Bundle Health Board 23 July 2020

10.00am Via Webex

Public Session

1 10:00 - MATERION AGORIADOL A LLYWODRAETHU EFFEITHIOL / OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 20.65 Sylwadau Agoriadol y Cadeirydd / Chair's Introductory Remarks - Mark Polin

Chair's Actions undertaken:

1. Llys Meddyg Contract
2. Q1 Plan approval
3. Ventilator procurement

1.2 20.66 Ymddiheuriadau am Absenoldeb / Apologies for Absence

Professor Nicky Callow

1.3 20.67 Datganiadau o Fuddiant / Declarations of Interest

1.4 20.68 Cofnodion Drafft Cyfarfod y Bwrdd Iechyd a gynhaliwyd yn gyhoeddus ar 14 Mai 2020 and 21 Mai 2020 er cywirdeb ac adolygu'r Cofnod Cryno o Weithredoedd / Draft Minutes of the Health Board Meeting held in public on 14 May 2020 and 21 May 2020 for accuracy and review of Summary Action Log

20.68a Minutes Board 14.5.20 Public V.02.docx

20.68b Minutes Board 21.5.20 Public V0.06.docx

20.68c Summary Action Log Public v198.doc

2 10:10 - EITEMAU AR GYFER CYDSYNIAD / ITEMS FOR CONSENT

2.1 20.69 Deddf Iechyd Meddwl 1983 fel y diwygiwyd gan Ddeddf Iechyd Meddwl 2007. Deddf Iechyd Meddwl 1983 Cyfarwyddiadau Clinigwyr Cymeradwy (Cymru) 2008. Diweddaru Cofrestr Meddygon Cymeradwy Adran 12(2) Meddygon i Gymru a Diweddaru Cofrestr Clinigwyr Cymeradwy (Cymru Gyfan) /Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinician (Wales) Directions 2008. Update of Register of Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales) - David Fearnley

Recommendation:
The Board is asked to ratify the attached list of additions and removals to the All Wales Register of Section 12(2) Doctors for Wales and the All Wales Register of Approved Clinicians.

20.69 Section 12 doctors.docx

2.2 20.70 Dogfennau a lofnodwyd dan Sêl / Documents Signed Under Seal 1.1.20 to 16.7.20 - Dawn Sharp

Recommendation:
The Board is asked to note the information presented.

20.70 Documents signed under seal v2.0 Approved.docx

2.3 20.71 Adroddiad Sicrwydd Blynyddol ar gydymffurfiaeth â Deddf Lefelau Staff Nyrsio (Cymru) / Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act - Gill Harris

Recommendation:
The Board is asked to note the report.

20.71a Nurse Staffing Levels Annual Assurance Report template.docx

20.71b Nurse Staffing Levels Annual Assurance Report_Appendix 1.docx

20.71c Nurse Staffing Levels Annual Assurance Report_Appendix 2.docx

3 I'W DRAFOD / FOR DISCUSSION

3.1 10:20 - 20.72 Covid-19 Diweddariad ar y Pandemig / Covid-19 Pandemic Update - Chris Stockport

Cyflwyniad i ddilyn
Presentation to follow

3.2 10:35 - 20.73 Diweddariad ar Brofi, Olrhain a Diogelu / Test, Trace & Protect Update - Teresa Owen

Recommendations:
The Board is asked to:
1\. Reflect on the TTP arrangements across the region
2\. To note the update and the formal reporting route through the Strategy\, Partnerships & Population Health Committee\.

20.73 Test Trace Protect.docx

3.3 10:50 - 20.74 Adroddiad Monitro Cynnydd Cynllun Chwarter 1 / Quarter 1 Plan Monitoring Report - Mark Wilkinson

Recommendation:
The Health Board is asked to note the report.

20.74a Q1 Plan Monitoring Report template.docx

20.74b Q1 Plan Monitoring Report - June 2020 FINAL.pdf

3.4 11:05 - 20.75 Adroddiad Ansawdd a Pherfformiad / Quality & Performance Report - Mark Wilkinson

Recommendations:
The Board are asked to
1\. Note the revised format for this report\.
2\. Note that performance management is formally stood down during Covid\-19 and therefore the information provided is management information that has been scrutinised via the Finance & Performance and Quality\, Safety & Experience Committees of the Board\.

20.75a QaP Report template.docx

20.75b QaP Report.pdf

3.5 11:20 - 20.76 Adroddiad Cyllid Mis 1 / Finance Report Month 1 - Sue Hill

Recommendation:
It is asked that the report is noted.

20.76 Finance Report M1.docx

3.6 11:25 - 20.77 Adroddiad Cyllid Mis 2 / Finance Report Month 2 - Sue Hill

Recommendation:
It is recommended that the report is noted.

20.77 Finance Report M2.docx

3.7 11:40 - **Egwyl** **comfort break**

3.8 11:50 - 20.78 Adroddiadau Sicrwydd Cadeiryddion y Pwyllgorau a'r Grwpiau Cynghorol / Committee and Advisory Group Chair's Assurance Reports

20.78.1 Audit Committee (Cllr M Hughes) 29.6.20
20.78.2 Quality, Safety & Experience Committee combined report for 17.3.20, 5.5.20 & 3.7.20 (Mrs L Reid)
20.78.3 Finance & Performance Committee 4.6.20 (Mr M Polin)
20.78.4 Remuneration & Terms of Service Committee 15.6.20 (Mr M Polin)
20.78.5 Strategy, Partnerships & Population Health Committee (Mrs L Meadows) 9.6.20
20.78.6 Charitable Funds Committee 25.6.20 (Ms J Hughes)
20.78.7 Digital Information & Governance Committee 19.6.20 (Mr J Cunliffe)
20.78.8 Stakeholder Reference Group 22.6.20 (Mr Ff Williams)
20.78.9 Healthcare Professionals Forum 19.6.20 (Mr G Evans)

20.78.1 Chair's Assurance Report Audit 29.06.20 V1.0.docx

20.78.2 Chair's Assurance Report QSE March to July V1.0.docx

20.78.3 Chair's Assurance Report FPC 4.6.20 v1.0 approved.docx

20.78.4 Chair's Assurance Report RTS 15.6.20 v1.0.docx

20.78.5 Chair's assurance report SPPHC 9.6.20 v1.0.docx

20.78.6 Chair's Assurance report CFC 25.06.20.docx

20.78.7 Chair's Assurance report DIG 19.6.20 v1.0.docx

20.78.8 Chair's Report HPF 19.6.20 v1.0.doc

20.78.9 Chair's report SRG 22.06.20 v1.0.doc

3.9 12:10 - 20.79 Gwasanaethau Fasgwlaidd: Diweddariad ar yr Adolygiad Annibynnol / Vascular Services : Update on Independent Review - David Fearnley

Recommendation:
The Health Board is asked to note the progress made by the Vascular Task and Finish Group.

20.79a Vascular Update_report template.docx

20.79b Vascular Update_Appendix 1.docx

3.10 12:30 - 20.80 Cyfweliadau Llywodraethu Arolygiaeth Gofal Iechyd Cymru: Adolygiad Cenedlaethol o Wasanaethau Mamolaeth / Healthcare Inspectorate Wales : National Review of Maternity Services - Gill Harris

Recommendations:
The Board are asked to receive this report for information regarding the HIW Maternity Review, and to note for assurance:
1. The action progress made by the Health Board in response to inspections undertaken during phase 1 and phase 2 of the review, and that no actions are overdue
2. The arrangements in place for coordination of the Board member interviews in phase 2
3. The readiness of the Health Board to coordinate the patient engagement and community clinic inspections expected in phase 2

20.80a HIW Maternity report.docx

20.80b HIW Maternity - Appendix 1.pdf

20.80c HIW Maternity - Appendix 2.docx

20.80d HIW Maternity - Appendix 3.pdf

4 I'W BENDERFYNU / FOR DECISION

4.1 12:40 - 20.81 Cynllun Chwarter 2 / Quarter 2 Plan - Mark Wilkinson

Recommendation:
It is recommended that the Board:
1. Receive and approve the draft Q2 plan to support service delivery during the Pandemic.
2. Provide feedback as to what they would wish to see covered in the Q3 plan.

20.81a Quarter 2 Plan_report.docx

20.81b Quarter 2 Plan 03.07.2020 v1.4.pdf

4.2 13:10 - 20.82 Strategaeth Rheoli Risg / Risk Management Strategy - Gill Harris

Recommendations:
The Board is asked to:
1. Ratify the approval of the revised Risk Management Strategy and Policy by the Audit Committee
2. Note there may be a delay in the 1st October 2020 implementation date from operational teams due to the effect from returning to business as usual following the Health Board's response to the COVID Pandemic arrangements.

20.82a Risk Management Strategy and Policy-final_report template.docx

20.82b Risk Management Strategy and Policy-Final V5.0_Appendix 1.docx

20.82c Risk Management Strategy and Policy - EqIA Impact Assessment v2_Appendix 2.docx

5 13:20 - ER GWYBODAETH / FOR INFORMATION

5.1 20.83 Documents Circulated to Members

A range of Covid related briefings and updates continue to be circulated on a daily basis
In addition:
1.6.20 Chairs Assurance Reports for Local Partnership Forum held on 7.1.20, Remuneration & Terms of Service Committee held on 17.1.20, 21.1.20 & 23.1.20 and Audit Committee held on 19.3.20
1.6.20 Joint Committee Briefing from 12.5.20, Emergency Ambulance Services Committee briefing from 12.5.20 and minutes from 28.1.20 & 10.3.20
17.6.20 Planned Care briefing
23.6.20 Shared Services Partnership Committee Assurance Report from 21.5.20
23.6.20 Consultation document draft Senedd Cymru (Disqualification) Order 2020
8.7.20 Copy of Quarter 2 Plan submitted to Welsh Government
15.7.20 Copy of April Quality and Performance Report

6 MATERION I GLOI / CLOSING BUSINESS

6.1 20.84 Dyddiad y Cyfarfod Nesaf / Date of Next Meeting

24th September 2020
Annual General Meeting (9.30am) and Board Meeting (10.30am)

7 20.85 Heb y Wasg a'r Cyhoedd / Exclusion of Press and Public

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

Betsi Cadwaladr University Health Board (BCUHB)
Draft minutes of the Health Board meeting held in public session on 14.5.20
Via WebEx Conferencing

Present:

Mr M Polin	Chair
Prof N Callow	Independent Member ~ University
Cllr C Carlisle	Independent Member
Mr J Cunliffe	Independent Member
Mr S Dean	Interim Chief Executive
Mrs M Edwards	Associate Board Member, Director of Social Services
Mr G Evans	Chair of Healthcare Professionals Forum
Dr D Fearnley	Executive Medical Director
Mrs S Green	Executive Director of Workforce & Organisational Development (OD)
Mrs G Harris	Executive Director of Nursing & Midwifery / Deputy Chief Executive
Mrs S Hill	Acting Executive Director of Finance
Mrs J Hughes	Independent Member
Cllr M Hughes	Independent Member
Mrs Ff Johnstone	Area Director West (for Dr Chris Stockport)
Mr E Jones	Independent Member
Mrs L Meadows	Independent Member
Miss T Owen	Executive Director of Public Health (*part meeting)*
Mrs L Reid	Vice Chair
Ms D Sharp	Interim Board Secretary
Mrs L Singleton	Acting Director of Mental Health & Learning Disabilities
Mr A Thomas	Executive Director of Therapies & Health Sciences
Mrs H Wilkinson	Independent Member
Mr M Wilkinson	Executive Director of Planning & Performance
Mr Ff Williams	Chair of Stakeholder Reference Group

In Attendance:

Mrs K Dunn	Head of Corporate Affairs (for minutes)
Mrs M W Jones	Board Adviser
Mrs L M Roberts	Executive Business Manager (Chair's Office)

Agenda Item Discussed	Action By
20/45 Chair's Introductory Remarks **20/45.1** The Chair informed members that the meeting was being recorded with the intention of testing sharing the recording within the public domain. Officers were also testing streaming options for subsequent meetings. Members then introduced themselves bilingually. **20/45.2** The Chair reported that the Minister had recently approved a 12 month extension of tenure for Mr Ffrancon Williams as Chair of the Stakeholder Reference Group (SRG) ahead of amendments to the Regulations being made, to allow for continuity. In addition	

the SRG has supported a 12 month extension to Mr Gwilym Ellis-Evans' tenure as SRG Vice Chair. **20/45.3** The Chair reported that Chair's Action had been taken to approve business cases for the procurement and construction of the three temporary hospitals at Bangor, Llandudno and Deeside and to approve an SBAR on the provision of piped oxygen infrastructure. The Vice Chair had authorised the paperwork to avoid a potential conflict of interest relating to Mr Polin's role with the temporary hospital group. **20/45.4** The Chair reported that Finance & Performance (F&P) Committee Chair's Action had been undertaken to approve contract awards for managed service contracts for Electrophoresis and Glycated Haemoglobin services. The Executive Director of Therapies & Health Sciences reported that a concern expressed by one of the Independent Members regarding the length of contract had been resolved outside of the meeting. **20/45.5** The Chair reported that he had taken Chair's Action regarding the settlement of a high value claim with permission given for the Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience to instruct counsel via the Claims Manager to commence negotiation at a joint settlement meeting. **20/45.6** Finally the Chair indicated that the organisation was now working to return to a situation of business as usual, as far as possible, whilst maintaining Covid-19 specific work also and that a sub-group of Cabinet had assumed responsibility for examining the governance arrangements for this work.	
20/46 Apologies for Absence Mr Andy Roach, Dr Chris Stockport	
20/47 Declarations of Interest The Interim Chief Executive declared a general interest in that his substantive role remained with Welsh Government.	
20/48 Draft Minutes of the Health Board Meeting held in public on 15.4.20 for accuracy and review of Summary Action Log **20/48.1** The minutes were agreed as an accurate record pending the inclusion of Miss T Owen as having submitted apologies. **20/48.2** Updates were provided to the summary action log.	
20/49 Covid-19 Update **20/49.1** The Executive Director of Workforce & OD provided an overview and update of the work ongoing relating to responding to the Covid-19 pandemic. She reminded	

members that detailed information was provided to the Cabinet meetings, Board Briefings and other groups. She undertook to provide members with a copy of a report submitted to the Strategic Coordination Group relating to data on confirmed numbers, deaths from Covid-19 and actual tests carried out. She was aware of a perception that cases were increasing in the West and stated that whilst this had been the case the number was now levelling off and remained below numbers for the Centre and East. It was reported that Personal Protective Equipment (PPE) issues were being managed, and work continued to address concerns in care homes.	SG
20/49.2 With regards to the modelling work the Executive Director of Workforce & OD reported this was not yet fully aligned and would need to be built into the organisation's planning processes going forward. The Executive Medical Director confirmed that the Clinical Pathways workstream was keen to see this progressed as it impacted upon a number of assumptions. The Interim Chief Executive reflected that the modelling was hugely dependent upon any relaxation or extension of the social distancing and lockdown arrangements. The Board Adviser asked about regional and sub-regional variability and the Executive Director of Public Health indicated that the smaller the numbers the less useful the data and therefore BCU continued to use the Welsh "R" figure as the benchmark whilst remaining aware of the need to reflect local variations. The Vice Chair referred to a dataset which suggested that Wales had a much higher rate of infection per 100,000 of population. The Executive Director of Public Health indicated this would be a result of size, denominators and differences in testing approaches. She suggested that members review the data on the Public Health Wales dashboard which she felt would increase confidence. The Interim Director of Finance undertook to arrange access to the Covid-19 information dashboard for members.	SH
20/49.3 The Vice Chair raised the matter of maintaining essential services and whilst accepting the complexity she felt there was a need to map out Covid and non-Covid pathways, as it was challenging to explain why patients were waiting for scans or blood tests for example when there was capacity within the organisation. The Executive Director of Therapies & Health Sciences reported that for endoscopy in particular, capacity should increase over the next few weeks, but the need to decontaminate treatment rooms between patients did affect the numbers that could be seen. Work continued with CT scanning teams and radiology on alternatives to endoscopy. The Interim Chief Executive felt that performance reporting needed to evolve to accommodate both Covid and non Covid issues. The Chair agreed.	
20/49.4 In response to a question regarding the testing facility within North Wales, the Executive Director of Public Health confirmed that this was now operational within Ysbyty Glan Clwyd (YGC), however, numbers were not as high as anticipated. The Chair referred to a related conversation on the all Wales Chairs and CEOs call recently and whether there was an opportunity for redistribution of reagent. The Executive Director of Public Health indicated she had raised the same issue but the issue was that there were different kits and agents being used across different parts of Wales. She offered to share the related correspondence with members. The Chair reported that Council Leaders were very keen to see early progress with community testing and they maintained their concerns over testing in care homes. He asked that the criteria be clarified for Leaders. The Executive Director of Public Health accepted there were significant challenges ahead with testing, however, she assured the Board that the organisation had sufficient capacity to test at the moment although this would become more difficult as a return to business as usual occurred.	TO TO

20/49.5 The Chair indicated he had shared some information around District General Hospital (DGH) admissions data and questions had been asked regarding the occupancy rate at YGC and that a response from the Hospital Management Team would be helpful for members to better understand the situation. The Executive Director of Public Health reminded the Board that deprivation and the demography of Wales affected communities and had a knock on effect on hospital admissions.

20/49.6 In response to a question regarding wider support to care homes the Area Director (West) reported there were daily conversations with Care of the Elderly and Community Resource Teams, working across health and social care to identify hot spots with the aim of avoiding unnecessary hospital admissions. The Associate Board Member (Director of Social Services) stated that the sharing of intelligence is key to ensuring the challenges facing residential care can be taken forward constructively with partners.

20/49.7 In terms of workforce the Executive Director of Workforce & OD reported there was a significant amount of work ongoing. She highlighted that the aim was to retain the additional staff that had been recruited and deploy them where needed. She also noted the need to be mindful of the impact of 'test, track and trace' on the workforce in terms of the number of staff who may have to isolate as a result. She also reported there had been a good take up of the health and well-being hubs. In response to a question from an Independent Member, she confirmed that the testing and tracking of agency staff was managed within the Health Board.

20/50 Maintaining Governance Covid-19

20/50.1 The Interim Board Secretary presented the paper which had been updated since being presented at the April Board meeting and also included the terms of reference for the Cabinet. She indicated there would need to be a further refresh once outstanding governance arrangements had been finalised.

20/50.2 The SRG Chair reported that the Advisory Group was due to meet in June and he would welcome a steer as to what the SRG could usefully focus on at this stage in terms of providing advice to the Board. An Independent Member suggested that re-engaging with stakeholders formally was important at this time. The Executive Director of Therapies & Health Sciences indicated that conversations were being held regarding the next meeting of the Healthcare Professionals Forum (HPF). The Interim Board Secretary confirmed that diarised June dates for Committees and Advisory Groups were to remain, however, the decision whether the meeting was necessary was for the respective Chair and Lead Officer to make following a review of planned business. She wished to flag that if all scheduled meetings did go ahead then this would impact upon the capacity of Executives, officers, members and secretariat support, as additional Covid structures were also being supported. The Chief Executive suggested that requirements to prepare papers should be minimised. The Chair added that meetings should be short and focused and that attendance by Executives could be on a "as required" basis.

20/50.3 An Independent Member referred to the introduction of the paper which detailed what assurances the Board should be receiving, and expressed doubt that this was being

fully covered. The Interim Board Secretary indicated that Welsh Government guidance had been received within the last week which was now being cross-checked with the Board's auditors and others to determine what governance arrangements needed to be in place and a route map for issues. The Independent Member added that she felt essential services should be standing item for the Baard. The Chair suggested it was placed on the next agenda for consideration as to how this could be appropriately scheduled going forward. **20/50.4 It was resolved that** the Board: 1. Note the updated report 2. Approve the additional variations to the Standing Orders 3. Note the continued revised approach to Board decision making 4. Note the continued revised approach to meetings in public 5. Approve the Covid-19 Cabinet Terms of Reference	DS
20/51 Finance Report Month 12 **20/51.1** The Interim Executive Director of Finance presented the report which provided a briefing on the draft unaudited financial performance for the year to 31st March 2020, and confirmed that the final draft accounts had been submitted to WG on the 7th May 2020. She drew members' attention to the requirement for the Health Board to delegate authority to approve the accounts to the Audit Committee who would meet on the 29th June 2020. The Interim Executive Director of Finance highlighted an increase to expenditure by £31.6m due to the effect of the employer's superannuation costs having been paid by WG on behalf of the Health Board, and that a revised forecast deficit of £41m was now reported. It was also reported that the draft unaudited position of the Health Board was an overspend of £39.2m with significant issues being around an underspend against Referral to Treatment (RTT) and the offset of Covid expenditure. Members' attention was drawn to the total value of savings schemes delivered in year of £35.6m with cash releasing savings achieved of £33.2m against a plan of £35.0m giving a shortfall of £1.8m. Appendix 1 showed a summary of financial performance, and it was highlighted that RTT expenditure was detailed in Appendix 2. **20/51.2** The Vice Chair of the F&P Committee was keen to see what learning would be taken forward in terms of delivering savings and achieving the control total in 2020-21. The Interim Executive Director of Finance accepted that whilst valuable transactional savings had been made, there was a need to deliver more transformational savings and convert schemes into cash releasing plans. An Independent Member noted with disappointment that despite the focus and provision of external support on finance in 2019-20, plans still fell short. Another Independent Member concurred and suggested that it was difficult to see that the Board had been in any better position at M10 than previous years, bearing in mind all the support that it had received. The Chair acknowledged the significant level of savings which had been delivered and that the situation could have been far worse, however, he agreed that pace in delivering savings was key and would be even more challenging when balancing with Covid work. It was agreed the Interim Executive Director of Finance would consider and advise on when the savings programme could recommence and how it might capture service change opportunities which had arisen during the response to Covid-19.	SH

20/51.3 An Independent Member felt that there was learning to be had from the Covid experience in terms of how services had had to be delivered in the pandemic situation, and that this approach could enable transformation. **20/51.4** The Executive Medical Director felt it was timely to re-establish the Board's thinking around a clinical services strategy and there was a good environment currently in terms of clinical engagement and support. **20/51.5** The SRG Chair suggested that members had a responsibility to reiterate and reinforce the need to drive forward schemes that would both transform services and result in savings. He was concerned around agency costs and that the existing initiatives should be refreshed to address this as soon as possible. The Interim Executive Director of Finance responded that controls were being identified which would support a potential cost reduction but there were a number of national decisions which would impact on this area. The SRG Chair had also submitted a written question around superannuation costs and pensions which would be responded to outside of the meeting. **20/51.6** An Independent Member raised the issue whether there could be potential savings in terms of rationalising the BCU estates and using office space differently, learning from how the home working option had been utilised during the Covid pandemic. The Executive Director of Planning & Performance accepted that some aspects could well be normalised as the Board returned to business as usual, however, the Executive Director of Workforce & OD reminded the Board that there would be associated responsibilities regarding the maintenance of social distancing as staff did return to work. **20/51.7 It was resolved that** the Board: 1. Note the report. 2. Delegate authority to approve the audited annual accounts and returns to the Audit Committee at their meeting of 29th June 2020.	SH
20/52 Integrated Quality Performance Report (IQPR) **20/52.1** The Executive Director of Planning & Performance presented the shortened report which provided end of year key performance indicator data without exception reports. He noted a worsening position in terms of patient care – for example in terms of RTT and access to diagnostics – and suggested this was primarily due to the onset of the pandemic situation. *[Miss T Owen left the meeting*] The Executive Director of Planning & Performance confirmed that a revised format for the IQPR was in development with the aim of bringing to the June Health Board. **20/52.2** The Vice Chair made the comment that without the narrative component of the report it was difficult to fully interpret the figures, and she expressed a particular concern around infection levels which had been increasing despite the additional focus in this area even before Covid. She also referred to a discussion at the Quality, Safety & Experience (QSE) Committee on the May 2020 and that estates issues were preventing a particular Ward from being cleaned to the required standard. The Executive Director of Nursing & Midwifery confirmed that this issue had been escalated and the relevant	MW

Hospital Management Team would feed back to the Chair of QSE. She added that work was also being taken forward to identify those "unavoidable" infections. The Vice Chair also referred to stroke care and the impact of thrombotic issues that Covid was now presenting which could result in a further deterioration in the service. The Executive Director of Planning & Performance undertook to take an action away to look at adverse trends around stroke and infection prevention specifically for the next report. In response to a question posed by the Chair, the Executive Director of Planning & Performance undertook to see when the performance report for April could be circulated. **20/52.3** The Vice Chair requested that the learning and recovery work arising from the pandemic should incorporate learning from the reduced attendances at Emergency Departments. The Executive Director of Planning & Performance suggested there would be multifaceted reasons for the lower attendances but agreed that it should be considered as to how learning could be built into new ways of working. **20/52.4** The Executive Director of Therapies & Health Sciences highlighted the efforts of diagnostics teams in that there had been a reduction in numbers waiting for endoscopy from 2500 in August 2019 to around 450 by the end of March 2020. An Independent Member also raised concerns around Child & Adolescent Mental Health Services and Looked After Children performance, and said that she had a series of meetings scheduled with the service lead. **20/52.5 It was resolved that** the Health Board note the report.	MW MW
20/53 Corporate Risk Register **20/53.1** The Executive Director of Nursing & Midwifery introduced this agenda item but in acknowledging that risk management was the subject of a range of ongoing conversations and said she did not feel the report as presented provided the required level of assurance to allow the Board to consider the recommendations as stated. She noted that the stepping down of Committees had caused delays and challenges in ensuring that risks were updated, scrutinised and approved but that the Executive Team had now committed to reviewing each risk they were responsible for. Secondly she highlighted that the decision to de-escalate the care home risk taken earlier in the year had been superceded by a Gold command decision but this had not been reflected in the paper. **20/53.2** The Vice Chair made a range of comments. From an assurance perspective she confirmed that a conversation had been held between herself, the Audit Committee Chair, the Vice Chair of the F&P Committee, the Interim Board Secretary, the Acting Associate Director of Quality Assurance and the Assistant Director of Information Governance & Assurance regarding the management of Covid related risks. She was assured there was work being undertaken in this regard which was not reflected in the paper. Secondly she clarified that the Audit Committee had requested a cleanse of the risk register rather than the QSE Committee as indicated in the paper. Finally she felt that the paper suggested that the Risk Management Group had overridden a QSE Committee decision regarding	

the scoring of risks which was not reflective of the situation. She confirmed that this point related to health and safety risks which were indeed reviewed by the QSE Committee. The Audit Committee Chair wished to support the comments made by the Vice Chair and he added that in his view there was an issue to be resolved around the relationship between QSE Committee and the Risk Management Group. **20/53.3** The Chair welcomed the comments but was concerned as to why the paper had been submitted to Board in its current format if the Executive Team did not feel it provided the necessary assurance for members. He asked that the mechanism to clear papers be revisited and would pick this up with the Interim Board Secretary. **20/53.4 It was resolved that** the Corporate Risk Register would be updated and resubmitted to the June Health Board meeting.	DS GH
20/54 Mental Health Act 1983 as amended by the Mental Health Act 2007. Mental Health Act 1983 Approved Clinician (Wales) Directions 2008. Update of Register of Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales) **20/54.1 It was resolved that** the Board ratify the additions and removals to the All Wales Register of Section 12(2) Doctors for Wales and the All Wales Register of Approved Clinicians.	
20/55 Vascular Services Item deferred to extraordinary Board meeting on 21st May 2020	
20/56 Documents Previously Circulated for Information Noted.	
20/57 Date of Next Meeting The next Health Board meeting would be held on Thursday 21ST May 2020 @ 2.30pm	
20/58 Exclusion of Press and Public **It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

Betsi Cadwaladr University Health Board (BCUHB)
Draft minutes of the extraordinary Health Board meeting held in public session on 21.5.20 via Webex Conferencing

Present:

Mr M Polin	Chair
Prof N Callow	Independent Member ~ University
Mr J Cunliffe	Independent Member
Mr S Dean	Interim Chief Executive
Mrs M Edwards	Associate Board Member, Director of Social Services
Mr G Evans	Chair of Healthcare Professionals Forum
Dr D Fearnley	Executive Medical Director
Mrs S Green	Executive Director of Workforce & Organisational Development (OD)
Mrs G Harris	Executive Director of Nursing & Midwifery / Deputy Chief Executive
Mrs S Hill	Acting Executive Director of Finance
Mrs J Hughes	Independent Member
Cllr M Hughes	Independent Member
Mr E Jones	Independent Member
Mrs L Meadows	Independent Member
Miss T Owen	Executive Director of Public Health
Mrs L Reid	Vice Chair
Ms D Sharp	Acting Board Secretary
Dr C Stockport	Executive Director of Primary & Community Services
Mr A Thomas	Executive Director of Therapies & Health Sciences
Mrs H Wilkinson	Independent Member
Mr M Wilkinson	Executive Director of Planning & Performance
Mr Ff Williams	Chair of Stakeholder Reference Group

In Attendance:

Dr K Clark	Secondary Care Medical Director
Mrs K Dunn	Head of Corporate Affairs (for minutes)
Mrs M W Jones	Board Adviser
Mrs L M Roberts	Executive Business Manager (Chair's Office)

Agenda Item Discussed	Action By
20/60 Chair's Introductory Remarks **20/60.1** The Chair apologised for the delay in starting the meeting which was due to technical difficulties in live streaming the meeting. He reported that the meeting was instead being recorded and would be published to social media platforms and the Board's website. He then asked all members to introduce themselves bilingually. **20/60.2** The Chair welcomed everyone to the extraordinary meeting of the Health Board which had been convened to allow the Board to consider the Vascular Services Review report which was commissioned soon after the configuration of the new vascular services across North Wales in April 2019. He wished to extend his thanks to the Community	

Health Council (CHC) for sharing their own report with the Health Board at an early stage, and which he found helpful and informative, whilst challenging.	
20/61 Apologies for Absence Apologies were recorded for Mrs Lesley Singleton and Cllr Cheryl Carlisle.	
20/62 Declarations of Interest Prior to the meeting, Mrs Nicky Callow had expressed an interested in the subject matter in that she knew Professor Dean Williams (a vascular surgeon) through her line management responsibility of him in his Bangor University Head of the School of Medical Sciences position.	
20/63 Vascular Services **20/63.1** The Executive Medical Director presented the report. He highlighted that the report was the outcome of a review of some 9 months and followed many years of change within the service. He wished to bring to the Board's attention changes that had taken place in terms of the new hybrid theatre and also changes in staff which had led to a rapid improvement event towards the end of 2019 and a series of actions to address areas for further improvement. The Executive Medical Director welcomed that the CHC had shared their report with the Health Board in February 2020 and acknowledged a mutual desire to work towards improving patient healthcare through a partnership approach. He was sorry to have heard of the experiences of patients and staff as contained within the CHC's report and stated his intention to set out actions to address these. **20/63.2** The Executive Medical Director went on to set out some context to the paper in terms of the case for change within the development of vascular services, noting that this had been an extremely complex process but that patient safety had remained the priority at every stage. He alluded to challenges in ensuring there was a consensus to phases of the development, and that the facilities and staff were in place to allow the Board to deliver ambitious but necessary vascular services across North Wales. He reminded the Board that there was support to the principle of a centre of excellence for vascular services and that in 2015 the Royal College of Surgeons (RCS) had been invited to undertake a review which whilst candid and challenging, did support the case for change. The Executive Medical Director noted that the opening of the service in April 2019 was testament to the dedication and hard work of the staff. In terms of the concept of centres of excellence and specialisation it had become clear that North Wales needed to centralise some of its complex arterial operations and that the team undertaking this work would over time become increasingly specialised, therefore leading to better outcomes for patients. This model has been endorsed by the RCS and the Vascular Society and underpinned the case for change. **20/63.3** The Executive Medical Director noted that the need to move forward was set out in the papers and the associated action plan, highlighting the need to think about future services and the Board's ambition to develop world leading complex arterial vascular	

surgery and the infrastructure for treating other vascular conditions. He stated that the Board was committed to seeing this necessary challenge through and developing the research and innovation to underpin it. Data continued to be collected, shared and compared with national data as it was important to examine outcome measures against performance data to ensure the organisation could be aware of the need to accelerate or pause change to ensure safe and high quality care. Members were informed that the data before and after the service change in 2019 had been compared and whilst reporting had improved it must be borne in mind that there was now a new service which needed benchmarking across the UK. In terms of the examples of poor patient experience set out in the CHC report this was taken very seriously and he would continue to work with the CHC to identify any outstanding actions that needed to be incorporated into the Board's action plan. The Executive Medical Director confirmed that the Board welcomed feedback from both patients and staff and that existing systems would be reviewed to ensure they were accessible and effective.

