progress update - Awareness training is included within the Infection Prevention mandatory training module.	Delay
	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on water safety and provide assurance of compliance to the water safety group. November 2022 progress	Delay

					update - Business case has been approved and looking at appointing to the roles.	
	24081	Audit response following the Shared Services Authorised Engineer for Water Audit	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Address any shortfalls identified as a result of the audit which will be required to be implemented. November 2022 progress update - Audit for the Central Region currently underway.	On track

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 November 2022
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2025
There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Fire Safety Policy established and implemented, annual report reported to Board and supported by Welsh Government. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Annual Compliance returns submitted to Welsh Government.

6. Escape routes identified and evacuation drills undertaken, established and implemented. 7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff. 8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens. 9. Appointed Authorising Engineer for fire safety in place through NHS shared services (specialist estates services).	

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments. 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals. Ysbyty Gwynedd - Programme BC submitted to WG currently in discussion to secure capital for professional fees to develop a priority list of fire safety measures in advance of the site wide re-development. Wrexham Maelor Hospital - £54m requested to the site which includes fire safety for active and passive fire safety measures.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Request for additional funding (£2.93m over a two year programme) through the All Wales EFAB (Estates Funding Advisory Board) route, this request is for upgrades to fire compartmentation and fire alarm systems for premises identified through fire safety risk assessments.

4. Corporate Health and Safety audit undertaken and a number of recommendations made which are being acted upon over the forthcoming months.
5. Action ID 12276 - Action delayed due to awaiting the All Wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Meeting to be arranged with Corporate Health and Safety to ensure interim measures are in place.
6. Action ID 15036 - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023.
7. Identification of new action ID 24397 to implement the recommendations following the Corporate Health and Safety audit.

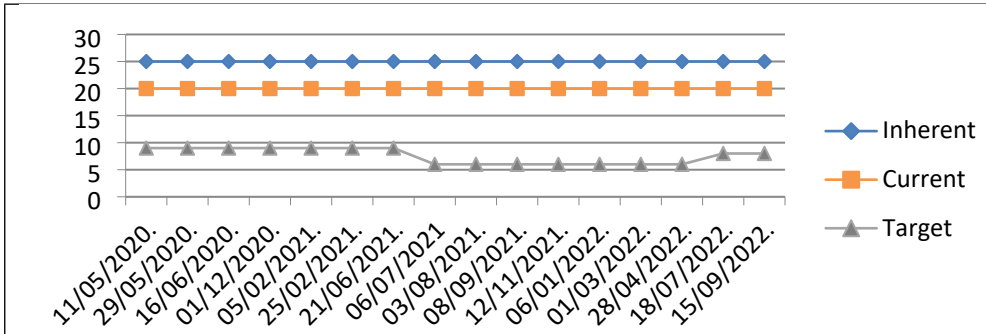
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. November 2022 progress update - Action delayed due to awaiting the All Wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Meeting to be arranged with Corporate Health and Safety to ensure interim measures are in place.	Delay
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order. November 2022 progress update - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023.	Delay
	24142	Develop a Management structure to ensure adequate capacity to deliver Fire Safety	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Ensure compliance with Fire Safety Legislation. Business case to be developed to	On track

		requirements within the Health Board.			secure funding to align with the new Fire Management structure.	
	24397	Implement recommendations following the Corporate Health and Safety audit	Mr Rod Taylor, Director of Estates & Facilities	31/12/2022	Ensure recommendations from the Corporate Health and Safety audit are implemented which will strengthen current policies and procedures.	On track

CRR20-05 – Proposed changes to be made to this Risk (see below)

CRR20-05	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15th September 2022
	Risk: Timely access to care homes	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 September 2022
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Multi-Agency Oversight Group and Care Provider Operational Group continue to meet to oversee the ongoing Covid response, to support recovery and ensure sustainability of the sector to respond to care home and domiciliary care demand with clear pathways for escalation in place.	1. Oversight via the Care Home Operational Group which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW).

2. North Wales care homes single action plan provides the framework for the Multi-Agency response and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). 3. Development of the Quality Assurance Framework - this work is overseen by a Multi-Agency Implementation Group with sign up from the 6 Local Authorities and the RPB. The work is supported by 6 work streams which picks up the ongoing work around Covid and recovery. This work is progressing well and risks are well managed and is now embedded into core work. 4. Continuing Health Care Operations Group in place to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees is also in place.	2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board.

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report has now been published in draft (subject to ratification by the Health Board and 6 Local Authorities by October 2022). Urgent demand and capacity work has commenced as part of the requirement to commission an additional community care placements by October 2022 (243 placements for North Wales). 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge, but insufficient domiciliary care provision to step down to. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report and as part of the additional community care placements. 3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. Work ongoing with IT and Performance to develop digital system which is currently being piloted. This will provide a more robust system of data collection, including delays by Local Authority. 4. No signed Pre Placement Agreement (PPA) - lack of controls in place for addressing concerns, monitoring quality - there is only informal voluntary co-operation. This gap in control is shared with the 6 Local Authorities. There is a joint PPA working group in place but failure to 'sign off' continues. Regional Commissioning Board has sought legal advice. The final draft PPA is currently with the LA commissioning teams, prior to being issued to independent providers in October. 5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards, but due to increasing economic pressures this is already being challenged as insufficient by providers. .

6. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation

Progress since last submission
1. Due to the gaps in controls, and the current demands on patient flow, agreement for a review of this risk with the intention of splitting into two. One in relation to contracting and finance, and the second in relation to quality and assurance (including MFFD). This is still in progress. 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls updated to reflect that there is a work programme in place to review the discharge policy which will include a task and finish group to address the gaps in medically fit for discharge with a report providing a standardised approach for North Wales. In addition work progressing with IT looking at a national data set. 4. Assurances updated to reflect current risk position. 5. The Health and Social Care transition plan was updated on 18th July 2022, the extension to the Target risk due date will to allow time to interpret and implement the next stages required. 6. Pre-Placement Agreement is in the final stages by the 6 Local Authorities and Care Forum Wales and will be sent out to providers for signing in September. Consideration is being given to the implications of any provider refusing to sign the PPA with the aim of having a joint response plan for the 6 LAs and Health Board. 7. In response to recommendation 2 and 4 of the Welsh Audit Office report on Commissioning Older Person's Care, a workshop is being arranged for September. *Recommendation. 2 - The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.* *Recommendation 4 – North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and following this, develop an associated delivery plan.*

8. Action ID 18025 – the action remains delayed and is linked to action ID 20074. This was escalated to the Regional Workforce Board in July with the recommendation of appointing some dedicated support.
9. Action ID 20074 - Action closed as it is not considered deliverable. Point 6 above provides mitigation.
10. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk.
11. Significant progress has been made by the HB and partners in identifying 243 additional care placements (Gaps/ Controls). Capacity will be phased in from end of September. The schemes identified to achieve the additional capacity is being co-ordinated at Integrated Health Economy level, with the respective LAs, and will be subject to an assessment of deliverability (particularly focused on workforce availability). We will you now continue to work with social care, colleagues, colleagues in BCU and particularly work force, to ensure that there is no / minimal negative impact / destabilisation on other aspects of the Health and Social Care system. Reporting requirements and baselines are yet to be agreed.

Links to	
Strategic Priorities	**Principal Risks**
Primary and community care	BAF21-03

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/04/2022	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge. September 2022 progress update - Action delayed. This was escalated to the Regional Workforce Board In July with the recommendation of appointing some dedicated support.	Delay

	20074	Development of an interim relief bank for health and social care	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/01/2022	Allow flexibility in relation to staffing within homes. Action closed as it is not considered deliverable. Pre-Placement Agreement is in the final stages by the 6 Local Authorities and Care Forum Wales and will be sent out to providers for signing in September. Consideration is being given to the implications of any provider refusing to sign the PPA with the aim of having a joint response plan for the 6 LAs and Health Board.	Completed
	22182	Review and update Health Board Discharge policy.	Ms Jane Trowman, Care Home Programme Lead	30/09/2022	Discharge policy reviewed, updated and will support the assessment around medically fit for discharge patients.	On track

CRR20-05 - Proposed Changes (CRR20-05 to be split into 2 separate risks) – 1.

	Director Lead: Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding**.**	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 November 2023
There is a risk that the current systems for commissioning placements with the independent sector has limited assurance in relation to delivering the right care, is improving outcomes and is providing value for money. This is caused by insufficient resource and expertise within the CHC and contracting teams and the Wales Audit recommendation to establish a Business Support Hub This may lead to people not receiving the correct package of care which may lead to harm, or that the Health Board is funding packages of care which people are not eligible for, it may also lead to delays in discharge/patient flow.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Continuing Health Care Operations Group - to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees is also in place. 2. Regional Commissioning Board (RCB) – joint chaired by Health & LAs and is responsible for delivery of the Wales Audit Management Plan for Commissioning Older Persons placements. 3. Fees Sub Group – reviewing current fees across health & Local Authorities. Fees methodology agreed for 2023 / 2024 (Sub-group of the RCB) in principle. Fees for this year do not have sufficient controls. 4. Senior Management Team – Care Providers. Membership and Terms of Reference under review to ensure fit for purpose 5. Contract Monitoring reporting for care home providers quarterly reported to PFIG and noted in the CHC Operational Group 6. Market Stability & Population Needs Assessment group with LAs to address commissioning strategies 7. BroadCare patient information system in place allowing for consistent monitoring of placements including numbers and finance 8. Establishment of the CHC Improvement Group – October 2022 (is also a gap as resources needed to deliver)	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. Welsh Audit Management Action Plans

Gaps in Controls/mitigations
1. No signed Pre Placement Agreement (PPA) - current gap in contracted services with a risk of providers choosing not to sign a new PPA when it is approved for release: Individual CHC commissioners and wider teams continue to support an approach of as if inferred contract basis until the new PPA can be released early in 2023. Webinars are being arranged to provide information prior to release. 2. Financial overspend of £1.6m at month 5: Commissioned providers are experiencing high costs of care, which they continue to pass to commissioners on a case by case basis outside of regional fee agreements. Regional LA fees have been uplifted mid

year which has eroded the CHC enhancement we have always paid. Clarity on the HBs position and the potential financial impact to the HB will be covered in an Fees option to go to Executive team 23/11/2022
3. The regional fees group have agreed a single recommendation to section 151 LA officers for 2023 / 24, however the picture is complicated and this is unlikely to result in a single fee in reality, rather a single methodology where variations are described. This will be managed by representation from HB CHC and Contracts on the fees group.
4. Delivering the Older People's Care Home Placements Audit Wales recommendation two - reviewing arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by RCB
5. Delivering the Older People's Care Home Placements Audit Wales recommendation four - to develop a regionally agreed care home commissioning strategy and associated delivery plan. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by the RCB.
6. CHC Audit Wales recommendation 3 – CHC Team Structure (reasonable assurance). How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
7. CHC Audit Wales recommendation 5 – CHC Contracting and establishment of the Business Support Hub (no assurance) – There is no formal structure or governance arrangements in place for the BSH. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
8. No procurement, contractual and business support structures in the HB in addition to those to be supported by the proposed CHC Business hub for the required Direct Payments in CHC required by WG. – Linked to Recommendation 5 of Audit Wales.
9. CHC Audit Office Recommendation 2 –CHC Framework Training & Education, need to undertake Training Needs analysis for the organisation. CHC training attendance is challenging due to operational staffing issues. Currently exploring feedback of wider teams regarding recorded sessions with IT. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
10. CHC Audit Wales recommendation 1 - Weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of CHC. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
11. BroadCare - Finance teams are working to develop more efficient back office functions with BC functions to remove unnecessary manual processes.
12. Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & Safety Corporate Risk)
13. CHC improvement Group established October 2022 – this work will not progress without dedicated support. Currently trying to release funding from this year's IMPT to support critical elements of this work.

Progress since last submission
This risk was formally part of CRR20-05 which is now being split into 2 separate risks, 'Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding' and 'The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow.' 1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Identification of six new actions following the revision of the risk.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score		To develop a regionally agreed care home commissioning strategy and associated delivery plan. Clearly setting out the elements of the HBs commissioning strategy to include Commissioning of specialist placement on a regional basis (low	Kath Titchen, Commissioning Manager CHC	30/06/2023	1) Establish a Task and Finish group under the Regional commissioning Board to take this work forward	

		numbers / high cost) - (Gap / control No.4,5,13)				
		Agree mechanism for agreeing Fees – In year agree HBs position 2023/ 24 agree mechanism with LAs – (Gap / control No. 2 & 3)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/01/2023	1) Regional Fees Group in place – agree set of principles for all partners 2) In year up-lifts, further paper to Execs (end Nov 2022) setting out the current position and options for implementation including financial and flow risks	
		Full implementation of the Pre-Placement Agreement (Gap / control No. 1)	Kath Titchen, Commissioning Manager CHC	31/03/2023	3) Finalize PPA 4) Set up webinars for providers prior as part of the implementation 5) Establish a mechanism for electronic signature in line with IG 6) Agree with the LAs what the escalation process is for Homes which do not sign the PPA – will we commission placements?	
		To establish a Business Support Hub for the commissioning / procurement / brokerage (Gap / control No. 7,6,8,10,11,12)	Jane Trowman, Acting Assistant Director Care Homes Support &	30/06/2023	1) Draw down funding from IMPT to commence implementation including addressing CHC, Contracting, IT support 2) Via the CHC Improvement Group agree medium and longer term way forward	

			CHC Commissioning		3) Confirm arrangements for where this sits as part of the Operating Model (Commissioning / Contracts / Finance)	
		Move from spot purchasing to commissioning / placement / block purchasing with approved providers and be able to respond strategically e.g. with clear commissioning intentions to support the outcomes of the updated population needs assessment (Gap / control No. 4, 5, 7,8,10)	Kath Titchen, Commissioning Manager CHC	30/09/2023	1) Agreed process compliant with procurement requirements. Part of the Market stabilized Service specification 2) Lessons learnt from the Block Purchasing of Additional community Capacity 3) Establish a compliant process for Block purchasing in readiness for 23/24 winter pressures	
		CHC Framework – Training Needs analysis and development of key CHC role for admin and clinical staff competencies (Gap/control No. 9)	Sian Kelbrick, Head Of CHC Performance And Compliance	30/09/2023	1) Baselining the existing training programme, linking into nationally evolving CHC training requirements and support 2) Facilitate mitigation of imperfect patient journeys from the start of their care journey with CHC. 3) Through the existing regional LA HB CHC education strategic group will ensure that the key	

					themes across the region for CHC are addressed in the lessons learnt fed back into the training programs, hot spots identified and targeted support offered and associated wider system influencing issues escalated appropriately.	

CRR20-05 - Proposed Changes (CRR20-05 to be split into 2 separate risks) – 2.

	Director Lead: Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	**Date of Committee Review:** Revised Risk
		Target Risk Date: 31 January 2024

Due to the current fagility of the independent sector there is a risk that the quality and safey of patients who need to have their care delivered by independent providers could be compromised and there is potential for harm.

This could be caused by lack of timely prevention and early intervention from across Health & Social Care due to staffing (recruitment & retention), training education.

This may lead to unnecessary admission or conveyance to hospital, long lengths of unnecessary stay in hospital, untimely discharge from hospital (Patient Flow), insufficient staff within the care placement, and staff without the appropriate training and education. Organisational reputation due to high numbers of Medically Fit for Delays and inability to respond to other system pressures (Unscheduled & Planned Care)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. North Wales care homes single action plan provides the framework and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). 2. Quality Assurance Framework Implementation Group – underpinned by evidenced based Clinical Quality Tools 3. Programme of support to care providers (Training & Education) via the Care Provider Quality Assurance Framework. 4. Senior Management Team for Independent Providers – currently reviewing membership and terms of reference to ensure fit for purpose	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. CHC Improvement Group when fully established 4. Welsh Audit Management Action Plans

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report has now been published in draft (subject to ratification by the Health Board and 6 Local Authorities by October 2022). Urgent demand and capacity work in progressed as part of the DU work on increasing community capacity to meet winter pressures (243 placements for North Wales). 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge and to avoid hospital admission but insufficient domiciliary care provision to step down to. Health Teams providing domiciliary social care due to lack of LA commissioned services. HB currently becoming registered with CIW as a domiciliary care provider. 3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. Work ongoing with IT and Performance to develop digital system which is currently

being piloted. This will provide a more robust system of data collection, including delays by Local Authority – this will link with national work on Pathways of Care Delays

4. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation to avoid further ombudsman reports of HB maladministration due to overdue reviews.

5. Overdue CHC placement annual reviews: Staffing issues, vacancies, recruitments and sick leave are affecting all areas: A breakeven at least business recovery proposal has been submitted through the IMTP, CHC Improvement group and HBLT.

6. CHC Audit Office Recommendation 3 – Consistent structure for CHC teams – not progressed as expected.

7. CHC Improvement Group Established – but insufficient resource to progress the work

8. Lack of Service Specification for care homes for nursing placements

9. Lack of Service specification for Domiciliary Complex care

10. Lack of Support to residential homes to prevent escalation in care needs in a timely way

11. Lack of Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & contracting risk)

12. Discharge Policy is out of date, WG currently revising Policy – including Reluctant Discharge Policy. Need to ensure consistent application of the policy and clear escalation pathways to support discharge

13. Impact on CHC teams to deliver services traditionally outside of CHC including LPS (Risk CRR21 -14) implementation, management and control of additional processes in reviews for circa 1500 complex patients annually. Implementation of interim arrangements and new emerging arrangements for Direct Payments, management of pathways outside of CHC/FNC/ and joint funded care for e.g. d2ra/ s2ra pathway.

14. Lack of and assurance framework with the independent sector to evidence that the care commissioned is being delivered and demonstrate how this is improving outcomes.

Progress since last submission
This risk was formally part of CRR20-06 which is now being split into 2 separate risks. 1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Identification of five new actions following the revision of the risk. 4. Action ID 22182 – Action transferred over from CRR20-05, action remains delayed due to the National review of the discharge policy. Draft is due to be issued November 2022, and full national launch in Jan 2023. 5. Action ID 18025 – Action transferred over from CRR20-05, action remains delayed with the Regional workforce board on the 14 November 2022. 6. Action ID 20074 – Action transferred over from CRR20-05, action closed. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the Health Board bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for Health Board, Local Authority and the provider at each level of escalation.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score		Programme of support to Residential Homes (Gap Control 1)	Marianne Walmsley, Head Of Quality For Care Homes	31/03/2023	1) Quality Assurance framework includes residential home developments 2) Clinical quality Support tools developed and being promoted to all local Authorities with some implementing across residential homes 3) All Corporate Care quality team training webinars made available to residential home staff 4) Funding sourced for residential care staff to attend local training courses in Llandrillo college 5) Monthly Provider brief to update on key issues, developments and training 6) Draft service specification for care providers	On track
		Additional resource to address Backlog of	Kath Titchen, Commissioning Manager CHC	31/01/2024	1) Options appraisal paper to HBLT to agree	On track

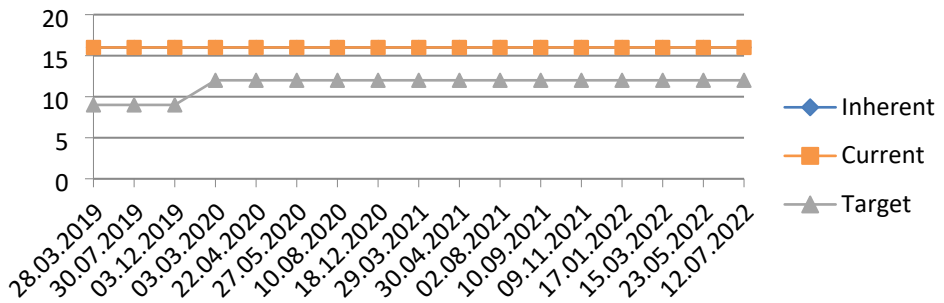
		reviews (Gap/control no.5)			preferred way of addressing the backlog 2) Establish Implement programme to address back log- prioritising on high risk quality categories 3) Identify quarterly trajectory	
		Airedale Programme to support Care homes including a focus on post discharge support (Gap/control No. 12)	Marianne Walmsley, Head Of Quality For Care Homes	31/12/2023	1) Funding identified from WG to pilot the project 2) Work commenced on identifying key homes with a high rate of WAST calls 3) Project group to oversee the pilot	On track
		Increasing Community Placements – Winter Pressures, including improving access to Domiciliary Care (Gap/control no. 1, 8)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2023	1) Fortnightly meetings with DU and LAs 2) Delivery plan with monthly trajectories 3) Develop service specification for block purchasing beds in care homes to support flow 4) Develop pipeline schemes to further support winter pressures 5) Identify what works well and scale across North Wales	On track

	22182	Review and update Health Board Discharge policy. (Gap/control No. 12)	Ms Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/3/2022	This has been delayed due to the National review of the discharge policy. Draft is due to be issued November 2022, and full national launch in Jan 2023. Reminders to the operational teams have been issued to ensure they are working to the current policy including issuing of patient leaflets re: discharge and they have no right to remain in hospital when medically optimised for discharge Develop Standard Operating Procedure for the Health Board.	Delay
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers (Gap/control No. 4).	Mrs Marianne Walmsley, Head Of Quality For Care Homes	30/04/2022	Regional workforce board 14/11/2022.	Delay
	20074	Develop and Interim Bank for (Gap / Control No. 4)	Mrs Marianne Walmsley, Head Of Quality For Care Homes	31/01/2022	Action closed November 2022 It has been agreed with partners that due to the current work force pressures across all sectors it is highly	Completed

					unlikely that the Health Board bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for Health Board, Local Authority and the provider at each level of escalation.	
		Implement the Audit Wales Management Action Plan for BCU – Currently limited assurance (Gap /Control No. 6)	Ms. Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/07/2023	1) Management Action Plan to be submitted to Audit by 28th November 2022. 2) Implement Actions (TBC)	On track

CRR20-06 – Proposed changes to this risk (links into CRR22-32 and CRR23-33)

CRR20-06	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 28 March 2019
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 12 July 2022
	Risk: Informatics - Patient Records pan BCUHB	**Date of Committee Review:** 12 July 2022
		Target Risk Date: 30 September 2024
There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Informatics Strategy in place, with regular reporting to, Partnership, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group. 3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance

4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established, monitoring compliance with the legislation, monitoring compliance with legislation and supporting the rectification of commingling within patients clinical notes. 6. Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the Infected Blood Inquiry. 7. Medical Examiners Service (MES) support teams established on each site to respond to the new requirements for providing scanned patient records to the MES in line with their standard operating procedures.	and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Delayed implementation and recruitment, to be able to digitalise all specialties within 4 years. Improved relationship with supplier and recruitment to take place with a phased approach for digital implementation. 2. Fit for purpose on site estate to hold physical records with the lack of current plans to scan records. The estate to hold physical records requires upkeep, current off site storage in place. 3. Lack of attendance at the Patient Records Group. Not all records custodians in attendance, monitoring and contacting leads within areas to implement change. 4. Lack of central oversight of records sent out by other departments. Urgent meeting to support standardisation and consistency of processes. Reporting of compliance to Patient Records Group to be implemented. 5. Compliance check for information sent out not robust. Band 4 staff currently quality checking information sent. 6. Local site improvement plans being developed in a silo manner without standardised approach across the Health Board. Health Records representation on improvement boards to be established.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Action ID 12429 – Action remains on hold until the Mental Health Business Case is progressed with the Welsh Government. 4. Identification of new action ID 23746 to establish a new all encompassing Patient Records Programme that pulls all streams of work under one overall governance arrangement. 5. Identification of new action ID 23747 for the identification of recruitment for a Programme Manager to bring all strands of the patient records programme together. 6. Identification of new action ID 23748 for the Acting Executive Director of Therapies and Health Sciences to become the Senior Responsible Officer for the Clinical Records Standards element and The Chief Digital and Information Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System elements. 7. Identification of new action ID 23749 to ensure that the DHR Programme is re-scoped into an Electronic Document Record Management System. 8. Identification of new action ID 23750 for the immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness, to improve integrity and quality of information in clinical records as they are now in paper form.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented	12423	Development of a local Digital Health Records system.	Aspinall, Mrs Nia, Head of Patient	30/09/2024	July 2022 progress update – An SBAR will be presented to the Executive Board during	On track

to achieve target risk score			Records and Digital Integration		August, requesting a re-scope of the project. However the early adopter work is still ongoing with both vascular and rheumatology. Full update and agreed recommendations to be provided after the Executive Board.	
	12425	Digitise the clinic letters for outpatients.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	31/12/2022	July 2022 progress update - Action remains delayed due to a delay in the start of the Medical Transcribing Electronic Discharge project, resources now in place.	On track
	12426	Digitise nursing documentation through engaging in the Welsh Nursing Care Record.	Brady, Mrs Jane, Senior Lead Nursing Informatics Specialist	30/09/2024	July 2022 progress update - Business case approved February 2022. Welsh Nursing Care Record now live across East community hospitals and all East medical and surgical wards in secondary care. This concludes the Welsh Nursing Care Record rollout in East. Planning for Central implementation has commenced with a proposed go live of mid-September 2022, starting in Ysbyty Glan Clwyd.	On track
	12429	Engage with the Estates Rationalisation	Aspinall, Mrs Nia, Head of	31/01/2023	ON HOLD until the Mental Health Business Case is	On Hold

		Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Patient Records and Digital Integration		progressed with the Welsh Government (5 case business cases) – break ground circa 2023, we will not be able to start the work to explore if the Ablett can be retained and redesigned for health records until the business cases are signed off. The date for the Mental Health Full Business Case is September 2022.	
	23746	A new all encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	A programme in place that will support the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23747	The identification or recruitment of a Programme Manager established for the overall programme and management to ensure all three elements are scoped and re-costed.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	The action will provide support in the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23748	The Acting Executive Director of Therapies and Health Science become the Senior Responsible Officer for the Clinical Records Standards element and the Chief	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	These programmes require their scopes clearly being defined so that all are clear what they aspire to deliver and how to support the reduction in the risk score and reduce the volume of incidents, complaints	On track

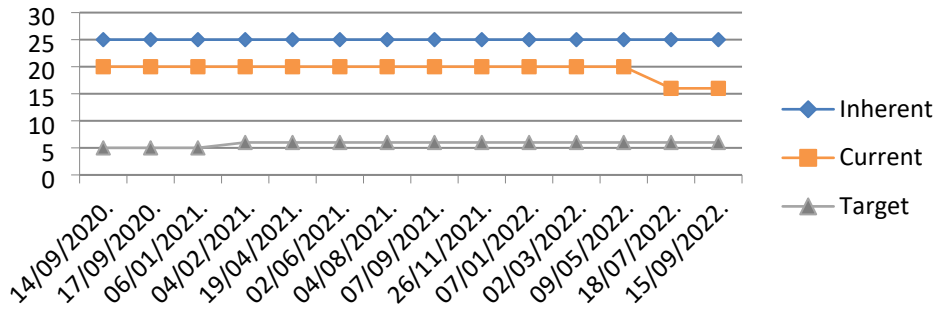
		Digital and Information Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System (EDRMS) elements.			and claims regarding inappropriate record keeping.	
	23749	The Digital Health Record Programme is re-scoped into an Electronic Document Records Management System.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	To focus on addressing the more immediate patient records management challenges facing the Health Board utilising the proven capabilities of the CITO product.	On track
	23750	Immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness and to improve integrity and quality of information in clinical records as they are now in paper form.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	Part of this work is currently underway as part of the Ysbyty Glan Clwyd improvement plan and when fully implemented will support the reduction in the risk score.	On track

CRR20-08 – Proposed changes to be made to this Risk (see below)

CRR20-08	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 September 2022
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 December 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Decreased		

Controls in place	Assurances
1. Outsourcing process and group in place to review progress against the contract.	1. Risk is regularly reviewed at local

2. Cataract outsourcing - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. 'Once for North Wales' process is in place, partially across all sites, Cataract patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access. 4. Once for North Wales/mutual aid process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed. 5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites. 6. Monthly monitoring of the application of the Cataract Priority Targeting List (PTL) to ensure Pan BCU reduction of access inequity. 7. ODTC Single Tender Waiver enabled continuation of use of Primary Care Optometry (until September 2022). 8. Clinical condition dashboard now available for beta stage is live and implemented to support documentation and site self-management of clinical condition use to manage services. 9. Pan BCU Clinical Lead now appointed.	Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators. 4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government. 5. Performance reviewed at Secondary Care Accountability Meetings.

Gaps in Controls/mitigations
1. Further table-top risk stratification is challenged by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of those at risk of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case. 2. Outsourcing of the cataract activity is in place along with additional temporary administration support, however, there is need for sustainability moving forward. 3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans. 4. National standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 2.8-3.6, differences in national standards between number of cataract procedures per list.

Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions. First session took place on the 28th February 2022. GIRFT (Get it right first time) to commence working with Ophthalmology in Autumn 2022.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. The service will look to disaggregate the risk by the clinical conditions which will enable the risks to reflect impact on patient safety/care by the clinical conditions. Risk 1 - Delay of care leading to increased potential risk of Irreversible Sight-Loss (Predominantly Glaucoma/Diabetic Retinopathy/AMD). Risk 2 - Delay of care leading to increased potential risk of reversible Sight-Loss/risk of social isolation/falls/poor quality of life (Predominantly Cataract). The service are to meet with the Senior Management Team for Eye Care to discuss the risks and further develop. It is anticipated that the revised risks will be submitted to the next Risk Management Group meeting in December 2022.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	20392	Following approval of the internal eye care business case, recruitment to support additional Intra Vitreal Therapy capacity is ongoing as well as the digital programme.	Alyson Constantine, Site Acute Care Director	31/12/2021	Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation. August 2022 progress update - Partial recruitment mitigation, all sites recruited to all but Consultant posts. Consultant recruitment potential to be maximised through amalgamating vacancies to progress a Pan BCU post. Breakdown of current vacancies is being shared with pan BCU clinical lead who is exploring the potential of pan BCU posts with colleagues.	Delay

CRR20-08 – Proposed changes – AMD (Risk to be managed at Tier 1 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Age related Macular Degeneration: Intra Vitreal Injection Service (AMD)	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2023
There is a risk that delayed access to timely AMD** care Pan BCU will lead to irreversible sight-loss for “New” and “Follow up” patients across North Wales. Inequities in timely access to care has been identified as a risk. Sustainability/core delivery challenges with staffing resource and training shortfall in all 3 sites. Leading to variance in access of timely treatment. Nov 2022 census: 257 patients overdue target wait (East 5/Central 229/West 23) Data Challenges (see separate Datix Data Quality Risk) have impacted on Data availability for performance modelling and Once for Wales’s equity assurance. Estates challenges in West (lack of “clean’’ room facilities) entail use of Theatre for IVT—entailing loss of Theatre capacity		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

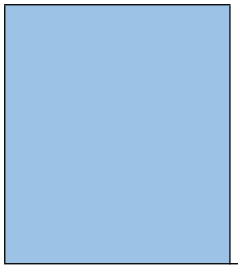
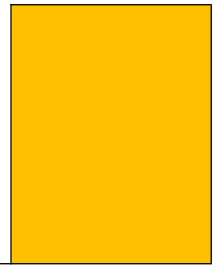
Controls in place	Assurances
1. Continuous monitoring of North wales AMD waiting list, to ensure equity through delivery of mutual aid and/or additional clinics (as required) 2. Dashboard to inform “live” (weekly refresh) waiting time position by site and pan BCU to inform continuous monitoring for equity assurance.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
1. Partial recruitment to funded posts, with East 0.5 WTE Consultant post and Central Nursing Band 3 0.3WTE outstanding. Clinical Lead/Sites exploring amalgamation of Consultant vacancies Pan-BCU with to achieve 1.0 WTE post with greater feasibility of recruitment.

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Transformation bid-secured staffing trained to enable competencies sign-off (Q2, 2022) 2. All non-Consultant Transformation funded posts recruited to, with exception of Band 3 HCSW (Central). West Locum mitigation/12 month Consultant recruitment recruited. Partial additional activity commenced April 22 (Full Achievement dependent on recruitment of Consultant 0.5wte vacancy and 0.3wte Band 3) 3. The identification of 2 open actions.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	TBC	Continuous modelling of AMD waiting time BCU to inform additional Super-Saturday and Twilight Clinic requirements and Pan BCU Mutual Aid.	Operational Managers: Mandy Thomas, (East)/ Paula Betts, (Central)/ Alison Davies (West)	30/06/2021	Action Closed -Ensure equity of access across North Wales.	Completed
	TBC	Establish funding to train additional (1 per site minimum) non-medic to provide a more sustainable workforce (2022)	Jackie Forsythe, Network Manager/Eoin Guerin, Clinical Lead	30/06/2021	Action Closed -Increase service sustainability -Reduce waiting times	Completed
	TBC	Establish funding/recruit additional Nursing/Consultant/Administration Staffing to deliver 2 Lane IVT National Pathway	Jackie Forsythe, Network Manager/Eoin Guerin, Clinical Lead	30/06/2021	-Increase service sustainability -Reduce waiting times	Delay
	TBC	Longer-term: Explore potential of Regional Treatment Centre (RTC) potential to provide additional IVT Estates.	Jackie Forsythe, Network Manager/Roger Haslett, Clinical Lead	31/03/2023	-Provide estates to ensure 2-lane pathway, pathway delivery for patients Pan North Wales	On track

					-Redress of West IVT “Clean Room” capacity gap -Redress West Theatre capacity- loss to providing estate for IVT	

CRR20-08 – Proposed changes Cataract (Risk to be managed at Tier 2 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Cataract: Sustainability challenges and delay in equitable and timely access: causing reversible sight-loss	**Date of Committee Review:** Revised Risk
		Target Risk Date: 01 April 2024
There is a risk that (red Risk rated) Cataract patients will experience reversible sight loss. This is due to Pre-Covid demand-capacity gaps, increasing waiting times arising from a combination of:- delayed implementation of High Volume Low Complexity (HVLC) pathways, non-maximised theatre utilisation, staffing/skill-mix capacity gaps, estates that do not support effective pathway delivery, inequity of access across North Wales and Welsh 50% increase in waiting list backlog from Covid-19 mitigation. Red risk-rated Cataract Patients with delayed care are at risk of; social isolation, reduced quality of life, compromised employment and increased falls risk. In addition, organisational reputation from complaints erodes organisational reputation.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	3	4	12
	Current Risk Rating	3	4	12
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in – Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Increased Theatre utilisation plan for Complex patients. 2. Outsourcing mobilised and group in place to review progress against the contract. 3. Cataract outsourcing - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. 4. 'Once for North Wales' process is in place, partially across all sites, Stage 1 Cataract patients may be shared across all three units in North Wales to ensure equity of access. (Do not have discrepancy wait exceeding 4 weeks across sites) 5. Once for North Wales/mutual aid process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed.	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators. 5. Performance reviewed at Secondary Care Accountability Meetings. (Performance Information Governance and Finance Group)

Gaps in Controls/mitigations
1. Mutual aid for patients with a discrepancy wait of >4 weeks in comparison to waiters on other sites has not commenced. Mitigating process is in development (Target Q4, 2022) 2. Complex theatre utilisation increase (BCU-based surgery) to ≥4 patients per theatre session (September 2022 target) delayed due to nursing capacity challenges. Matron review to identify solutions to commence November 2022 (Matron recruitment 1.11.22)

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Complex patient theatre utilisation roll-out Go Live commenced September 2022 on two sites (East and West). 2. Outsourcing capacity has increased from 400 to 600 monthly slots per month (including Stage 1 and Stage 4 provision) 3. Increased theatre utility (BCU-based surgery) to ≥4 patients per theatre session (East and West) from September 2022 4. Dashboard (patient level) disaggregated to cataract /weeks waited/risk level has significantly redressed “postcode” inequity of waiting times and assured care offered to longest-waiting patients with greatest risk and/or at risk of breaching Ministerial targets. 5. Identification of 3 open actions.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	TBC	Develop Pan BCU Referral Refinement Pathway (Integrated with Primary and Secondary Care)	Operational Leads Mandy Thomas and Sarah Hughes (East)/ Alison Davies and Karen Evans (West)/Paula Betts and Andrew Collier (Central)	March 2019	Action closed March 2019 -Delivers risk stratification within 48 hours of referral. -Ensures patients with greatest risk provided with target date that reflects risk and quality of life impact to prioritise timely access to care for those with greatest risk of reversible sight loss	Completed
	TBC	Establish Dashboard (patient level) disaggregated to clinical condition/weeks waited/Risk level: with	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	June 2022	Action closed June 2022 -Assures patients with greatest need offered equitable, timely access to care (outsourced and within BCU)	Completed

		Pan BCU and by health community level			-Timely identification of cohort for HVLC and/or Outsourcing Pathway streaming: reducing prior clinician capacity-demand to deliver case-note review	
	TBC	Outsource 400 routine Stage 1 and/or Stage 4 (Local Anaesthesia Cataract patients/month): rising to 600/month September 22	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	31/03/2023	Redresses delayed care and waiting list backlog for Routine Cataract patients. On target for Stage 1 & 4 Ministerial target of zero >104 week breaches by close of March 2023	On track
	TBC	Increase theatre utility (BCU-based surgery) to ≥4 patients per theatre session from September 2022	Roger Haslett Clinical Lead	31/03/2023	Redresses delayed care and waiting list backlog for Complex Cataract patients. On target for Stage 1 & 4 Ministerial target of zero >104 week breaches by close of March 2023 Action on track for East and West Regions, anticipated delay for Central Region.	On track
	TBC	Deliver longer-term Cataract service sustainability through developing Regional	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	31/03/2027	Provides the estates and staffing resources to enable High Volume, Low Complexity Day	On track

		Treatment Centres in North Wales.			Case: essential for more sustainable Cataract services	

CRR20-08 – Proposed changes – Data Quality (Risk to be managed at Tier 2 level)

Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
Risk: Risk of Sight-Loss from Delayed Care as a consequence of Data Quality & Completeness gaps (All Patients)	**Date of Committee Review:** Revised Risk
	Target Risk Date: 31 March 2023
There is a risk that Data Quality challenges are negatively impacting upon assuring equitable and timely delivery of care to patients where delayed care can potentially lead to irreversible sight-loss. This is caused by a combination of: null data entry of "clinical condition" sub-speciality and/or codes used interchangeably for diverse clinical conditions across North Wales. West performance approaching "tolerance" until April 22 WPAS migration: requiring re-entry of Clinical Condition. Data quality is negatively impacting on demand & capacity modelling, planning, monitoring, equitable access assurance, transformation trajectory setting and identifying patients suitable for nurse-led and/or Integrated Pathways. (Nov 2022 Census: 6697 patients with "null" entry for clinical condition)	

		Impact	Likelihood	Score
To be populated following approval	Inherent Risk Rating	3	4	12
	Current Risk Rating	3	4	12
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Dashboard to enable sites to monitor (to patient level) null entries/ "live" performance. 2. Standard operating procedure (SOP)	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

3. Monthly performance reports to inform Operational Teams	

Gaps in Controls/mitigations
1. Administration capacity gaps from vacancies and unplanned leave, in addition to increased demand from increased Integrated Pathway activity, negatively impacted on redress of “historic nulls” and “coding variance”. 2.5 WTE additional (fixed term to 2023) admin resourcing funded from “Eye Care” to increase team capacity. Operational teams exploring administration capacity gaps, to identify longer-term solutions with Eye Care Network Manager. 2. Induction/training effectiveness “learning” and/or Operational Leadership capacity reduction contributed to reoccurrence of prior input-error trends. Operational teams refreshing “whole team” compliance with SOP. 3. Target for redressing “null” entries reset: Q2, 2021/ Q2, 2022/ Q3, 2022. Additional “pump-prime” administration resourcing released to close of March 2023. 4. Delayed care/delivery of Health Risk Factor Target date (appointment set by clinician that reflects risk-level/patient specific need): potentially leading to increased risk of Irreversible Sight-Loss.

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Sites established Standard Operating Procedures and refreshed staff June 2021 2. Power bi Clinical Condition & HRF Dashboard achieved (June 2022) * Further enhancement/coding breakdown July 2022. 3. Additional “fixed term” administration support funded to March 2023, to increase team capacity. 4. Identification of 2 open actions.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	TBC	All sites to establish Standard Operating Procedures to guide WPAS inputters	Operational/Clinical Leads (Ophthalmology)	31/12/2021	-Assures standardised data (Clinical Condition and Sub-spec coding) to redress “root cause” and reduce “new null” additions.	Completed
	TBC	Clinical Condition and HRF Dashboard to be established	Clinical Lead/Operational Lead	31/03/2022	- Enables “live” weekly monitoring and patient-level “drill down” to support timely site self-management of Data Improvement and maintenance	Completed
	TBC	Sites to deliver action plans to redress backlog of historic” nulls”	Clinical Lead/Network Manager	31/12/2021 (reset target)	Identification of patients “by condition” enables streaming to appropriate pathways, including Integrated Pathways resourced by Primary Care: reducing patient waiting times and risk from delayed care	Delay
	TBC	Review Administration capacity/gap analysis	Operational Leads	31/03/2023	Ensure sustainable workforce to deliver and Data Quality and completeness	On track

CRR20-08 – Proposed changes – Diabetic Retinopathy (Risk to be managed at Tier 2 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Risk of Irreversible Sight-Loss from Delayed Care for "New" and "Follow-Up" Diabetic Retinopathy Patients	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2024

There is a risk that equitable access to timely Diabetic Retinopathy** care will lead to irreversible sight-loss for patients across North Wales. This is caused by sustainability challenges arising from a combination of: delayed delivery of National Digital (E-referral and electronic patient record) essential for effective Integrated delivery, staffing capacity gaps, West estate resource challenges, non-medic skills shortfall for enhanced role achievement, Ophthalmologist capacity shortfall delaying "non-medic" competency sign-off and variance in clinician appetite to progress integrated (primary Optometrist & secondary care) pathways to release capacity and reduce waiting times.

**All Retinopathy patients are R1 (at risk of irreversible sight-loss from delayed care.) Currently patients on waiting list Pan BCU: with 1,533 breaching National KPI ≤25% over target wait. (Breakdown: East zero. Central 610, West 923.*)

*Caveat: Data Challenges impact on "live" quantification/assurance of waiting list "by condition" numbers (See Datix Data Quality Risk)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	3	12
	Current Risk Rating	4	3	12
	Target Risk Score	4	2	8
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Efficient flow of Diabetic Retinopathy patients to Integrated pathways delivered by contracted Primary Optometry Diagnostic & Treatment Centres (P-ODTCs) B. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in Diabetic retinopathy monitoring 1. Nurse, Orthoptist and Optometrist skills developed through courses, placements and Ophthalmologist competency oversight: to deliver skilled workforce working to top of competence. This workforce to release Medic and/or senior nurse capacity. C. Once for Wales Secure record sharing (National Openeyes Digital System) 1. BCU plan for implementing National Digital System: to enable effective information sharing for Integrated pathways delivery. System is key determinant for expanding Integrated Pathways whilst mitigating capacity demand on hospital administration.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Central IHC paused flow of a combined total of 480 Diabetic/Glaucoma patients to Primary Care ODTCs from September 21, due to Administration vacancy/unplanned leave impacts. 2. Historic capacity gap in hospital placement provision and Ophthalmologist mentors for Higher qualification and competency “sign-off capacity” has negatively impacted on delivery of “enhanced-skill” Nursing and Optometrist workforce. 3. Primary Care OTDC capacity (West and East) reduced by circa 25%, due to unplanned leave. Partial mitigation achieved through “recovery” trajectory. National Contractual Reform to commence 2022/2023: which would expand Primary Care “workforce”. Workforce predicted Nationally to offer >30% follow up capacity for Diabetic Retinopathy Follow ups. In interim, current P-ODTC contract revisited to offer “wider” cohort of contractors delivering current trajectory, to provide improved contingencies and patient access (Q4, 2022)

B. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring

1. North Wales region is a national outlier in terms of Primary-care non-medic workforce: in terms of staffing numbers and Higher level qualifications.
2. There is a Nursing enhanced role shortfall, with Ophthalmologist capacity shortfall/vacancies delaying “non-medic” competency sign-off

Currently all sites offering Primary Care placements, within capacity. Capacity to support placement challenged by vacancies of senior clinician roles (Consultant 1.5WTE/Registrar 2.0WTE and Band 7 Nursing). BCU currently exploring with Welsh Government proposal to establish a Train & Treat Centre in North Wales. This would offer two years funding (Welsh Government) and additional treatment for a minimum of 1000 glaucoma, 800 AMD and 2000 acute patients per year. (On basis of full-capacity of 12 Independent Prescribing, 6 Higher glaucoma and 6 Medical Retina Higher Qualification placements)

D. Once for Wales Digital “Secure Folder/file Sharing

1. National programme delayed by circa 9 months, with consequence of significant increase on administration capacity, due to increased scanning/secure sharing of information with Primary Care contractors to mitigate delayed digital enabler. Interim digital solutions explored with Informatics. Diabetic Retinopathy Referral refinement pathway cannot commence until system implemented: delaying achievement of 30%-50% “false positive” Retinopathy referrals waste reduction (Specific to referrals from Diabetic Eye Screening Wales.)

E. Workforce Review to assure a sustainable, prudent workforce

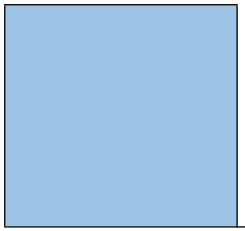
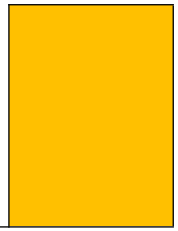
1. A full service review with supporting 5 year workforce plan was recommended in 2019, within 2019 Transformation Business case that concluded *“workforce is historical and not based on population demand”*. 2021 Wales Audit report called for development of a “*single medium-term workforce plan for eye care services (acute and NHS funded community services) that links to the future intended models of care”*: with BCU Audit recording Workforce as Leading delivery. This will be raised as a priority to develop within Ophthalmology and Planned Care strategic meetings in Q3, 2022. A determining factor to delivery is confirmation of Contractual Reform Pathways (circaQ1, 2023)

Progress since last submission
Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Central IHC paused flow of a combined total of 480 Diabetic/Glaucoma patients redressed. Flow recommenced September 22. Once for Wales Digital "Secure Folder/file Sharing 1. "Go Live Testing of internal systems Interim digital solution to mitigate Delayed National programme successfully tested/governance assured. Test of Change completed, with implementation on track for Q3 implementation for feasible pathways This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. The Identification of 5 open risks.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	TBC	Deliver Interim Digital systems prior to National System "Go Live"	Dewi Edwards, BCU Regional Architect	31/12/2022	Partially reduce avoidable capacity loss, negatively impacting on administration teams and consistent delivery of Primary ODTC pathways (Currently unfeasible for "referral refinement" pathways)	On track

	TBC	Review and assure consistent flow of patients to P-OCTCs	Paula Betts, Lead Manager - Surgical (Central)	31/12/2022	-Assure maximum utilisation of contracted capacity -Reduce Diabetic Retinopathy patient waiting times -Redress (central) patient inequitable access to Care Closer to Home	On Track
	TBC	Explore delivery of Welsh Government funded Train and Treat Centre in North Wales	Richard Price, Optometry Advisor/Jackie Forsythe, Eye Care Network Manager/Roger Haslett, Clinical Lead	31/03/2023	- Redress historic capacity gap in hospital placement provision -Reduce competency-oversight demand on Senior Nurse/Ophthalmologist's -Increase "pool/cohort" of Non-medics with Higher qualifications/competencies to enable extension of "Integrated Workforce"	On track
	TBC	Development of a "single medium-term workforce plan for eye care services (acute and NHS funded community services)	Nikki Ffoulkes, Planned Care/Roger Haslett, Clinical Lead/Richard Price, Optometry Advisor	30/06/2023	- Identify skill mix and capacity requirement of workforce to provide sustainable delivery of intended models of care	On track
	TBC	Complete Non-Medic Training Needs Analysis	Richard Price, Optometry Advisor/ Mannon Jones Ophthalmology Sister (West)/	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased "pool/cohort" of Non-medics with Higher qualifications/competencies to	On track

			Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central		enable extension of “Integrated Workforce”	

CRR20-08 – Proposed changes – Glaucoma (Risk to be managed at Tier 1 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Risk of Irreversible Sight-Loss from Delayed Care for "New" and "Follow-Up" Glaucoma Patients	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2024

There is a risk that delayed access to timely Glaucoma** care Pan BCU will lead to irreversible sight-loss for "New" and "Follow up" patients across North Wales. This is caused by sustainability challenges arising from a combination of: delayed delivery of National Digital (E-referral and electronic patient record) essential for effective Integrated delivery, staffing capacity gaps, West estate resource challenges, non-medic skills shortfall for enhanced role achievement, Ophthalmologist capacity shortfall delaying "non-medic" competency sign-off and variance in clinician appetite to progress integrated (primary Optometrist & secondary care) pathways to release capacity and reduce waiting times.

**All Glaucoma patients are R1 (at risk of irreversible sight-loss from delayed care.) Currently 8,381 Glaucoma patients on waiting list Pan BCU: with 5,562 breaching National KPI ≤25% over target wait. (Breakdown: East 2,303. Central 2,341, West 918.)

*Caveat: Data Challenges impact on "live" quantification of waiting list "by condition" numbers (See Datix Data Quality Risk)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Site assurance of efficient utilisation of peripheral Hospital clinics estates capacity; to release estate and staff resource capacity in secondary care, for reinvestment to achieve waiting time reduction. 2. Efficient flow of patients to Integrated pathways delivered by contracted Primary Optometry Diagnostic & Treatment Centres (P-ODTCs) B. Waiting List Reduction through SOS:- 1. Ocular Hypertensive and Glaucoma Stable SOS pathway (2016 directive from Welsh Government) reviewed and commenced progression Q2, 2022. C. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring: 1. Nurse, Orthoptist and Optometrist skills developed through courses, placements and Ophthalmologist competency oversight: to deliver skilled workforce working to top of competence. This workforce to release Medic and/or senior nurse capacity. D. Once for Wales Secure record sharing (National Openeyes Digital System) 1. BCU plan for implementing National Digital System: to enable effective information sharing for Integrated pathways delivery. System is key determinant for expanding Integrated Pathways whilst mitigating capacity demand on hospital administration.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. West IHC have been challenged in securing peripheral clinics estates to deliver nurse-led ODTCs in Alltwen Hospital. Nursing Matron actively exploring alternate options.

2. Covid social-distancing mitigations reduced Nurse-led ODTC clinic utilisation from Pre-Covid 8 patients/ per clinic to av. 5/clinic Pan BCU. IHCs progressing target to achieve Pre-Covid capacity and progression of 9 patients/clinic toward National target. Q3, 22
3. Central IHC paused flow of a total of 480 Glaucoma patients to Primary Care ODTCs from September 21, due to Administration vacancy/unplanned leave impacts. Flow recommenced September 22.
4. Historic capacity gap in hospital placement provision and Ophthalmologist mentors for Higher qualification and competency "sign-off capacity" has negatively impacted on delivery of "enhanced-skill" Nursing and Optometrist workforce.
5. Primary Care OTDC capacity (West and East) reduced by circa 25%, due to unplanned leave. Partial mitigation achieved through "recovery" trajectory. National Contractual Reform to commence 2022/2023: which would expand Primary Care "workforce". Workforce predicted Nationally to offer >30% follow up capacity for Glaucoma Follow ups. In interim, current P-ODTC contract revisited to offer "wider" cohort of contractors delivering current trajectory, to provide improved contingencies and patient access (Q4, 2022)

B. Waiting List Reduction through SOS:-
1. Variation in Clinician appetite/"Buy In" for Integrated Pathway partnership with Primary Care. Shared understanding supported by engagement sessions held in 2019, 2021 and 2022. Continuous improvement Networks additionally review current practice against National Pathways: with outcome of East and West "On Track" for SOS and Intraocular Pressure Pathway trajectory delivery in Q3, 2002. SOS Lead, liaising with Central clinical colleagues Nov 22

C. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring
1. North Wales region is a national outlier in terms of Primary-care non-medic workforce: in terms of staffing numbers and Higher level qualifications.
2. There is a Nursing enhanced role shortfall, with Ophthalmologist capacity shortfall/vacancies delaying "non-medic" competency sign-off.
Currently all sites offering Primary Care placements, within capacity. Capacity to support placement challenged by vacancies of senior clinician roles (Consultant 1.5WTE/Registrar 2.0WTE and Band 7 Nursing). BCU currently exploring with Welsh Government proposal to establish a Train & Treat Centre in North Wales. This would offer two years funding (Welsh Government) and additional treatment for a minimum of 1000 glaucoma, 800 AMD and 2000 acute patients per year. (On basis of full-capacity of 12 Independent Prescribing, 6 Higher glaucoma and 6 Medical Retina Higher Qualification placements)

D. Once for Wales Digital "Secure Folder/file Sharing

1. National programme delayed by circa 9 months, with consequence of significant increase on administration capacity, due to increased scanning/secure sharing of information with Primary Care contractors to mitigate delayed digital enabler. Interim digital solutions explored with Informatics. Glaucoma Referral refinement pathway cannot commence until system implemented: delaying achievement of 30% “false positive” Glaucoma referral waste reduction

E. Workforce Review to assure a sustainable, prudent workforce

1. A full service review with supporting 5 year workforce plan was recommended in 2019, within 2019 Transformation Business case that concluded *“workforce is historical and not based on population demand”*. 2021 Wales Audit report called for development of a “*single medium-term workforce plan for eye care services (acute and NHS funded community services) that links to the future intended models of care”*: with BCU Audit recording Workforce as Leading delivery. This will be raised as a priority to develop within Ophthalmology and Planned Care strategic meetings in Q3, 2022. A determining factor to delivery is confirmation of Contractual Reform Pathways (circaQ1, 2023)

Progress since last submission

Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :-

1. IOP Integrated pathway revisited by Clinical Networks and ratified Pan BCU July 22. East and West IHCs commenced roll-out October 22. Central agreement to partially commence confirmed Q3, 2022.

Waiting List Reduction through SOS:-

1. SOS Discharge pathway (Ocularhypertensive and Glaucoma stable) revisited: with East and West Integrated Health Communities commencing roll-out November 22.

Skill-Enhancement of Non-Medics:

1. Transformation bid formulated and funding to close of March 23 agreed with Welsh Government (WG). This is enabling backfill to release three Band 6 Nurses for placement/skill-enhancement to enable additional non-medic activity for high-risk patients in 2023 (with provisional WG funding agreement for Twilight funding upon completion of training (23-2024)

Once for Wales Digital “Secure Folder/file Sharing

1. “Go Live Testing of internal systems Interim digital solution to mitigate Delayed National programme successfully tested/governance assured. Test of Change completed, with implementation on track for Q3 implementation for feasible pathways.

This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks.

1. The identification of 7 open actions.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	TBC	Explore peripheral estate options for Nurse-led ODTCs	Sandra Robinson-Clark, Ophthalmology Nursing Matron (West)	31/12/2022	-Releases estate capacity within Ysbyty Gwynedd Eye Clinic	On Track
	TBC	Deliver increased nurse-led ODTC clinic utilisation “Test of Change”	Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes,	31/03/2023	-Reduces Glaucoma patient waiting time	On track

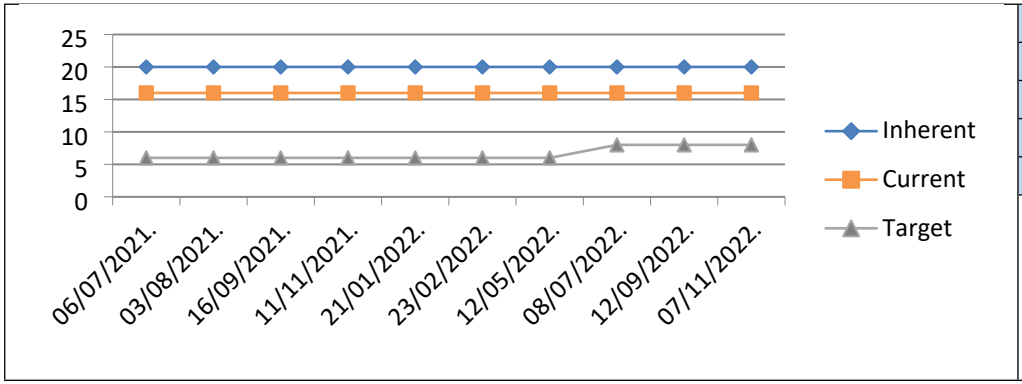
			Ophthalmology Sister Central			
	TBC	Deliver Interim Digital systems prior to National System “Go Live”	Dewi Edwards, BCU Regional Architect	31/12/2022	Partially reduce avoidable capacity loss*** negatively impacting on administration teams and consistent delivery of Primary ODTC pathways (***Currently unfeasible for “referral refinement” pathways)	On track
	TBC	Review and assure consistent flow of patients to P-OCTCs	Paula Betts, Lead Manager - Surgical (Central)	31/12/2022	-Assure maximum utilisation of contracted capacity -Reduce Glaucoma patient waiting times -Redress (central) patient inequitable access to Care Closer to Home	On Track
	TBC	Explore delivery of Welsh Government funded Train and Treat Centre in North Wales	Richard Price, Optometry Advisor/Jackie Forsythe, Eye Care Network Manager/Roger Haslett, Clinical Lead	31/03/2023	- Redress historic capacity gap in hospital placement provision -Reduce competency-oversight demand on Senior Nurse/Ophthalmologist’s -Increase “pool/cohort” of Non-medics with Higher qualifications/competencies to enable extension of “Integrated Workforce”	On track
	TBC	Development of a “single medium-term workforce plan for eye care services (acute	Nikki Ffoulkes, Planned Care/Roger Haslett, Clinical Lead/Richard	30/06/2023	- Identify skill mix and capacity requirement of workforce to provide sustainable delivery of intended models of care	On track

		and NHS funded community services)	Price, Optometry Advisor			
	TBC	Complete Non-Medic Training Needs Analysis	Richard Price, Optometry Advisor/ Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased “pool/cohort” of Non-medics with Higher qualifications/competencies to enable extension of “Integrated Workforce”	On track

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 december 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 30 December 2025

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board.
This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Workforce Recruitment and Retention Strategy in place and actively monitored with initiatives in place to maximise recruitment and retention across the nursing workforce. 2. Nurse Staffing Policies NU28/MHLD 0028/ outlines standards and escalation in relation to identifying and mitigating nurse staffing shortfalls across wards and departments. Nurse staffing vacancies and recruitment activity is monitored through the nursing recruitment and retention group which currently reports to the Strategic Workforce Group. 3. Bi-annual Nurse Staffing calculations are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing calculations are also undertaken in other areas of acute services such as admission portals, Emergency Departments and areas of high care. 4. A Strategic Recruitment and Retention Group in place to monitor and develop forward look recruitment and retention initiatives to mitigate nursing shortfall over the next 5 years. 5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to ensure roster performance is actively managed to enable maximum utilisation of nursing workforce across the Health Board. 6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised. 7. Utilisation of the SafeCare allocate system to provide a live/real time view of nurse staffing levels, skill mix, and patient demand. The system provides nurse managers with visibility across wards and areas enabling acuity based, safety driven decisions regarding nurse staffing and the deployment of staff. 8. BCUHB Nursing Career Framework in place and utilised to develop and train our existing nursing workforce to meet identified workforce gaps and meet succession plans across the Health Board. 9. Workforce planning and commissioning process in place to triangulate the requirements to develop and deliver the nursing pipeline to meet the current and future needs within the nursing workforce across BCUHB.	1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings. 2. Compliance with the Nurse Staffing Act and Nurse Staffing calculations are reported to the Board bi-annually (May/November) via the Quality, Safety and Experience Committee as the designated committee. 3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support4. Monthly SafeCare compliance reports have been developed to identify areas in need of targeted support to enable a live view of nurse staffing levels, skill mix, and patient demand. 5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy 6. Monthly sickness absence reports produced by WOD, monitored via the workforce utilisation meetings, and managed locally by senior nursing teams.

10. Full representation and active participation in national policy and decisions making forums such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group.	

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to Key Performance Indicators e.g. Annual Leave/training. A Workforce Nursing Utilisation Dashboard has been developed and introduced to senior nursing teams to optimise nurse staffing rosters. 2. Whilst adult acute medical and surgical, and Area Teams Central and West have fully implemented the Safecare Allocate System, East Area, paediatrics and Mental Health are yet to implement. Although the Health Board has been using the system for some time there has been a significant change at matron and ward manager level and it is recognised that additional support is required to these areas to re-establish the discipline and compliance required to enable acuity based, safety driven decisions regarding nurse staffing. An implementation plan will oversee the roll out in outstanding areas. The All Wales SafeCare Standard Operating Procedure will further guide and strengthen the use of the system at an operational level. The newly appointed Nurse Staffing Programme Lead will oversee the implementation and associated training requirements relating to the SafeCare System. 3. Not all Nursing staff groups are on electronic rotas and not everyone is IT literate, due to personnel changes there is a requirement for refresher training. Plan being developed to move all nurse staff groups onto roster with a specific IT training plan aligned to this initiative. 4. Whilst the recruitment and retention strategy and plan are in place, this needs updating in line with the update of the Health Board's People strategy. Individual initiatives are in place to inform data analysis and the revised strategy will take these into account along with the wider All Wales recruitment and retention initiatives. This is being led by Director of Nursing for Workforce Staffing and Professional Standards. 5. There remains a gap in filling of nursing vacancies across the Health Board, continued advertising and recruitment and development of business case for the oversees programme and support within the nurse recruitment team.