20/63.4 It was highlighted that both reports referred to a disruption of services at Ysbyty Gwynedd (YG) and he confirmed that changes had taken place over the last year which resulted in temporary changes being put in place as to where patients would receive their care. He accepted that in some cases this had resulted in a poor patient experience and a rapid improvement event had been held in December 2019 at which many ideas had been put forward to further develop vascular services across North Wales, particularly around diabetic foot care and looking at best practice from other Health Boards. The integration of care pathways would be a key strategic approach and remained a key element of service configuration for the Health Board not only for vascular services but for other services such as renal care, diabetic care and palliative care.

20/63.5 The Executive Medical Director stated that the report had identified amputations as an area for examination. He acknowledged that these were serious and potentially life-changing surgical interventions which were undertaken after informed consent and when the evidence indicated it was the right treatment. Research around amputations continued to develop and within BCUHB additional care and support was provided from limb specialists to individuals who had undergone this surgery. Amputations were part of a national vascular annual audit which BCU would continue to participate in to learn from the data and to ensure this intervention was only provided when required and to a high standard.

20/63.6 The Executive Medical Director went onto explain that the service had made progress in some areas which were set out in the report and included reductions in the average length of hospital stay; a reduction in cancellations; a reduction in the number of outlier patients in hospitals far from their homes; vascular emergencies now being almost entirely undertaken in the hybrid facility at Ysbyty Glan Clwyd (YGC); and improvements to recruiting vascular surgeons. The Executive Medical Director then made reference to aspects of culture and the willingness of staff to speak out and raise concerns, acknowledging that this would be an essential element to the work over the coming months.

20/63.7 The Executive Medical Director concluded that the Board had received a set of very detailed and comprehensive papers and he acknowledged the work undertaken by colleagues in their preparation. The work had led to a number of recommendations which he went onto to describe, and the development of an action plan. This action plan set out intended areas for improvement focusing on the alignment of inpatient beds for vascular patients; pathways of care; engagement and communication; quality, safety and experience matters; and access to the service. Finally the Executive Medical Director welcomed the opportunity to present the paper to the Board having set out the key aspects of the review and acknowledging the CHC report. He confirmed there was a partnership approach with a stakeholder group ready to oversee the actions within an appropriate governance structure.

20/63.8 The Executive Director of Nursing and Midwifery wished to reiterate that the Board genuinely wished to hear any feedback or concerns from patients and public in order to improve services, and she was grateful for the feedback received via the CHC report.

20/63.9 The Chair then invited questions from board members.

20/63.10 It was noted that within the introduction of the review report reference was made to an anticipation that approximately 300 complex cases would be sent to the hub but it was understood that the figure was much higher and an explanation was sought.
The Executive Medical Director explained that due to some temporary challenges a number of patients expected to have gone to YG were referred into YGC but this had now been realigned so the numbers were expected to even out. He confirmed that if it later became apparent there was a pathway issue then this would be addressed but there was no reason to believe this was the case currently.

20/63.11 An explanation was sought as to the apparently conflicting comments about surgical trainees being withdrawn from YGC and/or YG. The Executive Medical Director reported that the current position with trainees was that there were trainees in Wrexham but none in YGC or YG although there would be from August. He explained that when consultants had left the service, other doctors had been reallocated and it had been difficult to re-establish the training programme so far and progress had also been impacted upon by the Covid pandemic.

20/63.12 An update was sought on the outcome of the nurse recruitment exercise. The Executive Director of Nursing and Midwifery acknowledged there were significant challenges in terms of nurse vacancies across the Health Board including within the vascular service. In addition, staff who worked in the specialist centres would have additional requirements associated with demonstrating the necessary competencies within that specialty. Recruitment success had been affected by the impact of Covid-19 and but there were currently 19 in post against an establishment of 22. That said, here remained work to do. The Executive Director of Workforce and OD added that the nurse establishment continued to operate safely.

20/63.13 In terms of amputations a question was posed as to whether the reported 30% increase between 2018 and 2019 could be explained. The Executive Medical Director responded that the data on amputation needed to be taken with a degree of caution as two different services were being compared. Part of the reason for undertaking the review into vascular services was to build up meaningful data as it was known BCU was an

outlier in respect of having low rates of amputations due to a number of reasons. Having looked at the evidence and noting the consensus amongst vascular surgeons, the view was that BCU were now undertaking amputations at a level closer to the number expected for the size of the population but the priority was that when an amputation was considered informed consent was obtained following a full conversation on the implications and risks with the patient. Any concerns that were brought to the organisation's attention would of course be investigated but the Board was not aware from current data nor from the feedback from the Vascular Society nor an external vascular surgeon that this was a particular area of concern. He stated it must be acknowledged that these matters related to very difficult clinical decisions and once there were was a consistent approach for diabetic foot care this would also provide further assurance. A supplementary question was posed regarding the expected rate of amputations for the population size and whether by implication it was felt that previously the Board had not been treating some patients in the most clinically appropriate way. The Executive Medical Director responded that there were now better systems for data collection and there was support to challenge the previous service model and how it was being delivered. He reiterated there had previously been a model of longer stays in hospitals and high antibiotic use and there was now a different approach recommended through the principles of "A Healthier Wales". Although the current approach still had its challenges it did have the support of professional bodies. He also explained the need to focus on patient outcome measures and the follow up required, and that this would be a role for the Task and Finish Group. **20/63.14** With regards to readmission rates, clarification was sought as to whether there was an increasing trend as appeared to be the case within the reports. The Executive Medical Director felt that there hadn't yet been sufficient time to understand the data and it could be open to interpretation. This would be an area of work for the Task and Finish Group reporting to the Quality, Safety & Experience (QSE) Committee for scrutiny who would identify and monitor any underlying trends. **20/63.15** It was noted that the report referred to several high level risks and clarification was sought as to whether they had gone through the appropriate process for escalation and mitigation. The Executive Director of Nursing and Midwifery responded that risks relating to incidents were investigated locally but challenged and overseen by the corporate risk team which provided a level of objectivity. Any open incidents would be discussed at the Quality Safety Group (QSG) and reported up to the QSE Committee. In terms of risks around pathways, staffing and service reputation - these had been articulated within the action plan and would be tested through the Task and Finish Group as part of the governance arrangements. **20/63.16** The Chair questioned whether in light of the comments made within the CHC report some amputations were being undertaken unnecessarily, the organisation should be doing more and undertake a review of a sample of cases to ensure the clinical decision making was robust. He also suggested that the previous practice of over-reliance on antibiotics should be looked into. The Executive Medical Director accepted that both these areas could be explored by the Task and Finish Group, and they would therefore form part of the action plan. **20/63.17** A comment was made concerning the varied views within the two reports, acknowledging they had been prepared with differing methods of analysis and methodologies. In terms of moving the findings of the reports forward the question was	DF

asked as to what engagement and communication processes would be utilised with stakeholders and staff to ensure that public trust and confidence in the organisation could be maintained or restored. It was also noted with disappointment that the CHC report indicated staff were reluctant to come forward to raise concerns about the service. The Executive Medical Director responded that the various views would best be taken forward via triangulation at a stakeholder group. The Chief Executive was assured around the robustness of the processes and policies in place to support staff in raising a concern, but felt the challenge was to increase staff's confidence in those processes. The Chair added that vascular services were also clearly a subject that polarised views particularly amongst clinicians and whilst it was admirable to note how much effort had gone into trying to bring views together, the organisation had had a responsibility to make a decision and move forward. He suggested that the time it took to reach this decision may have impacted on levels of confidence within the organisation and this would be something to learn from for the future. **20/63.18** The question was asked as to how satisfied the Executive Team were that the service currently being provided across all three sites, including after care, met the original requirements for service improvement and was appropriate for patients at this point in time. The Executive Medical Director felt confident in the outcome measures around the service and reported that he had visited sites to speak to surgeons and staff, and was assured that there were many examples of a high quality service being provided. He accepted however there were also examples where the patient outcome had been less than desirable and there was a need to reflect on these honestly and be clear as to the way forward through a process of continuous improvement in partnership. He also was aware of how the service had stepped up during the current pandemic to keep patients safe and that was a positive indication of the leadership within the service. **20/63.19** A question was asked in relation to how the poor patient experiences that had been raised through the CHC report would be addressed. The Executive Medical Director indicated there was a clear need to offer support to the CHC and to those patients and families who shared their experiences with the CHC and to put in place those mechanisms that would have been offered if they had raised those experiences directly with the Health Board. This would be pursued. The Executive Director of Nursing and Midwifery added that even if some patients felt unable to come forward to work with the Health Board, it would be important to obtain a broader stakeholder view of what a good service looked like from their perspective, not just through a clinical lens. She added that there were lessons to learn around being explicitly clear as to why previous models could not be sustained. **20/63.20** The QSE Committee Chair reported that the Committee had considered the vascular review report at its meeting on 5th May 2020 and she was grateful to the Executive Medical Director and others for pulling together responses to a number of queries that had been raised by Committee members. She wanted to assure the Board that these would be followed up by the Committee who would also receive progress reports directly from the Task and Finish Group. She also welcomed the proposal in the action plan to review culture across the service and the wider organisation. The Executive Director of Nursing and Midwifery agreed that if staff felt unable to raise concerns this would impact on an already vulnerable workforce and there was a need to understand what these concerns were. She added her regret that some staff had reported they had been let down by the organisation. The Chair suggested that an engagement event be arranged with staff, involving the QSE Committee Chair, the Chair and also the CHC.	DF DF

This suggestion was welcomed and it was agreed that the Executive Medical Director would take this forward. The Chair also referred to the need to progress with improving listening and learning mechanisms across the Health Board. The Executive Director of Nursing and Midwifery confirmed this had been discussed at the QSE Committee with a suggestion to establish a separate group to focus on this aspect was being examined. She felt that more pace could be put behind this. The QSE Committee Chair acknowledged that real improvements had been made over the past year or so in terms of capturing feedback but that the development of the learning aspects remained challenging and this would be tied in with a planned review within the patient safety team around incident reporting and considered at QSE Committee. **20/63.21** The Executive Director of Workforce and OD felt that it was important for Board Members to understand whether any of the examples of poor experience in the CHC report correlated with incidents that had already been reported and potentially investigated which may enable assurances to be given that practises had changed as a result. The Chair indicated that he and the Interim Chief Executive were meeting with the CHC Chair and Chief Officer and would extend the invitation to the Executive Medical Director and the Secondary Care Medical Director also, where this issue could be picked up. **20/63.22** The Chair noted that several comments had been made regarding a lack of confidence in the procedures available to staff to raise concerns. The Executive Director of Workforce and OD was of the view that there was a need to review and refresh to ensure processes were robust and appropriate. She added however that there was a difference between having a robust process in itself, and staff feeling able to use it and being confident that their views would be listened to and acted upon. The Independent Member (Trade Unions) clarified that there was an all Wales policy for staff to raise concerns, and a local safe haven procedure. She felt that a refresh would be timely and that best practice could be sought from other organisations. **20/63.23** A concern was expressed around clinical pathways and that the review indicated that they were insufficiently robust or clear which was regrettable. The question was asked as to what progress had been made since the improvement event held in December 2019. In addition the member felt that the risk around clinical pathways had been scored too low and he suggested there was a clear link between pathways and patient experience. The Chair concurred that pathways were fundamental to service change. The Executive Medical Director accepted that infrastructure such as pathways needed to be in place at an early stage to support service change and this had been the aim of the improvement event, however, early in 2020 conversations around Covid-19 began to impact on capacity to move things forward. What had been learnt was that pathways needed to be integrated and make better of use of technology and electronic health records to calibrate the risks. **20/63.24** A point was raised regarding the national vascular registry which contained performance data for the organisation but this intelligence did not appear to have been referenced within the review report which the member felt was an omission. The Executive Medical Director reported his understanding that this was published in retrospect and therefore the available data would have been pre-service configuration. He accepted the importance of maintaining a record of benchmarking data but that it would be 12 months before the vascular registry information could provide a useful indication of service outcomes and comparison.	MP SG

20/63.25 In terms of the timeframes for delivery of the action plan, the question was asked to what extent the organisation was limited by Covid-19 in terms of capacity. The Executive Medical Director accepted this would need to be worked through in terms of prioritisation.

20/63.26 A comment was made that in order to improve services and make them sustainable centralisation was often necessary but the significant delay between the decision and implementation for vascular services had not been helpful. Therefore a timeframe against the recommendation relating to an independent review would be welcomed.

20/63.27 General comments were made that the open and transparent discussions that had taken place were welcomed and that the four recommendations provided a framework for good governance and triangulation. A co-production approach would be the way forward for other aspects of service delivery in the future. Integration of clinical pathways and the development of the teams including nurse staffing would be key. A reflection was made around the resourcing of change and that given the level of transformation that the Health Board was required to introduce, this would need to be addressed. It was noted that the Interim Chief Executive had written along similar lines to Welsh Government and a response was awaited.

20/63.28 A question was asked regarding the diabetic foot service which was also referenced within the CHC report. The Executive Medical Director confirmed that this remained a key area to be progressed and that the aim was for a consistent pathway.

20/63.29 The Chair referred to the configuration of capacity including critical care. The Executive Medical Director agreed this would need to be one of the first actions for the Task and Finish Group.

20/63.30 Some amendments to the recommendations were considered and **it was resolved that the Board:**

1. Approve the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations. An amendment to the terms of reference was agreed to include CHC or patient/public representation.
2. Request the Task and Finish Group to consider the draft action plan to identify any further required actions and recommend key performance indicators.
3. Agree progress reporting arrangements are via the Quality, Safety and Experience Committee.
4. Commission an external, independent multi-disciplinary assessment of the North Wales Vascular Service provided across the Health Board to assess the quality and safety of the service and patient outcomes. Terms of Reference and a timeline for the assessment would be developed as a matter of urgency by the Task and Finish Group for submission to the QSE Committee. DF

20/63.31 The Chair concluded that the nature of the review had been challenging but he welcomed the findings and those of the helpful CHC report. He extended his thanks to all those involved in their production. He acknowledged that in terms of service change and reconfiguration the matter hadn't gone as would have been hoped but there had been

some improvements. He accepted that service change was always difficult with a range of differing opinions being made but that the Board continued to move forward together to support staff and deliver a high quality service. He thanked members for their candour, questions and response and then closed the meeting.	
20/64 Date of Next Meeting The next Health Board meeting would be held on 18th June 2020 @ 10.30am **POST MEETING NOTE** – next date subsequently confirmed as 23rd July 2020.	

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

HEALTH BOARD SUMMARY ACTION LOG – ARISING FROM MEETINGS HELD IN PUBLIC

Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Action to be closed
Actions from Health Board 15.4.20				
J Parry	**20/39.4** Arrange for the Board to receive a briefing on Recovery arrangements in due course	14.5.20	Scheduling yet to be agreed at most appropriate forum 14.5.20 Clarification provided that action related originally to the recovery from Covid-19. Noted that some Boards had established a recovery workstream and members were keen to know how would be approached within BCU. 14.7.20 Gold Command stood down and normal Board and Committee arrangements now in place with revised supporting management governance structures.	Closed
Actions from Health Board 14.5.20				
S Green	**20/49.1** Provide members with a copy of a report submitted to the Strategic Coordination Group relating to data on confirmed numbers, deaths from Covid-19 and actual tests carried out.	28.5.20	15.7.20 Latest health data slides from SCG circulated.	Closed
S Hill	**20/49.2** Arrange access to the Covid-19 information dashboard for members.	28.5.20	14.7.20 This action was requested from the IMT department who have confirmed access has been granted to the IMs.	Closed
T Owen	**20/49.4** Share with members the	28.5.20	Completed and additional update circulated 15.7.20	Closed

	correspondence regarding redistribution of test reagent across Wales			
T Owen	**20/49.4** Provide clarification for Council Leaders on the criteria for testing in care homes	28.5.20	15.7.20 As part of the 'Care home' work, a weekly meeting is now held with the 6 testing leads in Local Authorities. In addition, a Single Point of Contact for all care home queries has been established, and regular updates are provided to stakeholders on the national guidance, which continues to evolve. (e.g. on the 15/7/20 – we have received the latest request for care home staff testing – information has been shared).	Closed
D Sharp	**20/50.3** Agenda discussion on essential services at next Board meeting	18.6.20	Paper submitted to Board Briefing	Closed
S Hill	**20/51.2** Consider and advise on when the savings programme could recommence and how it might capture service change opportunities which had arisen during the response to Covid-19.	18.6.20	14.7.20 This action was considered at the July Finance & Performance Committee within a formal report. Further actions have been agreed to identify and validate both savings opportunities and the capability and capacity required to support 7delivery.	Closed
S Hill	**20/51.5** Respond to written question regarding superannuation from SRG Chair	28.5.20	Response emailed by SH on the 13.7.20	Closed
M Wilkinson	**20/52.1** Work to finalise revised format for IQPR for next Board	23.7.20	New Quality and Performance Report (QPR) now developed and in use	Closed
M Wilkinson	**20/52.2** Review adverse trends around stroke and infection prevention specifically for the next report.	18.6.20	14.7.20 The data relating to Stroke Services has been reviewed and found to be accurate. The performance on stroke consultant review is affected by the timing of stroke presentations, recognition of strokes and timeliness of admission	Closed

			to the stroke unit and stroke consultant rotas. When a stroke consultant is not on call, patients are reviewed by the post take Consultant. The pandemic has impacted on the access to the stroke units. The narrative within this months QPR covers the context of the levels of healthcare acquired infections.	
M Wilkinson	**20/52.2** Identify and confirm when the performance report for April could be circulated.	28.5.20	15.7.20 April QPR circulated	Closed
D Sharp	**20/53.3** Follow up and strengthen mechanism for clearance of board papers	18.6.20	In agreement with Chair, Board and Committee corporate deadlines have reverted back to 8 working days ahead of the meeting to enable more time for QA of papers.	Closed
G Harris	**20/53.4** Resubmit refreshed corporate risk register to next meeting	23.7.20	14.7.20 CRR now scheduled for September Board to allow the report to be informed by the risk workshop taking place in August.	Closed
Actions from Health Board 21.5.20				
D Fearnley	**20/63.16** Ensure that the Task and Finish Group (via the action plan): 1) Undertake clinical review of some amputation cases to look into the issues raised around amputations being performed potentially unnecessarily 2) Look into the potential practise of over-reliance on antibiotics.	23.7.20	14.7.20 The Vascular Network Task and Finish group will be reviewing amputations and antibiotic prescribing. Chief Pharmacist will be preparing discussion for next meeting on 17 July 2020. Discussion has taken place to plan a case review with the service and Senior Associate Medical Director. This will be discussed further at the next task and finish group and followed up in that group, reporting to QSE.	Closed
D Fearnley	**20/63.19** Offer support to the CHC and to those patients and families who shared their experiences with the CHC and to put in place those mechanisms that would have been	23.7.20	14.7.20 The CHC was contacted on the 26.6.20 by Executive Medical Director, and CHC agreed to respond with comments. CHC are part of the Vascular Task and Finish Group and this will be raised at the next meeting on 17.7.20 and followed up by the group, reporting to QSE.	Closed

	offered if they had raised those experiences directly with the Health Board.			
D Fearnley G Harris	**20/63.20** Arrange a staff engagement event involving the CHC and L Reid as QSE Chair	23.7.20	14.7.20 Event is scheduled for 13.8.20	closed
M Polin	**20/63.21** Invite D Fearnley and K Clark to meeting with CHC Chair and Chief Officer	28.5.20	Meeting held	Closed
S Green	**20/63.22** Arrange for review and refresh of BCU policies/procedures supporting staff raising concerns	23.7.20	Timeframe to be confirmed by Executive Director of Workforce & OD.w	
D Fearnley	**20/63.32** Develop Terms of Reference and a timeline for the external, independent multi-disciplinary assessment of the North Wales Vascular Service, for submission to the QSE Committee.	3.7.20	Paper published with QSE agenda, however, item was deferred due to the postponement of the majority items due to the need to release Executive capacity to complete the Q2 Plan. Vascular update on agenda for Health Board 23.7.20 which incorporates the ToR and an improvement action plan with timeline.	closed

V198

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
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 Section 12(2) Approved Doctors for Wales and Update of Register of Approved Clinicians (All Wales)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Mrs Heulwen Hughes, All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors
Craffu blaenorol: **Prior Scrutiny:**	Dr David Fearnley
Atodiadau **Appendices:**	**Appendix 1:** Mental Health Act 1983 as amended by the Mental Health Act 2007Mental Health Act 1983 Approved Clinician (Wales) Directions. Update of Register of Approved Clinicians for Wales **Appendix 2:** Mental Health Act 1983 - Update of Register of Section 12(2) Approved Doctors for Wales

Argymhelliad / Recommendation:

The Board is asked to ratify the attached list of additions and removals to the All Wales Register of Section 12(2) Doctors for Wales and the All Wales Register of Approved Clinicians.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Sefyllfa / Situation:

Betsi Cadwaladr University Health Board is responsible for the initial approval, re-approval, suspension and termination of approval of Approved Clinicians and Section 12(2) Doctors in Wales.

Cefndir / Background:

The change introduced to the Mental Health Act 1983 was the abolishing of Responsible Medical Officers (RMOs) and Community Responsible Medical Officers (CRMOs) and the introduction of Approved/Responsible Clinicians (ACs and RCs) in their place.

The Minister for Health and Social Services agreed that as of the 3rd November 2008, Wrexham Local Health Board (LHB) would act as the Approval Body for Approved Clinicians and section 12(2) Doctors on behalf of the LHBs in Wales. The transfer of function from Wrexham Local Health Board to Betsi Cadwaladr University Health Board took place on 1st October 2009.

Asesiad / Assessment & Analysis

Strategy Implications

It is important to ensure the highest standards of governance for approving and re-approving practitioners who are granted these additional responsibilities, which apply when people are mentally disordered

Financial Implications

The Approvals Team receive a ring-fenced budget from Welsh Government to support the monitoring and approvals of Clinicians in Wales.

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.

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

Impact Assessment

An impact assessment is considered unnecessary for this update paper. The Approval Process is part of the Legislative process

Update of Register of Approved Clinicians and Section 12 (2) Approved Doctors for Wales 29th April 2020 – 29th June 2020		
	AC	**S12 (2)**
Approvals and Re-approvals	6	5
Removed – Expired	2	1
Approvals suspended	0	0
Approvals re-instated – returned to work in Wales	1	0
Approval Ended	0	0
Retired	1	0
Removed – AC approved	NA	2
No longer registered	0	0
Transferred from AC register	NA	0
Approval Ended as no longer working in Wales	0	0
Registered without a licence to practice	0	0

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

APPENDIX 1

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

Mental Health Act 1983 Approved Clinician (Wales) Directions

Update of Register of Approved Clinicians for Wales

29th April 2020 – 29th June 2020

Approvals and re-approvals – 6

Surname	First Name	Workplace	Expiry Date
Briggs	Patrick	Ysbyty George Thomas, The Mattie Collins Way, Treorchy CF42 6YG	06 May 2025
Henderson	William Austin	Crisis Resolution and Home Treatment Team, Fan Gorau, Montgomery County Infirmary, Llanfair Road, Newtown, Powys SY16 2DW **SEE COMMENTS"	10 May 2025
Ivenso	Michael	Mental Health Services for Older People, University Hospital Llandough, Penlan Road, Llandough, Cardiff CF64 2XX	11 May 2025
Ball	Claire Louise	St David's CAMHS, St David's Hospital, Cowbridge Road East, Canton, Cardiff CF11 9XB	21 May 2025
Naik	Anita	Bridgend Generic CAMHS, Princess of Wales Hospital, Coity Road, Bridgend CF31 1RQ	28 May 2025
Lendon	Rebecca Ann	Caswell Clinic, Glanrhyd Hospital, Tondu Road, Bridgend CF31 4LN	10 June 2025

Approvals re-instated – 1

Surname	First Name	Workplace	Expiry Date
Luffingham	Mark	St Teilo House, Rhymney, Gwent NP22 5NF	23 November 2020

Approvals expired – 2

Surname	First Name	Workplace	Expiry Date
Summers	Zelda	Celtic Court, Tremains Road, Bridgend CF31 1TZ	01 June 2020
Poole	Rob	Centre for Mental Health and Society, Academic Unit, Wrexham Technology Park, Croesnewydd Road, Wrexham LL13 7YP	28 April 2020

Approvals Suspended – 0

Surname	First Name	Workplace	Expiry Date

Retired – 1

Surname	First Name	Workplace	Expiry Date
Vas Falcao	Isabel	Y Delyn, Glangwili General Hospital, Carmarthen SA31 2AF	28 May 2020

No longer Registered - 0

Surname	First Name	Expr1004	Expiry Date

No longer working in Wales – 0

Surname	First Name	Expr1004	Expiry Date

Approvals Ended – 0

Surname	First Name	Workplace	Expiry Date

APPENDIX 2

Mental Health Act 1983

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

29th April 2020 – 29th June 2020

Approvals and Re-approvals – 5

Surname	First Name	Workplace	Date Approval Expires
Mudondo	Nyasha Primrose	Maelor Hospital (GPOOH), Croesnewydd Road, Wrexham LL13 7TD	3 May 2025
Zaidi	Syeda Zehra	Cefn Coed Hospital, Cockett, Sketty, Swansea SA2 0GH	10 May 2025
De Almeida	Anusha	Litchard House, Princess of Wales Hospital, Coity Road, Bridgend CF31 1RQ	3 May 2025
Majoe	Ashleigh	Older Persons Mental Health Team, 1st Floor, Kier Hardie Health Park, Aberdare Road, Merthyr Tydfil CF48 1BZ	24 June 2025
Sadi	Hamidreza	Change-Grow-Live, Rotherham PREV: Felindre Unit, Bronllys Hospital, Brecon, Powys LD3 OLU	28 June 2025

Removed – Expired - 1

Surname	First Name	Workplace	Date Approval Expires
Sadi	Hamidreza	Change-Grow-Live, Rotherham PREV: Felindre Unit, Bronllys Hospital, Brecon, Powys LD3 OLU	23 June 2020

Removed – AC approved – 2

Surname	First Name	Workplace	Date Approval Expires
Naik	Anita	St David's Hospital, Cowbridge Road, East Canton, Cardiff CF11 9XB	5 January 2021
Lendon	Rebecca Ann	Caswell Clinic, Glanrhyd Hospital, Tondu Road, Bridgend CF31 4LN	31 January 2022

No longer registered – 0

Surname	First Name	Workplace	Date Approval Expires

Transferred from AC Register – 0

Surname	First Name	Date Approval Expires	Workplace

No longer working in Wales – 0

Surname	First Name	Workplace	Date Approval Expires

No longer registered – 0

Surname	First Name	Workplace	Date Approval Expires

Removed – Retired – 0

Surname	First Name	Workplace	Date Approval Expires

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Documents signed under seal 1.1.20 – 16.7.20
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dawn Sharp, Acting Board Secretary
Awdur yr Adroddiad **Report Author:**	Liz Jones, Assistant Director of Corporate Governance
Craffu blaenorol: **Prior Scrutiny:**	Executive Team.
Atodiadau **Appendices:**	-

Argymhelliad / Recommendation:

The Board is asked to note the information presented.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	**x**

Sefyllfa / Situation:

This report complies with Standing Order 8.1.1, which requires a report of all documents signed under seal to be presented to the Board for noting at least twice per year.

Cefndir / Background:

Leases, contracts and similar documents require sign off at Chief Executive/Chair level, requiring the application of the Health Board's official seal.

Asesiad / Assessment & Analysis

The documents requiring the official seal to be applied, since 17.12.19, are listed below:

Document	Date Processed
Ysbyty Glan Clwyd mental health inpatient unit (the Ablett) supply chain partner approval – BAM Construction Ltd	17.12.19
Safe Clean Care East region – measured term contract for refurbishment work – Read Construction Holdings Ltd	17.12.19
Land Registry Title of part of registered titles (TP1) – land and buildings at Ambulance Headquarters, HM Stanley Hospital, St Asaph	19.12.19
Licence for alterations, Hillcrest Surgery, Wrexham	19.12.19
Sub lease by reference to superior lease, Hillcrest Surgery, Wrexham	19.12.19
Abergele Hospital IVT suite alterations – Pen y Bryn Joinery Ltd	19.12.19
Underlease, 15a London Road, Holyhead	19.12.19
HM Land Registry form TR1 (transfer of whole of registered titles), Health Centre, Blaenau Ffestiniog	19.12.19
Lease, Villa Romano, Grove Road, Wrexham	20.12.19
DS1 (HM Land Registry; Cancellation of entries relating to a registered charge - Land on the South side of Lluesty Hospital, Old Chester Road, Holywell	27.01.20
HM Land Registry For TR1, Land and buildings at the North of Towyn Road, Blaenau Ffestiniog, Gwynedd, LL41 3UR (Former Physio Clinic)	27.01.20
(Sale) Contract, Land and buildings on the north of Towyn Road, Blaenau Ffestiniog, Gwynedd, LL41 3UR (Former Physio Clinic)	27.01.20
Underlease, part ground, part first and part second floor of WOW Training Centre, Old Chapel, 15a London Road, Holyhead	27.01.20
License to Underlet, change use and carry out works - part ground, part first and part second floor of WOW Training Centre, Old Chapel, 15a London Road, Holyhead	27.01.20
St David's Hospice fit out at Fali Ward - Penrhos Stanley Hospital, Holyhead x 2	21.01.20
North Denbighshire Community Hospital Supply Chain Partner - NDCH, Rhyl	26.02.20
Land Registry Form TR1 (Transfer of whole of registered title(s) - Ruabon Medical Centre, High Street, Ruabon	17/06/2020
Covid 19 - Emergency Fit Out of Ward 6 Empty Shell to provide 36 Ventilation Capable Bed Ward	04/06/2020

Covid 19 - Emergency Fit Out of Ward 10 Empty Shell to provide 36 Ventilation Capable Bed Ward	04/06/2020
Multi Agency Adult Substance Misuse Service Base	02/06/2020
License to Assign - Connahs Quay Primary Care Resource Centre, Fron Road, Connahs Quay, Flintshire CH5 4PQ	19/06/2020
Land Registry Transfer of Whole of registered title (TR1) First Floor Premises, Connahs Quay Primary Care Resource Centre, Fron Road, Connahs Quay, Flintshire CH5 4PQ	19/06/2020
Supplemental Agreement - Premises at Connahs Quay Primary Care Resource Centre, Fron Road, Connahs Quay, Flintshire CH5 4PQ	19/06/2020
Deed of Covenant - First Floor, Connahs Quay Primary Care Resource Centre, Fron Road, Connahs Quay, Flintshire CH5 4PQ	19/06/2020
Re-location of Services from Mount Street Clinic, Ruthin to encompass the re-development of Ruthin and Denbigh Community Hospitals - Contractor documents (Read Construction).	18/06/2020
Lease of Workplace Nursery, Ground Floor, Cerrig Llwyd, Ysbyty Bryn Y Neuadd, Llanfairfechan, Conwy by Ty Bryn Ltd.	16/07/2020
Deed of Covenant relating to lease of Ruabon Medical Centre, High Street, Ruabon by MedicX Properties Ltd	16/07/2020
Deed of Assignment; Deed of Covenant; transfer of whole of registered title; Lease of; and underlease by reference to Superior Lease.of Rhoslan Surgery, West End Medical Centre, Conway Road, Colwyn Bay LL29 7LS.	16/07/2020
Lease of Block 5, Carlton Court, St Asaph Business Park, St Asaph, LL17 0JG.	16/07/2020

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Debra Hickman, Secondary Care Nurse Director
Craffu blaenorol: **Prior Scrutiny:**	The designated person has the responsibility of presenting an Annual Assurance report to the Board. Staffing Breaches and Harms are reported quarterly via the Secondary Care Quality and Safety group by each Site Director of Nursing, escalation of significant issues are reported via the corporate Quality Safety Group (QSG). The following summary report has been presented to QSG and to the Quality, Safety & Experience (QSE) Committee on the 3rd July 2020.
Atodiadau **Appendices:**	Appendix 1 - Annual Assurance Report Appendix 2 - Summary of Required Calculated Establishment

Argymhelliad / Recommendation:

The Board is asked to note the report.