Progress since last submission
1. Controls reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. The Autumn nurse staffing reviews are complete with the statutory nurse staffing levels report due at board early November 2022. 4. The overseas nurse recruitment business case is in the final stages of approval, having been noted at Executive Delivery Group, with minor amendments required prior to final approval. 5. Action ID 15635 – Action closed, the original business case has been superseded and incorporated into the new People Operating Model, action closed and will be implemented as part of the role out of the new People Operating Model. 6. Action ID 17433 – Action delayed, Proposal to extend the action due date from the 31/03/2022 to the 31/03/2023 as this piece of work will fall under the 'Our way of Working' workstream. The first pilot cohort of a Matrons Leadership Programme concluded in September 2022. The programme has been recently evaluated and a report on the outcomes is to be presented to Nurse Directors Group in December 2022. A leadership summit event to review leadership provision and develop a collective view on core principles is planned to take place at the end of November 2022. 7. Action ID 17509 – Action delayed, Director of Nursing Workforce to contact Welsh Government lead to ascertain the current position. Anticipated delay to the action due date. 8. Action ID 18834 – Action delayed, dashboard now developed, initial implementation will commence during November 2022, and a full implementation timetable will be in place by end of December 2022. 9. Action ID 22121 – Action delayed, Nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated until the end of November 2022. 10. Action ID 22122 – Action delayed, dependant on the people strategy being developed and approved including investment in the oversees nurse programme and nursing team, anticipated completion by December 2022. 11. Action ID 23095 - Action closed, business case submitted and being prioritised as part of the Integrated Medium Term Plan for 23/24. Initial gap analysis completed and initial team in place on a non-recurrent basis. 12. Action ID 24185 - Plans in place to Corporately recruit Health Care support Workers in readiness for the winter surge. A Corporate led recruitment event has taken place in November 2022 with a second planned for early December 2022. During the November event approximately 38 whole time equivalent Health Care Support workers were recruited to the Health Board.

Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler) Strengthen our wellbeing focus	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	30/11/2021	Action closed 07/11/2022 This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and Key Performance Indicators of the business case are linked to the relevant sections of our corporate risk register. November 2022 progress update - The original business case has been superseded	Completed

					and incorporated into the new People Operating Model, Action closed and will be implemented as part of the role out of the new People Operating Model.	
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce. In 2021/2022 the Health Board embarked on an ambitious three year people and organisational development journey (Mewn undod mae Nerth/Stronger Together). This was and is aimed at enabling the organisation to move forward and deliver its Clinical Strategy/Plan through delivery of its People Strategy and Plan – Stronger Together. The feedback from over 2,000 staff has informed the development of 5 programmes of work, one of which is 'the Best of our Abilities', this includes the development of	Delay

					an integrated Leadership & Management Development Framework for all professional groups, aligned to a new Learning and Education Academy. The risk associated with the development of specific leadership offers related to specific staff groups, i.e. Head of Nursing and Ward Manager programmes will be reviewed as part of this work, with a proposal to develop a new Framework which will be inclusive of all professions and will provide a more streamlined, multi-disciplinary approach. November 2022 progress update - the first pilot cohort of a Matrons Leadership Programme concluded in September 2022. The programme has been recently evaluated and a report on the outcomes is to be presented to Nurse Directors Group in December 2022. A leadership summit event to review leadership provision and develop a collective view	

					on core principles is planned to take place at the end of November 2022. Proposal to extend the action due date from the 31/03/2022 to the 31/03/2023 as this piece of work will fall under the 'Our way of Working' workstream	
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development November 2022 progress update - Director of Nursing Workforce to contact Welsh Government lead to ascertain the current position. Anticipated delay to the action due date.	Delay
	18834	Introduce targeted monitoring across rosters, through Key Performance	Mr Nick Graham, Workforce	30/06/2022	Effective utilisation of substantive staff.	Delay

		Indicators management to reduce agency expenditure and maximise substantive staff usage.	Optimisation Advisor		November 2022 progress update - Dashboard now developed, initial implementation will commence during November 2022, and a full implementation timetable will be in place by end of December 2022.	
	18835	Support and progress existing band 4 roles through to fastrack nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mr Ade Evans, Vocational Education Manager	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce. November 2022 progress update - Action remains on track for December 2022.	On track
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle.	Mandy Jones, Deputy Executive Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board. November 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is	On track

					ongoing to implement the programme.	
	22121	Implement Allocate Safecare system to all clinical areas and associated training requirements.	Mrs Alison Griffiths, Director of Nursing Workforce	30/09/2022	Ensure that Health Board has increased visibility of the Nursing workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level. November 2022 progress update - Nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated until the end of November 2022.	Delay
	22122	Refresh and update the Nursing Recruitment and Retention strategy	Mrs Alison Griffiths, Director of Nursing Workforce	30/06/2022	This will allow an integrated medium term plan to be developed and implemented to ensure nurse recruitment and retention better identifies and resolves nurse staffing challenges. November 2022 progress update - Dependant on the people strategy being	Delay

					developed and approved including investment in the oversees nurse programme and nursing team, anticipated completion by December 2022.	
	23095	Develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	Action closed 07/11/2022 The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio. November 2022 progress update - Action closed. Business case submitted and being prioritised as part of the Integrated Medium Term Plan for 23/24. Initial gap analysis completed and initial team in place on a non-recurrent basis.	Completed
	24185	Corporate recruitment of Health Care Support workers to close the vacancy gaps and provide a stable and resilient workforce ahead of anticipated winter pressures.	Mrs Alison Griffiths, Director of Nursing Workforce	31/12/2022	Provide a stable and resilient workforce ahead of anticipated winter pressures, and associated increased activity and patient acuity. 3 phased approach will be taken phase 1 will recruit from the existing bank of staff,	On track

					phase 2 will recruit from an identified number of individuals that have recently applied for a post within the Health Board, and phase 3 will involve a well-publicised recruitment campaign targeted at the public, this is provisionally booked for mid November 2022 with checks and offers being made on the day. N 2022 progress update - Plans in place to Corporately recruit Health Care support Workers in readiness for the winter surge. A Corporate led recruitment event has taken place in November 2022 with a second planned for early December 2022. During the November event approximately 38 whole time equivalent Health Care Support workers were recruited to the Health Board.	
	24359	Monitor prioritisation of the Nurse Workforce and staffing resource requirements as part of the IMTP planning process to ensure	Mrs Alison Griffiths, Director of Nursing Workforce	31/03/2023	Provide sufficient resource to support nurse recruitment and retention in areas such as overseas nurse recruitment and student nurses.	On track

		sufficient resources are made available to support nurse recruitment on a recurrent basis.				

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 24 October 2022
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 04 November 2022
		Target Risk Date: 31 October 2023

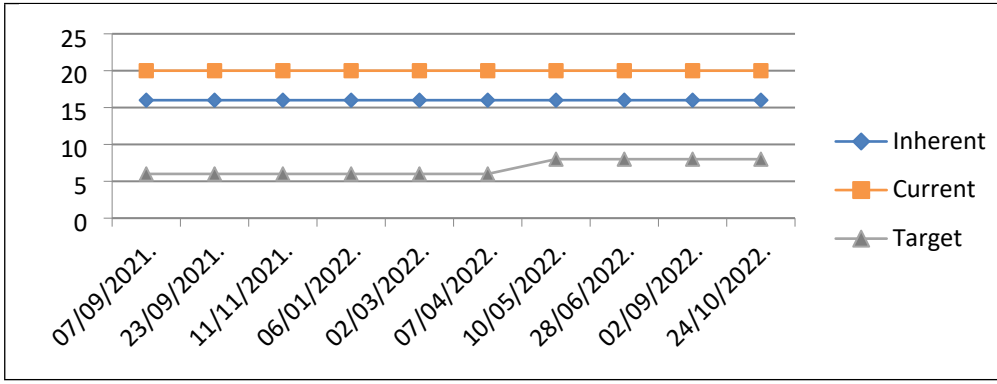
There is a risk that the increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

This may be caused by the increased number of patients who are refusing admission or who have a mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

This is due to the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for Deprivation of Liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.

The amendments to the Mental Capacity Act, resulting in new legislation and the required preparation by the Welsh Government for the implementation of the Liberty Protection Safeguads (LPS) requires engagement at a National, Regional and Local level which has resulted in the divertion of resources.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and an increase in financial cost, poor patient experience and reputational damage for BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022.	Unchanged		

Controls in place	Assurances
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory Adult at Risk training Levels 2 and 3 are in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 7. Welsh Government non recurring monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Board Workshop. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews.

8. Liberty Protection Safeguards (LPS) Implementation group is in place to inform the organisation of LPS and to commence the preparation for the receipt of COP and future implementation of LPS across the organisation reporting to the Mental Health Capacity and Compliance Committee [MHCCC] Committee. 9. Welsh Government non recurring monies are identified to strengthen training and implementation of LPS for 16/17 year olds. 10. Heads of Safeguarding Strategic Objectives are cross referenced and include actions from the identified Safeguarding Risks ensuring triangulation and governance. These risks are monitored following the Safeguarding Governance Framework. 11. Welsh Government non recurring monies have supported the development of training materials for MCA, and the appreciation and understanding of capacity, which has included the reiteration of the safeguarding Team and the contact details.	6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government. 7. A Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the safeguarding team, which is reported to the MHCCC (Mental Health Capacity Compliance Committee). 8. The MCA awareness materials were disseminated from 14th November – Safeguarding Week.

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised Code of Practice. A BCUHB Business Case has been approved as part of the Integrated Medium Term Plan (IMTP) 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. The business case has been delayed presentation to the Board Workshop due to challenges (The next available date is Feb 2023). To support additional activity WG non recurring monies has supported the implementation of additional roles and activities. 3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention. 4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and

national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies.
5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator to wards noting the timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training.
6. New Liberty Protection Safeguards Code of Practice is proposing that the commissioning arrangements of Independent Mental Capacity Advocates will be the responsibility of Health Boards on behalf of both health and local authorities. At present there is a lack of commissioned service in place and new arrangements require establishments in terms of governance arrangements and quality monitoring. Confirmed with WG and meeting arranged with the 6 local authorities.
7. Sudden rise in the number of DoLS assessment resulting in a backlog. We are, currently using non recurring Welsh Government monies to support current post holders to work additional hours, weekends and evenings (we are unable to recruit to specialist posts).
8. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting, this was identified in a Court of Protection DoLS case and it is noted that this is not unique to BCUHB. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance. Immediate safeguards are in place and work is taking place alongside the Risk Team who has developed a SoP.
9. There are local and national staffing challenges with regard to the recruitment of MCA and DoLS (BIA) specialist staff. This has been recognised by Welsh Government. There are currently no Best Interest Assessor courses available to train staff as a result of the delayed authorisation of the Legal Framework. We are supporting flexible working arrangements, the immediate recruitment to vacancies and current post holders (BIAs) are working enhanced hours to deliver out of hours support. From November/December a 7 day MCA and DoLS advisory service using WG non recurring monies will be in place.
10. During Q2 2022-23 there has been an increase in the number of DoLS applications submitted by the Managing Authority 74% of all applications required amendments to the application prior to authorisation. A rolling audit activity with immediate escalation is in place.
11. The team and service is experiencing a combined sickness and vacancy position of 30%. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.
12. The development and ratification of strategic activities are delayed and some are outside of the original timescales. Risk assessments against each activity are in place to identify the risk and priority of the activity. Specific activities are highlighted to reporting Committees/Groups to obtain agreement if timescales require amendment or escalation.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in Controls reviewed to ensure relevance with current risk position. 3. Welsh Government monies identified to strengthen training and implementation of LPS for 16/17 year olds. 4. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance in relation to identified community settings. 5. Action ID's 18117 and 21213 – Actions remain delayed. The Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The Workforce advice is to be obtained prior to submission to the Board Workshop. 6. Action ID 20957 – Action delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023. 7. Action ID 23066 – Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action (ID 24305) for the monitoring of Mental Capacity Act [MCA] training has resulted from the closure of this action as BCUHB continue to evidence low compliance with MCA mandatory training data. 8. Action ID 23505 – BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG guidelines and national legislation. 9. Identification of new action - Using WG non recurring monies, current safeguarding team members are undertaking additional 'out of hours' (7 day service) DoLS assessments in-line with WG guidance and approval. This is monitored weekly to prevent staff 'burn out' and to support their health and wellbeing. This is funded via non recurring WG monies. 10. Identification of new action - Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients within the community. National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services to support the development of a Standard Operating Procedure is underway. Training Data is under review relating to key services, with the objective to develop a bespoke training provision and evidence improved identification of service users who require a legal deprivation to be in place. 11. Identification of new action - Embed regular audits to monitor and implement actions to improve the current quality of DoLS applications. This will ensure that the documentation meets the requirements of the legal framework and BCUHB's legal duties in line with the Deprivation of Liberty Safeguards legislation.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	BCUHB IMTP resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. The delay in the draft LPS Code of Practice has resulted in challenges to identify posts and evidence the required resource specific to LPS for the BCUHB safeguarding Business Case. Progress update WG has released non recurring monies (based upon a business case model) to support the preparation for LPS. This is to focus upon the	Delay

					implementation and awareness of the MCA and reduce the DoLS backlog. The Corporate Safeguarding IMTP has been agreed and we were informed in January 2022 that safeguarding is on the reserve list. Work is taking place to agree the current Safeguarding Budget with Finance. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. Workforce advice has been obtained prior to submission to the Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve	

					monies for this financial year 2022-2023 Non recurring WG funding has been utilised to support out of hours BIA assessments and enhanced roles and responsibilities of existing staff – recruitment to specialist roles remains to be a challenge.	
	20957	Development of implementation plan in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. October 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023.	Delay
	21213	Utilise the agreed BCUHB IMTP funding application to support the	Michelle Denwood, Director of	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the	Delay

		increased activity within Safeguarding.	Safeguarding and Public Protection		increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice is to be obtained prior to submission to Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve monies for this financial year 2022-2023	

	23066	Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.	Michelle Denwood, Director of Safeguarding and Public Protection	30/11/2022	Action Closed 24/10/2022. Welsh Government monies will support additional resource and educational tools to inform the workforce regarding capacity and harm which will reduce risk and improve patient care. October 2022 progress update - Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action for the monitoring of MCA training has resulted from the closure of this action as BCU continue to evidence low compliance with MCA mandatory training data.	Completed

	23505	Establish commissioning and governance arrangements for IMCAS as directed by the LPS code of practice. In line with WG guidelines ensure that there is suitable provision of IMCA services across the geographical area.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	The appointment of Independent Mental Capacity Advocates and delegated resource will ensure patients voice and choice will be heard and will be part of the legal considerations given to a patients Deprivation of Liberty. Additional IMCA's will support the LPS process and provide patients with an independent voice under the legal framework. Working with the six LA's provides assurance that all interested agencies are aware and engaged in the process. October 2022 progress update - BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG	On track

					guidelines and national legislation.	
	23506	Establishment of operational groups to support the implementation of LPS within clinical and operational service delivery.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	To ensure that the service and function is embedded in front line practice. This will reduce unlawful detention and comply with the Code of Practice.	On track
	24304	Implementation of a task and finish group for Court of Protection DoLS within key community settings to ensure internal engagement to establish clear lines of accountabilities, escalation and governance.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	This will reduce the likelihood of unlawful detention relating to the directions of the court.	On track
	24305	Improve the implementation and understanding of the Mental Capacity Act (MCA) and improve MCA Mandatory training compliance.	Michelle Denwood, Director of Safeguarding and Public Protection	30/10/2023	Improve understanding and unlawful detention of service users. Update Position Training resource and a variety of materials are to be disseminated throughout the	On track

					organisation during Safeguarding Week 14th Nov. Enhanced Training Audit activities are to be identified.	
	TBC	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding to engage in the development of a SoP to support to manage the complex process of Community DoLS and for the identification of patients who may be eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors and Commissioned Service Providers National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with	On Track

					Commissioning Services has commenced.	
	TBC	Develop, implement and trial a 7 Day Out of Hours MCA and DoLS advisory service utilising WG funding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Utilise WG funding to ensure out of hours MCA and DoLS compliance amongst frontline services. Undertake audits of applications and BIA activity/performance within the trial period. Review the trial 7 day service to determine the long term requirements of services.	On track
	TBC	Embed regular documentation audits into practice to provide assurance that there is no delay in the quality or completion of DoLS applications.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Updating current audit activity will ensure that the submitted DoLS and MCA documentation meets the requirements of the legal framework in line with the Deprivation of Liberty Safeguards legislation.	

					An improvement in the documentation submitted will reduce the time taken to process applications, reduce the time taken by front line staff having to amend or revisit documentation, and ultimately speed up the process of authorisation which will ensure compliance with the legal framework.	

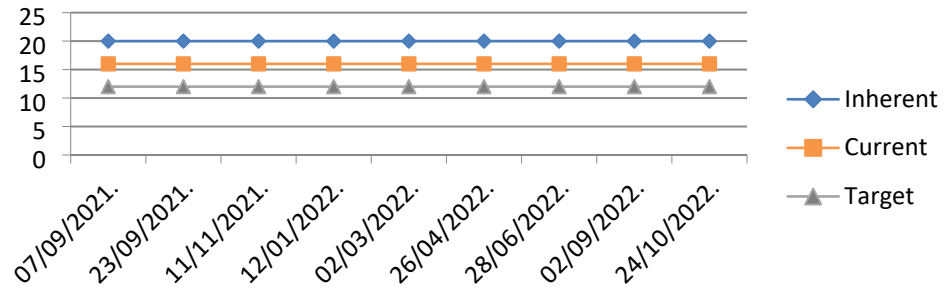
CRR21-15	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 24 October 2022
	Risk: There is a risk that patients and service users may be harmed due to non-compliance with the Social Services and Well-Being (Wales) Act 2014	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 October 2023

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

There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children ,the Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] in addition to the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.

This may be caused by a failure to engage and implement appropriate safeguarding legislation and statutory arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.

This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. All Wales and North Wales Safeguarding procedures approved and in place. 2. BCUHB local work programmes is in place and aligned to the National strategies which are regularly reported to Welsh Government. 3. Risk Management has been embedded into the processes of the reporting framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums agendas. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and Wales Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 6. The BCUHB Children's Division have appointed the named Doctor for Safeguarding Children. A period of supervision and support is taking place due to the identified learning needs of the appointee. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 8. Welsh Government interim monies has been utilised to increase physical capacity out of hours. 9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation. SARC remains the accountability of the Central Integrated Health Community (IHC). 10. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews. 11. Monies secured and implemented for the role of Independent Domestic Violence Advocate in YG and YGC and WMH.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the Safeguarding Governance and Performance group, MHACCC and is reported into the Welsh Government.

12. Health Board Leading on Emergency Department Safeguarding Action plans to support the Health Inspectorate Wales [HIW] findings, recommendations and overarching HIW action plans reporting and monitored at the relevant Safeguarding Forums and to the Safeguarding Governance and Performance Group 13. Undertaking bespoke supervision/peer support activities within high risk and low compliance areas/departments via Hospital Management Team's, reporting to the Safeguarding Governance and Performance Group. 14. Targeted intervention for key areas ie. the 3 Emergency Departments and a number of identified wards and areas within Mental Health and Learning Disabilities is in place, with escalation taking place accordingly. 15. Temporary appointment to the position of Head of Safeguarding Business, Quality and Governance which has enabled engagement and discussions to ensure the Safeguarding agenda and Safeguarding Reporting Framework are reviewed to reflect and support the new Operational Model.	

Gaps in Controls/mitigations
1. The increase in safeguarding activity, with enhanced complexity as a result of COVID, and the increase in victims recognised as a result of Domestic Abuse and Sexual Violence, Refugees, Modern Day Slavery/Human Trafficking, Prevent and County Lines, has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place and the development of a Safeguarding Business Case. 2. The inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated. 3. The lack of a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments relating to non-accidental injuries for children under the age of 2 years, with alternative platforms in place when they have limited digital patient records. 4. Lack of consistent approach by the 6 Local Authorities in North Wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can

result in reduced compliance. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible.
5. Compliance rates of training does not provide assurance against the knowledge and application of the training into clinical practice. Measuring understanding and application of training materials using desktop reviews, audit and utilising a survey monkey is to be developed and monitored by implementation plans. Targeted activity for low compliance and high risk areas.
6. A number of senior and operational posts remain vacant following recruitment, risk assessment are in place focusing upon service delivery and the identification of activities to ensure compliance and engagement.
7. IHC Safeguarding Forums are not consistently taking place, there is proactive engagement taking place with the chairs to review membership and the agenda including the cycle of business to ensure full engagement and escalation. This will be supported by the review of the terms of reference and reporting framework relating to the Safeguarding Governance and Performance Group (SGPG).
8. There is a lack of engagement at the Safeguarding Governance and Performance Group from the existing membership as a result of the new BCUHB Operating Model. Contact made with IHC Leads/Directors and Corporate Leads to ensure engagement in the revised Terms of Reference and Reporting Framework. A meeting is arranged with the Assistant Director of Governance to support this review.
9. The number of Child Practice Reviews/Adult Practice Reviews/Domestic Homicide Reviews have increased considerably, this places increased pressure upon the Team to allocate statutory membership and statutory participation. The newly appointed Head of Safeguarding Business, Quality and Governance is reviewing the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and the identification of Trends. Processes are in place to ensure engagement and participation following National and Local procedures.
10. There is a lack of standardised engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team and the Safeguarding Team. The newly appointed Head of Safeguarding Business, Quality and Governance is agreeing a pathway and developing a Standard Operating Procedure (SoP) to ensure consistency, engagement and collaboration, this activity has commenced.
11. There is reduced engagement and embedded process agreed with HMP Berwyn regarding access by the prison clientel for NHS services and the management of risk and governance. The newly appointed Head of Safeguarding Business, Quality and Governance is developing a pathway and SoP to ensure consistency, engagement and collaboration with the prison service to ensure a framework is in place and is effective. Discussions have taken place to inform safeguarding of any current required engagement.
12 Audit data has shown there is a reduction in Statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding (Crime and Disorder Act 2014). This had resulted in immediate interim controls to be put in place but a review of the Safeguarding Standard Operating Procedure and awareness Training has commenced.

Progress since last submission
1. Controls in place updated to reflect current risk position. 2. Gaps in controls updated to reflect current risk position. 3. Action ID 18113 – Action remains delayed, National agreement still awaited. Professional Allegation/Position of Trust workplace group to be considered and developed in light of the delay Nationally and Regionally. 4. Action ID 18120 – Action delayed, the task and finish group has disseminated future dates to re-commence this work on a National footprint, first group meeting was held on the 26th October 2022, which replaced the intended meeting of the 18th October 2022. 5. Action ID 21216 - Action remains delayed with the Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice has been obtained prior to submission to Executive Management Group. 6. Identification of new action ID 24306. As a result of the BCUHB new operating model the current Safeguarding Governance and Reporting Framework requires review and updating to ensure reporting and escalation is aligned to the new operating model. 7. Identification of new action - The increase in statutory Multi-agency Child and Adult Death Reviews has resulted in the need to review and to refresh the Safeguarding Standard Operating Procedure (SoP) to ensure appropriate engagement and the triangulation of themes and trends. 8. Identification of new action - There is a lack of standardised engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team. 9. Identification of new action - There is reduced engagement and an embedded process agreed with HMP Berwyn regarding access by the prison clientel for NHS services and the management of risk and governance. Engagement has commenced and dates agreed to progress with this work. 10. Identification of new action - Audit data has shown there is a reduction in Statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding, as required by the Crime and Disorder Act 2014. Immediate controls have been put in place and the Standard Operating Procedure and awareness training has commenced.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	18113	Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].	Michelle Denwood, Director of Safeguarding and Public Protection	20/12/2021	The process and the development of Key Performance Indicators' can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings. October 2022 progress update - National agreement still awaited. Professional allegation/Position of trust workplace group to be considered and developed in light of the delay Nationally and regionally.	Delay
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	The revised Procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of	Delay

					Organisational risks. October 2022 progress update - The task and finish group has disseminated future dates to re-commence this work on a National footprint, first group meeting was held on the 26th October 2022, which replaced the intended meeting of the 18th October 2022.	
	21216	Utilise the agreed BCUHB IMTP funding application to support the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-Being [Wales] Act 2014to support the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. The Corporate Safeguarding IMTP has been agreed and we were informed in January 2022 that safeguarding is on the reserve list. Work is taking place to agree the current Safeguarding Budget with Finance.	Delay

					The delayed LPS Code of Practice has impacted upon the development and revised proposed Safeguarding Structure and Business Case. October 2022 progress update - Action remains delayed with the Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice has been obtained prior to submission to Executive Management Group. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve monies for this financial year 2022-2023	
	23507	Mental Health &Learning Disability to include the identification of resource to	Michelle Denwood, Director of	31/03/2023	A single point of contact and physical presence will support the front line clinician to	On track

		support a Safeguarding physical presence within the Mental Health Units.	Safeguarding and Public Protection		identify and to safeguard service users who may be at risk of harm. Will support the implementation of safeguarding practice and training. This action has again been discussed with the interim Director of Nursing MHLD	
	24085	Review IHC/MHLD/Womens Safeguarding Forums Terms of Reference and the reporting framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that reporting and governance is in line with the organisations revised structure ensuring operational and strategic safeguarding activity is aligned to the organisations performance and risk management activities ensuring compliance with safeguarding legislation relating specifically to the NHS. Deadline for the return of comments for the Terms of Reference is 17th November 2022. Some responses have been received. Meeting taking place with the Associate Director of Governance and	On track

					Communication on the 11th November 2022.	
	24086	Monitor and review that Safeguarding Forums are convened in line with the Safeguarding reporting framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that the Safeguarding agenda is embedded and key areas of risk escalated within the identified Health Economies and Mental Health and Learning Disabilities. Meeting has already taken place with the IHC Associate Director of Nursing East who has agreed to trial the new agenda and exception reporting template for the Safeguarding Forum, this will take place in November. IHC Director of Nursing Central and West are meeting with the Head of Safeguarding Governance on the 16th November 2022	On track
	24306	Update and review Safeguarding Governance and Performance Group Terms of Reference and the Safeguarding Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding Governance and Reporting activity will be in line with BCU's governance framework. This will ensure direct line of accountability remains with the Chief Executive and Safeguarding remains everyone's business. This will ensure risks are reduced and key activities	On track

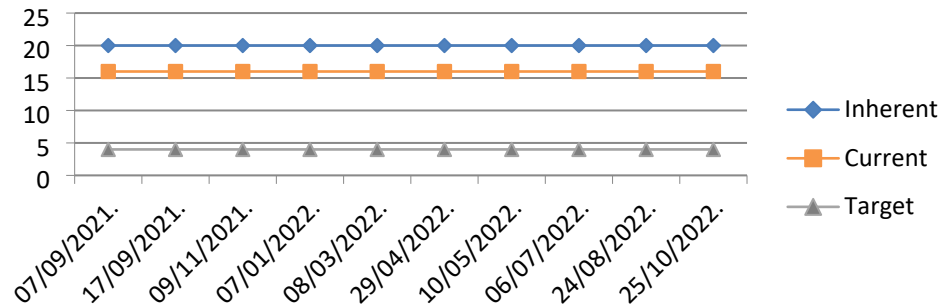
					obtain support and engagement. As a result of the BCUHB new operating model the current Safeguarding Governance and Reporting Framework requires review and updating to ensure reporting and escalation is aligned to the new model. This will be reviewed following a planned meeting with the Associate Director of Governance and Communication on 11th November 2022.	
	TBC	Ensure panel members, Chairs and Reviewers of Multi-agency Child and Adult Death Reviews have the necessary skills and expertise to engage and to ensure monitoring arrangements are embedded into the role and responsibilities.	Michelle Denwood, Director Of Safeguarding And Public Protection	31/09/2023	The newly appointed Head of Safeguarding Business, Quality and Governance is reviewing the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and improve the identification of themes and trends. The Practice Development Lead is developing specialist	On track

					Training to support panel members and to increase the availability of BCUHB safeguarding specialist as the designated Chairs and Reviewers for complex multi-agency death reviews.	
	TBC	Improve the consistency of escalation and engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team with the Safeguarding Team	Michelle Denwood, Director Of Safeguarding And Public Protection	31/07/2023	The newly appointed Head of Safeguarding Business, Quality and Governance is agreeing a pathway and developing a Standard Operating Procedure (SoP) to ensure consistency, engagement and collaboration, this activity has commenced.	On track
	TBC	Improve and embedded processes agreed with HMP Berwyn relating to the access by the prison clientel of NHS services, to strengthen the management of risk, governance and communication.	Michelle Denwood, Director Of Safeguarding And Public Protection	30/06/2023	Engagement has commenced and dates agreed to progress with this work. Immediate safeguards are in place for HMP to notify where appropriate safeguarding.	On track
	TBC	Ensure and improve the statutory participation at MAPPA 2 and MAPPA 3	Michelle Denwood, Director Of	30/05/2023	Immediate controls have been put in place and the development of a Standard	On track

		(Very High Risk Individuals) meetings by Corporate Safeguarding, and MHLD as required by the Crime and Disorder Act 2014.	Safeguarding And Public Protection		Operating Procedure and a notification agreement with the MAPPA Co-ordinator. Awareness training has commenced.	

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 25 October 2022
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 20 June 2023

There is a risk that insufficent Manual Handling training could lead to staff and patient injury, lost work time, Health and Safety Executive enforcement action (recent related Improvement Notices for Patient Falls, Patient Handling and Portering Load Handling risk assessments) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties. There is an increased risk due to mass recruitment of HCA's, Nurses leading to failure to deliver compliance.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	1	4
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Health & Safety Strategy has been approved which includes Manual Handling. 2. Training plan is in place specifically in relation to Manual Handling, training compliance is monitored by the Mandatory training group.	1. Regular oversight and review by the Occupational Health & Safety Team.

3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment. 5. A full review of the training was completed in August 2021 to ensure the training provided was in line with the All Wales Manual Handling training passport scheme. 6. Suite of fully functional training rooms secured. 7. Datix system is monitored daily by the Health and Safety team to review incidents and follow up on lessons learnt. 8. Multi-disciplinary team including Manual Handling representative set up and currently auditing compliance with patient handling risk assessments.	2. Reviewed at the Strategic Occupational Health and Safety Group. 3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.

Gaps in Controls/mitigations
1. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing. 2. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance, however with the lack of trainers in place improvement in compliance rates is challenging. 3. Lack of integrated booking system with the ESR system and ESR is not easy to use. Manual bookings currently in place. 4. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains a gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme. 5. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented, but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 56%. 6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, action plan developed to comply with HSE improvement notice and Multi-Disciplinary Team set up to audit internal compliance.

Progress since last submission
1. Description of the risk reviewed and updated to reflect current position. 2. Controls in place reviewed to reflect current position. 2. Gaps in Controls reviewed and updated to reflect current position. 3. Recruitment of 3 Manual Handling trainers has taken place, however, this is to replace current vacancies.

4. Administration support for the Manual Handling team to monitor DNA's at training has taken place.
5. Gap identified as a result of the Health and Safety Executive investigation into facilities staff compliance with training, with the potential for a prosecution for the Health Board. Training package is in place to ensure facilities staff are suitable trained. This has now been addressed with 100% of facilities staff (currently in work) from within the identified area having now benefitted from the training. HSE have been informed of the compliance.
6. Action ID 17979 – Action remains delayed, Manual Handling Team manager commenced post on the 1st September, has since left the post on the 30th September. Recruitment out on the TRAC system for 2x band 6 manual handling advisors. With current post vacancies for advisors at 4.6. Band 4 trainers currently have 3 vacancies, these have been recruited to and are awaiting start dates.
7. Action ID 18859 – Action delayed, draft policy is in place, and a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 December 2022, the delay with this action is as a result of the vacant manager post. Ratification process will follow the completion of the policy review.
8. Action ID 23660 - Action now delayed as a result of the vacant manager post. The external trainer has continued to provide training following the trial in August 2022.
9. Action ID 24051 – Action closed, increase in the numbers of staff within the training sessions has taken place, 1-12 for both orientation and for refresher training and agreed with the trainers.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented	17979	Additional trainers sought, to be clinically trained as per the standards set	Mrs Susan Morgan, Head of	30/11/2021	Additional trainers to provide training to the standard set within the Passport for clinical	Delay

to achieve target risk score		within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Health and Safety		qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB. October 2022 progress update - Manual Handling Team manager commenced post on the 1st September, has since left the post on the 30th September. Recruitment out on the TRAC system for 2x band 6 manual handling advisors. With current post vacancies for advisors at 4.6. Band 4 trainers currently have 3 vacancies, these have been recruited to and are awaiting start dates.	
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Mrs Susan Morgan, Head of Health and Safety	01/04/2023	Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.	On track

					October 2022 progress update - In depth checks using the ESR system to identify staff sickness trends and high risk areas, this remain ongoing.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mrs Susan Morgan, Head of Health and Safety	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff. October 2022 progress update - Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 December 2022, the delay with this action is as a result of the vacant manager post. Ratification process will follow the completion of the policy review.	Delay

	23660	Consideration of alternative methods of Manual Handling training.	Mrs Susan Morgan, Head of Health and Safety	30/09/2022	Looking at alternative training delivery will improve capacity to increase compliance rates to support the prevention of staff and patient injury. October 2022 progress update - Action now delayed as a result of the vacant manager post. The external trainer has continued to provide training following the trial in August 2022.	Delay
	24050	Muscular-skeletal disorder group to be re-instated to review trends in incidents and follow up improvement actions.	Mrs Susan Morgan, Head of Health and Safety	31/12/2022	Identify hot spot areas and to target those areas for intervention. October 2022 progress update - First Meeting held on the 6th October with Terms of Reference to be agreed moving forwards.	On track
	24051	SBAR to be developed to request authorisation to increase staff numbers in training sessions	Mrs Susan Morgan, Head of Health and Safety	31/10/2022	Action closed 25/10/2022 Increase the number of available seats and therefore increase the numbers of staff trained. October 2022 progress update - Increase in the numbers of staff within the training	Completed

					sessions has taken place, 1-12 for both orientation and for refresher training and agreed with the trainers.	

<table>
<tr><td rowspan="3">CRR21-17</td><td>Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 09 November 2022</td></tr>
<tr><td rowspan="2">Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.</td><td>Date of Committee Review: 01 November 2022</td></tr>
<tr><td>Target Risk Date: 31 March 2023</td></tr>
<tr><td colspan="3">There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to Child and Adolcent Mental Health Services (CAMHS) to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:
• Current operational hours of CAMHS is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• crisis presentations to the Emergency Departments with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
• awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.</td></tr>
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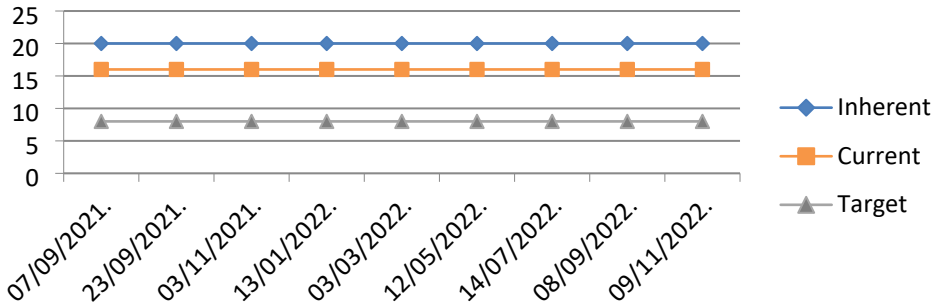


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Integrated Health Community Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Integrated Health Community Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. Access to Legal and Risk to support the Health Board when a young person has a Depravation of Liberty Safeguards in place via court of protection. 9. Safeguarding discharge Standard Operating Procedure for young people in place.	1. A scoping exercise or report of Child and Adolcent Mental Health Services (CAMHS) Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB approach. 3. Risk also regularly discussed at the Area - Quality and Safety Group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with Welsh Government, joined with Mental Health Division on a quarterly basis.

10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS, which includes incident notifications. 11. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff. Currently working with recruitment agencies and established multi-disciplinary team is already in place. 2. Lack of suitable Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all health economy areas and Local Authority partners. 3. Lack of agreed consistency, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Task and Finish Group set up looking at the s136 policy specifically in relation to Children and Young people and to review the escalation processes and produce a flow chart that will be clear and easy to follow. 4. Action ID 23091 - Action closed, Campaign has taken place, action closed, however there remains an ongoing issue in relation to vacancies which are being managed through locum staff. 5. Action ID 17956 – Action delayed, Crisis Intervention pathway. Priority focus on establishing CAMHS pathway to support 111+2 for mid-December. Crisis and Unscheduled Programme Group now established under CAMHS Targeted Intervention. 6. Action ID 17964 – Action closed, Training is being delivered and there is a schedule in place. Youth Mental Health First Aid has commenced roll out across the region and will be ongoing to April 2023. Further training requirements will be identified once the updated policy has been completed, and will become a BAU function. 7. Action ID 18334 – Action delayed, ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing. The timescales for this requires extension.

8. Action ID 21236 – Action delayed, the recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways. November 2022 progress update - Action delay, Crisis Intervention pathway. Priority focus on establishing CAMHS pathway to support 111+2 for mid-December. Crisis and Unscheduled Programme Group now established under CAMHS TI.	Delay

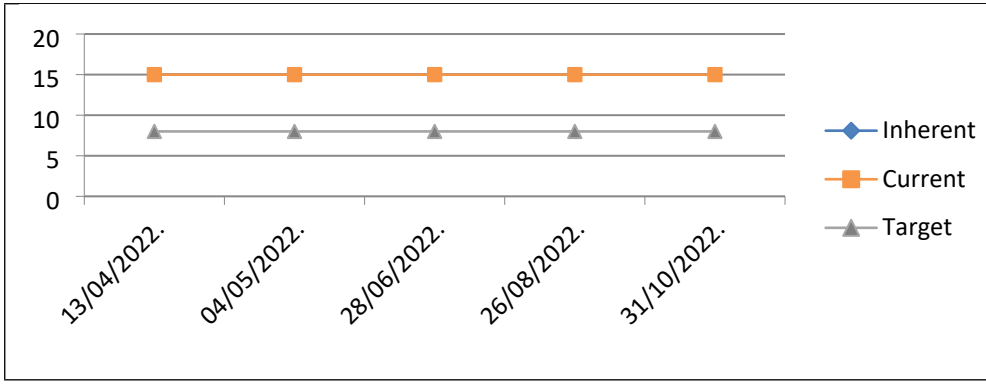
	17963	Task and Finish Group to review SCH03 Policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	31/12/2022	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions. November 2022 progress update – T&F group established with 3 dates identified before the end of December 2022. Additional work is required to streamline existing guidance. There is a requirement to update MH2 first and then SCH03.	On track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ Emergency Department staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/10/2022	Create awareness and develop skill in assessment and improve staff morale. August 2022 progress update - Plans being developed to deliver training of youth Mental Health First Aid, this will be delivered within each Integrated Health Community, further work required to develop a rolling programme of training which will extend beyond the action due date. Training requirements are highlighted in the new NICE	Completed

					guidance and recommendation in relation to supervision for staff. November 2022 progress update – Action closed. Training is being delivered and there is a schedule in place. Youth Mental Health First Aid has commenced roll out across the region and will be ongoing to April 2023. Further training requirements will be identified once the updated policy has been completed, and will become a BAU function.	
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital. November 2022 progress - Ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing. The timescales for this requires extension.	Delay
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing	31/10/2022	Provide further assurance following a review by an external body and the implementations of any	Delay

					recommendations to support the development of high quality and safe care. August 2022 progress update - Implementation of recommendations remain ongoing. November 2022 progress update – The recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention.	
	23091	Progress with recruitment to bespoke campaign for Child psychiatry.	Mrs Louise Bell, Assistant Director CAMHS	31/10/2022	Action closed 09/11/2022 Implementation will help to deliver a safe and sustainable service within BCU. November 2022 progress update - Action closed, Campaign has taken place, action closed, however there remains an ongoing issue in relation to vacancies which are being managed through locum staff.	Completed

CRR22-18	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 31 October 2022
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2024

There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB.
This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies.
This could lead to an increase in healthcare associated infections, patient harm and loss of reputation to the organisation.



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workloads for all staff in the team e.g. ensuring experienced Infection Prevention nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. 5. Reviewing and prioritising attendance at meetings and on groups etc.	1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. 2. Alert organism statistics. 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee.

6. Employed senior manager via an agency to support the team. 7. Supporting and protecting existing team with measures including weekly team meetings and reviews. 8. Plan in place on how Infection Prevention can support the Infection Prevention Champions to help promote Infection Prevention with numbers growing each month.	4. Patient incident reviews. 5. Regular review of Datix Incidents which are alerted to the team when logged on the system for learning purposes and for rectification. 6. Outbreaks are monitored, managed and reported to Infection Prevention Sub Group. 7. Regular review of Infection Control and Prevention trajectory reported at Local Infection Prevention Groups. 8 Risk regularly reviewed at Infection Prevention Sub Group.

Gaps in Controls/mitigations
1. There is a national issue recruiting into Infection Prevention and Control roles, particularly at a senior level (7s and above). Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 2. Experienced Infection Prevention Agency nurses only want to work remotely. Staff members working remotely are required to review policies produce reports which in turn releases non-remote working staff to undertake clinical work. 3. The 2 vacant band 8bs have been advertised but there were no suitable applicants. Post re-advertised and currently cross covering within the service with Senior members of the Infection Prevention team (IP) providing support to other areas as well as their own. Recruited internally to senior 8a level supported by other senior Infection Prevention staff.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Action ID 20654 – Action closed, plan in place, over 300 Infection Prevention champions now in place, continuing with sessions to increase this number across the Health Board. Action closed as this is now business as usual and an ongoing activity.

4. Action ID 20659 – Action delayed, awaiting for meeting to be set up with Finance to review current allocation due to not being aligned with current establishment.
5. Action ID 21696 – Action delayed, appointing at lower grade and providing training to staff members is in place and remains ongoing.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-09

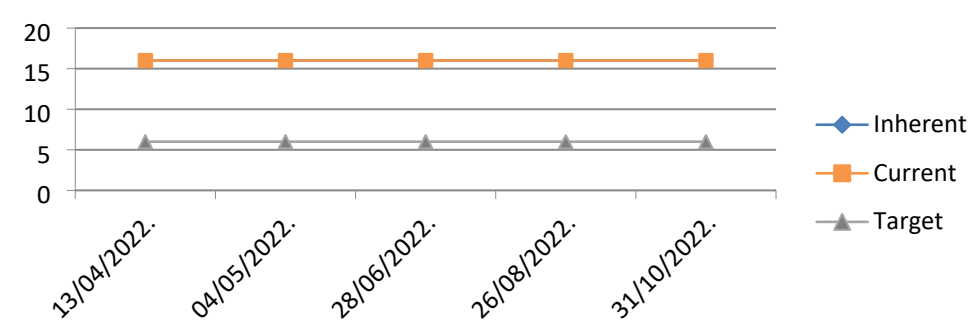
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	20654	Use Infection Prevention Champions to promote good practice.	Mr Dafydd Williams, Infection Prevention Nurse	30/09/2022	Action closed 31/10/2022. To help promote IP in their own departments whilst visibility of the IP team will be low October 2022 progress update - Plan in place, over 300 IP champions now in place, continuing with sessions to increase this number across the Health Board. Action closed as this is now business as usual and an ongoing activity.	Completed

	20659	Business case for expanding current team	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	To outline case to the Executive that more staff are required and obtain approval for funding October - Awaiting for meeting to be set up with Finance to review current allocation due to not being aligned with current establishment.	Delay
	21696	Recruit to current vacant Infection Prevention posts	Mrs Andrea Ledgerton, Specialist Matron IP	30/09/2022	Fill current vacant posts October 2022 progress update - Appointing at lower grade and providing training to staff members is in place and remains ongoing.	Delay
	21698	Work with Communications and Workforce to develop a Recruitment Campaign for Infection Prevention nurses	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To help attract IP staff to BCU	On track
	22927	Promote Infection Prevention Massive Open Online Course education programme	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/01/2023	To improve knowledge, practice and compliance with IP in wards and departments. October 2022 update – Health Board have been informed there is a new	On track

					course lead at Bangor University and that the programme will recommence in the new year but no date has been given yet and there is now a waiting list to attend. A presentation slide has been updated for the October IPSG meeting to inform key stakeholders.	

CRR22-19	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 February 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 31 October 2022
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2024

There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including:
1. Sterile service departments air handling units require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade.
2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes and washer disinfectors at YGC and WM are at end of life. Also they rely on a paper track and trace system.
3. There is a lack of robust approved SOPs for decontamination.
This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Decontamination audits have been increased to twice yearly. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention team.

3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning. 4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board. 5. Single use scopes are being used where possible removing the requirement for decontamination. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard. 7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment which has been completed. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.	3. Decontamination audits by Authorised engineers. 4. Sterile services departments have audits carried out by notified bodies in accordance with the Medical Device Directives/Regulations. 5. Risk register on decontamination.

Gaps in Controls/mitigations
1. The Decontamination Advisor currently on a period of extended leave. Staff member currently acting up into the position to cover this period. Exploring with Agencies whether external appointments could be made. 2. Some Consultants do not want to use single use scopes – Looking at exploring alternative methods of decontamination for the re-usable scopes. 3. There are not many risks on Datix related to Decontamination and there is inconsistency in scoring e.g. one site has a risk related to track and trace in Sterile Services and Disinfection Units scoring 10, another scores it 4. There needs to be review of all risks relating to Decontamination and updates requested from de-contamination group members. Decontamination Group have met on the 25th August, with significant improvement in relation to the risk register entries, with work ongoing to further improve. 4. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans.

Progress since last submission
1. Control in place review to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Action ID 22149 – Action closed, meeting held with Head of Estates and the Hospital Management Teams in YGC and WM to highlight the findings of the Shared Services Strategy Report and highlight the issues at their hospitals. Requested they add key items to the capital programme for submission in October. Assistant Director Of Finance also updated. 4. Action ID 22153 – Action delayed, Shared Services report received and shared with all managers, Meetings to be arranged for November 2022 with the Estates teams. 5. Action ID 24069 – Action delayed, awaiting the start date for the newly appointed Decontamination Consultant who will lead on the action, anticipated start date is the 8th November. 6. Action ID 24070 – Action delayed, funding approved, recruitment of the post has taken place with a start date of the 8th November anticipated.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-02 BAF21-09

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	22147	Policies and Standard Operating Procedures written/revised and approved for Decontamination.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	As part of good governance and so staff are aware of their responsibilities and roles and how to decontaminate medical devices.	On track

					The action will focus on policies and procedures due for review by the end of 2022.	
	22148	Purchase new washer disinfector for endoscopy unit at YG	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/03/2023	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated October 2022 progress update - Capital bid has been submitted however anticipated delay to the action due date.	On track
	22149	Meet with key stakeholders re scope issues at Ysbyty Glan Clwyd and Wrexham Maelor	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/09/2022	Action Closed September 2022 To highlight key issues and establish a way forward September 2022 - Meeting held with Head of Estates and the Hospital Management Teams in YGC and WM to highlight the findings of the Shared Services Strategy Report and highlight the issues at their hospitals. Requested they add key items to the capital programme for submission in	Completed

					October. Assistant Director Of Finance also updated.	
	22152	Community Dental Services, Assets and Facilities group to reform and form a plan for moving forwards.	Peter Greensmith, Business Support Manager - Dental	31/03/2023	To establish formal timeframe and funding for plans. October 2022 - Group has reformed and is in the process of developing plans to address the funding required.	On track
	22153	Estates to meet with sterile services managers	Mr Arwel Hughes, Head of Operational Estates	30/09/2022	To revise risk assessments and make plan for upgrading Sterile services departments October 2022 - Shared Services report received and shared with all managers, Meetings to be arranged for November 2022 with the Estates teams.	Delay
	23024	To seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To demonstrate the improvement and high standards achieved by Endoscopy at the Unit.	On track
	24069	Establish a stakeholder group to review the Shared Services report	Ms Rebecca Gerrard, Director of Nursing Infection	31/10/2022	To make improvements to the decontamination facilities and infrastructure. October 2022 progress	Delay

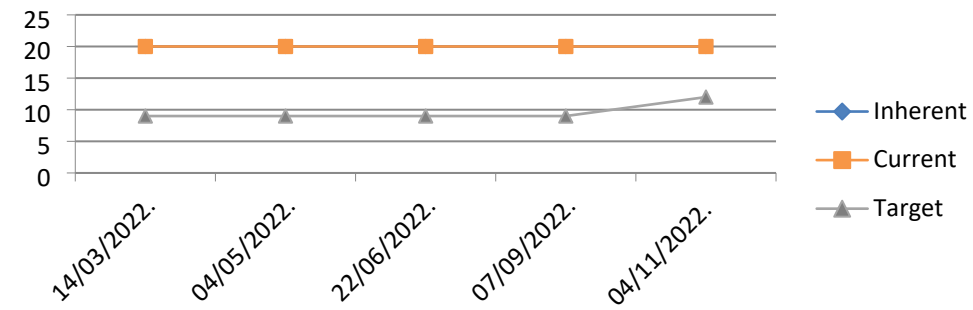
			Prevention & Decontamination		update - Awaiting the start date for the newly appointed Decontamination Consultant who will lead on the action, anticipated start date is the 8th November.	
	24070	Recruitment of an External Consultant to facilitate and progress the recommendations following the Shared Services report.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	Develop a decontamination strategy and business cases and to ensure that the recommendations are fully implemented which will result in the improvement of the infrastructure and facilities for decontamination. October 2022 progress update - Funding approved, recruitment of the post has taken place with a start date of the 8th November anticipated.	Delay

CRR22-20	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 04 November 2022
	Risk: There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 December 2025

There is a risk that residents in North Wales may be unable to achieve a healthy weight and may become overweight and obese.

This may be caused by behaviours involving food intake, current circumstances, lack of physical activities, the living environment, food production and consumption, socio-economic factors and a lack of engagement with health professionals.

This may have an impact on or lead to unhealthy weight and obesity and place them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Continue to take a life course approach to implementing prevention based healthy weight initiatives which will report progress via a number of routes including the Healthy Weight Healthy Wales National Group, the BCU Population Health Group, and the Regional Partnership Group. 2. The continuation and further targeted development of 'Healthy Start' which provides vouchers for pregnant women and eligible families to buy milk, fruit, vegetables and pulses in local shops. 3. Continuation and further development of Maternity and Healthy Visiting Services supporting breastfeeding and weaning to support the Infant feeding Strategy, monitored via the North Wales Strategic Infant Feeding Group. 4. Community Dietetics Services will work with childcare provision embedding 'Tiny Tums' programme across all Early Years settings to encourage healthy, nutritious eating habits from early years. 5. Further supporting schools to take a 'whole schools' approach to health and wellbeing with a particular focus on diet through initiatives such as Come and Cook with your child and considerations regarding developing healthy eating habits and increased physical activity. 6. Let's Get Moving North Wales - a continuing programme encouraging residents of North Wales to move more often will operate alongside Sport North Wales, physical literacy development in schools and communities. 7. Continue to support the workforce to make healthy choices such as a balanced diet, active travel and moving more often through targeted campaigns and supportive services/infrastructure. Working with catering, dieticians, estates and occupational health colleagues to contribute to planning which considers these factors. 8. Further develop the whole system partnership approach to tackle risk factors through influencing priorities such as environmental planning and design, access to healthy food and active travel. 9. Further develop the links and access to Social Prescribing that encourages physical activity through partnership working with Primary Care, Local Authorities and Third Sector. Developing North Wales planned approaches and accessing intelligence regarding access and uptake via the Elemental software. Progress will be reported via	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinatnts. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

the Population Health Group, Primary Care groups and via the Well North Wales Programme (including Partner organisations).	

Gaps in Controls/mitigations
1. The risk requires System-wide approach to tackling the wider determinants of health. 2. The current Health Board provision is not operating at scale to meet the current and forecast needs of the population. 3. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success. 4. Part of the existing service provision is via non-recurrent and short term funding. 5. There continues to be some recruitment issues, re-evaluation of posts has taken place.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Proposal to amend the target risk score from 9 (Consequence x3 x Likelihood x3), to a 12 (Consequence x4 x Likelihood x3) to reflect the current social and economic conditions and factors. 3. Performance & Risk Management Group meet monthly as part of Public Health's governance and communications structure 4. Performance and Risk Management Group report to the Population Health Executive delivery group. 5. Business cases for weight services submitted as part of Integrated Medium Term Plan process.

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

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	22372	Whole system approach to healthy weight	Ceriann Tunnah, Consultant in Public Health	31/03/2025	Taking a whole system approach to healthy weight will ensure that all partners are prioritising the issue of healthy weight and considering the impact of their decision-making on the population's ability to achieve a healthy weight. Obesity is a complex multi-factorial problem that requires a whole system approach. Key partners that are crucial to this work include spatial planners, transport providers, education providers, food providers, leisure providers etc. October 2022 progress update - Continuation of Full time public health team member working on whole system approach along with funding to support.	On track
	22373	Healthy Choices in the workplace	Ceriann Tunnah, Consultant in Public Health	31/05/2023	The working age adult population spend a significant amount of their time in the workplace. As a result it is crucial that we support workplaces to be health	On track

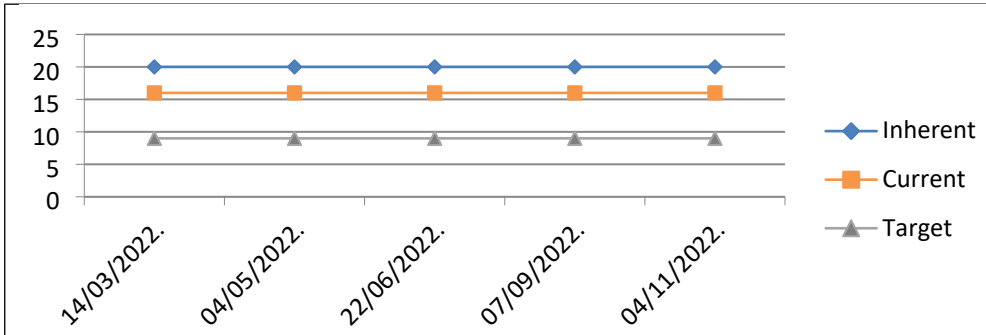
					promoting. This means ensuring staff have access to healthy food choices, equipment to make healthy meals, enough time away from work to prepare and eat a healthy meal. It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight. October 2022 progress update - Continuation of the plan approved via Health Weight Health Wales and prevention on early years National funding.	
	22375	Social prescribing	Ceriann Tunnah, Consultant in Public Health	16/01/2023	Increasing physical activity levels is crucial in supporting people to achieve and maintain a healthy weight. One way that we can support people to do this for free is by promoting access to the natural environment. By doing this will also improve people's mental health as well as their physical health. This approach will also develop people's appreciation for nature and the need to protect it. One way of doing	On track

					this is to optimise access through social prescribing. October 2022 progress update - Received proposal from Local Authorities which contribute to delivering the outcomes identified within the project initiation document. Plans are moving into delivery phase.	
	22376	Pre-diabetes programme	Ceriann Tunnah, Consultant in Public Health	31/03/2025	By identifying patients who are at risk of developing diabetes and supporting them to access specialist weight management services we are taking a teachable moment opportunity and ensuring the patient is supported to improve their health and wellbeing. Primary care brief interventions are crucial in motivating people to change by implementing this programme across North Wales it is hoped more of the population who are overweight or obese will seek support to achieve and maintain a healthy weight.	On track
	22377	Weight management services	Ceriann Tunnah, Consultant in Public Health	31/03/2023	By ensuring those residents in North Wales who are overweight or obese can effectively access and engage	On track

					with specialist weight management services working alongside the remaining whole system approach we will start to reduce the overall prevalence of overweight and obesity in North Wales. October 2022 progress update - Continue to offer the services, tier 3 children's obesity service with tier 2 adult's in place and looking to expand the service. Range of ongoing projects within tier 1 funded through National funding streams as part of Healthy Weight, Health Wales and prevention and early years programme, and have contributed to the development of the Public Health communications plan.	

CRR22-21	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 04 November 2022
	Risk: There is a risk that adults who are overweight or obese will not achieve a healthy weight due to engagement & capacity factors	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 December 2025

There is a risk that adults who are overweight or obese will not achieve a healthy weight. This could be caused by non-engagement with services or demand for services exceeding capacity.
This could impact on the health outcomes for these individuals by placing them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Healthy Weight Healthy Wales funding to support with the implementation of the All Wales Adults Weight Management Pathway. 2. Additional investment in Foodwise for life for those residents with a BMI of 25-35. 3. The establishment of Level 2 weight management services through Foodwise for residents with a BMI of 25-35 and Slimming World vouchers for residents with a BMI of 30-35 with certain health conditions.	1. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 2. Building a Healthier Wales Programme and Healthy Weight

4. The establishment of a Level 3 weight management service KindEating programme for residents with a BMI of between 35-45. 5. Investment in dedicated obesity leads within each of the LA National Exercise Referral programmes. 6. The establishment of a BCU Healthy Weight Healthy North Wales group to oversee the delivery of specialist weight management services.	Healthy Wales Programme (both nationally funded). 3. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board). 4. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement and Reducing inequalities Group (chaired by DoPH). 5. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25). 6. Confirmation of the Population Health Executive Delivery Group is now in place. The group will meet during July with review of Tier 1 risks in August.

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements. 2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success. 3. Provision currently through National funding, with funding identified for 2 years, cost pressures for the health board if the national funding were withdrawn. 4. Recruitment pressures - lack of weight management workforce available - both ability to attract and numbers.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Assurance reviewed and updated to reflect current risk position. 3. Gaps in controls updated to reflect current position. 4. Actions reviewed and progress provided against the actions. 5. Business cases have been prioritised by the Population Health Executive Delivery Group. 6. Risk is reviewed and monitored at the Population Health Executive Delivery Group. 7. Business cases for weight services submitted as part of Integrated Medium Term Plan process.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	22357	Insight work	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Insight work will enable us to improve outcomes for patients who were identified as overweight or obese. Factors that will be considered will include how patients access services, the intervention they receive and the factors that led to then disengaging. This information will allow us to design our weight management services to meet	On track

					the needs of patients achieve better outcomes i.e patients achieving a healthy weight and adopting healthy behaviours October 2022 progress update - There is an approved plan in place for the development of this work.	
	22358	pregnancy weight management service	Ceriann Tunnah, Consultant in Public Health	31/12/2023	Providing a weight management service during pregnancy will ensure that women are able to achieve a healthy weight during and after pregnancy and maintain their healthy behaviour postnatally. October 2022 progress update - In the process of delivering the plan.	On track
	22359	performance management dashboard	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Developing a performance management dashboard will ensure that we are able to monitor the uptake of the service by population groups that are at increased risk of adverse outcomes from obesity. The dashboard will enable us to monitor both uptakes and outcomes by ethnicity, gender and deprivation decile	On track

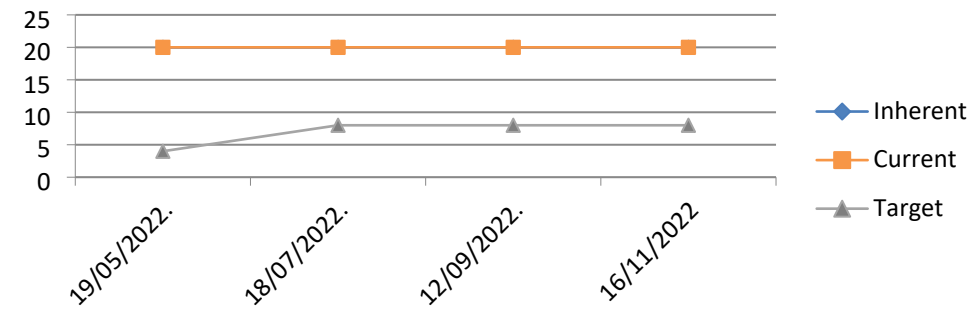
					October 2022 progress update - Development work continues, linking in with the national team at Public Health Wales and local informatics.	
	22943	Implement Healthy Weight Healthy Wales Programme Plan	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Funded activity targeted at improving healthy eating habits and tackling obesity. October 2022 progress update - Approved by Welsh Government and funding identified to support the work, on track.	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 November 2022
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 December 2022

There is a risk that BCUHB staff cannot access their mandatory resuscitation training.

This is due to several factors including:
A lack of 'fit for purpose' training accommodation and equipment across the sites; Insufficient numbers of Resuscitation Officers/Trainers.

This could lead to failure to deliver effective patient care resulting in preventable harm or death from impaired or unsuccessful resuscitation. Additional risk of financial claims against BCUHB resulting from preventable harm/deaths.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. 2. Training plan in place governed by the UK core skills framework. 3. Resuscitation training is a mandatory training programme across the Health Board. 4. Delivery of the training has been re-designed to increase capacity, this has resulted in the reduction of clinical staff's time away from clinical duties. 5. Systems and processes are in place to manage attendance at training sessions. 6. Additional temporary training footprint sourced within the Central region. 7. Assurance that all resuscitation attempts by the emergency response teams are led by staff who hold the current Advanced Life Support qualification for the respective teams. The assurance of this is being supported by the reinstatement of the daily test bleeps for the teams in Central, and with a log of the current advanced resuscitation qualification status recorded each day as team members respond to the test bleep. Where an 'expected team leader' does not hold the required qualification, then the team leadership role is deferred to another team member who does hold the required qualification.	1. The risk is reviewed monthly by the Resuscitation Services senior management team, and is presented to the Resuscitation committee on a quarterly basis. 2. Training figures and capacity are regularly reviewed on a quarterly basis at the Resuscitation Committee via site reports. 3. The risk has been presented to PSQ (Performance Safety & Quality), and Clinical Effectiveness groups.