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:

In line with the All Wales approach provide assurance to the Health Board with regards to the compliance with the Nurse Staffing Levels (Wales) Act 2016 where by any associated harms are as a result of breaches in nurse staffing establishments and actions taken to mitigate any risk identified.

Cefndir / Background:

The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to provide sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive lead has delegated the operational activity via the Secondary Care Nurse Director for the identified Medical & Surgical Inpatient wards within the Act. As part of the triangulated approach consideration is given to those quality indicators that are particularly sensitive to care provided by a Nurse: Patient falls, Pressure Ulcers, Medication errors and Complaints associated to Nurse staffing and Nursing care as provided in the Assurance report within.

Asesiad / Assessment & Analysis

Strategy Implications

Inability to provide appropriate Nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Boards ability to deliver Health Care effectively.

Financial Implications

Changes to the nurse-staffing establishment's in-line with the triangulated approach as determined within the Act.

Escalation capacity of which is unfunded and therefore does not support the nurse staffing establishment.

Risk Analysis

The governance issues are:

- the current vacancy position and its impact on 25B wards
- the impact of the COVID pandemic and the changes of ward profile to meet the COVID demand
- any instances whereby investigations identify staffing deficits
- due to delay in acuity audits being undertaken as directed by the CNO this may also impact on the presentation to the Board on the recalculation of the nurse staffing levels for 2020.

Legal and Compliance

Nurse staff Calculations are presented annually to the Health Board. Changes to ward establishments outside of the Biannual Calculation are approved by the Executive Director of Nursing.

Impact Assessment

Undertaken as part of the Biannual calculations

	Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act
Health board	Betsi Cadwaladr University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	23rd July 2020
Reporting period **Requirements of Section 25A** Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels **in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.**	6th April 2019 – 5th April 2020 The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to provide sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive lead has delegated the operational activity via the Secondary Care Nurse Director for the identified Medical & Surgical Inpatient wards within the Act with annual reports provided to the designated Committee. In addition to the wards for where Section 25B of the Act applies a series of reviews have also commenced in areas where nursing services are applied/commissioned which include: • Outpatient departments • Admission portals • Critical care / High dependency units • Theatre areas • Procedural units • Day case areas • Rehabilitation areas Although the above areas do not fall directly under the auspice of section 25B, a structured and triangulated approach has been applied to calculate and inform the nurse staffing levels required for each area and to ensure consistency of approach. Consideration of National Guidelines regards Nurse staffing levels for each speciality, specific Nurse sensitive indicators that may be relevant and professional judgment will form the basis of the triangulated approach.

Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards** • **Adult acute <u>surgical</u> inpatient wards** (Ref: paragraph 26-30)	To assure compliance with the Act, a series of activities are undertaken of which include the following: • Nurse rosters are developed to ensure the effective use of Nursing resource utilising electronic systems for efficiency and consistency • Staffing is reviewed on a daily shift by shift basis utilising patient acuity / demand and professional judgment with all mitigations / decisions recorded as per HB Nurse Staffing Policy • A Biannual review of Nurse Staffing - this process combine's acuity and dependency data applying the Welsh Levels of Care as the means of assessment alongside key Nurse Sensitive Indicators and Professional Judgement to determine the required establishment to meet the care needs for the patients in each Acute Adult Medical and Surgical Inpatient ward. • Workforce requirements are reviewed on Annual basis in line with current and future site and Health Board wide strategies or whereby there is a change in ward profile. Training and Education requirements are commissioned in line with both Site and HB wide strategies to develop and secure a nursing workforce that is equipped for both service and patient needs. • Utilisation of workforce profiling data ensures the appropriate level of focus on recruitment and retention including forward planning and maximising resource and opportunities Of which are described in more detail below. The process for determining the Nurse staffing levels at Betsi Cadwaladr University Health Board has three steps: 1. Acuity and dependency data is collected for a full month for all wards falling under the concern of the Act. This data is reviewed and validated via the Senior Nurse teams. 2. Upon completion and publication, this data is utilised as part of a triangulated method at local Ward reviews. The triangulation includes the review of a range of Nurse Sensitive Indicators, Professional Judgement using the Chief Nursing Officers guiding principles. The local review meetings are multi-disciplinary and consider factors such as escalation beds, increases in demand and activity and national focus. 3. A recommendation for the planned staffing establishment for each ward is concluded. The Hospital Nurse Director verifies this with proposed changes being notified to the designated Secondary Care Nurse Director prior to final approval by the Executive Director for Nursing and Midwifery. For audit purposes, each ward completes the designated proforma available within the 'Nurse Staffing levels (Wales) Act 2016' Operational Guidance as evidence. Following the above process, the outcome of the above review was presented to QSE as the designated receiving committee in November 2019, the detailed nurse staffing for each of the designated wards at that time, together with the rationale and the committee received recommendations.

Using the triangulated approach to calculate the nurse staffing level on section 25B wards (Ref: paragraph 31-45)	The Triangulated approach as prescribed in the Nurse Staffing Levels (Wales) Act 2016 is utilised across the HB for the calculation of nurse staffing levels for wards designated in section 25B, this forms part of the HBs Nurse Staffing policy and underpins the work undertaken on a bi-annual basis. The Nurse Staffing policy was audited in 2019, whereby several recommendations were made to strengthen the process of calculation and reporting, all of which have now been addressed and completed.
Informing patients (Ref: paragraph 20-25)	Information whiteboards display the planned safe staffing requirements at the entry of each ward. These are audited as part of the HBs Ward Accreditation process. Patients have access to bilingual Frequently Asked Questions information leaflets, which includes how to raise concerns about the Nurse Staffing Levels.
	Section 25E (2a) Extent to which the nurse staffing levels are maintained
The extent to which the nurse staffing levels have been maintained (Ref: paragraph 13-19)	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and Health Boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all Health Boards/Trusts in Wales have been working, as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis. In lieu of a single ICT solution to enable each organisation to demonstrate the extent to which the Nurse staffing levels across the Health Board have been maintained in areas, which are covered by Section 25B/C of the Act For the 2019/20 Annual report, this Health Board - together with all other Health Boards/Trusts in Wales - is providing narrative to describe the extent to which the Nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. For the 2020/21 reporting period, it is anticipated that this section of the Annual report will contain quantitative data for part of the year at least. This data, once available for every Health Board in Wales, will be presented collectively in a consistent manner. Staffing is reviewed on a daily, shift-by-shift basis by the Senior Nursing teams within each of the Acute Sites, all actions / mitigations are recorded in the electronic rostering system. Whereby any consideration of harm because of staffing breaches, these are reported via the HB's incident reporting system – Datix. As part of the Workforce efficiency streams, ongoing reviews / monitoring have been implemented regards roster and nurse staffing deployment efficiencies, supported by key metrics.

	New opportunities have been further embedded across the Health Board expanding opportunities for home grown Nurse Registrants. A focus on preceptorship programmes for our Newly Qualified staff to aid and support their development and career within the Health Board has received positive feedback. However, we cannot overlook the ongoing challenge regards to Nurse vacancies and the continued efforts regards recruitment and retention.
Process for maintaining the nurse staffing level (Ref: paragraph 13-19)	The process for maintaining safe Nurse staffing levels are supported by a number of elements of which include: • Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to • Roster optimisation – ensuring that all rosters are completed as per policy and that all rosters are constructed correctly to ensure that the correct number of staff are able to be provided • Roster approval process – all nurse rosters are subject to a double approval process monitored by the senior nurse team to ensure safe and effective rosters • Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered to temporary workforce solutions, in advance to provide the best opportunities of not only securing the shift but attracting suitably skilled and regular staff • Streamlined fast track recruitment for internal staff • Centralised recruitment team to support campaigns for Nurse recruitment • Partnership working with local universities to maximise opportunities for recruitment and retention • New Role developments

((Ref: paragraph 43-44)	Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels														
Patient harm incidents (i.e. nurse-sensitive Serious Incidents /Complaints)	**1) Total number of closed serious incidents/complaints during last reporting period**			**2) Total number of closed serious incidents/complaints during current reporting period.**			**3) Total number of serious incidents/complaints not closed and to be reported on/during the next reporting period**			**4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods**			**5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor**		
Hospital acquired pressure damage (grade 3, 4 and unstageable).	YWM 37	YG 31	YGC 16	YWM 22	YG 7	YGC 25	YWM 0	YG 1	YGC 0	YWM Decrease of 15	YG Decrease of 24	YGC Increase of 9	YWM 0	YG 0	YGC 0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	YWM 14	YG 25	YGC 16	YWM 13	YG 18	YGC 10	YWM 0	YG 1	YGC 0	YWM Decrease of 1	YG Decrease of 7	YGC Decrease of 6	YWM 0	YG 0	YGC 0
Medication related never events.	YWM 0	YG 3	YGC 1	YWM 0	YG 0	YGC 0	YWM 0	YG 0	YGC 0	YWM Static	YG Decrease of 3	YGC Decrease of 1	YWM 0	YG 0	YGC 0
Complaints about nursing care	YWM n/a	YG n/a	YGC n/a	YWM 3	YG 0	YGC 2	YWM 0	YG 1	YGC 0	YWM n/a	YG n/a	YGC n/a	YWM 0	YG 0	YGC 0

Section 25E (2c) Actions taken if the nurse staffing level is not maintained	
Actions taken when the nurse staffing level was not maintained	• Participation in collaborative work for hospital acquired pressure ulcers • Launch of revised Ward Sister / Matron audits • Test of change for falls prevention • Daily site incident review meetings • Issues of escalation at daily safety huddle • Development of medicines management framework • Embedding SAFER principles
Conclusion & Recommendations	
	As a Health Board there has been underpinning work to secure and assure plans for safe staffing and compliance with the act to date, of which is ongoing. There is continual development as greater comprehension and information is gained locally and nationally. However, it is also acknowledged that there are further actions that can be undertaken to develop and further assure the process and importantly focus and measure the actual impact of staffing on patient harm. The Board are asked to note and support the following next steps: • Targeted focus of Nurse recruitment including resource to support campaigns both locally and regionally • Exploration of a clinical fellowship programme for nurses • Ongoing analytics regards leavers and ‘what could we do better?’ • Review of implementation of new roles to support the nursing recruitment pipeline • Expansion of harm avoidance collaborative to assist in reducing variation • Development of a nurse performance dashboard as a further monitoring and assurance tool in real time • Further analysis of deviations from previous reporting periods

Appendix: Summary of Required Establishment
Betsi Cadwaladr University Health Board

Health board/trust:	Name: Betsi Cadwalader UHB	
Period reviewed:	Start Date: 1st of April 2019	End Date: 31st of March 2020
Number of wards where section 25B applies:	**Medical:**	**Surgical:**
	Number: YG 7 YGC 8 YWM 9	**Number: YG 4 YGC 5 YWM 4**

To be completed f EVERY wards where section 25B applies

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

YG Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Aran	22.62	14.11	Partially	22.62	14.11	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 2-4-20
Glyder	13.49	8.01	Yes	13.49	8.01	Partially	In part	No	January calculation deferred due to COVID-19	No	No	
Glaslyn	16.82	22.62	Yes	16.82	22.62	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Hebog	24.96	11.42	Yes	24.96	11.42	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Prysor	12.77	8.51	Yes	12.77	8.51	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Moelwyn	22.62	8.51	Partially	22.62	8.51	Partially	In part	No	January calculation deferred due to COVID-19	No	No	

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Tryfan	17.71	8.51	Partially	17.71	8.51	Partially	In part	No	January calculation deferred due to COVID-19	No	No	

YG Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Dulas	21.5	14.78	Yes	21.5	14.78	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 2-4-20
Enlli	12.54	7.3	Partially	12.54	7.3	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward re purposed as a COVID 19 critical care area – step down – CPAP patients. Staff are deployed from critical care and other areas of the site dependant on need 2-4-20 base establishment maintained
Ogwen	16.13	21.5	Partially	16.13	21.5	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 6-4-20
Tegid	26.89	18.82	Yes	26.89	18.82	Partially	In part	No	January calculation deferred due to COVID-19	Yes	No	To enable a shift pattern to meet the needs of the ward and to provide patients and staff with safe mitigation of risk the following is recommended: The permanent change of roster template for Tegid ward to introduce an AP shift Monday to Friday and 5 HCA on a

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
												weekend instead of the 6th trained.

YGC Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 1	18.53	16.01	Yes	18.53	17.93	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	9/4/20 S.25B ward repurposed due to COVID-19 21/5/20 Returned to S.25B ward Uplift in HCSW initiated in 2019 establishment review
Ward 2	18.53	16.01	Yes	18.53	17.93	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	9/4/20 S.25B ward repurposed due to COVID-19 21/5/20 Returned to S.25B ward. Uplift in HCSW initiated in 2019 establishment review
Ward 4	18.53	15.01	Yes	18.53	15.01		In part	No	January calculation deferred due to COVID-19	No	No	
Ward 9	18.53	15.01	Yes	18.53	16.71	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	26/3/20 S.25B ward repurposed due to COVID-19 Uplift in HCSW initiated in 2019 establishment
Ward 11	24.33	13.64	Yes	24.33	16.71	Yes	In part	Yes	January calculation	Yes	Yes	12/3/20 Ward became positive COVID respiratory ward. To include admission area for patients requiring NIV / CPAP.

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
									deferred due to COVID-19			HCSW increased to support COVID acuity.
Ward 12	18.53	15.01	Yes	18.53	17.62	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	14/3/20 S.25B ward repurposed due to COVID-19 Uplift in HCSW initiated in 2019 establishment review.
Ward 14	24.33	10.91	Yes	24.33	14.09	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Ward remains a S.25B adult medical ward. Uplift in HCSW initiated in 2019 establishment review.
Ward 19	18.53	19.88	Yes	18.53	19.88	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	

YGC Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 3	19.81	9.2	Yes	19.81	10.54	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward remains an S.25B Adult Surgical Ward This ward forms part of site COVID escalation plan and has the potential to be escalated to 23 beds. Uplift in HCSW initiated following establishment review March 2020.
Ward 5	24.33	16.49	Yes	24.33	16.49	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	17/4/20 S.25B ward repurposed due to COVID 19 18/5/20 Return S.25B Adult Surgical Ward
Ward 7	24.07	22.92	Yes	24.07	22.92	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Ward 8	18.53	15.01	Yes	18.53	15.01	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	
Ward 6 ABH	23.29	9.43	Yes	23.29	9.43	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	17/3/20 Ward closed as elective orthopaedic service suspended on the YGC site as part of COVID preparation plan. All staff redeployed to YGC adult acute wards and departments.

YWM Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Morris	18.91	13.63	Yes	16.35	18.55	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Based on 21 beds – previously funded at 27 beds.. HCSW dependency increased due to nature of patient cohort. RN reviewed at night in line with CNO for 21 pts. (Budget confirmed 11/05/2020)
Mason	18.91	13.63	Yes	18.91	14.76	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Currently suspected pts COVID-19 ward – based on Erddig Ward template. No changes required due to acuity & dependency of patients. Agreed at establishment review. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Evington	15.18	12.63	Yes	15.18	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Establishment based on 21 beds (Budget confirmed 11/05/2020)
Erddig	24.02	12.4	Yes	24.02	16.09	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Establishment reviewed for COVID-19 high care CPAP area – based on POW template currently. No adjustment needed due to acuity of patients – CPAP/NIV Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Cunliffe	18.91	12.3	Yes	18.91	12.3	Yes	In part	No	January calculation deferred due to COVID-19	No	No	

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Bromfield	10.23	4.92	Yes			Yes	In part	NA	January calculation deferred due to COVID-19	NA	NA	N.B Currently Bromfield not in use as Act Ward due to COVID-19. Staff supporting COVID-19 areas.
Bersham	18.91	8.71	Yes	24.02	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Increase for RN acuity. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
ACU	29.14	7.38	Yes	29.14	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Bonney COVID-19 (Arrivals staff)	22.74	16.4	Yes			Yes	In part	NA	January calculation deferred due to COVID-19	Yes	Yes	Repurposed as COVID-19 to support Women's Services Pathway. Staffing allocated accordingly from Arrivals staff but not fully funded complement for inpatient area 24/7. Supplemented from staffing from other areas.

YWM Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Fleming ward 23 funded	20.69	10.02	Yes	29.43	17.40	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing assessment x 2 in 2019/20 Increase in beds from 23 to 29 funded surgical beds and noted increase in acuity following ward reconfiguration
ENT ward 19 funded	16.01	12.05	Yes	15.21	11.93	Yes	In part	Yes	January calculation deferred due to COVID-19	NA	Yes	Completed assessment of staffing establishment x2 Decrease in HCA as budget covered ENT ward and ENT clinic. Completed assessment of staffing establishment x2
Pantomime ward 29 funded	23.74	18.25	Yes	23.74	21.13	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 Increase in HCA to support activity on night duty for assessment unit

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Prince of Wales ward 21 funded	16.01	12.05	Yes	15.21	11.93	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 decrease in HCA and R/N as staffing reduced at weekend
Prince of Wales ward 27 funded On Pantomime ward template for COVID19			Yes			Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 COVID Ward and increase from 21 to 27 beds (6 extra beds no funding but staff levels added) Currently elective orthopaedic ward closed but staff have moved to Pantomime ward template to cover a COVID 19 ward and therefore staffing for this ward does not normally reflect the funded 21 bed for POW. Gaps in the day having to be covered from other clinical areas from medicine and surgery. Decrease in HCA and R/N as staffing reduced at weekend.

Cyfarfod a dyddiad: Meeting and date:	Health Board 23rd July 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	North Wales Test, Trace and Protect (TTP) Programme
Cyfarwyddwr Cyfrifol: Responsible Director:	Miss Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Miss Teresa Owen, Executive Director of Public Health
Craffu blaenorol: Prior Scrutiny:	Board Members have received regular updates on the TTP programme in recent weeks. This paper has been written specifically for the Health Board meeting (public session) on 23.7.20
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Board is asked to:
1. Reflect on the TTP arrangements across the region
2. To note the update and the formal reporting route through the Strategy, Partnerships & Population Health Committee.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	**X**	**Ar gyfer sicrwydd For Assurance**	**X**	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

This paper provides an update to the Board on the TTP programme in North Wales.

Cefndir / Background:

Test, Trace, Protect is the Welsh Government's (WG) approach to testing and contact tracing to help us live with Covid-19 (coronavirus) whilst work continues to find more effective treatments and a vaccine. The strategy aims to enable citizens and businesses of Wales to resume normal activity gradually and safely.

The strategy is in the interests of protecting people's health, and currently works by:

1. **Testing** people with coronavirus symptoms, asking them to isolate from wider family, friends and their community whist waiting for a result.
2. **Tracing** people who have been in close contact with anyone who tests positive, requiring them to take precautions through self-isolation for 14 days.

3. **Protecting** the vulnerable or those at risk from the virus, providing advice, guidance and support, particularly if they develop symptoms or have been identified as a contact through the contact tracing process.

The North Wales TTP programme is a multiagency partnership activity, with BCUHB as the lead agency driving the programme forward. The programme commenced operational delivery on the 1 June 2020.

From a governance perspective, and given the clinical elements of the programme, the main reporting route for the programme is through the SPPH Committee of the Board who will receive updates on the programme and activity. The Recovery Coordination Group (RCG) will receive regular updates on the activity.

From a Welsh Government perspective, a new Chief Operations Officer, Mr Jeremy Griffiths has been brought in to support the TTP programme delivery across Wales.

Asesiad / Assessment & Analysis

The following section provides a high level description of work underway in each of the TTP areas – Test, Trace and Protect.

TESTING

Covid19 testing is not new work for BCUHB, and Board members have received updates previously. However – testing now forms part of the TTP programme, and as such updates will be provided to the Board as part of the programme overview.

A new WG Testing Plan for Wales is expected to be published during the week commencing the 13 July 2020. This plan will include detail on both antigen and antibody testing. In the meantime, the HB continues to test significant numbers of people everyday.

Antigen *(This tests if someone with symptoms has Covid-19. This type of test is now in widespread use in Wales. It plays an important role in supporting contact tracing and managing the spread of the virus)*

- Four Coronavirus Testing Units (CTUs) are currently operational in North Wales. These sites are staffed by the Health Board and the samples from these sites go to Ysbyty Glan Clwyd (YGC) and South Wales laboratories for processing.
- Two mass testing units (utilizing the UK Gov model) are in place across the region. The Deeside site was the first to utilise the full UK Gov approach, and Llandudno has now transferred to the UK Gov model too. This means that they are staffed through the UK Gov approach and the samples are processed through the Lighthouse Laboratory in Manchester.
- Home testing kits are also available for the public to use.
- The weekly data reports on testing across the Health Board is shared with Board members on a weekly basis. This information is also shared with the North Wales Strategic Co-ordinating Group (SCG)
- We await the dashboard of regular data on volumes and Turn Around Times (TAT), and a prototype has been developed. Discussions have commenced on a national standard for the TAT element of testing.

- The BCUHB team are working hard to understand the end to end process for the home testing kit approach, given some reporting issues as new IT equipment is installed to support the national electronic request portal.
- Care home testing continues – as per WG requirements.
- A reporting cell has been established to support the issuing of results when the normal mobile text results approach fails.
- The current laboratory capacity in the North Wales laboratories is still 800 tests a day. Public Health Wales (PHW) were looking to temporarily place the Gwent Machine (Starlet) in North Wales but this is now going to its original site in South Wales. Another machine (Nimbus) was installed on the 13 June at Bangor and this will increase capacity by 288 / day once verified and fully operational. PHW expect a second machine (Nimbus) to arrive in about two weeks' time (based on current company advice) in Wrexham which will offer the same daily capacity.

Antibody (*This tests to see if someone has previously had the virus. The test works by taking a blood sample and testing for the presence of antibodies to see if you have developed some immunity to the virus. Antibodies are produced by the body in response to an infection (immune response). They can usually be found in the blood around 2 weeks after a recent infection*).

Mr Adrian Thomas is leading this work for the Health Board. On Monday the 15th June, antibody testing for NHS staff and key workers started in BCU as part of a national programme. Three dedicated phlebotomy units opened in North Wales at Ysbyty Gwynedd, Ysbyty Enfys, Llandudno and Ysbyty Maelor, Wrexham.

Priority of testing is set following national guidance from the Welsh Government. Initially, tests were offered to some teaching staff from all six North Wales Local Authorities, as part of the preparations to reopen schools. The Health Board worked with Local Authority (LA) partners to organise this testing. There has also been some availability for BCU staff to be tested. This testing is being organised locally using guidance from the National Antibody Testing Group and Occupational Health.

As at the 9th July, the total number of antibody tests undertaken in BCUHB was 3641. Of the 3641 tests, 254 were positive (7%).

CONTACT TRACING

Since the 1 June 2020 contact tracing is being undertaken across the region.

Most of the contact tracing occurs at the local tier – with teams established by the Local Authorities. The work is undertaken by redeployed staff to support the service. The work is undertaken 7 days a week.

The more complex cases are dealt with by the regional tier (regional cell) This team is based in Preswylfa, and is also operational seven days a week. The regional cell continues to be much busier than anticipated in the model developed by PHW and WG.

When the service commenced, the national IT system was not available for use, and the region developed its own system to support the programme of work. This product development was kindly led by Gwynedd LA.

From the 15th June, a national IT system was in place, and the North Wales teams agreed to utilize the new system – the CRM. The information below illustrates the volumes of cases being dealt with by the teams across the region. (*The information is presented differently given the IT systems in place*).

- Between the 1-14 June, 661 index cases were reported to the region.
- From the 15/6/20 to the 30/6/20, 703 index cases were reported to the region, of which 502 were eligible for follow up. This generated 899 contacts, and 841 contacts eligible for follow up.

Numbers of confirmed cases have reduced in recent weeks. The index case activity for the week commencing 6/7/2020 is as follows:

	06/07/2020	07/07/2020	08/07/2020	09/07/2020	10/07/2020	11/07/2020	12/07/2020
Wrexham	7	16	5	10	0	7	2
Flintshire	0	4	11	0	0	10	0
Gwynedd	0	1	2	0	0	8	0
Anglesey	2	0	0	0	0	4	3
Denbighshire	0	0	0	0	0	0	1
Conwy	2	0	0	0	1	0	1
TOTAL	**11**	**21**	**18**	**10**	**1**	**29**	**7**

Fuller information will be presented to the Strategy, Partnerships & Population Health (SPPH) Committee.

The funding letter for Contact Tracing from WG has been received. WG have confirmed that Ministers have allocated funding of up to £11.2M, to the 31 March 2021, to cover the forecast additional cost of the operation in the region. Work is now needed to understand the split of funding (local tier vs regional tier) and the models of each Local Authority and the Regional cell.

It has been agreed by the 6 LAs, that Flintshire LA will act as the lead employer for the contact tracers and contact adviser services at Local Authority level (Local Tier)

From a data sharing perspective, an in-principle agreement has been reached by all North Wales LAs with PHW that that all LAs will be joint controllers. An interim agreement stands until this is fully resolved.

Discussions are also underway to ensure that there is clarity on the interface between the regional tier (BCU led) and the national tier (PHW led).

PROTECT

There are many PROTECT type activities underway across North Wales already. The focus is on optimising the work underway and ensuring support is in place to support individuals as necessary. A regional mini workshop is being designed to ensure we build on the assets in place across partners. A date is being agreed as this paper is being finalised.

PROGRAMME MANAGEMENT

In terms of the programme management, a regional planning group has been established to support the TTP arrangements, and this is underpinned by seven key workstreams of activity.

The focus of this next period is to ensure the testing work, the contact tracing work, and 'Protect' work come into one overall programme. As the set up elements are now well underway, the team plan to move towards a regional oversight model, under the leadership of the Executive Director of Public Health. The TTP programme will report into the SPPH committee, and updates will be shared with the RCG too.

Testing – The main risks are:

- Business as usual elements are a concern, as staff are currently redeployed to support the sites in North Wales. Programme of recruitment underway.
- BCUHB is working with PHW Lab colleagues in YGC given some concerns regarding long delays and testing out of turn underway.
- The Turn Around Time dashboard is awaited, but due to be shared this week.
- The financial costs of the testing work are being collated in readiness for WG discussions.

Contact Tracing – The main risks (as noted on the 13 July) are noted below (as per workstream updates):

Workstream	RAG RATING
Technology	RED: An upgrade was undertaken on the CRM on the 13 June. This should resolve the exposure date and SMS issues. With these issues resolved, the CRM will progress to GREEN.
Data and reporting	RED: The Data Sharing Agreement is progressing. The finer detail is in discussion.
Communications and Public Engagement	RED: Concern about the breadth and penetration of the TTP comms and engagement. Particularly as Wales opens to tourists.
Finance	GREEN: Funding envelope has been agreed.

Workstream	RAG RATING
Regional cell	AMBER: Recruiting to support significant workload ongoing. Need to build resilience for summer period and in preparation for winter.
Workforce	AMBER: The recruitment programme is in progress. Urgency to build stable workforce.
Structure and Governance	AMBER: Data Sharing Agreement and MoU have not been signed. Governance of programme needs to be observed.

Protect – None identified at this stage.

INCIDENTS/ OUTBREAKS

The TTP programme in North Wales has helped identify two significant outbreaks in North Wales. Outbreak control meetings are still being held by PHW for the two sizeable Covid 19 outbreaks in the region:

1. Anglesey – An outbreak at the Two Sisters Food Group, Llangefni. (Poultry Processing Plant).
2. Wrexham – An outbreak associated with Rowan Foods, Wrexham.

The Outbreak Control Team (OCT) Communications activity is being led by PHW (as per national OCT policy).

The NW SCG is using its communications/media cell to support the wider messaging required – which goes beyond the OCT remit.

Cyfarfod a dyddiad: Meeting and date:	Health Board 23.07.2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quarter One Plan Monitoring Report (QOPMR)
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Dr Jill Newman, Director of Performance
Craffu blaenorol: Prior Scrutiny:	This paper has been scrutinised and approved by the Executive Team and the Executive Director of Planning and Performance.
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Health Board is asked to note the report.

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**	✓

Sefyllfa / Situation:

This report provides a self-assessment by the executive leads of the progress being made in delivering the key actions contained in the 2020/21 Operational Plan for Quarter 1.

Cefndir / Background:

The operational plan has a number of key actions required to be delivered during Quarter 1 of 2020/21. The Executive lead reviews on a monthly basis progress against their areas for action and RAG-rates progress. Where an action is complete this is RAG rated purple, where on course to deliver within agreed timeframe the rating is green. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery is no longer likely to be achieved. For Red rated actions a short narrative is provided.

Asesiad / Assessment & Analysis

Strategy Implications

Delivery of the operational plan actions is key to implementation of the Boards strategy

Options considered

Not Applicable

Financial Implications

Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources.

Risk Analysis

The RAG-rating reflects the risk to delivery of key actions

Legal and Compliance

This is the final iteration of the Quarter One Plan Monitoring Report as it will be replaced by the Quarter Two Plan Monitoring Report from July 2020.

Impact Assessment

The operational plan has been Equality Impact Assessed.

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

Cyfarwyddiaeth Cynllunio & Perfformiad
Planning & Performance Directorate

BCU Quarter One Plan Monitoring Report

June 2020

Overview and Purpose of this Report

- The Quarter 1 Plan of the Health Board has been agreed in Cabinet and submitted to Welsh Government
- The Plan is produced under Command and Control in relation to the Covid-19 Pandemic and recognises that the disruptive nature of the pandemic has shortened planning horizons, resulting in plans being time limited to quarterly plans for 2020-21
- The Quarter 1 plan relates to the mobilisation phase of Covid-19 response, need to maintain essential non Covid-19 services to minimise risk of harm for life-saving or life-impacting treatments.
- This report is a self-assessment by the SROs for each of the work streams of likelihood to deliver the actions set out in the plan by the 30.6.20. with supporting narrative where the risk to delivery is red rated i.e. highly unlikely to be achieved. This report provides an update from each SRO for the end of May 2020 actual position.
- Work is underway in developing the Q2 plan which will also reflect the shift in phasing of response to the pandemic from mobilisation towards parallel running of the pandemic and re-activation of some business as usual activities where it is safe to do so. This will reflect transition to sustainable service delivery phase of the plan. In the Q2 plan actions incomplete at the end of Q4 2019/20 will be included with revised timescales to deliver, where these actions are still relevant for delivery in 2020/21.