Gaps in Controls/mitigations
1. Despite controls above, there remains a deficit of approximately 2000 training places per year for resuscitation training at UKCSTF Level 3 on the Central locality. 2. There is no dedicated training accommodation on the Central locality. This lack of accommodation is in breach of the national standards as set by the Resuscitation Council UK. Continued breach could result in loss of course centre license on the Central locality which would cease all level 3 training from the site. The identified potential accommodation requires investment (quotations have been provided to Central Integrated Health Care (IHC) teams) to make safe and fit for purpose and there is currently no identified funding source. Identification of this funding source has been asked for from Central Site Management with support from Estates / Planning / Finance teams. 3. With particular relevance to the Ockenden report is the Newborn Life Support (NLS) provision which is running on limited capacity both East and West, and is at 0% capacity in central with no NLS training at all due to the lack of availability of suitable training accommodation. 4. The Audio-Visual system required for these courses is failing on the East site. In May 2022 two of the systems failed during the delivery of an Advanced Trauma Life Support course, which required those rooms to run without these resources for the

remainder of the course. This impeded the course delivery and will feature in the course report from the course director to the Royal college of Surgeons. The failure of the AV system will impact on every course run in the East venue and requires replacement.
5. There is currently no functional and reliable cardiac arrest audit within BCUHB. Therefore rates (other than raw switchboard data), outcome data, and improvement opportunities cannot be reliably established. Actions are in place to develop a functional audit of 2222 calls.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Plans drawn and quotations received for the required Estates works to provide dedicated training facilities for the Central Region. These plans have been provided to Central IHC with a request that funding is identified. Simultaneously Integrated Medium Term Plan submission has been progressed by the Resuscitation Services, but is awaiting an approval decision. 4. Reporting to the Executive Medical Director on the progress of the risk response and training trajectory information continues. 5. Meeting arranged to discuss the risk between the Executive Medical Director, Acting Deputy Executive Medical Director and the Resuscitation Services Senior Management Team set for the 29th November 2022. 6. Action ID 19313 – Action delayed with quotation received awaiting funding from either IMTP or the IHC. 7. Action ID 23208 – Action delayed with plans and costings received and shared, awaiting funding allocation. 8. Action ID 23754 – Action delayed as data collection in Central continues, Switchboard at the West site have a training date booked to begin their switch data collection.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Primary and community care Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-04 BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	19313	Provision of permanent and fit for purpose training and office accommodation on the YGC site	Mrs Sarah Bellis-Holloway, Resuscitation Services Manager	30/09/2022	"While it will not mitigate the clinical absence of Resuscitation Officers from the acute site, or loss of other non-training activity; the identification of a suitable commercial venue in which we can provide all levels of resuscitation training, along with F&P funding approval will lower the score in relation to training from 20 to 4 in the short term (lease period). This will mitigate the risk until a permanent venue within the YGC footprint is developed." November 2022 progress update – Quotation received awaiting funding from either IMTP or the IHC.	Delay
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Alyson Constantine, Site Acute Care Director	30/06/2022	This action will enable a building to be secured for delivering training on the Centre Site thereby helping mitigate and manage this	Delay

					risk in the long-term. November 2022 progress update – Plans and costings received and shared, awaiting funding allocation.	
	23754	Complete data collection design for 2222 electronic audit with Informatics support.	Mr Christopher Glyn Shirley, Resuscitation Officer	15/08/2022	Reliable and robust data will enable the health board to provide accurate data on cardiac arrest rates, and report on outcomes. It will also enable analysis of opportunities to reduce patient harm, reduce cardiac arrests, and aim to help to prevent unplanned critical care admissions. November 2022 progress update – Data collection in Central continues, Switchboard at the West site have a training date booked to begin their switch data collection.	Delay

<table>
<tr><td rowspan="3">CRR22-23</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Date Opened: 02 April 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 20 October 2022</td></tr>
<tr><td rowspan="2">Risk: Inability to deliver safe, timely and effective care - Wrexham Emergency Department.</td><td>Date of Committee Review: 01 November 2022</td></tr>
<tr><td></td><td>Target Risk Date: 09 January 2024</td></tr>
<tr><td colspan="3">There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity due to delayes to transfer of patients awaiting specialty beds. This could lead to:
• Delay/inability to triage new attendants within 15 minutes of arrival as per national key performance indicators in line with Emergency Department Quality and Delivery Framework/Welsh Government Targets, deterioration in health/condition and increase level of harm including increased length of stay, level of intervention required and potential increase in mortality, breach of infection prevention measures and standards, which would increase spread of infection and/or potential outbreak.
•I nability to bring patients into the department from ambulances, detrimental impact to the community in terms of redeployment/response of ambulances, inability to meet privacy and dignity needs of patients, breach of performance measures as set out and monitored by Welsh Government, and pressure on the workforce, i.e. increase in workload due absences, difficulty in recruitment and retention of staff.
• Negative feedback / patient experience that is reflected via Health Inspectorate Wales and Community Health Council national reviews.
• On going risk of patients leaving without being seen further impacting on Welsh Ambulance SService Trust demand and patients deteriorating in the community after leaving without being seen.</td></tr>
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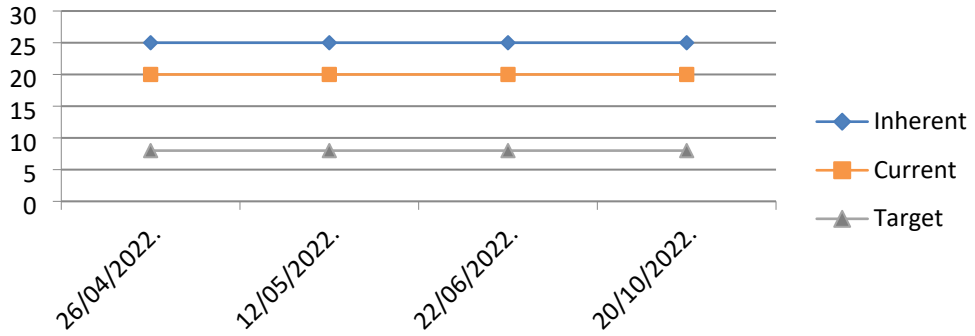


	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Site escalation policy in place. 2. Emergency department escalation policy in place. 3. Infection prevention policy in place. 4. Welsh Government guidelines in place. 5. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside ED. 6. Standard Operating procedure in place for triage of patients in relation to escalation of patients. 7. Matrons audit in place to identify areas i.e. welfare checks. 8. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients. 9. Screening process in place at point of entry to identify those at risk / suspected COVID with appropriate action taken.	1. Risk is reviewed at Emergency Care meeting and escalated to site Quality and Safety and Health and safety meeting. 2. Triage waits Key Performance Indicator data reported monthly through the Integrated Health Community (IHC) accountability meetings. 3. Report to Clinical Effectiveness Group. 4. Performance is monitored through harms, incidents, complaints and handovers. 5. Fortnightly reviews with Welsh Ambulance Service Trust of any harm/delays that may have occurred due to overcrowding.

Gaps in Controls/mitigations
1. Insufficient Capacity/physical environment to mitigate overcrowding, outpatients areas currently used for patients in the waiting room when minors are at capacity and all spaces blocked with patients waiting for beds. The plan moving forwards is to have a new minor injuries area co-located with urgent Primary Care Centre.

Progress since last submission
1. Description of the risk updated to reflect current risk position. 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls reviewed and updated to reflect current risk position. 4. The department continues to identify incidents linked to the risk and link the incidents to the risk on the Datix system. 5. Action ID 19516 - Action closed with the action plan having been reviewed for Unscheduled care Improvement Group and action holders identified. 6. Action ID 20605 - Action remains delayed, the initial business case, whilst fully recruited to, has not provided the required numbers of Health Care Support Worker's to support the workload in the Emergency Department. Additional request to be submitted to the Integrated Health Community (IHC) management team for additional recruitment. 7. Action ID 21360 – Anticipated delay to the action due to delays with the project, likely to be until February 2023. 8. Action ID 23001 - Action closed as appointment of 8 locum Consultants have taken place and individuals will be starting between November 2022 and February 2023. In addition recruitment has taken place in line with the business case for the non-medical workforce. 9. Action ID 23002 - Action remains delayed due to the need to remove the pods from Acute Medical Assessment Unit which will increase the patient co-hort that can be directed to this area. Due to site pressures the surgical SDEC becomes bedded therefore restricting the ability to direct patients to the area.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-14

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	19516	Review the action plan for Unscheduled care Improvement Group and identify action holders for updates.	Mrs Hazel Davies, Acute Site Director	30/09/2022	Action Closed 20/10/2022 This will de-congest ED of the excessive volume of patients who reside in Ed awaiting specialty beds Statistically we are seeing reduction in admission of high risk patient group and improved ambulance waits October 2022 progress update - Action completed with the action plan having been reviewed and action holders identified.	Completed
	20605	Increase establishment for additional Health Care Support Workers	Mrs Rachel Bowen, Deputy Head of Nursing EC	30/09/2022	This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in ED. October 2022 progress update - Action remains delayed, the initial business case, whilst fully recruited to, has not provided the required	Delay

					numbers of Health Care Support Worker's to support the workload in the Emergency Department. Additional request to be submitted to the Integrated Health Community (IHC) management team for additional recruitment.	
	21360	Increasing the footprint of ED to manage overcrowding to protect the minor injury stream (WMH)	Mrs Hazel Davies, Acute Site Director	01/12/2022	It will enable relocation of the minor stream of patients in ED to an alternative area which will reduce overcrowding within the department. October 2022 progress update - Anticipated delay to the action due to delays with the project, likely to be until February 2023.	On track
	23001	Ongoing recruitment to the approved Workforce Business Case.	Bloor, Mrs Lindsey Bloor, Directorate General Manager	31/08/2022	Action Closed 20/10/2022 This will support staffing in additional areas of ED once available October 2022 progress update - Action closed as appointment of 8 locum Consultants have taken place and individuals will be	Completed

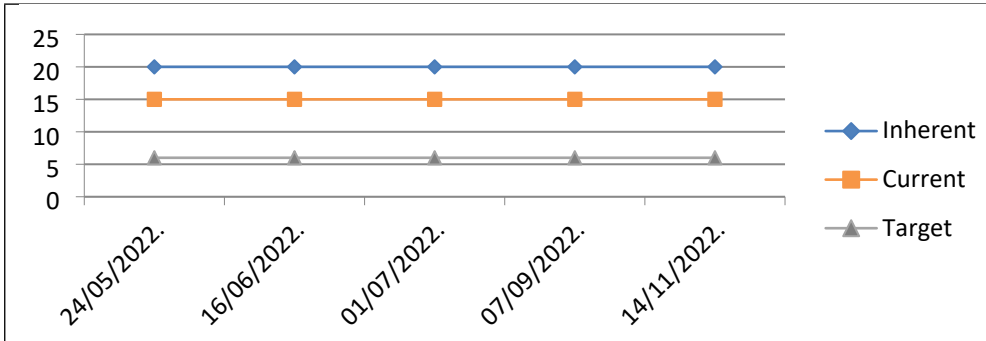
					starting between November 2022 and February 2023. In addition recruitment has taken place in line with the business case for the non-medical workforce.	
	23002	Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC)	Bloor, Mrs Lindsey Bloor, Directorate General Manager	16/09/2022	This will reduce the number of patients in ED waiting room October 2022 progress update - Action remains delayed due to the need to remove the pods from Acute Medical Assessment Unit which will increase the patient co-hort that can be directed to this area. Due to site pressures the surgical SDEC becomes bedded therefore restricting the ability to direct patients to the area.	Delay

CRR22-24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 04 April 2022
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 March 2023

There is a risk of senior leadership capacity & capability gaps during the transition to the new Operating Model as people depart the organisation through the VERS process and the challenges recruiting people to new posts (internally and externally) during the transition phase when all key posts have been filled.

This has been caused by the delay to the organisational change process resulting in a divergence of parallel actions relating to those individuals leaving the organisation via VERS, the subsequent vacant posts and the recruitment to the new posts. The default position is to use the mechanism of internal backfill. Where a suitable individual cannot be identified then the posts will need to fill by external subject matter experts on an interim basis.

This may lead to a slowdown in the decision making processes as decision and action delivery defaults up to the next level in the responsibility and accountability framework.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. For the small number of posts which will become vacant the default option will be to look internally for people who can step-up on a short-term interim basis. Acting arrangements being agreed with Executives as a mitigation. Where this is not possible will look to use experienced external interims. 2. The management oversight of the transition for those and induction of new teams members is a critical role of the programme of work called: How We Organise Ourselves and the project group called the roles and the people. Arrangements have developed for these leaving the Health Board including the Operational Transition Plan and Leaving Well Handover Guide & Repository. These products along with a suite of induction and network products will support new people and emerging teams with knowledge transfer. 3. The transition of affected departments will be overseen by Executive Directors between April and March 2023. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team.	1. Risks are reviewed every 4 weeks by the Risk Management Group (Board and Director level).

Gaps in Controls/mitigations
1. Capacity of Executive Directors to respond to rapid decision making requirements. How We Organise Ourselves now has a regular weekly slot on the Executive Team agenda. Weekly Divisional Q&A sessions with Chief Executive Officer, Executive Director of Integrated Services / Deputy CEO and Executive Director of Workforce and Organisational Development provides a route for rapid escalation. 2. The management of the East, Central and West Integrated Health Community Operational Transition project plans through weekly status meetings and the connectivity to the Programme Leader Group provides a route for rapid escalation of possible gaps. 3. Demand for interim roles across the UK health sector could out-strip supply - therefore we are working closely with our agency partners to ensure we have access to the widest pool of capable individuals. 4. An early go-live date could result in vacant new posts where backfill arrangements are not appropriate as those who are acting up into existing posts will have been appointed to their new role and the interim contract period could be too short to attract interested parties - each post will be reviewed and the appropriate mitigation solution put in place.

Progress since last submission
1. Risk description reviewed to reflect current risk position. 2. Controls in place reviewed ensure relevance with current risk position. 3. Gaps in controls reviewed to ensure relevance with current risk position. 4. Action ID 23333 – Action closed as all substantive posts holders have been appointed. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 5. Action ID 23334 – Action closed as selection and appointment process now complete. 6. Action ID 23335 – Action delayed, selection process taking place on 11 & 14 November 2022. 7. Action ID 23336 – Action closed, with selection and appointment process now complete. 8. Action ID 23337 – Action delayed, selection process taking place on 11 & 14 November 2022. 9. Action ID 24129 – Action closed as substantive posts holder have been appointed. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 10. Action ID 24130 – Action delayed, suitable candidate not identified. Post renamed to Chief Operating Officer and re-advertised.

Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler)	BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	23333	Set-up external selection process for Integrated Health Community Director roles (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	25/07/2022	No gaps in senior leadership roles **November 2022 progress update**	Completed

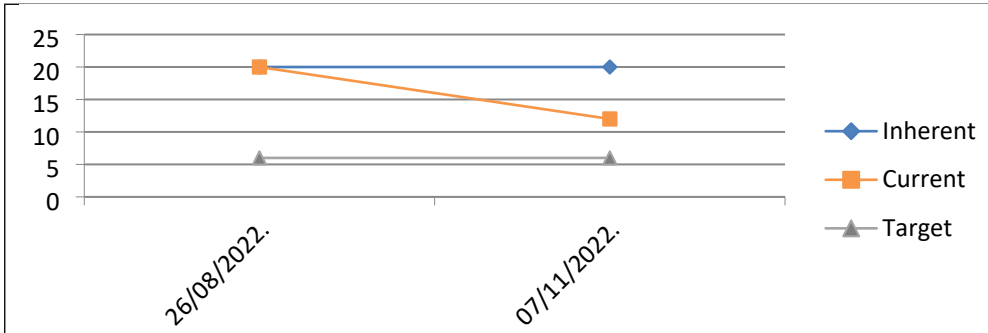
					All substantive posts holders have been appointmented. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	
	23334	Set-up internal selection process for Senior Nursing posts (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	27/06/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Selection and appointment process now complete.	Completed
	23335	Set-up internal selection process for Senior Medical posts (format, panel representation).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles - **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	23336	Set-up external selection process for Senior Nursing posts (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	01/08/2022	No gaps in senior leadership roles -interim/acting up arrangement in place	Completed

					November 2022 progress update Selection and appointment process now complete.	
	23337	Set-up external selection process for Senior Medical posts (format, panel representation) (If required).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	24129	Set-up internal selection process for Deputy Director posts – Regional services and Primary Care (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	31/10/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Substantive posts holder have been appointmented. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	Completed
	24130	Set-up external selection process for Deputy Director posts – Regional services and Primary Care	Lesley Hall, Assistant Director – Employment Strategies & Practices	30/12/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update**	Delay

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

CRR22-25 – Risk De-escalated to Tier 2 level.

CRR22-25	**Director Lead:** Executive Medical Director	**Date Opened:** 20 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of failure to provide full vascular services due to lack of available consultant workforce	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023
There is a risk that there will be delays in the delivery of emergency, urgent and routine care for vascular patients. This is caused by to lack of consultant workforce which has impacted on services recently and meant only emergency and urgent services can be provided for a short period of time. Business Continuity plans are not adequate to mitigate and patients may need to be transferred NHS England for the the provision of urgent and emergnecy services.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	4	3	12
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

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

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

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

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

4. Action ID 23819 - Action closed, business continuity meetings have been running with gold command structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.
5. Action ID 23999 - Action closed, this is managed as business as usual through surgical operation team processes.
6. Action ID 24000 - Action closed, dual on call for AAA continues in the event that Vascular service cannot provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.
7. Action ID 24001 – Action delayed, The service is now able to provide a full Vascular service with 9 doctors working at Consultant level, work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed support through NHSE by 31/03/2023.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	23819	Develop local business continuity plans with Hub and Spoke Site Directorate Managers	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/07/2022	Action closed 07/11/2022 Provide appropriate escalation and plans to mitigate risks Work is in progress, all three General Managers across each site are currently working on the business continuity plan. October 2022 progress update	Completed

					- Action closed. Business continuity meetings have been running with gold command structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.	
	23999	Daily review of all overdue patients to ensure urgent patients are recognised and discussed with clinicians to ensure no harm due to delay in treatment	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Ongoing daily reviews to ensure no harm due to delay in treatment October 2022 progress update - Action closed. This is managed as business as usual through surgical operation team processes.	Completed
	24000	Chief Medical Officers Meetings with HB Executive Medical Director to discuss where support can be offered from in the event of inability to provide emergency and time critical care.	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Agreement with Liverpool (LiVES) Vascular services to support MDT decision making to ensure patients are prioritised Work in progress with Stoke Hospital to receive Urgent and Emergency Patients if required. October 2022 progress update	Completed

					- Action closed. Dual on call for AAA continues in the event that Vascular service cannot provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.	
	24001	Identifying all vascular patients on the waiting lists and prioritising in the event of all day-case and outpatient services need to be transferred out to England	Jenny Farley Vascular Network Director	31/08/2022	The service is now able to provide a full Vascular service with 9 doctors working at Consultant level. 3 x weekly meetings with each site to report any urgent or time critical patients that require escalation for clinical intervention. October 2022 progress update. Exec approved data has been provided to NHSE and work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed	Delay

					support through NHSE by 31/03/2023.	

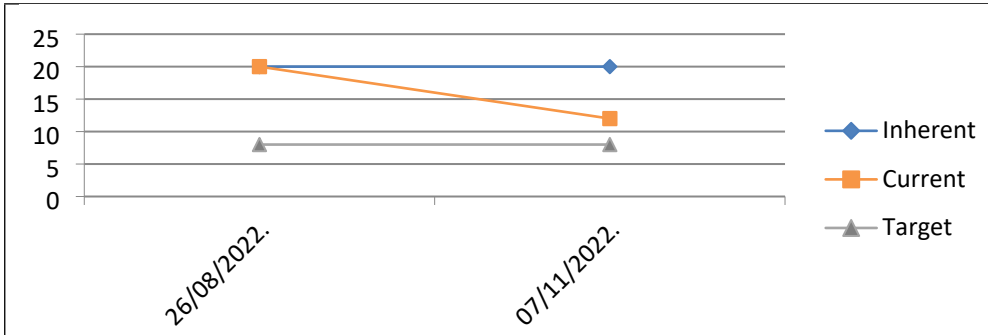
CRR22-26 – Risk De-escalated to Tier 2 level.

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

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

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

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1.Reintroduction of dual consultant operating (for aortic patients only) 2.Implementation of a focussed recruitment plan 3. Enhanced MDT oversight by a specialist centre.	1. Additional support during the AAA operation to limit risk of complications

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

Gaps in Controls/mitigations
1. High sickness and annual leave reduces the ability for dual operating and potentially short notice 2. Poor reputation of service makes recruiting to consultant posts challenging, plus geography of the Health Board 3. Delays in patient decision making when insufficient MDT members attend the MDT 4. 100 + actions, plus actions from the Vascular Quality Panel review, insufficient workforce to support the delivery of the actions in a timely manner 5. May happen at such short notice that immediate transfer of emergency and urgent patient is required with limited notice for NHS England providers

6. Waiting List size significant post Covid, with little capacity to manage anything other than emergency and time critical urgent patients

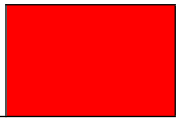
Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Proposal to de-escalate the risk from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3) and the risk to be managed at a Tier 2 level. Since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

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented	24004	Additional funding requested to ensure	Ms Jenny Farley, Vascular	31/12/2022	All consultant vacancies recruited to (with the exception of the CD post interviews	On track

to achieve target risk score		effective medical and therapy workforce model	Network Director		august 2022). Ensures consistently safe patient care across all three sites. Reduces the reliance on agency workforce October 2022 progress update - IMTP has approved £5.8m funding for Vascular and Diabetic services which will enhance the current workforce, recruitment has commenced.	
	24006	Vascular Improvement Plan lead in post and Vascular Network Director in post for wider transformation	Ms Jenny Farley, Vascular Network Director	31/12/2022	Supports the co-ordination of actions needed to deliver against the recommendations. Ensures regular updating of the improvement plan Longer term transformation of the services for stability October 2022 progress update - Vascular network team now includes nursing governance operational transformational interim support until the 31/03/2023, 9 vascular consultants, 7 day cover in place for middle grades across all 3 sites.	On track
	24007	Business Continuity planning in place	Mrs Elaine Hodgson,	30/09/2022	Ensures all risks are identified and mitigated to support patient	Delay

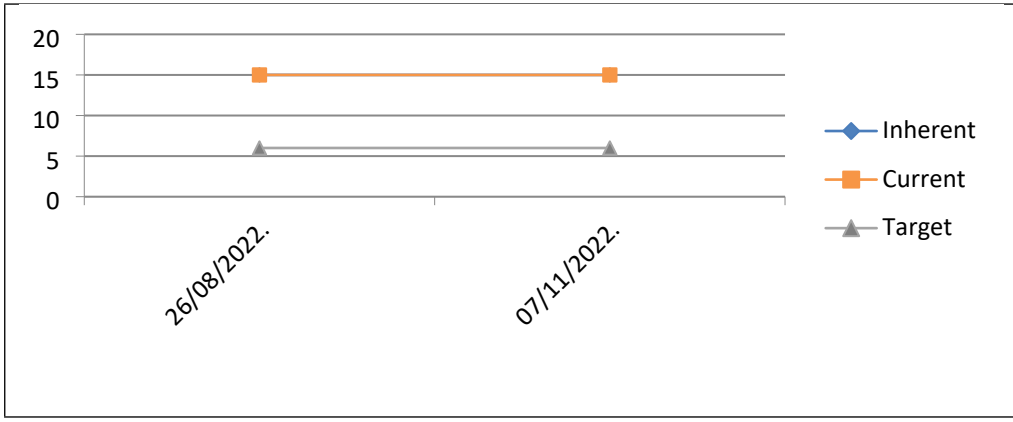
			Directorate General Manager		safety, enables immediate response to crisis Away Day agreed for the 16th September to complete business continuity plan. October 2022 progress update - Business continuity plans continue through the gold command structure, vascular service now fully supported by 9 consultants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

					addition to the established contract with Liverpool Vascular Service.	

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 28 April 2023

There is a risk that the Vascular medical workfroce documenation is non-compliant with regulatory standards for recording keeping.

This could impact on patient outcomes, patient safety, reputation of the service, poor patient experience and clinical staff fitness to practice.



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Weekly case note audits in YGC are undertaken to monitor standards of record keeping actions are taken when poor documentation is identified 2. During the MDT meeting the audit results are fed back monthly. This had demonstrated a significant improvement in the standard of record keeping	1. All actions relating to this risk are included on the RCS Vascular improvement plan reviewed monthly at the Vascular Steering Group which feeds into Quality, Safety, and

3. Refresher training on consent has been provided between March and May 2022 from HIW and the GMC. 4. We continue with the pilot scheme for “CITO” an electronic MDT proforma and work continues to identify if this as an effective document repository. 5. MDT forms process of being filed by MDT co-ordinator in the notes on the same day. 6. Funding MDT admin support have been approved, and work is in progress to get those posts in place. 7. Clinical Governance admin support has also been approved, Job descriptions has been completed 8. Handover from not vascular surgical nigh on call teams	Experience Committee, and then Board

Gaps in Controls/mitigations

1. Permanent ward clerk to file in patient records including MDT outcomes documentations (temporary arrangements in place)
2. The pilot for Cito only covers MDT documentation. (HB wide issues)
3. There is no electronic system to cover daily ward round progress notes (HB wide issue)
4. Currently the surgical on call team has no electronic access to the vascular inpatient list which impacts on the ability to update the list for the vascular team (mitigated by oral handover)

Progress since last submission

1. Controls in place reviewed to ensure relevance with current risk position.
2. Appointment of the clinical director of Surgery to lead Vascular Services.
3. Appointment of clinical lead for a vascular on the 10th November 2022 to support the Vascular Services.
4. Additional PAs have been approved for governance, workforce and training and development for medical staffing, as well as developing closer links to the University for medical teaching.
3. Weekly audits continue to be reported monthly through the Vascular steering groups, chaired by the Medical Director.
4. Action ID 24076 – Action delayed as the pilot CITO continues with the MDT process.
5. Action ID 24078 – Action delayed, medical teams have devised a single communication document to enable clarity on all communications undertaken between medical teams and patients. Work continues to have a similar process for nursing and

therapy teams. Nursing workforce shortages have delayed the implementation. The appointment of a vascular network nursing and governance lead will provide the leadership required to progress this with the aim of having a process in place where communication is captured in one single place, anticipated by 31/01/2023. 6. Action ID 24079 – Action delayed, Intermediate Medium Term Plan funding will allow the appointment of a band 5 governance co-ordinator to support the management of governance processes. The funding has been approved for a National Vascular register inputter, which will support adequate reporting to the National register for Vascular procedures. Interim Network nursing and governance lead has been appointed to support implementation of all governance procedures and processes as well as service re-design of the current clinical governance pathways. 7. Action ID 24080 - Anticipated delay to the action due date, there has been no permanent ward clerk who is responsible for filing in place, which has delayed the ability to provide training. Although temporary support is in place.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-02

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	22282	Reference to RCS vascular improvement plan	Mr Laszlo Papp Newly appointed Clinical Lead	31/12/2022	The actions aim to further identify issues, complete weekly audit for assurance of improvement, provide standardised documentation such as clerking and ward round documentation to prompt quality, involvement of regulatory bodies for training, 1:1 meetings with clinicians to review audits results and	On track

					improvement requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues. There is a large number of actions assigned to improvement for documentation / consent processes which is kept up to date and reported on monthly. This is an ongoing activity. There are objective signs that the Consent process and note keeping standards have gone up.	
	24076	Pilot CITO as part of MDT	Hans Desmarowitz Vascular Governance lead	31/10/2022	To ensure legible documentation. Enhancing security and patient data storage. October 2022 progress update - Pilot CITO continues with the MDT process. November CITO pilot continues indefinitely at present	Delay

	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Ms Jenny Farley, Vascular Network Director	31/10/2022	Will ensure holistic approach to patient care, will improve communication October 2022 - Medical teams have devised a single communication document to enable clarity on all communications undertaken between medical teams and patients. Work continues to have a similar process for nursing and therapy teams. Nursing workforce shortages have delayed the implementation. The appointment of a vascular network nursing and governance lead will provide the leadership required to progress this with the aim of having a process in place where communication is captured in one single place, anticipated by 31/01/2023.	Delay
	24079	Administrative and governance workforce analysis undertaken, identify gaps to support governance processes	Ms Jenny Farley, Vascular Network Director	31/10/2022	Identify the investment required to support effective documentation governance infrastructure	Delay

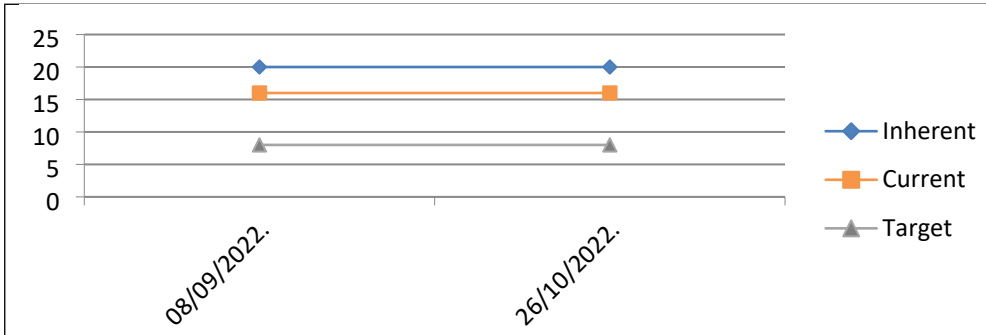
					October 2022 progress update – Intermediate Medium Term Plan funding will allow the appointment of a band 5 governance co-ordinator to support the management of governance processes. The funding has been approved for a National Vascular register inputter, which will support adequate reporting to the National register for Vascular procedures. Interim Network nursing and governance lead has been appointed to support implementation of all governance procedures and processes as well as service re-design of the current clinical governance pathways.	
	24080	Case note filing training to be given to Ward Teams	Miss Victoria Stafford, Ward Manager	30/11/2022	Will ensure correct filing processes for all patient records reducing the risks associated with poor documentation October 2022 progress update - There has been no permanent ward clerk who is responsible for filing in place, which has delayed the ability to	Delay

					provide training. Anticipated delay to the action due date.	

CRR22-32 (former CRR20-06)	**Director Lead:** Chief Digital And Information Officer	**Date Opened:** 08 September 2022
	Assuring Committee: Partnerships, People and population Health Committee	**Date Last Reviewed:** 26 October 2022
	Risk: Retention and Storage of Patient Records	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 30 September 2024

There is a risk that patient information is not available when and where required, this may be caused by lack of suitable and adequate storage space, uncertain retention periods (Infected Blood Enquiry/Covid) and logistical challenges of sharing and maintaining standards of paper case records across the organisation.

This could lead to substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Digital, Data and Technology Strategy in place, with regular reporting to Partnerships, People and Population Health Committee. 2. Corporate and Health Records Management Policies and Procedures are in place pan-BCUHB, monitored by the Patient Records Group.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance

3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the Infected Blood Inquiry. 6. New scanning and destruction provider Storetec in place, ISO 9001 accredited who are beginning to scan records directly into the CiTO records management system.	and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Lack of fit for purpose on site estate to hold physical records with no plans to back record convert all patient records. Health and Safety review ongoing to establish safe storage options, including off site storage. 2. Lack of central oversight of records sent out by other departments. Urgent meeting to support standardisation and consistency of processes. Reporting of compliance to Patient Records Group to be implemented. Meeting held with Concerns Team and revised process implemented to ensure standard centralised process followed. 3. Local site improvement plans being developed in a silo manner without standardised approach across the Health Board. Health Records representation is now on improvement boards. 4. Lack of digital systems in place, CITO programme underway to implement an electronic document patient record and integration with National systems.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. It is anticipated that a current score of 12 will be achieved by the 30 September 2023. 4. Action ID 24372, action transferred from risk CRR20-06, former action ID 12429. 5. Action ID 24374, action transferred from risk CRR20-06, former action ID 23746. 6. Action ID 24375, action transferred from risk CRR20-06, former action ID 23747. 7. Action ID 24376, action transferred from risk CRR20-06, former action ID 23749. 8. Action ID 24378, action transferred from risk CRR20-06, former action ID 23750.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	24372	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	31/01/2023	Formally action ID 12429 from risk CRR20-06. Mental Health Business case has been agreed, further discussion ongoing with Estates to secure current accommodation for patient records October 2022 progress update – New roof in Wrexham commenced 23/10/22. New floor in the Ablett unit now in place.	On track
	24374	A new all encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Formally action ID23746 from risk CRR20-06. A programme in place that will support the mitigation of the risk	On track

			Digital Integration		October 2022 – Meeting 26/10/22 with Integrated Clinical services leads to discuss funding for a programme lead.	
	24375	The identification or recruitment of a Programme Manager (8a) established for the overall programme and ensure all three elements are scoped and re-costed.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Formally action ID 23747 from risk CRR20-06 The action will provide support in the mitigation of the risk. October 2022 – Meeting 26/10/22 with Integrated Clinical services leads to discuss funding for a programme lead.	On track
	24376	The DHR Programme is re-scoped into an EDRMS.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Formally action ID 23749 from risk CRR20-06. To focus on addressing the more immediate patient records management challenges facing the Health Board utilising the proven capabilities of the CITO product.	On track
	24378	Immediate review of the patient record policies, standard operating procedures and the associated delivery of	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Formally action ID 23750 from risk CRR20-06. Ensure all policies are up to date and relevant with new	On track

		training and awareness to improve integrity.	Digital Integration		processes and raising awareness amongst staff.	
	24379	Review all files and utilise off site storage for files due for destruction.	Nia Harrison, Health Records Manager	31/03/2023	Will increase the storage capacity onsite. Ongoing – Identification of files being undertaken to be sent off site to Storetec for scanning	On track
	24380	Risk assess all file storage locations including racking at main sites - To be undertaken by Health and Safety and Fire Safety Officers.	Nia Harrison, Health Records Manager	30/03/2023	Provide safe and secure location for patient files and staff working environment.	On track
	24381	Meeting to be set up with estate management to discuss current issues i.e. – Wrexham roof, YGC porta cabins and temporary locations.	Mrs Jane Carney, Health Records Site Manager	31/12/2022	Work towards providing a safe working environment for staff and the protection of Patient records. October 2022 progress update - further discussion ongoing with Estates to secure current accommodation for patient records. New roof in Wrexham commenced 23/10/22. New floor in the Ablett unit now in place.	On track
	24382	Project to be set up to look at back record conversion of Patient records via scanning technology.	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Provide digitalised copies of records and reduce facility requirements of patient records.	On track

			Digital Integration		Ability to meet our legislative and Health and Safety responsibilities along with reputational damage and reduce any fiscal penalties.	

CRR23-33 (former CRR20-06)	**Director Lead:** Chief Digital Information Officer **Assuring Committee:** Partnerships, People and Population Health Committee **Risk:** Lack of access to clinical and other patient data **lated following approval**		**Date Opened:** 28 October 2022 **Date Last Reviewed:** 28 October 2022 **Date of Committee Review:**		
				Impact	Likelihood	Score
		Inherent Risk Rating		4	5	20
		Current Risk Rating		4	4	16
		Target Risk Score	Revised Risk	4	2	8
		Risk Appetite	**Target Risk Date:** 01 April 2025	low level		1-8

There is a risk that Patient Information is not available when and where required, this is due to a lack of access to a single clinical data repository for patient records, unconnected separate clinical systems and local data repositories.

This could result in substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.

Controls in place	Assurances
1. Digital, Data and Technology Strategy in place to set the direction and vision for digital integration, with regular reporting to, Partnerships, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group for the handling and management of records. 3. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group) with assurance provided to the Performance, Finance and Information Governance Committee.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee. 3. Internal Audit Annual Information Governance Compliance Audit.

4. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 5. Paper file identified as the Master Copy of the full record. 6. Access to current clinical systems to print clinical information ready to store in the Master File. 7. Information Governance Toolkit embedded with operational group oversight and monitoring. 8. Contract in place with third party supplier who are ISO accredited to scan directly into CiTO and destroy clinical paper records confidentially.	4. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Lack of oversight held outside of the central patient records function, for example Mental Health and Paediatrics. 2. Lack of integrated systems with a single source of truth. CiTO Programme underway to implement an electronic document patient records. 3. Single Paper Record repository. Records are held across various sites as limited transportation available which leads to delays in record availability. Current weekly collections in place, but this is not sustainable for the future.

Progress since last submission
This risk is linked to CRR22-32 – Retention and Storage of Patient Records.

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

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	24326	Establish the cost and resources requirements to back scan all live records.	Nia Aspinall, Head of Patient Records and Digital Integration	31/10/2023	The action will support a reduction in the risk score as records will be available electronically pan BCUHB.	On track
	24327	Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Partnerships, People and Population Health Committee.	Nia Aspinall, Head of Patient Records and Digital Integration	01/04/2024	The action will identify all locations of record storage, with the intention to provide a greater level of assurance with standards and compliance.	On track
	24328	Undertake a review of national systems to ensure these can be integrated in the Health Board's CiTO System.	Angharad Wiggin, DHR Programme Manager	01/04/2025	The action will provide single access to all patient data and support the achievement of the target risk score.	On track

<table>
<tr><td rowspan="3">CRR23-34</td><td>Director Lead: Executive Director of Public Health</td><td>Date Opened: 28 June 2017</td></tr>
<tr><td>Assuring Committee: Partnerships, People and Population Health Committee</td><td>Date Last Reviewed: 31 October 2022</td></tr>
<tr><td rowspan="2">Risk: There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.</td><td>Date of Committee Review: New Risk</td></tr>
<tr><td>Target Risk Date: 31 March 2024</td></tr>
<tr><td colspan="3">There is a risk that residents in North Wales may be unable to quit smoking.
This may be caused by their current smoking behaviours including use of vapes and illicit tobacco, income levels, living in socio-economically deprived areas, have a mental health condition or disability, or are from ethnic backgrounds and/or from the LGBTQ+ community.</td></tr>
</table>

This may result in lack of confidence and/or capacity to engage with Help Me Quit Services. This may result in premature mortality and disease including cancers, respiratory diseases and cardio vascular disease, including strokes, heart attacks and dementia. This may impact on the Board's ability to achieve its national performance target. This will impact on the Board's ability to comply with the Smoke Free Regulations 2020.

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15
	Target Risk Score	3	4	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. Continuation of the HMQ for Baby Service with additional investment from Prevention and Early Years funding to support the development and pilot of an Incentivisation Scheme in one area. 2. Continuation of the HMQ in Hospital Service with additional investment from WG Prevention and Early Years funding to support the further development of this service in line with NHS Performance Framework 22-23 to support both staff and patients. 3. Investment from the WG Prevention and Early Years funding to provide support for patients with mental health conditions to support introduction of Smoke Free Regulations. 4. Pharmacy Level 3 Services supported by Prevention and Early Years funding.	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the

6. Insight work to understand barriers identified by priority groups in accessing HMQ Services. 7. HMQ Communications Plan to include a focus on promotion of new service developments and informed by engagement with priority groups with targeted social media to encourage take up of Services. 8. Nicotine Replacement Therapy for staff insight report. 9. BCUHB's Smoke Free Regulations response to include support for staff, patient documentation, no smoking policy, signage, mental health services provision, compliance support and interface with Local Authorities. 10. Business Case for Hospital Compliance Officers (Smoke Free Environment Officers). 11. 'No Ifs No Butts' campaign with partners across the region. 12. De-normalisation actions with partners across the region.	Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements. 2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success. 3. Provision currently through National funding, with funding identified for 2 years, cost pressures for the health board if the national funding were withdrawn. 4. Services are not based onsite at all main hospitals. 5. There are difficulties attracting to vacant posts due to fixed term nature - funding is not recurrent.

Progress since last submission

A small BCUHB group has been established to update the policy in line with smoke free legislation relating to mental health and to complete an updated and more comprehensive EQIA alongside this policy. Occupational health are currently leading this supported by BCUHB colleagues. It is anticipated that this work will be completed by end November, following this the reports will then be submitted to relevant BCUHB groups/committees for information.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	22820	Communication - social media HMQ	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit	On track
	22823	HMQ Services Strengthening the Service	Mrs Gwyneth Page, Public Health Assurance & Development Manager	30/12/2022	Encourage smokers to access services and quit	On track
	22824	Communication - Partnership Plan	Mrs Gwyneth Page, Public Health Assurance &	31/03/2023	Encourage smokers to access services and quit	On track

			Development Manager			
	22825	HMQ Services - Accommodation of staff	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/12/2022	Encourage smokers to access services and quit	On track
	24229	Maternity incentive pilot	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	This will encourage people to attempt quit, accept support and stay quit. Reduction in pregnant smokers in line with priorities in the tobacco control action plan.	On track
	24230	Primary Care Project (EAST Managed Practices)	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Engaging with smokers through local GP practice to encourage interaction with service and quit attempts.	On track

CRR23-35	**Director Lead:** Executive Director of Finance and Performance	**Date Opened:** 19 November 2018
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 November 2022
	Risk: Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	**Date of Committee Review:** New Risk
		Target Risk Date: 31 March 2027
There is a risk of system failure in regard to the Infrastructure on the Wrexham Maelor site which is becoming increasingly obselete due to age and condition.		

The impact could result in an immediate and unplanned loss of clinical services.

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	3	2	6
	Risk Appetite	Select low, moderate or high level		1-8
	Movement in Current Risk Rating Since last presented to the Board in – New Risk	New Risk		

Controls in place	**Assurances**
1. On Call Estates Officers and site shift staff available to attend in the case of a failure or outage. Specialist Electrical and Mechanical Engineering Contractors on-call to attend site 2. Specialist Imprest stock held in stores. 3. Bi monthly meeting of Business Continuity Team which includes representation of all stakeholders impacted by this risk. 4. The BCU Planning Team (Chaired by the Hospital Director) have developed a Business Continuity Plan for essential mitigation of electrical infrastructure associated site risks and also includes those services which would be affected and need to relocate.	1. Risk discussed at Estates Divisional meeting - Bi-monthly. Discussed at the East Site and IHC Risk Management Groups. 2. Authorised engineers (auditors) that assess compliance with current HTMS.

Gaps in Controls/mitigations
Redevelopment Programme planning although recommenced is not finalised.

Progress since last submission
New Risk

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	21570	Business Continuity Planning	Mr Rod Taylor, Director Of Estates	01.04.2022	The aim of this approach is to provide Corporate assurance that a sequence of progressive management actions are in place to mitigate and react to site developments in order to provide near continuous support to YMW based services.	Completed
	21488	Internal Gateway Review -YWM PBC	Mr Rod Taylor, Director Of Estates	31.03.2023	This approach will provide assurance review to confirm if sufficient resource has been made available and how the risk will be managed until all issues are resolved.	Completed
	21571	YWM Continuity Programme Phase One	Mr Rod Taylor,	31.03.2024	This will provide clarity on the deliverables, timelines and identify any un-resourced areas.	On track

			Director Of Estates			
	23751	YWM Redevelopment Programme	Mr Ian Donnelly, Ihcd Operations East	31.03.2024	This will provide assurance that all elements of the PBC have been implemented and associated risk will therefore have been effectively managed and reduced.	On track
	24340	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace full sections of cable between substations in their entirety therefore reducing the amount of joints and as such improving resilience. In order to mitigate the risks the following replacements are proposed with 11kv rated armoured cable:	On track
	24341	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	To provide the level of resilience security and switching control required it is proposed that a new substation is constructed which can accommodate a 6-panel distribution panel, this is also to accommodate a separate switchgear from the DNO which will controlled by the Health Board.	On track
	24342	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	It is proposed that to provide greater resilience for this element that the substation is fitted with 2 No. ring main units and 2 No. 1,000 KVA transformers replacing the currently defective equipment.	On track

	24343	Phase 1 Continuity Scope of Works - Heating Systems in EMS Part of YWM Site	Mr Rod Taylor, Director Of Estates	31.03.2024	The risks with the heating systems will be mitigated by: Retaining pipework where there is a 2-pipe system and replacing areas served by 1 pipe systems – to increase the efficiency of the system. Installing separate heating systems for each of the outbuildings connected to the central boiler house, such that each building is self-sufficient – removing a single point of failure to the outbuildings. Installation of injection circuit stations at the head of each department – to provide greater control and aid commissioning. Installation of above ground distribution pipework – to allow maintenance and reduce any down times. Installation of instantaneous point of use water heaters to hand basins and sinks - removing the single point of failure to the outbuildings.	On track
	24344	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	The installation of 9 new area valve service units and new distribution pipework at a high level both externally and within the buildings for ease of access.	On track

					NIST (Non-interchangeable screw threads) Lockable Line Valves will be provided where applicable so to minimise disruption to the Hospital should any future works to the system be necessary. The pipe run design has been sized at 35mm diameter to provide capacity for the system to work in pandemic conditions.	
	24345	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new vacuum plant to plant rooms 1.4 and 8a with associated pipework to run in areas which allow for ease of maintenance. This also allows for N+1 resilience and an overall capacity of 6,505L/min.	On track
	24346	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new multiplex medical air plant complete with safety valves and integral controls. To service the increased capacity required of 6,800L/min and providing N+1 resilience.	On track
	24347	Phase 1 Continuity Scope of Works - Fire Detection Upgrade L1 and Fire Alarm Panels	Mr Rod Taylor, Director Of Estates	31.03.2024	The renewal of previously installed panels, including loop isolators which have become obsolete and the installation of a new separate network.	On track

					A new network loop will be installed across the whole site excluding the residential facilities located within the north site.	
	24348	Phase 1 Continuity Scope of Works - Nurse Call including Emergency and Panic Alarms	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace the Nurse call and Panic Alarms to all wards within the YMW site.	On track
	24349	Phase 1 Continuity Scope of Works - Heating Calorifiers and Roofing Works	Mr Rod Taylor, Director Of Estates	31.03.2026	To improve obsolete systems associated with Hot Water generation and distribution by upgrading existing Hot Water Calorifiers. Roofing refurbishment will take place to EMS Flat Roof areas and valleys.	On track
	24350	Phase 1 Continuity Scope of Works - Critical Ventilation Systems	Mr Rod Taylor, Director Of Estates	31.03.2027	Critical Ventilation Systems and plant replacement for Theatres 1 to 8 including upgrading the Main Kitchen Ventilation system.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	20
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR21-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-20	There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents.	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR21-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce.	Proposal to de-escalate risk to be managed at Tier 2 if approved by QSE Committee		
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	Proposal to de-escalate risk to be managed at Tier 2 if approved by QSE Committee		
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		
CRR22-32 (Formally CRR20-06)	Retention and Storage of Patient Records	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-33 (Formally CRR20-06)	Risk of Lack of access to clinical and other patient data	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-34	There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	Executive Director of Public Health	Partnerships, People and Population Health	15
CRR23-35	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.	Executive Director of Finance	Quality, Safety and Experience	16
CRR23-36	Cost of Living Impact on Staff and Patients - the risk associated with the impact of the increased cost of living on Staff and Patients and how that translates to the quality of Patient Care that BCUHB delivers	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-37	Targeted Intervention - risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care	Deputy Chief Executive (Proposed)	Quality, Safety and Experience	
CRR23-38	Workforce - The need to consolidate existing workforce risks into an appropriate described risk/risks that reflect the pan BCUHB position for the provision of services to patients. Also, to note a	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
	separate workforce risk related to statutory and regulatory requirements of being an employer			
CRR23-39	Patient Flow - Impact on Access and Quality of Care	Executive Director of Nursing and Midwifery (Proposed)	Quality, Safety and Experience	

Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Risk Key Field Guidance / Definitions of Assurance Levels V2

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Teitl adroddiad: ***Report title:***	Targeted Intervention Update Report
Adrodd i: ***Report to:***	Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	26 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to share key information with the Board relating to the Targeted Intervention Improvement Framework. (TI) Specifically, the report seeks to provide Assurance that the most recent and future TI Programme focus and activity reflects the approach agreed with the BCUHB Board in November 2022 and subsequent meetings with Welsh Government, the TI Senior Responsible Officers (SROs) and TI Domain Leads. On 29 November 2022 the TI Programme Team arranged a workshop with Welsh Government, TI Domain Leads and TI SROs to establish with as much clarity as possible the key measures/ improvements that need to be taken to meet the targets agreed at the BCUHB Board Meeting. A summary of this is provided in this report. Finally, the Board also agreed on 24 November 2022 to revamp the Performance Domain Matrix by end of December 2022 and to separate out vascular and emergency care from the YGC matrix by December 2022. This work has been undertaken and the next steps have been outlined in this update report.
Argymhellion: ***Recommendations:***	The Board is asked to: 1. Note the TI Programme work undertaken since the last Board Meeting on 24 November 2022. 2. Be assured that the work being undertaken is in line with the agreed TI Programme Governance and reflects an appropriate focus to meet the ambitions of the Health Board TI targets that were set on 24 November 2022.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Deputy Chief Executive

Awdur yr Adroddiad: ***Report Author:***	Phil Meakin, Associate Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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

Acceptable assurance has been indicated because some evidence needed to provide significant assurance is not appropriate to be attached as appendices. For example, Draft Plans on a Page and response to Welsh Government letters. The report author can provide any information to Board members in advance of the Board meeting if requested. Phil.meakin@wales.nhs.uk

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	1: Improve physical, emotional and mental health and well-being for all/ Improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Welsh Government Targeted Intervention Improvement 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?***	No, because this report is sharing information on a specific report rather than any direct impacts of TI
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No, because this report is sharing information on a specific report rather than any direct impacts of TI.
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 RMG have approved the development of a new "overreaching" risk that is being developed following feedback from the TI Steering Group. (*There is a risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care*

	and the ability of our staff to deliver effective Patient Care.) It should be noted that the BCUHB Targeted Intervention programme has 6 different but inter-dependent domains. There are a number of existing risks in the Datix system that relate to these 6 domains.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No direct Financial Implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No direct Workforce Implications.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been shaped by the following meetings • The BCUHB Board Workshop on 13 October 2022 • The BCUHB Board Report on TI on 24 November 2022 • TI Meetings with Welsh Government, 10 November 2022. • TI Working Group and Workshop with Welsh Government on 29 November 2022 • The TI Steering Group scheduled for 3 January 2023 TI Evidence of Outcomes Group on 12 January 2023
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Draft BAF Risk Number 1.2 "Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety, resulting in a deterioration of care and harm to patients and service users"
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential Committee (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** Implementation of next steps outlined in Section 4 of the report.	

Rhestr o Atodiadau: ***List of Appendices:*** ***None***

BOARD MEETING IN PUBLIC
26 January 2023
TARGETED INTERVENTION UPDATE REPORT

1. Introduction/Background

1.1 The purpose of this report is to share key Information with the Board relating to the Targeted Intervention Improvement Framework (TI).

1.2 Specifically, the report seeks to provide Assurance that the TI Programme focus and activity reflects the approach agreed with the BCUHB Board in November 2022 and subsequent meetings with Welsh Government, the TI Senior Responsible Officers (SROs) and TI Domain Leads.

1.3 BCUHB has six TI Domains that have been agreed with Welsh Government. Each domain has to self-assess (each November and May) against a maturity matrix that ranges from 0-5. The Board agreed a self-assessment position on 24 November 2022 – See Table 1 below.

1.4 At the last Health Board meeting the Board agreed to a formal self-assessment position of the 6 TI Domains as at November 2022. In addition, the Board agreed to a targeted position for both May 2023 and November 2023.

1.5 On 29 November 2022 the TI Programme Team arranged a workshop with Welsh Government, TI Domain Leads and TI SROs to establish with as much clarity as possible the key improvements that need to be taken to meet the targets agreed at the BCUHB Board Meeting. A summary of this is provided in the next section of this report.

Table 1 - November 2022 BCUHB Self-Assessment

November Board Self - Assessment Position Now Agreed as of 24 November

Domain	Board Agreed Target for November 2022 (at May 2022 Board)	Board Agreed Reference Point for November 2022. (Further Moderated at October TI Steering Group)	Board Agreed Target for May 2023. (Moderated at October TI Steering Group)	Board Target to achieve by November 2023 (Moderated at October TI Steering Group)
All ages Mental Health	3	2	2	3
Strategy & Planning	3	2	2	3
Leadership	2	2	2	3
Engagement	4	2	3	3
Performance	N/A	1	1	2
Ysbyty Glan Clwyd	N/A	1	2	2

2. *Outcome From Workshop with Welsh Government on 29 November - Developing a Clear Approach To Achieve The May 2023 and November 2023 targets.*

2.1 The last two TI reports to the Board have rightly and necessarily focussed on reforming the TI Programme processes and the self-assessment position for November 2022 and target positions for May 2023 and November 2023.

2.2 As a result of this work processes have been improved and for the first-time colleagues in BCUHB have a "longer term" view of the target positions and Welsh Government have supported the Board's reflective approach to the self-assessment.

2.3 Now this clarity has been established there is an opportunity to develop a targeted strategy and approach to meet the targets by November 2023. This report describes the additional work that has taken place since the 24 November 2022 Board to focus on the key deliverables that will have an impact on the outcomes for patients and/or the BCUHB workforce.

2.4 The Workshop with Welsh Government on the 29 November 2022 provided a clearer indication of what the Welsh Government and BCUHB TI SRO and Domain leads consider to be key deliverables and these were documented. The workshop resulted in an ask of all TI Domain leads to produce a "1st Draft Plan on a Page" showing the key milestones to be achieved for each TI Domain. This has now been completed and a report was presented to the TI Steering Group in January 2023. The TI Steering Group met virtually and has signed off the first draft by the due date of 6th January 2023.

2.5 These plans are really critical to the delivery of the TI Targets as they provide a more summarised and clearer focus than the existing maturity matrices. The clarity on the milestones also means that the Maturity Matrices can be "thinned out" to reflect these "plans on a page" and the TI Evidence of Outcomes Group can focus its work on ensuring that the evidence that it reviews is in line with the measures that really matter to our patients and/or workforce. This will be completed by the end of January.

2.6 Furthermore, the plans on a page and reformed Maturity Matrices can be used to re-engage more powerfully with colleagues and stakeholders so that we can produce and collate the evidence that we need to demonstrate our progression to the target TI scores for May 2023 and November 2023 and improve evidence of outcomes for Patients and our workforce.

2.7 Welsh Government have clarified in writing on the 2 December that they wish to see "final agreements on the steps/stages to arrive at level 3 by next November" at our next meeting with them in February. As noted in Section 2.3 the TI Steering Group have signed off the First draft. The approval of the "plans on a page" should provide assurance to the Board that this work is in line with expectations of Welsh Government and the TI Steering Group membership.

2.8 Finally, the Associate Director of Governance has linked with Cwm Taf Morgannwg Health Board and the key link from Welsh Government to make sure that good practice is shared between Health Boards under Targeted Intervention and to support on consistency of approach to the design of maturity matrices. Welsh Government links have encouraged and supported this work.

3. *Performance Domain, Ysbyty Glan Clwyd (YGC) and TI Correspondence With Welsh Government.*

3.1 It was agreed with the Board and with Welsh Government that the TI Performance Matrix would be revamped by the end of December 2022. This has been completed by the TI Performance Domain Leads and shared with the Independent Member (IM) Link. This draft version has been shared with Welsh Government with the provision that further comments may come from either the TI Steering Group or IM Link. This report confirms that the revamped Performance Matrix has been approved by the TI Steering Group members who met virtually in January 2023. The IM link will continue to be engaged as we develop a final version.

3.2 It was also agreed that Vascular and Emergency Care would be separated from the YGC Maturity Matrix by December 2022. This has been agreed and a "plan on a page" has been developed for each of the following: YGC-Leadership, Governance and Culture, YGC-Emergency Department and YGC-Vascular Services.

3.3 It has been agreed with Welsh Government that the 3 YGC Maturity Matrices will be focussed and aligned with the Plans on a Page by the end of January 2023 (in line with the timescales outlined below.)

3.4 After each TI Meeting with Welsh Government a letter from the Director General confirms agreements and key actions. A response detailing the progress on all actions agreed in the Welsh Government letter of 02 December was sent on 30 December from the BCUHB Chief Executive, in line with the timeframe set by Welsh Government.

4. *Summary of Next Steps Following The TI Steering Group*

4.1 Domain Leads and SROs have reviewed and amended the 1st Draft of the Plans on a Page. (Completed by 14 January 2023)

4.2 Domain Leads/SROs will have shared the final "Plans on a Page" with the appropriate Independent Member Link by 16 January 2023 at the latest.

4.3 Dr Nick Lyons and Phil Meakin will sign off the final versions for presentation to Welsh Government by 28 January 2023.

4.4 Existing Maturity Matrices will be streamlined on the basis of the content in the "Plans on a Page" by end of January 2023.

4.5 The "Plan on Page" and Streamlined Maturity Matrices will be presented to Welsh Government by early February. Following this, the TI Programme and TI domain leads will commence their engagement plan with key stakeholders who can influence the ability to meet these requirements.

5. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

5.1 There are no budgetary implications associated with this paper.

6. Rheoli Risg / Risk Management

6.1 The RMG have approved the development of a new “overreaching” risk that is being developed following feedback from the TI Steering Group in November 2022. “*There is a risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care and the ability of our staff to deliver effective Patient Care*.”

6.2 It should be noted that the BCUHB Targeted Intervention programme has 6 different but inter-dependent domains. There are a number of existing risks in the Datix system that relate to these 6 domains.

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

7.1 Not applicable.

Health Board

26th January 2023

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Committee Chair's Report

Name of Committee:	Cabinet – YGC Improvement Plan
Meeting dates:	8th December 2022, and 12th January 2023
Name of Chair:	Mark Polin
Responsible Director:	Gill Harris, Interim Chief Executive
Background and summary of business discussed:	Cabinet has been convened in response to the tripartite decision to escalate YGC into Targeted Intervention with effect from 7.6.22. Cabinet's role is to provide oversight and assurance to the Board for these improvements to include those in the Emergency Department and the Vascular network, as well as more widely across the YGC site, and demonstrate the Board's commitment to delivering safer services for our patients. During the cabinet meetings, the YGC improvement plan has been reviewed in order to monitor progress against the implementation of key mitigations. Cabinet has overseen progress reports on implementation of the YGC Improvement plan. Work is being progressed to determine further support from WG and partner organisations. Regular update reports are provided to all meetings on: • Vascular Services • Targeted Intervention • Make it Safe (paediatrics) Cabinet has maintained oversight of the provision of additional resources and support for current and new staff in relation to vascular services **Summary highlights since last Board meeting** **08.12.22** • **SRO Report – There are indications that** improvements continue to be seen across the YGC site, and the IHC model is embedding. The committee noted the feedback that had been

	received from HIW on areas of improvement which was considered to be measured and fair, recognising the commitment to implementing remedial actions and also the scale, challenge and pace of change. Work was due to be undertaken on theatre utilisation and job planning to ensure best utilisation of available space. • **'Right Patient, Right Place'** – A presentation was received demonstrating dashboard / service barometer for the site which would identify blockages and support wards to discharge. • **Vascular report** and update received. • **Winter Resilience Gold Update** – Cabinet endorsed the decision for mandatory wearing of face masks in all areas; and this would be reviewed on a fortnightly basis. An update was provided on plans for all sites with regarding to forthcoming industrial action, with a Tactical Control Centre being set up with full emergency response for the days of industrial action. discussions held with the Royal College of Nursing regarding staffing and derogation. Plans were in place to ensure staffing of critical services, and looking at what services could continue without the need of nursing support. Corporate nurses were on standby to provide clinical support if needed. **12.01.23** • **Vascular Update** – The final report from the Vascular Quality Review Panel report was awaited, and key headlines from the draft report were provided to Cabinet. A further update would be provided to the January Board meeting. • **'Journey to Excellence'** – A presentation was given on the work undertaken to date, and plans going forward. Work was moving at pace and was demonstrating some improvements that required full support of the IHCs and the Executive Directors to ensure full impact. • **HIW Inspection** – Cabinet were advised that the Health Board had received feedback following the unannounced inspection late November 2022. Immediate action plan had been submitted and the final report was awaited. Key immediate actions were reported to Cabinet. HIW had confirmed acceptance of the action plan and reported back positively on the actions being proposed.
Key assurances provided during the meetings:	Good progress being made as part of YGC improvement plan, in terms of engagement with staff, planned care, and transformation work.
Key risks including mitigating actions and milestones	**08.12.22** – Cabinet remained concerned regarding vacancy levels and recruitment continued to remain a risk. This had been discussed at the Board Workshop on 1st December 2022. The People Strategy and Plan would be discussed at the PPPH Committee on 17th January 2023 to note the achievements of the

	Year 1 Delivery Plan, and to note the process to refresh the People Strategy and Plan, and Year 2 Delivery Plan. **12.01.23** - Cabinet acknowledged work and progress made to-date in terms of improvement work and stressed the need for full support of the IHCs and Executive Team in order to progress this work.
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None
Well-being of Future Generations Act Sustainable Development Principle	The items considered by Cabinet gave consideration to the sustainable development principles indicated below: 1.Balancing short term need with long term planning for the future; 2.Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4.Putting resources into preventing problems occurring or getting worse; and 5.Considering impact on all well-being goals together and on other bodies
Planned business for the future meetings:	• YGC Improvement Plan • Vascular Services Update • Update on Targeted Intervention
Date of next meeting:	To be confirmed

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Audit Committee: Chair's Report

Name of Committee:	Audit Committee
Meeting date:	13/1/23
Name of Chair:	Richard Medwyn Hughes, Independent Member
Responsible Director:	Molly Marcu, Interim Board Secretary
Summary of business discussed:	Completed audit reports for 2022/23 have been presented as follows: **Substantial** Welsh Information Governance Toolkit Management of utility usage, expenditure and efficiency **Reasonable** Voluntary Early Release (VER) Scheme Chair's actions Speak Out Safely Follow Up – Audit Wales: Effectiveness of Counter Fraud Arrangements Follow up – Audit Wales: Continuing Healthcare Arrangements Five Limited Assurance reports are automatically escalated to the Board as described below. The Committee reviewed the following reports from Audit Wales • Tackling the planned care backlog • Public Sector readiness for net Zero Carbon • National Fraud initiative in Wales • Equality Impact Assessments, more than a tick box exercise? • Cyber-attacks/security (also being discussed by PPPH) Audit Wales stated that they intended to issue their board effectiveness report by the end of January. Update on Clinical Audit – the committee will discuss further where this issue should report in.
Issues to be referred to another Committee	General Dental Services Assurance Report – to PFIG

Matters requiring escalation to the Board:	We received limited assurance audit reports in full and spoke to management representatives in respect of: • Welsh Language Commissioner: Documents on the • Website • Effective Governance – Ysbyty Gwynedd • Effective Governance – Ysbyty Wrexham Maelor • Board and Committee Reporting • Charitable Funds
Well-being of Future Generations Act Sustainable Development Principle	The purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance. As such, the Committee considers the sustainable development principles in their widest sense but in particular, the focus on progress of internal and external audit reports supports the principle of putting resources into preventing problems occurring or getting worse.
Planned business for the next meeting:	Year end close-down plan
Date of next meeting:	21 March 2023

Health Board
26 January 2023

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Committee Chair's Report

Name of Committee:	**Performance, Finance and Information Governance Committee**
Meeting date:	22.12.22
Name of Chair:	John Cunliffe, Independent Member
Responsible Director:	Steve Webster Interim Executive Director of Finance

Summary of business discussed:	The Committee agenda was revised to reduce and prioritise items, recognising the December pressures in regard to personnel, industrial action and winter pressures.
	
	The Committee:
	
	received presentations on
	• Recovery Programme : Savings 23/24 Summary
	  • Transactional Pipeline Opportunities – Short Term
	  • Ring Fenced Allocations – Funds Allocated and Current Slippage in 22-23
	  • Savings Plan 2023-24 - DRAFT
	  • Transformational Savings
	• Financial Planning and Budget setting: Allocation update
	
	discussed and noted the following items
	
	• Finance report month 8
	• Financial Control monitoring plan update
	• Transformation and Improvement Plan
	• People (Workforce) report
	
	noted the following item for information
	• Quality and Performance report
	
	The Committee considered the following in private session:
	• Plas Gororau Tender
	• Lease and sub lease
	• Neurodevelopment assessment contract

Key assurances provided at this meeting:	Green shoots of improvement in some areas were noted within the Quality and Performance report
Key risks including mitigating actions and milestones	• In regard to the Financial recovery programme significant challenges in the coming year would continue to be monitored. • The financial control monitoring report would be reformatted to incorporate a risk assessment procedure to inform a robust assessment of progress, with associated RAG ratings. • In regard to the previous year's unqualified accounts, it was understood an assessment on progress made in reducing the level of uncertainty on the opening trade creditors balance, which had formed the basis of the prior year's qualification would be undertaken by the newly appointed Executive Director of Finance. • The Committee was dissappointed that the Welsh Government (WG) allocation was yet to be advised to Health Boards, as the Board's discussion and planning would be extremely challenging. • Pace of the Transformation programme delivery was of concern - none were currently reporting at Green due to the level of programme maturity.
Issues to be referred to another Committee	• Assurance was provided that the Scheme of Reservation and Delegation would be reviewed regularly as part of a process of continuous improvement which would be subject to Audit Committee monitoring. • Improving resource management planning and Agency / Locum usage was referred to the Partnerships, People and Population Health Committee
Matters requiring escalation to the Board:	• Savings plan and delivery of savings is still escalated to the board
Planned business for the next meeting:	Regular reports plus • Financial aspects of the Integrated Medium Term Plan
Date of next meeting:	19.1.23

Teitl adroddiad: ***Report title:***	Conwy & Denbighshire Public Services Board Well-being Plan
Adrodd i: ***Report to:***	Health Board
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	Conwy & Denbighshire Public Services Board (PSB) draft Well-Being Plan 2023 – 2028 is presented to the Board for approval. The Plan was developed to respond to the updated well-being assessment for the Conwy and Denbighshire area which was produced in 2022. The plan is intended to address the key areas which pose the greatest need or challenge for communities, where the PSB can make the greatest contribution towards social, environmental, cultural and economic well-being, adding value to existing partnerships and core services.
Argymhellion: ***Recommendations:***	The Committee recommends that the Board • Receive the well-being plan for 2023 – 2028 • Approve the Plan, as part of the partner scrutiny and approval process, prior to formal sign off at the PSB in March 2023 NOTE that The Committee has requested further detail on implementation plans be provided to it for oversight.
Arweinydd Gweithredol: ***Executive Lead:***	Chris Stockport, Executive Director of Transformation, Strategic Planning and Commissioning
Awdur yr Adroddiad: ***Report Author:***	Conwy & Denbighshire PSB officer team Cover report – Sally Baxter, Assistant Director – Health Strategy

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 production and implementation of the Well-being Plan is part of the Health Board's duties under the Well-being of Future Generations (Wales) Act 2015 and supports the strategic goal of improving health and well-being
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Production of the well-being assessment and the well-being plan are key tasks of the PSBs, for which the Health Board is a named participant. The Health Board has a statutory duty as a designated public services body to fulfil the requirements of the Well-being of Future Generations Act.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do *Y* A well-being impact assessment was undertaken in support of the plan, which is an integrated impact assessment encompassing equality impact.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do *Y* A well-being impact assessment was undertaken in support of the plan, which is an integrated impact assessment encompassing socioeconomic impact.
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)***	Risks identified by the PSB include: • Risk that the PSB lacks influence or control to deliver against the objectives • Risk of duplication with work ongoing in other organisations • Risk of over-ambitious objectives unable to be delivered • Risk of not achieving approval in line with statutory deadline of March 2023
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no immediate financial implications arising from the plan, although further assessment of any resource or capacity required will be undertaken when taking forward steps in the plan.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No immediate workforce implications are identified arising from the plan.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Engagement and consultation was undertaken by the PSB during the summer and autumn of 2021 to capture views on what is working well and what needs to be focused on for the benefit of future generations. The

	development of the plan was supported by the Co-Production Network for Wales. Public consultation on the draft plan took place between 17 August – 9 November 2022. The plan was submitted to PPPH Committee on 17 January 2023 and was supported, subject to provision in due course of further detail on the implementation plans, actions and outputs, given the high level of the priorities and outcomes set out within the current document.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: ***Next Steps:*** The plan is currently being submitted to all partners for approval, and will be presented to the PSB on 23 March 2023 for formal sign off.	
Rhestr o Atodiadau: ***List of Appendices:*** Conwy and Denbighshire Public Services Board Well-Being Plan 2023 - 2028	

HEALTH BOARD MEETING IN PUBLIC
26 JANUARY 2023
CONWY AND DENBIGHSHIRE PUBLIC SERVICES BOARD
WELL-BEING PLAN 2023 - 2028

1. Introduction/Background

In April 2016, the Well-being of Future Generations (Wales) Act 2015 (the WFG Act) established a statutory board, known as a Public Services Board (PSB), in each local authority area in Wales. Conwy and Denbighshire have used the power within the Act to merge both of their separate PSBs into a single board for the Conwy and Denbighshire region. The PSB is a collection of public bodies working together to improve the well-being of their county – to improve the economic, social, environmental and cultural well-being of the Conwy and Denbighshire area by working towards the seven national Well-being goals. Membership consists of senior representatives from partner organisations including the Health Board.

The WFG Act places a statutory requirement on each PSB to produce a Local Well-being Plan for their area. The Local Well-being Plan must set out how the PSB intends to improve the economic, social, environmental and cultural well-being of its area by setting local objectives that will maximise the contribution made by the Board to achieving the well-being goals in its area. The Local Well-being Plan must be published no later than one year after the publication of its Well-being Assessment. Conwy and Denbighshire therefore are working towards a proposed deadline of March 2023 for publishing the Local Well-being Plan.

2. Corff yr adroddiad / *Body of report*

The Well-being Plan, attached to this report, 2023 to 2028 will set the Conwy and Denbighshire PSB's well-being objectives for the next 5 years.

In early 2022 the findings of the Well-being Assessment were reviewed in detail, and strategic issues where the PSB could collectively make a difference as a group of partners were identified. This work was supported by the Co-Production Network for Wales. From our analysis, the Board came up with a long list of strategic issues. The Health Board and Public Health Wales representatives on the PSB have been involved in the development of the plan throughout.

A series of workshops were then held in the summer of 2022 to prioritise areas of greatest need along Social, Cultural, Environmental and Economic themes, and to develop potential solutions. This was done by considering the synergies between priorities, the impact the PSB could have, the long-term implications, and where work was already taking place. This resulted in redefining the plan into a single priority area focusing on Conwy and Denbighshire being a more equal place with less deprivation.

Further consultation was held with the public and partners on the draft plan between August and November 2022. This included discussions with the Well-being of Future Generations Commissioner's Office. The final draft plan was then presented to the PSB in November 2022 before commencing scrutiny and approval process through the PSB partner organisations.

In addition to the involvement of officers within the development of the plan, the Health Board's Public Health team submitted comments in response to the plan which agreed with the objective within the plan, the approach and the measures of success. However attention was drawn to a number of important pieces of evidence of exacerbation in inequalities following the Covid pandemic. Public health input and expertise will be vital in ensuring the implementation of the plan continues to address these areas of inequality.

As noted above, the deadline for publication of a Public Services Board's well-being plan is within one year of publication of the well-being assessment. The Conwy and Denbighshire well-being assessment was completed by April 2022, therefore the deadline for publication of the well-being plan is by April 2023. Further PSB well-being plans for the North Wales partnerships are being finalised for scrutiny and approval and will be brought to the Board in due course.

3. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

There are no immediate financial implications arising from the plan, although further assessment of any resource or capacity required will be undertaken when taking forward steps in the plan.

4. Rheoli Risg / Risk Management

Risks related to the publication and implementation of the plan have been identified by the PSB and will be mitigated and monitored by the PSB.

There is a risk to the Health Board and other North Wales organisations which are members of the PSB that priorities in Conwy and Denbighshire differ from priorities in other areas. The plan is however a local plan and is built on local needs assessment and co-production. The PSB officers across North Wales work together as a network to share best practice and utilise resources effectively where possible.

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

The well-being impact assessment which was undertaken in support of the plan can be found with the agenda and papers for the PSB at Denbighshire County Council - Agenda for Conwy and Denbighshire Public Services Board on Wednesday, 30 November 2022, 2.00 pm

Health Board
26.1.23

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Committee Chair's Report

Name of Committee:	**Partnerships, People and Population Health (PPPH) Committee**
Meeting date:	17.1.23
Name of Chair:	Linda Tomos, Independent Member
Responsible Director:	Chris Stockport, Executive Director Transformation and Planning

Summary of business discussed:	The Committee agreed
	• Living Healthier, Staying Well Strategy updates would be received at 6 monthly intervals
	• Latest draft of Integrated Medium Term Plan (IMTP) would be provided to members for consideration prior to discussion at Board workshop on 7.2.23
	• Estate Strategy to be submitted to the Health Board to consider approval
	• Draft Conwy and Denbighshire Public Service Board Wellbeing Plan to be submitted to March Health Board to consider approval
	
	The Committee received the following strategy and service updates:
	• Clinical Services Strategy update
	• Draft Winter Resilience Plan 2022/23
	• Learning Disability Strategy update
	• Third Sector Strategy update including progress with revising BCU's Volunteering strategy
	• People Strategy and Plan progress
	• Test, Trace, Protect (TTP) Programme update
	• North Wales Regional Partnership Board update
	• Speak Out Safely update
	• Population Health : Violence Prevention update
	• Primary Care update : Cluster Development and Planning
	• Board Assurance Framework
	• Corporate Risk Register
	• Chair assurance reports:
	  ○ People Executive Delivery Group (EDG)
	  ○ Population Health EDG
	  ○ Mid Wales Joint Committee
	  ○ Strategic Equalities Forum

	In private session the Committee considered cyber security and risk as well as Workforce Planning activities
Key assurances provided at this meeting:	• The Winter resilience planning including business continuity plans had been utilised during recent periods of industrial action and elevated staff sickness rates. Learning events were scheduled to take place the following month on Critical Incidents that had taken place in order to feedback into future processes and plans. • Successful Learning Disability leadership was highlighted as potential evidence to support Targeted Intervention work and also a subject for the Board to consider as a Patient Story. • Positive partnership working with Local Authorities in regard to Learning Disability support. BCU is currently first in Wales to successfully undertake pooled budget pilot with Ynys Mon council. • 2023/28 Volunteering Strategy is progressing well and the Committee is supportive of the approach being undertaken. • Extensive work is being undertaken in regard to Violence Protection to meet with statutory guidance and involves other partnership organisations • Whilst the TTP programme is drawing to a close Welsh Government is funding a 1 year Health Protection programme team which will also include a budget for vaccination provision • Accelerated Cluster Care planning is being undertaken with a target date of developing realistic, deliverable, aligned annual plans by the end of 2023/4. Strong investment in developing leadership skills is being made to ensure future success.
Key risks including mitigating actions and milestones	• Alignment of BCU's Clinical Services strategy with IMTP • There is inadequate funding to meet the rapid improvement of BCU estate required, therefore long term non-compliance with some areas of statutory safety will remain. Development of new pathways and transforming ways of working may reduce the need for some buildings in the future. • Insufficient grasp of BCU non-estate assets remains an unquantifiable risk for patient and public safety. • Condition of Learning Disability estate has been long standing under investment issue • Clarity is being sought to ensure RPB risks are reflectively aligned within BCU • Concern regarding confidence of employee trust in the Speak Out Safely process

	• Evidence of population health outcomes to support Targetted Intervention • The Committee also noted the corporate risk register and the Board Assurance Framework.
Issues to be referred to another Committee	There were no items for referral to other committees.
Matters requiring escalation to the Board:	The Committee escalated Cyber resilience to the Health Board for discussion in private session.
Planned business for the next meeting:	To be agreed.
Date of next meeting:	14.2.23

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Name of Committee:	Targeted Intervention Improvement Framework (TIIF) Steering Group
Meeting date:	21.11.22
Name of Chair:	Nick Lyons, Deputy Chief Executive / Executive Medical Director
Responsible Director:	Nick Lyons, Deputy Chief Executive / Executive Medical Director
Summary of business discussed:	• Nick Lyons has taken over from Gill Harris as Chair of the TI Steering Group following the recent change in positions. • It has been agreed to set a twelve month target for the TI self assessment scores for each domain rather than a six month target which has been previously in place. • During the meeting with Welsh Government on 10.11.22 the self assessment scores for each domain were agreed. • A TI Working Group workshop is taking place on 29.11.22 and Olivia Shorrocks from WG has agreed to join the meeting and share some key deliverables to focus on to reach level 3 and beyond. • There is a need to ensure TI is at the front and centre of the Health Board work, that we are all using the same language and that the same issues are being discussed in relevant meetings across the organisation. • The Group approved the submission of evidence received from the YGC domain to move for a level 0 to a level 1. • The Group considered and discussed an appropriate risk for the TI programme. • The Terms of Reference for the TI Working Group, TI Evidence of Outcomes Group and TI Steering Group were discussed. • The Performance maturity matrix was shared with the Group and a revised version will go to the next meeting of the Group for formal approval before being shared with WG.
Key assurances provided at this meeting:	• Governance arrangements are in place to monitor TI progress via Steering Group oversight.

Key risks including mitigating actions and milestones	• No risks were raised
TIIF Domain addressed	• All
Issues to be referred to another Committee	• The TI programme risk will be discussed at the Risk Management Group.
Matters requiring escalation to the Board:	• None
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1. Balancing short term need with long term planning for the future* – covered by the strategy, planning and performance domain. *2. Working together with other partners to deliver objectives* – covered by the engagement work *3. Involving those with an interest and seeking their views* – covered by the engagement work; *4.Putting resources into preventing problems occurring or getting worse* – via WG funding allocation; *5. Considering impact on all well-being goals together and on other bodies* – covered by engagement work.
Planned business for the next meeting:	• Approval of Performance Maturity Matrix
Date of next meeting:	19.12.22

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Name of Committee:	Targeted Intervention Improvement Framework (TIIF) Steering Group
Meeting date:	19.12.22 & 03.01.23 (Please note both the December and January meetings were cancelled due to the announcement of an Internal Critical Incident on these dates)
Name of Chair:	Nick Lyons, Deputy Chief Executive / Executive Medical Director
Responsible Director:	Nick Lyons, Deputy Chief Executive / Executive Medical Director
Summary of business discussed:	• The TI Steering Group meetings due to take place on 19.12.22 & 03.01.23 were cancelled due to the announcement of an Internal Critical Incident on these dates and the priority support required to assist. • The papers due to be discussed at the meeting on 19.12.22 were rolled forward to the meeting due to take place on 03.01.23. • As the January meeting was cancelled, the agenda bundle was circulated to all members of the Group via email requesting papers / recommendations to be reviewed and comments to be returned by 06.01.23. • The following recommendations were included:1 ➢ Consider and support the next steps following the TI Working Group Workshop on 29 November 2022. ➢ Note and consider the first draft of the TI Domain "Plan on a Page" documents and refine these by 10.01023 ready for informal review by Welsh Government from 13.01.23. ➢ Consider and support the next steps related to the development of the Performance Maturity Matrix. ➢ Approve the evidence for the YGC Maturity Matrix (Vascular) ➢ Note the next steps required to refine the Maturity Matrices ➢ Note the response letter from Gill Harris to Judith Paget. ➢ Note the next steps required in relation to the ongoing key actions in the update section of the letter from Judith Paget dated 02.12.22.

	• The TI Evidence of Outcomes Group is taking place on 12.01.23 where the "Plan on a Page" documents will be shared and the evidence submissions for the YGC Domain (which includes Leadership, Governance and Culture, ED and Vascular) will be approved. •
Key assurances provided at this meeting:	• Governance arrangements are in place to monitor TI progress via Steering Group oversight.
Key risks including mitigating actions and milestones	• No risks were raised
TIIF Domain addressed	• All
Issues to be referred to another Committee	• N/A
Matters requiring escalation to the Board:	• None
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1. Balancing short term need with long term planning for the future* – covered by the strategy, planning and performance domain. *2. Working together with other partners to deliver objectives* – covered by the engagement work *3. Involving those with an interest and seeking their views* – covered by the engagement work; *4.Putting resources into preventing problems occurring or getting worse* – via WG funding allocation; *5. Considering impact on all well-being goals together and on other bodies* – covered by engagement work.
Planned business for the next meeting:	•
Date of next meeting:	07.02.22

Health Board
26 January 2022

To improve health and provide excellent care

Advisory Group Chair's Report

Name of Advisory Group:	Healthcare Professionals Forum (HPF)

Meeting date:	2 December 2022

Name of Chair:	Jane Wild, Scientific Advisory and HPF Chair

Responsible Director:	Gareth Evans, Acting Executive Director of Therapies & Health Science and Executive Lead HPF

Summary of key items discussed:	**H22/34 Welcome, Introductions and Apologies** **H22/34.1** The Chair opened the meeting and welcomed those present. The Chair noted the absence of apologies for Adrian Thomas, previously the Executive Lead at HPF who has recently retired. The Chair wished to note gratitude for Adrian Thomas's support and contributions to the HPF over the years, and the members joined the Chair in wishing Adrian a very long and happy retirement. **H22/34.2** Apologies received: John Speed, Community Pharmacy Representative Dr Stuart Porter, Mental Health Medical Representative **H22.34.3** The Chair noted that there are three members, herself as Healthcare Science Representative, Mandy Jones, Nursing Representative and John Speed, Community Pharmacy Representative whose first term tenures are due to be renewed on 7 December 2022, and the process of renewals will be initiated following the meeting. **H22.34.4** The Chair extended a special welcome to two new members at HPF. Stuart Porter, who unfortunately had to send his apologies for today's meeting, joins the HPF as a temporary member in the absence of Dr Faye Graver, Primary and Community Care Medical representative who is currently on maternity leave; and Steven Grayston, who joins us as the Therapy Representative while Gareth Evans is acting as Lead Executive. The HPF members made their introductions for the benefit of the guest presenters and the new members.

	H22/38 Targeted Improvement (TI) Update - Presentation by Phil Meakin (PM), Associate Director of Governance The Chair welcomed the Associate Director of Governance to update the HPF members on the position of Targeted Intervention within BCUHB, what has changed since the last update and key areas of focus of importance to our patients and staff. PM gave a brief introduction of his previous experience and current responsibilities then went on to highlight the definition of 'Targeted Intervention' and the specific changes relating to BCUHB in more detail. It was noted that a formal self-assessment had taken place and targets agreed by the Board and with Welsh Government for the next 12 month period. Following the presentation, a question and answer session ensued. It was confirmed that the HPF representatives would continue to be welcomed at the TI Evidence and Outcomes group meetings that will be ongoing. The Chair thanked Associate Director of Governance very much for joining the meeting and for the very interesting and informative discussion with the members. **H22/39 Annual CEO Update** – verbal update from Gill Harris (GH), Interim CEO The Chair welcomed the Interim CEO to the HPF meeting and the members made their introductions. The Interim CEO began the verbal update with good news to share and to say thank you and congratulations to everyone regarding the awards received over the last 12 months, across both Wales and the UK, and in particular, the event held at Venue Cymru on 21 October celebrating the achievements of our staff across the Health Board. It was a fantastic event that highlighted the phenomenal amount of progress and innovation that was required to continue throughout times of Covid and the pandemic, keeping patients both safe and informed, and we need to continue to recognise the work being taken forward when times are tough. Unfortunately, there continues to be significant challenges in terms of our workforce and gaps in our workforce and our ability to care for patients. However, thanks go out for the care and compassion, on every level, which is amazing at a time when there is tiredness and stress, added to that facing an incredibly difficult winter, also now facing industrial action and troublesome and challenging times ahead.

	The Interim CEO is having conversations with colleagues and teams on the cost of living crisis, a number of staff are really suffering and taking ideas to Executive colleagues to see how we can support our staff during these incredibly difficult times. It was noted that it is important to ensure that team leaders are listening to staff, and recognition that it is not easy to acknowledge financial difficulties, particularly in the lead up to Christmas, which is a considerable additional burden on top of the general stresses of daily life. A number of refugees have been accommodated within North Wales, and thanks go out to our colleagues stepping up to help support local authorities with that action, with safeguarding and screening that needs to be undertaken and once again recognising the additional stress for our public health colleagues. It was noted that the Duty of Quality and Candour becomes live in April 2023. The Nursing and Quality team have been doing a huge amount of work on this, and have moved into a more transparent and positive space with this. There are conversations taking place with Air Ambulance Wales concerning their flying base. Our own engagement colleagues are fully involved in this wider engagement exercise, to ensure that our public are also fully involved with us on this process, and WAST colleagues are having their own conversations. As mentioned earlier in the update, winter planning is in progress, working with Local Authority colleagues and WAST, who are experiencing similar problems regarding staffing of care homes, care home packages and trying to prevent people being admitted into the hospitals. A lot of work is being done to develop the primary care strategy, the accelerated cluster programme, and how we can work differently with pharmacy colleagues, optometry colleagues and therapy colleagues to look for alternatives before going through the emergency department route. A huge amount of engagement is taking place and the timeline for this strategy is before the end of March. In relation to the Targeted Intervention presentation, financial challenges and performance challenges puts us under Welsh Government (WG) scrutiny and by end of this financial year believe to be in deficit by 10 million. It is important to try to prevent unnecessary expenditure to bring the Health Board back to a break-even position, and we are working with teams for a greater level of flexibility, and credibility. The Integrated Health Community Director's are beginning to look for ways to work differently, making decisions locally to best

	support our patients and best support our innovation. The Healthcare Inspectorate Wales visited Ysbyty Glan Clwyd (YGC) earlier this week, there was acknowledgement that improvement work is gradual, however we know there is more to be done. There was recognition of the engagement of staff even under the current pressures. The Interim CEO summed up the update to say that a huge amount work is going on across the HB, there is a focus on progressing business case's to support more planned activity at speed, and support more green activity in order to support both unscheduled and planned care. The planning framework was presented this week, and progress is ongoing for the Integrated Mid Term Plan (IMTP), which is due to be presented to WG in March 2023. A question and answer session ensued. The Chair thanked the Interim CEO very much for the comprehensive and informative annual update. **H22/40 Introduction to Regional Treatment Centres -** Presentation by Hugh Mullen (HM), Interim Regional Treatment Centre Programme Director The Chair welcomed the Interim Regional Treatment Centre (RTC) Programme Director to the HPF meeting and introductions were made by the members present. The presentation and discussion slides regarding the RTCs were shared with the Forum members prior to the meeting. The presentation included the following: - Update from the presentation shared at the HPF meeting June 2022 - Establishment of Programme and summary of progress to date - Overview of complexity and challenges - Invitation for continued involvement and engagement The Interim Programme Director gave an overview of the RTC programme including the Strategic Outline Case, the scope of the progamme, the model base and the requirement for transformational change. Also a list of specialities included within the RTC model. The programme update included the focus of the recent work to drive the development forward; strengthening of programme governance including the creation of the Strategic Clinical

	Reference Group; engagement with external suppliers; completion of a model of care; continued engagement with Welsh Government (WG) and refining the plan establishing realisit timescales for the required work. It was emphasised that clear effective comprehensive communication and engagement is ensured and the opportunity to join the HPF meeting today is welcomed. The Interim Programme Director extended the offer to meet and engage with any groups that the HPF members represent separately. It was highlighted that the clinical support will be key to the successful development of the proposal and the views of the members on how best to engage and communicate would also be welcomed. A question and answer session ensued. The question of locations and workforce were raised, and the potential for the RTCs to be operational a minimum of 6 days per week. In terms of the workshops, there was a request that an invitation is extended for a pharmacy representative to attend, also for a further conversation with the Chief Pharmacist and the three pharmacy directors. The question of preparation of starting the pathway work and giving sufficient time to upskill the workforce was raised. Project managers are being appointed in order to support the pathway work, which will be starting in January 2023 and will expect that to be multi disciplinary. Further questions in terms of workforce and in terms of delivering service by appropriate medical nursing staff and availability to perfom the work were raised. Emphasis was requested to be placed on the multi disciplinary aspect of the workforce, and finance to support this right from the start of planning. A question regarding sufficient clinic rooms to deliver the services required was raised, and if growth factored in to the space plans. There was a question as to whether there would there be consideration for integration of dentistry into the RTCs. Future proofing for technologicial and IT advances over the next 4 to 5 years was also raised. The digital workstream is due to start this month. The Chair thanked the Interim RTC Programme Director very much for joining the HPF meeting, and for the useful, informative and engaging discussion. **H22/41 Chair's and member's summary reports** H22/41.1 HPF Member Report_Healthcare Science (HCS) H22/41.2 HPF Member Report_Nursing H22/41.3 HPF Member Report_Dentistry H22/41.4 HPF Member Report_Primary and Community Care H22/41.5 HPF Member Summary Report_Optometry

	H22/41.6 HPF Member Report_Midwifery and Women's Services H22/41.7 HPF Member Summary Report_ Mental Health Medical H22/41.8 HPF Member Summary Report_Therapy Services H22/41.9 HPF Member Summary Report_Pharmacy and Medicines Management H22/41.10 HPF Member Summary Report_Specialist & Tertiary Care
Key advice / feedback for the Board:	**H22/43 Summary of information to be included in Chair's report to the Board** • Targeted Intervention HPF members were pleased that the forum will continue to contribute to the targeted intervention programme through HPF representation on the TI evidence and outcomes group. • Regional Treatment Centres HPF members supported the approach being taken to develop clinical pathways and new models of service delivery in preparation for the regional treatment centres' availability. Members highlighted the need for workforce considerations within the early planning phases from both a capacity and capability perspective, with specific emphasis on the multi-professional requirements for the RTCs. HPF members highlighted the current challenge in releasing clinical staff to focus on the transformational change that will be required to maximise the impact of the RTCs and that this was a risk that should be considered. • IMTP HPF members were pleased to be able to provide feedback to planning team colleagues on the IMTP at a dedicated workshop in November. Members recommended that consideration be given to the development of clear decision and implementation processes related to any disinvestment or substitution of services. • Workforce HPF members wish to acknowledge pressures on existing workforce that are increased due to recruitment and retention challenges. The HPF welcomed longer term plans associated with the development of the North Wales Medical and Health Science School and were very supportive of a joined up approach to the training and development of the broad healthcare workforce required in North Wales. The members suggested that there may be opportunities to build upon existing plans to provide novel and collaborative approaches to education and training and HPF would be happy to provide further input and advice as the plans for

	the North Wales School develop. The forum also discussed the importance and potential benefit of developing broader support systems for early career professionals or staff moving into North Wales, including consideration of support related to accommodation provision, opportunities for social interaction and general well-being support.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Planned business for the next meeting:	Range of standing items plus: • Mental Health Strategy • Quality Strategy Update
Date of next meeting:	Friday, 3 March 2023

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Health Board	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	**Stakeholder Reference Group**
Meeting date:	**05.12.22**
Name of Chair:	**Clare Budden, Chair of Stakeholder Reference Group**
Responsible Director:	**Helen Stevens-Jones, Director of Partnerships, Communications & Engagement**
Summary of key items discussed:	• Discussion with the Chairman, Mark Polin • Inverse Care Law Programme • Digital, Data & Technology
Key advice / feedback for the Board:	• The Chair made reference to the meeting schedule going forward confirming that the Stakeholder Reference Group (SRG) will meet four times per year for no more than two hours at a time and will also have two workshop style sessions in between these meetings. • The Group had the opportunity for a discussion with the Chairman and expressed a desire to engage more effectively going forward. • The Chairman was keen to ensure that all Groups and Committees that support the Board are engaged with the work and intended direction of the Board and are able to help shape the way we go forward as an organisation. • The agenda for future meetings of the Group will include a standing item on feedback from the Board which will address the impact of the comments from the Group to the Board and vice versa. • The Inverse Care Law programme was presented with the aim of seeking advice from the Group as to how stakeholders can support the programme. • Strong views were raised in relation to health inequality. • The work of the programme may prove difficult in the current climate. • The key priority for the programme is to get partners working

	together more effectively to tackle some long standing health inequality issues. The Group members agreed to take an active part as appropriate in each of the three pilot areas. • In relation to the Digital, Data and Technology item, there is a need to support and challenge the Health Board to deliver the basic capabilities across the organisation first e.g. phone services and a recognition that digital service transformation will take time. • There needs to be recognition that a “one size fits" approach won’t work as some people will not be able to or will resist accessing services and information digitally. • The discussion linked back to health inequality and the inverse care law work and the group supported the need for digital exclusion to be addressed. • The Chair also made reference to the SRG workshop sessions which will be taking place next year and asked the Group to highlight any topics they would wish to be included.
Targeted Intervention Improvement Framework Domain addressed	• Engagement (patients, public, staff and partners)
Planned business for future meetings:	• SRG Annual Report including review of terms of reference and cycle of business
Date of next meeting:	Monday 6th March 2023

Health Board
24.11.22

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	**Charitable Funds Committee**
Meeting date:	18.10.22
Name of Chair:	Jackie Hughes, Independent Member
Responsible Director:	Rob Nolan, Acting Executive Director of Finance
Summary of business discussed:	The Committee **received** presentations on • Brewin Dolphin Investment Manager Portfolio Report • How we got to where we are now – look back on NHS charitable fundraising and strategy report on • findings by Fundraising Training Ltd in regard to Strategy Review and Fundraising Feasibility **approved** • Committee Work Plan for 2022/2023 • Application by Parabl for funding **discussed and noted** • Audit Wales 21/22 Audit Plan • Staff Hardship Funding Paper • Summary of Expenditure Requests • Charitable Funds Finance Report Q1 2022/23 A loss in quarter one due to the loss on investments was recorded. Donations were £290k in Q1, which was £90k up on the same quarter last year. Income in the first quarter was £1k, which was £4k down on the same quarter last year. Grants and funded expenditure was £166k, being an increase of £36k on the same period in Q1 last year. Fundraising expenditure was £53k, which was an £8k decrease on the same period in Q1 last year.
Key assurances provided at this meeting:	• The investment management company Brewin Dolphin had been taken over by Bank of Canada however, the investment manager assured that this would have no effect on current management

	arrangements and would be a positive step in Brewin Dolphin's future. • Further exploration of governance and financial information would be undertaken prior to entering into the scheme submitted • The Committee requested that more analysis be undertaken on the findings of the Fundraising Training Ltd report
Key risks including mitigating actions and milestones	• Recent external market conditions had affected BCU's Charitable investment portfolio. However, the investment manager was confident of long term improvement. • A decision to withdraw investment associated with Russia would be dealt with at the next meeting, pending the receipt of further information to aid decision making. The Committee reaffirmed its committment to retain its ethical stance on investments. • It was agreed that Trustee workshops on Governance and Training would be incorporated into the existing Health Board workshop schedule to strengthen Board members' understanding of their roles and undertakings as Charity Trustees • Audit Wales would be carrying out work to include three areas of significant risk which had been raised i.e. Transfer of Investment Company, New Charity Accountant and Management Override, which was expected to be completed by January 2023
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None
Planned business for the next meeting:	Regular reports plus: Feedback on staff hardship report
Date of next meeting:	29.12.22

Teitl adroddiad: ***Report title:***	Quality & Performance Report to 30th November 2022			
Adrodd i: ***Report to:***	Health Board			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report outlines performance against the key performance and quality measures identified as a priority for the Health Board and reported to the Performance, Finance and Information Governance, and Quality, Safety and Experience Committees. The summary of the report is now included within the Executive Summary pages of the Quality and Performance Report and demonstrates the work related to the key measures contained within the 2022-23 National Performance Framework. This framework has been revised to provide performance measures including Ministerial Priority Measures under the Quadruple Aims set out in A Healthier Wales. The structure of the report follows the sub-chapter headings within the Quadruple Aims. Following feedback from members of the Board, the trend arrows have been replaced with 12 month trend charts which better illustrate past performance and direction of travel of performance.			
Argymhellion: ***Recommendations:***	The Health Board is asked to scrutinise the report and to advise whether any areas need further details and assurances sought.			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	David Vaughan Head of Performance Assurance			
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:*** There are a number of under-performing key areas across the Health Board with limited evidence and assurance that improvements will be made and/or sustained – hence the partial assurance. **Steps to improve this rating:** We will continue focus on improving performance reporting and workflows, which includes supporting leads and services to improve the connection between correcting actions, plans and improvements – to benefit both our local population health and well-being and that of our workforce.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2022-23.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Performance, Finance and Information Governance Committee.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo *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?***	Do/Naddo *N* The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	The pandemic has produced a number of risks to the delivery of care across the healthcare system
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within the annual plan will have direct and indirect impact on the financial recovery plan of the Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on our current and future workforce.

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed in parts (narratives) by senior leads across the Health Board and relevant Directors. And the full report has been reviewed by the report author.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	This QP report provides an opportunity for areas of under-performance to be identified and subsequent actions developed to make sustained improvement.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** *Continued focus on any areas of under-performance where assurance isn't of sufficient quality to believe performance is or will improve as described.*	
Rhestr o Atodiadau: ***List of Appendices:*** *None*	

Quality and Performance Report

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

Performance to 30th November 2022
Presented on 26th January 2023

Health Board

Table of Contents

About this Report

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2022-23 NHS Wales Performance Framework published in mid 2022. The Report is structured according to themes and the Quadruple Aims as presented in A Healthier Wales. Only those measures requested to presented to Board are included in this report.

Report Structure

This report continues to evolve as we amend it to reflect the new NHS Wales Performance Framework for 2022-23. There are new measures where data wasn't previously collected – we are working on getting this into the report, as required/requested where applicable, as quickly as possible.

The latest validated data we have access to is contained within the report. A number of mental health measures are reported one month in arrears.

All NHS measures are reported (split) and presented in separate reports to PFIG and QSE committees. This Health Board version is a subset of only those measures requested. And is a replication of the sections from the latest PFIG and QSE reports – even if more recent data is available*.

This is to ensure consistency, e.g. that what is presented to QSE and PFIG committees is scrutinised and then presented here to the board.

This report is structured so that measures complementary to one another are grouped together. Narratives on the 'group' of measures are provided, as opposed to looking at measures in isolation.

Performance Monitoring

Narratives are provided on groups of red rated narratives – even if some are on target (green).

Additional charts are included that provide a performance position on key activity across the Health Board that aren't covered within the main body of this report – nor is the specific focus.

DTOC graphs and narrative have been removed as nationally D2RA is the focus and is being further developed. We will update and include as required.

Ongoing development of the Report

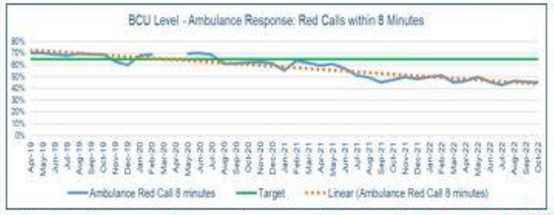
Work is underway to utilise the full suite of MS 365, including Power BI to produce a digitally interactive, flexible and insightful Dashboard more reflective of modern business intelligence systems.

**The Additional information section might include different data, including more recently reported*

Overall Summary Dashboard 1 of 2

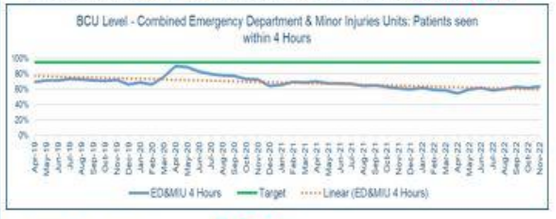
Unscheduled Care Measures

Ambulance Red Calls 8 Minutes: *45.0%

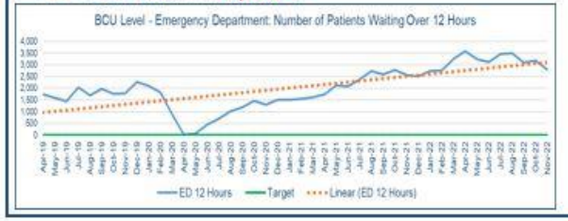


Ambulance Handovers Over 1 Hour: 1,871

Combined ED&MIU 4 Hours: 63.66%



ED 12 Hours: 2,802



ED 24 Hours: 1,057 *Latest Data October 2022

Stroke Admission 4 Hours: 27.50%

Stroke Consultant 24 Hours: 77.70%

Sickness Absence Rate: 6.16%

Planned Care Measures

*Latest Data October 2022

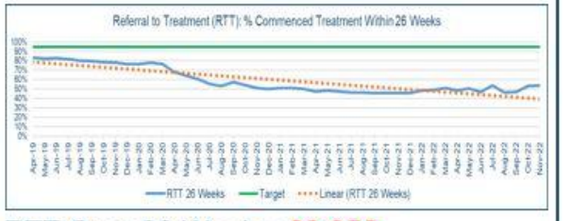
Diagnostic Waits 8 Weeks: 8,034

Therapy Waits 14 Weeks: 4,271

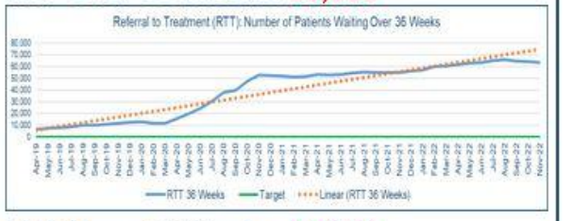
Total Follow Up Backlog: 210,840

Follow Up Over 100%: 65,834

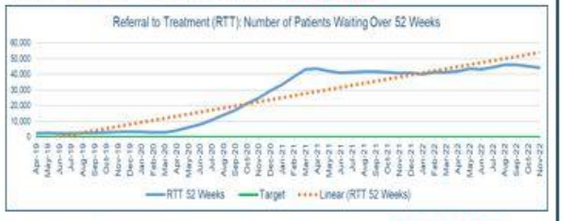
RTT within 26 Weeks 53.69%



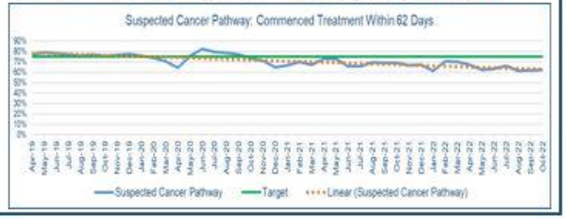
RTT Over 36 Weeks: 63,356



RTT Over 52 Weeks: 44,119



Suspected Cancer Pathway: *62.33%

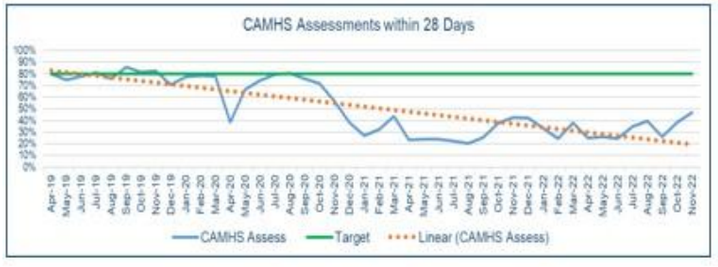


Overall Summary Dashboard 2 of 2

CAMHS – Therapy within 28 Days: 20.48%

Number of New Never Events: Q2 July-Sep 2022 3

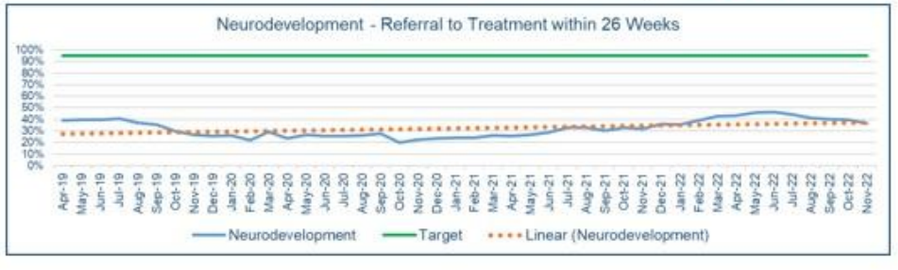
CAMHS – Assessed within 28 Days: 46.95%



Adult MH Assessed within 28 Days: 70.82%

Adult MH Therapy within 28 Days: 76.29%

Neurodevelopment within 28 Days: 36.74%



Adult Psychotherapy within 26 Weeks: 89.77%

Executive Summary 1 of 2

Improving Position

- Number of patients waiting across Cardiology and Endoscopy continue to reduce, as does Diagnostics over 8 weeks
- Dental access for both new children and adult patients, plus existing patients shows a promising trend upwards
- Number of patients waiting more that 104 weeks for referral to treatment has been reducing since March 2022 (18,475) to November 2020 (12,947)
- Number of patients waiting more than 36 weeks for referral to treatment has also started to show a gradual reduction over the last 3 months (65,959 to 63,356)
- Number of patients waiting more than 14 weeks for a specified therapy continues to reduce (6 month trend now) and stands at 4,271)
- Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by the Health Board has now been above target for 4 consecutive months and is currently at 86.7% (national target is 85%)
- Percentage headcount by the Health Boad who have had a PADR/medical appraisal in the previous 12 months (including doctors and dentists in training) has improved each month for the past 4 - and stands at 71% (target is 85%)

Static Position

- Important metrics within Emergency Department, such as 4 and 12 hour waits remain fairly static over the past three months as does median time to triage and assessment by a senior clinical decision maker
- Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes remains fairly static, which is could be viewed as a positive considering current pressures
- Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of referral route) has remained fairly static from August to October (latest data) at around 62%
- Percentage of patients waiting less that 26 weeks for referral to treatment remained constant for the last 2 months (and an improvement on the 2 months prior to that)
- Sickness absence has remained stable for October and November 2022 at 6.2%

Declining Position

- Percentage of 111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being completed continues to decline - currently at 50.8% (November 2022), compared to 84% in December 2021
- Diagnostic Radiology (Total) waits increased from 3787 (October) to 4317 (November) after reducing in October from September (4591).
- Percentage of ophthalmology R1 appointments attended which were within their clinical target date has shown a slight decline over the last 6 months - from 54% in June to 51% in November
- Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% has been steadily declining over the last few months (but this decline appears to be slowing) - currently standing at 65,834 (November 2022)
- Agency spend has increased in October and November

Executive Summary 2 of 2

Improving Position

- % of patients waiting less than 28 days for a first appointment for Specialist Child and Adolescent Mental Health Service improved for last three months, where data is available, to 100% (caution small numbers though)
- % Mental Health assessments (for under 18 years) undertaken within 28 days of referral, whilst still well below target, has improved from September to November 2022
- % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health has improved over the four months to November 2022 - all being above the target of 80%
- % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service for adults aged 18 years+ has improved month-on-month from September to November 2022 and is nearly at target (76.3% against a target of 80%)

Static Position

- The last four months, August to November 2022, have seen performance of % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service - remain fairly static, but well below the target of 80% (for under 18 years)
- % of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years has been above target (90%) for all but one (89.2%) month in the last 12
- Both adult psychiatric measures have been at 100% since reported in April 2022
- % of Mental Health assessments undertaken within 28 days from the date of receipt of referral for adults aged 18 years+ has been fairly consistent from December 2021 to November 2022 (mostly around 70% - against a target of 80%)
- % of Health Board residents in receipt of secondary Mental Health services who have a valid care and treatment plan for adults 18 year+ has been very consistent between 81.7% to 87.1% over the past 12 months and not far from a target of 90%

Declining Position

- % of children and young people waiting less than 26 weeks to start an Attention Deficit Hyperactivity Disorder or Autistic Spectrum Disorders neurodevelopment assessment has slightly and steadily declined from June through to November 2022
- Complaints responded to in a timely manner has been trending downwards from September 2021 (68%) to November 2022 (approximately 22%) - against a target of 75%

Chapter 1

Quadruple Aim 2:

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

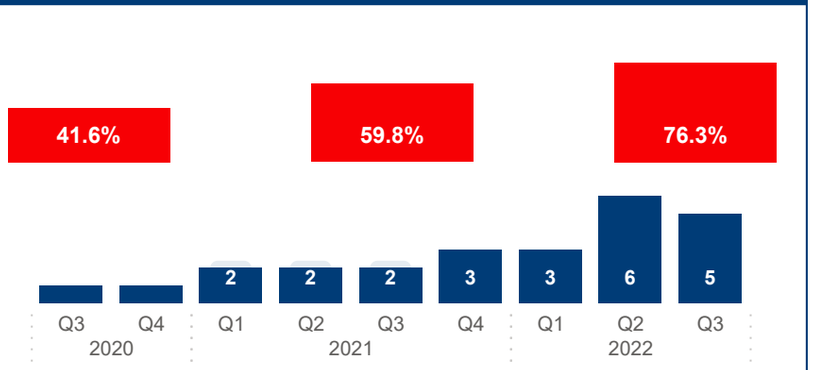
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwalar University Health Board

1a: Primary & Community Care

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

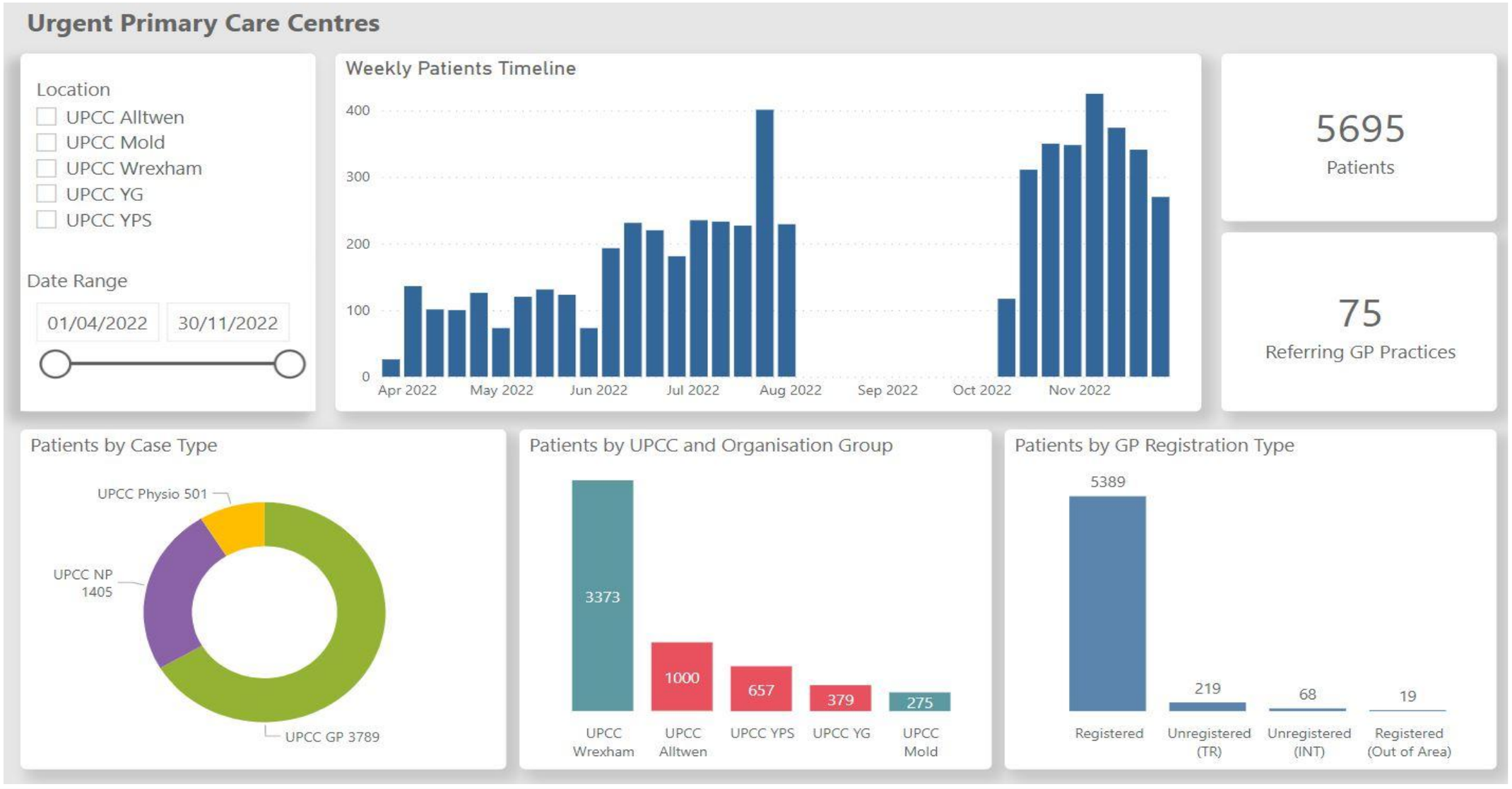
Measures: Primary & Community Care

Committee	Period	Measure	Target	Actual
PFIG	2021/22	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%	76.3%
PFIG	2021/22	Number of Urgent Primary Care Centres (UPCC) established in each Health Board footprint (i.e. both UPPC models)	As outlined in Health Board's Six Goals Programme Plan	5



Committee	Period	Measure	Target	Actual
PFIG	Nov	Number of new patients (children aged under 18 years) accessing NHS dental services	4 quarter improvement trend	1625
PFIG	Nov	Number of new patients (adults aged 18 years and over) accessing NHS dental services	4 quarter improvement trend	2265
PFIG	Nov	Number of existing patients accessing NHS dental services	4 quarter improvement trend	13.5K

Urgent Primary Care Centres (UPCC)



GP Out of Hours

MUC REPORT - April 2019 to July 2022

All Contacts (excludes NHSD Advice, Pharmacy Appointments/Walk Ins and UPCCs)

Select Area

All | All Reg. Pts. | West | Centre | East

Select Financial Year

Select all | 2019/2020 | 2020/2021 | 2021/2022 | 2022/2023

All Contacts by Month

Total Contacts to Date

355,235

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019				12,499	12,052	11,076	10,201	11,254	10,281	10,459	11,126	12,938
2020	10,608	9,789	9,681	8,314	9,269	7,772	8,006	9,734	8,441	8,282	7,504	9,305
2021	9,916	7,136	7,866	9,206	11,071	9,169	6,882	7,368	6,177	7,236	6,495	7,003
2022	7,003	5,758	6,500	8,243	8,022	7,824	7,769					

Community Pharmacy Enhanced Services Activity and Discharge Medicines Reviews

Situation Report (Overview)

Pressure Level	Number	Percentage
1	75	50%
2	59	40%
3	13	9%
4	2	1%

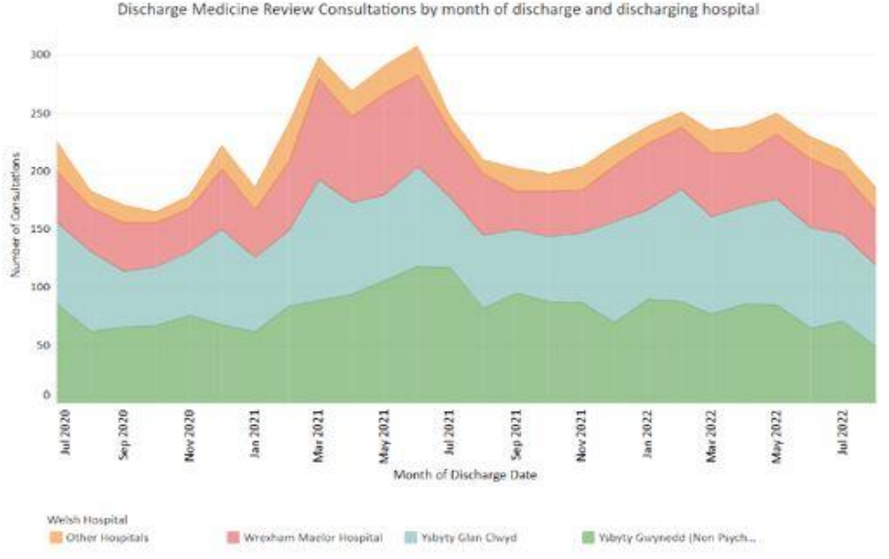
- **Pressure levels:** stable with significant pressure spread across North Wales
- **Temporary suspension of services:** Significant fall in early Nov (cf. 2021). Ongoing workforce issues reported by contractors. New process from 1 Nov
- **Support to care homes** – Plan being drafted to ensure full offer made to homes in Q4
- **PIPS –** 22 sites live. Peak of c.1,000 consultation in August, 752 carried out in Oct 2022
- **CCPS** – Sore Throat Test and Treat & Bridging now in CAS element of CCPS, but still rolling out. Bridging Contraception likely to be available from Dec onwards; CAS conditions review underway
- **Adherence support** – Two sites live in Blaenau Ffestiniog, with view to add up to 10 sites in Dwyfor cluster over the next 8-10 weeks.
- **Clusters & Collaboratives –** Working with Pharmacy Collaborative Leads to establish new structure and move to unified ToR for collaboratives; some issues around admin support to collaboratives
- **Periods of treatment –** hesitance in some practices to progress, but supporting where possible – possible risk to community pharmacy capacity.
- **Repeat Dispensing** – activity stable, good engagement in some areas, but most are limited

Current priorities

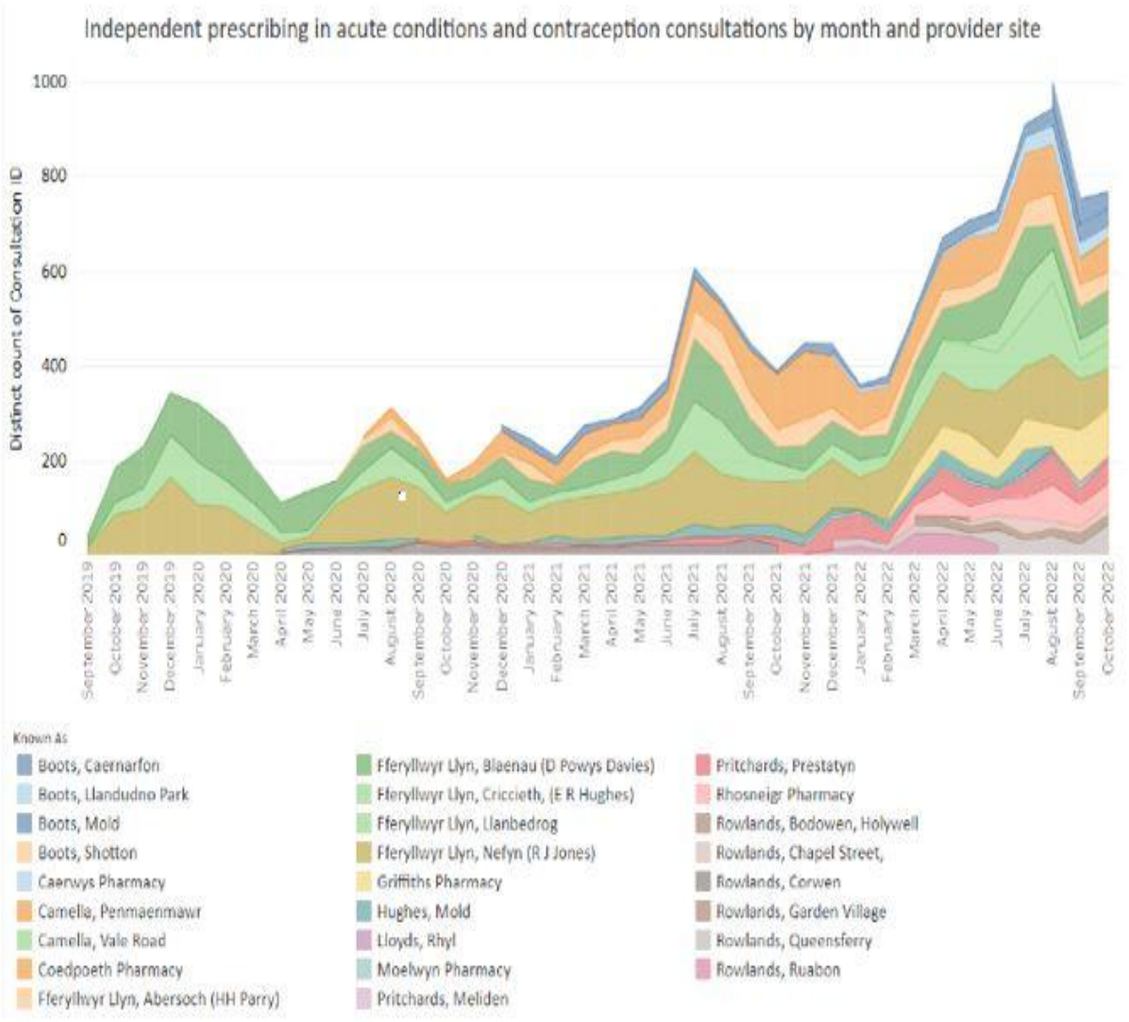
- **Urgent Primary Care –** Service rollout; service delivery and availability tools; integrating urgent care services into wider primary care offer
- **Medicines Optimisation** – Repeat Dispensing, MHOL & Periods of Treatment; support to care homes; MDT care home reviews; adherence support programme; National MAR chart service
- **Population Health** – Campaign to relaunch HMQ@ Pharmacy service; Flu programme delivery & quality
- **Network efficiency and effectiveness** – promoting healthcare professional lines & NHS emails over fax; Walk in My Shoes scheme; supporting recruitment; escalation tool; CPLPT support; Encouraging lunch breaks; Education & training strategy

Key risks and mitigation

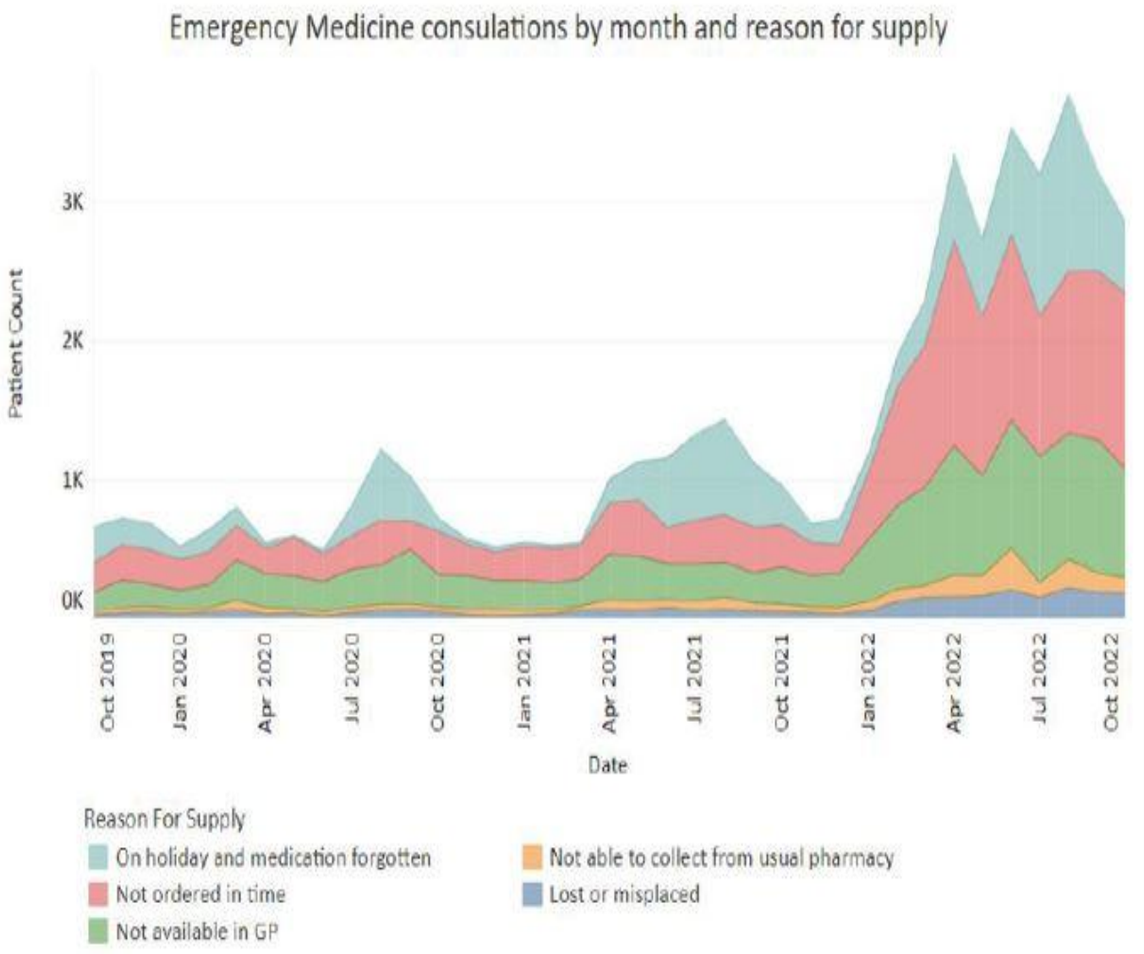
Risk	Mitigation
Workforce shortages and pressure on teams > reducing OOH cover	Monitoring closures & pressure; CPLPT support to staff; aiding recruitment (Just 9 programme); Temporary suspension processes; supporting mitigating action to minimise impact on patients
Shortage of DPPs limiting IP training opportunities	Continuing to link pharmacists up with potential trainers and supporting pharmacists to become DPP-ready; HEIW to fund DPPs in 2023/24
Periods of treatment	Working with GP practices where possible to support move to increased PoT; escalated to WG regarding issues in dispensing practices moving to longer PoT