RAG	Every month end	By end of Quarter	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points explaining why and what is being done to get back on track
Amber	Some risks being managed	N/A	Where RAG is Amber: No additional Information required
Green	On track, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

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Chapter 1 Planning Work-stream Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: SRO Planning Workstream *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP1.1	MW	Continue to monitor current and future COVID-19 demand, its impact on capacity and the implications for other services;	G	G	P
QOP1.2	MW	Consider the options for deploying surge capacity and make recommendations as to scope and timing of deployment;	G	G	P
QOP1.3	MW	Monitor the impact of changes within our services upon key performance measures e.g. screening programmes, cancer standards, access to primary and secondary care etc. and review service delivery recommendations accordingly;	G	G	P
QOP1.4	MW	Monitor the quality and safety impacts of services and associated risks, and recommend changes to Executives as required;	A	A	P
QOP1.5	MW	Maintain a dynamic organisational service delivery, activity and performance plan for the Health Board;	A	A	P
QOP1.6	GH	Capture and collate pathway changes and new ways of working to ensure these are optimised – Deputy Chief Executive	G	G	P

Chapter 2 Covid-19 Response Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: COVID 19 Gold Commander *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP2.1	MW	Continue to revisit planning assumptions on a regular basis as further information and analysis becomes available. Version 2.5 of the model, which is more optimistic, is currently being evaluated.	A	G	P
QOP2.2	MW	Undertake further specific work on demand and provision of patient ventilation, where demand across Wales appears to be much lower than the current models predict, and on projecting demand on a health community basis.	G	G	P
QOP2.3	MW	Prioritise analytical support to include health and care to guide short term decision making. Work with local partners and other Health Boards to share modelling approaches to inform demand for health and care.	A	A	P

Chapter 3 Covid-19 Test, Track & Protect (TTP) Key Actions: 18th May to 30th June 2020

Ref	Lead	SRO: Director of Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP3.1	TO	Scale up testing. Implement testing requirements from Welsh Government as these develop e.g. care home staff and residents	G	G	P
QOP3.2	TO	Establish a dedicated work stream to urgently support and deliver locally the national Public Health Protection Response Plan e.g. Preventing the spread of disease: Test, Trace and Protect (A large non-specialist workforce will be required to deliver.)	A	G	P
QOP3.3	PHW	North Wales testing laboratory facility operational	G	G	Not Applicable

Chapter 4 Primary and Community Care Operational Delivery Key Actions: 18th May to 30th June 2020 *(Page 1 of 2)*

Ref	Lead	Lead: SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating –likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP4.1	CS	Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.	G	G	P
QOP4.2	CS	Review the role and number the Local Assessment Centres (LACs) as part of a longer term plan to care for COVID patients.	G	G	P
QOP4.3	CS	Work with partners to stratify and proactively contact high-risk patients with ongoing care needs; proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to COVID19, with a focus on Chronic Conditions Management , new pathways and managing demand changes for non COVID patients.	G	G	P
QOP4.4	CS	Review of OOH staffing risks and mitigation and development of future OOH plans, working more closely with in hours provision	A	A	A
QOP4.5	CS	Continue to deliver a community based stroke rehabilitation services whilst planning for the reintroduction of sustainable stroke services	R	A	A
QOP4.6	CS	Increase acute paediatric OPD activity remotely and with reintroducing face to face appointments particularly for new referrals, Reach agreement with tertiary care re outreach specialist clinics and restarting Increase advice and support for professionals (GPs)	A	G	P
QOP4.7	GH	All key areas of Eye Care are being reviewed to include cataract stratification, glaucoma refinement and ongoing care. The review also considers diabetic and other medical retina conditions such as age related macula degeneration (WMD).	A	A	P

Chapter 4 Primary and Community Care Operational Delivery Key Actions: 18th May to 30th June 2020 *(Page 2 of 2)*

Ref	Lead	Lead: SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP4.8	CS	Further improve access to End of Life Medication to ensure these critical medicines are accessible across North Wales	G	G	P
QOP4.9	CS	Work with secondary care colleagues to implement the 'Consultant Connect' specialist advice service; ensure cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate.	G	G	P
QOP4.10	CS	Support care homes, including the implementation of the revised discharge policy and with a review of current service provision, sharing of good practice e.g. virtual ward rounds	A	G	P
QOP4.11	CS	Provide local support to NHS communications campaigns encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.	G	G	P
QOP4.12	CS	Further develop escalation reporting for Community Pharmacies	G	A	P
QOP4.13	CS	Feed into medical staff planning for field & community hospitals, ensuring that medical workforce plans are aligned to agreed GP roles in hospitals, Local Assessment Centres, out of hours services and general practice demand	A	A	A
QOP4.14	CS	All approved plans to establish community hospital additional surge bed space will be complete in order that the Hospitals are responsive to changes in volumes of COVID patients and flexible to increasing non-COVID activity as capacity allows.	G	G	P

Chapter 5 Operational Acute Care Delivery Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: SRO Operations Acute *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP5.1	GH	Ensure our consent process informs patients of risk during their admission (East are piloting this using revised documentation) Any patient showing signs and symptoms for COVID would be not be offered surgery	G	G	P
QOP5.2	GH	Development of pathways for urgent pre-operative assessment and diagnostics which are at the early stages of development.	G	G	P

Chapter 6 Covid-19 Surge Plan Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: SRO Operations Acute & SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP6.1	GH	Develop early warning/trigger systems E.g. R value, 111, primary care, WAST, local authorities	G	A	A
QOP6.2	GH	West, Centre and East will develop plans to demonstrate how a split COVID hospital could work operationally	A	A	P
QOP6.3	GH	Complete assessment of Llandudno infrastructure to support elective surgery.	A	G	P
QOP6.4	GH	Abergele site plan prepared. We will make a decision on use of Llandudno and Abergele as these sites could be considered for both COVID and non-COVID demand. This would require decisions being made about current patients on the Llandudno site and Colwyn Bay to accommodate existing patients.	A	R	A
QOP6.5	GH	In the absence of face-to-face visits, work together to stratify and proactively contact high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.	A	A	A
QOP6.6	GH	We will explore cold sites or external providers to support with planned care activity. A pilot has commenced at Wrexham Maelor for additional theatre capacity to test the model from 27/04/2020	A	G	P
QOP6.7	GH	We will consider development of a single site “Hub and Spoke” model for surgery	A	G	P
QOP6.8	GH	Triggers to be determined for opening any additional capacity in line with demand to be approved through command structure (on receipt of new modelling)	A	A	P
QOP6.9	GH	Spire contract will cease 5th July 2020 with action required to provide notice by 5th June 2020 regarding any future plans or requirements)	G	G	P

Chapter 7 Workforce Plan Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: SRO Workforce *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP7.1	SG	Ensure working conditions are safe for our staff including provision of PPE equipment and ensuring appropriate rest and working patterns for staff	A	A	A
QOP7.2	SG	Continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area.	A	A	A
QOP7.3	SG	Ensure that appropriate testing systems for staff are in place as determined by the Testing Strategy	A	A	A
QOP7.4	SG	Implement Black, Asian and minority ethnic (BAME) guidance	A	A	A
QOP7.5	SG	Ensure that workforce planning is integral to our revised clinical pathways and plans to re-introduce essential and routine services.	A	A	A
QOP7.6	SG	Co-ordinate appropriate re-deployment and training and utilising key transferable skills	G	G	P
QOP7.7	SG	Provide on-going recruitment to our substantive structures	G	G	P
QOP7.8	SG	Co-ordinate of support from our volunteer workforce	G	G	P
QOP7.9	SG	Provide wellbeing and psychological support	G	G	P
QOP7.10	SG	Monitor sickness levels and reasons	G	G	P

All the Actions in this chapter are either ongoing or due for completion in Quarter 2

Chapter 8 Maintaining Essential Services Key Actions: 18th May to 30th June 2020

Ref	Lead	Lead: Director of Nursing and Midwifery *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020	Position at the End of June 2020
QOP8.1	GH	Review harm, prioritise and risk stratify waiting lists.	A	A	A
QOP8.2	GH	Specialty plans developed in line with essential services framework and other key guidelines	A	A	P
QOP8.3	GH	Continue to implement alternative pathways including use of e- consultation and patient initiated outpatient follow up (e.g. resulted in 30% reduction in Orthopaedic outpatient demand)	G	G	P
QOP8.4	GH	Maintain provision of essential services where it is safe to do so, delivered through our re-defined care pathways and making use of all available capacity within NHS and independent hospitals.	G	G	P

QOP8.1 - Stage 4 risk stratification is almost complete for the key at risk services identified through option 5, further specialties will then follow

Further Information

Further information is available from the office of 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.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quality and Performance Report (QaP)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director Of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Dr Jill Newman, Director of Performance Mr Edward Williams, Head of Performance Assurance
Craffu blaenorol: **Prior Scrutiny:**	This report is constructed from the QaP reports scrutinised by the Finance and Performance and the Quality Experience and Safety Committees of the Board
Atodiadau **Appendices:**	1. QaP report for July 2020

Argymhelliad / Recommendation:

The Board are asked to
1. Note the revised format for this report.
2. Note that performance management is formally stood down during Covid-19 and therefore the information provided is management information that has been scrutinised via the Finance & Performance and Quality, Safety & Experience Committees of the Board.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	**x**	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:

This report reflects the key management information in relation to the Welsh National Delivery Framework measures, the Covid-19 pandemic and the maintenance of essential services

Cefndir / Background:

Nationally performance reporting and performance management arrangements have been stood down to enable organisations to focus on addressing Covid-19. The Essential Services Framework is in place with guidance for each service to ensure risk of harm is minimised for patients who have non-covid life threatening and life limiting conditions. The new National Delivery Framework has been issued to Healthboard and measures within these require internal management.

Asesiad / Assessment & Analysis
Strategy Implications The Quality and Performance report will continue to report against national strategic performance measures and align to the delivery of the quarterly operational plans developed during Covid-19. Delivery of improved performance in relation to key performance indicators is the subject of Special Measures and is strategically important in demonstrating improvement in service process and outputs and ultimately outcomes for our patients. **Financial Implications** The financial aspects of operational delivery are reported within the finance papers, however they are integral to delivery of the actions within the operational plan. The alignment of resources to support delivery of performance measures is recognised. **Risk Analysis** The balance of risk is important in managing Covid-19 and non-covid Essential Services to reduce the risk of harm to patients. As we move to re-starting services for planned care the risk stratification of care and equity of access to available capacity is an important element in managing risk.

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

Quality & Performance Report







Health Board

July 2020

Put patients first • Work together • Value and respect each other • Learn and innovate • Communicate openly and honestly

About this Report

Covid-19 Pandemic

It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance. It is also important to note that national reporting and performance management arrangements have been suspended at this time. In order to release staff time to manage the mobilisation of the pandemic response normal validation and sign off processes have been reduced, so caution needs to be applied to data quality presented in the report.

This report is the first presentation to the Health Board of the proposed Quality & Performance (QaP) Report, replacing the Integrated Quality and Performance Report (IQPR) used in 2019-20.

The format of the report reflects the published National Delivery Framework for 2020-21 which aligns to the Quadruple aims contained within the statutory framework of A Healthier Wales. Sections are added to reflect Covid-19 key performance indicators and the work on maintaining essential services.

The 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.

The operational planning for 2020-21 has been impacted by the pandemic with planning cycles re-defined into quarterly plans. The Quarter 1 operational plan was submitted to Welsh Government on 18th May. The progress against the actions contained within the operational plan are reported in the accompanying Q1 Operational Plan monitoring report..

As a consequence of the changes in the planning cycle for 2020-21 and the uncertainty around the future levels of Covid-19 the ability to produce month on month profiles to monitor performance against is severely limited. Therefore the report contains factual information on performance indicators.

Where monthly data is provided this is submitted as of 31st May 2020 position. This data has been scrutinised by the relevant Committee of the Board. Information relating to subsequent months will be reviewed at the next meeting of these Board Committees and reflected in future board reports. Where data is not reported monthly the information in this report relates to the latest available information that has been scrutinised by a committee of the Board.

The direction of travel of performance is indicated through trend arrows (*shown below*)

- ⬆ Performance has improved since last reported
- ⬇ Performance as got worse since last reported
- ➡ Performance remains the same as last reported

The performance has not been RAG (Red, Amber, Green) rated against the National Target as national performance management arrangements have been stood down.

The intention for future reports is to continue to align the reporting of Covid-19 related pandemic indicators with the essential services service status and the National Delivery Framework while developing the reporting against the actions in the quarterly operational plans.

Headlines

Test Trace and Protect

Maintain Essential Service Provision

Clinically Prioritised pathways of care

Key Messages

Performance arrangements have been adapted during the Pandemic

Covid-19 management and monitoring remains a high prioirity

Delivery of Essential Services to minimise risk of harm

Executive Summary

May 2020 continued to be challenging for all being the second full month in lockdown to slow down the spread of Covid-19.All services have been impacted by the Covid-19 Pandemic. Continuous monitoring and management of performance remains important; it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Covid-19

Unfortunately, there have been deaths confirmed as Covid-19.

Increased capacity for testing in the BCU area established. The Test, Trace and Protect work stream is in place and will continue to be implemented in the coming weeks to assist in controlling the rate of transmission.

As at 21st June 2020, **28,500** people were tested for Covid-19 in North Wales, **3,365** of which tested positive and **25,135** tested negative.

Essential Services

The third assessment of services ability to deliver care for patients with life-threatening of limiting conditions has taken place. This has identified that the majority of services are compliance with guidelines. However risks to patients are increasing due to potential late referrals, delays for diagnostic services and the extended period since the commencement of the pandemic. Referral rates are starting to increase but remain lower than the pre Covid mean.

The Essential Services framework has been updated in June 2020, taking account of the enduring nature of the impact of the pandemic on provision of care for patients and longer term population health.

Quadruple Aim One: Prevention and Self-Management

Due to the Covid-19 Pandemic, a number of screening programmes run by Public Health Wales were stopped in March 2020. Bowel and Breast Screening are planned to recommence in July 2020. Performance information on Bowel Screening in North Wales will be provided in this report under Quadruple Aim 1.

Quadruple Aim 2: Accessible Digitally Supported Services.

Unscheduled Care

Although they remain low, attendances to our Emergency Departments have begun to increase.**11,525** attendances in May 2020 compared to **21,087** in May 2019 and an average of **19,875** attendances per month over the last 2 years. Performance on the unscheduled care indicators is significantly improved compared to pre-Covid-19 performance. Emergency admissions are increasing and combined with care home safe discharge policies are contributing to increasing bed occupancy.

Planned Care

Planned care services are adapting to deliver virtual support through the use of technology for outpatients. Services where face to face contact is required are completing the re-set safety checklist with a view to recommencement of risk stratified services in July. Only essential surgery is being undertaken at the present time. Surgical capacity is severely reduced to manage the risk to staff and patients. This does mean that waits for routine treatments has significantly increased. Options for re-setting surgical provision are under-development with a view to moving from essential services (priority 1 and 2) to priority 3 patients during the quarter.

Quadruple Aim 3: Workforce

Covid-19 has impacted on staff absences rates due to need to self-isolate or positive test results. Staff have responded rapidly with changes in working patterns and location of work to meet the immediate Covid-19 response. Support for staff well-being is available via occupational health.

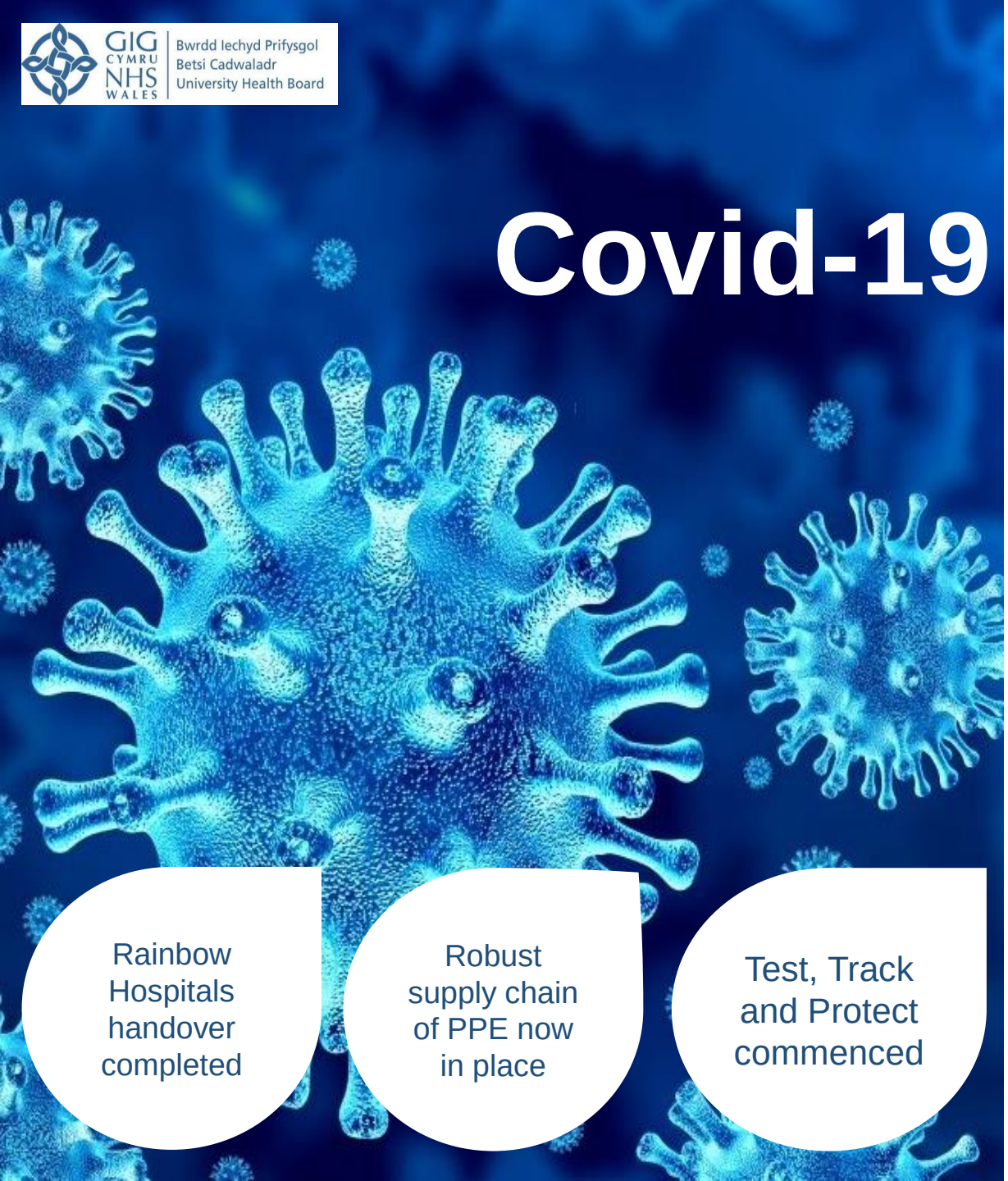
Quadruple Aim 4: Value-based, outcome focussed healthcare

Due to impact of Covid-19 additional resources have been required to support mobilisation. These will be reported within the Finance papers

Dental Care – This measure will normally be reported under Quadruple Aim 4 in line with the National Delivery Framework

Due to impact of Covid-19 Pandemic and the measures put in place to prevent the spread of the virus, all routine dental services have been suspended however, patients can access dedicated urgent dental care services established in North Wales

Covid-19



Rainbow Hospitals handover completed

Robust supply chain of PPE now in place

Test, Track and Protect commenced

Key Messages

Covid-19 has impacted on overall service provision

Testing for Covid-19 is continually being increased

Modelling suggests the Covid-19 incidence will continue for some time

Measure	at 25th June 2020
Total number of tests for Covid-19	**30,538**
Number of results: Positive/suspected	**3,515**
Number of results: Negative	**27,023**
% Prevelance of Positive Tests	**11.5%**
Number of Deaths - Confirmed Covid-19	**350**

Source: Public Health Wales coronavirus Dashboard, accessed 26th June 2020

Essential Services

Key clinical pathways reviewed and Implemented

Definitions of “Essential Services” Published

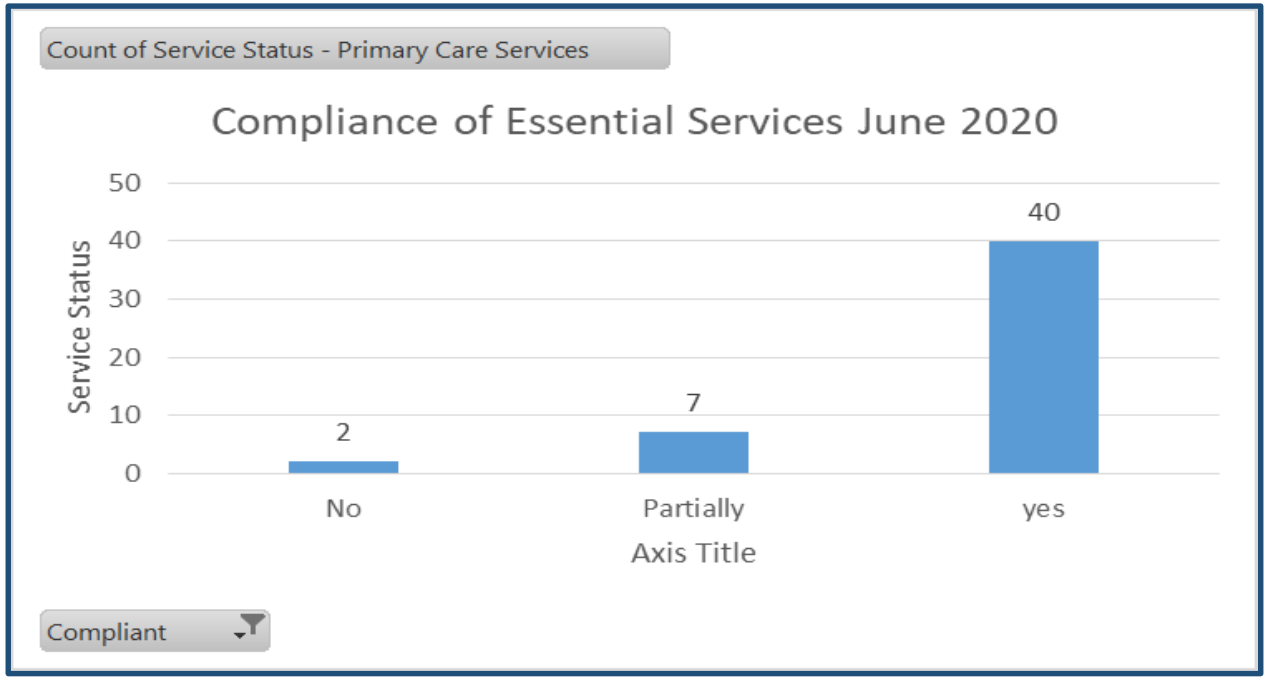
Developing plans for future provision of Planned Care

Key Messages

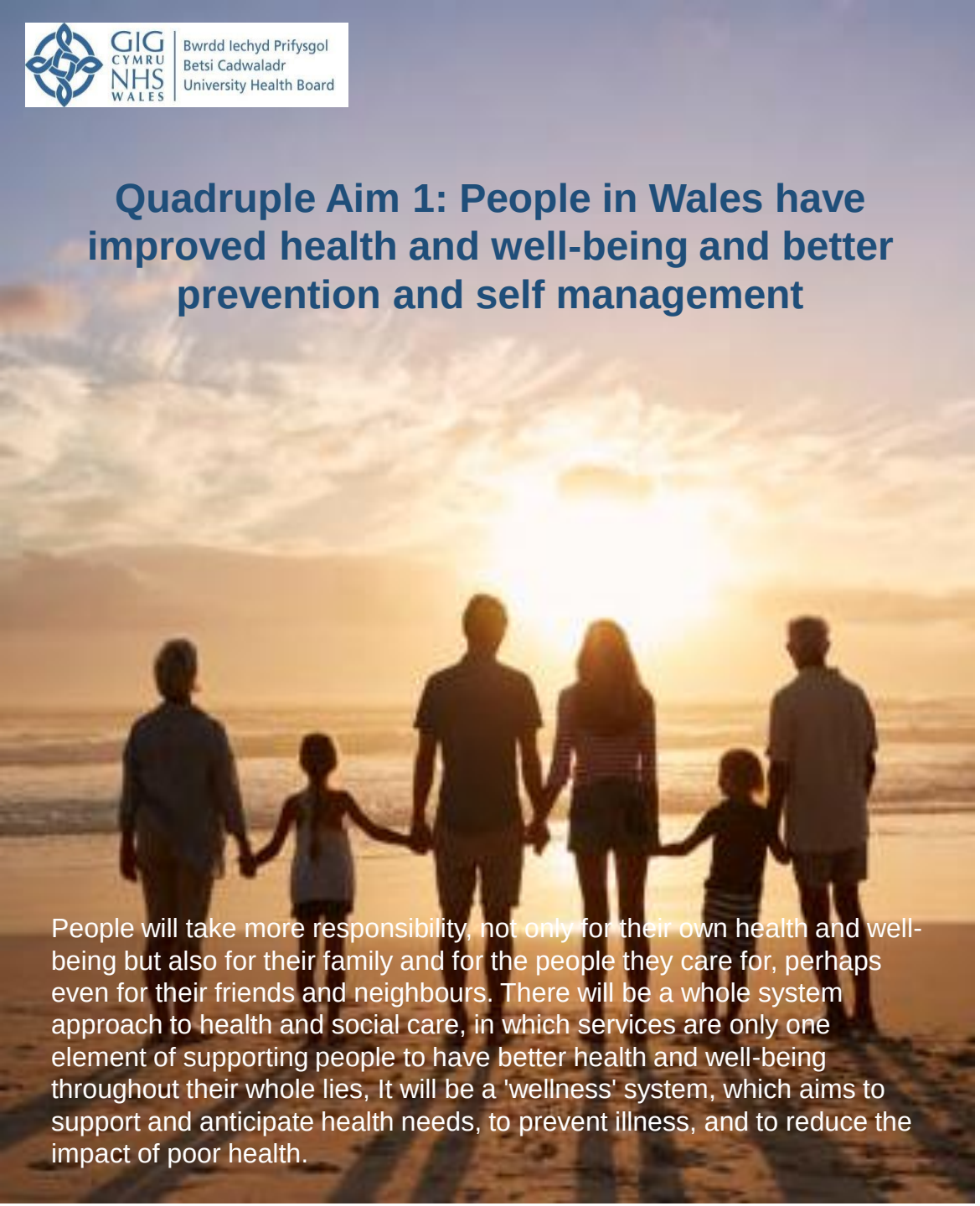
Essential Services are those elements of service required to mitigate harm of life-threatening or life-changing conditions that must be maintained throughout Covid-19

3 internal and 1 commissioned service reviews completed

Increasing pressure expected on these services in future months



Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self management



People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lies, It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Key Messages

- Screening services suspended under Covid-19 are to restart from July 2020
- Cover report for Childhood vaccinations at March 2020 showed good levels of take-up of programmes
- Extended crisis support provided for families and young people during lock-down

Measures

Committee	Frequency	Measure	Target	Actual	Trend
QSE	Quarterly	3 doses of the hexavalent '6 in 1' vaccine by age 1	**>= 95%**	96.70%	↑
QSE	Quarterly	2 doses of the MMR vaccine by age 5	**>= 95%**	94.80%	↑
QSE	Monthly	Care and treatment plan (aged under 18 years)	**90%**	90.40%	↑
QSE	Monthly	Care and treatment plan (aged 18 years and over)	**90%**	89.02%	↓
F&P	Monthly	Bowel Screening			
F&P	Monthly	Cervical Screening			
F&P	Monthly	Breast Screening			

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

There will be an equitable system which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.

Consultant Connect advice service implemented

Mental Health Access being re-established

Emergency Optometry and Dental Hubs established

Key Messages

- Primary Care digital access and virtual consultations established
- Delayed Transfers of care significantly reduced
- New discharge pathways implemented and monitored as to impact on future bed capacity

Top 5 Measures (based on movement up or down)

Measure	Target	Actual	Trend
Emergency Department 4 Hours	>75%	88.95%	↓
Emergency Department 12 Hours	0	72	↓
Ophthalmology R1	>= 95%	46.60%	↓
Diagnostics Waits: 8 Weeks	0	12,032	↓
RTT: 36 Weeks	0	19,913	↓

Quadruple Aim 2: Measures

Committee	Frequency	Measure	Target	Actual	Trend
QSE	Monthly	Cumulative rate of E-Coli cases per 100,000 population	TBC	52.26	↑
QSE	Monthly	Cumulative number of E-Coli cases	TBC	61	↑
QSE	Monthly	Cumulative rate of S.Aureus cases per 100,000 population	TBC	16.28	↑
QSE	Monthly	Cumulative number of S.Aureus cases	TBC	19	↑
QSE	Monthly	Cumulative rate of MRSA cases per 100,000 population	TBC	1.71	↑
QSE	Monthly	Cumulative numberof MRSA cases	TBC	2	↑
QSE	Monthly	Cumulative number of MSSA cases	TBC	17	↑
QSE	Monthly	Cumulative number of Klebsiela cases	TBC	15	↑
QSE	Monthly	Cumulative number of Aeruginsoa cases	TBC	8	↑

Committee	Frequency	Measure	Target	Actual	Trend
QSE	Monthly	Percentage of mental health (Adult) assessments undertaken within 28 days	>= 80%	84.91%	↑
QSE	Monthly	Percentage of therapeutic interventions (Adult) within 28 days	>= 80%	85.11%	↑
QSE	Monthly	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	26.49%	↓
QSE	Monthly	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	30.95%	↑
QSE	Monthly	Total Number of health board delayed transfer of care	Reduction	20	↑
QSE	Monthly	Total Number of health board delayed transfer of care bed days	Reduction	1,046	↑

Quadruple Aim 2: Measures

Unscheduled Care

Committee	Frequency	Measure	Target	Actual	Trend
F&P	Monthly	Children regularly accessing NHS Primary Dental Care		*Not available	N/A
F&P	Monthly	Out of Hours 1Hr Assessment	100%	**None	N/A
F&P	Monthly	Ambulance Cat A 8 Minutes	>= 65%	69.53%	↓
F&P	Monthly	Ambulance Handovers 1 Hour Breaches	0	30	↑
F&P	Monthly	Emergency Department 4 Hours (Includes Minor Injuries Units (MIU)	>75%	88.95%	↓
F&P	Monthly	Emergency Department 12 Hours	0	72	↓
F&P	Monthly	Hip Fracture Survival 30 Days	>= 80%	88.90%	↑
F&P	Monthly	Stroke: 4 Hours	>= 50%	45.00%	↓
F&P	Monthly	Stroke: 24 hours	>= 85%	50.00%	↑
F&P	Monthly	Stroke: SLT Time	TBA	43.90%	↓
F&P	Quarterly	Stoke: 6 Month Follow Up	TBA	41.80%	↑
F&P	Monthly	DToC: Non Mental Health (Patients)	> 30	6	↑

Planned Care

Committee	Frequency	Measure	Target	Actual	Trend
F&P	Monthly	Cancer: 31 Day	>= 98%	99.40%	↑
F&P	Monthly	Cancer: 62 Day	>= 85%	79.60%	↑
F&P	Monthly	Cancer: Single Cancer Pathway	TBA	70.3%	↑
F&P	Monthly	Diagnostics Waits: Over 8 Weeks	0	12,032	↓
F&P	Monthly	RTT: Under 26 Weeks	>= 95%	64.41%	↓
F&P	Monthly	RTT: Over 36 Weeks	0	19,913	↓
F&P	Monthly	RTT: Over 52 weeks	0	6,156	↓
F&P	Monthly	Follow Up Outpatients: Total	Reduce	195,857	↑
F&P	Monthly	Follow Up Outpatients: 100% Overdue	Reduce	60,871	↓
F&P	Monthly	Ophthalmology R1	>= 95%	46.60%	↓

All non-urgent dental services supsended due to Covid-19
Out of Hours Patients required very urgent assessment in May 2020

***No**

Quadruple Aim 2: Narrative – Infection Control

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

At this stage the Welsh Government have not set an Improvement Goal for Health Care Acquired Infections (HCAIs) this financial year, however HBs and Trusts, "are encouraged to continue to strive to reduce healthcare associated infections in line with the overall requirements of the UK 5 year AMR strategy and action plan". For BCU this will be a continuation of the trajectories for 2019/20 taking into consideration the 12% reduction applied to Clostridium Difficile Infection (CDI) for 2019/20.

The numbers of infections in terms of rates/1,000 admissions to date have increased across Wales. This is likely in most cases to be due to a reduction in elective admissions in recent months, but we are monitoring these numbers closely and will continue to respond and report to any potential clusters and or significant increases and trends.

It is not unusual to see variation in numbers month on month. This is expected. CDI infections are slightly higher than the same period last year but have decreased since last month, April.

MRSA infections are inaccurate due to a lab error whereby an MSSA Blood Stream Infection (BSI) infection, was recorded as an MRSA BSI. A datix has been completed and we have been assured this will be removed for next months reporting from Public Health Wales (PHW). The other MRSA infection was unavoidable as a Healthcare Associated Infection (HCAI) as it was due to an injecting drug user in the community.

Compared to the same period last year MSSA infections and all the other gram negative infections are lower than the same period last year apart from Pseudomonas, 8 infections to end of May, 50% were community onset and had positive blood cultures on admission.

Quadruple Aim 2: Narrative – Mental Health

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

CAMHS
In March all families were contacted, needs and risks reviewed and prioritised. Support was paused if the contact/intervention could wait three months. For families needing ongoing support this was provided remotely using telephone and Skype and those young people assessed as high risk continued having face to face support, with PPE in place.

Routine activity stopped and resources were moved into extending the hours of crisis provision up until 22:00, to support young people admitted to the paediatric wards with self-harming or suicidal presentations.

Early Intervention work in the school setting stopped, discussions now underway with Education to plan how to provide support as schools re-open.
Capacity to meet the MHM target in April was significantly impacted. In May this was an improved position, however outcome data inputting was problematic due to remote working and is being addressed and updated. Referrals are down by 61%

Adult Mental Health
The Leadership in Mental Health has been strengthened with the Medical Director becoming the Executive Lead for the Service.

Patients inadvertently discharged at the start of the pandemic have been contacted to assess their needs and return to service as appropriate. Investigation is progressing to understand the learning from this incident.

Weekly reporting of service status is showing all services are operational.

Delayed Transfers of Care (DToC)
Delayed transfers of care are not currently reported, however BCU have maintained the delayed transfers of care data base demonstrating significant reduction in delayed transfers of care
.
New discharge pathways and suspension of previous continuing health care arrangements have contributed to this improvement.

Medically fit to discharge and daily discharges for these patients are now reported. The 5 new discharge pathways are reported as snapshots twice weekly.

As policy changes have been applied to protect the care home sector the number of patients requiring testing and self-isolation prior to transfer to a care home is increasing. With the impact of 28 days post positive test for admissions to care homes being implemented the risk to the care home sector and to hospital bed capacity is being kept under review, with consideration being taken of the requirements for surge capacity.

Quadruple Aim 2: Narrative - Unscheduled Care

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Emergency Department (ED) Performance

Although performance against the 4 hour wait target remains significantly improved through May 2020, it should be noted that the number of attendances to our ED has been reduced by around a half in light of Covid-19 Pandemic. The number of 12 hour breaches and ambulance handover delays have also seen a considerable reduction, again due to the unprecedented reduction in numbers attending ED across all three sites. However, given the reduction in number of attendances, there has still been a small rise in number of patients experiencing delays over 12 hours, up from 20 in April to 72 in May 2020.

The rise in ED Attendances through June 2020 are approaching pre Covid-19 levels, indicating a likelihood in a rise in the number of 4 hour and 12 hour breaches being reported next month.

Stroke Care Performance

The rate of patients being admitted to the ASU within 4 hours of presenting at ED has fallen to 45% compared to 60% in April 2020. This is despite the continued low numbers of patients attending ED with suspected stroke. The delay in being admitted to the ASU is also impacting on the rate of patients being seen by a Stroke Consultant within 24 hours, which was 50% for May 2020 compared to an average of 80% pre Covid-19. Data is being analysed to confirm whether or not delayed attendance to ED is impacting on the rate of thrombolysis.

Continued increase in communication to remind patients to present at the earliest opportunity should symptoms of stroke be experienced.

BCU has been able to maintain the delivery of the stroke pathway in accordance with the essential services framework guidelines.

Delayed Transfers of Care Performance

Delayed transfer of care (DTOC) reporting has been stood down nationally. However in BCU the DTOC database is actively used as a operational tool enabling us to continue to monitor the level of DTOC. The number of patients experiencing a delay to their discharge or transfer of care continues to fall.

The new discharge to assess process and the temporary pause of the Continuing Health Care Assessment Process have been put in place. The Home First Hubs are working on the 5 new pathways and performance on these are being captured twice weekly and reported weekly. Daily identification of patients medically fit for discharge and review of outcomes of the discharge plan is taking place each day and showing good compliance with the plans.

Due to the need to protect care homes from Covid-19 transmission a test and 14 day isolation period prior to return to care homes has been introduced. Additional step down facilities have been commissioned to support this. These 14 days are not recorded as part of DTOC but are captured on the weekly discharge pathway reports.

Quadruple Aim 2: Narrative - Planned Care (page 1)

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Referral to Treatment (RTT) Performance

Elective activity undertaken in May 2020 was based on clinical risk assessment. This activity was based on the Essential Services Framework guidelines. This related to Cancer and urgent potentially life-threatening or life-impacting conditions. Waiting times for these patients is relatively short. Therefore activity, while clinically appropriate, did not support delivery of the RTT targets. Activity was also low in volume, mitigating against the risk of nosocomial transmission and protecting capacity for management of Covid-19. Consequentially, the volume of elective patients waiting beyond 36 weeks has increased significantly ,following the pattern reported in April.

The re-set plans for elective care are being put in place. A number of outpatient clinics aim to re-commence at the beginning of July. These will be for clinically risk assessed patients where virtual consultation is suitable. Capacity for urgent surgery will continue through Spire Yale until the beginning of September. The option appraisal for non-essential surgery to recommence will be concluded by the end of June.

Importantly the activity which has been delivered is in line with current guidance. Moving forward to a re-set of elective activity requires detailed planning to ensure a balanced management of risk while covid-19 is still circulating. The impact of shielding, social isolation, social distancing, and PPE requirements results in activity at a lower level than pre-Covid-19. This will impact negatively on waiting times for patients.

Cancer Performance

Referrals for cancer services is starting to recover. However it remains lower than pre-covid-19.The reduction in referrals has resulted in a reduction in the waiting list size from 3,312 in early March to 2,189 on 10th June. This is a concern, if patients present later and with more advanced disease. We have increased communications to encourage patients to present .

Within the cancer pathways the latest guidance is being applied. This means some patients have been deferred for surgery or managed on alternative treatments.

Access to diagnostics especially endoscopy has been particularly challenging. A new pathway using Faecal Immunochemical Testing has been implemented. Endoscopy has re-commenced on all 3 acute sites. However activity will be low and not sufficient at present to fully address the backlog created.

Quadruple Aim 2: Narrative - Planned Care (Page 2)

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Narrative for Follow-up Backlog Performance

Progress is being made on implementation of Attend-anywhere. This is a virtual consultation product, supported for 12 months by WG. It enables video consultations for patients or multi-disciplinary team working. The Programme Board is being clinically –led by our clinical information officer. 9 Consultants will have completed testing by the end of June. Roll out will commence in July.

In the meantime virtual telephone consultations have been taking place. The initial focus of these is patients cancelled during Covid-19 and clinically high risk stratified patients.

As attendance for new patients has been low the additions to the follow up waiting list has also been low. The overall waiting list has reduced by 6,000 between end of March and the end of May 2020. However, the volume of patients overdue their clinical target date has increased by nearly 14,000 during the same period. This means that the percentage of the waiting list that is overdue has increased to 55.4% (from 46.8%). Risk stratification of this waiting list combined with optimising virtual consultations is important to mitigate harm.

The paediatric and ophthalmology specialties will be re-commencing clinics from the end of June, subject to compliance with national operational guidance

Narrative for Ophthalmology Performance

The emergency eye care pathway implemented during Covid-19 has been effective with over 2400 patients managed via this pathway. Only 12.4% of patients required transfer to the hospital eye service.

Despite the implementation of the urgent eye care pathway in April 2020, the volume of R1 patients overdue their appointment has increased. Clinical table top reviews have enabled some patients to be safely deferred for a short period. This period is coming to an end and therefore this specialty has been prioritised to re-commence outpatient clinics. These will be in a socially distanced environment. Capacity will be lower than previously and so risk stratification of patients will continue.

Optometry practices are working to re-commence services later this month. This is welcome, however there is a potential for an increase in referrals which will need to be balanced with the managing the increased backlog of patients overdue their appointment.

Diagnostics Performance

The high volume of previous activity, combined with low level of non-essential service capacity result in significant increases in waiting times for patients.

Radiology services continued to provide access for essential services patients, while supporting imaging of covid-19 patients. The requirements of social distancing and cleaning and PPE is reducing capacity by at least 35%. A small amount of activity has been undertaken at Spire Yale to support CT,MRI and Ultrasound imaging.
Cardiac diagnostics were increasing pre-covid-19 due to staff shortages. These waits are continuing to increase.

Endoscopic waits remain a concern as reported under the cancer section.
Neurophysiology waits have been risk assessed and the majority at not considered high risk.

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable

New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnerships will support this with education providers and learning academies focussed on professional capability and leadership.

Rate of final replies to complaints improved and almost on target

New clinically developed pathways in place

Staff absence rates impacted by Covid-19

Key Messages

- Increased clinical leadership and engagement demonstrated
- Additional psychological support provided for staff
- Excellent joint working with staff representatives

Measures

Committee	Frequency	Measure	Target	Actual	Trend
QSE	Monthly	Percentage of complaints that have received a final reply	75%	72.00%	↑
QSE	Monthly	Number New Never Events	0	1	↓
F&P	Monthly	Personal Appraisal and Development Review (PADR)	>= 85%	66.81%	↓
F&P	Monthly	Mandatory Training	>= 85%	85.01%	↓
F&P	Monthly	Sickness Absence Rate	< 5%	5.65%	↓

Quadruple Aim 3: Narrative

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Final Reply Concerns

There has been a continued focus on ensuring timely completion of complaint responses during the COVID-19 pandemic and the corporate team has supported and deployed staff into local teams in order to maintain the progress that has been made. The corporate team has also implemented a new virtual contact centre for complaints to improve experience and process. The review of the complaint process was put on hold, and has been re-started in June 2020.

New Never Events

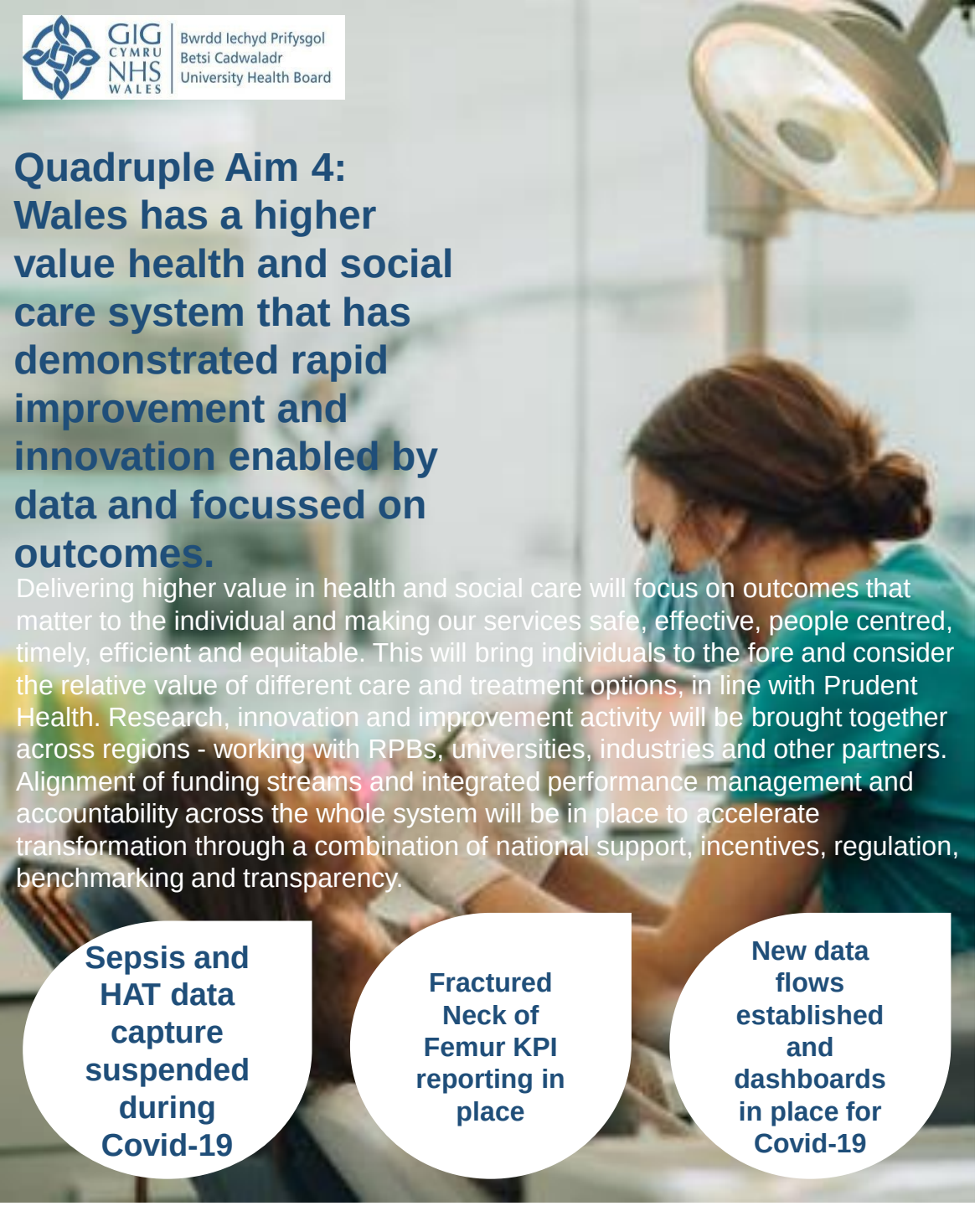
One Never Event occurred in the month. This is subject to a serious incident investigation and is detailed within the SI Report to the QSE Committee.

WOD

PADR Compliance has fallen slightly to 66.81% due to services focussing on the COVID-19 response. Activity over the next 4 weeks will focus on working with specific areas who have the lowest compliance.

Mandatory training remains above target at 85.01%. ELearning and virtual training is supporting maintenance of the target. Next steps are implementing safe training methodologies and supporting the areas with the lowest compliance rates.

Sickness Rates are being addressed via the Workforce Wellbeing Group and the 3 regional Staff Wellbeing Support Service hubs. They are clinically led and have seen in the region of over 1500 staff since opening in April 2020



Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation enabled by data and focussed on outcomes.

Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring individuals to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions - working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.

Sepsis and HAT data capture suspended during Covid-19

Fractured Neck of Femur KPI reporting in place

New data flows established and dashboards in place for Covid-19

Key Messages

- Continued increase in Mortality Rate, up from 0.74% to 0.85% in 12 months
- Increased system working to link Health and Social Care Data
- Fracture Neck of Femur collaborative developed

National Hip Fracture Database - Best Practice Measures

Overview of Wales	BCU			Benchmarks				
	YG	YGC	WMH	NHFD	Wales	England	Northen Ireland	Expectation
Prompt Orthogeriatric review %	**46%**	**47%**	**69%**	89%	61%	91%	82%	**75%**
Prompt Surgery %	**75%**	**61%**	**69%**	68%	65%	69%	20%	**75%**
NICE Compliant Surgery %	**68%**	**65%**	**74%**	72%	71%	72%	74%	**75%**
Prompt Mobilisation %	**82%**	**79%**	**87%**	80%	73%	81%	83%	**75%**
Not delirious post-op %	**27%**	**43%**	**40%**	66%	51%	67%	35%	**75%**
Return to original residence %	**71%**	**73%**	**75%**	69%	70%	69%	75%	**75%**

Source: National Hip Fracture Database, accessed 25th June 2020

Quadruple Aim 4: Measures

Committee	Frequency	Measure	Target	Actual	Trend
QSE	Monthly	Crude hospital mortality rate (74 years of age or less)	**Reduction**	0.85%	↓
QSE	Monthly	Percentage of deaths scrutinised by an independent medical examiner	**Improve**	***Not available**	
QSE	Monthly	In-patients 'Sepsis Six' within one hour of positive screening	**Improve**	100%	→
QSE	Monthly	Emergency Department 'Sepsis Six' within one hour of positive screening	**Improve**	55.50%	↑
QSE	Monthly	Patients meeting NICE head injury guidelines that receive a CT scan within 60 minutes	**TBC**	***Not available**	
QSE	Monthly	Hip fracture that received an orthogeriatrician assessment within 72 hours age 60 and over	**>= 75%**	54.00%	**New**
QSE	Monthly	Episodes clinically coded within one reporting month	**>= 95%**	92.60%	↑
F&P	Monthly	NHS Dentist re-attendances	TBA	***Not Available**	↓
F&P	Monthly	Lost Critical Care bed-days	Reduce	13.20%	↑
F&P	Monthly	Agency Spend % of Total Spend	Reduce	4.30%	→

**** All non-urgent dental services supsended due to Covid-19***

Quadruple Aim 4: Narrative

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Narrative Mortality

During the Covid 19 pandemic, the stage 1 mortality screening reviews have continued on all sites (92% compliance overall) although the stage 2 reviews were stood down.

At the current time there is no Medical Examiner in post although active recruitment has started and candidates will be interviewed in July 2020 with a view to taking up posts in September 2020.

National Hip Fracture Database - Best Practice Measures

Overview of Wales	BCU			Benchmarks				
	YG	YGC	WMH	NHFD	Wales	England	Northen Ireland	Expectation
Prompt Orthogeriatric review %	**46%**	**47%**	**69%**	89%	61%	91%	82%	**75%**
Prompt Surgery %	**75%**	**61%**	**69%**	68%	65%	69%	20%	**75%**
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Return to original residence %	**71%**	**73%**	**75%**	69%	70%	69%	75%	**75%**

Source: National Hip Fracture Database, accessed 25th June 2020

Timely Interventions

Sepsis

During the Covid-19 pandemic, the sepsis improvement meetings and data collection was stood down. Therefore the data are unreliable with 10 or less completed forms across the Health Board from April 2020. Work is in progress to re-establish the weekly improvement meetings and so improve data capture. (NB this is from the Sepsis Dashboard in IRIS). Once these are re-established we will consider a further virtual collaborative event. The crude mortality for non-elective septicaemia remains below the peer group (to April 2020; Source CHKS).

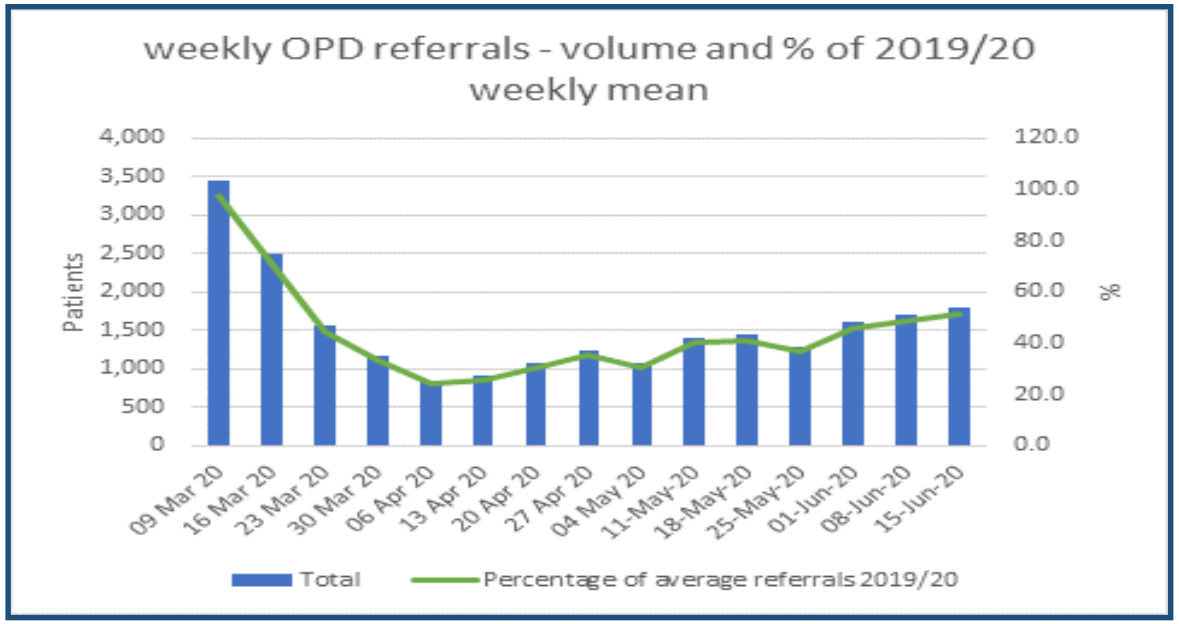
Hip Fracture Orthogeriatrician Review

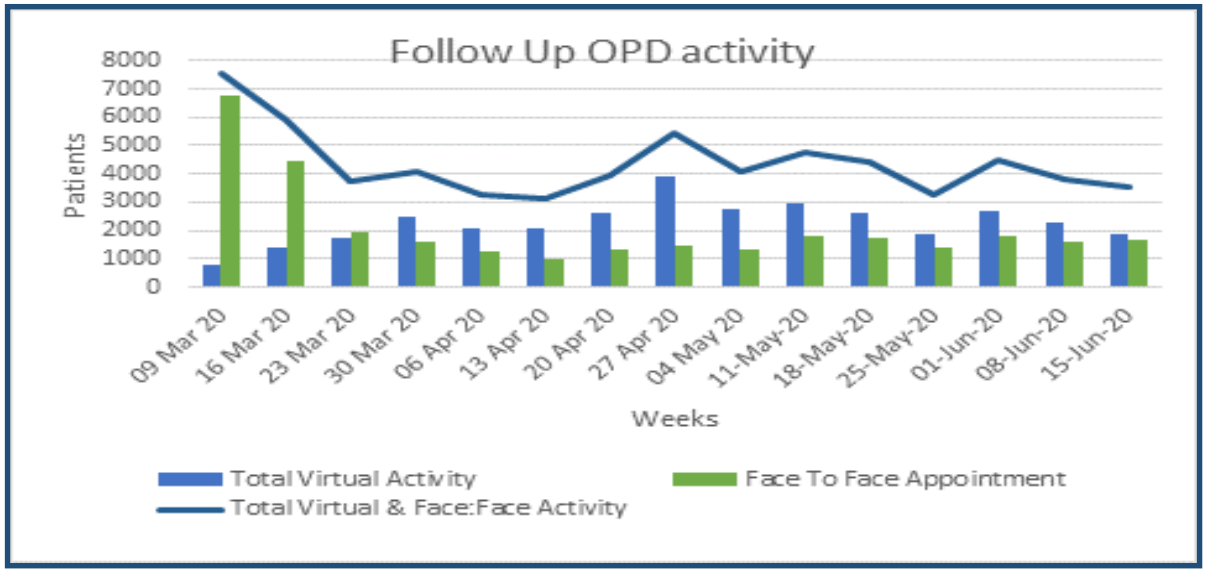
A new measure in the NHS Wales Delivery Framework for 2020/21, this measure is one of 6 reported via the UK-wide National Hip Fracture Database (NHFD). The latest available figures are for April 2020.

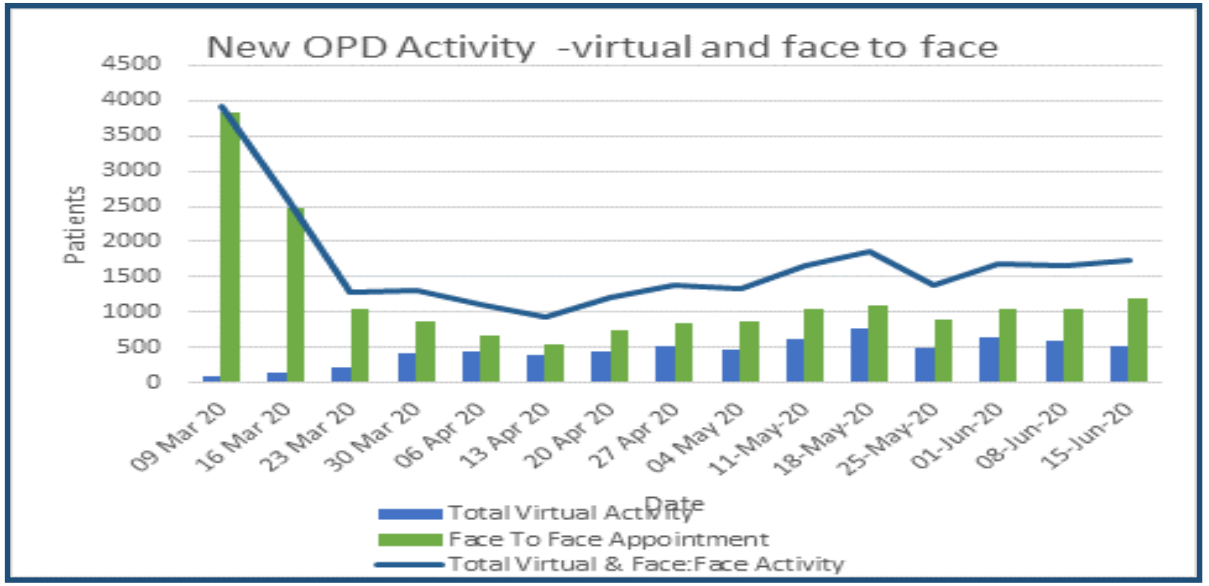
Overall BCU performance at 54% against an expectation of at least 75%. Performance at Wrexham Maelor Hospital is highest at 69%, with Ysbyty Gwynedd and Ysbyty Glan Clwyd at 46% and 47% respectively. However, it should be noted that performance against this measure is low across Wales at 58% when compared to an average of 78.2% for the rest of the UK.

Essential Services

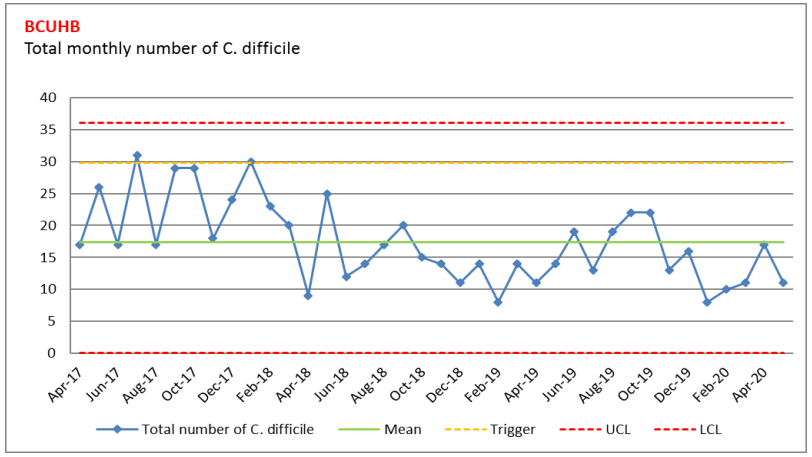
Weekly Referrals and Outpatient Activity 9th March to 15th June 2020

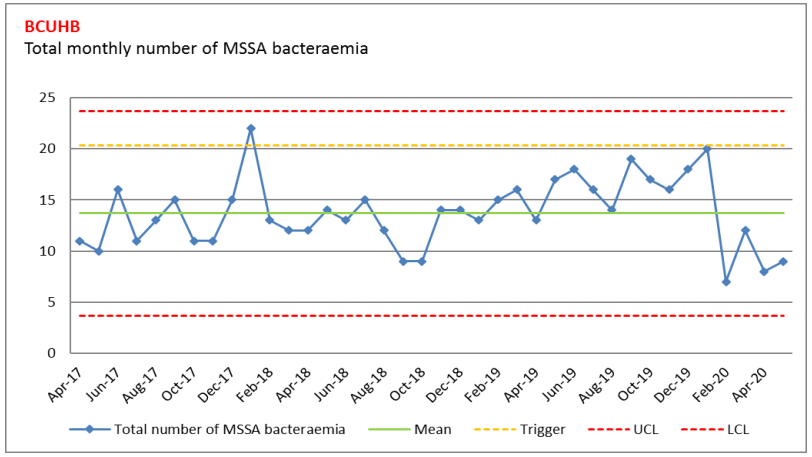


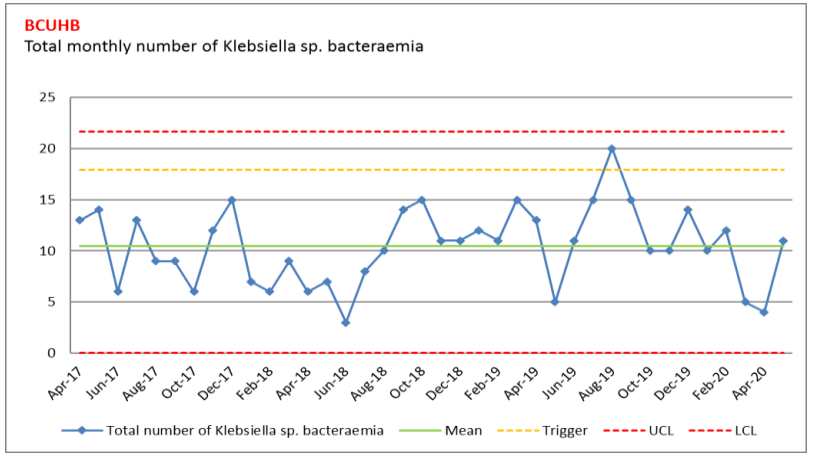


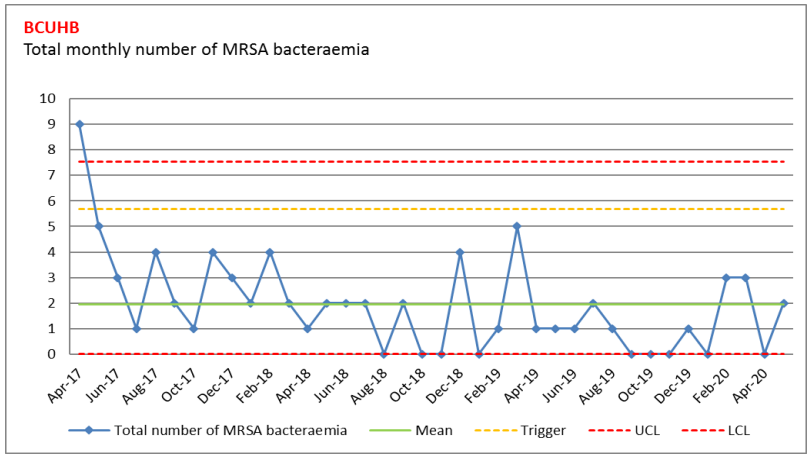


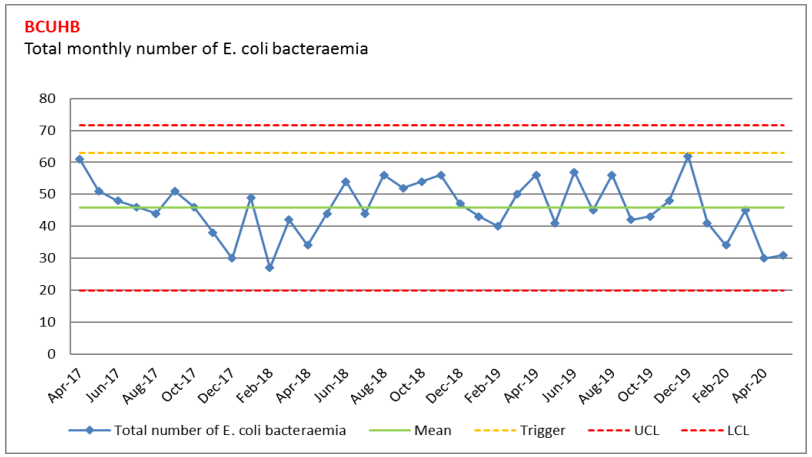
Quadruple Aim 2: Charts Infection Control page 1