Community Pharmacy Enhanced Services Activity and Discharge Medicines Reviews

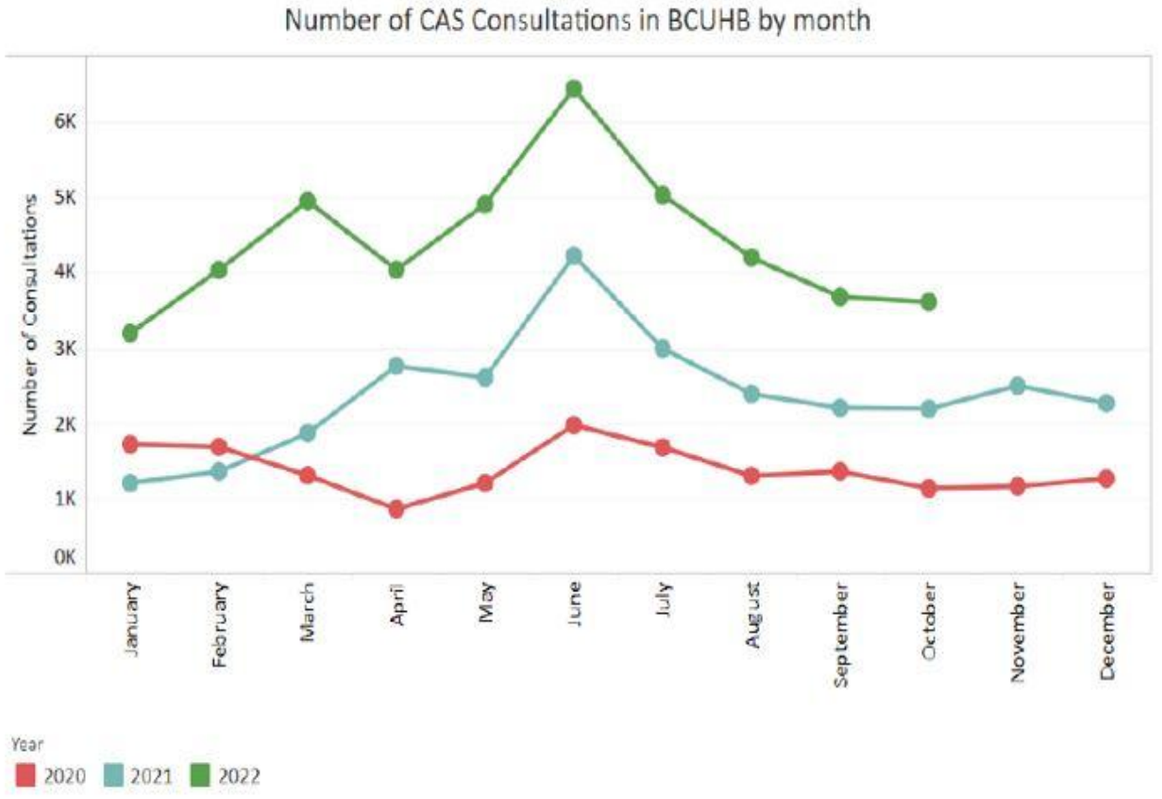


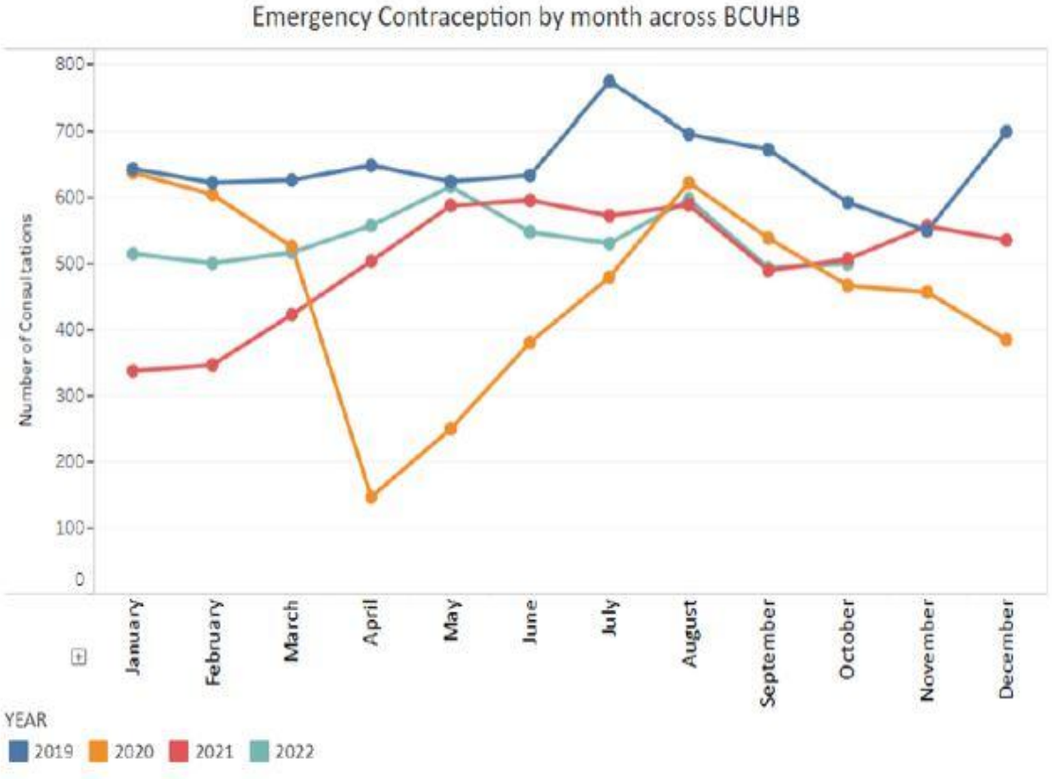
Independent Prescribing Service data updated to 31 October 2022 (Interactive chart)



Emergency Medicines Service data updated to 31 October 2022 (Interactive chart)

Community Pharmacy Enhanced Services Activity and Discharge Medicines Reviews





1b: Urgent & Emergency Care

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

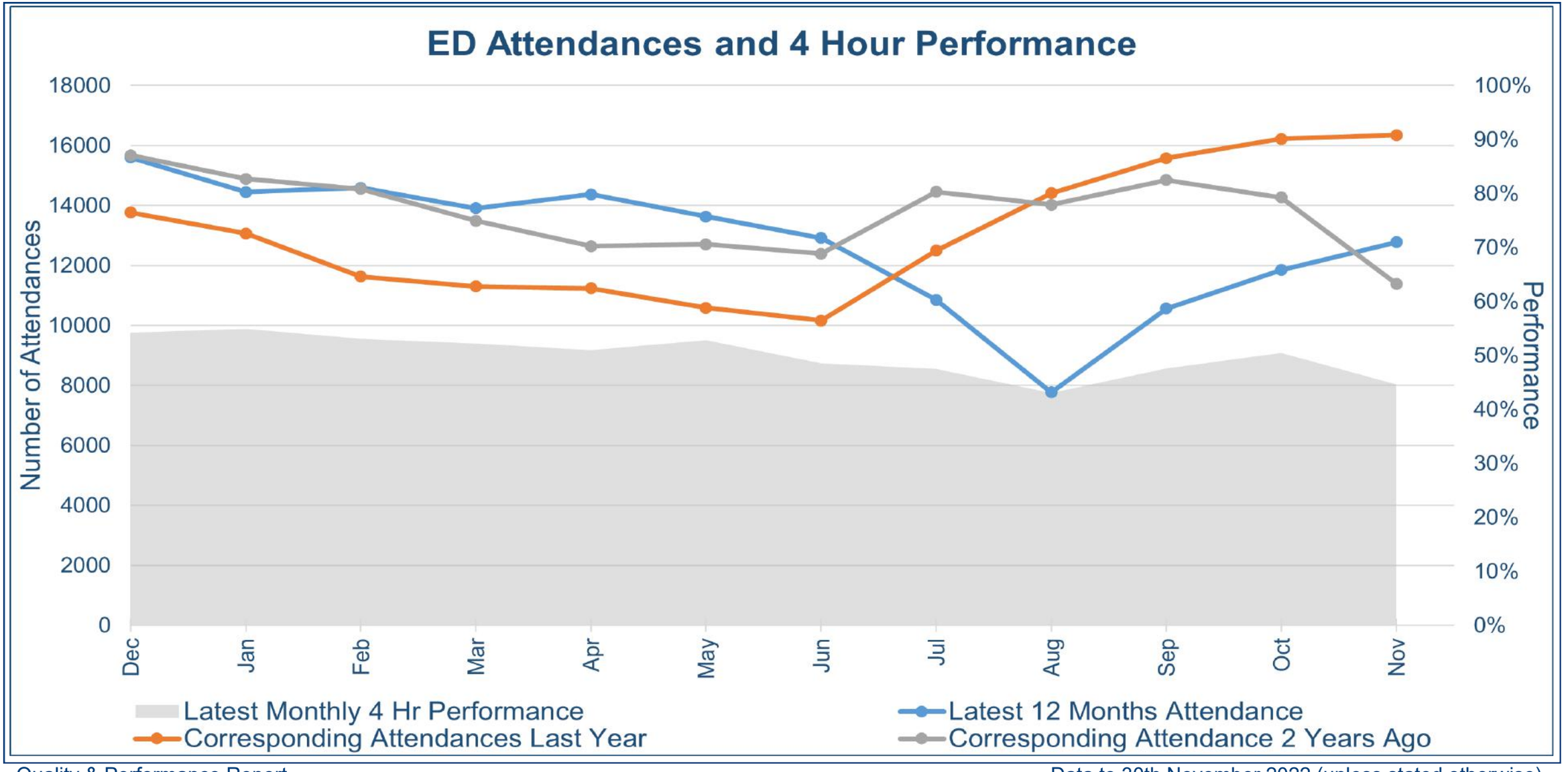
Measures: Urgent & Emergency Care Page 1

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Nov	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	95%	63.7%	60.2%	62.1%	58.7%	58.5%	54.9%	59.8%	61.8%	58.4%	60.7%	62.9%	61.9%	63.7%
PFIG	Nov	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	0	2802	2502	2728	2763	3245	3584	3249	3124	3462	3507	3106	3178	2802
PFIG	Nov	Median time (minutes) from arrival at an emergency department to triage by a clinician	12 month reduction trend	26	27	25	34	38	43	37	34	34	27	28	27	26
PFIG	Nov	Median time (minutes) from arrival at an emergency department to assessment by a senior clinical decision maker	12 month reduction trend	135	151	129	158	179	188	177	154	175	166	143	142	135
PFIG	Nov	Percentage of 111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being completed	90%	50.8%	84.0%	85.2%	85.3%	83.2%	68.7%	69.1%	72.8%	64.5%	Data not available (system issues)			50.8%

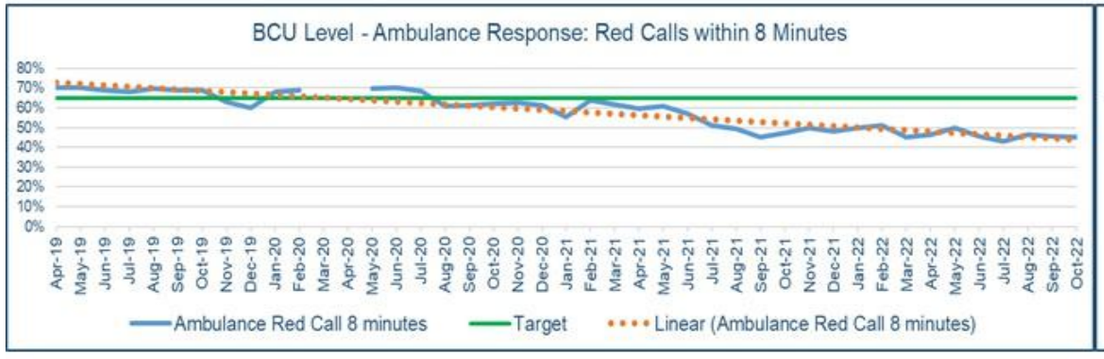
Measures: Urgent & Emergency Care Page 2

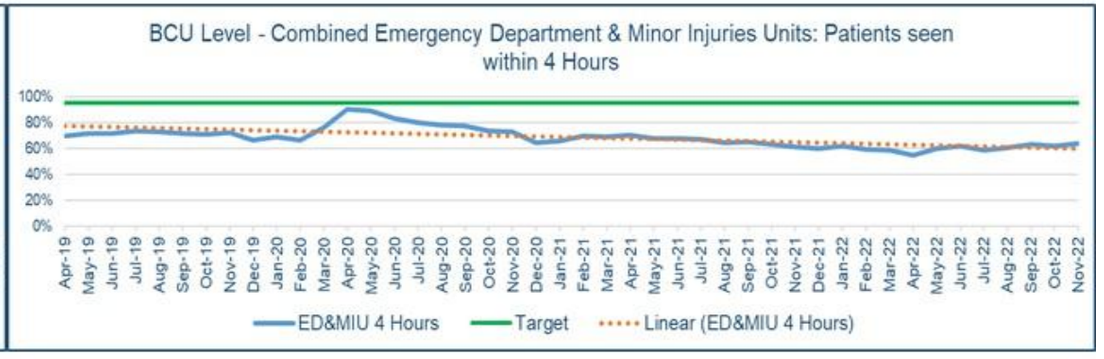
Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Nov	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patients clock start time	SSNAP UK national quart ave	27.5%	23.6%	15.0%	14.1%	16.7%	10.6%	13.6%	27.2%	38.3%	32.4%	21.9%	14.7%	27.5%
PFIG	Nov	Percentage of stroke patients who receive mechanical thrombectomy	10%	0.0%	2.2%	1.7%	1.4%	0.0%	0.0%	5.9%	1.9%	0.0%	0.0%	3.0%	2.5%	0.0%
PFIG	Aug	Percentage of patients (aged 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	12 month reduction trend	67.2%	74.0%	73.3%	73.3%	72.3%	72.4%	71.1%	69.3%	68.7%	67.2%	Awaiting Data		
PFIG	Oct	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	45.0%	48.1%	49.7%	51.0%	45.3%	46.2%	49.7%	45.6%	42.9%	46.2%	45.5%	45.0%	Await Data
PFIG	Nov	Number of ambulance patient handovers over 1 hour	0	1871	1743	1998	1958	2003	1749	1884	1932	2037	1898	1908	2027	1871
PFIG	Oct	Percentage of total conveyances taken to a service other than a Type One Emergency Department	4 quarter improvement trend	2.1%	2.1%	2.2%	2.1%	2.2%	2.1%	2.5%	2.2%	2.4%	3.0%	2.8%	2.1%	Awa it Dat

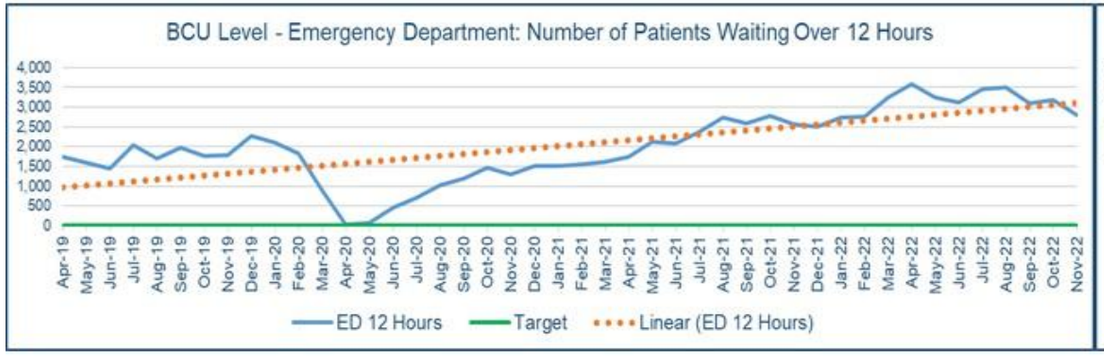
Charts: Emergency Department Attendances & Performance

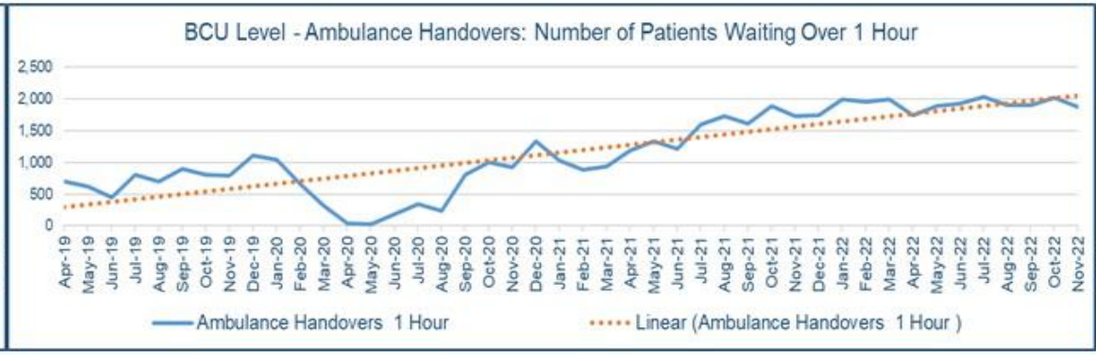


Charts: Unscheduled Care









Narrative: Emergency Care

Why we are where we are

Significant pressures continue to be experienced across NHS Wales due to a number of attributing factors that are impacting on unscheduled and emergency care services. Flow through the hospitals and Integrated health community remain the main contributory factor that results in gridlock within the emergency departments and hamper the ability to off load ambulances in a timely fashion due to capacity. Attendances to the emergency department remain constant with hourly occupancy rates continue to rise.

The ability to reach the required targets for Emergency care remains a challenge, including the 4-hour target, ambulance delays, patient harm, low staff morale and increased number of complaints

What we are doing about it

Ambulance handovers, following on from the ministerial briefing it has been identified that a zero tolerance to delays greater than two hours with a review of all Integrated Health Community (IHC) Emergency Department (ED) escalation process to support the ability to maintain flow and capacity within the emergency departments. Access to Physician triage assessment and streaming (PTAS) to support early interaction with 999 calls that can be supported with care closer to home.
Implementation of a pan North Wales Paramedic pathfinder direct access to Same day emergency care (SDEC) to reduce the need for access to the emergency departments (Goals 2 of the six goals for urgent and emergency care)
Streaming of minor category patients that can be managed through the urgent treatment centres (UTC's) or minor injury units (MIU's) to support improving 4 hours performance for those patient that have a lower triage category that are clinically stable for streaming.
The six goals for Urgent and Emergency care programme has identified working groups that cover all elements of the six goals programme, to support improvement on the clinical journey for all patients by utilising staff experience on service development.

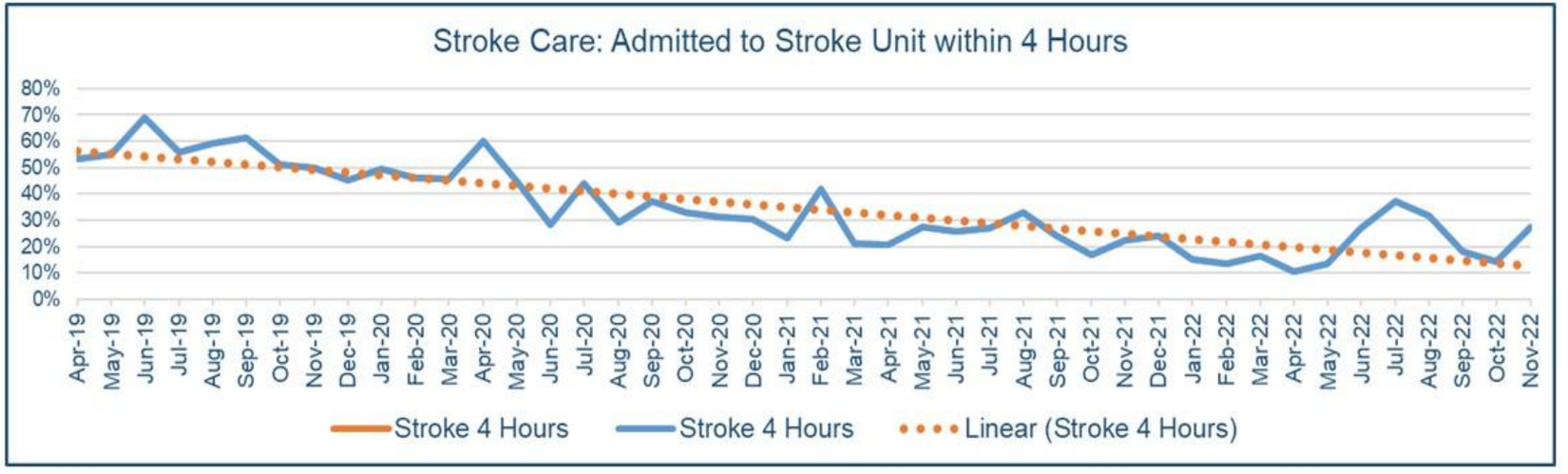
When we expect to be back on track

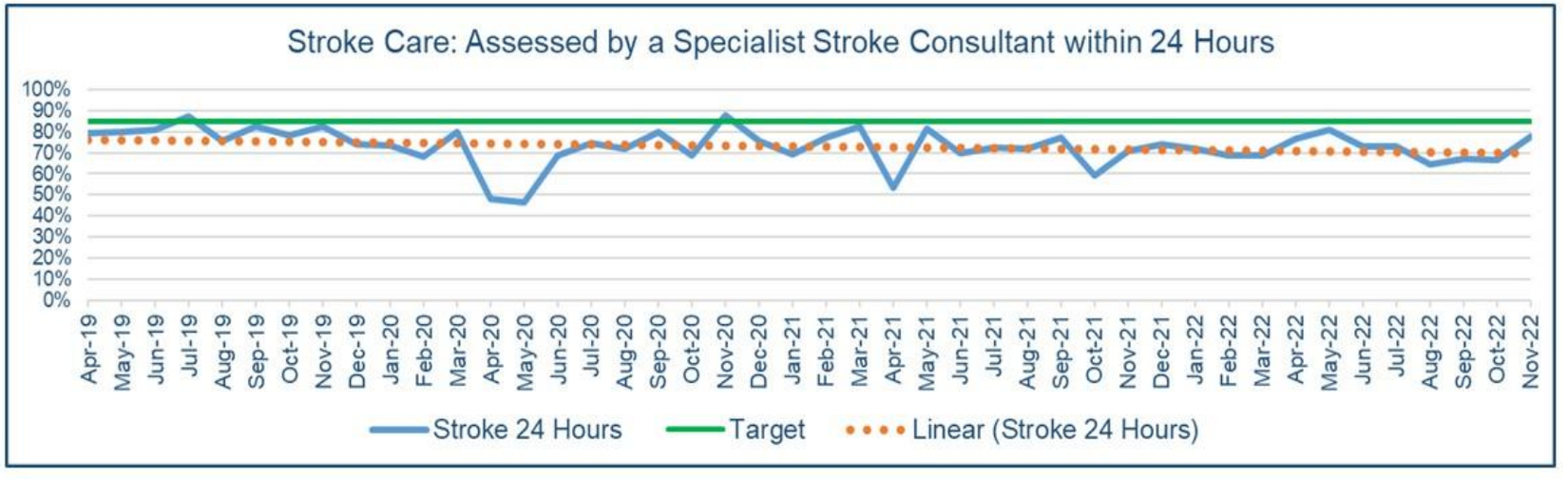
Trajectories have been agreed along with the most recent ambulance handover performance, over the next 3 months with the agreed trajectories there should be a marked improvement on performance with a reduction in lost hours, along with minors attendances to the emergency departments and an increase in attendances to the MIU's/UTC's.

What are the risks and mitigating actions

Key risks remain in situ regarding the inability to discharge patients that are medically fit for Discharge (MFFD), which impacts on flow through the sites for planned and unscheduled care - Initial mitigation is being created by utilising the MIU/UTC's to reduce the attendances to the emergency departments.

Charts: Stroke Care





Narrative: Stroke

Why we are where we are

YGC - The Stroke Awareness and Formal Swallow training package - Refresher and new team member sessions have been arranged for Emergency Department (ED) nursing staff in November and December.
Daily links with the Site team to re-patriate stroke patients not on the ASU. Continue to develop the use of 'Right Patient, Right Place' to be identified via stream patients allocated in-patient beds in the incorrect destination/ward. Recruitment of the 4th Acute Stroke CNS to extend CNS cover hours has been completed with training now completed. SRU move planned for end of Nov / early Dec.
YG - Site pressures – regularly at level 3 or above which impact on flow. Lack of pre-alert by WAST, awaiting responses from Walton Hospital, Medical team not responding to stroke bleep, Medical team not clerking patients in a timely manner. Covid outbreak on ward making it difficult to outlie and discharge to peripheral hospitals, residential/ nursing homes and to POCs.
WXM - Non availability of beds when the ward is full, lack of dedicated ASU. Workforce training is now in place, ESD ward not complete, limited on ESD movement. Site team required to continue supporting provision for a Thrombolysis bed on ASU 24/7.

What we are doing about it

YGC - Non availability of beds when the ward is full, lack of dedicated Acute Stroke Unit (ASU). Workforce training is now in place, Early Supported Discharge (ESD) ward not complete, limited on ESD movement. Site team required to continue supporting provision for a Thrombolysis bed on ASU 24/7.
YG - Use of pre-alerts by WAST and stroke bleep with location and type of potential stroke in ED. Met with WAST agreed to continue with staff training, ED activating stroke bleep through switchboard. Agreed with Stroke Consultant that Patients can be admitted to ASU whilst awaiting response from Walton. Emails sent to medical doctors to remind need to attend to stroke bleeps and ensure clerking completed in timely manner.
WXM - Straight to test CT pathway meeting with WAST (23rd Nov meeting). Deeside and ESD phasing of patients will commence from January. ASU January to support all strokes, TIAs, pull from ED rather than push. Protected rehab beds along the pathway, training for staff in ED on Swallow screening continuing. New stroke staff started in November, training commenced.
ALL - Breach validation and cases reviewed by each site for lessons learnt. Doctor cover remains a challenge within the centre, no cover at weekends.

When we expect to be back on track

All 3 sites development of the pathways to ESD sites when complete will see the delivery of the Phase 1 stroke programme. We will see improvements from this stage. Work with WAST / Radiology / ESD to discuss direct to CT pathways and then from CT to ASU on each site has commenced. ASUs improvements linked to ESD will shift improvement of 4 hrs time to ASU. Improvements across each measure will fluctuate, but continue to improve. Each site has an improvement plan. Performance improvement in SNAP scores is expected to start in April when the West Rehabilitation unit will be live and ESD service will be building up across the 3 areas, enabling a managed return home and rehab support at home for people following a stroke. East and Central Rehabilitation units will be ready by end Quarter 2 and the full ESD team and acute nursing team will be in place by end Quarter 1. 6 month review clinics have recommenced in East at the beginning of May 2022 (the backlog was 12 months in April 22 due to Stroke Coordinator shortage). Waits are at 7 months as of mid October 2022 and are expected to return nearer to 6 months by the end of the calendar year.

What are the risks and mitigating actions

YGC - To link daily with the Site Teams to support Stroke patients not on ASU, ensuring Stroke Multi-Disciplinary Team (MDT) are aware of the patients. On-going training and awareness supporting board rounds, next destination on stream and use of Right Patient, Right Place Dashboard operationally.
YG - . 2 beds ring fenced, staff on ASU ensuring outliers are identified, and that the Stroke nurses liaise closely with ward manager, CSM and ED are highlighting when there is a confirmed stroke in ED and the need for a bed, Stroke Nurses now fully recruited with 1 x Band 7 and 3 x Band 6 in place. Out Of Hours (OOH) working hours will be finalised once all are fully trained.

1c: Patient Flow & Discharge

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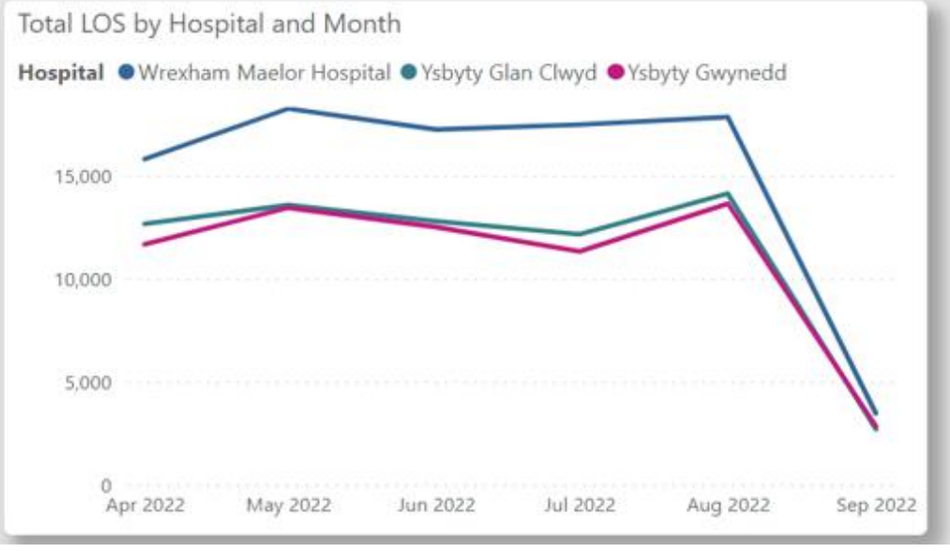
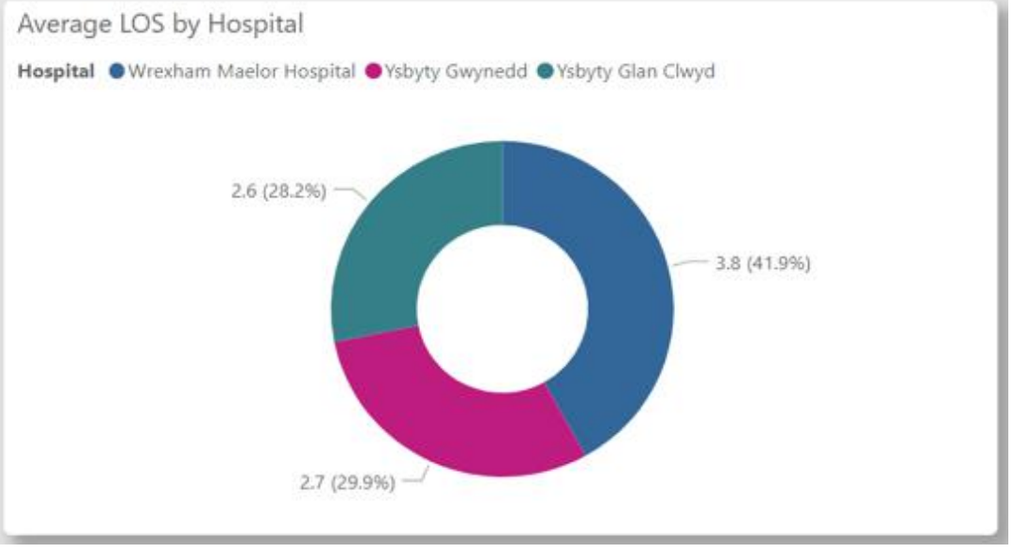
Measures: Patient Flow & Discharge

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Nov	Percentage of stroke patients that receive at least 45 minutes of speech and language therapy input in 5 out of 7 days	50%	37.7%		54.1%	52.0%	64.0%	70.0%	66.3%	54.6%	45.0%	56.9%	49.0%	53.2%	44.8%	37.7%
PFIG		Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission	12 month reduction trend	New Measure - Awaiting Data													
PFIG		Percentage of total emergency bed days accrued by people with a length of stay over 21 days	12 month reduction trend	New Measure - Awaiting Data													
PFIG		Percentage of people assigned a D2RA pathway within 48 hours of admission	4 Qtr Improve trend (target 100%)	New Measure - Awaiting Data													
PFIG		Percentage of people leaving hospital on a D2RA pathway	4 quarter improvement trend	New Measure - Awaiting Data													

Charts: Patient Flow & Discharge

Month	April		May		June		July		August		September		Total	
Hospital / Specialty	Average LOS	Discharges	Average LOS	Discharges	Average LOS	Discharges	Average LOS	Discharges	Average LOS	Discharges	Average LOS	Discharges	**Average LOS**	**Discharges**
⊞ **Wrexham Maelor Hospital**	**3.8**	**4,116**	**3.8**	**4,753**	**3.9**	**4,377**	**3.8**	**4,643**	**3.9**	**4,595**	**3.6**	**963**	**3.8**	**23,447**
⊞ **Ysbyty Glan Clwyd**	**2.7**	**4,734**	**2.6**	**5,301**	**2.6**	**4,935**	**2.5**	**4,940**	**2.7**	**5,268**	**2.3**	**1,156**	**2.6**	**26,334**
⊞ **Ysbyty Gwynedd**	**2.7**	**4,399**	**2.8**	**4,862**	**2.7**	**4,571**	**2.5**	**4,556**	**3.0**	**4,489**	**2.9**	**997**	**2.7**	**23,874**
Total	**3.0**	**13,249**	**3.0**	**14,916**	**3.1**	**13,883**	**2.9**	**14,139**	**3.2**	**14,352**	**2.9**	**3,116**	**3.0**	**73,655**





Narrative: Patient Flow and Discharge

Why we are where we are

Significant pressures continue to be experienced across NHS Wales due to a number of attributing factors that are impacting on unscheduled and emergency care services. The ongoing inability to discharge patients who are Medically fit for discharge (MFD) and no longer require an acute or community hospital bed continues to be a significant barrier to patient flow, with 1/3 of BCUHB hospital beds occupied by medically fit patients. This impacts on the capacity within Emergency Departments (ED) which are experiencing high numbers of attendances of very poorly patients who are presenting with high acuity and the ability to admit patients onto appropriate wards from ED efficiently as well as effectively handover patients from ambulances.

What we are doing about it

Work has commenced collaboratively with Health & Social Care colleagues to implement Pathways of Care delays reporting within an initial 3 month pilot (Nov – Jan), to meet the ministerial requirement to conduct a monthly snapshot census of delayed transfers of care on the third Wednesday of each month. Data for all delays which meet the criteria set out in national guidance (any adult patient post 48 hours, clinically optimised, who has not been discharged and is still occupying an acute or community hospital bed) are entered onto the national reporting database to enable census reporting. Robust validation processes between health and social care are in place to ensure validation and agreement of Social Care delays by Local Authority colleagues prior to submission.
A number of schemes across Health and Social Care are in place to provide additional community capacity as part of the All Wales 1000 additional placements initiation for Winter with regular review and monitoring processes in place locally and nationally.

When we expect to be back on track

Pathways of care reporting pilot will conclude end of January 2023 following which Health Boards will be required to fully implement and embed Pathways of Care Delays reporting processes with agreed milestones for 2023-24 and monitor the progress of safe and timely discharge of patients in line with the NHS planning framework. Ministerial launch on 6th December for the Optimising Hospital Patient Flow Framework, will focus on tools and processes to be activated for patients admitted to a hospital bed, including SAFER principles; revised Discharge to Re-Assess (D2RA) pathways; preventing deconditioning and discharge planning, which is expected to be implemented in the New Year. Revised all Wales discharge guidance is being finalised by Welsh Government (WG) for implementation by Health Boards early 2023.

What are the risks and mitigating actions

Inability to recruit to sufficient health and social care workforce to provide the necessary support services in the community to enable patients to be discharged to the most appropriate setting as well as support individuals to remain at home and avoid unnecessary admissions.
Competing priorities and ongoing pressures within teams that are already stretched to capacity, resulting in a lack of engagement to effectively implement the patient flow framework. Fragility of the independent sector due to staffing and inflation, and challenges to the HB on the current level of fees.

1d: Elective Planned Care

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Measures: Elective Planned Care Page 1

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Oct	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Target of 80% by 2026	62.3%		67.4%	61.4%	69.3%	69.3%	67.2%	62.3%	63.3%	66.1%	61.7%	61.8%	62.3%
PFIG	Nov	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	=>95%	51.0%		50.4%	44.6%	43.5%	49.3%	47.4%	50.0%	54.0%	54.0%	54.5%	52.2%	52.5%	51.0%
PFIG	Nov	Percentage of patients waiting less than 26 weeks for referral to treatment	Target of 95% by 2026	53.7%		47.6%	48.8%	48.8%	51.2%	50.5%	50.8%	47.0%	54.0%	46.6%	46.9%	53.4%	53.7%
PFIG	Nov	Number of patients waiting more than 36 weeks for referral to treatment	Target of 0 by 2026	63.4K		55953	59330	60281	61685	62866	63273	64871	65959	64788	64070	63356
PFIG	Nov	Number of patients waiting more than 104 weeks for referral to treatment	Target of 0 by 2024	12.9K		13829	15120	16950	18475	17795	16824	15943	15301	15392	14677	13922	12947

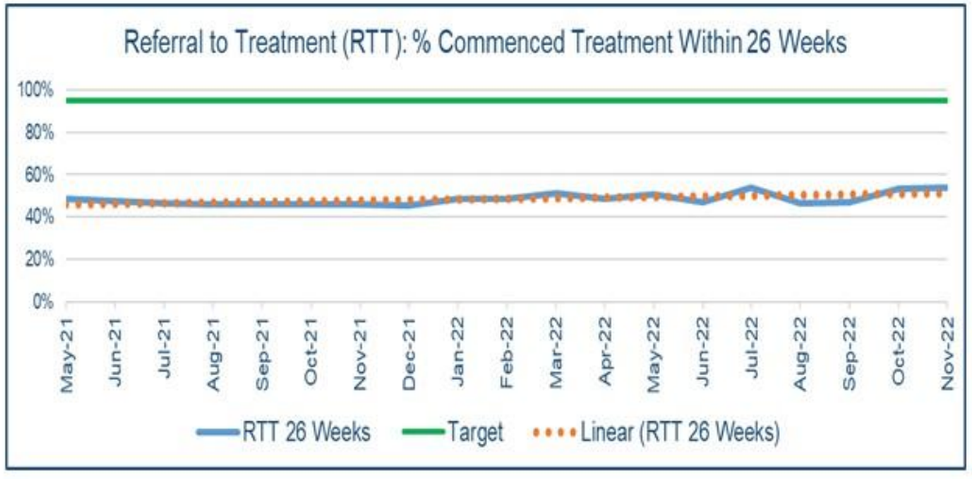
Month in Arrears

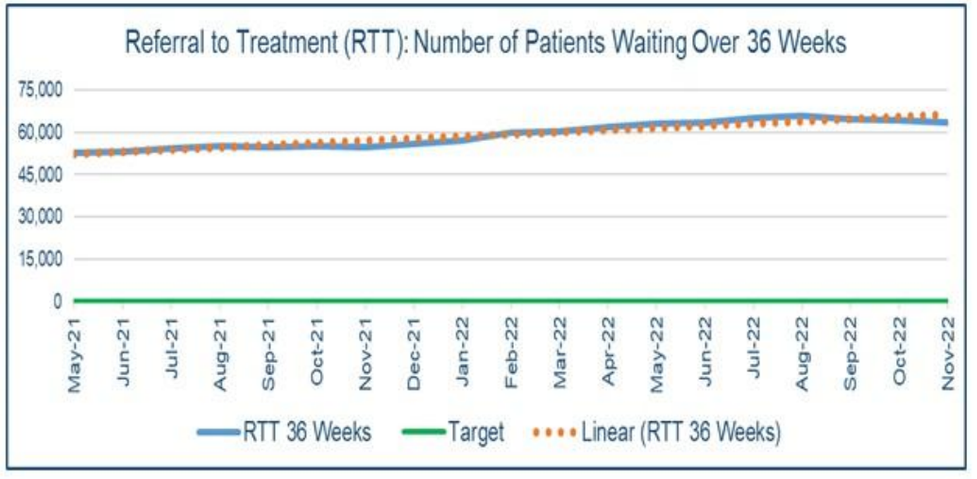
Measures: Elective Planned Care Page 2

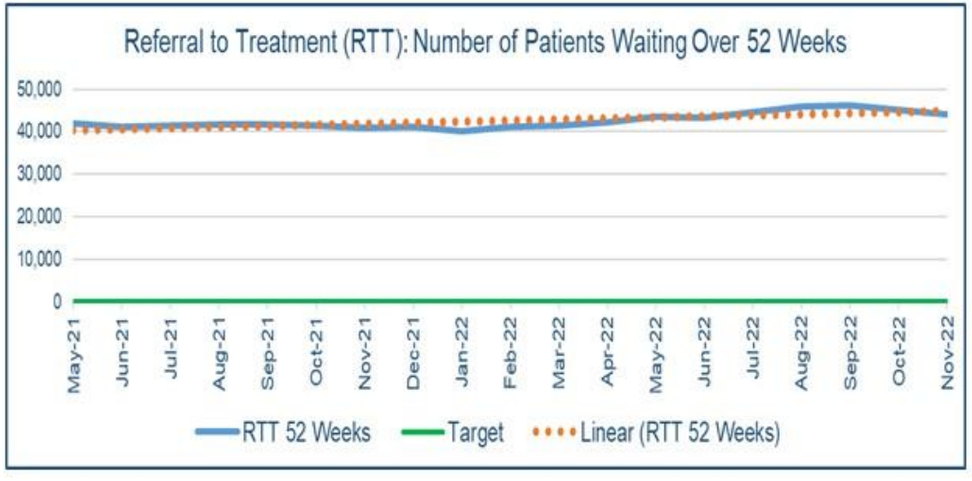
Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Oct	Number of patients waiting over 52 weeks for a new outpatient appointment	Target of 0 by 2023	25.4K	23756	23076	23407	23809	24223	24405	24641	25379	26515	26475	25419	
PFIG	Nov	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Target 30% reduction by Apr 2023	65.8K	56026	56693	55442	54815	55708	55714	59128	61480	64371	63286	64927	65834
PFIG	Nov	Number of patients waiting more than 8 weeks for a specified diagnostic	Target of 0 Apr 2024	8034	7287	7694	7145	6829	8168	8761	8848	9078	9776	9464	8068	8034
PFIG	Nov	Number of patients waiting over 8 weeks for a diagnostic endoscopy	Target of 0 Apr 2024	1745	3329	3482	3156	2719	2667	2563	2463	2306	2260	2250	1964	1745
PFIG	Nov	Number of patients waiting more than 14 weeks for a specified therapy	Target of 0 Apr 2024	4271	5039	5776	6171	6486	6364	6682	6602	6151	5837	5450	5037	4271

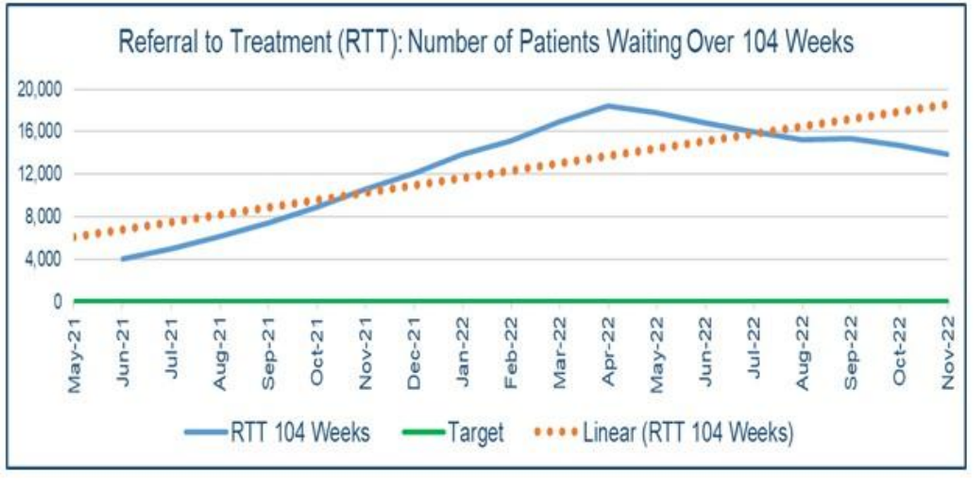
Month in Arrears

Charts: Referral to Treatment



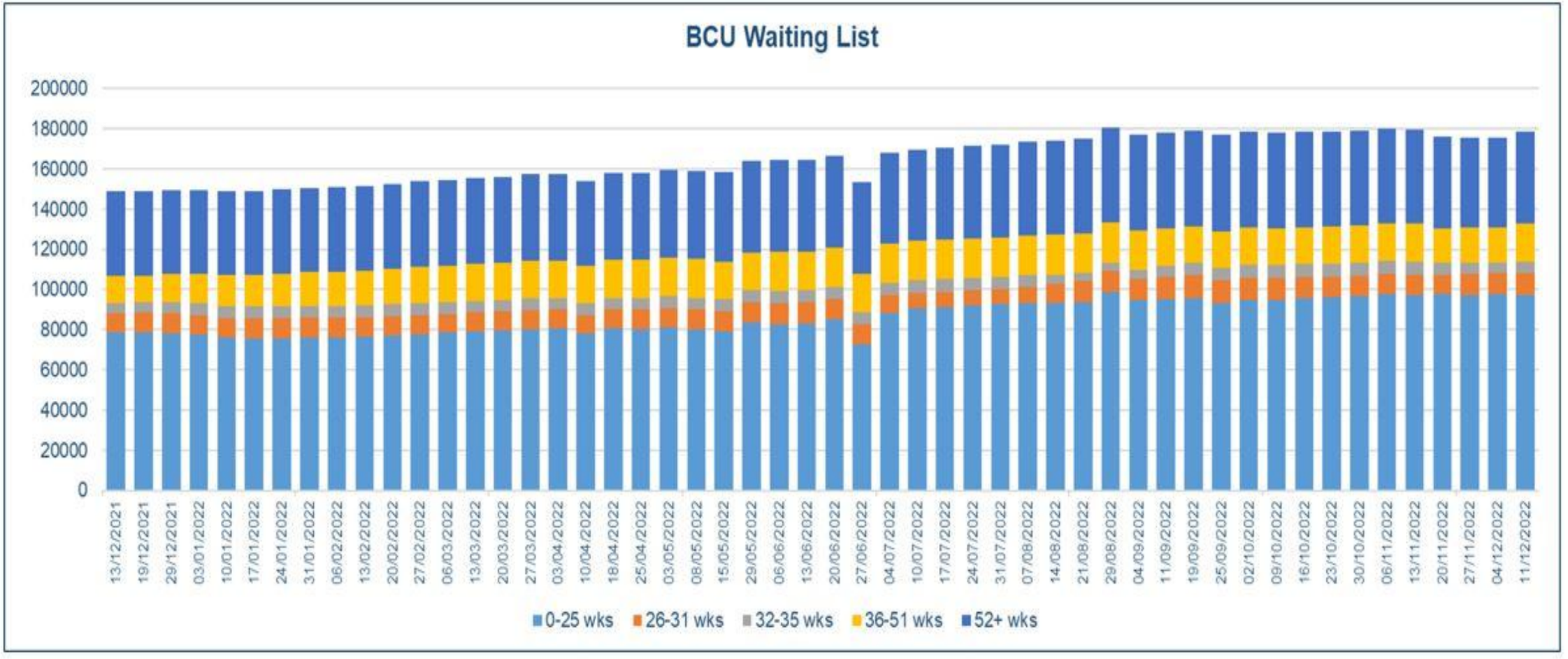






Charts: Planned Care Waiting List

Data as at, 11th December 2022



Narrative: Referral to Treatment

Why we are where we are

The outcome of the Covid pandemic had a detrimental impact on the waiting times, this with the reduced capacity in the system further added to the pressures in secondary care.
In addition to our Did Not Attends (DNA) and not discharging patients that had not attended their new outpatient appointment, resulting in increases from 51.1% in 2019/20 to 64% currently for 2022/23. This means we are rescheduling 13% more (Stage 1 / New) patients than 2019/20.
Over the past 12 months we have had 3,862 patients booked for appointments more than 3 times due to their non-attendance (4 or more DNA's). At an average 12 patient attendance per outpatient clinic this equates to (at least) 322 clinics or 161 days' worth of clinics lost due to patients repeated (4 or more DNA's) non-attendance.

What we are doing about it

We have put in place plans that; i) treat our patients in turn ii) reduce the backlog and ensure that we have a clear and acute picture of the demand on the service. And by validating our records, enhancing and following policies and procedure ensuing that we use our capacity in the most efficient manor.
We are investigating technology and pathways to support an ever-evolving health care service that moves with innovation, thus making it easier to move into patient provision of health care that may not be in their immediate locality, but to support the provision of care equality and the care for the patient at that time. For our Stage 1 >52 week waits we have plans in place to reduce this by 70% (from a September baseline), which we are on track to achieve (subject to the impact of strike action) with plans being drawn to further improve this position with the aim of meeting the ministerial targets.

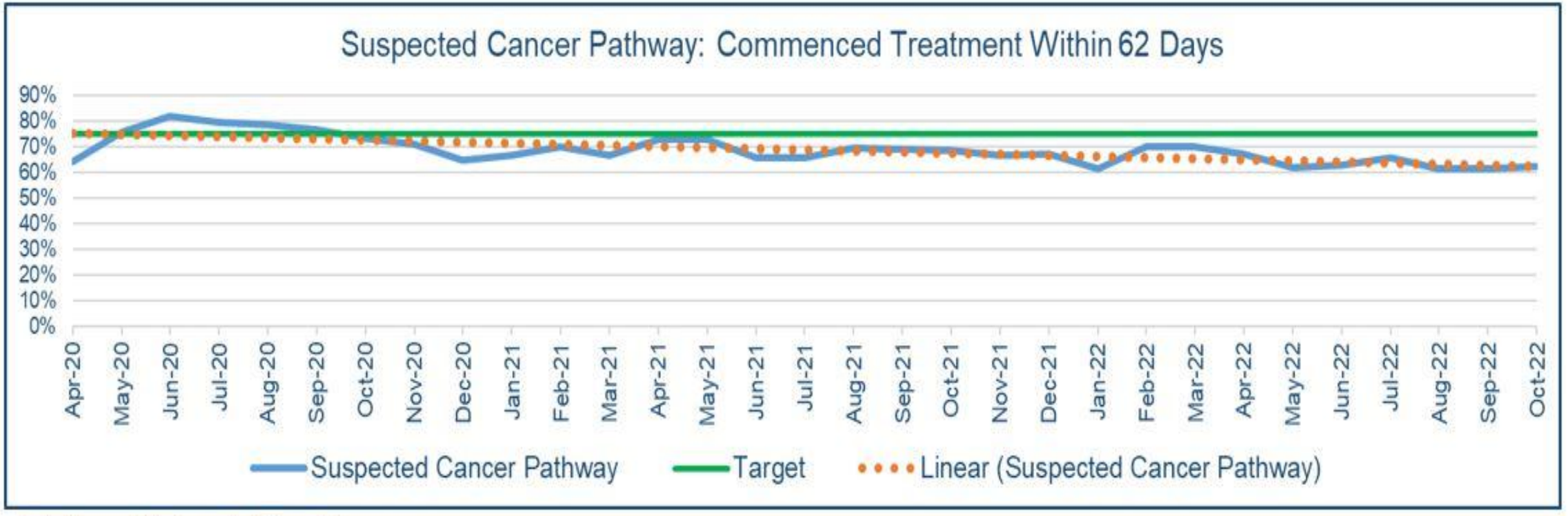
When we expect to be back on track

We are working to the ministerial priorities of;
- No patients waiting >52 weeks for their first outpatient appointments at the end of the year, in most specialities
- No patients waiting >104 weeks for any stage of their pathway at the end of March 2023, in most specialities.

What are the risks and mitigating actions

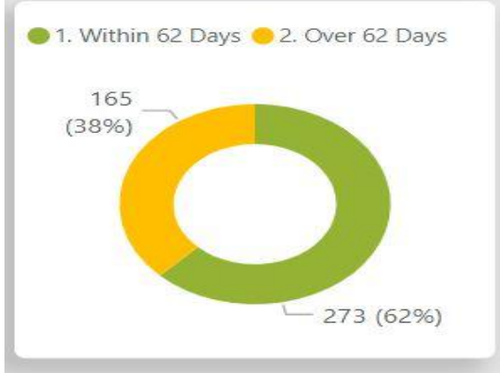
We are conscious of the pressures in the health service and the pressures on our staff (both clinical and managerial) that they are working under. Thus, the retention of a healthy workforce is a risk this with attracting [recruiting] more support to deliver the services we deliver and with this retention and recruitment are a risk.

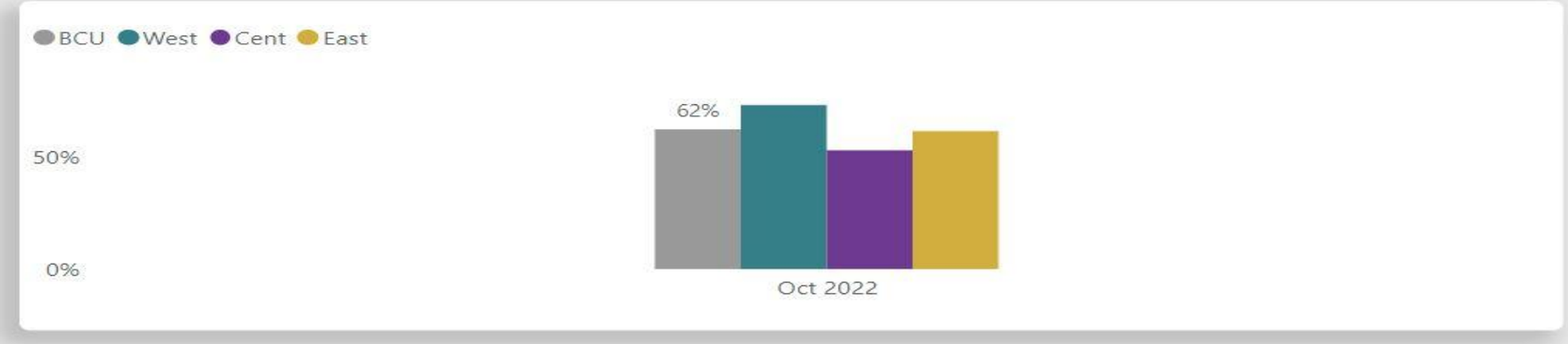
Charts: Cancer

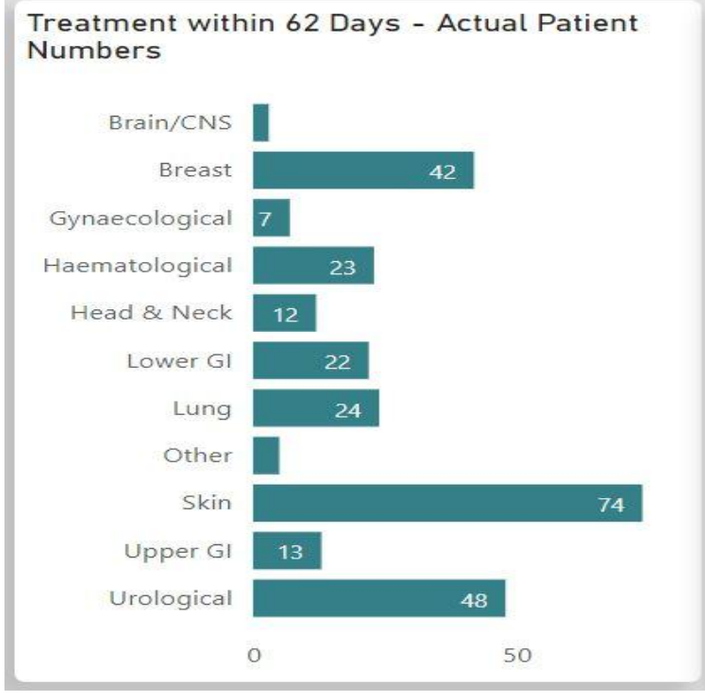


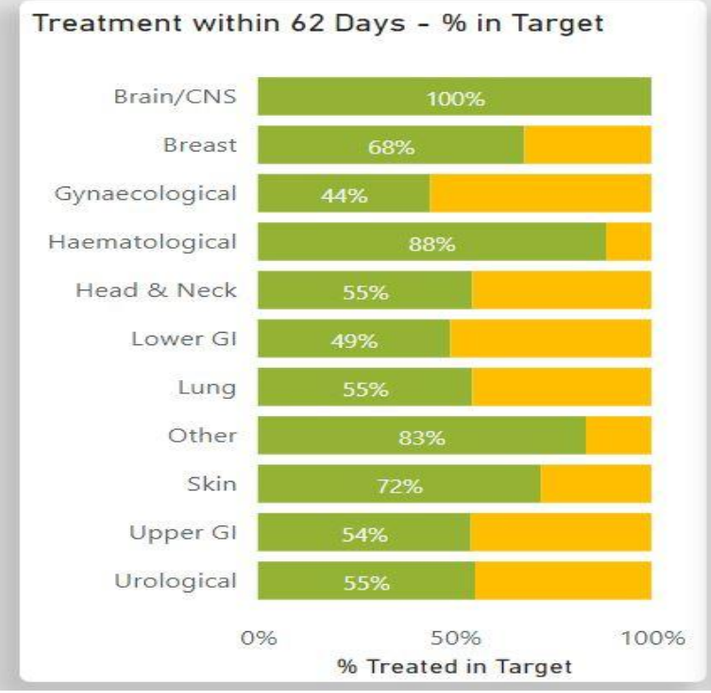
Note: Cancer Data is reported 1 month in arrears

Charts: Cancer









Tumour Site	1. Within 62 Days	2. Over 62 Days	Total
Brain/CNS	3		**3**
Breast	42	20	**62**
Gynaecological	7	9	**16**
Haematologica	23	3	**26**
Head & Neck	12	10	**22**
Lower GI	22	23	**45**
Lung	24	20	**44**
Other	5	1	**6**
Skin	74	29	**103**
Upper GI	13	11	**24**
Urological	48	39	**87**
Total	**273**	**165**	**438**

Narrative: Cancer

Why we are where we are

In October 2022 BCU reported 62.5% of patients (273 out of 437) treated in target. Main breach reasons detailed below:
- Diagnostic - 46 patients were delayed to a diagnostic test, primarily endoscopy (32.6%) and wait for biopsy/faecal immunochemical test (FIT) tests (52.1%)
- Treatment- Delays to surgery remain the leading cause of breaches (42.8%). Delays were primarily within urology and skin
- Volume of Referrals: Volume of referrals continues to surpass pre Covid-19 average (2352 GP referrals per month); in October there were 3797 GP urgent suspected cancer referrals

What we are doing about it

- All services continue to prioritise suspected cancer patients with engagement from local and regional access meetings.
- New process Access Escalations meetings currently continue (including smaller, focussed escalations meetings to address and resolve urgent concerns and unresolved issues- significant impact on pathways noted). These include redirecting referrals to other hospital sites as required (primarily in breast)
- All clinic templates have been reviewed to ensure sufficient capacity to meet 80th percentile (and 95th where possible) weekly demand for suspected cancer patients
- FIT testing used to triage referrals appropriately (straight to test vs outpatients) on suspected colorectal cancer pathway. Data now received from Bowel Screening Wales laboratories regarding number of referrals by GP practice allowing us to identify GP practices who may not be fully utilising FIT testing
- Pathway review workshops completed for colorectal and prostate with changes agreed and task and finish sub-groups established to implement changes

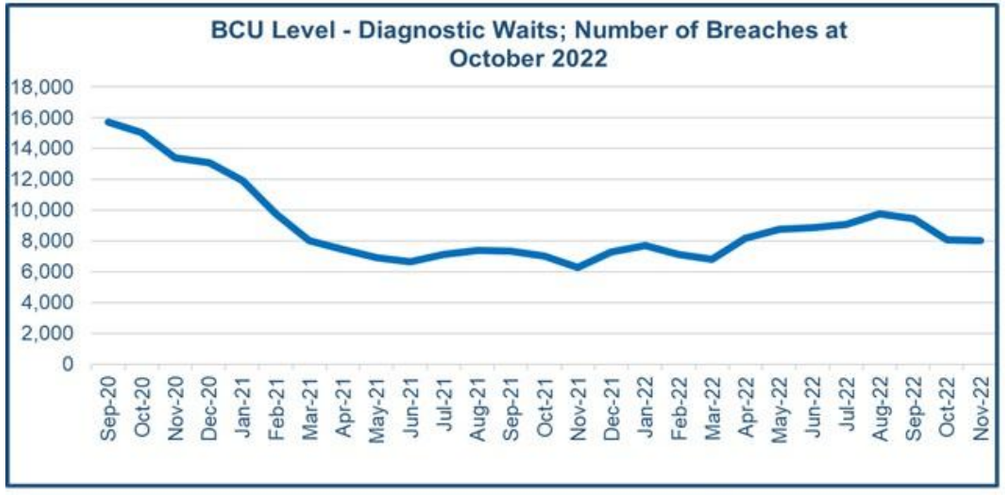
When we expect to be back on track

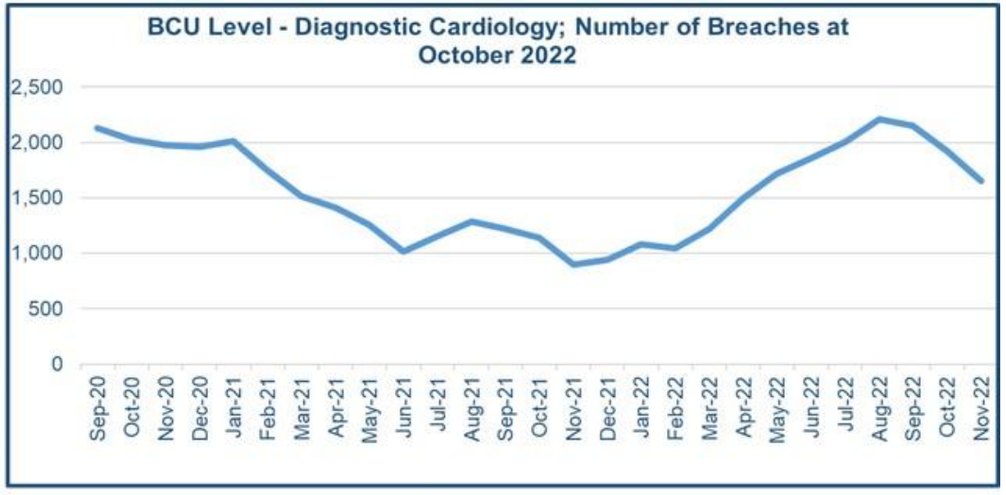
The Health Board continues to work towards 75% target performance by the end of 2022, although current pressures make the interim target from Welsh Government of 70% more likely. A trajectory dashboard re patients still active over day 62 is now in place for teams to monitor progress.