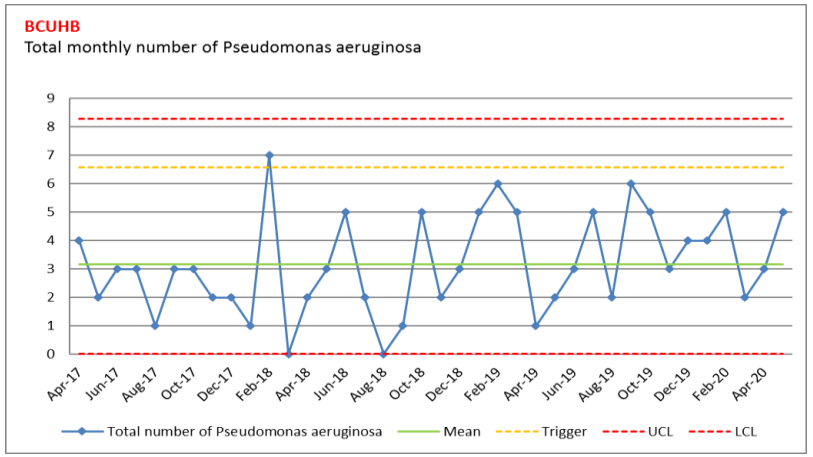




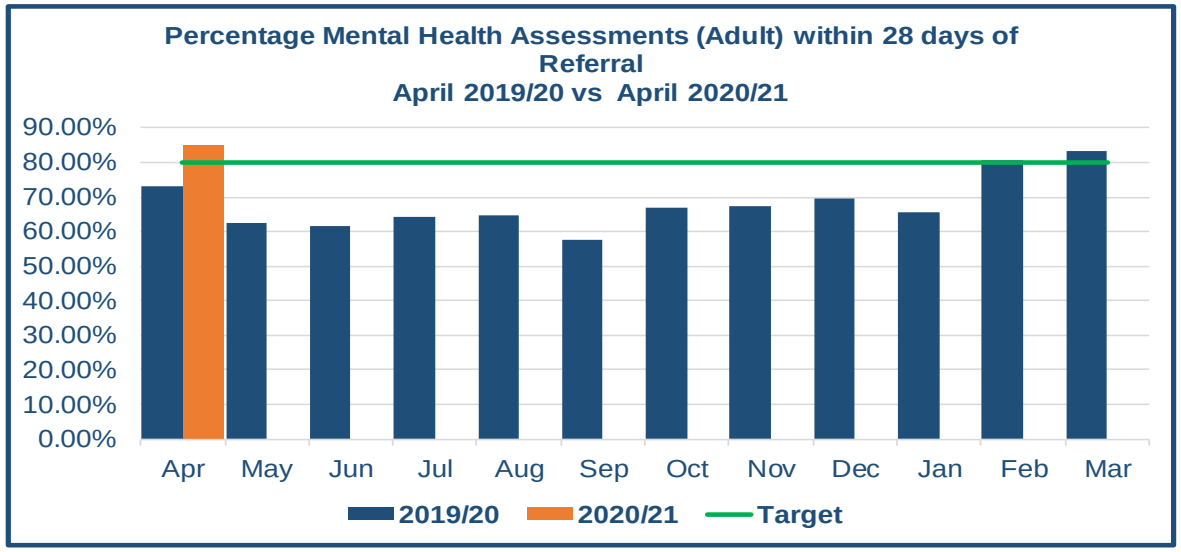


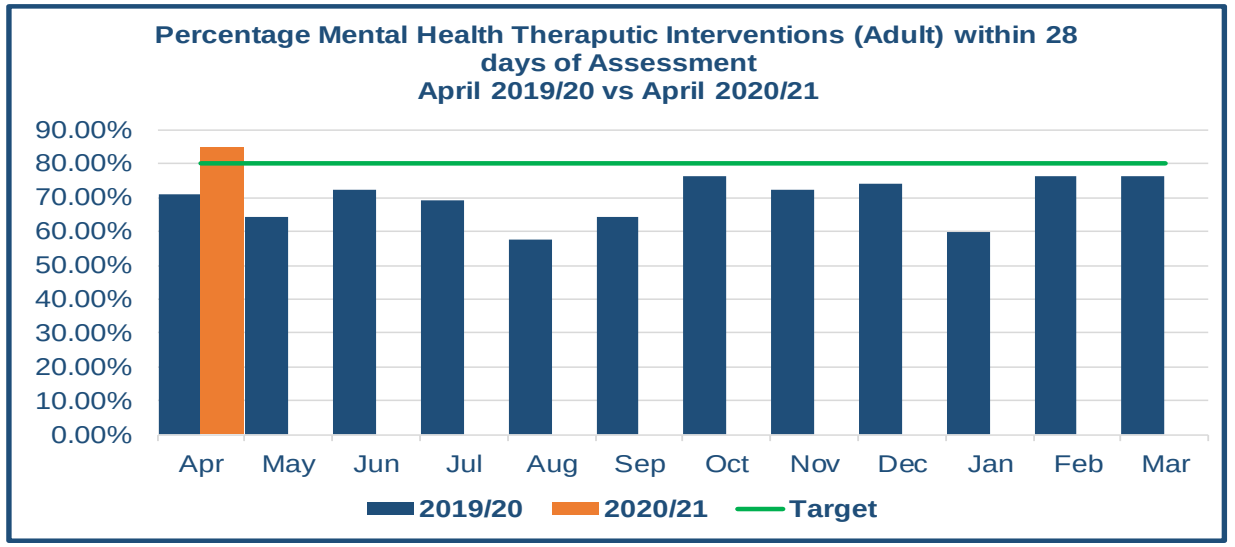


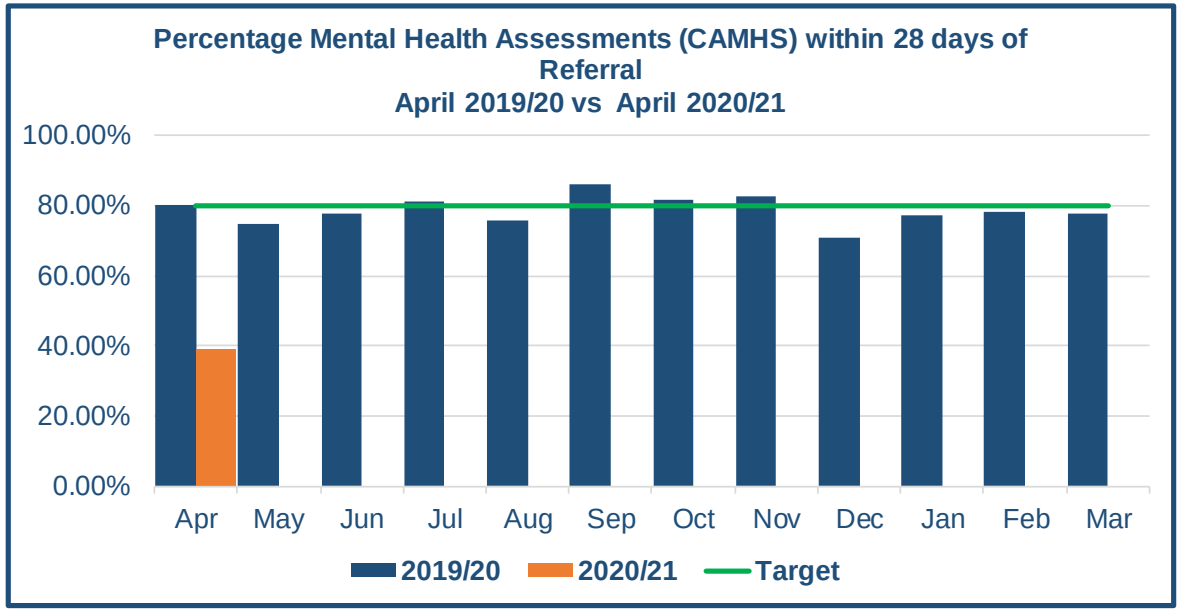


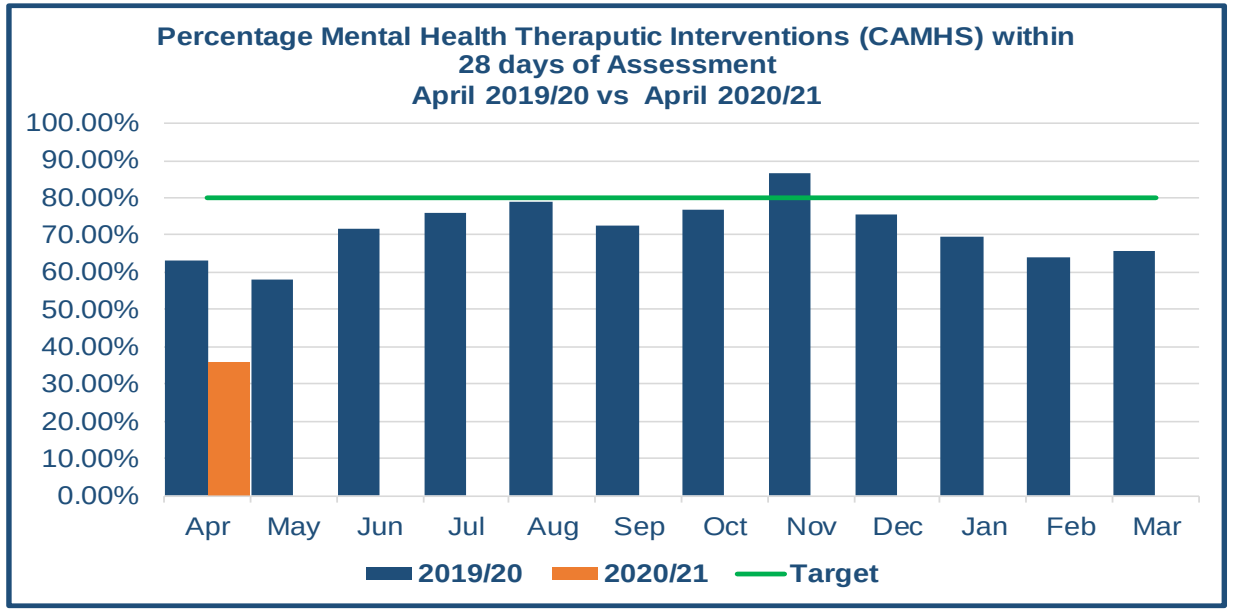


Quadruple Aim 2: Charts Mental Health and CAMHS

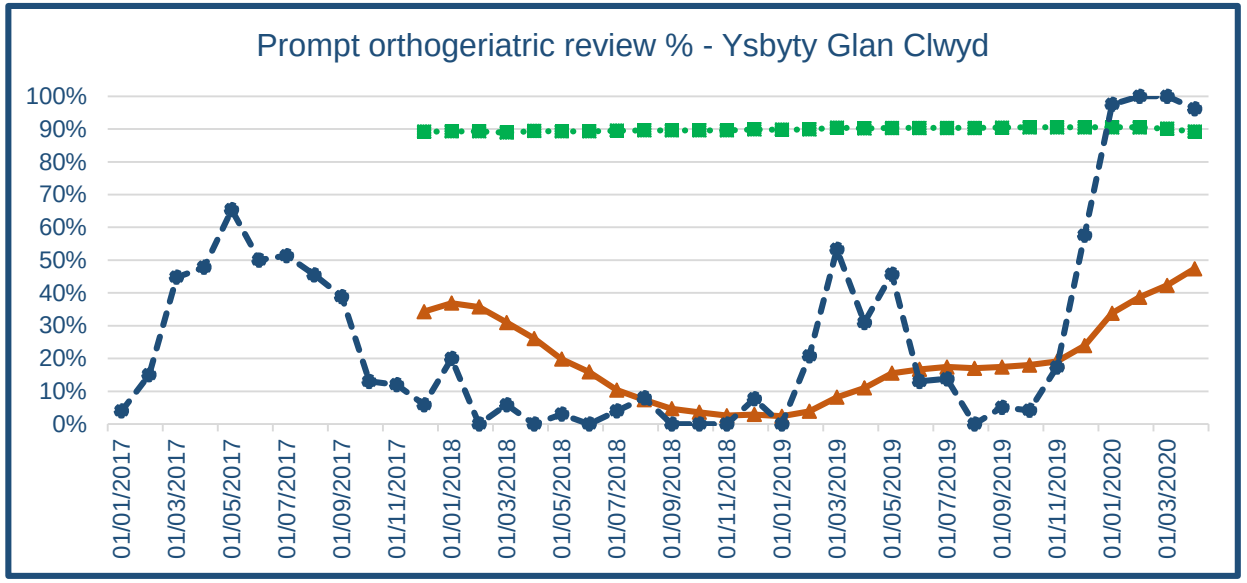


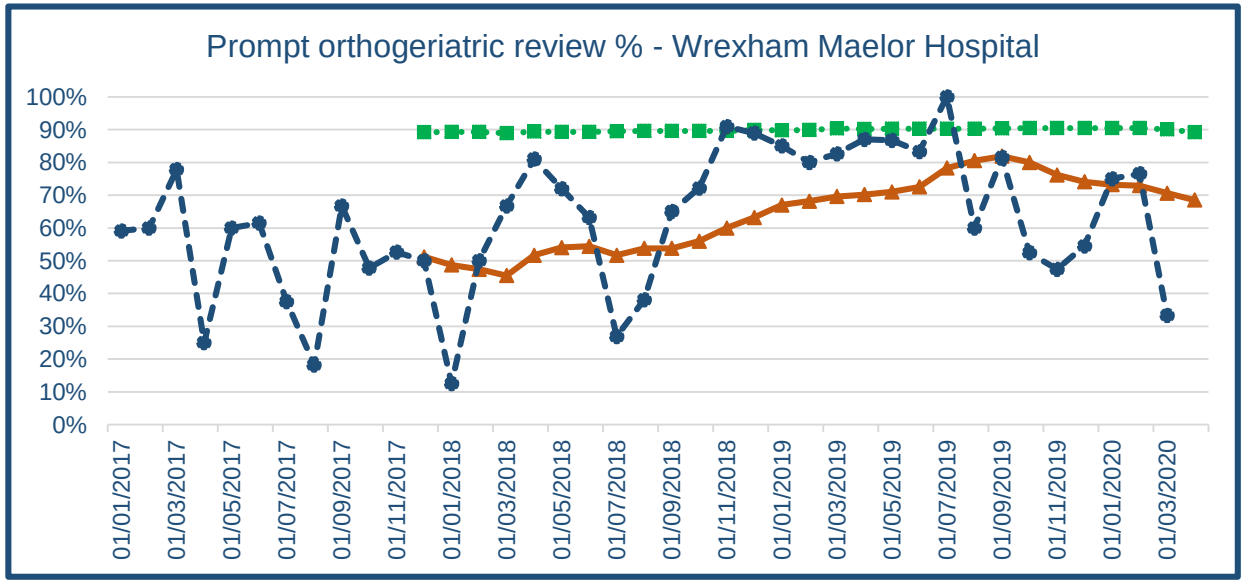


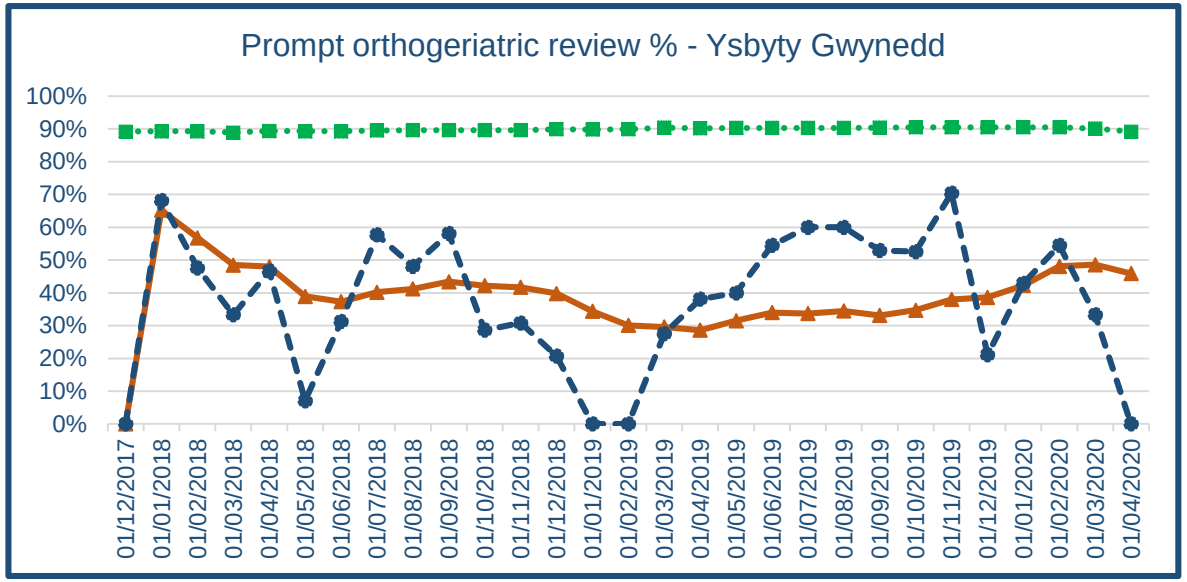




Quadruple Aim 2: Charts Fractured Neck of Femur







Key:

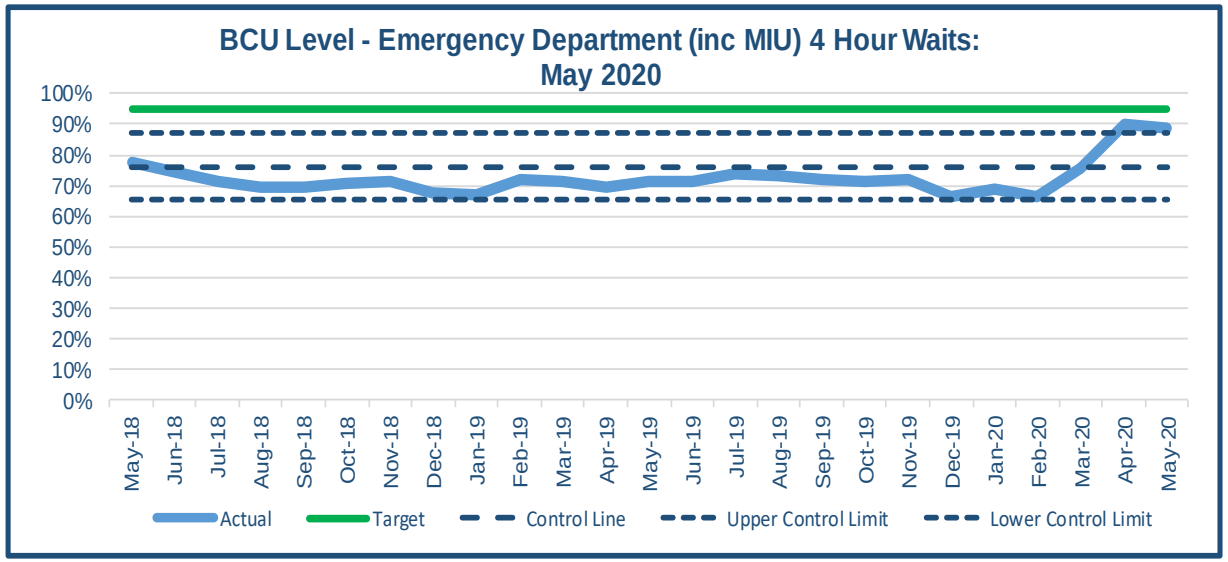
■ = UK Average (NHFD)

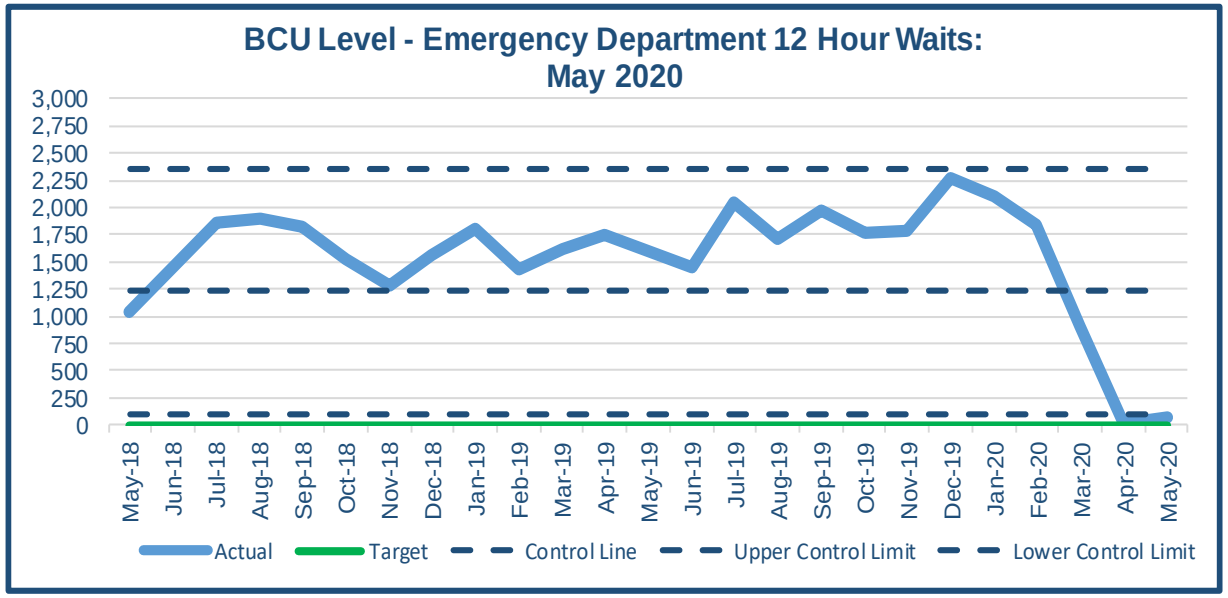
▲ = Annual (12 month) Average

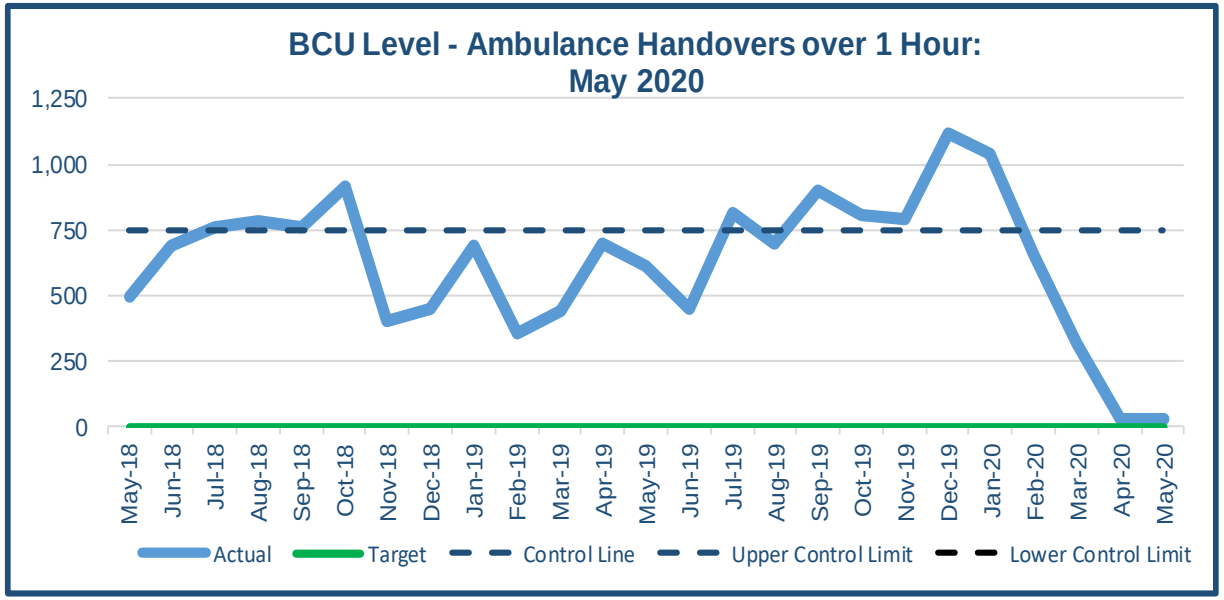
● = Monthly

Source of Graphs and Data – National Hip Fracture Database (NHFD) – accessed 22nd June 2020

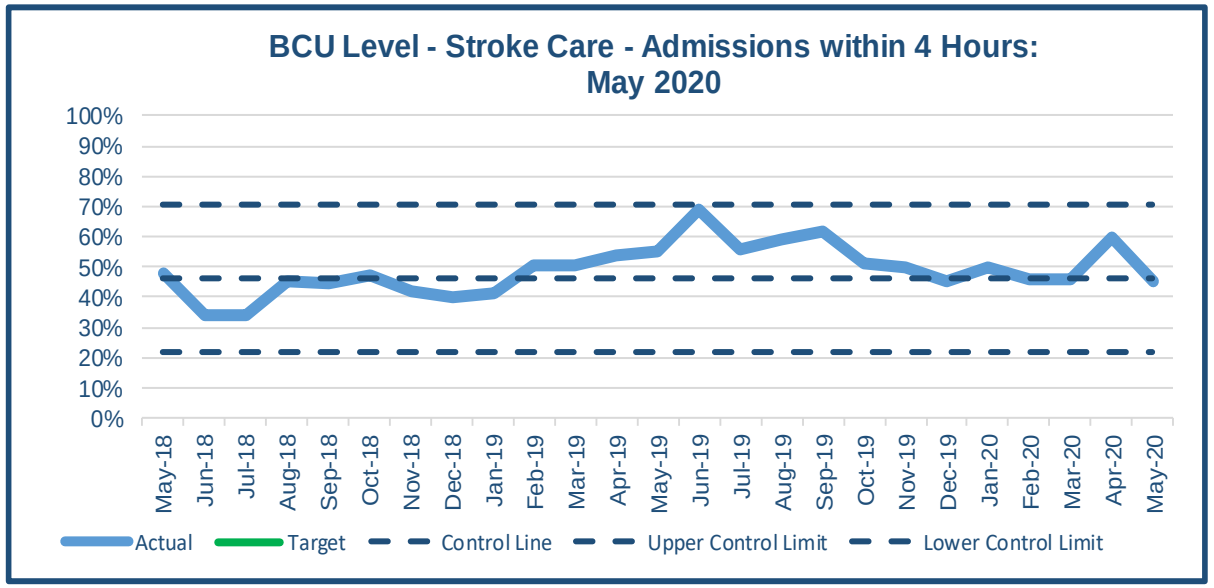
Quadruple Aim 2: Charts Unscheduled Care Page 1

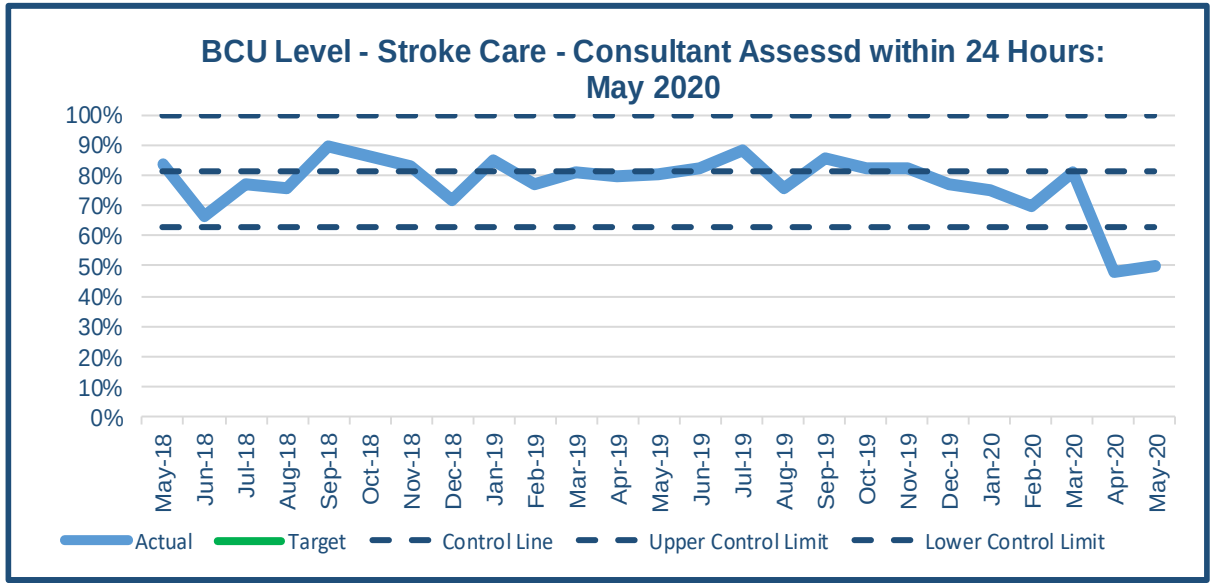


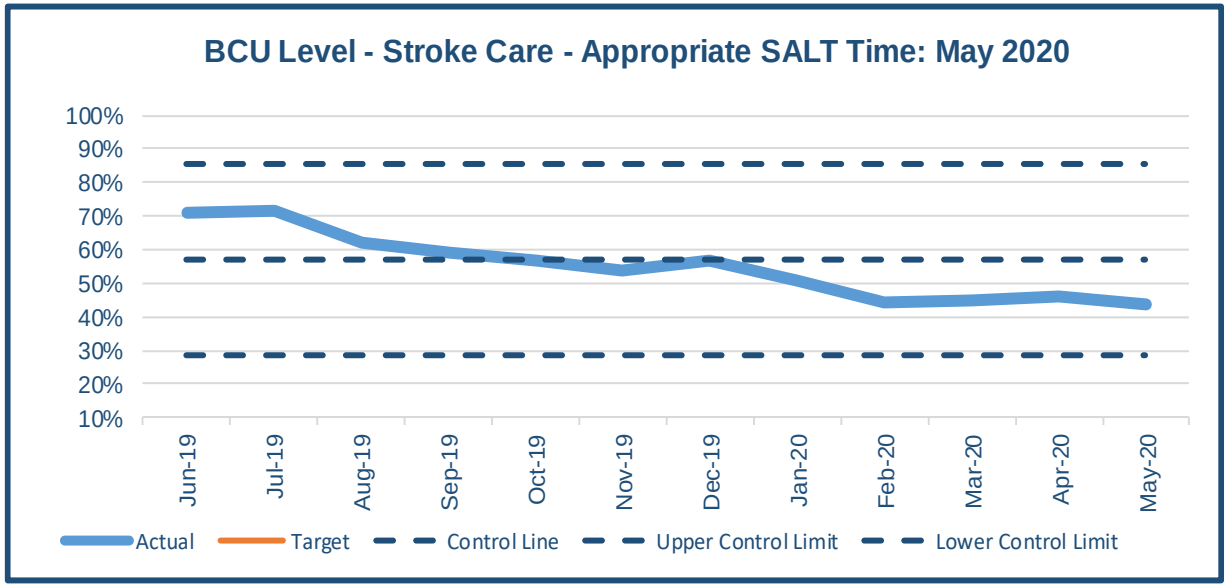




Quadruple Aim 2: Charts Unscheduled Care Page 2

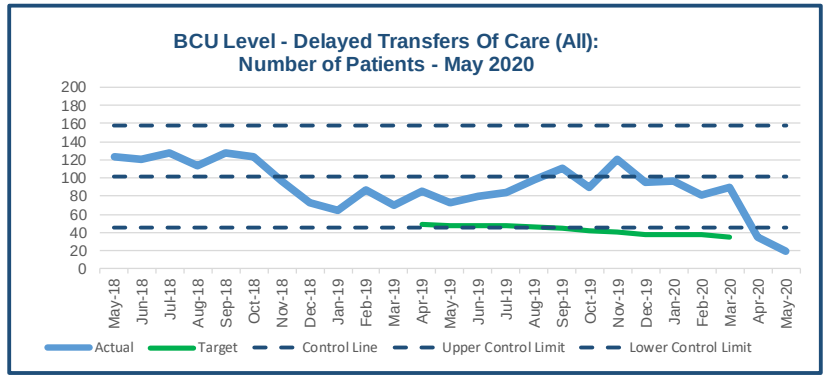


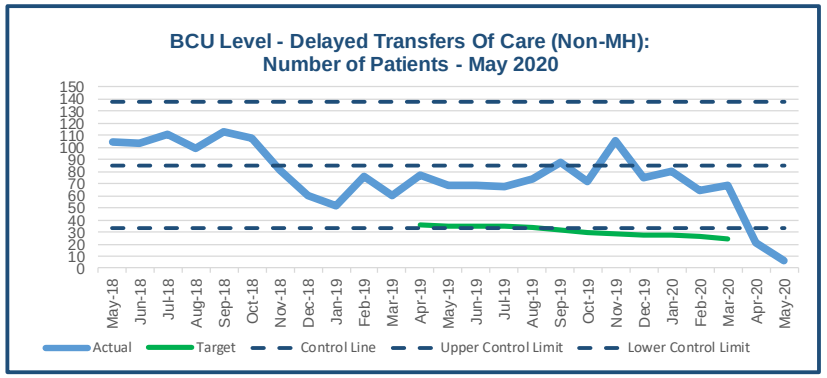


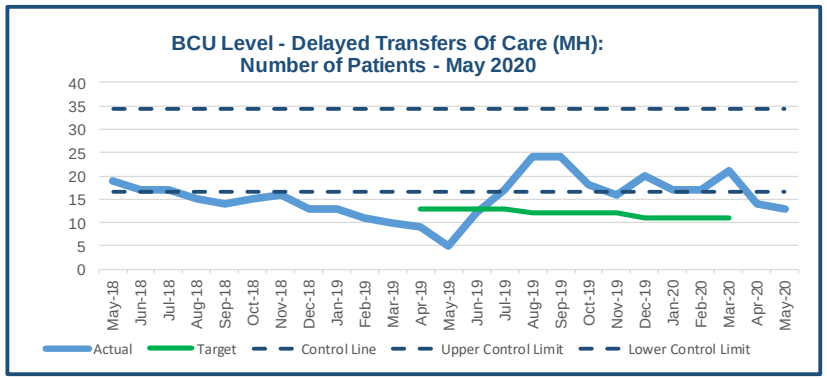


Quadruple Aim 2: Charts Unscheduled Care page 2

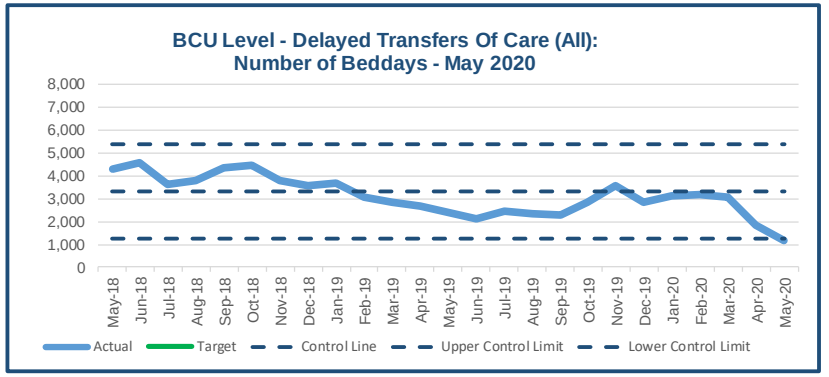
Delayed Transfers of Care (DToC) Number of Patients