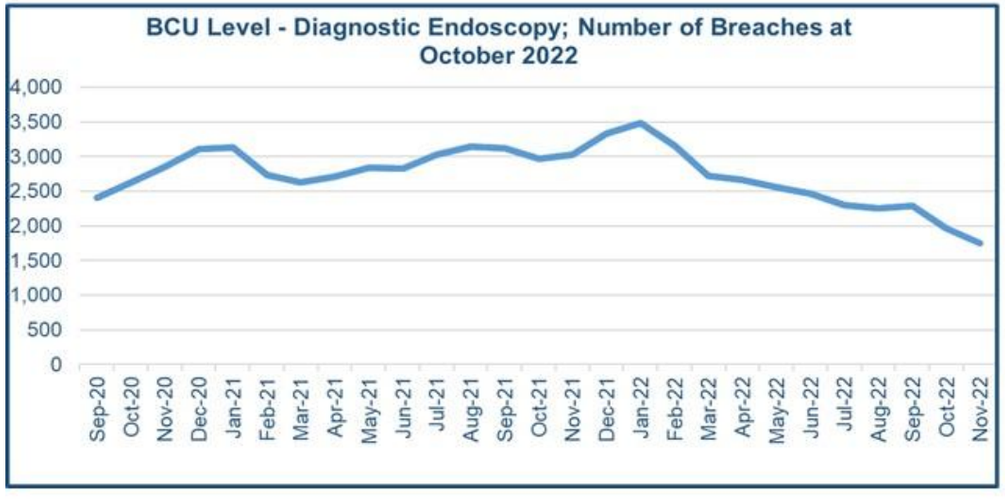
What are the risks and mitigating actions

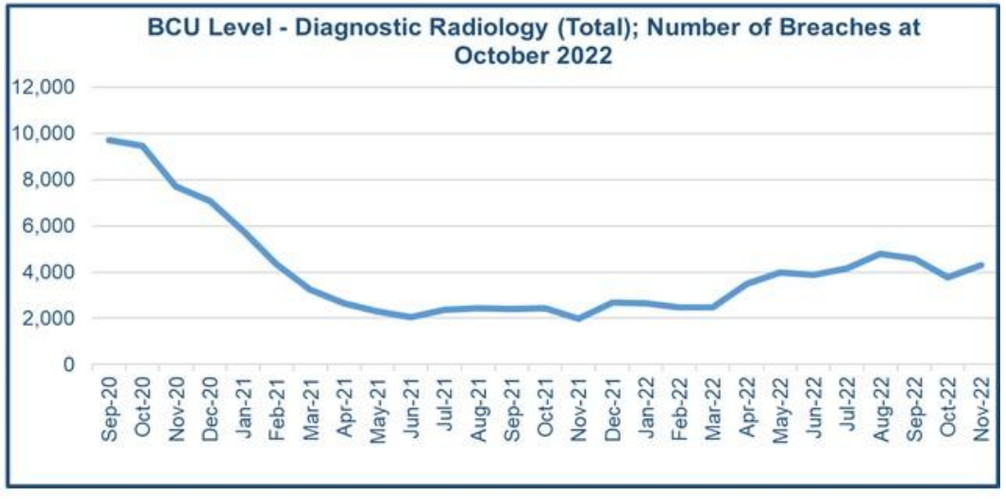
- Diagnostic Capacity – Prostate biopsy capacity currently being addressed by Urology teams
- Volume of Referrals – GP Urgent Suspected Cancer (USC) Referrals continue to remain above average in comparison to pre Covid-19 levels
- Oncology Staffing – Oncology staffing remains an ongoing priority with agreement now in place with Clatterbridge patients with regards to both Head and Neck and Dermatology oncology patients with locums already in post covering both neurological malignancies and Lower GI patients. Positive news with clinical oncologist previously planning to leave recently agreeing to stay within BCU.

Charts: Diagnostics









Narrative: Diagnostic Waits-Radiology & Neurophysiology

Why we are where we are

Radiology: The number of patients waiting over 8 weeks for radiology diagnostics end of October is 3856, a decrease of 749 on the end of September 2022 position. By modality: CT (138 breaches, +44); MRI (1234 breaches, -197); Ultrasound (2484 breaches, -482). Continuing high demand limiting the ability to reduce breaches further. The second mobile MRI scanner has contributed significantly to the reduction in the waiting time for these scans. Ultrasound staffing levels were higher in month with lower leave than the summer months, leading to the improvement seen here.

Neurophysiology: The number of patients waiting over 8 weeks is 643, an increase of 92 from the end of September 2022 position. There are 477 EMG (consultant-led) breaches and 166 NCS (physiologist-led) breaches.

What we are doing about it

Radiology: We are aligning resources to meet the demands of the service, recruiting to unfilled vacancies, flexing staff between CT/MRI. Planned Wrexham Maelor MRI scanner upgrade will reduce overall capacity for the next two months so unlikely progress will be maintained given demand levels.

Neurophysiology: Physiologist staffing levels remain the primary concern, with replacement locum still being sought. Recruitment to the two vacant posts is progressing. Completion of Wrexham accommodation works has been delayed until March 2023.

When we expect to be back on track

Radiology: Demand and capacity work has highlighted significant risk to waiting times due to expected growth in demand in 2023 across all areas of radiology, including the plain film service. Review of solutions for 2023-24 is ongoing with recommendations / cost estimates to follow. Forecast remains 0 breaches in Radiology by end 2023-24.

Neurophysiology: The delay in completion of the Wrexham Maelor service base limits the opportunity to progress backlog clearing sessions in Q4. Tender for insourcing will be aligned with handover for commencement in April, with expected backlog elimination by Q2 2023-24.

What are the risks and mitigating actions

Radiology: In spite of record activity, the is a risk that overall capacity will be insufficient to meet demand in 2023-24. All current solutions needs to be maintained as a minimum with identification of additional capacity a priority for the team.

Neurophysiology: Recruitment to vacant posts remains the main risk, with other actions set to complete by the end of Q4.

Narrative: Diagnostic Waits-Endoscopy

Why we are where we are

The Covid-19 pandemic led to a short pause in non-emergency endoscopy activity in response to guidance from professional bodies. When activity re-started there were significant constraints on the volume of work which could be undertaken, influenced particularly by clinical guidelines regarding infection prevention and control. During the ongoing COVID-19 pandemic period, the limited number of gastrointestinal endoscopy procedures undertaken were prioritised based upon clinical and/or oncological indications was optimised due to the limited capacity available. As a result the waiting list grew significantly, even when services recommenced, due to continued staff absence and reduced productivity caused by enhanced infection prevention controls.

What we are doing about it

Given the backlog faced, continued insourcing is essential in the short to medium term. This provides increased capacity by 32 lists per week (approximately 190 procedures) to reduce the significant backlog and address the increasing demand, as the endoscopy service continues to recover post Covid-19. This use of insourcing will be phased out as we make substantive appointments across our workforce to deliver a health board led 7 day working service in line with the Endoscopy business case. The Health Board is also working to improve this position by ensuring robust systems are in place to monitor the productivity and efficiency measures as set out by the National Endoscopy programme to ensure fully utilised lists.

When we expect to be back on track

Our capacity and demand modelling demonstrates a recoverable position during 24/25 based on a number of assumptions, including insourcing, current staffing levels being maintained, recruitment and 3 list days.

What are the risks and mitigating actions

Our main risks to delivery are around maintaining our existing workforce and recruitment of new staff in line with the endoscopy business case.
There are also estates investment requirements in particular around decontamination facilities in both Centre and East to ensure the service can continue.

Narrative: Cardiology

Why we are where we are

We continue to see the waiting list grow and are unable to achieve the eight-week diagnostic target. Cardiac Physiology is a known area of challenge nationally due to workforce shortages, which means we have held vacancies across North Wales.

There is increase demand for cardiac physiology diagnostics. We have returned to pre-COVID capacity; however, additional activity addressing the backlog has resulted in our waiting lists growing. Across North Wales, the departments are balancing inpatients, outpatients and pre-operative diagnostics based on patients clinical need. The longest waits are for echocardiograms, and we have 1468 patients breaching with patients waiting over 52 weeks.

What we are doing about it

-The service is undergoing demand and capacity modelling for future service provision
-We are recruiting across North Wales. We remain hopeful to fill the posts, as YG (Bangor Hospital) has recently appointed two skilled staff members
-We are expanding our Physiologist led pathways in both community and secondary care
-Additional waiting lists sessions are ongoing across all sites
-Short-term utilisation of locum staff
-Ongoing transfers of patients to support YG with the longest waiting patients
-The implementation of the heart failure business case will support several areas of the pathway

When we expect to be back on track

We are on track to be under 52 weeks by March 2023 and will be moving into the 36 weeks category.

What are the risks and mitigating actions

Risks
- A continued increase in referrals for cardiac diagnostics.
- Workforce Recruitment
- No Funding agreed to support the national project

Mitigation
- Ongoing additional waiting lists
- Pan BCUHB operational group monitoring and support
- Introduction of NT-proBNP blood test

Charts: Eye Care

Eye Care Measure Dashboard | Welsh Government Submission

Area

West | Central | East

Reporting Month

November 2022

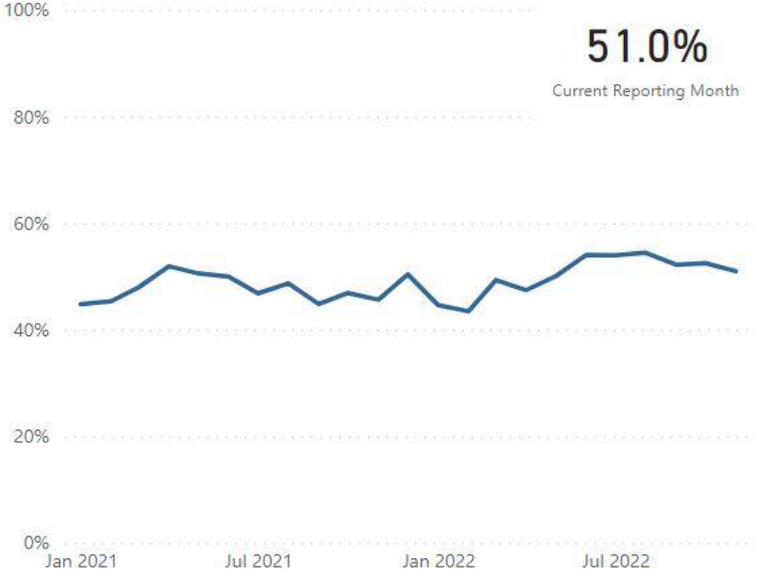
Open Pathways

Health Risk Factor	No Target Date	Not Overdue	0 - 25%	26 - 50%	51 - 100%	Over 100%	Total
R1	113	11,614	1,715	1,699	2,983	16,588	**34,712**
R2	8	1,914	364	464	804	3,076	**6,630**
R3	1	413	78	60	139	927	**1,618**
No HRF	766	198	29	61	147	209	**1,410**
Total	**888**	**14,139**	**2,186**	**2,284**	**4,073**	**20,800**	**44,370**

Attendances

Health Risk Factor	No Target Date	Not Overdue	0 - 25%	26 - 50%	51 - 100%	Over 100%	Total
R1	520	1,295	1,731	493	405	1,490	**5,934**
R2	39	52	13	10	15	265	**394**
R3	5	51	11	6	8	59	**140**
No HRF	241	67	101	13	5	22	**449**
Total	**805**	**1,465**	**1,856**	**522**	**433**	**1,836**	**6,917**

R1 Attendances < 25% Overdue



Did Not Attend

Health Risk Factor	Total Did Not Attend
R1	428
R2	67
R3	20
No HRF	25
Total	**540**

Patient Cancellations

Health Risk Factor	Not Overdue	Overdue	Total
R1	172	990	**1162**
R2	8	126	**134**
R3	12	19	**31**
No HRF	18	59	**77**
Total	**210**	**1194**	**1404**

Narrative: Eye Care

Why we are where we are

A. Sickness and staffing vacancies impact on core activity, recovery and Eye Care Measure (ECM) transformation capacity.
B. Historic Data Quality and Completeness impact on effective data availability for modelling/planning/sustainable delivery of equitable services
C. Reduced resources (staffing and estates) impact on capacity and transformational pathway delivery. I.e. Reduced Cataract Outpatient and theatre utility and reduced flow of Glaucoma and Diabetic Retinopathy patients to Integrated Pathways'.
D. Delay in National Digital programme delivery "Go Live". (Key enabler of Integrated Primary & Secondary Glaucoma and Retinopathy Services)
E. Continuity challenges with Clinical and Operational Leadership from prior/current/impending vacancies impacting on leadership for change.

What we are doing about it

A. Ophthalmology Teams progressing 100% Pre-Covid capacity delivery plans. Integrated Teams progressing Transformational pathway delivery
B. Ophthalmology Area Teams to deliver action plan to redress Clinical Condition data gaps by close of November 2022.
C. Capacity recovery from Cataract Outsourcing (400 Routine Patients/month rising to 600/month Sept 2022).
D. Expand BCUHB Digital pre-mobilisation to include Glaucoma and Cataract: to ensure Go Live readiness when National Programme functional.
E. BCU Clinical Lead recruitment and role review being led by Medical Director and current lead. Pan BCUHB posts v's long-term "local" vacancies.

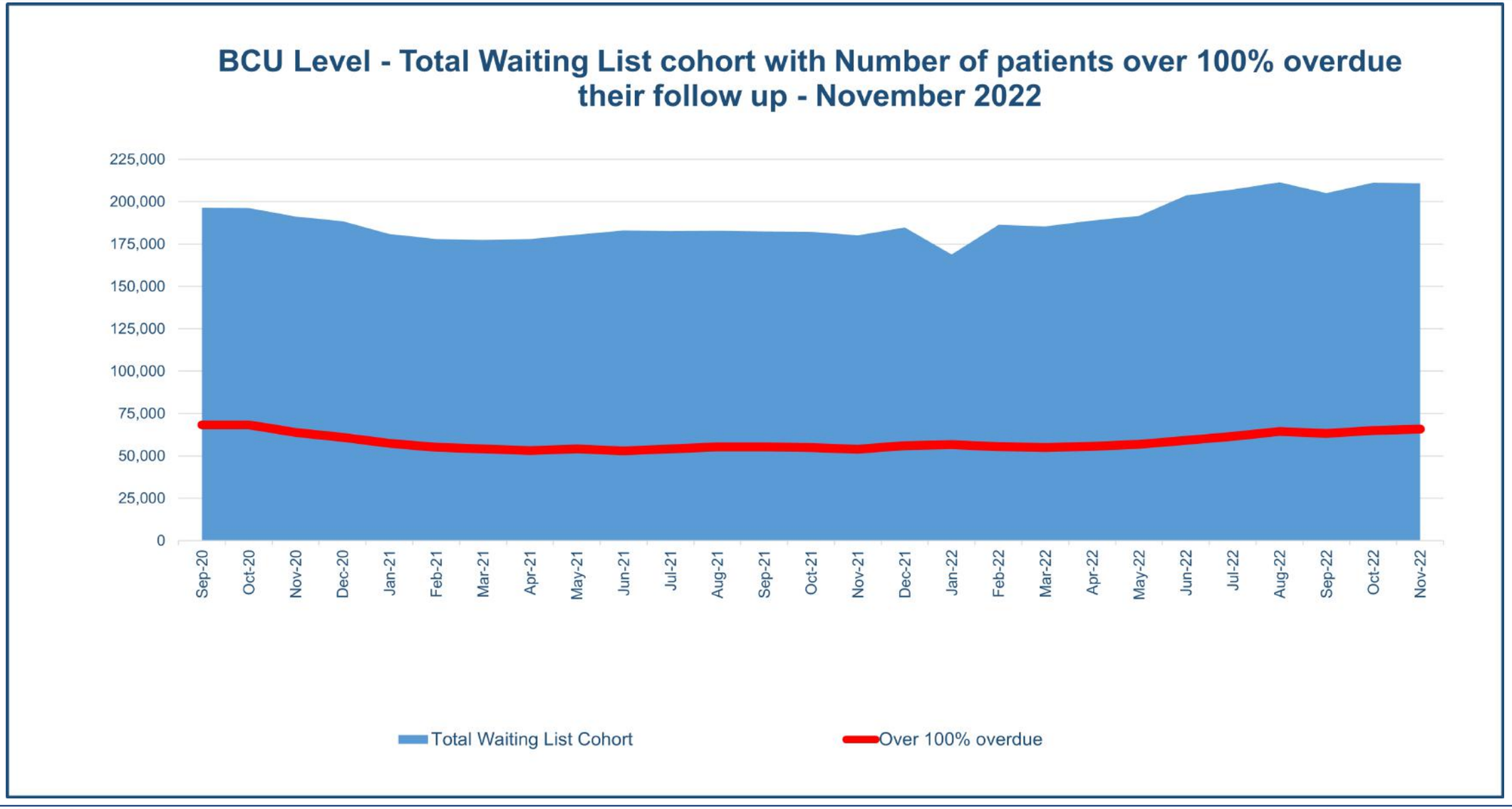
When we expect to be back on track

A. ECM Integrated Pathway 2022 activity reduced by 30% due to Primary and Secondary care unplanned leave. Optometry Contractual Reform in 2022 will expand Integrated workforce and provide mitigation from increased partner pool. Welsh Government (WG) to confirm Go Live date/roll-out.
B. August 2022 target for services to address historic Clinical Condition "null" entries reset to November 22. Target outstanding.
C. Outsourcing of appropriate patients consistently achieving Trajectory, reducing risk and waiting times. BCU readiness for Digitalisation Go Live Glaucoma Tests and Cataract mobilisation completed within deadline/on track. National programme delayed by 8 months.
E. Vacancy review completed. Pan BCUHB Clinical Lead retires December 22. Active recruitment and Pan-BCUHB posts' progression reviewed monthly.

What are the risks and mitigating actions

A. Pandemic mitigation recurrence/unplanned leave impact on Primary Care partners. Mitigation: Expanding number of Primary Care partners, Q4
B. Admin capacity gaps (vacancies/sickness). Partial Mitigations: Operational Teams utilising overtime/recruitment to vacancies
C. Outsourcing short-term solution. Sustainable mitigations commenced. Increased Theatre Utility and efficiencies. Getting It Right First Time (GIRFT) Partnership (Q3)
D. Extended Digital lead time. Mitigation: Expanded BCU pre-mobilisation to include additional Pathway delivery
E. Delayed delivery of sustainable pathways. Mitigation: Monthly RAG rated report highlighting/escalating risks within Eye Care Collaborative

Charts: Follow Up Outpatient Waiting List



Narrative: Follow Up Outpatient Waiting List

Why we are where we are

The outcome of the COVID pandemic had a detrimental impact on the waiting times, this while the reduced capacity in the system further added to the pressures in secondary care. The increase in Follow-up appointment demand is further added to as we increase activity as the front of the pathway (to reduce the backlog of New appointment requests) this also adding pressure to the demand of follow-up appointments.

What we are doing about it

We are on boarding new pathways across many specialties such as See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU). As of end of November 22, the current uptake of these pathways in the 10 priority pathways across BCUHB is 5.8% - this is an increase from 2.4% in Jan 2022. Planned Care have presented the use of SOS/PIFU pathways at BCUHB Regional Treatment Centres (RTC) workshops to support with spread and adoption. Planned care is also increasing the virtual follow-up's (telephone/video consultations) with 23,117 patients attended a video consultation with 42 different specialties having this available with more coming on-board towards the end of the Financial Year.

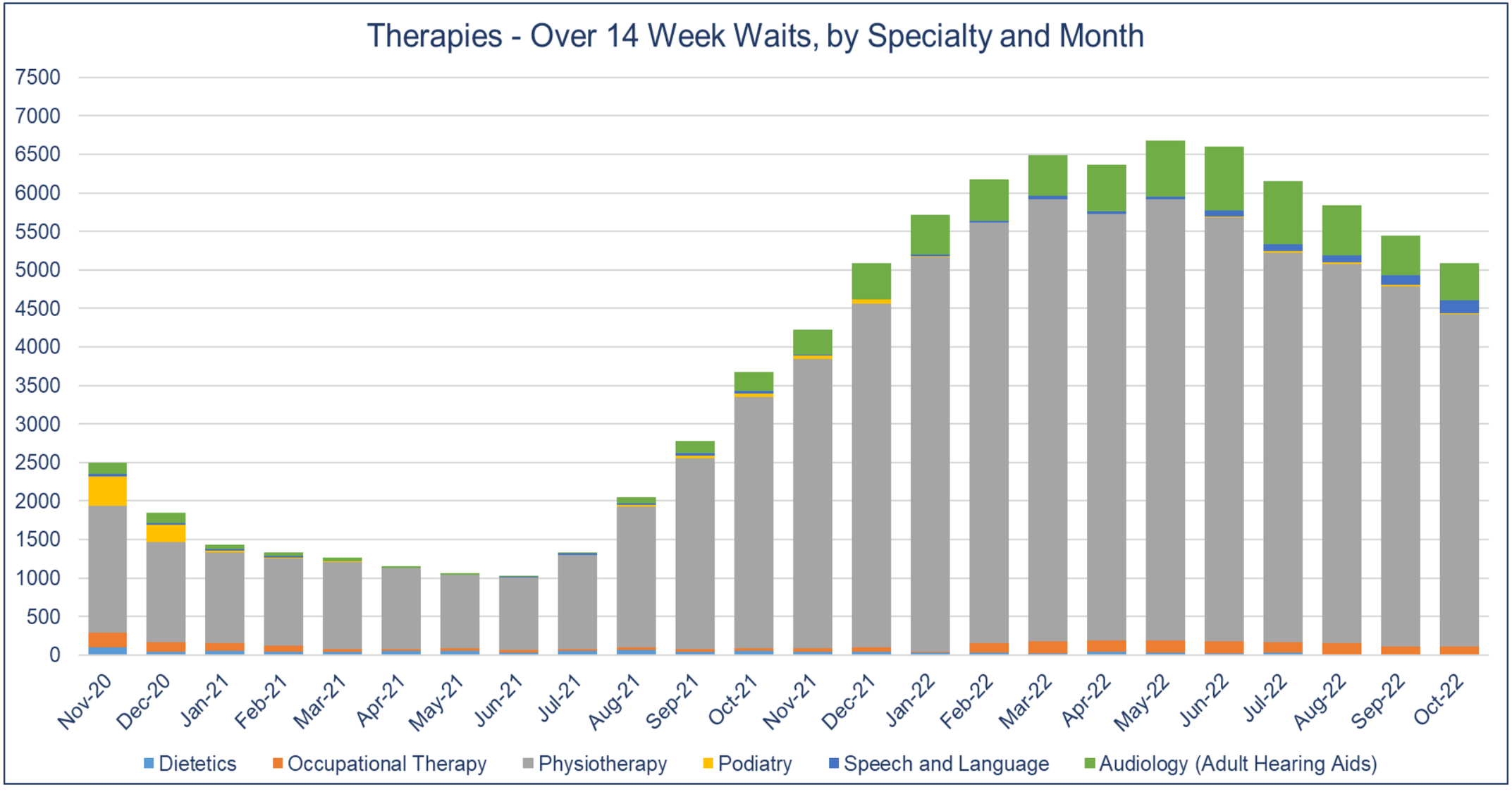
When we expect to be back on track

BCUHB has met the 10 ministerial priority specialty pathways for SOS & PIFU and operating as Business As Usual (BAU), by March 2023. Usage is now dependent on clinical adoption.
All appropriate SOS and PIFU pathways in place are standardised pan-BCUHB, by March 2024.

What are the risks and mitigating actions

Clinical Engagement is vital and requires frequent senior level clinical leadership to encourage utilisation of new pathways and also for higher usage of virtual clinics.
Project Management and Information Analyst support is vital to the delivery and is currently under recruitment with start dates early 2023.
Outcomes – data is reliant on the correct outcome/usage of pathways being recorded accurately within the Patient Administration System (PAS).

Charts: Therapy Waits



Narrative: Therapy Waits

Why we are where we are

In all Integrated Health Communities (IHC) areas Therapies have faced post-COVID backlogs (for new and follow up patients) due to cancellation of routine activity and staff redeployment.
There are high numbers of staff vacancies/difficulty recruiting and a shortage of locums.
Waiting list validation was not prioritised due to service pressures.
East IHC Physio faced the loss of outpatient accommodation due to Maelor hospital reconfiguration from Autumn 2020.
Increased orthopaedic activity has an ongoing impact on waiting lists as post operative patients are seen urgently by Physiotherapy, impacting on the routine caseload.
Therapy Services is however pleased to report an improving position against the 52 week target.

What we are doing about it

Remote and face to face locums established.
Continuing to actively pursue recruitment with a Therapies pan BCUHB ‘recruitment drive’ planned.
Thorough waiting list validation.
Overtime/evening and weekend working by clinicians and admin.
Temporary outpatient accommodation for Physiotherapy IHC East now open.
Capacity planning and ensuring templating of diaries to make best use clinical time.
Where possible utilising groups/classes and remote activity and the use of assistants/student Therapists with active training programmes.

When we expect to be back on track

West IHC expects all services to be under the 52 week target by the end of December 2022.
Central IHC is working hard towards ensuring Physiotherapy patients are under the 52 week target by the end of December 2022, all other services are within the target.
East IHC expects all services to be under the 52 week target by the end of December 2022.

What are the risks and mitigating actions

Recruitment/retention of staff. Impact of staff sickness/annual leave over Christmas period. Further delays in the timelines for Physiotherapy accommodation IHC East.
Increase in orthopaedic activity/ward pressures/staff pulled to cover ‘front door’ activity and support flow during winter pressures.

Narrative: Therapy Waits (CMATS)

Why we are where we are

In all Integrated Health Community (IHC) areas Clinical Musculoskeletal Assessment and Treatment Service (CMATS) has faced post-COVID due to cancellation of routine activity, creating a backlog of patients waiting.
There was reduced capacity as a result of social distancing - some clinic capacity has not returned post-pandemic.
There are high numbers of staff vacancies/difficulty recruiting.
There is an increasing trend in the number of referrals to the service –trend of 4%.
East IHC acquired Shock Wave Therapy (ECSWT) patients who were previously outsourced –this caseload was not accompanied by additional resource.
West IHC has recently transferred onto WPAS –new ways of booking and reviewing clinic spaces to allow for Can Not Attend (CNA) etc.

What we are doing about it

Continuing to actively pursue recruitment, including development posts, with a Therapies pan BCUHB 'recruitment drive' planned.
Thorough waiting list validation.
Overtime/evening and weekend working by clinicians and admin.
Closed the ECSW waiting lists with the patients being referred to previous outsourced arrangements.
Reviewing templates to return to pre-pandemic activity levels.
East IHC to pursue change to Welsh Patient Administration System (WPAS) to create efficiencies around referral inputting and triage.

When we expect to be back on track

In all IHC areas CMATS expects to achieve the 52 week target, with all services showing a reduction in the longest waiting times.

What are the risks and mitigating actions

Recruitment and retention, Impact of staff sickness/annual leave over Christmas period. Access to clinical accommodation.

1e: Child and Adolescent Mental Health Services (CAMHS)

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

Measures: Children and Adolescent Mental Health Services

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Nov	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	36.7%	36.1%	35.7%	39.0%	42.7%	43.0%	45.8%	46.3%	44.2%	41.2%	40.1%	39.6%	36.7%
QSE	Nov	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	80%	100.0%	100.0%	100.0%	54.5%	60.0%	100.0%	50.0%	66.7%	100.0%	100.0%	100.0%	Awaiting Data	
QSE	Nov	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	80%	47.0%	41.9%	33.3%	24.4%	38.0%	25.0%	26.1%	24.3%	35.1%	39.8%	26.1%	38.5%	47.0%
QSE	Nov	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years	80%	20.5%	54.4%	48.4%	33.3%	31.4%	18.2%	30.8%	20.1%	46.3%	26.5%	22.9%	26.9%	20.5%
QSE	Nov	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	80%	94.6%	93.9%	96.5%	92.3%	92.2%	93.3%	94.6%	89.2%	94.1%	93.0%	95.0%	93.3%	94.6%
QSE	2021/22	Rate of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population	Annual reduction	5.9	4.5 (2018/19)	5.2 (2019/20)	5.1 (2020/21)	5.9 (2021/22)								

Narrative 1: Children and Adolescent Mental Health Services

Why we are where we are

Performance against WG targets Nov 22: SCAMHS – 80% seen under 28 days. Mental Health Measure (MHM) Part 1a 47% 1b 20.5%, MHM Part 2 94.6%
- Performance position at end of November in line with WG approved improvement trajectories (regional) for Part 1a and 1b
- Consistently meeting MHM Part 2 and SCAMHS targets
- Demand for mental health assessment and intervention has increased by 5%
- Increase in N:R ration to 10:1 in comparison to pre-pandemic levels of 7:1, this is associated with increased complexity and acuity of patients seen nationally and impacts flow
- Recruitment of new posts within the service has seen internal transfer of staff which results in ongoing vacancies.

What we are doing about it

- Fortnightly check, challenge and support meetings with WG Delivery Unit in place
- Regional and local Choice and Partnership Approach (CAPA) action plans are under development for monitoring through TI Access Workstream from February 2023
- Monitoring of performance against improvement trajectory is ongoing across all teams and through the established Regional CAMHS Performance Delivery Group with escalation to Associate Directors and IHC Directors of Operations as appropriate
- Monthly scrutiny of external providers uptake and throughput
- Recruitment to posts identified in 2022/23 funding bids is ongoing with a focus on early intervention and prevention services to improve the early help offer within schools and primary care, manage demand into specialist services and increase capacity within core services
- Review of efficiency measures to improve access waiting times

When we expect to be back on track

- Revised trajectories agreed during November 2022 for recovery against MHM Part 1.
- Trajectories indicate achievement of MHM Part 1a by end of March 2023 and for Part 1b by end September 2023

What are the risks and mitigating actions

- Fortnightly check, challenge and support meetings with WG Delivery Unit in place
- Regional and local Choice and Partnership Approach (CAPA) action plans are under development for monitoring through TI Access Workstream from February 2023
- Monitoring of performance against improvement trajectory is ongoing across all teams and through the established Regional CAMHS Performance Delivery Group with escalation to Associate Directors and IHC Directors of Operations as appropriate
- Monthly scrutiny of external providers uptake and throughput
- Recruitment to posts identified in 2022/23 funding bids is ongoing with a focus on early intervention and prevention services to improve the early help offer within schools and primary care, manage demand into specialist services and increase capacity within core services
- Review of efficiency measures to improve access waiting times

Narrative 2: Neurodevelopment (ND)

Why we are where we are

Our performance against achieving the Welsh Government (WG) target at the end of October 2022 has reduced to 40% waiting within target to start a ND assessment. This is affected by:
- The gap between core capacity and demand is significant, at approximately 800 assessments per annum, and affected by staff turnover, recruitment of skilled workforce, and clinical accommodation availability.
- The need to redesign and refocus the service to ensure it is needs led and provides timely, consistent and supportive services to children and their families.
- Delivery of phases 1 and 2 by external provider off trajectory with phase 3 capacity significantly lower than agreed levels due to lack of provider capacity

What we are doing about it

- Development and implementation of a service improvement and development plan is in progress; funding will be essential to make the impact required. Programme Manager is prioritising work streams.
- Recruitment and retention strategy will be developed to support building of sustainable teams across the region, specific review of psychology workforce under review. Support from workforce requested around specific workforce campaign. Development of an agreed model of care for the service, which will include co-production and testing models to ensure they meet needs
- We continue to work with the external provider to deliver a recovery plan for all phases of the contract.
- Ongoing use of external providers is essential in order to meet demand; approval of further tender approved by Performance Finance and Information Governance (PFIG) committee and is going for Ministerial approval. Anticipation of new contract to be in place by July 2023

When we expect to be back on track

- External provider performance escalated via risk register. Anticipate external provider trajectory will be completed by March 2023.
- Service Improvement and Development Plan under development through transformational and programme team with an incremental 3-5 year plan in order that a sustainable service fit for the future needs of our population is achieved.

What are the risks and mitigating actions

- Financial risks identified with phase 1 and 2 paid as per contract (paid on referral) with delivery outstanding. Recovery plan to ensure all outstanding referrals are closed prior to year end; phase 3 activity may impact on 2023/24 finances – no payment made currently this is been managed by finance team. No additional funding identified to increase internal capacity.
- Risk of reputational damage due to inability to deliver activity by external provider mitigated by contacting all patients to maintain open and clear communication.
- Ongoing risk around internal recruitment and retention impacting on internal capacity and skill mix mitigated through development of recruitment and retention strategy.
- Lack of external provider contract from April 2023, prioritisation of service redesign/improvement is essential for the sustainability of the ND service.

1f: Adults Mental Health Services

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

Measures: Adults Mental Health Services

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Oct	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital between 09:00 and 21:00 hours that have received a gate-keeping assessment by the CRHT service prior to admission	95%	100.0%	New Measure for 2022/23				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Awaiting Nov Data
QSE	Oct	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital who have not received a gate keeping assessment by the CRHTS that have received a follow up assessment by the CRHTS within 24 hours of admission	100%	100.0%	New Measure for 2022/23				100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
QSE	Nov	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	80%	70.8%	66.2%	46.6%	63.2%	63.2%	54.5%	62.5%	69.5%	75.2%	77.1%	66.8%	72.2%	70.8%
QSE	Nov	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years and over	80%	76.3%	73.5%	64.4%	79.8%	75.1%	77.8%	78.5%	82.2%	81.2%	72.9%	71.8%	73.4%	76.3%
QSE	Nov	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	89.8%	78.6%	76.2%	76.4%	74.3%	69.6%	64.4%	74.6%	79.4%	88.0%	93.7%	94.4%	89.8%
QSE	Nov	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	90%	83.8%	86.1%	87.1%	85.5%	85.4%	86.5%	86.7%	83.2%	81.7%	84.3%	84.2%	84.7%	83.8%

Narrative 1: Mental Health Measure

Why we are where we are

As at the end of November we are reporting 70.8% against part 1a, 76.3% for part 1b, 83.8% for part 2 and 100% for part 3 of the Mental Health Measure. Whilst we are currently off target, we are achieving the levels forecast as part of our improvement trajectory for the month of November. We have maintained the position achieved last month despite seeing an increase in referrals across some of our county teams in November, most notably in Ynys Mon, Gwynedd and Flintshire.

What we are doing about it

We continue to pursue all recruitment opportunities both substantive and temporary to ensure we can both provide a quality service and to ensure our existing staff are supported. Due to the significant improvements made in the East, the East team are now seeking to support colleagues in teams in other areas as a part of the mitigation of risk to delivery over the winter months. Focus remains on waiting list reduction with capacity being used to address both long waiters and clinical prioritisation. The 111 press 2 service will go live in January 2023 and we anticipate that this will alleviate some of the demand typically routed through to the Mental Health Measure teams. We will be monitoring this impact carefully through both the 111 reporting and the monitoring of the wider Mental Health and Learning Disability (MHLD) services.
Longer term solutions continue to be worked through and additional project support will be aligned to the development of Tier 0/1 service improvement work from January 2023. The work to date has been developed alongside the project for 111 press 2 and the Delivery Unit (DU) have been involved in the discussion, agreement and sign off of pathways that will enable effective patient management through our services.

When we expect to be back on track

Our current forecast will bring us to compliance with the measure at the end of March 2023. Routine monitoring of our activity and the contributing risk factors will allow us to rapidly assess any adjust for any deviation from the current trajectory

What are the risks and mitigating actions

Staffing remains our biggest risk factor both with recruitment to substantive posts, implementation of approved bank staff solutions and seasonal pressures on staffing including sickness. As noted above routine monitoring of risk factors will allow us to consider early alternate solutions to staffing provision and consider its impact on our forecast position.

Narrative 2: Adult Psychological Therapy

Why we are where we are

We are currently 90% (November 2022) compliant, well above the national 85% target. The National Delivery Unit have informed us we are now reporting the best compliance in Wales.

What we are doing about it

We continue the whole system strategic improvement work aimed at increasing and sustaining the staffing and associated supportive infrastructure to ensure long term improvements in access to specialist interventions in secondary care mental health services. This includes ongoing capacity/demand analysis, stepped care training and supervision to MDT colleagues to increase access to lower step interventions (as per Matrics Cymru guidance), waiting list review and no waits prioritising and fast track high risk and need, proactive recruitment efforts, and active support for existing staff to ensure retention. In year we have been working closely with HEIW on the national Clinical Associate in Applied Psychology (CAAPs) workforce pilot, and are due to start 2 new Clinical Associates in January 2023 as a proof of concept to increase the available workforce and are also training additional psychologists as per Health Education Inspectorate Wales (HEIW) funded places and the national workforce plan. We continue the programme of increased access to and modes of delivery, including face to face groups and online delivery. We have service level research to indicate their benefit to service users across North Wales, in multiple teams and tiers of service within primary care mental health and secondary care mental health teams. We have recently taken part in the national review of waiting time targets by the National Delivery Unit, and look forward to further recommendations on these targets next year.

When we expect to be back on track

Currently on track but we remain vigilant in our monitoring due to the risks noted below.

What are the risks and mitigating actions

With a small specialist resource and the national picture of increased demand for psychological input (the pandemic and economic crisis impact), there remains constant challenges such as maternity leaves, sickness, and staff turnover vacancies to manage on a day to day basis. We continue to try and address the capacity demand mismatch by proposing plans for Service Improvement Funding (SIF) to further build and improve the available resource and infrastructure within Betsi Cadwaladr University Health Board (BCUHB) to sustain these improvements long term and manage the increase in demand which we are now seeing post pandemic, and are actively seeking ways to attract new qualified recruits to BCUHB by networking.

Chapter 2

Quadruple Aim 3:

The health and social care workforce in Wales is motivated and sustainable

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

2a: Motivated & Sustainable Workforce

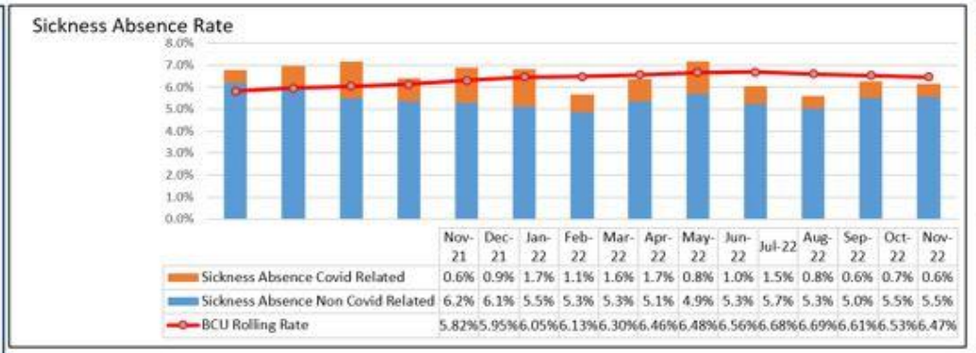
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

Measures: Motivated & Sustainable Workforce

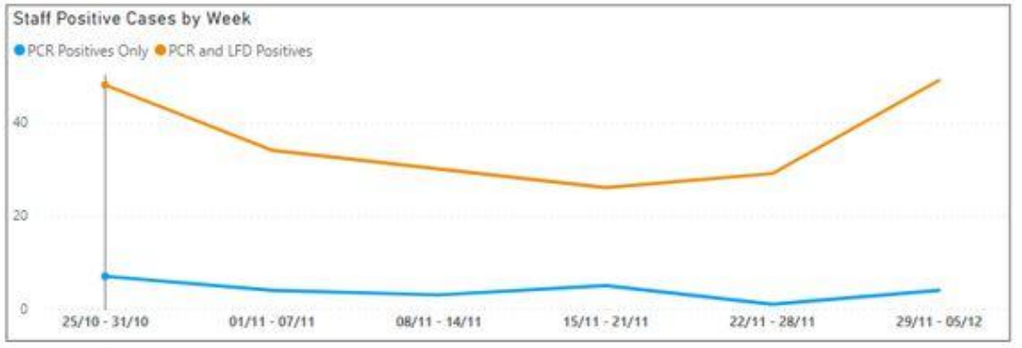
Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
PFIG	Nov	Agency spend as a percentage of the total pay bill	12 month reduction trend	8.4%	5.5%	7.9%	6.3%	7.5%	6.1%	6.8%	7.1%	7.2%	6.8%	6.5%	8.3%	8.4%
PFIG	Nov	Percentage of sickness absence rate of staff	12 month reduction trend	6.2%	7.0%	7.2%	6.3%	6.9%	6.8%	5.7%	6.4%	7.2%	6.1%	5.6%	6.3%	6.2%
PFIG	Nov	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	85%	86.7%	84.4%	84.5%	84.6%	84.9%	85.0%	84.7%	84.8%	84.8%	85.5%	86.2%	86.7%	86.7%
PFIG	Nov	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	85%	71.0%	67.8%	67.3%	67.1%	66.1%	65.5%	65.3%	66.2%	65.3%	66.3%	67.7%	69.7%	71.0%

Impact of COVID-19 Pandemic on Planned Activity

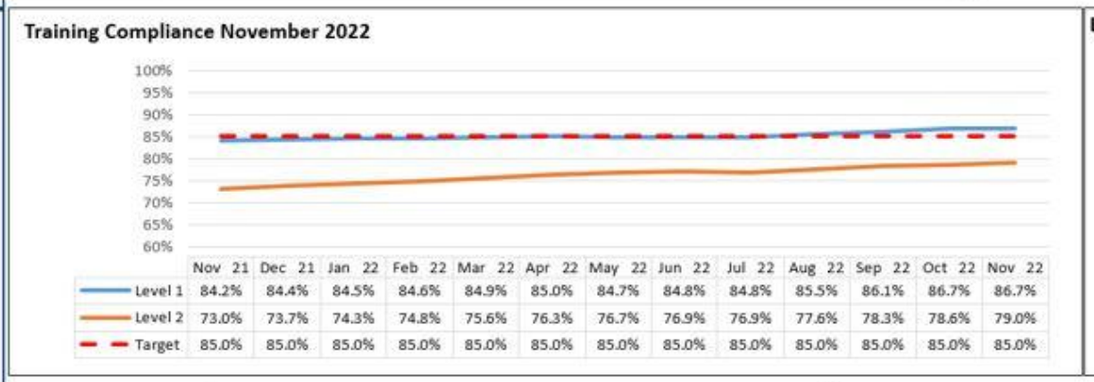
Sickness absence Rates



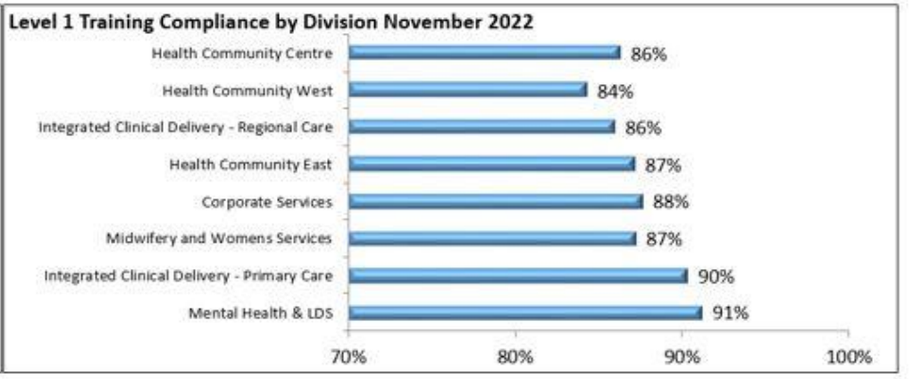
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Sickness Absence Covid Related	0.6%	0.9%	1.7%	1.1%	1.6%	1.7%	0.8%	1.0%	1.5%	0.8%	0.6%	0.7%	0.6%
Sickness Absence Non Covid Related	6.2%	6.1%	5.5%	5.3%	5.3%	5.1%	4.9%	5.3%	5.7%	5.3%	5.0%	5.5%	5.5%
BCU Rolling Rate	5.82%	5.95%	6.05%	6.13%	6.30%	6.46%	6.48%	6.56%	6.68%	6.69%	6.61%	6.53%	6.47%



Core Mandatory Training Rate

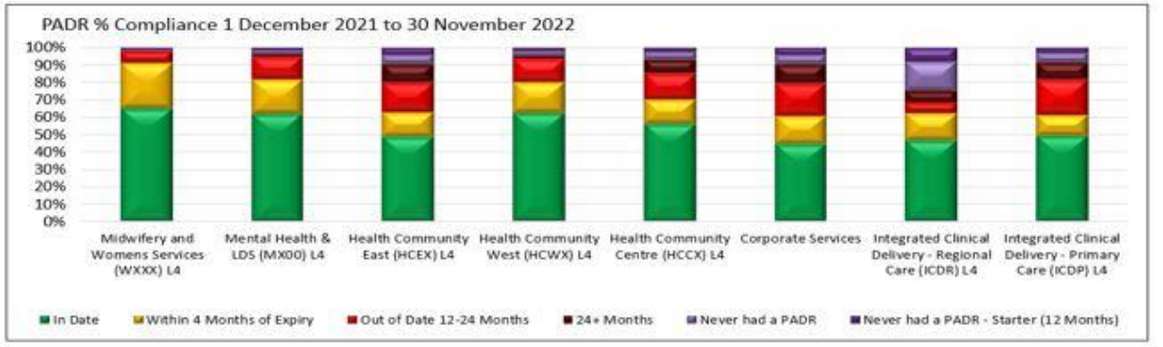


	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22
Level 1	84.2%	84.4%	84.5%	84.6%	84.9%	85.0%	84.7%	84.8%	84.8%	85.5%	86.1%	86.7%	86.7%
Level 2	73.0%	73.7%	74.3%	74.8%	75.6%	76.3%	76.7%	76.9%	76.9%	77.6%	78.3%	78.6%	79.0%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



PADR

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Actual	67.9%	67.8%	67.3%	67.1%	66.7%	65.5%	65.3%	66.2%	65.3%	66.4%	67.7%	69.7%	71.0%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



Narrative: Sickness Absence

Why we are where we are

Rolling sickness absence performance is at 6.47% a slight decrease from 6.53% in October, due to a decline in COVID absence. As at the end of November there were 1343 staff recorded as absent of which 562 had been off work for more than 28 days. The average length of absence is currently 15.1 days.
21.9% of all sickness absence is attributable to anxiety, stress or depression.
The staff groups that recorded the highest sickness levels are nursing Health Care Support Workers (HCSW) and band 2 staff both recording sickness rates of 8.8%.
The Trade Unions are reporting that the cost of living crisis is impacting upon the overall wellbeing of staff from a food and energy perspective.

What we are doing about it

HR teams are working with managers to focus on the management of both frequent absences and long-term sickness particularly stress
Meetings between Well-being, HR and Occupational Health colleagues to look at hotspot areas and support options.
Refresher training and coaching for managers on the Managing attendance at work policy
Monthly Multi-Disciplinary Team (MDT) Case management meetings are taking place to provide support for staff with more complex needs and include staff, managers, occupational health, H&S and well-being colleagues as needed. Sending out Health Matters newsletters to staff who are off with work due to stress
Promote the Staff wellbeing and support services including counselling and psychological therapies in addition to flu and COVID vaccines
A cost of living group has been established to provide advice to the organisation on where practical support can be sourced.

When we expect to be back on track

It is anticipated that over the winter there will be higher levels of respiratory illnesses such as flu due to lower levels of exposure in recent seasons.
Staff are also likely to be conflicted by involvement or non-involvement in industrial action potentially leading to stress and anxiety. It is therefore unlikely that absence levels will fall significantly before the spring.

What are the risks and mitigating actions

Risks include increased level of winter respiratory viruses and stress due to industrial action.
Increased communications to further promote access to the Wellbeing Services available for staff.
Focus on early intervention support and supporting managers to have conversations with staff around wellbeing (from OH/HR).
Use of Healthy Working Relationships training and implementation of facilitated discussions to address breakdowns in working relationships.

Narrative: PADR

Why we are where we are

Personal Appraisal Development Review (PADR) compliance has once again seen a steady increase to 71% in November, this is a significant increase of 3.27% since September. We have not seen PADR compliance reach over 70% since June 2021. This reinforces the intrinsic link PADR has to Pay Progression, (as progression through increments is not approved unless a PADR conversation has taken place) as 370 staff have received Pay Progression since October. During the first month of Pay Progression being implemented (October) BCUHB were the only health board in Wales to declare 100% success rate where all staff who were due a pay progression conversation received one and these were entered onto Electronic Staff Record (ESR).

What we are doing about it

Over recent months the local Pay Progression group which has been set up to monitor local implementation and progression of the National standards has been meeting bi-weekly with numerous actions taking place. Some of the groups key achievements include:-

- Developing and facilitating PADR/Pay Progression workshops including live demonstration of entering a Pay Progression meeting into ESR to over 500 staff members
- Developing an on-line toolkit (including infographics, guides, process, FAQs etc) to ensure mechanisms are in place empowering staff to follow the process seamlessly
- Dealing with individual queries and supporting managers to ensure that 370 staff have received their Pay Progression since October.

When we expect to be back on track

An increase in organisational compliance suggests that the implementation of Pay Progression is contributing to ensure that PADR's are being conducted effectively and recorded accurately in ESR. We expect to see positive increase in compliance month on month.

What are the risks and mitigating actions

Continued operational pressures as well as industrial action may impact on the capacity of line managers and staff to complete PADRs. To mitigate this, we will continue to communicate across the health board as a gentle reminder of the importance of conducting PADR conversations and its links to Pay Progression.

Narrative: Mandatory Training

Why we are where we are

Compliance for Mandatory Training increased again this month and continues to exceed the national target with level 1 training at 86.72% .
Level 2 training increased by 0.40% and is currently illustrated as 79%.
The rise in Personal Appraisal Development Review (PADR) rates has seen an increase also in Mandatory Training compliance across all staff groups.
November saw an increase across all level 1 and level 2 training with the exception of Manual Handling level 2 training which decreased by 0.23%.
Did not attend [DNA] figures for Manual Handling course remains a concern with DNA figures rising to 30% with some face to face practical [level 2] courses.

What we are doing about it

Following a detailed review with BCUHB Manual Handling lead there has been a requirement to review the Orientation schedule for new starters to include a more robust process to ensure Manual Handling training is included within the corporate orientation schedule, this will ensure attendance of new starters for Manual Handling training therefore reducing the waiting list for level 2 Manual Handling training.
A Situation Background Assessment Recommendation (SBAR) for a 'recruitment improvement review' has been submitted for Manual Handling to include a programme for improving compliance for Manual Handling training.

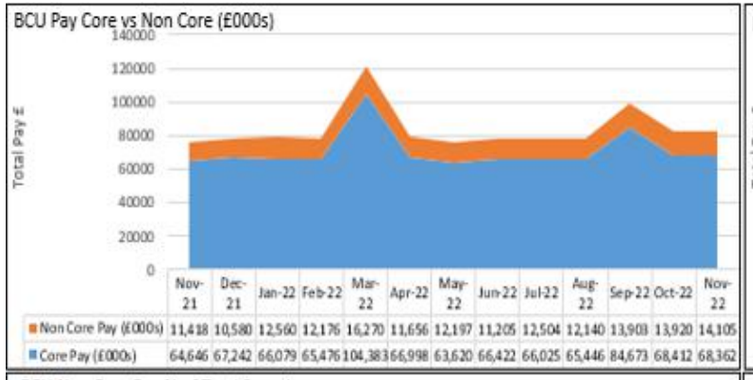
When we expect to be back on track

The orientation schedule amendment will take place for courses being delivered from January 2023 so it is expected to see an increase in Manual handling level 2 training from February 2023.

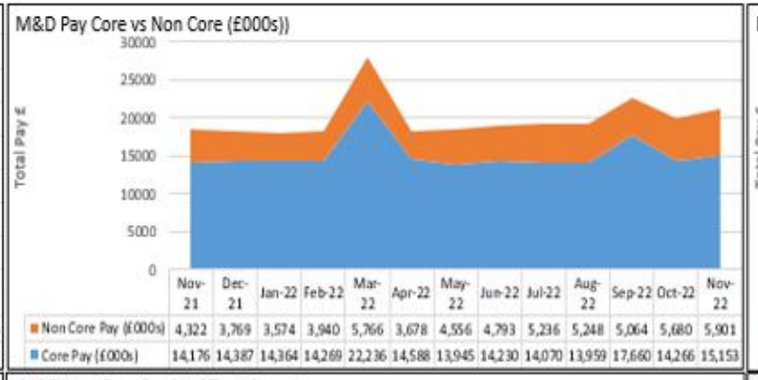
What are the risks and mitigating actions

There is still a significant concern with the 'did not attend' figures particularly with classroom sessions which require a practical competence. This concern has been addressed within the 'Recruitment Improvement review' for Manual Handling.

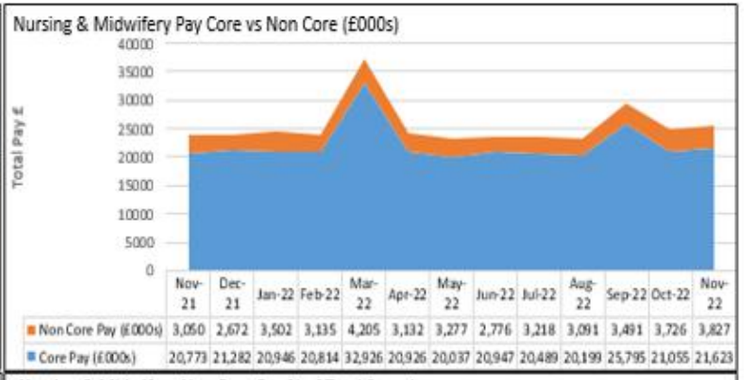
Charts: Agency & Locum Spend



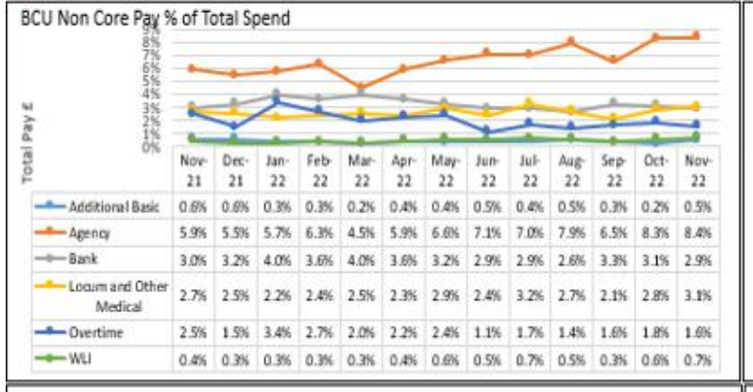
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Non Core Pay (£000s)	11,418	10,580	12,560	12,176	16,270	11,656	12,197	11,205	12,504	12,140	13,903	13,920	14,105
Core Pay (£000s)	64,646	67,242	66,079	65,476	104,383	66,998	63,620	66,422	66,025	65,446	84,673	68,412	68,362



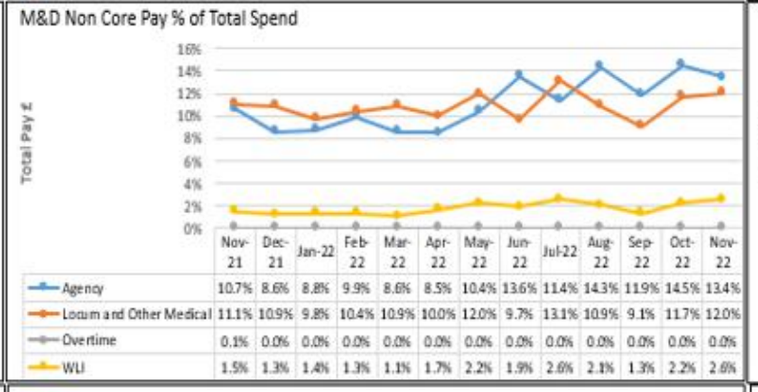
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Non Core Pay (£000s)	4,322	3,769	3,574	3,940	5,766	3,678	4,556	4,793	5,236	5,248	5,064	5,680	5,901
Core Pay (£000s)	14,176	14,387	14,364	14,269	22,236	14,588	13,945	14,230	14,070	13,959	17,660	14,266	15,153



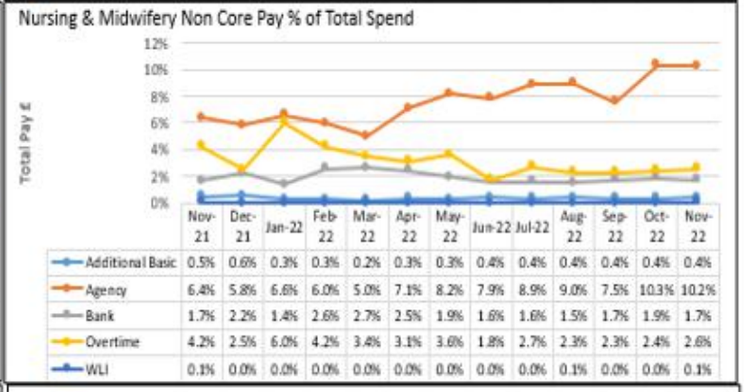
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Non Core Pay (£000s)	3,050	2,672	3,502	3,135	4,205	3,132	3,277	2,776	3,218	3,091	3,491	3,726	3,827
Core Pay (£000s)	20,773	21,282	20,946	20,814	32,926	20,926	20,037	20,947	20,489	20,199	25,795	21,055	21,623



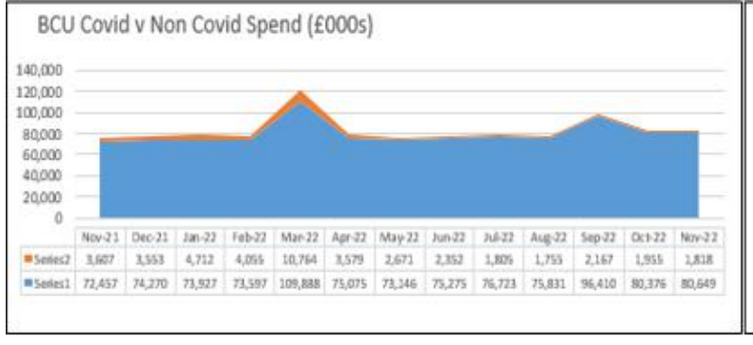
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Additional Basic	0.6%	0.6%	0.3%	0.3%	0.2%	0.4%	0.4%	0.5%	0.4%	0.5%	0.3%	0.2%	0.5%
Agency	5.9%	5.5%	5.7%	6.3%	4.5%	5.9%	6.6%	7.1%	7.0%	7.9%	6.5%	8.3%	8.4%
Bank	3.0%	3.2%	4.0%	3.6%	4.0%	3.6%	3.2%	2.9%	2.9%	2.6%	3.3%	3.1%	2.9%
Locum and Other Medical	2.7%	2.5%	2.2%	2.4%	2.5%	2.3%	2.9%	2.4%	3.2%	2.7%	2.1%	2.8%	3.1%
Overtime	2.5%	1.5%	3.4%	2.7%	2.0%	2.2%	2.4%	1.1%	1.7%	1.4%	1.6%	1.8%	1.6%
WLI	0.4%	0.3%	0.3%	0.3%	0.3%	0.4%	0.6%	0.5%	0.7%	0.5%	0.3%	0.6%	0.7%



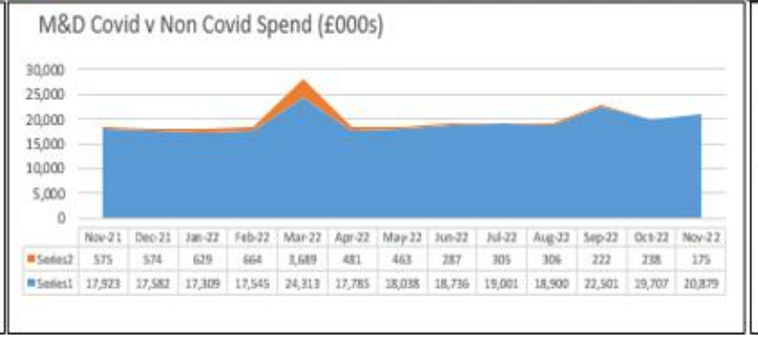
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Agency	10.7%	8.6%	8.8%	9.9%	8.6%	8.5%	10.4%	13.6%	11.4%	14.3%	11.9%	14.5%	13.4%
Locum and Other Medical	11.1%	10.9%	9.8%	10.4%	10.9%	10.0%	12.0%	9.7%	13.1%	10.9%	9.1%	11.7%	12.0%
Overtime	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
WLI	1.5%	1.3%	1.4%	1.3%	1.1%	1.7%	2.2%	1.9%	2.6%	2.1%	1.3%	2.2%	2.6%



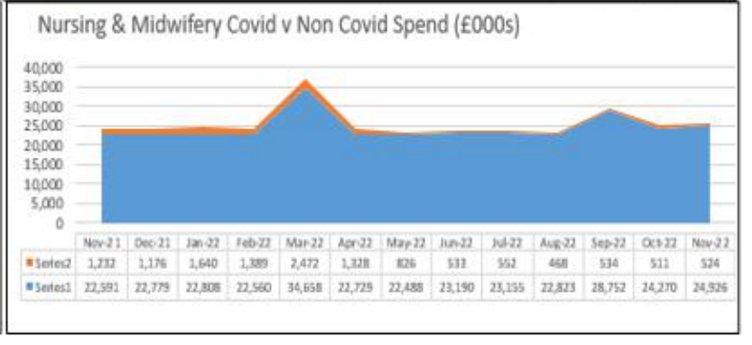
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Additional Basic	0.5%	0.6%	0.3%	0.3%	0.2%	0.3%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Agency	6.4%	5.8%	6.6%	6.0%	5.0%	7.1%	8.2%	7.9%	8.9%	9.0%	7.5%	10.3%	10.2%
Bank	1.7%	2.2%	1.4%	2.6%	2.7%	2.5%	1.9%	1.6%	1.6%	1.5%	1.7%	1.9%	1.7%
Overtime	4.2%	2.5%	6.0%	4.2%	3.4%	3.1%	3.6%	1.8%	2.7%	2.3%	2.3%	2.4%	2.6%
WLI	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Series2	3,607	3,553	4,712	4,055	10,764	3,579	2,671	2,352	1,805	1,755	2,167	1,955	1,818
Series1	72,457	74,270	73,927	73,597	109,888	75,075	73,146	75,275	76,723	75,831	96,410	80,376	80,649



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Series2	575	574	629	664	3,689	481	463	287	305	306	222	238	175
Series1	17,923	17,582	17,309	17,545	24,313	17,785	18,038	18,736	19,001	18,900	22,501	19,707	20,879



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Series2	1,232	1,176	1,640	1,389	2,472	1,328	826	533	552	468	534	511	524
Series1	22,591	22,779	22,808	22,560	34,658	22,729	22,488	23,190	23,155	22,823	28,752	24,270	24,926

Narrative: Agency & Locum Spend

Why we are where we are

Non-core pay spend overall has increased by £202k from £13,192,000 in October 22 to £14,105,000 in November 22. This increase is primarily driven by Medical Locum spend Overtime. Drivers behind the ongoing high levels of staff usage across all areas of the Health Board are the ongoing pressure on unscheduled care, and more activity across the Planned Care Recovery programme in terms of a higher usage across the nursing staff group.
Medical non-core spend is has increased by £220k this month to £5.9m. There increase is seen across all elements of nor-core pay across Agency Medical Locum and Waiting List Initiative (WLI) spend. As noted, we are still seeing ongoing activity across Planned Care Recovery and the ongoing pressures on Unscheduled Care across the Health Board.
Nursing non-core spend is up by £101k this to £3.8m. This increase is driven by an increased usage across all non-core elements and in particular supports the increased pressures on Unscheduled Care nursing across the Health Board where short notice cover is required.