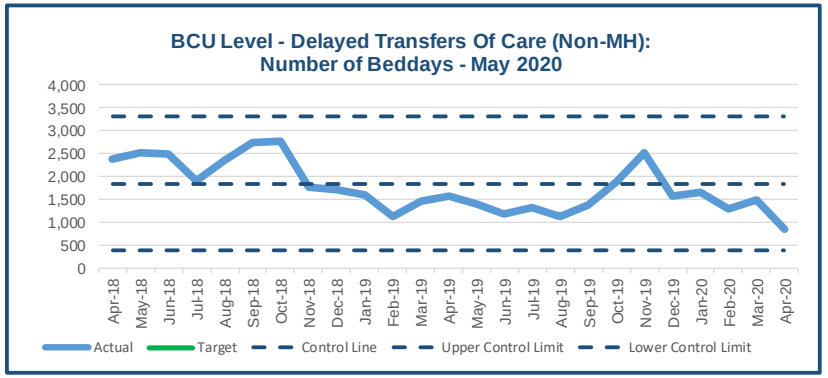


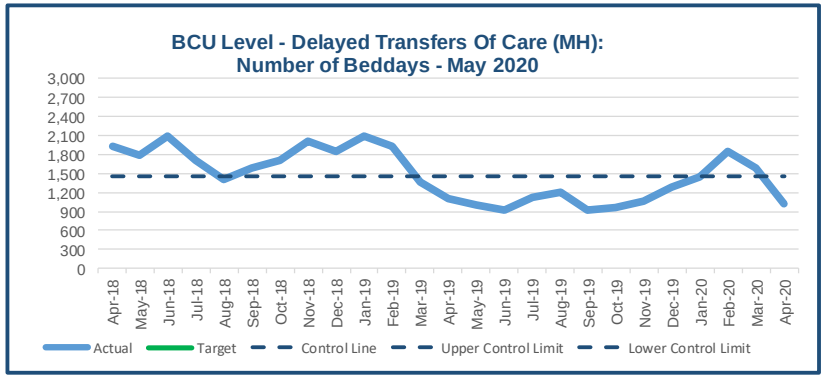




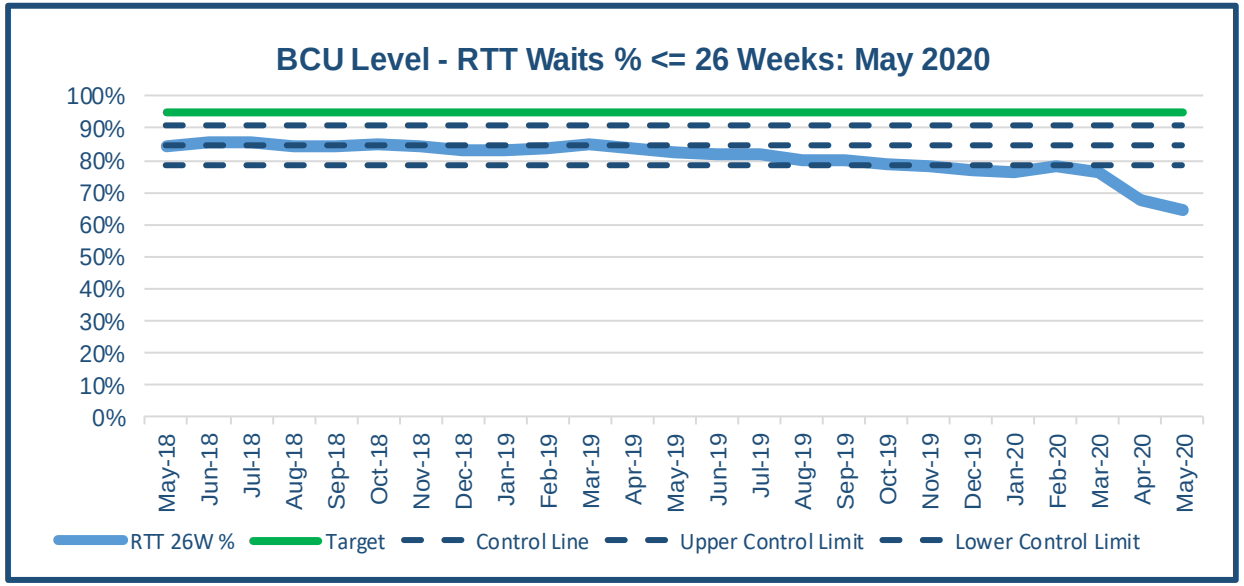
Delayed Transfers of Care (DToC) Number of Beddays

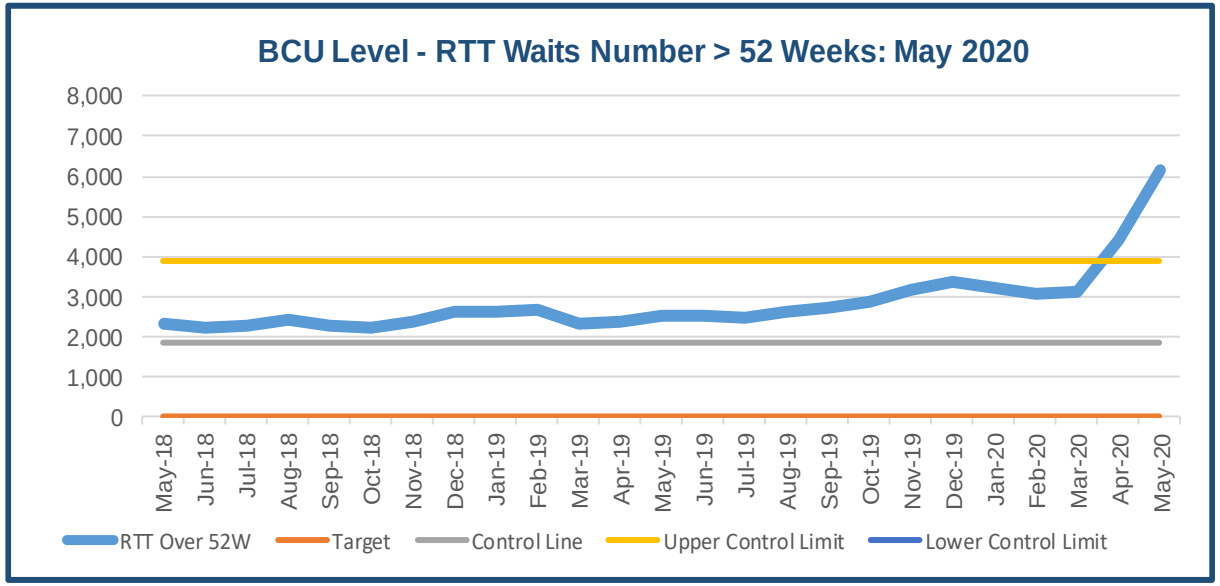


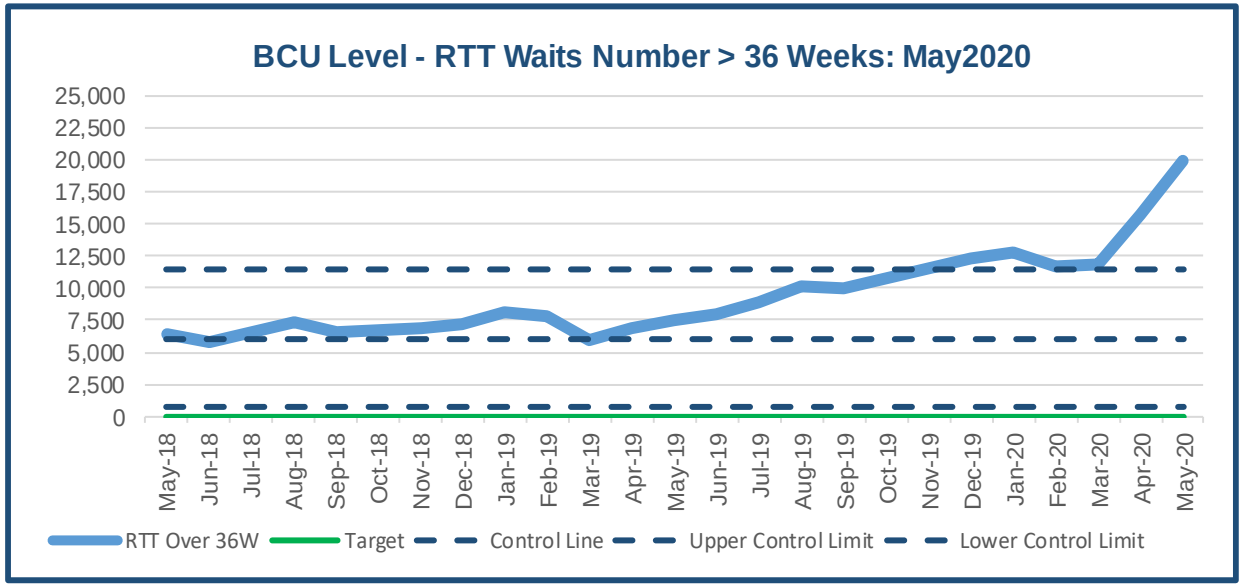


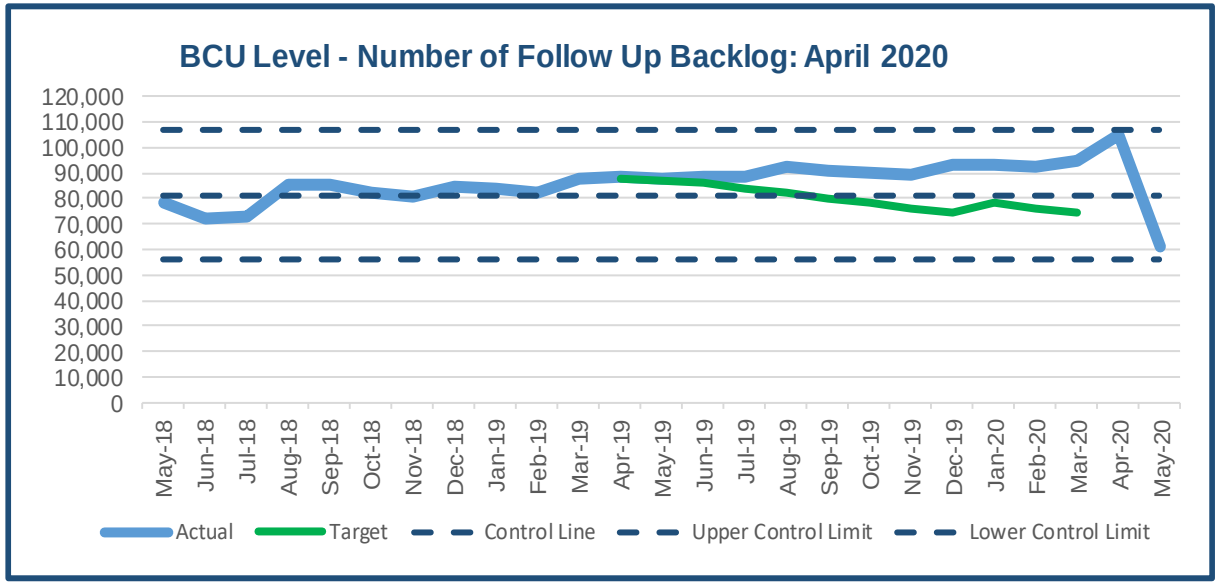


Quadruple Aim 2: Charts Planned Care page 1

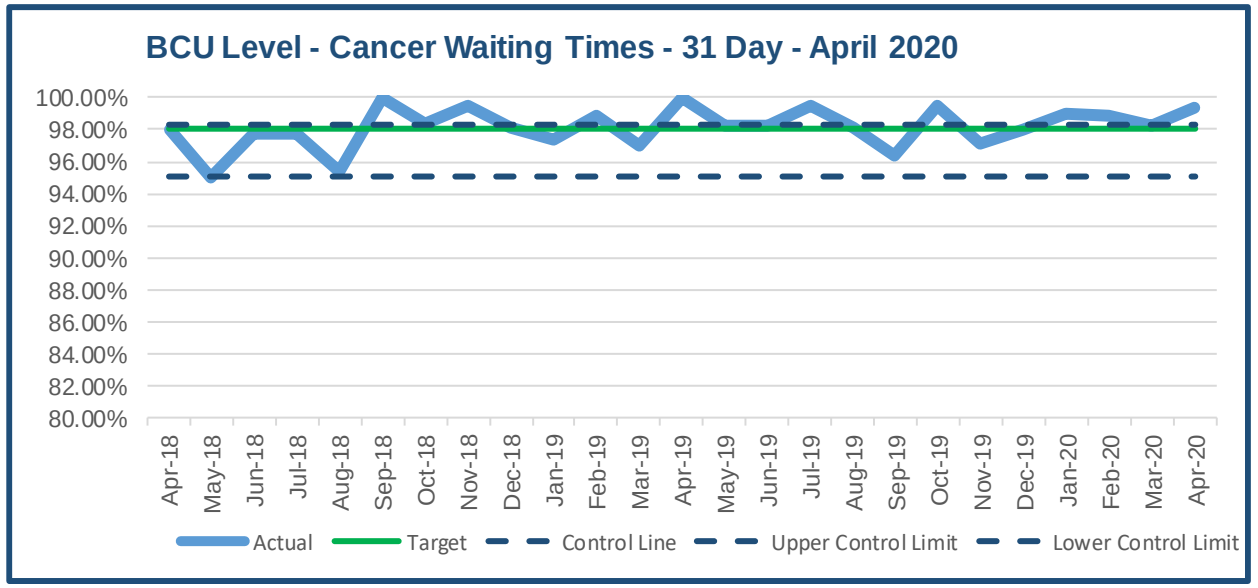


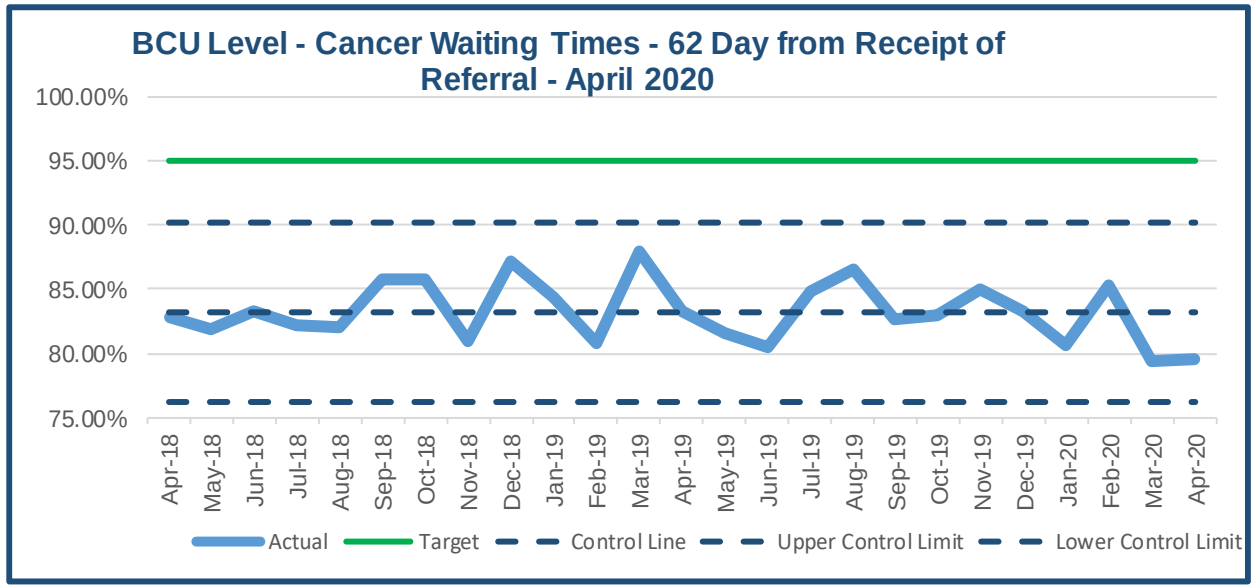


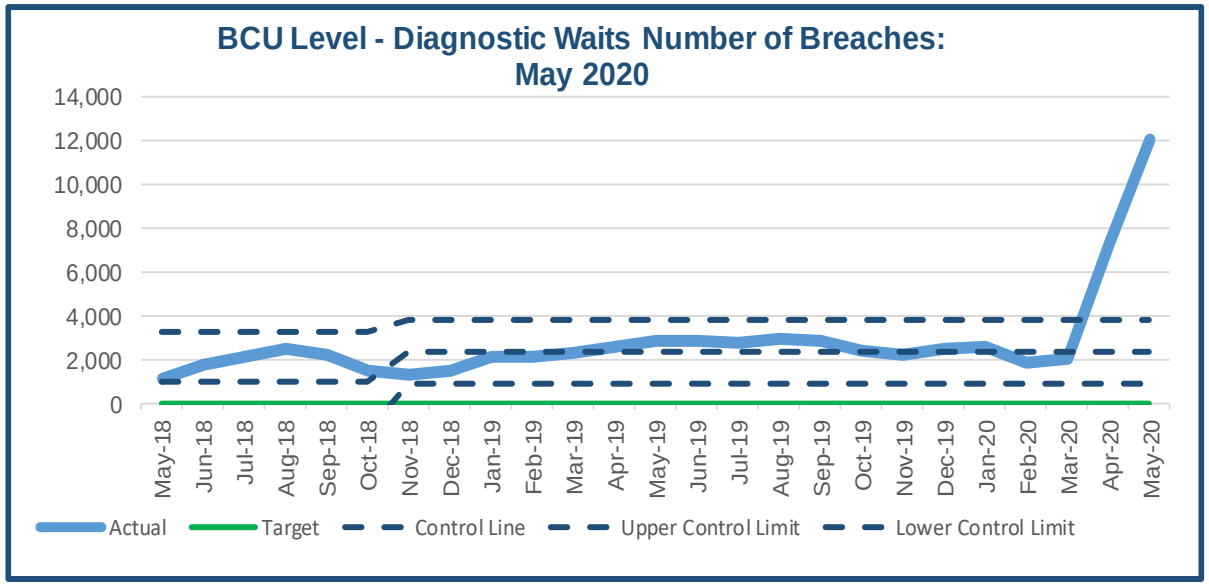




Quadruple Aim 2: Charts Planned Care page 2

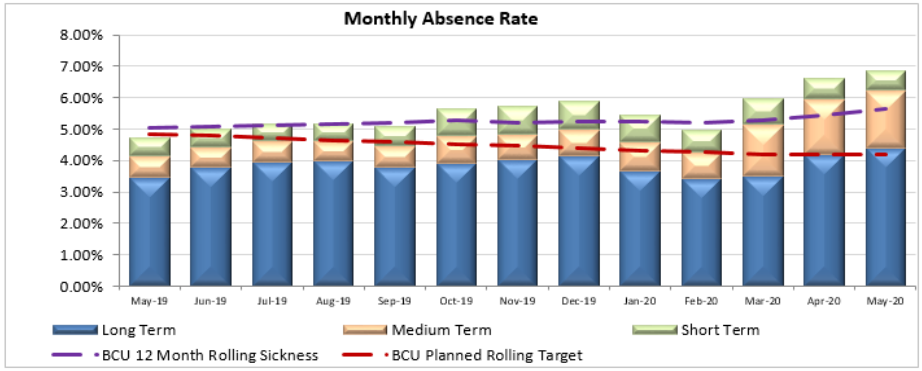


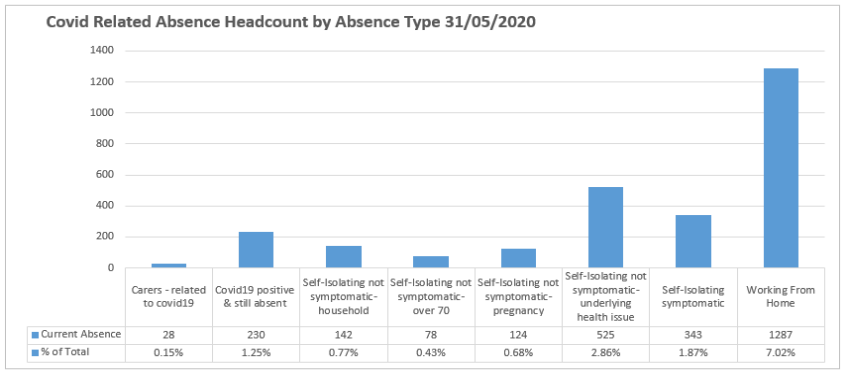




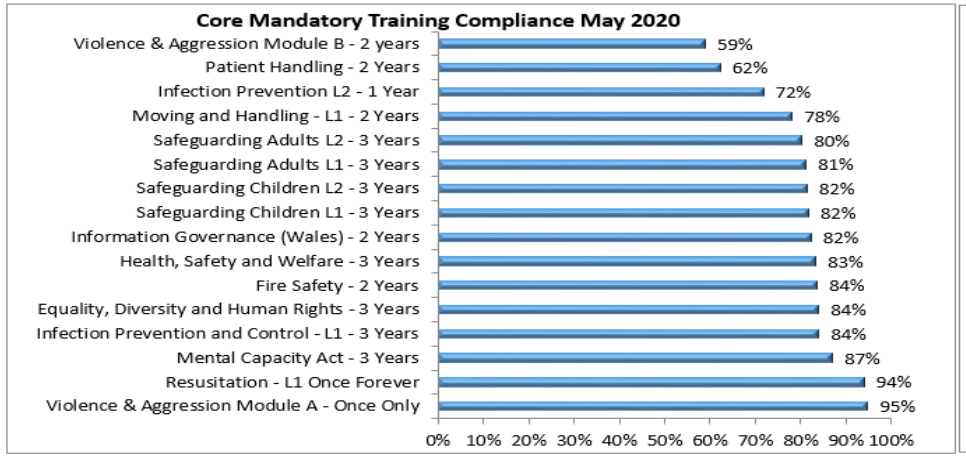
Quadruple Aim 3: Charts Workforce

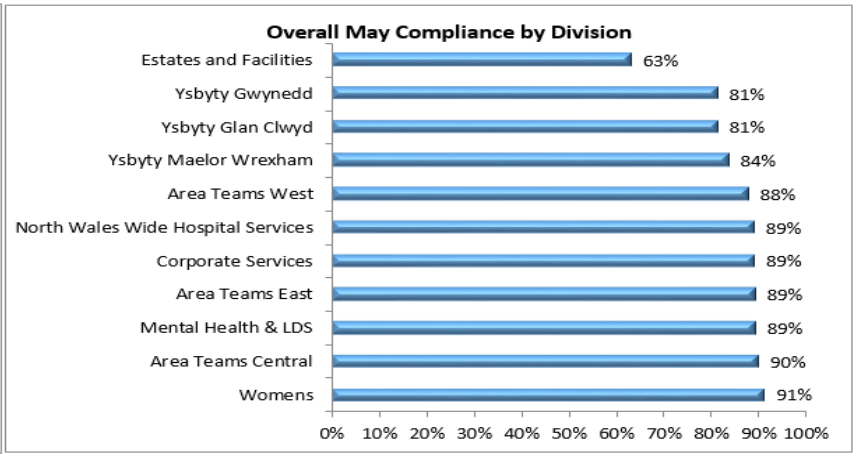
Sickness absence Rates



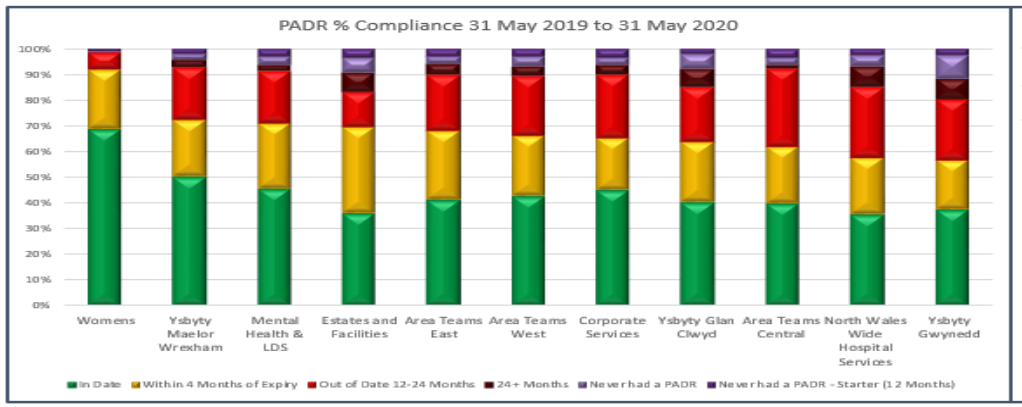


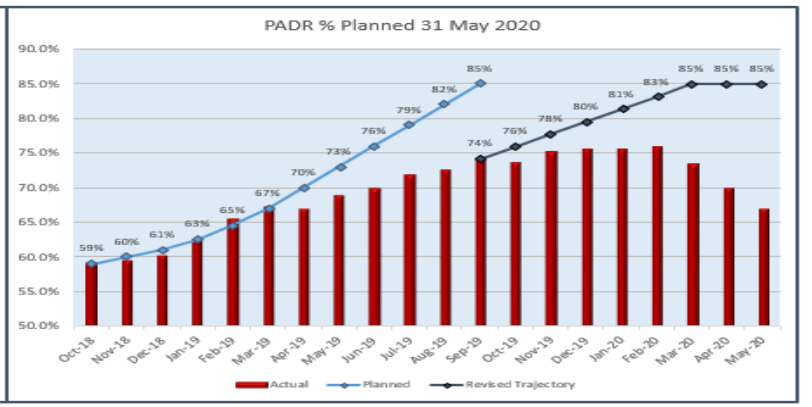
Core Mandatory Training Rate



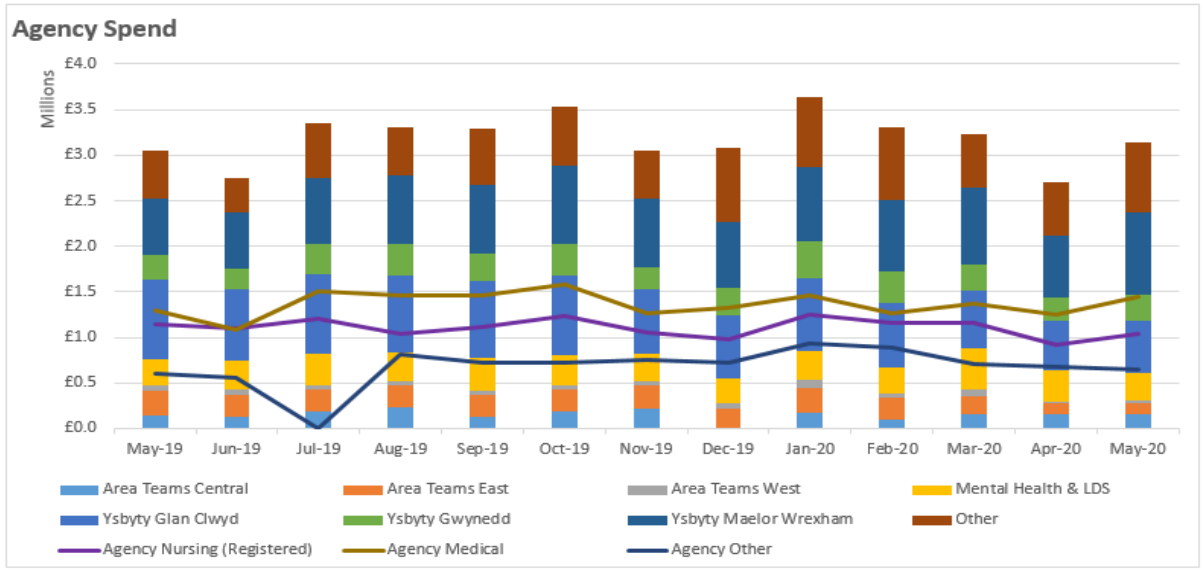


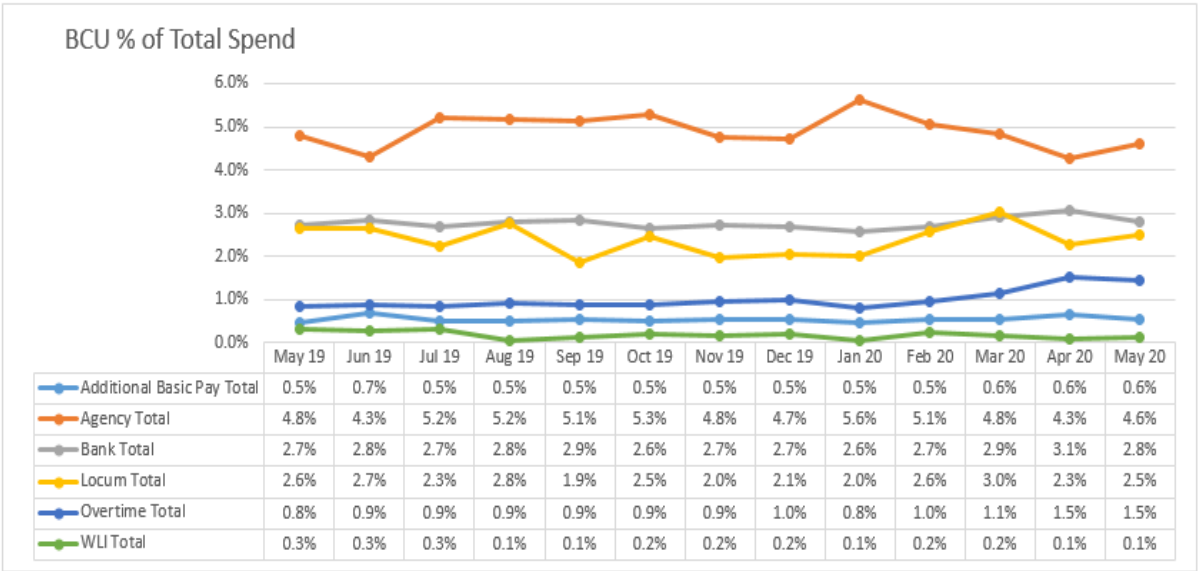
PADR



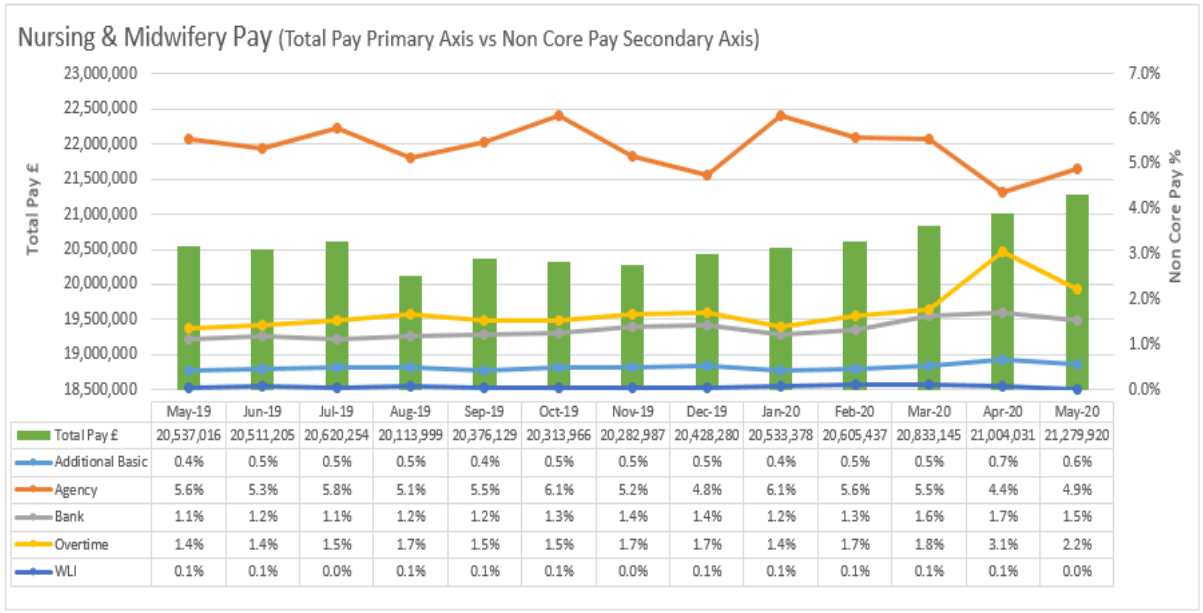


Quadruple Aim 4: Charts Agency and Locum Spend

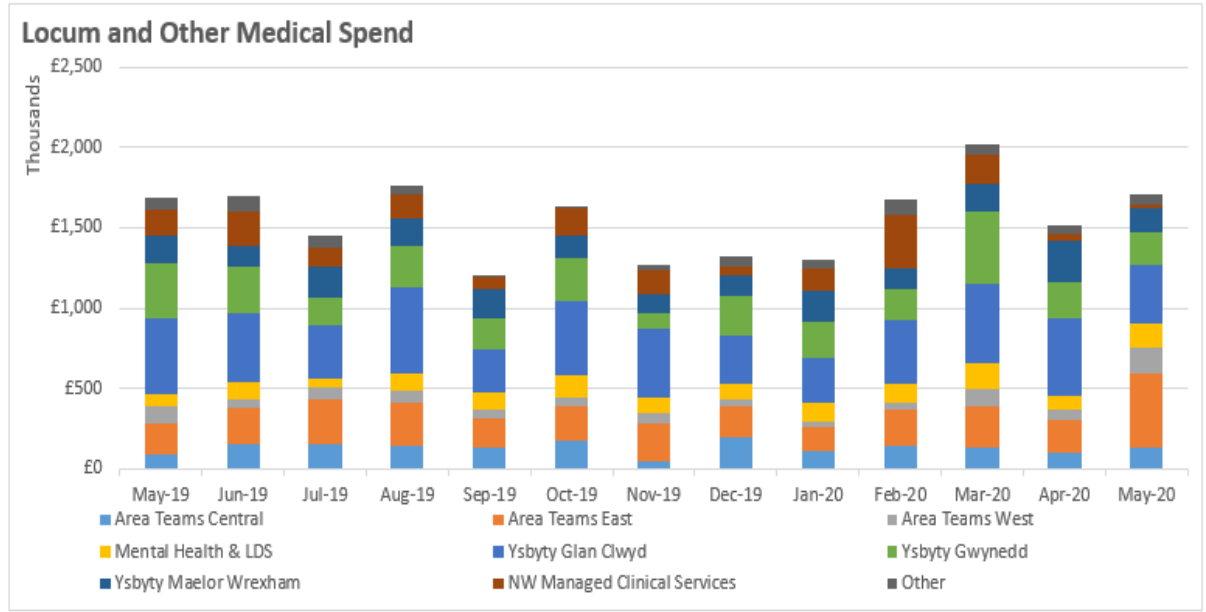




	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Additional Basic Pay Total	0.5%	0.7%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%
Agency Total	4.8%	4.3%	5.2%	5.2%	5.1%	5.3%	4.8%	4.7%	5.6%	5.1%	4.8%	4.3%	4.6%
Bank Total	2.7%	2.8%	2.7%	2.8%	2.9%	2.6%	2.7%	2.7%	2.6%	2.7%	2.9%	3.1%	2.8%
Locum Total	2.6%	2.7%	2.3%	2.8%	1.9%	2.5%	2.0%	2.1%	2.0%	2.6%	3.0%	2.3%	2.5%
Overtime Total	0.8%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	0.8%	1.0%	1.1%	1.5%	1.5%
WLI Total	0.3%	0.3%	0.3%	0.1%	0.1%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
Total Pay £	20,537,016	20,511,205	20,620,254	20,113,999	20,376,129	20,313,966	20,282,987	20,428,280	20,533,378	20,605,437	20,833,145	21,004,031	21,279,920
Additional Basic	0.4%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%	0.7%	0.6%
Agency	5.6%	5.3%	5.8%	5.1%	5.5%	6.1%	5.2%	4.8%	6.1%	5.6%	5.5%	4.4%	4.9%
Bank	1.1%	1.2%	1.1%	1.2%	1.2%	1.3%	1.4%	1.4%	1.2%	1.3%	1.6%	1.7%	1.5%
Overtime	1.4%	1.4%	1.5%	1.7%	1.5%	1.5%	1.7%	1.7%	1.4%	1.7%	1.8%	3.1%	2.2%
WLI	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%