What we are doing about it

The British Association of Physicians of Indian Origin (BAPIO) initiative to attract overseas doctors from India to the Health Board is on track with 46 Full-Time Equivalent (FTE) vacancies identified for the campaign. Alongside this, a campaign to recruit doctors from across the Middle East with a planned rollout in Q4.
The ongoing focus on Nursing recruitment is showing progress with the overseas nurse recruitment delivering success. Routine open days for nursing across the Integrated Health Communities (IHCs) were held in December and will be scheduled to run bi-monthly for the following year. This corporate-led recruitment should put our nursing recruitment in a more positive position, leading to increased capacity across the nursing workforce. This work is being undertaken by Nursing with support from Workforce Organisational Development (WOD).

When we expect to be back on track

The sustained expected impact for medical and nursing recruitment activity should be seen through Q4 of 22/23.

What are the risks and mitigating actions

The service delivery model and replication of predominantly bed-based services continues to result in challenges in respect of rotas for both medical and nursing staffing. The Clinical Workforce Service reviews alongside new recruitment initiatives ensure wherever possible pathways are aligned and aware of existing and future workforce challenges.

It is acknowledged that there is a UK shortage of nurses (band 5 in particular), therefore recruitment campaigns will reduce rather than eradicate the vacancy levels. Increased recruitment to identified hotspots with the implementation of the workforce capacity health check dashboard will enable teams to target resources where they will have greatest impact to ensure service continuity.

Chapter 3*

Operational and Local Measures:

Operational Measures (ref: A-H), which are not routinely reported at National Levels, but must be tracked

Local Measures (LM---) that do not form part of the NHS PF 2022-23, but which have been identified by the Health Board as important to monitor, and escalate if needed

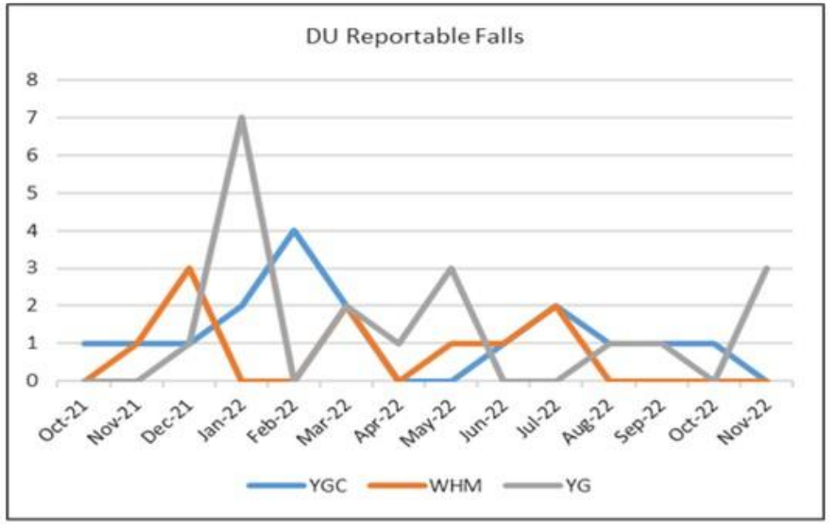
**This chapter is being reviewed as previously nationally reported measures have been retired with new Operational and Local Measures to be confirmed and collected accurately*

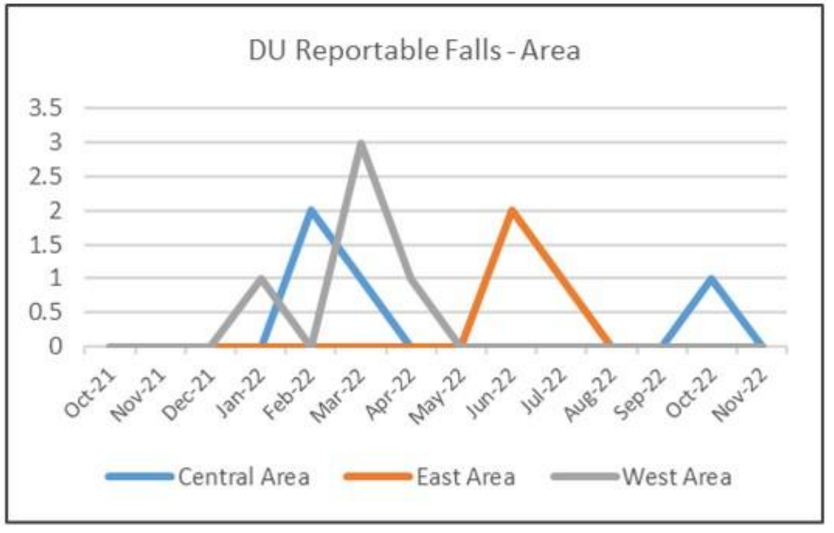
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwalar University Health Board

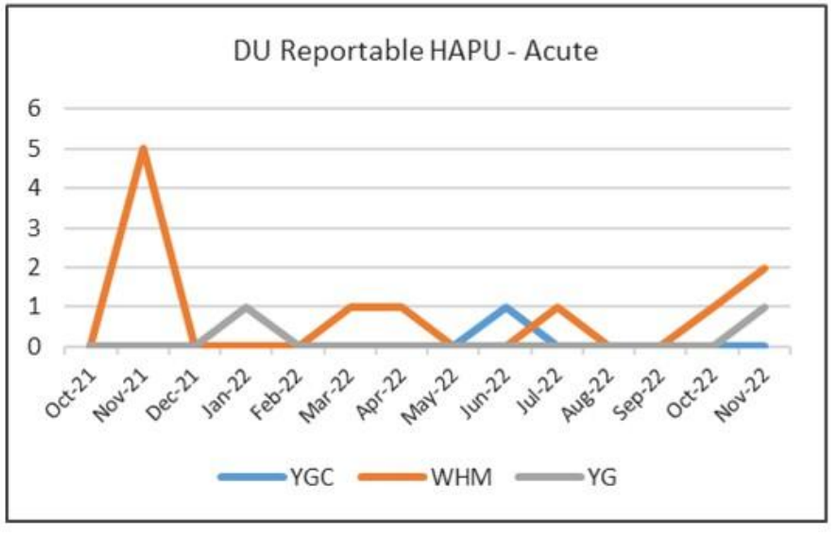
3a: Incidents and Complaints

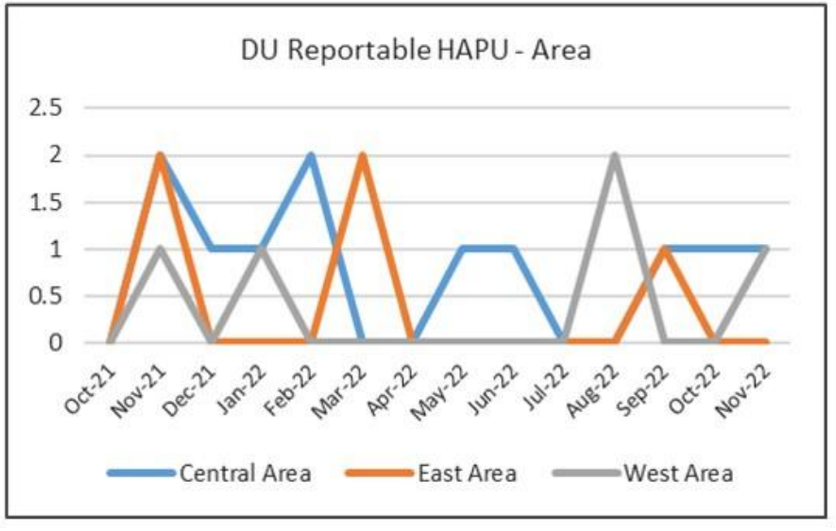
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

Charts 1: Incidents

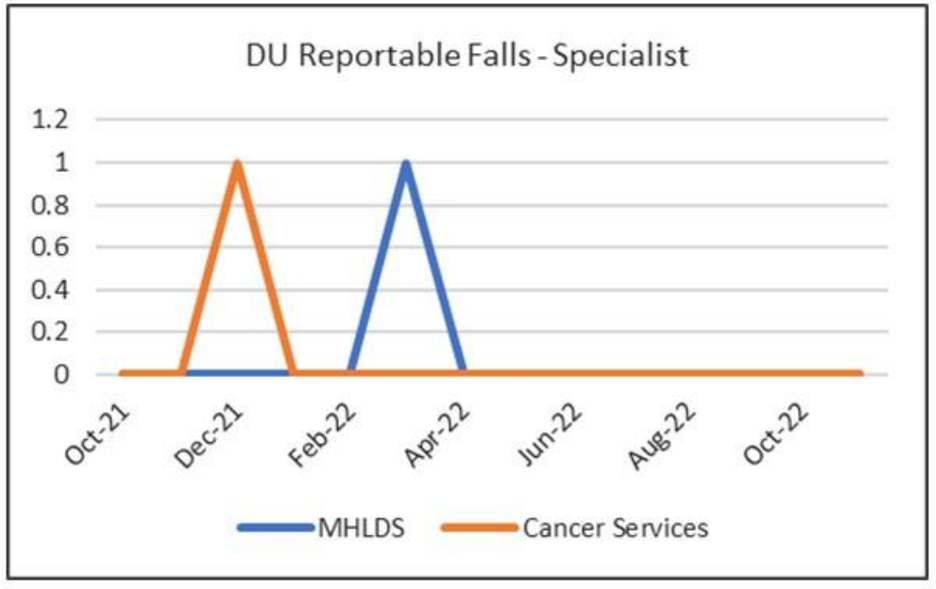


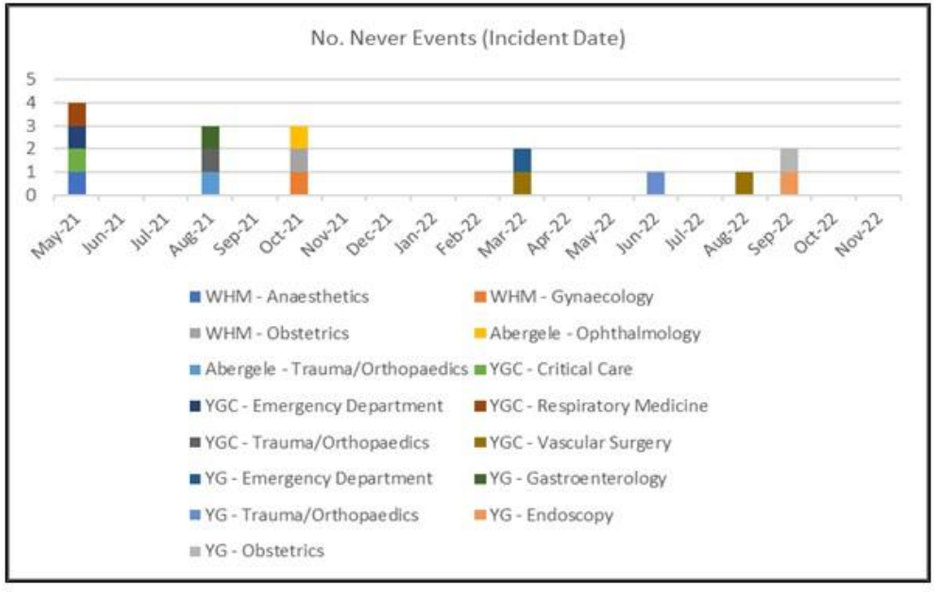






Charts 2: Incidents





Narrative: Incidents

Why we are where we are

During this time period there were zero never events reported. There were seven healthcare acquired pressure ulcers (HAPUs) (grades 3, 4 and ungradeable) reported and five falls (with harm) reported. Further details are found in the Patient Safety Report.
There is one patient safety alert for which compliance is overdue (PSA057 – Emergency steroid therapy cards). The Deputy Executive Medical Director is leading work to ensure compliance with the notice.

What we are doing about it

In respect of the top three themes, there is ongoing work led by the Falls Improvement Group, Sepsis Trigger, Escalation and Antibiotic stewardship Review (STEAR) Improvement Group and the HAPU improvement Group, all of which take a collaborative approach to improve patient safety underpinned by improvement methodology. Further details are found in the Patient Safety Report.

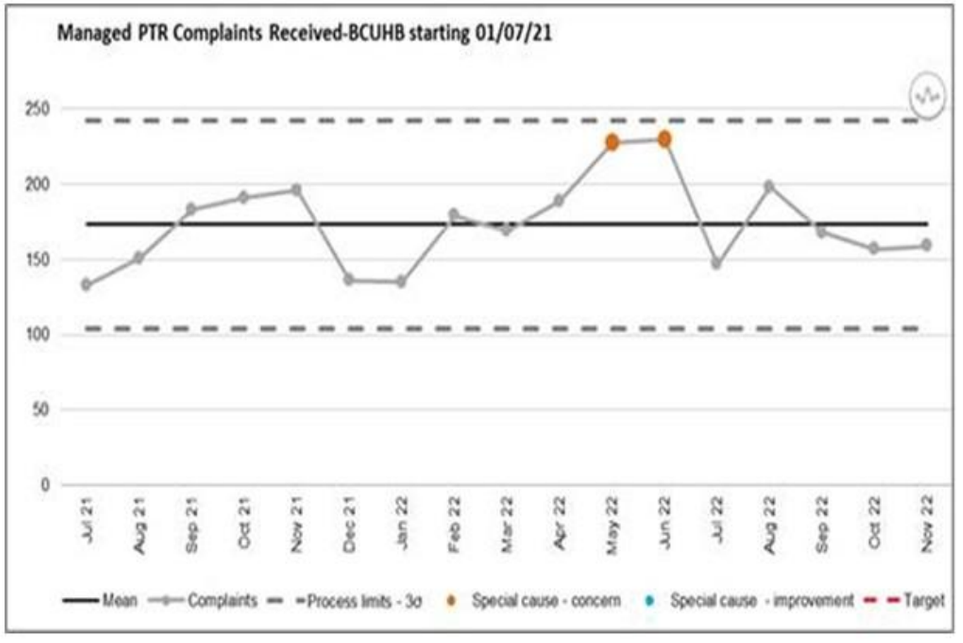
When we expect to be back on track

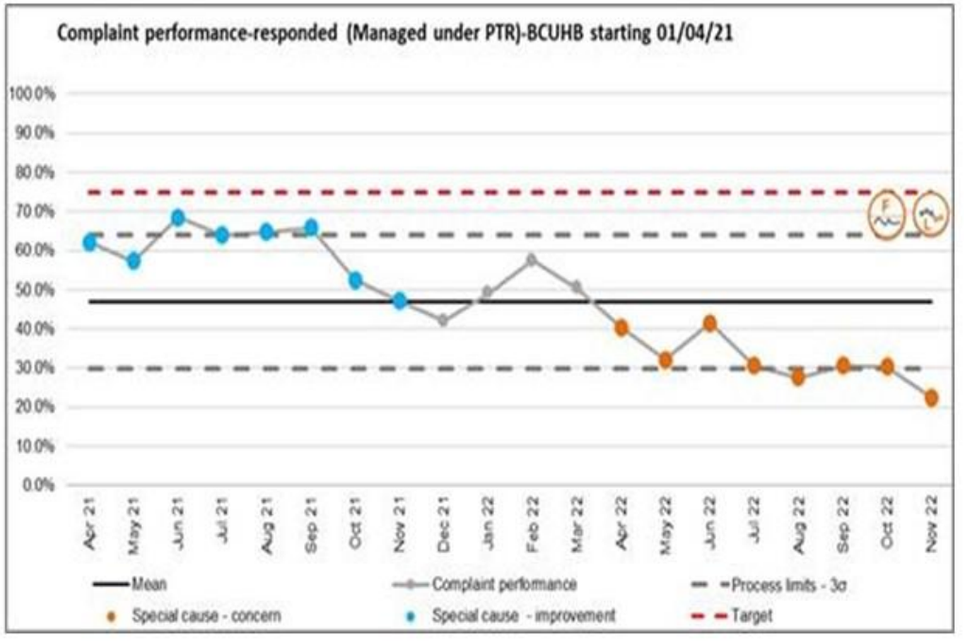
The overdue incident review position is being progressed and the aim is to achieve the national targets by April 2023. Further details are included in the Patient Safety Report.

What are the risks and mitigating actions

The capacity within services to manage both the current and backlog position of investigations is a main risk – weekly reporting is in place. The system for sharing and embedding of learning remains a risk for the organisation. As part of the restructure of the Quality Team, there are plans for a dedicated team that will be tasked with developing and improving the way in which the Health Board shares learning. An Organisational Learning Forum is being established in February 2023.

Charts: Complaints





Narrative: Complaints

Why we are where we are

During the months of October and November 2022, 26.33% (average) of complaints were responded to within 30 working (against a target of 75%). 487 complaints were overdue in October which reduced to 342 complaints overdue at the end of November. The consistent themes highlighted were particularly in relation to treatment and care, discharge, communication and appointment waiting times. The impact of the COVID pandemic has increased the number of delayed appointments and waiting times, which has contributed to delayed treatment, and an increase in complaints in light of these factors. However, the services have worked pro-actively with the support of the Complaints Team and Patient Advice Liaison Service (PALS) to provide a proactive, timely resolution to enquiries, Grade 1 and 2 complaints, which has contributed to a reduced number of open complaints and a focus on addressing the backlog of overdue complaints.

What we are doing about it

A weekly complaints report is cascaded across all services with proactive support by the Complaints Team. Scrutiny is consistently being applied, ensuring that all complaints are managed under Putting Things Right (PTR) as required, whilst seizing opportunities to provide timely resolution where applicable. This has already demonstrated a gradual reduction in the number of complaints managed under PTR where there is no allegation of harm, particularly Grade 1 complaints. Specific review and support meetings have commenced with the Directors and Heads of Nursing, providing an overview of the current status of their complaints, highlighting the number of complaints overdue and grading in order to implement a collaborative approach on complaint management. The team continues to work with services to provide accurate and detailed performance data on a weekly basis with a new complaint management approach adopted via “rapid resolution workshops” to resolve the backlog of overdue complaints. In addition, empowering staff to resolve low level concerns by offering on site training sessions, caseload review sessions, weekly reviews with the Executive Director of Nursing who is personally responding to lower level complaints ensuring consistent Executive management level involvement.

When we expect to be back on track

The aim is for recovery of the position by the end of the financial year, with a focus on prioritising the most significant and most overdue first. Progress will be monitored via the weekly reporting mentioned above but also through Accountability Meetings with the Executive Team.

What are the risks and mitigating actions

The capacity within services to manage both the current and backlog position is the main risk. Additionally, a risk exists that services may not achieve trajectories in the Complaints Recovery Plan impacted by the current re-organisation, particularly vacant posts, and the impact of potential staff absence during what is likely to be a busy winter period. In mitigation, dynamic management of the recovery plan is in place through weekly review and monitoring in Accountability Meetings with the Executive Team.

Additional Information

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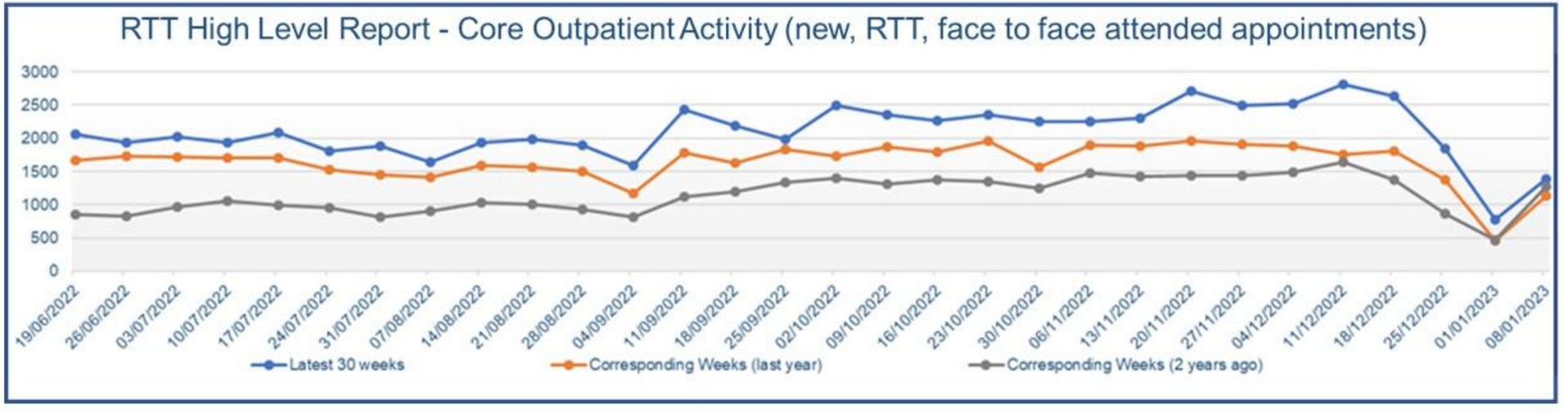
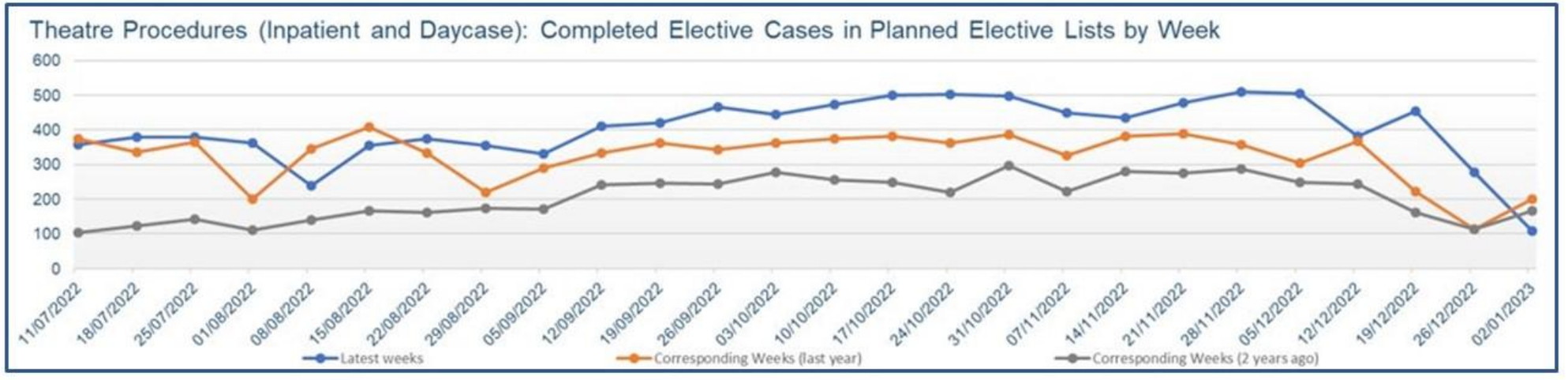
Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

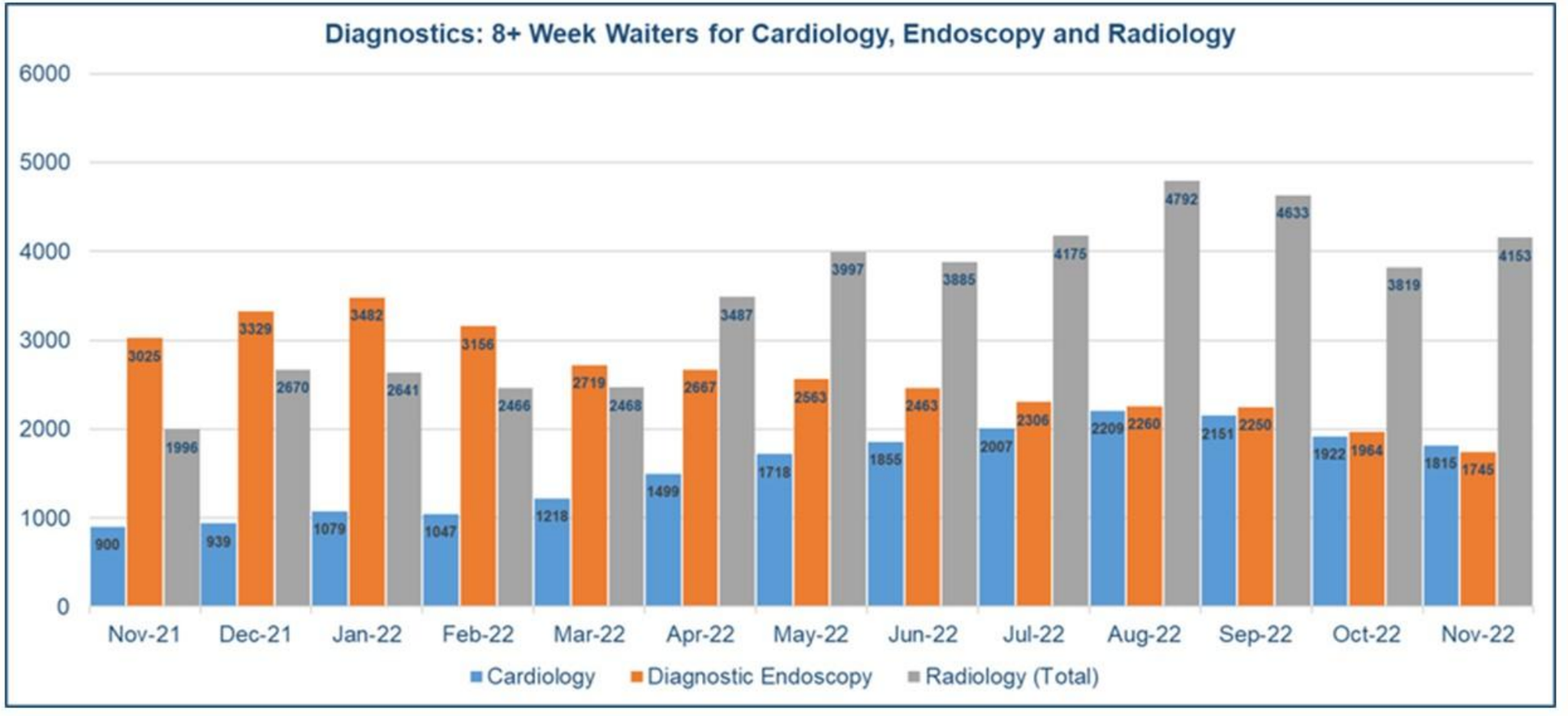
Charts: Planned Care Referrals & Outpatient Activity



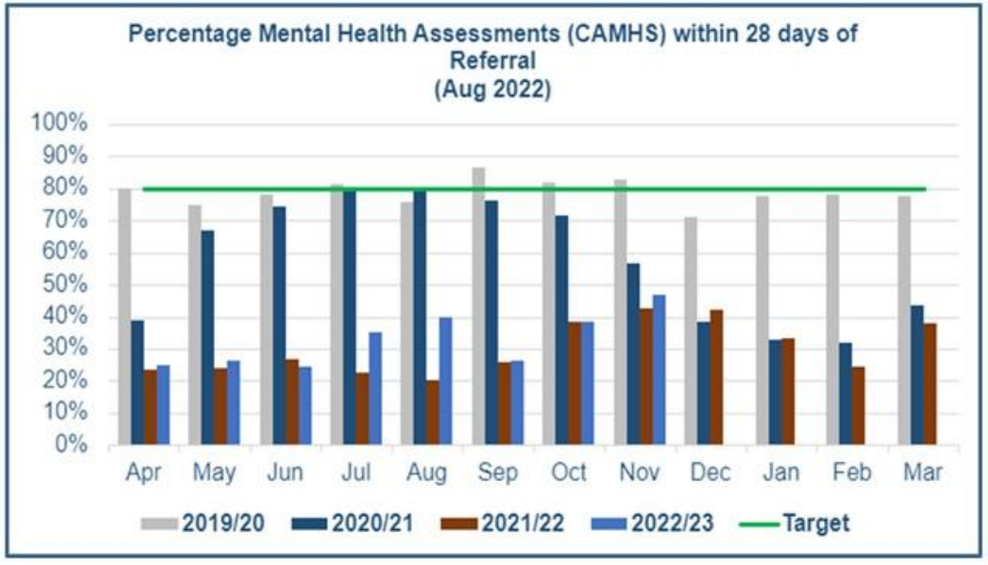
Charts: Planned Care Theatre Sessions

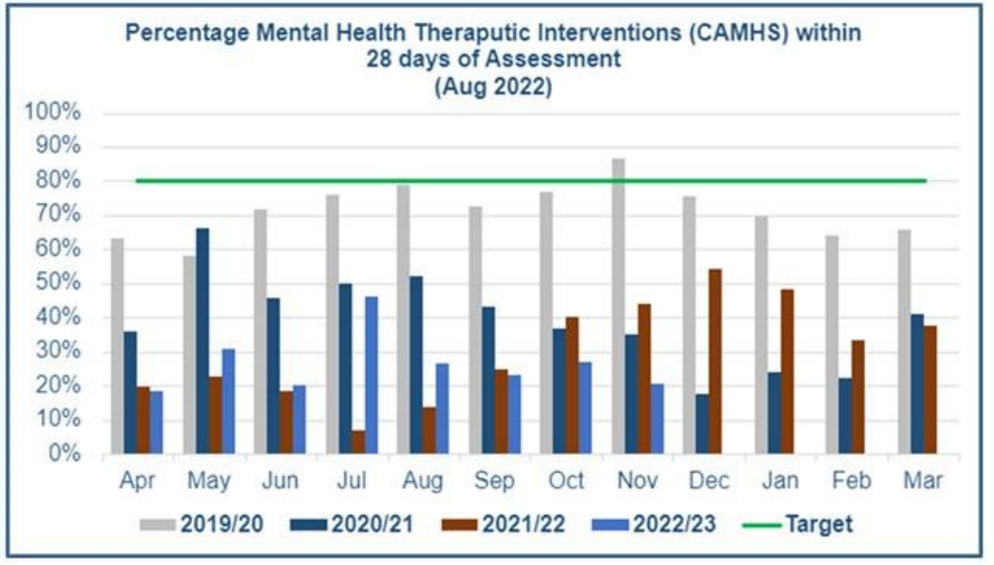


Charts: Diagnostic Waits (3 major wait categories)

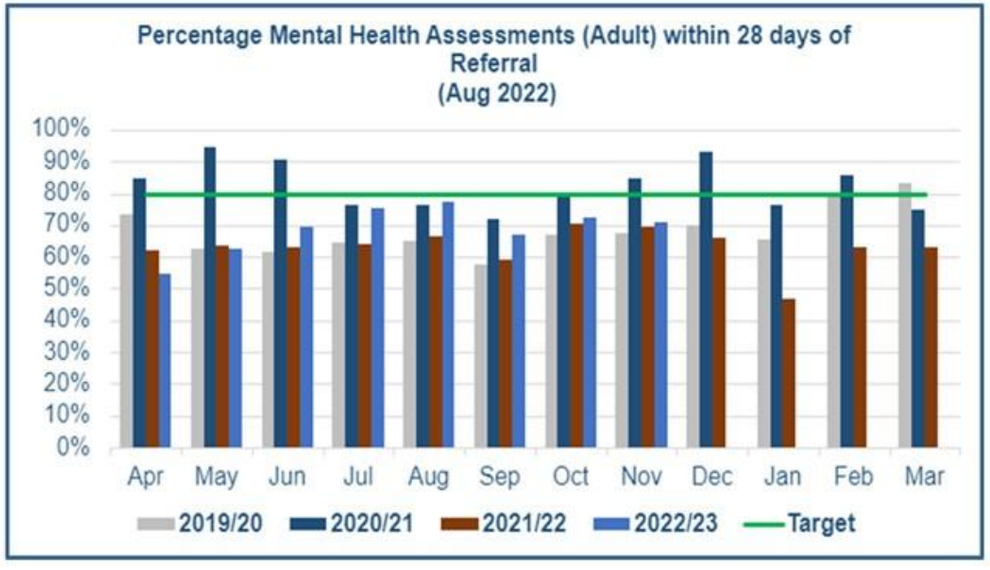


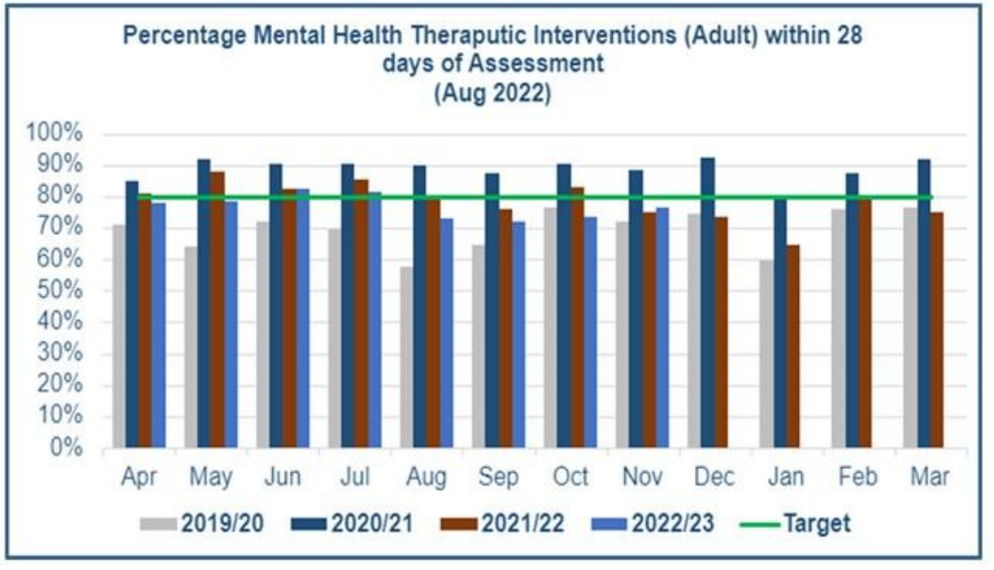
Charts: CAMHS



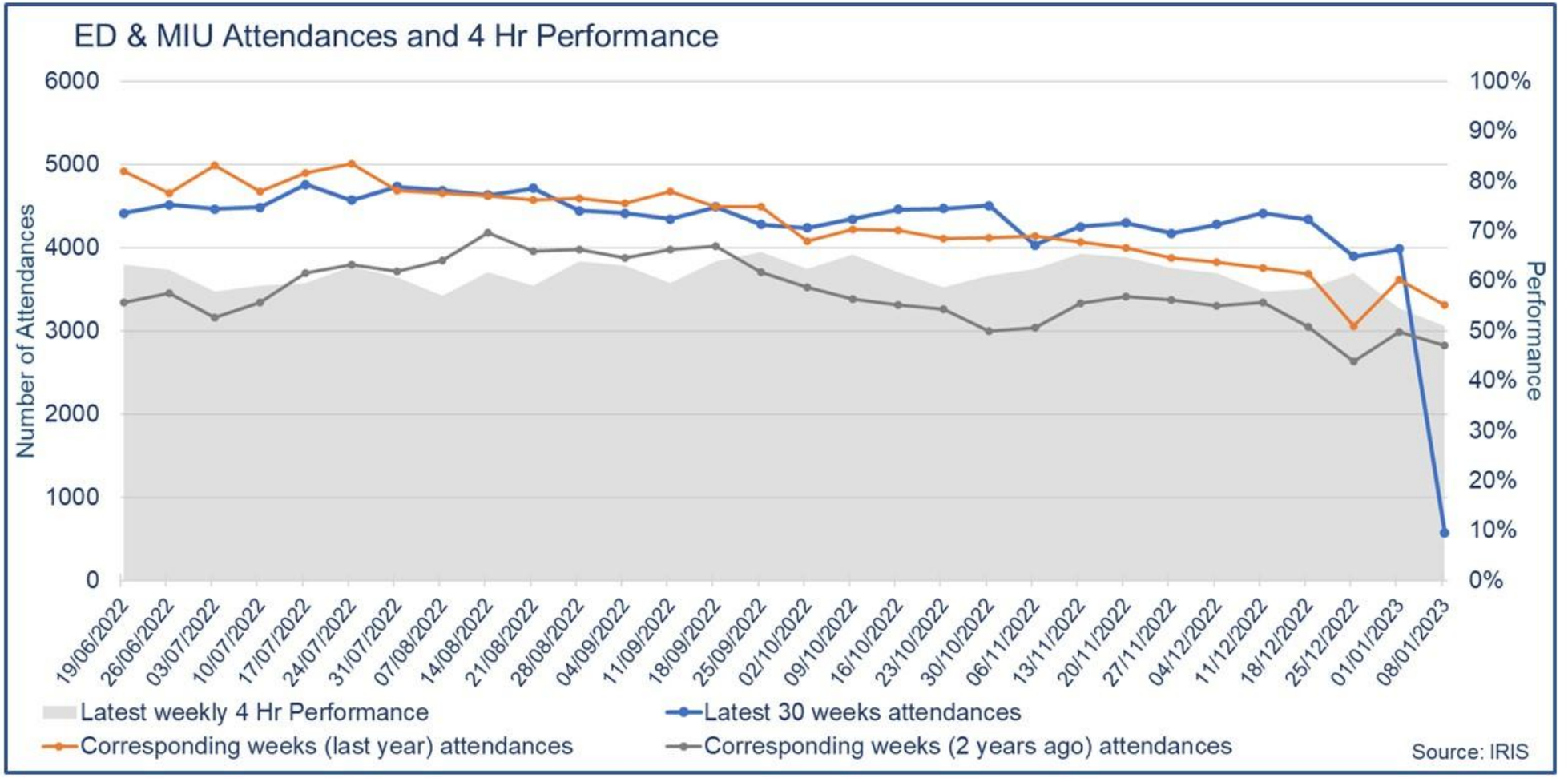


Charts: Adult Mental Health





Impact of COVID-19 Pandemic on Unscheduled Care



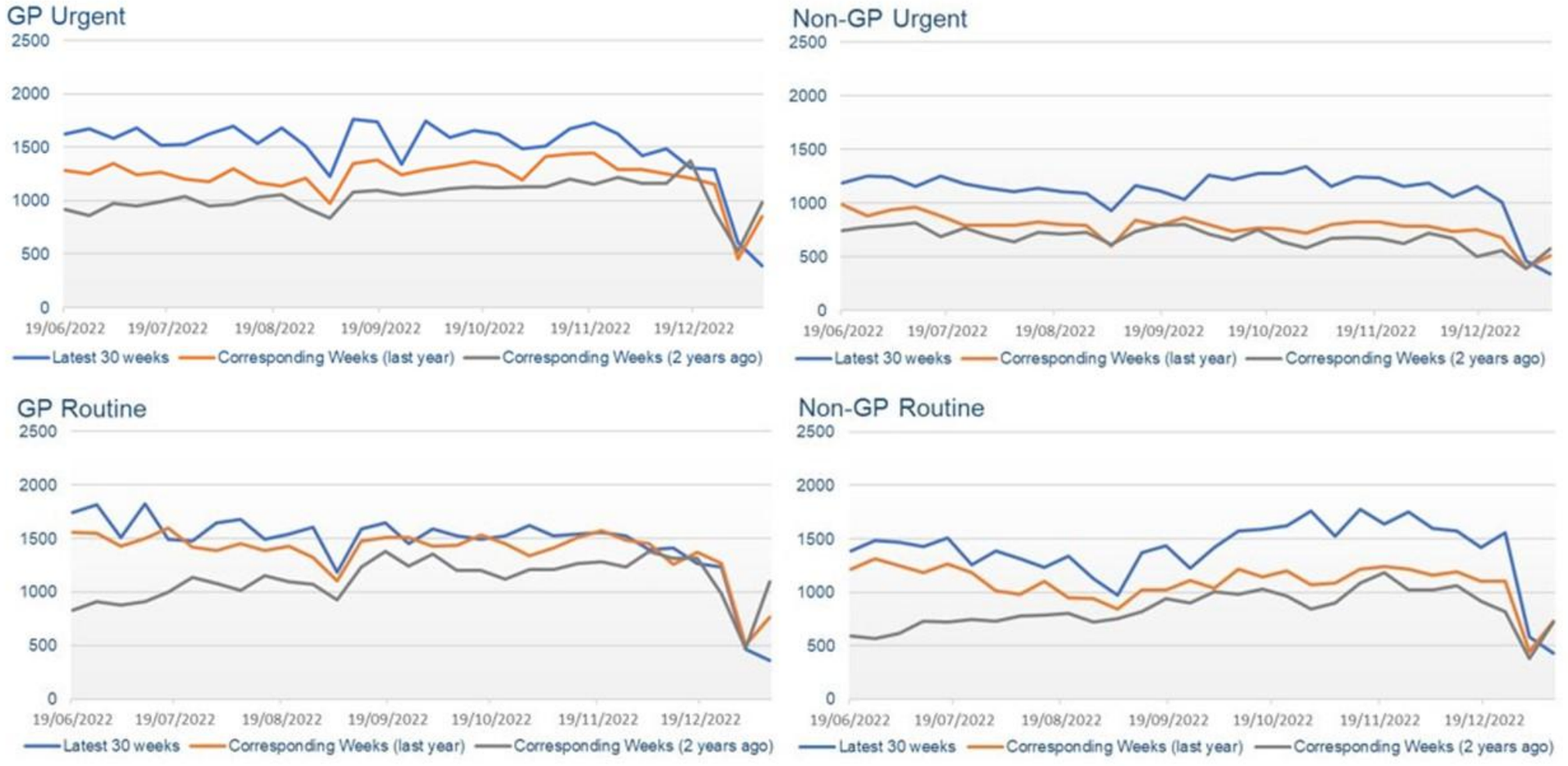
Impact of COVID-19 Pandemic on Unscheduled Care

Position as at end of 8th January 2023	Sep 22	Oct 22	Nov 22	Dec 21	Dec 22	January 1st - 8th 2022	January 1st - 8th 2023
ED&MIU 4 Hour Performance	62.94%	61.87%	64.00%	60.24%	58.75%	59.19%	**62.92%**
ED 4 Hour Performance	50.83%	50.18%	53.18%	50.96%	48.76%	50.96%	**54.14%**
ED 12 Hour Breaches	3106	3178	2802	2501	3383	698	**694**
1 - 2 Hour Ambulance Handover	547	552	617	612	500	184	**130**
2 - 3 Hour Ambulance Handover	355	402	373	379	325	99	**89**
3 - 4 Hour Ambulance Handover	272	279	259	261	269	65	**78**
4 - 5 Hour Ambulance Handover	244	242	214	168	233	49	**54**
Over 5 Hour Ambulance Handover	490	552	408	323	798	102	**193**
Red 8 Minute	45.45%	45.00%	44.83%	48.05%	37.62%	45.18%	**44.27%**

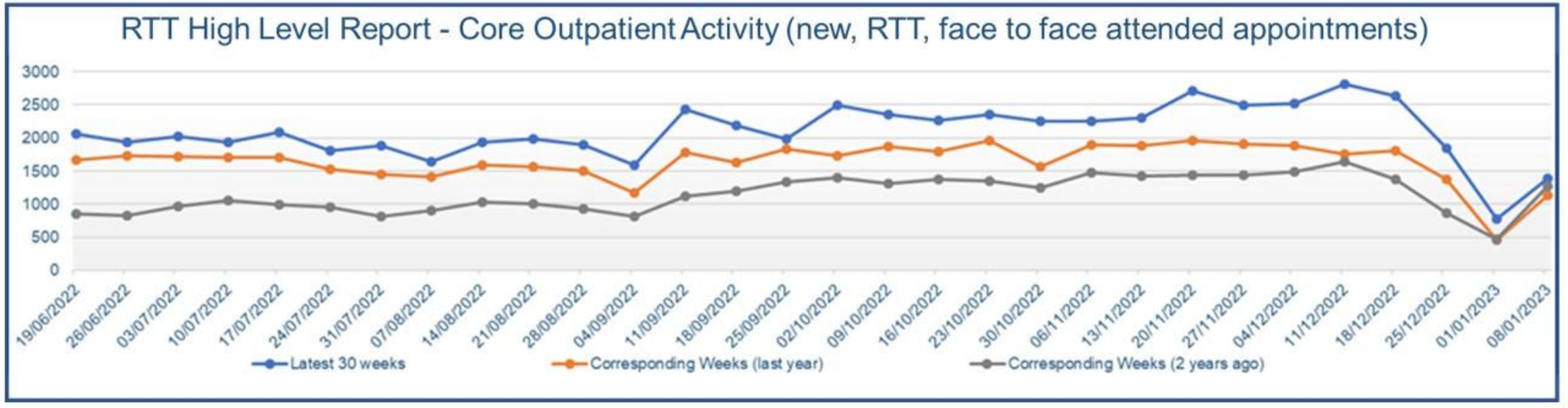
Red 8 Minute data from Nov 22 onwards is unvalidated and not for sharing outside this report.

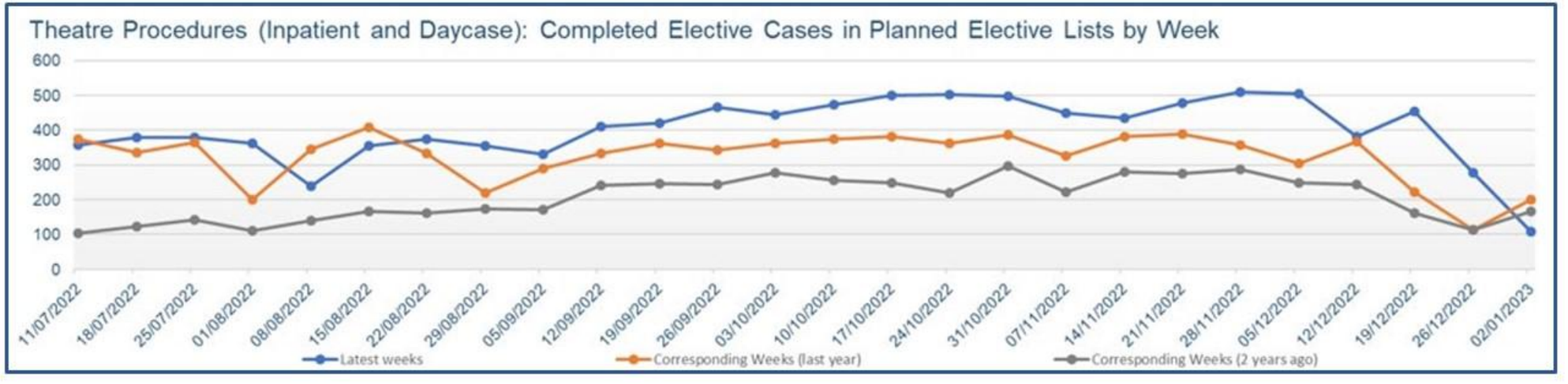
Sources: Red 8 Minute - StatsWales (to Oct 22) and WAST Health Board Area Report
ED and Handover - IRIS, accessed 10/01/2023

Impact of COVID-19 Pandemic on Referral Rates



Impact of COVID-19 Pandemic on Planned Activity





Further Information

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

Further Information

Quality & Performance Report
Betsi Cadwaladr University Performance, Finance & Information Governance Committee

Further information is available from the Director of Performance which includes:

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

We also post regular updates on what we are doing to improve healthcare services for patients on social media:
follow @bcuhb
http://www.facebook.com/bcuhealthboard

Teitl adroddiad: ***Report title:***	Finance Report for Month			
Adrodd i: ***Report to:***	Public Health Board Meeting			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board for the eight months from 1st April 2022 to 30th November 2022. The cumulative position for the year is a deficit against plan of £6.3m, (0.33% of allocation). The Health Board is forecasting a £10m deficit by the end of the financial year. The Executive team has set up a Financial Recovery Group in order to oversee improvements in the financial position. Savings delivered in the eight months to November 2022 was £20.2m against a plan of £17.5m, an overachievement of £2.7m. The savings forecast is £25.3m, which is £9.7m below the target of £35m for the year. Of the £25.3m forecast, £14.5m are non recurring.			
Argymhellion: ***Recommendations:***	It is recommended that the report is noted.			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Finance Director - Commissioning & Strategy			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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.
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?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments 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?***	Naddo N 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)***	There is a significant risk that the Health Board does not meet its statutory financial duty for 2022-23. BAF 2.3
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There is a significant risk that the Health Board does not meet its statutory financial duty for 2022-23. BAF 2.3
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)*	BAF 2.3 Risk of the Health Board's failure to meet the break-even duty.
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*** Not applicable	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix 1: Finance Report November 2022 – M8	

Guidance:

CYFARFOD CYHOEDDUS BWRDD Y CYFARWYDDWYR
RHOWCH Y DYDDIAD
TEITL YR ADRODDIAD

BOARD OF DIRECTORS MEETING IN PUBLIC
INSERT DATE
REPORT TITLE

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

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

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

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

4. **Rheoli Risg / Risk Management**

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

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

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

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

   If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include a Socio-economic Duty (SED) Impact Assessment (SEIA) as well as a completed Equality Impact (EqIA) as an appendix.

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

Finance Report
November 2022 – M8

Steve Webster

Interim Executive Director of Finance

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

Executive Summary

Objective

To provide assurance on financial performance and delivery against Health Board financial plans and objectives and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.

Positives & Key Assurances

- ✓ Key financial targets for Cash, Capital and PSPP all being met.
- ✓ From Month 5 onwards The Health Board started to report under the New Operating Model, which means Area Teams, Hospital Teams and relevant facilities are grouped under the relevant Integrated Health Communities on slide 5 and 11.

Issues & Actions

- ➢ Current Month is reporting a deficit position of £1.9m and cumulative deficit of £6.3m as at end of November.
- ➢ The Health Board has set a savings target of £35m for 2022/23. Full year forecast for Saving Schemes identified as Green total £25.3m against a target of £35m. Including red schemes, for which assurance reviews must be completed, the full year forecast totals £25.4m.
- ➢ The forecast outturn deficit of £10.0m is based upon a number of assumptions which carry some risks. These equate to £56.1m as per the Risks Table (Slide 13).
- ➢ The review of forecast outturn has resulted in the development of a Recovery Plan.
- ➢ Should the industrial action proceed, this is expected to result in a reduction in non pay expenditure due to reduced activity, but may also impact on other expenditure categories.

Key Messages

- ❖ The November position is reporting a deficit of £1.9m and year to date deficit of £6.3m.
- ❖ The Health Board is reporting a forecast outturn deficit of £10.0m. This is based on the assumption that the Health Board is able to use any slippage from the Strategic support and Recovery funding which includes £30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support.
- ❖ Further to the deep dive review of forecast outturn, the Health Board has developed a Recovery Plan. Weekly meetings are being held to monitor progress and will be reported to the Performance and Quality Recovery Group. The savings delivered through this plan are expected to be circa £10.0m. The recovery plan is being led by Interim Director of Regional Delivery.
- ❖ Full year forecast for Saving Schemes identified as Green total £25.3m against a target of £35m. Including red schemes, for which assurance reviews must be completed, the full year forecast totals £25.4m. The Transactional savings target of £17.5 will be met in terms of total savings delivered. Transformational savings have not been identified and are profiled towards the final quarter; therefore the risk on delivery will cause an increasingly adverse variance. As part of the of the recovery plan a further stretch on transactional schemes, which equates to 0.75% of the projected expenditure has been introduced further to the deep dive review.

Summary of Key Numbers

Month 8 Position

In Month £160.8m against plan of £158.9m.
£1.9m adverse

YTD £1,274.4m against plan of £1,268.1m
£6.3 adverse

Forecast

Projected Position but this is subject to inflationary risk.

£10.0m deficit

Divisional Performance Mth 8

West IHC	£8.8m adverse
Central IHC	£10.5m adverse
East IHC	£6.9m adverse
Womens	£0.3m adverse
MH & LD	£2.4m adverse
Commissioning Contracts	£3.6m favourable
ICD Primary Care	£0.5m favourable
ICD Regional Services	£1.8m adverse
Support Functions & Other Budgets	£20.4m favourable

Savings

In-month: £9m against target of £2.4m
£6.6m favourable

YTD: £20.2m against target of £13.6m
£6.6m favourable

Savings Forecast

£25.4m, including pipeline savings, against target of £35.0m

£9.6m adverse

COVID-19 Impact

£28.8m cost YTD

£41.2m forecast cost.
Funded by Welsh Government (with risk)
£NIL impact

Income

£95.0m against budget of £92.5m

£2.5m favourable

Pay

£631.8m against budget of £623.8m

£8m adverse

Non-Pay

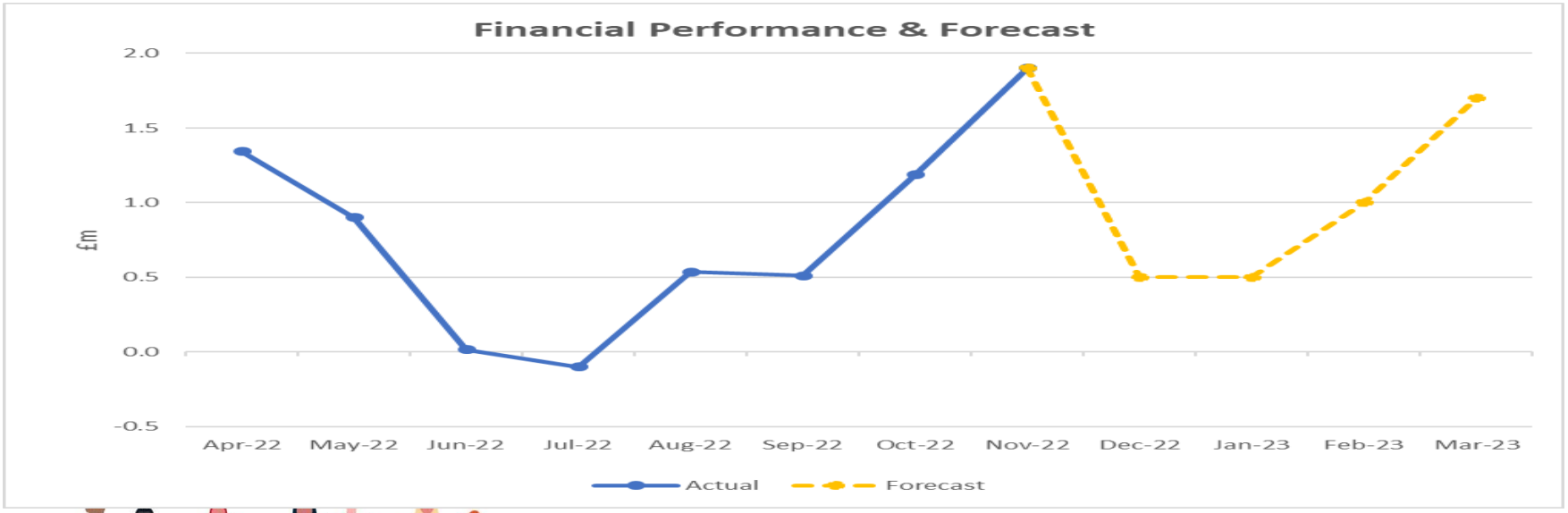
£737.7m against budget of £736.8m

£0.9m adverse

Revenue Position

- The in month position is reporting a deficit of £1.9m and a cumulative deficit of £6.3m as at the end of November.
- The total cost of COVID-19 in November is £3.5m (£28.8m year to date), an increase of £0.6m from October. Total year forecast cost of COVID-19 is £41.2m for which Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.
- As at Month 8 the forecast outturn is reporting a £10.0m deficit. This is based on the assumption that the Health Board is able to use any slippage from the Strategic support and Recovery funding.
- The forecast position is also dependent on Welsh Government fully funding all anticipated income and not clawing back any allocations received to date including ring fenced allocations and any benefits gained from the Annual Leave accrual.

	Actual M1 £m	Actual M2 £m	Actual M3 £m	Actual M4 £m	Actual M5 £m	Actual M6 £m	Actual M7 £m	Actual M8 £m	2022/23 Cumulative Budget £m	Actual £m	Variance £m	Variance %	Forecast Actual £m
Revenue Resource Limit	(152.9)	(151.6)	(152.4)	(159.6)	(158.9)	(175.0)	(158.9)	(158.9)	(1,268.1)	(1,268.1)	**0.0**	0.0%	(1,897.3)
Miscellaneous Income	(11.3)	(10.8)	(11.4)	(11.1)	(13.9)	(12.1)	(12.0)	(12.4)	(92.5)	(95.0)	**-2.6**	2.8%	(142.0)
Health Board Pay Expenditure	76.6	73.4	75.4	76.3	75.1	95.8	79.4	79.7	623.8	631.8	**8.0**	1.3%	954.4
Non-Pay Expenditure	88.9	89.9	88.5	94.3	98.2	91.8	92.7	93.5	736.8	737.7	**0.9**	0.1%	1,094.9
Total Deficit	**1.3**	**0.9**	**0.0**	(0.1)	**0.5**	**0.5**	**1.2**	**1.9**	**(0.0)**	**6.3**	**6.3**		**10.0**



Forecast Outturn

- The Health Board's financial plan for 2022/23 was to deliver a balanced position which includes the £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition £38m funding has also been received for Planned and unscheduled Care Sustainability.

- The £42m Performance and transformation funding was included as recurrent in the Minimum Data Set. The three year financial plan included in the Integrated Medium Term Plan submission also assumed that funding for Performance and transformation would continue beyond 2023-24. The Health Board has been clear that it is committing recurrently against this funding in order to be able to deliver the required outcomes.

- As per request from Welsh Government, the Health Board has been requested to reflect the £42m as non-recurrent, which will consequently revise the underlying carried forward deficit to £82m.

- Further to the deep dive review of the forecast outturn position in Month 6, The Health Board's forecast position is reporting a deficit of £10.0m. The forecast position is based on the assumption that the Health Board is able to use any slippage from the Strategic support and Recovery funding; and is also dependent on Welsh Government fully funding all anticipated income and not clawing back any allocations received to date including ring fenced allocations and any benefits gained from the Annual Leave accrual.

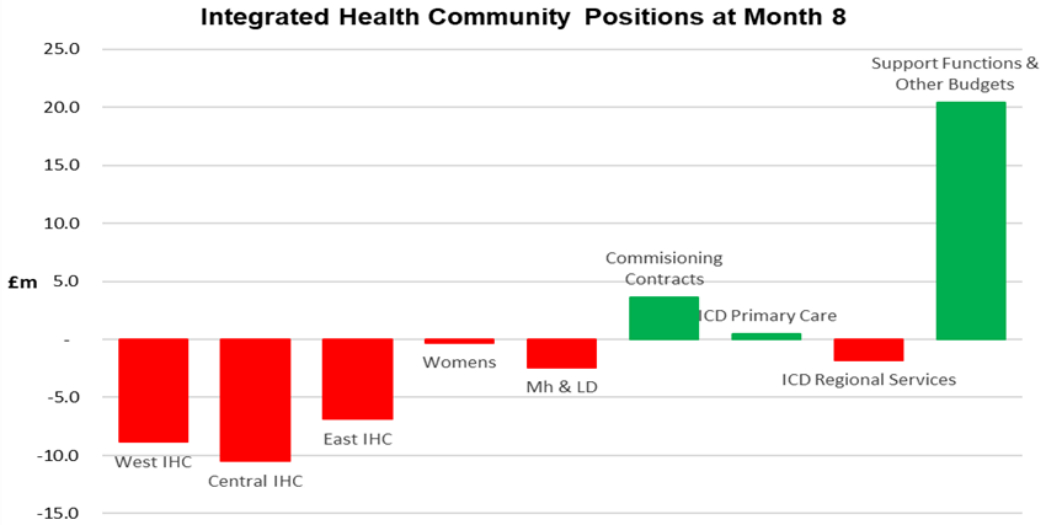
- The below Table summarises the Forecast Outturn position of £45.0m, and the £40.0m mitigations actions required bring the forecast position down to a forecast deficit of £10.0m.

- In response to the deterioration in the forecast outturn, the Health Board has developed a Recovery Plan, which was approved by the PFIG Committee in October. Weekly meetings will be held to monitor progress which will be reported to the Performance and Quality Recovery Group. The savings delivered through this plan are expected to be circa £10.0m. The recovery plan is being led by Interim Director of Regional Delivery.

	2022/23 Planned Forecast	
	£'m	£'m
Financial Risk (Worst Case)		(45)
Less:		
Improvement in savings delivery	10	
Reduction in Expenditure Forecast	7	
Release of Annual leave Accrual	10	
		27
Review commitments against Ring Fenced		8
Total 22/23 Forecast Deficit		**-10**

Divisional Positions

	In Month			Cumulative			Forecast Year End Variance
	Budget £000	Actual £000	Variance to Plan £000	Budget £000	Actual £000	Variance to Plan £000	£000
WG RESOURCE ALLOCATION	**-158,923**	**-158,923**	**0**	**-1,268,131**	**-1,268,131**	**0**	0
WEST INTEGRATED HEALTH COMMUNITY							
Management	217	77	-141	217	133	-85	4
West Area	15,105	15,629	524	117,601	120,757	3,156	5,700
Ysbyty Gwynnedd	9,319	10,489	1,170	75,687	81,044	5,357	10,180
Facilities	1,034	1,036	2	7,808	8,213	405	826
Total West	**25,676**	**27,231**	**1,555**	**201,313**	**210,148**	**8,834**	**16,710**
CENTRAL INTEGRATED HEALTH COMMUNITY							
Management	218	62	-156	218	73	-145	0
Central Area	20,133	20,717	584	155,863	155,871	8	3,300
Ysbyty Glan Clwyd	11,722	13,775	2,052	94,626	104,399	9,773	18,641
Facilities	1,142	1,292	150	9,152	10,006	853	1,438
Total Central	**33,216**	**35,846**	**2,630**	**259,860**	**270,349**	**10,489**	**23,379**
EAST INTEGRATED HEALTH COMMUNITY							
Management	272	138	-135	272	167	-106	-50
East Area	23,284	23,854	570	177,007	179,312	2,305	5,400
Ysbyty Wrexham Maelor	10,251	11,178	927	82,487	86,588	4,101	9,204
Facilities	996	1,196	199	8,098	8,672	574	925
Total East	**34,803**	**36,365**	**1,562**	**267,864**	**274,739**	**6,875**	**15,479**
Total Midwifery and Women's Services	**3,537**	**3,546**	**10**	**28,711**	**29,019**	**308**	**1,181**
Total Mental Health and LDS	**12,398**	**12,647**	**249**	**98,375**	**100,802**	**2,427**	**3,981**
Total Commissioning Contracts	**20,549**	**17,030**	**-3,519**	**167,400**	**163,784**	**-3,616**	**-2,808**
INTEGRATED CLINICAL DELIVERY PRIMARY CARE							
Covid Programmes	1,784	1,784	-0	12,761	12,761	0	-1
Dental North Wales	3,525	3,578	53	22,904	22,904	0	0
Community Dental Services	534	468	-66	4,088	3,485	-603	-750
ICD Primary Care Management	51	23	-28	51	23	-28	-28
Other Primary Care	440	481	41	-1,017	-839	178	369
Total Integrated Clinical Delivery Primary care	**6,334**	**6,334**	**-0**	**38,788**	**38,334**	**-453**	**-410**
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES							
Provider Income	-1,774	-1,807	-33	-14,134	-13,587	547	675
Diagnostic and Specialist Clinical Support	5,919	6,308	389	46,649	47,679	1,030	3,155
Cancer Services	4,684	4,549	-135	36,366	36,586	220	1,202
Total Integrated Clinical Delivery	**8,829**	**9,050**	**221**	**68,881**	**70,677**	**1,797**	**5,032**
Total Service Support Functions and Other Budgets	**14**	**13**	**-1**	**137**	**117**	**-20**	**-52,544**
TOTAL INCOME AND EXPENDITURE	**0**	**1,881**	**1,881**	**0**	**6,279**	**6,279**	**10,000**



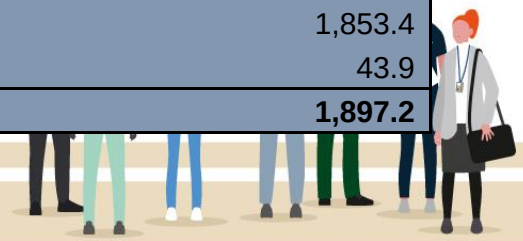
- Key impacts affecting divisional positions include additional pay costs which are due to variable pay costs, particularly Agency costs.
- Non Pay pressures continue within CHC, due to more complex packages driving an increase in costs, prescribing costs and a number of general non pay inflationary costs.
- Non delivery of CRES is also having an impact.
- Other Budgets & Reserves includes Performance, Transformation and Sustainability schemes funding, for which some costs have been reported within the Divisions, but have yet to have funding released from reserves. The reserves profile has been adjusted to account for these costs, which is resulting in an underspend in other budgets.

Income

Description	£m
Allocations Received	1,853.4
Total Allocations Received	**1,853.4**

Description	£m
Allocations anticipated	
Capital	0.7
COVID-19	25.1
Energy (Price Increase)	11.5
Real Living Wage	2.5
IM&T Refresh Prorgamme	1.9
Urgent Primary Care Centres	1.0
MSK Orthopaedic Services	1.2
SDEC	1.6
WPAS	0.8
Annual Leave Overtime (Flowers Case)	0.2
All Wales Robotics Partnership	0.5
Real Living Wage B1 & B2 - from April 22	0.6
Service transfer for local public health team to HBs	0.9
Removal of IFRS-16 Leases (Revenue)	- 6.1
Other	1.4
Total Allocations Anticipated	**43.9**

	£m
Total Allocations Received	1,853.4
Total Allocations Anticipated	43.9
Total Welsh Government Income	**1,897.2**



- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). The RRL is currently £1,897.2m for the year, of which £1,268.1m has been profiled into the cumulative position which is £3.2m more than 8/12ths of the allocation.
- The RRL includes confirmed allocations to date of £1,853.4m, with further anticipated allocations in year of £43.9m.
- The anticipated allocations includes £25.1m for COVID-19 income, as £16.1m of COVID-19 funding has now been received within the allocation. £25.1m of COVID-19 funding has been profiled into the cumulative position to match expenditure.
- Also, within the allocations received includes £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition, £38M has also been received for Planned and Unscheduled Care Sustainability Fund.

COVID -19 Funding	£m
Total COVID-19 costs in 2022/23	41.2
Total Covid -19 funding	**41.2**

Received	16.1
Anticipated	25.1

Expenditure

Pay Costs	M1	M2	M3	M4	M5	M6	M7	M8	Cumulative YTD Budget	Cumulative YTD Actual	Cumulative YTD Variance	Full Year Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	11.4	10.0	11.0	10.8	11.0	14.1	11.5	9.9	91.9	89.6	2.3	140.2
Medical & Dental	17.6	17.3	17.9	18.2	18.0	21.7	18.6	19.7	138.6	149.0	(10.4)	221.6
Nursing & Midwifery Registered	23.7	22.9	23.4	23.3	22.8	28.8	24.3	25.0	199.3	194.2	5.1	288.5
Additional Clinical Services	11.2	10.6	10.7	11.0	10.6	15.0	11.6	11.7	84.2	92.2	(8.0)	36.0
Add Prof Scientific & Technical	2.9	2.9	2.9	3.0	3.0	3.5	3.1	3.2	27.5	24.6	2.9	136.8
Allied Health Professionals	5.0	4.7	4.7	5.0	4.9	6.1	5.3	5.4	39.8	41.2	(1.5)	65.2
Healthcare Scientists	1.3	1.2	1.3	1.3	1.3	1.5	1.3	1.4	11.1	10.6	0.5	15.5
Estates & Ancillary	3.5	3.7	3.5	3.6	3.5	5.0	3.8	3.3	30.9	29.8	1.1	45.1
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.6	0.6	0.0	0.5
Health Board Total	**76.6**	**73.4**	**75.5**	**76.3**	**75.1**	**95.8**	**79.4**	**79.7**	**623.8**	**631.8**	**(8.0)**	**949.4**
Other Services (Incl. Primary Care)	2.0	2.4	2.2	2.3	2.5	2.8	2.9	2.8	16.1	19.8	(3.7)	29.2
Total Pay	**78.7**	**75.8**	**77.6**	**78.5**	**77.6**	**98.6**	**82.3**	**82.5**	**639.9**	**651.6**	**(11.7)**	**978.6**

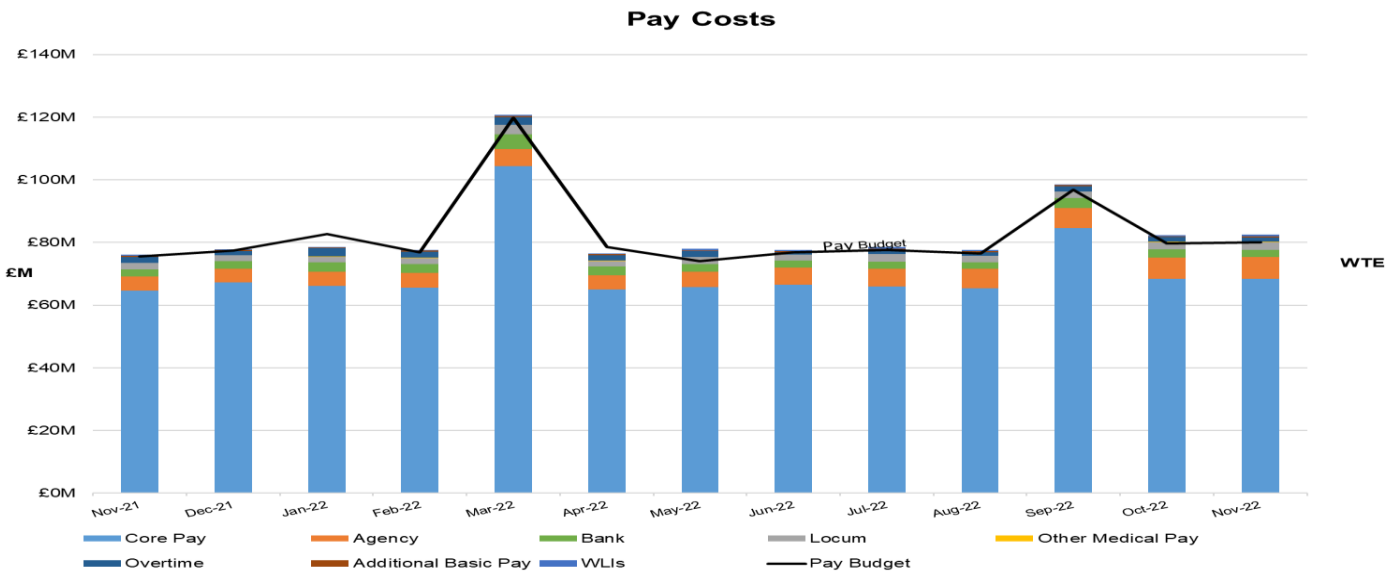
Non-Pay Costs	2022-23 M1	M2	M3	M4	M5	M6	M7	M8	Cumulative YTD Budget	Cumulative YTD Actual	Cumulative YTD Variance	Full Year Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractors	18.1	18.1	16.8	18.2	17.6	18.3	19.1	22.3	151.0	148.6	2.4	223.3
Primary Care Drugs	8.7	8.8	9.9	10.1	10.3	10.5	9.9	9.9	70.5	78.2	(7.7)	118.1
Secondary Care Drugs	7.0	7.3	5.4	6.7	7.2	7.2	7.0	7.4	52.2	55.1	(2.9)	82.9
Clinical Supplies	6.1	6.8	6.7	5.9	5.9	6.1	6.8	7.8	47.7	52.1	(4.4)	75.0
General Supplies	4.2	3.9	4.7	1.5	5.8	5.3	4.4	0.1	28.2	29.9	(1.8)	43.0
HC Services Provided by Other NHS	25.1	24.3	26.2	27.9	24.7	25.7	24.6	21.5	203.2	200.0	3.2	302.3
Continuing Care and FNC	9.4	9.4	9.4	10.2	9.6	5.5	8.7	8.8	65.5	71.0	(5.5)	105.0
Other	7.8	9.0	7.1	8.1	13.9	10.2	9.1	10.1	89.5	75.2	14.4	108.2
Non-pay costs	**86.4**	**87.5**	**86.1**	**88.6**	**95.0**	**88.7**	**89.6**	**88.1**	**707.8**	**710.1**	**(2.3)**	**1,057.8**
Cost of Capital	2.5	2.5	2.5	5.9	3.3	3.3	3.3	5.6	29.0	29.0	(0.0)	37.1
Total non-pay	**88.9**	**90.0**	**88.6**	**94.5**	**98.4**	**92.1**	**92.9**	**93.7**	**736.8**	**739.1**	**(2.3)**	**1,094.9**

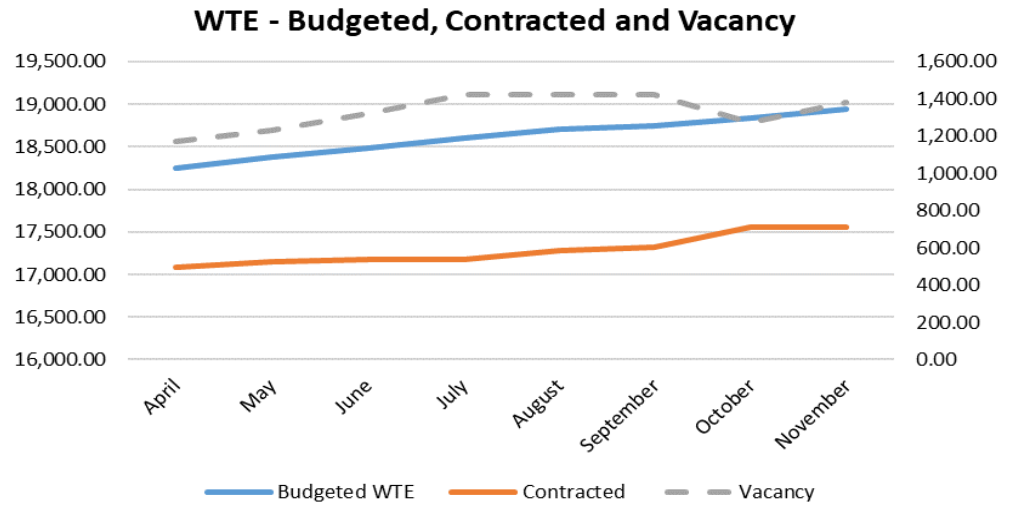
Variable Pay	2022-23 M1	M2	M3	M4	M5	M6	M7	M8	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Agency	4.6	5.0	5.5	5.5	6.2	6.4	6.8	6.9	46.9
Overtime	1.8	1.8	0.9	1.3	1.1	1.6	1.5	1.3	11.2
Locum	1.7	2.1	1.8	2.5	2.0	2.0	2.2	2.5	16.8
WLIs	0.3	0.4	0.4	0.5	0.4	0.3	0.5	0.6	3.4
Bank	2.8	2.5	2.3	2.3	2.0	3.2	2.6	2.4	20.1
Other Non Core	0.1	0.1	0.0	0.1	0.1	0.0	0.1	0.1	0.6
Additional Hours	0.3	0.3	0.4	0.3	0.4	0.3	0.2	0.4	2.6
Total	**11.7**	**12.2**	**11.2**	**12.5**	**12.1**	**13.9**	**13.9**	**14.1**	**101.6**

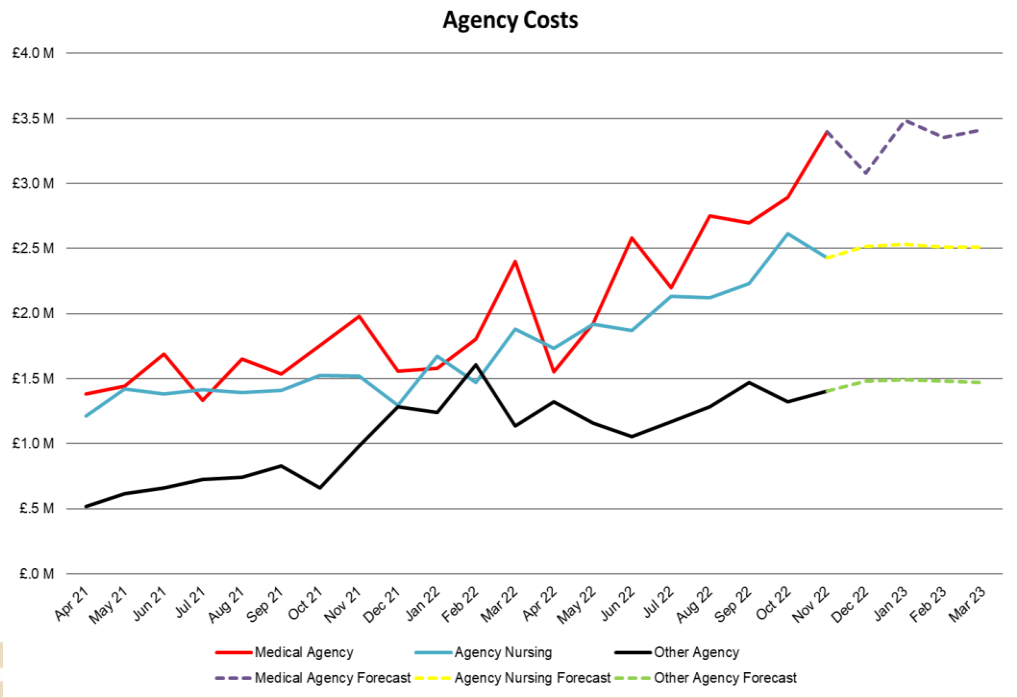
- Total Pay costs are £82.5m in November, an increase of £0.2m from October, and £1.5m above forecast. The Annual Leave accrual released in Month 8 is £1.6m with total year to date released is £3.3m, of which £2.8m is reported as an Accountancy Gain.
- The 22/23 NHS Pay Award total year forecast cost is £40.1m, however the 22/23 Pay Award funding allocation received from WG is £38.3m, therefore leaving a pressure of £1.8m. It is currently assumed this will not impact on the forecast deficit of £10m, but this remains a risk.
- Total Variable Pay is £14.1m, an increase of £0.2m from Month 7. Month 8 Variable Pay includes Agency spend of £6.9m, Bank £2.4m and Overtime £1.3m. Agency costs have increased by £0.1m from previous month and is £1.2m higher than previous monthly average.
- A total of £1.8m pay costs were directly related to COVID-19 in November, which is £0.1m less than October spend.
- Non Pay expenditure is £88.1m, an reduction of £1.5m from October. Year to date Non Pay is reporting an adverse variance of £2.3m.

Pay Costs

- Total Pay costs are £82.5m in November, an increase of £0.2m from October. The Annual Leave accrual released in Month 8 is £1.6m with total year to date released is £3.3m, of which £2.8m is reported as an Accountancy Gain.
- Total Variable Pay is £14.1m, of which Agency is £6.9m, Bank £2.4m and Overtime £1.3m. Agency costs have increased by £0.1m from October and is £1.2m higher than previous monthly average. Of the £6.9m, the 3 hospital sites accounted for £3.7m of the costs.
- The below graphs summarises monthly Pay costs and WTE trend, including WTE Vacancies.



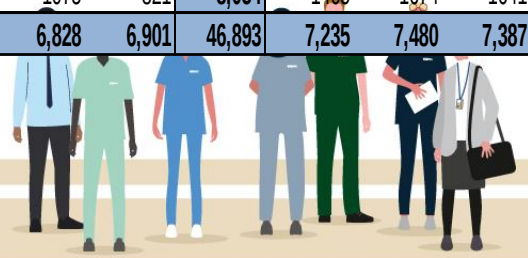




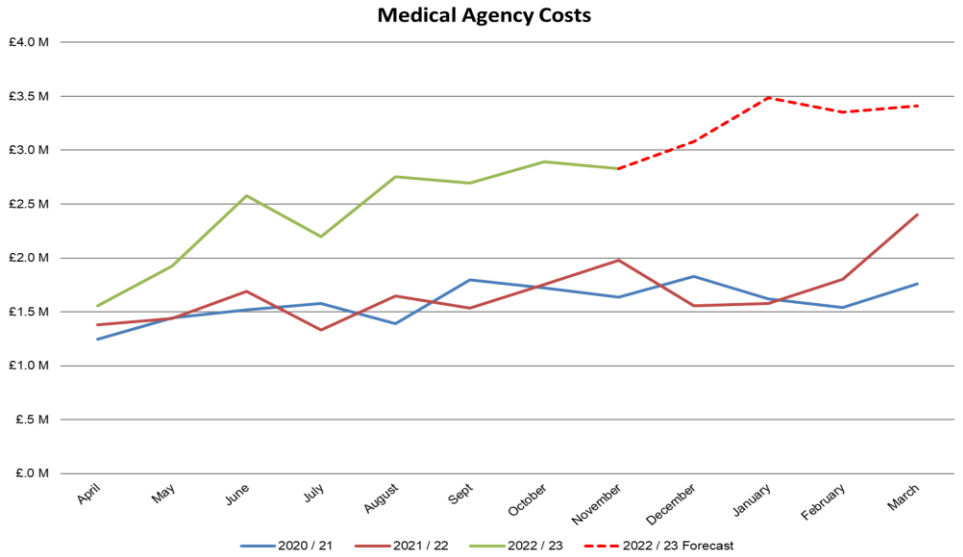
Pay Costs - Agency

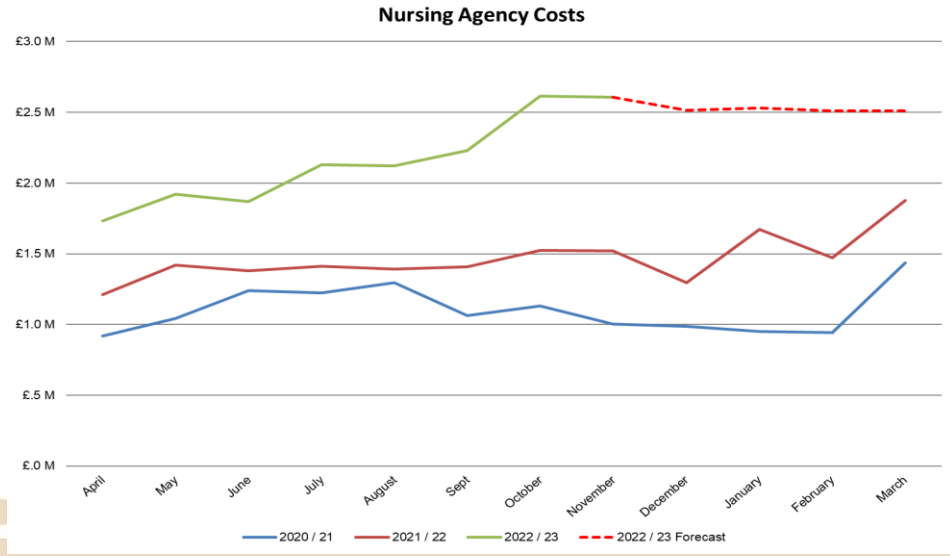
- Total agency costs were £6.9m for November which have increased by £0.1m from October, and is £1.2m higher than the previous monthly average, although less than the £7.2m forecast for November. Of the £6.9m, the 3 hospital sites accounted for £3.7m of the costs. Total Forecast Agency spend is £76.4m, an increase of £27.6m from 2021/22 Agency outturn position.
- November Agency costs is 8.4% of total pay and is projected to increase to 9.0% of total pay in March 23. Total 22/23 Agency costs is forecast to be 8.9% of total pay costs in 22/23 (5.2% in 21/22).
- Medical agency spend is £2.8m which is £0.4m more than the monthly average in 2022-23.
- Agency nursing spend is £2.6m in November, £0.5m more than the 2022-23 monthly average

	22-23 Actual													
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total Year to Date	Dec-22	Jan-23	Feb-23	Mar-23	Total Full Year Forecast
West Area	118	155	156	191	195	127	384	205	**1,531**	65	65	65	65	**1,791**
Ysbyty Gwynedd	570	564	565	568	651	710	779	785	**5,193**	744	744	744	744	**8,169**
Central Area	234	351	155	294	553	487	543	420	**3,037**	438	438	438	438	**4,789**
Ysbyty Glan Clwyd	914	1,110	1,261	1,376	1,238	1,613	1,542	1,805	**10,859**	2190	2190	2190	2190	**19,617**
East Area	576	574	1,042	357	939	758	886	975	**6,107**	721	765	725	737	**9,056**
Ysbyty Maelor Wrexham	760	812	808	1,005	923	1,062	1,084	1,072	**7,525**	1069	1062	1042	1017	**11,714**
Mental Health & LDS	446	436	505	598	680	570	535	819	**4,587**	543	543	543	543	**6,757**
Other	992	1,003	1008	1,108	980	1,067	1075	821	**8,054**	1465	1674	1641	1631	**14,464**
Total Agency	**4,609**	**5,004**	**5,502**	**5,497**	**6,159**	**6,394**	**6,828**	**6,901**	**46,893**	**7,235**	**7,480**	**7,387**	**7,364**	**76,358**

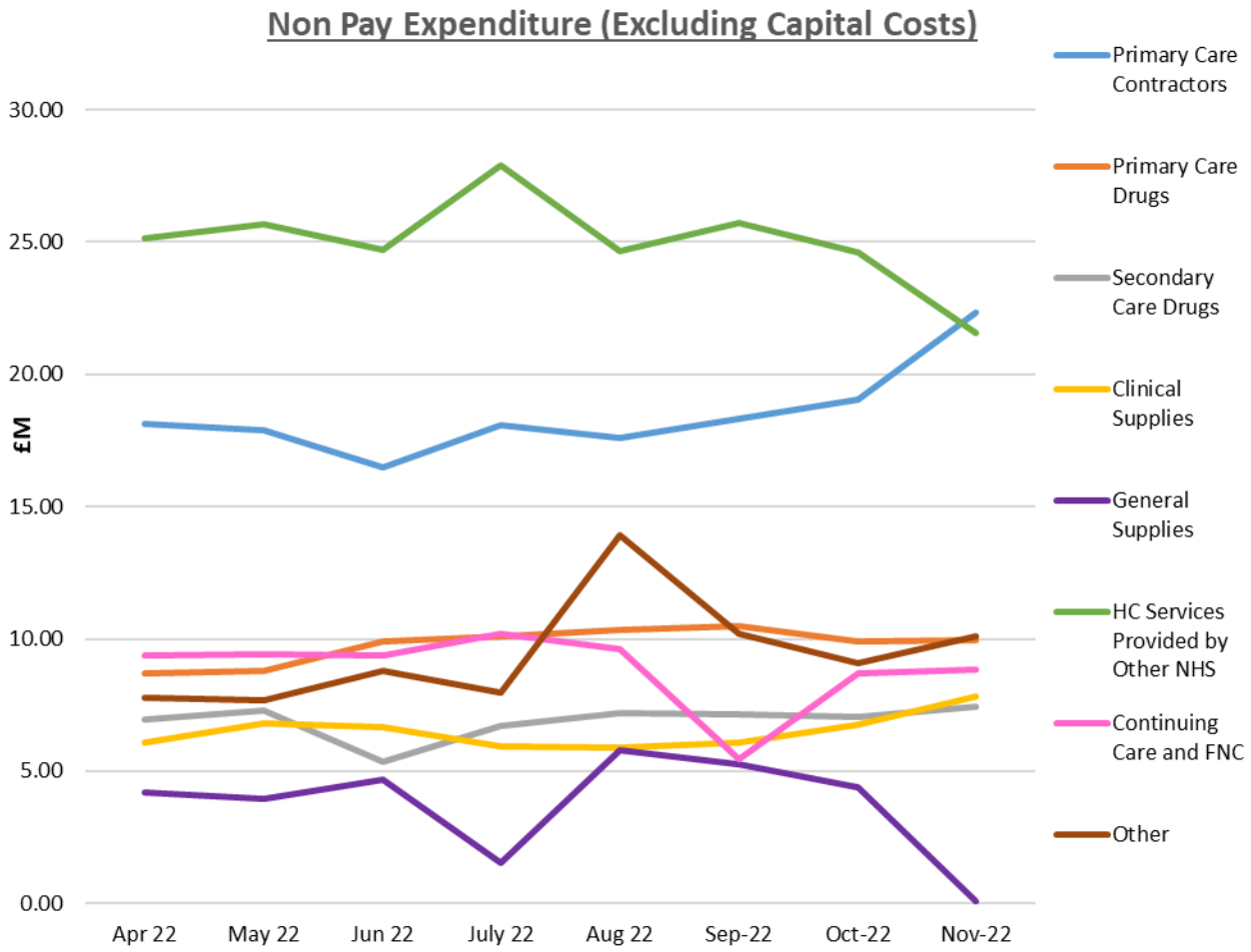


- The below graphs shows increases in both Medical & Agency Nursing costs from 2020/21 and 2021/22.





Non-Pay Costs



Total Non-Pay Expenditure: November spend is £88.1m (excluding capital charges), which is £1.5m less than October Non Pay spend, but £0.2m more than the forecast spend. The main areas of changes in month are included below:

Primary Care Contractor: November expenditure is £22.3m and £3.4m (18.1%) higher than previous month spend. The movement from last month is due to the increase in GMS and GDS Pay Award uplift. Pressures also remain within GMS Dispensing costs and increase in Winter Pressures Access Schemes.

Primary Care Drugs: Spend is in line with October expenditure.

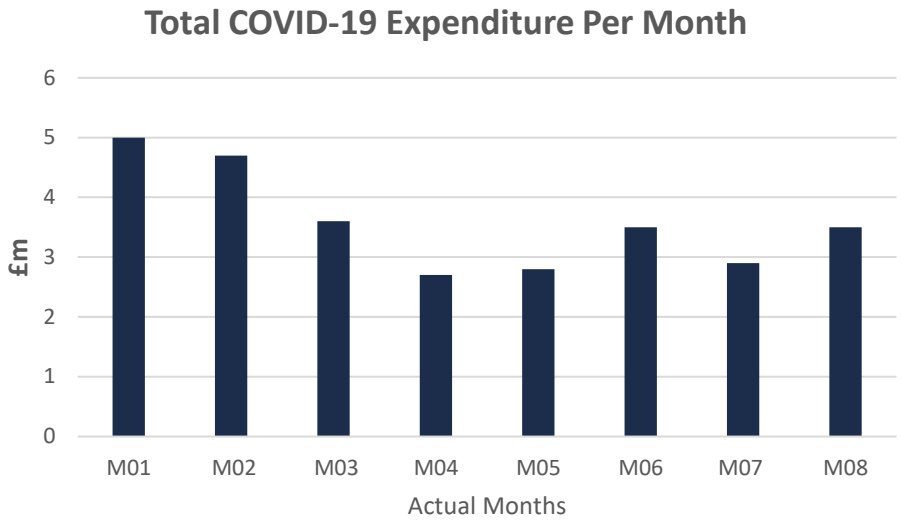
Healthcare Services provided by Other NHS Bodies: Spend has decreased by £3.1m (12.5%) on previous month. The in month favourable movement in English Provider performance is due to greater clarity around the contract agreements and assurance provided that the English Non Contracted Activity (NCA's) accrual can be reduced, of which £3.4m has been reported as an accountancy gain in Month 8.

Continuing Health Care (CHC) and Funded Nursing Care (FNC): Expenditure in November is £0.1m higher than October.

General Supplies is affected by the technical adjustment for IFRS 16, which is a movement between non pay and Capital costs for leases.

Impact of COVID-19

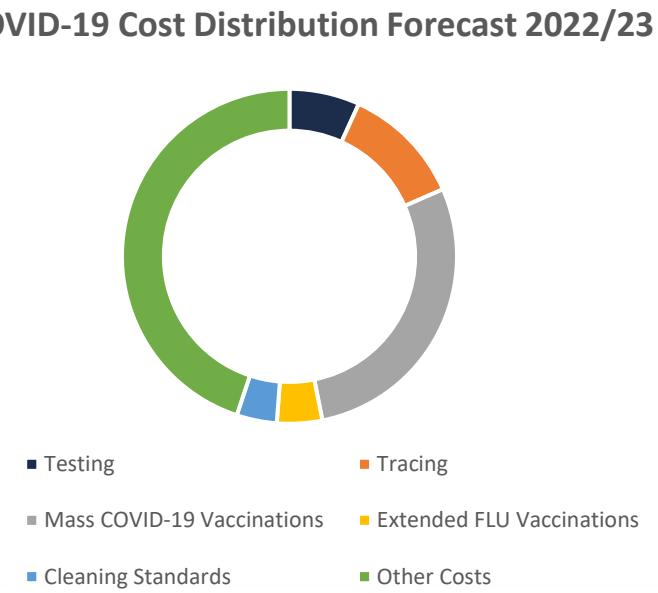
	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual M05 £m	Actual M06 £m	Actual M07 £m	Actual M08 £m	Total YTD 2022/23 £m	Forecast 2022/23 £m
Testing	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	1.9	2.8
Tracing	1.0	0.9	0.9	0.1	0.2	0.2	0.2	0.3	3.8	4.8
Mass COVID-19 Vaccinations	0.7	1.1	0.8	0.8	0.8	1.1	1.4	1.4	8.1	11.7
Extended Flu Vaccinations	0.0	0.0	0.1	0.0	0.0	0.1	0.1	0.3	0.6	1.8
Cleaning Standards	0.1	0.1	0.2	0.1	0.1	0.1	0.0	0.2	0.9	1.6
Other Costs	2.9	2.3	1.4	1.5	1.5	1.7	1.0	1.1	13.4	18.5
Total COVID-19 expenditure	**5.0**	**4.7**	**3.6**	**2.7**	**2.8**	**3.5**	**2.9**	**3.5**	**28.7**	**41.2**
Welsh Gov COVID-19 income	(5.0)	(4.7)	(3.6)	(2.7)	(2.8)	(3.5)	(2.9)	(3.5)	(28.7)	(41.2)
Impact of COVID-19 on Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**



- COVID-19 expenditure in November is £3.5m, which is £0.6m higher than in October. Total forecast cost of COVID-19 is currently £41.2m, a reduction of £0.3m from previous month forecast. The forecast is based on the assumption that COVID-19 costs will continue to have an impact for the whole year, however costs are expected to reduce over future months. Welsh Government income has been anticipated to fully cover this cost. COVID-19 forecast is regularly reviewed, revised and updated monthly.

- A further review will be undertaken to ensure that all relevant costs have been correctly charged to Covid, as in comparison to other Health Boards, BCU is charging much lower Discharge support costs and Additional Bed Capacity costs to Covid.

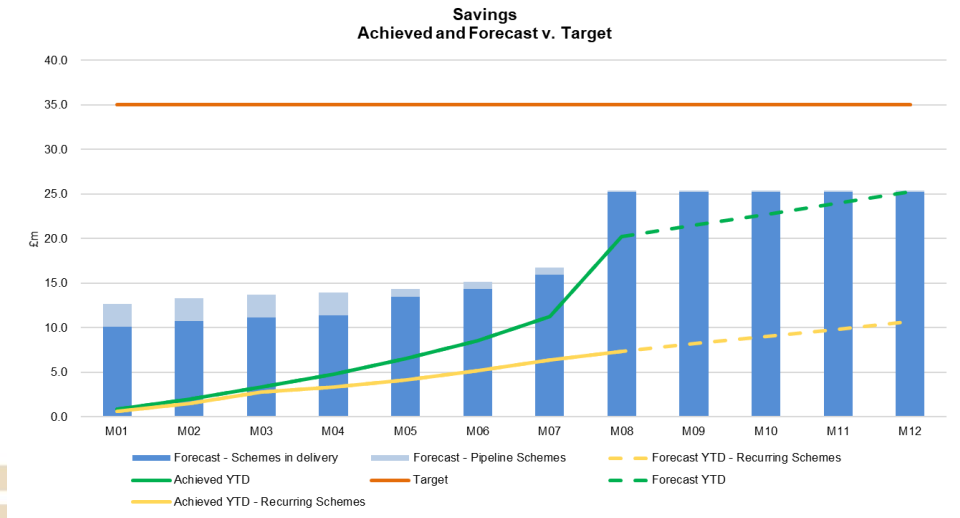
- COVID-19 Other Costs is £1.1m for November which includes costs for Long COVID, additional staffing and PPE due to COVID Surge, Investigation and learning from Nosocomial Case and Patient Charge Income Target (Loss of Dental income).



Savings

	Savings Target	SCHEMES IN DELIVERY									PIPELINE SCHEMES				PROGRAMME	
		Year to Date				Forecast										
	Savings Target	Savings Target	Recurring Savings Delivered	Variance in Recurring Savings	Non-Recurring Savings Delivered	Recurring Forecast	Variance	Non-Recurring Forecast	Total Forecast	Forecast FYE	Recurring Plan	Non-Recurring Plan	Total Plan	Plan FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
West Integrated Health Community																
Area - West	2,940	1,127	908	(219)	684	1,166	(1,774)	1,066	2,233	1,518	0	0	0	0	2,233	(707)
Ysbyty Gwynedd	3,124	1,198	134	(1,063)	51	280	(2,844)	68	349	463	0	0	0	0	349	(2,775)
Facilities	304	116	0	(116)	0		(304)								0	(304)
Total West	**6,368**	**2,441**	**1,042**	**(1,399)**	**735**	**1,447**	**(4,921)**	**1,135**	**2,581**	**1,981**	**0**	**0**	**0**	**0**	**2,581**	**(3,787)**
Central Integrated Health Community																
Area - Centre	4,942	1,895	1,590	(304)	1,214	2,339	(2,603)	1,224	3,563	2,564	0	0	0	0	3,563	(1,379)
Ysbyty Glan Clwyd	3,951	1,515	105	(1,409)	122	249	(3,702)	364	613	325	50	0	50	100	663	(3,288)
Facilities	341	131		(131)			(341)								0	(341)
Total West	**9,235**	**3,540**	**1,696**	**(1,844)**	**1,336**	**2,588**	**(6,647)**	**1,588**	**4,176**	**2,889**	**50**	**0**	**50**	**100**	**4,226**	**(5,009)**
East Integrated Health Community																
Area - East	5,080	1,947	1,294	(653)	1,007	1,593	(3,487)	1,338	2,931	1,697	0	0	0	0	2,931	(2,149)
Ysbyty Wrexham Maelor	3,171	1,216	402	(813)	1,214	814	(2,357)	1,659	2,472	1,346	0	0	0	0	2,472	(699)
Facilities	316	121		(121)			(316)								0	(316)
Total East	**8,567**	**3,284**	**1,696**	**(1,588)**	**2,221**	**2,407**	**(6,161)**	**2,997**	**5,404**	**3,044**	**0**	**0**	**0**	**0**	**5,404**	**(3,164)**
PAN North Wales Services																
MHLD	613	235	1,403	1,168	161	1,878	1,265	216	2,094	1,893	0	0	0	0	2,094	1,481
Womens Services	1,375	672	109	(563)	1,411	115	(1,260)	1,544	1,659	158	0	0	0	0	1,659	284
Diagnostic and Specialist Clinical Support	2,044	784	165	(618)	394	249	(1,795)	412	660	291	0	0	0	0	660	(1,384)
Cancer Services	1,542	591	910	318	0	1,469	(73)	0	1,469	1,469	0	0	0	0	1,469	(73)
Area - Other	235	90	118	27	0	235	0	0	235	235	0	0	0	0	235	0
Contracts	1,500	575	0	(575)	3,488	0	(1,500)	3,488	3,488	0	0	0	0	0	3,488	1,988
Provider Income	304	117	0	(117)	0	0	(304)	0	0	0	0	0	0	0	0	(304)
Total PAN North Wales	**7,613**	**3,063**	**2,705**	**(358)**	**5,454**	**3,945**	**(3,668)**	**5,661**	**9,606**	**4,047**	**0**	**0**	**0**	**0**	**9,606**	**1,993**
Corporate	3,217	1,233	219	(1,014)	3,131	339	(2,878)	3,145	3,484	562	110	0	110	110	3,594	377
Total	**35,000**	**13,561**	**7,358**	**(6,203)**	**12,877**	**10,726**	**(24,274)**	**14,526**	**25,251**	**12,523**	**160**	**0**	**160**	**210**	**25,411**	**(9,589)**

- Savings delivered in Month 8 total £9.0m against plans of £8.7m and a target of £2.4m.
- Year to date savings total £20.2m against plans of £17.5m and a target of £13.6m.
- The target in the ledger is based on early projections, and is profiled differently to submitted plans.
- The transactional target of £17.5m has therefore been met in terms of total actual savings delivered. However, recurring savings delivered is £7.4m.
- Full Year Forecast, an increase of £9.4m, totals £25.3m for Green and Amber schemes, indicating that a further £5.1m will be delivered this year, less than the required £14.8m.
- The ongoing reliance on smaller scale savings initiatives remains a concern and as Transformational savings are profiled towards the final quarter; the lack of plans and delivery will cause an increasingly adverse variance.
- £8.1m of the Month 8 increase relates to 8 new schemes, being the submission of schemes reflected in the ledger previously. These do not improve the overall position.



Risks and Opportunities (not included in position)

	RISKS	£m	Level	Explanation
1	Introduction of PAAR's rate of pay as per national agreement	£4.0m	High	The PAAR is applicable to all staff categories and with winter pressures could be a significant risk to the Health Board.
2	Anticipated Income for Exceptional costs – (Energy & RLW)	£14.0m	High	Anticipated income for Exceptional costs not being funded.
3	Potential of not receiving the MSK funding	£1.2m	High	
4	Ring fenced funds requirement to return any slippage	£15.6m	High	
5	Pay Pressures anticipated but may not be funded	£0.8m	High	(Flowers and Band 1 & 2 2022/23)
6	Risk of not receiving funding for COVID GDS loss of dental income over original allocation	£0.5m	Medium	
7	Non delivery of Recovery Plan	£10.0m	Medium	
8	Continued increased in Cost Pressures	£10.0m	Medium	Driven by Inflation, activity volumes and Agency costs and shortfall of funding for National agreed pay increases.
	Total Risks	**£56.1m**		

	OPPORTUNITIES	£m	Level	Explanation
1	Technical Adjustment	£5.0m	Medium	Potential of further opportunities relating to technical adjustments such as annual leave.
	Total Opportunities	**£5.0m**		
	NET RISK	**£61.1m**		

Balance Sheet

Non-Current Assets	Opening Balance Beginning of Apr 22 £'m	Closing Balance End of Nov-22 £'m	Forecast Closing Balance End of Mar 23 £'m
Property, plant and equipment	617.7	599.8	655.6
Intangible assets	1.0	0.9	1.0
Trade and other receivables	63.1	62.8	63.1
Non-Current Assets sub total	681.8	663.5	719.7
Current Assets			
Inventories	19.1	19.2	19.1
Trade and other receivables	105.8	121.5	113.1
Cash and cash equivalents	6.7	7.8	-32.5
Non-current assets classified as held for sale	0.0	0.0	0.0
Current Assets sub total	131.6	148.5	99.8
TOTAL ASSETS	813.4	811.9	819.5
Current Liabilities			
Trade and other payables	257.1	237.4	235.1
Provisions	52.0	63.6	64.4
Current Liabilities sub total	309.2	301.0	299.5
NET ASSETS LESS CURRENT LIABILITIES	504.2	510.9	520.0
Non-Current Liabilities			
Trade and other payables	0.8	0.8	31.4
Provisions	62.0	62.0	62.0
Non-Current Liabilities sub total	62.8	62.8	93.4
TOTAL ASSETS EMPLOYED	441.3	448.1	426.6
FINANCED BY:			
Taxpayers' Equity			
General Fund	298.0	304.7	273.6
Revaluation Reserve	143.3	143.3	153.0
Total Taxpayers' Equity	441.3	448.1	426.6

Capital

- The approved Capital Resource Limit (CRL) for 2022/23 is £22.3m as per below summary table

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
	Gross expenditure						
	All Wales Capital Programme: Schemes:						
1	Imaging	914	513	(401)	4,483	4,607	124
2	Wrexham Redevelopment	1,321	959	(362)	2,399	1,860	(539)
3	Nuclear Medicine	1	12	11	425	425	0
4	Substance Misuse-Holyhead	0	(1)	(1)	0	0	0
5	Digital Medicine	0	0	0	10	10	0
6	Ablett Unit	259	0	(259)	1,423	1,423	0
7	Linacs	133	136	3	1,922	1,916	(6)
8	Emergency Departments	84	3	(81)	418	418	0
9	Energy Saving Schemes	0	(2)	(2)	250	250	0
10	Enli Ward	0	23	23	0	500	500
	Sub Total	**2,712**	**1,643**	**(1,069)**	**11,080**	**10,659**	**(421)**
	Discretionary:						
43	I.T.	765	877	112	1,713	1,713	0
44	Equipment	986	1,299	313	1,379	1,379	0
45	Statutory Compliance	0	0	0	0	0	0
46	Estates	3,959	2,827	(1,132)	7,879	7,800	(79)
47	Other	0	0	0	0	0	0
48	**Sub Total**	**5,710**	**5,003**	**(707)**	**10,971**	**10,892**	**(79)**
	Other (Including IFRS 16 Leases) Schemes:						
49	Donated	249	249	0	358	358	0
50	Internally Generated	0	0	0	0	0	0
69	**Sub Total**	**249**	**249**	**0**	**358**	**358**	**0**
70	**Total Expenditure**	**8,671**	**6,895**	**(1,776)**	**22,409**	**21,909**	**(500)**
	Donations:						
77	Donations:	249	249	0	358	358	0
78	**Sub Total**	**249**	**249**	**0**	**358**	**358**	**0**
92	**CHARGE AGAINST CRL / CEL**	**8,422**	**6,646**	**(1,776)**	**22,301**	**22,301**	**0**
93	**PERFORMANCE AGAINST CRL / CEL (Under)/Over**		**(15,655)**			**0**	

Teitl adroddiad: ***Report title:***	Savings Delivery Update			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to update the committee on the progress to date against the savings delivery programme for 2022-23 and the plans for 2023-24. Year to Date actual savings total £20.2m. The transactional target has been met in terms of total actual savings delivered. However, the proportion of recurring savings remains a challenge – recurring total £7.4m The Full Year Forecast increased by £9.3m to £25.3m for Green and Amber schemes. Of this, recurring savings total £10.7m. This leaves an estimated £24.3m carry over into 23/24 (before actuals M9-12 considered). The Full Year Forecast also indicates that a further £5 m will be delivered this year, significantly less than the required £14.8m. The ongoing reliance on smaller scale savings initiatives remains a concern. £8.1m of the £9.0m delivered in month relates to 8 new schemes, which relate to movements already reflected in forecast outturn position, so they do not improve the overall position.			
Argymhellion: ***Recommendations:***	It is recommended that the report is noted.			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	Rob Nolan, Finance Director – Commissioning and Planning			
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):***	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.
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?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments 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?***	Naddo N 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)***	Achieving Financial Balance
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	Not Applicable

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)*	BAF 2.3 Risk of the Health Board's failure to meet the break-even duty
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:*** *Not Applicable* ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** None	

Savings Delivery Update

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

Background

A savings target was set for 2022/23 and subsequent 2 years at £35m p.a.

This represents 3% of the Health Board's discretionary expenditure.

The savings must be cash releasing and recurring.

Historically, the Divisions have delivered transactional savings plans.

Financial Year	22/23 £m	23/24 £m	24/25 £m
Transactional Savings	18	12	6
Transformational Savings	17	23	29
Savings Target	35	35	35

The financial target for 2022/23 was split 50/50 between Transformation and Divisional/ Transactional plans, with the expectation that 85% of savings are delivered through transformational change by 2024/25.

The target was not reached by end March and the submission of plans to WG.

The Divisions delivered cash releasing savings plans of £12.5m. Recurring savings inc. Red schemes £8.9m; excl. Red £7.8m

The original transactional target has been met in terms of total savings delivered. However, recurring savings fall short of the target, which presents a challenge.

The ongoing reliance on smaller scale savings initiatives also remains a concern. Savings plans from major programmes have not been delivered at this time.

The purpose of this document is to provide a summary of the position at Month 8.

FY Plan and Forecast – Update Month 8

Total target £35m

Red, Amber and Green Schemes:
- FY Plan M1 £12.6 m
- FY Plan M8 £22.8m:
  - increase of £8.1m this month relating to 8 new schemes, reflects outputs of deep dives and review of Forecast
  - decrease of £0.6m relating to the removal of red schemes
- FY Forecast has increased from £16.7m in M7 **to £25.4m**

Green and Amber Schemes:
- FY Plan M1 £10.1m
- FY Plan M8 £22.6m (£8.1m for eight new schemes)
- FY Forecast has increased from £15.9m in M7 to **£25.3m**
  - 3 Areas forecast up £0.3m to £8.7m
    Maintaining savings over their transactional target
    CHC remains a significant contributor
  - 3 Providers forecast up £1.4m to £3.4m
    Now £1.7m below transactional target
    Agency costs remain a significant pressure

£'000's	Target	FY Plan	Gap	FY Forecast	Gap
Transformation Savings	17,500	-	(17,500)	-	(17,500)
Divisional Savings (Amber & Green)	17,500	22,642	**5,142**	25,251	**7,751**
Total	**35,000**	**22,642**	(12,358)	**25,251**	(9,749)

	FY FORECAST (M8)		
£'000's	Recurring	Non Recurring	Total
Amber and Green Schemes			
Cash Releasing	10,229	6,868	17,097
Cost Avoidance	261	98	360
Accountancy Gains	235	7,008	7,243
Income Generation		551	551
	10,726	**14,526**	**25,251**
Red Schemes			
Cash Releasing	160	-	160
Cost Avoidance	-	-	-
Income Generation	-	-	-
	160	**-**	**160**
Total - Red, Amber and Green Schemes	**10,886**	**14,526**	**25,411**

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

Divisional Savings – FY Plan vs FY Forecast vs Actual – Month 8

1) Transformation Savings

- FY Target 17.5m
- FY Plan nil
- YTD delivered nil

2) Transactional (Divisional) savings:

Green and Amber schemes:

- FY Target £17.5m Transactional target
- FY Plan M8 £22.6m – increased
- FY Forecast M8 £25.3m, up £9.3m on M7
- FY Forecast M8 recurring savings £10.7m

- YTD Target £11.8m – flat profile
- YTD Plan £17.5m
- YTD Actuals £20.2m:
  - £2.7m favourable variance against YTD Plan* Increase on favourable variance reported last month (£0.3m)
  - £8.4m above YTD Target
- Month Only:
  - Achieved £9.0m vs £8.7m Plan and £1.4m transactional Target – flat (1/12) Target profile to be adjusted in line with savings plan profiles

£'000's	FY			YTD M8			
Total Plans	**Target**	**Plan***	**Forecast**	**Target**	**Plan***	**Actual**	**Variance to Plan**
Transformation Savings	17,500	-	-	1,750	-	-	0
Divisional Savings	17,500	22,642	25,251	11,811	17,521	20,235	2,714
	35,000	**22,642**	**25,251**	**13,561**	**17,521**	**20,235**	**2,714**
Divisional Plans	**Target**	**Plan***	**Forecast**	**Target**	**Plan***	**Actual**	**Variance to Plan**
Recurring	17,500	9,756	10,726	11,811	6,244	7,358	1,114
Non Recurring		12,887	14,526		11,278	12,877	1,599
Total	**17,500**	**22,642**	**25,251**	**11,811**	**17,521**	**20,235**	**2,714**

- YTD actual savings total £20.2m
- The transactional target has been met in terms of total actual savings delivered. However, the proportion of recurring savings remains a challenge – recurring total £7.4m
- FY Forecast (green & amber) increased by £9.3m to £25.3m for Green and Amber schemes. Of this, recurring savings total £10.7m. This leaves an estimated £24.3m carry over into 23/24 (before actuals M9-12 considered).
- The FY Forecast also indicates that a further £5 m will be delivered this year, significantly less than the required £14.8m. The ongoing reliance on smaller scale savings initiatives remains a concern.
- £8.1m of the £9.0 delivered in month relates to 8 new schemes, which relate to movements already reflected in the forecast outturn position, so these do not improve the overall position.
- Red schemes have been reduced by £0.6m in Estates.
- Capacity remains an issue given current portfolio of change and the need to focus on Recovery and planning for next year.

*variance analysis provided

Divisional Savings – FY Plan vs FY Forecast – Month 8
Movement in Recurring/ Non Recurring

	FY PLAN			FY FORECAST(M8)			VARIANCE		
£'000's	Recurring	Non Recurring	Total	Recurring	Non Recurring	Total	Recurring	Non Recurring	Total
Amber and Green Schemes									
Cash Releasing	9,286	5,549	14,836	10,229	6,868	17,097	943	1,319	2,262
Cost Avoidance	234	98	333	261	98	360	27	0	27
Accountancy Gains	235	6,688	6,923	235	7,008	7,243	0	320	320
Income Generation		551	551		551	551	0	0	0
	9,756	**12,887**	**22,642**	**10,726**	**14,526**	**25,251**	**970**	**1,639**	**2,609**
Red Schemes									
Cash Releasing	160		160	160	-	160	0	0	0
Cost Avoidance			-	-	-	-	0	0	0
Income Generation			-	-	-	-	0	0	0
	160	**-**	**160**	**160**	**-**	**160**	**0**	**0**	**0**
Total - Red, Amber and Green Schemes	**9,916**	**12,887**	**22,802**	**10,886**	**14,526**	**25,411**	**970**	**1,639**	**2,609**

Green and Amber schemes:

- FY Forecast has increased from £15.9m in M7 to **£25.3m** – gap £9.7m
  - Up £9.4m on Forecast at M7 (£15.9m)
  - Favourable variance against FY Plan M8: £2.6m (variance analysis provided)
  - Favourable variance against FY Transactional Target - £7.9m
- 3 Areas forecast variance is £1.4m favourable.
- 3 Providers forecast £850k adverse. Now £1.7m below transactional target.
- FY Forecast M8 recurring savings £10.7m

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
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University Health Board

Red Risk Schemes – reduced by £640k M8

Division	Scheme / Opportunity Title	Brief Description		WG Saving Definition	R/NR	MMR Categor	Sum of Current Year Annual Plan (£)	Update	Decision
Corporate	In-year property disposals		0	Cash-Releasi	NR	Non Pay	50,000	Scheme removed ahead of M8 24.11.22: Information not provided, no capacity to look into it but no disposals in plan so DW asks that this is removed, forwarded to Rob 30.09.22: Reviewed with RN, AMW, PD, KS 05.09.22: Scheme removed ahead of M5. (In-year revenue benefit marginal even if properties are disposed - DW)	01.12.22: Removal of scheme approved RN 30.09.22: Reinstate scheme. Decision will be reviewed once plan and calculations received.
Corporate	Transport/travel		0	Cash-Releasi	R	Non Pay	10,000	Awaiting documentation 30.09.22: Reviewed with RN, AMW, PD, KS 05.09.22: Removed ahead of M5. Minimal, does not warrant a scheme-DW.	30.09.22: Reinstate scheme. Decision will be reviewed once calculations received.
Corporate	Technology: eliminate unwarranted variation in staffing		0	Cash-Releasi	NR	Pay - Variable	540,000	Scheme removed ahead of M8 24.11.22: DW advised that this was based on proposal to implement staff management system but the project was not initiated, therefore requests removal of scheme - forwarded to Rob 30.09.22: Challenged in review (RN, AMW, PD, KS) 12.09.22: TW reviewed with DW and requested removal. (Underspend not proactive) 05.09.22: PID for n/r staff turnover to be developed. Responsibilities and capacity issues. Escalated to TW	01.12.22: Removal of scheme approved RN Leave in. Underspend can be included in savings schemes. Consistent with other schemes (e.g. Finance underspend, Transformation vacancy slippage)
Corporate	Decarbonisation		0	Cash-Releasi	R	Non Pay	100,000	24.11.22: DW will chase this one again - should be able to report something 30.09.22: Challenged in review. (RN, AMW, PD, KS) 12.09.22: TW reviewed with DW and requested removal. (Match funded) 05.09.22: PID to be developed. Responsibilities and capacity issues. Escalated to TW as agreed. Amount confirmed - RT	Leave in. Cost savings delivered through decarbonisation project can be reported as a savings scheme. Reduces funding requirement.
Provider - YG	Emergency Care - CAS Cards Stora	Sanning of CAS Cards in offsite storage		Cash-Releasi	R	Non Pay	2,500	AB has advised that delivery issue has impacted savings delivery- scheme to be removed	Remove for M8. AB advised of delivery issu
Corporate	Reduction in pay budget	Agreement to reduce pay in L001 or G002 rto achieve 3% saving on a recurrent basis		Cash-Releasi	R	Pay - Variable	50,000	24.11.22: DW advised that Nick L has plans for the post, did not agree to submitting a savings scheme. 30.09.22 Open queries. Escalated. PD email follow-up.	Relates to KM post. 22.11.22: DW advised
Provider - YG	Job Planning Review	Fully utilising Medical staffing DCCs - 1. Full diary exercise to be undertaken. 2. Exercise to be undertaken of mapping allocate to ledger. Potential sessions reduction		Cash-Releasi	R	Pay - Other (P	50,000		Flagged as an issue (lack of resource). Define requirement, check whether part of Workforce IG - PJ
Total							**802,500**		
							-642,500		
							160,000		

Divisional Savings – FY Forecast Month 8 against Target

The full year forecast for transactional savings plans totals £25.4m including Red, Amber and Green Schemes and income generation. This exceeds the original transactional target and contributes to the target for major programmes, for which plans to be confirmed.

		Forecast	Plan			
Total Improvement	Divisional Plans	Amber & Green	Red	Total YTD	Cash Releasing Target (Divisonal Transactional)	
1,455	Ysbyty Gwynedd	349	-	**349**	1,562	(1,213)
921	Ysbyty Glan Clwyd	613	50	**663**	1,976	(1,312)
2,721	Ysbyty Wrexham Maelor	2,472	-	**2,472**	1,586	887
5,097	**Hospital Sites**	**3,434**	**50**	**3,484**	**5,123**	(1,639)
1,182	North Wales Managed Services	2,129	-	**2,129**	1,793	336
1,430	Womens Services	1,659	-	**1,659**	688	972
7,709	**Secondary Care**	**7,223**	**50**	**7,273**	**7,604**	(331)
1,513	Area - West	2,233	-	**2,233**	1,470	763
3,208	Area - Centre	3,563	-	**3,563**	2,471	1,092
2,805	Area - East	2,931	-	**2,931**	2,540	391
235	Area - Other	235	-	**235**	118	118
3,488	Contracts & Provider Income	3,488	-	**3,488**	902	2,586
11,249	**Area Teams**	**12,450**	**-**	**12,450**	**7,501**	4,949
1,182	MHLD	2,094	-	**2,094**	307	1,788
3,649	Corporate	3,484	110	**3,594**	2,089	1,505
4,831	**Other**	**5,579**	**110**	**5,689**	**2,396**	3,293
-		-		**-**		0
23,789	**Total**	**25,251**	**160**	**25,411**	**17,500**	7,911

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Divisional Savings – FY Forecast Month 8 – IHC View

The full year forecast for transactional savings plans totals £25.4m including Red, Amber and Green Schemes and income generation. This exceeds the original transactional target and contributes to the target for major programmes, for which plans to be confirmed.

	Forecast	Plan			
Divisional Plans	**Amber & Green**	**Red**	**Total YTD**	**Cash Releasing Target (Divisonal Transactional)**	
IHC East					
Ysbyty Wrexham Maelor	2,472	-	2,472	1,586	887
Area - East	2,931	-	2,931	2,540	391
	5,404	**-**	**5,404**	**4,126**	1,278
IHC Centre					
Ysbyty Glan Clwyd	613	50	663	1,976	(1,312)
Area - Centre	3,563	-	3,563	2,471	1,092
	4,176	**50**	**4,226**	**4,447**	(221)
IHC West					
Ysbyty Gwynedd	349	-	349	1,562	(1,213)
Area - West	2,233	-	2,233	1,470	763
	2,581	**-**	**2,581**	**3,032**	(451)
North Wales Managed Services	2,129	-	2,129	1,793	336
Womens Services	1,659	-	1,659	688	972
MHLD	2,094	-	2,094	307	1,788
Area - Other	235	-	235	118	118
Contracts & Provider Income	3,488	-	3,488	902	2,586
	9,606	**-**	**9,606**	**3,807**	5,799
Corporate	3,484	110	3,594	2,089	1,505
Total	**25,251**	**160**	**25,411**	**17,500**	7,911

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Savings Development 2023-24

- Divisions were requested for savings proposals November 2022
- Delays in responding to request due to service pressures over the Christmas and New Year period
- To date proposals totalling £0.8m received

Service	Scheme / Opportunity Title	WG Saving Definition	RAG Rating	PID Status	R £	NR £	Grand Total £
DCSC & Cancer	Automated Blood Sciences Contract	Cash-Releasing Saving	Red	Ready for PID	200,000		200,000
DCSC & Cancer	EBME covid equipment maintenance	Cost Avoidance	Red	Ready for PID	60,017	3,236	63,253
DCSC & Cancer	Pathology Contracts & Batch Efficencies	Cash-Releasing Saving	Red	Ready for PID	39,900		39,900
DCSC & Cancer Total					299,917	3,236	303,153
Midw & Womens	Medical Agency	Cash-Releasing Saving	Red	Ready for PID	180,000		180,000
Midw & Womens	Vacancy Factor A&C	Cash-Releasing Saving	Red	Ready for PID		38,000	38,000
Midw & Womens	Vacancy Factor HCA	Cash-Releasing Saving	Red	Ready for PID		47,000	47,000
Midw & Womens	Vacancy Factor RGN & Midwifery	Cash-Releasing Saving	Red	Ready for PID		220,000	220,000
Midw & Womens	De-commission Obstetrics Contract	Cash-Releasing Saving	Red	Ready for PID	11,635		11,635
Midw & Womens Total					191,635	305,000	496,635
Grand Total					491,552	308,236	799,788

- Develop bottom up transactional savings plans
- Develop a plan for reviewing both local service investments and cost pressures, and corporately driven investments.
- Further develop transformation plans with proper benefits assessment and planning, which improve or maintain outcomes and release overall resource.
- Develop an approach around the sharing of resource release between reducing the recurrent deficit and re-investment

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Teitl adroddiad: ***Report title:***	Summary of Private Board Business – 24 November 2022			
Adrodd i: ***Report to:***	Health Board - Public			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.			
Argymhellion: ***Recommendations:***	The Board is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Molly Marcu – Board Secretary			
Awdur yr Adroddiad: ***Report Author:***	David Seabrooke – Interim Assistant Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	No - N/A/			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	No - N/A/			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	No - 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 ben undertaken?***	No - N/A/
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	No - N/A/
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None
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***	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*** The Health Board considered the following matters in private session on 24 November 2022 • Neurodevelopment tender • Regional Treatment Centre (RTC) – Extension to Lexica Contract	

- Vascular

Rhestr o Atodiadau:
Dim

List of Appendices:
None