Further Information

Further information is available from the office of the Director of Performance which includes:

- performance reference tables
- tolerances for red, amber and green
- the Welsh benchmark information which we have presented

Further information on our performance can be found online at:

- Our website www.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23.07.20
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Finance Report Month 1 2020/21
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Eric Gardiner, Finance Director, Provider Services
Craffu blaenorol: **Prior Scrutiny:**	Acting Executive Director of Finance Finance and Performance Committee
Atodiadau **Appendices:**	Appendix 1: Summary of Financial Performance Appendix 2: Covid-19 Impact Appendix 3: Expenditure Appendix 4: Financial Risks and Opportunities

Argymhelliad / Recommendation:

It is asked that the report is noted.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the financial performance of the Health Board as at April 2020 and reflects the financial impact of the evolving response to the Covid 19 pandemic.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m.

The plan does not take into account the impact of Covid-19, and therefore it will change throughout the year. It is likely that spending will be higher than planned due to the pandemic response and it is unlikely that savings delivery will be as high as originally planned, particularly in the early months of the year.

Due to the uncertainty around the consequences of the Covid-19 pandemic on the annual plan and the associated financial impact, forecasting a position for 2020/21 will be extremely difficult. The Health Board is currently anticipating that the plan of a £40m deficit will be achieved. This is based on the assumption that all Covid-19 costs will be funded by Welsh Government although this remains a significant risk to the financial plan.

Asesiad / Assessment:

1.0 Strategy Implications

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.

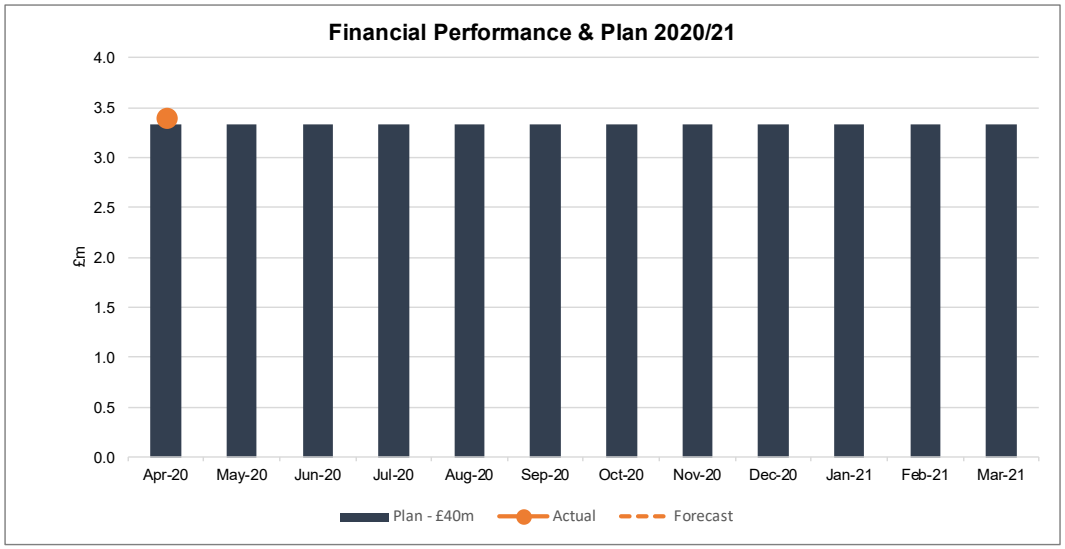
2.0 Options considered

Not applicable – report is for assurance only.

3.0 Financial Implications

3.1 Summary

Current Month		Year to Date		Full Year Forecast	
Plan	£3.4m Deficit	Plan	£3.4m Deficit	Plan	£40.0m Deficit
Actual	£3.4m Deficit	Actual	£3.4m Deficit	Forecast	£40.0m Deficit
Variance	Balanced	Variance	Balanced	Variance	Balanced



Achievement Against Key Targets

Revenue Resource Limit	✓	Public Sector Payment Policy (PSPP)	✗
Savings & Recovery Plans	✗	Revenue Cash Balance	✓
Capital Resource Limit	✓	Medium Term Plan	✗

3.2 Overview

- In month: The in-month position is a £3.4m deficit, which is in line with the plan for Month 1 and summary performance is included in Appendix 1. This position assumes that the total cost of Covid-19 will be funded by Welsh Government. In April, this cost is £30.8m, of which, £25m relates to the commissioning of the Field Hospitals.

	£m
Covid-19 expenditure	3.8
Field Hospital costs	25.0
Lost income	1.0
Non delivery of savings	3.7
Elective underspend	(2.3)
ICF Funding	(0.4)
Total Covid-19 costs	**30.8**

- Forecast: Due to the uncertainty around the costs of Covid-19 over the whole of 2020/21 and the number of unknown variables, forecasting a position for the year will be extremely difficult at this early stage. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

- Savings: The financial plan for 2020/21 is based on delivering savings of £45m. The savings requirement for Month 1 was £3.7m. The Recovery programme was stepped down during March, as the organisation fully focused on driving the Covid-19 plan, which has meant that the Health Board did not deliver any of the expected savings schemes in April. This has not impacted on the position, as it has been included in the cost of the Covid-19 response and funding from Welsh Government is anticipated to offset the financial impact.

3.3 Covid-19 Impact

- Total expenditure related to Covid-19 is £28.8m in April. Covid-19 has also impacted on other areas through lost income, non-delivery of savings and reduced elective care costs.

- The full set-up costs of the Field Hospitals have been accrued at a cost of £25m. This excludes the equipment that has been purchased via NHS Wales Shared Services Partnership (NWSSP). The accrual is based upon target costs as the final valuation for the cost of these hospitals is still to be determined and will be refined next month. The final valuation is dependent on other costs from sub-contractors and any potential retention or contingencies that may change the final outturn cost for the project. The reinstatement costs for the Field Hospitals are not included in these costs.

- The impact of Covid-19 has required resources to be mobilised quickly, allowing operational management to focus efforts on directly supporting the front-line demands. However, appropriate and effective management, maintenance of financial control and stewardship of Public Funds is still required.

- A Financial Governance Self-Assessment Group has been established to formally review the financial governance arrangements in respect of all Covid-19 income and expenditure. The purpose of the Group is to advise and assure the Board on whether effective arrangements were and are in place to support financial decision-making. Where appropriate, the Group will advise the Board on where and how its controls may be strengthened and developed further. The group includes members from Finance, Internal Audit, Commissioning, Counter Fraud, Payroll, Procurement, Corporate Governance and Information Governance.

- Further details on the cost and impact of Covid-19 are included in Appendix 2.

3.4 Income and Expenditure

	M01 £m	CUMULATIVE BUDGET	ACTUAL £m	VARIANCE £m
Revenue Resource Limit	(154.7)	(154.7)	(154.7)	0.0
Miscellaneous Income	(9.7)	(10.7)	(9.7)	1.0
Health Board Pay Expenditure	65.0	64.5	65.0	0.5
Non-Pay Expenditure	102.8	104.3	102.8	(1.5)
Total Against Plan	**3.4**	**3.4**	**3.4**	**0.0**

- Income: Most of the Health Board's funding is the Welsh Government allocation through the Revenue Resource Limit (RRL). Confirmed allocations to date total £1,517m, with further anticipated allocations in year of £155.6m, a total forecast of £1,673m for the year. Of this, £154.7m has been profiled into April. The Health Board is anticipating income to cover the costs of Covid-19 for 2020/21 but this has not yet been confirmed and is therefore listed as a significant risk to the financial position.

- Pay expenditure: Health Board pay costs in April are £65.0m, an increase of £0.7m on March and £2.1m higher than the 2019/20 monthly average. April costs include £1.1m directly related to Covid-19 and £1.3m for the Agenda for Change pay award. Non-medical pay budgets have been uplifted by 2.7% to fund the Agenda for Change pay award and the impact of the restructured bands. Total variable pay has fallen by £0.5m to £7.9m this includes a drop in agency costs of £0.4m and locum costs of £0.7m, whilst overtime has risen by £0.3m.

- Non-pay expenditure: Costs are £18.1m above the average for last year at £102.8m. Non-pay costs in April include £27.7m directly related to Covid-19, of which £25m has been incurred in commissioning the field hospitals. However, only a small number of elective care procedures have been undertaken during April, resulting in a reduction in spend totalling £2.3m across a number of non-pay categories.

- Further details on expenditure are included in Appendix 3.

3.5 Balance Sheet

- Cash: The closing cash balance for the Health Board was £14.1m.

- Capital: The Capital Resource Limit (CRL) at Month 1 is £22.7m. Year to date expenditure is £1.1m, which is in line with the plan.

4.0 Risk Analysis

There are three risks to the financial position detailed in Appendix 4.

5.0 Legal And Compliance

Not applicable.

6.0 Impact Assessment

Not applicable.

Appendix 1 – Summary of Financial Performance

	M01	CUMULATIVE		
		BUDGET	ACTUAL	VARIANCE
	£000	£000	£000	£000
WG RESOURCE ALLOCATION	(154,715)	(154,715)	(154,715)	0
AREA TEAMS				
West Area	13,969	13,746	13,969	222
Central Area	18,101	17,862	18,101	239
East Area	19,908	19,693	19,908	215
Other North Wales	364	278	364	86
Field Hospitals	25,037	25,037	25,037	0
Commissioner Contracts	17,951	18,016	17,951	(66)
Provider Income	(1,170)	(1,631)	(1,170)	461
Total Area Teams	94,160	93,001	94,160	1,157
SECONDARY CARE				
Ysbyty Gwynedd	8,248	8,144	8,248	104
Ysbyty Glan Clwyd	10,151	10,256	10,151	(106)
Ysbyty Maelor Wrexham	9,054	8,838	9,054	216
North Wales Hospital Services	8,520	8,451	8,520	69
Womens	3,404	3,203	3,404	201
Total Secondary Care	39,377	38,892	39,377	484
Total Mental Health & LDS	10,920	10,768	10,920	153
CORPORATE				
Chief Executive	213	170	213	42
Estates & Facilities	4,729	4,659	4,729	70
Utilities & Rates	1,508	1,307	1,508	201
Executive Director of Finance	739	722	739	17
Executive Director of Nursing & Midwifery	1,074	862	1,074	212
Executive Medical Director	1,760	1,662	1,760	98
Executive Director of Workforce & OD	1,068	950	1,068	118
Director of Planning & Performance	159	172	159	(13)
Executive Director of Public Health	135	122	135	13
Director of Corporate Services	0	(1)	0	1
Office to the Board	162	176	162	(14)
Director of Therapies	54	33	54	21
Executive Director of Primary Care & Comm Services	66	82	66	(16)
Director of Turnaround	98	137	98	(39)
Total Corporate	11,765	11,053	11,765	711
Total Other Budgets incl. Reserves	1,893	4,353	1,897	(2,456)
TOTAL	**3,400**	**3,352**	**3,404**	**49**

Appendix 2 – Covid-19 Impact

Covid-19 Expenditure

Type	M01 £'000
Field Hospitals	25,037
Area Teams	610
Secondary Care	2,133
Mental Health	289
Corporate	728
Total	**28,797**

Type	M01 £'000
Other Income	(30)
Total Income	**(30)**
Additional Clinical Services	170
Administrative & Clerical	151
Allied Health Professionals	22
Healthcare Scientists	10
Medical and Dental	437
Nursing and Midwifery Registered	313
Total Pay	**1,103**
Clinical Service & Supplies	1,258
Establishment Expenses	109
General Supplies & Services	521
Miscellaneous Services	96
Premises & Fixed Plant	25,413
Primary & Secondary Care	328
Total Non-Pay	**27,725**
Total	**28,797**

Funded via ICF	**338**
Funded by Welsh Government	**28,459**

Appendix 2 – Covid-19 Impact

- Pay costs are for additional work that is directly related to Covid-19. This includes agency costs, additional hours, overtime or enhancements over and above normal costs. Pay costs do not include the cost of staff that have been redeployed to help with the pandemic response.

- The largest element of non-pay costs relates to the cost of construction for the Field Hospitals. The majority of the Field Hospital costs are included in Premises and Fixed Plant, at a total of £24.7m. Also included in this category are minor building works across existing hospitals (£0.3m) and furniture costs (£0.1m).

- Included in Clinical Service and Supplies costs are medical and surgical equipment costs of £0.6m, laboratory equipment (£0.2m) and drugs costs (£0.1m). General Supplies and Services contains costs for bedding and laundry (£0.1m), protective clothing (£0.1m) and catering equipment (£0.1m).

- Additional Continuing Healthcare (CHC) placement costs, undertaken to release capacity in acute settings, have been funded from Intermediate Care Fund (ICF) monies.

Covid-19 Lost Income

	£m
Dental patient charges	0.6
Non-contracted activity (NCA's)	0.4
Other non-contracted income	0.1
	1.0

- Due to little patient activity being undertaken, there is a significant loss of patient related income for General Dental Services (GDS).

- Non-Contracted Activity (NCAs): Due to the restrictions on travel, it is anticipated that there will not be any NCA income or expenditure generated or incurred in April, as this arises from treatment of out of area patients. As this activity is not contracted, payments are not being maintained. The estimated impact of this in April is a net loss of income of £0.4m.

Other Financial Impacts

- Dental: General Dental Services (GDS) Contractor's will receive 80% of the agreed 2020/21 contract value, but other contract payments (such as rates and pension) remain fully protected. The loss of patient related income is forecast to be greater than the

reduced level of Contractor payments. In addition, the Health Board usually plans for a level of contract handback and clawback sums, which are used to commission additional non-recurrent schemes and activity. The Health Board is expecting the level of these to be significantly reduced, particularly in the first quarter of the year. Both of these limit the sum of resource available to use flexibly later in the year.

- General Medical Services (GMS): GP Practices are continuing to offer services, albeit with limited face to face patient access, and therefore are receiving the usual core contract payments in full. However, due the reduced level of direct patient attendance, Practices are unable to provide a full range of Enhanced and Additional services. As a result, Welsh Government have protected these elements of the GMS contract and payments are being made based on 2019/20 levels. Therefore, the Health Board is not expecting any significant change in the level of GMS contract spend for 2020/21 compared to previous years.

- Commissioning contracts have been agreed on the basis of block contracts, as agreed at a national level. This means that there are no reductions in cost arising from these contracts, despite planned care activity not being undertaken by other NHS organisations.

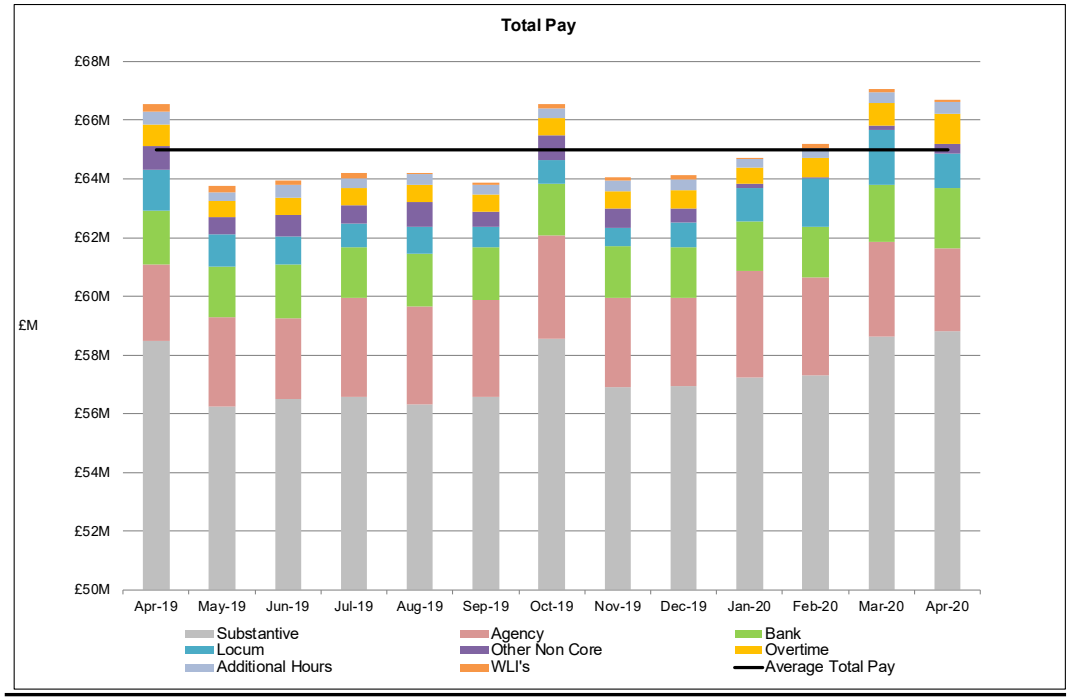
Forecast

- The Health Board is not providing a full year forecast at this stage for the financial year, as the impact of Covid-19 in 2020/21 is still evolving. A Quarter 1 operational plan has been submitted to Welsh Government, which assumes that:

  - The overall cost of Covid-19 to the Health Board will be fully funded by Welsh Government.
  - Savings delivery for the year will be reduced against the plan of £45m and indicative estimates are that this may be circa £9m (20% delivery).
  - Field hospital costs in April and May relate to the commissioning of the hospitals and are estimated at £25.6m.
  - Running costs have been estimated at this stage, based on 50% capacity from the start of July to the end of March 2021.
  - Costs for decommissioning the field hospitals are currently estimated at £2.2m.
  - Income lost due to Covid-19 will remain at the same level as in April for the rest of the year.
  - Elective under spends will continue for the rest of the year. Some elective work has commenced in May and it is expected that activity will increase over future months, but full capacity will not be reached in 2020/21 due to the requirements of social distancing for staff and patients.

Appendix 3 – Expenditure

Pay Expenditure

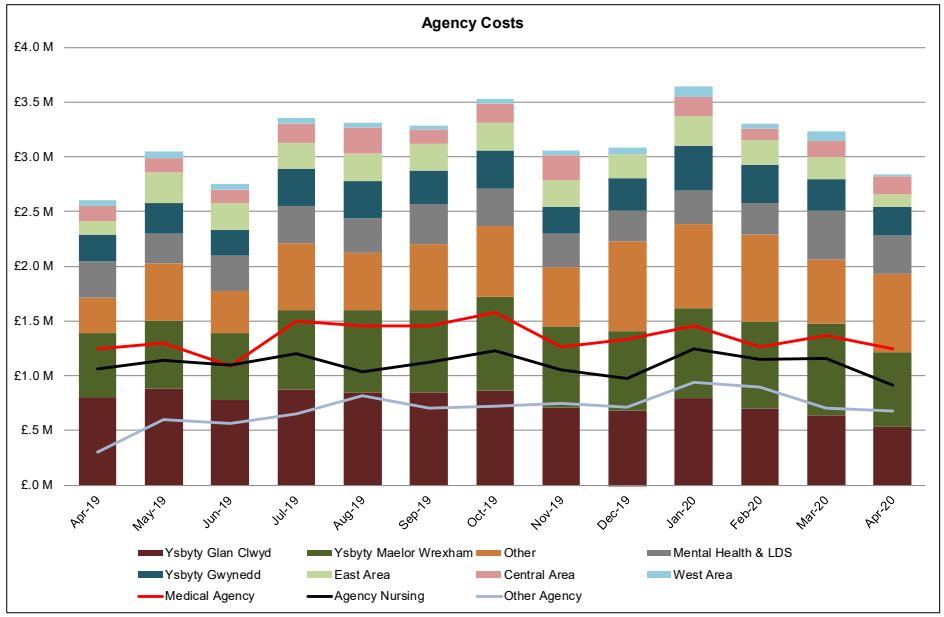


	2019/20 Average £m	M01 Actual £m	Cumulative YTD Budget £m	Cumulative YTD Actual £m	Cumulative YTD Variance £m
Administrative & Clerical	8.3	8.6	8.9	8.6	(0.3)
Medical & Dental	14.8	15.2	14.4	15.2	0.8
Nursing & Midwifery Registered	20.2	20.6	21.6	20.6	(1.0)
Additional Clinical Services	8.9	9.4	8.5	9.4	0.9
Add Prof Scientific & Technical	2.8	3.1	3.0	3.1	0.1
Allied Health Professionals	3.7	3.8	3.7	3.8	0.1
Healthcare Scientists	1.2	1.1	1.2	1.1	(0.1)
Estates & Ancillary	3.0	3.2	3.2	3.2	0.0
Students	0.0	0.0	0.0	0.0	0.0
Health Board Total	**62.9**	**65.0**	**64.5**	**65.0**	**0.5**
Primary care	2.0	1.7	1.5	1.7	0.2
Total Pay	**64.9**	**66.7**	**66.0**	**66.7**	**0.7**

Appendix 3 – Expenditure

Month 1 Variable Pay	£'000
Agency	2,836
Overtime	1,021
Locum	1,185
WLIs	73
Bank	2,038
Other Non Core	327
Additional Hours	431
Total	**7,911**

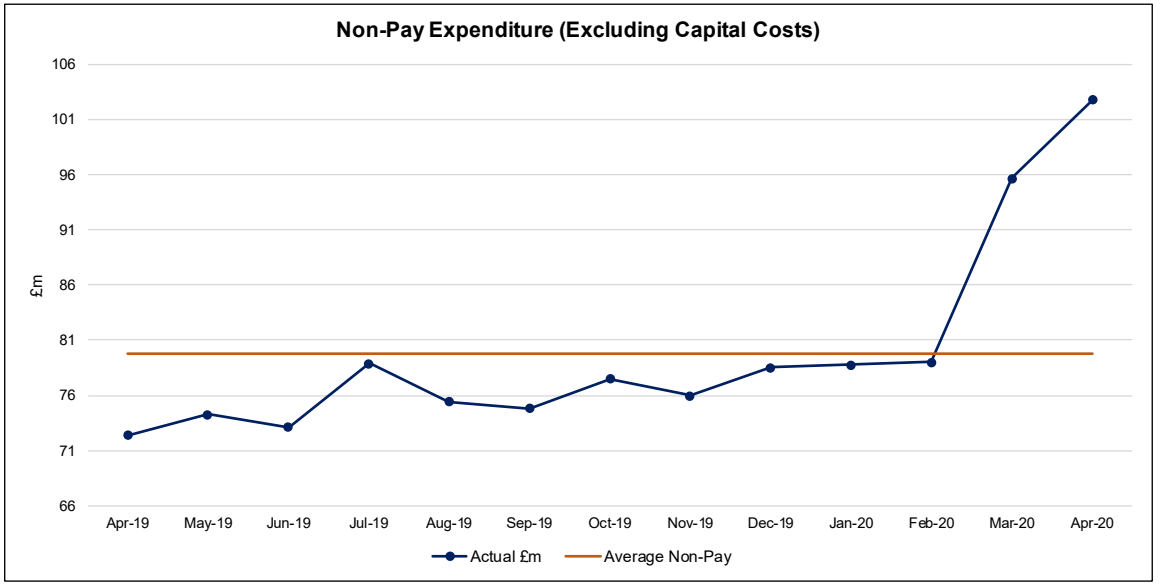
- Total variable pay in April was £7.9m (12.6% of total pay). This is £0.5m less than in March, but remains £0.2m above the average for 2019/20. Decreases have been seen particularly in locums (by £0.7m) and agency, whilst there was a £0.3m increase in overtime.



- Expenditure on agency staff for Month 1 is £2.8m, representing 4.3% of total pay, a decrease of £0.4m on last month. Agency costs are £0.3m lower than the average monthly cost for 2019/20.
- Medical agency costs have decreased by £0.1m to an in-month spend of £1.2m. The average monthly Medical agency spend for 2019/20 was £1.4m.
- Nurse agency costs were £0.9m for the month, £0.3m lower than in March and below the £1.1m monthly average for 2019/20.
- Other agency costs remained at £0.7m for April and mainly arise from Admin and Clerical (£0.4m) and Allied Health Professionals (£0.2m).

Appendix 3 – Expenditure

Non-Pay Expenditure



	2019/20 Average £m	M01 Actual £m	Cumulative YTD Budget £m	Cumulative YTD Actual £m	Cumulative YTD Variance £m
Primary Care	17.7	17.2	17.7	17.2	(0.5)
Primary Care Drugs	9.0	8.9	8.6	8.9	0.3
Secondary Care Drugs	6.0	5.4	5.8	5.4	(0.4)
Clinical Supplies	5.9	4.8	6.0	4.8	(1.2)
General Supplies	3.7	2.7	3.0	2.7	(0.3)
Healthcare Services Provided by Other NHS Bodies	21.7	22.7	22.7	22.7	0.0
Continuing Care and Funded Nursing Care	8.1	8.4	8.4	8.4	0.0
Other	5.8	30.3	29.7	30.3	0.6
Non-pay costs	77.9	**100.4**	**101.9**	**100.4**	(1.5)
Cost of Capital	6.8	2.4	2.4	2.4	0.0
Total non-pay including cost of capital	**84.7**	**102.8**	**104.3**	**102.8**	(1.5)

Appendix 3 – Expenditure

- Primary Care drugs: This remains one of the Health Board's key risks in 2020/21. Costs in April are in line with the average monthly spend last year, however the trend is still one of rising average costs.

- Secondary Care drugs: Costs are £0.6m lower than the 2019/20 average, despite incurring drugs expenditure of £0.1m in relation to Covid-19. Reductions were seen across Secondary Care due to lower patient activity.

- Clinical and General Supplies: Clinical Supplies costs include £1.3m relating to Covid-19, but still show a decrease of £1.1m compared to the prior year average. Similarly, General Supplies costs show a decrease of £1.0m compared to the prior year average, which is after spend of £0.5m relating to Covid-19. Both of these decreases are due to reduced planned care activity.

- Healthcare Services Provided by Other NHS Bodies: Due to the agreement to maintain payments to other NHS organisations via block contracts, there is no reduction in costs, despite those organisations not undertaking work on behalf of the Health Board.

- Other non-pay expenditure: The £25m cost of the Field Hospitals is included, along with an additional £0.6m of Covid-19 expenditure.

Appendix 4 – Financial Risks and Opportunities

	Issue	Description		Key Decision Point & Summary Mitigation	Risk Owner
1	**Risk:** WG Covid-19 funding	– Income has been anticipated for the estimated cost of Covid-19 for 2020/21. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The operational plan is still being developed and so all costs are only indicative at this stage.		– The Health Board is working with Welsh Government to quantify and understand the potential funding for the Covid-19 response and consequential actions. – As the operational plan is developed, there will be greater confidence around the assumptions within the current forecast and any potential mitigating actions can be agreed.	Sue Hill, Acting Executive Director of Finance
2	**Risk:** Junior Doctor monitoring	– There was a significant test legal case focusing on how NHS organisations should address monitoring for junior doctors.		– It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.	Sue Green, Executive Director of Workforce & Organisational Development
3	**Risk:** Holiday pay	– NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement are ongoing and the outcome of the Supreme Court appeal is awaited.		– The Health Board is monitoring the situation.	Sue Green, Executive Director of Workforce & Organisational Development

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23.07.20
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Finance Report Month 2 2020/21
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Eric Gardiner, Finance Director - Provider Services
Craffu blaenorol: **Prior Scrutiny:**	Acting Executive Director of Finance Finance and Performance Committee
Atodiadau **Appendices:**	Appendix 1: Summary of Position by Division Appendix 2: Covid-19 Impact Appendix 3: Expenditure Appendix 4: Financial Risks and Opportunities

Argymhelliad / Recommendation:

It is recommended that the report is noted.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	✓

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the financial performance of the Health Board as at May 2020 and reflects the financial impact of the continuing response to the Covid-19 pandemic.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m predicated on delivering savings of £45m.

The plan did not take into account the impact of Covid-19, and therefore it will change throughout the year. It is likely that spending will be higher than planned due to the pandemic response and savings delivery will be significantly reduced as the Health Board prioritises the clinical and operational response to the pandemic, particularly in the early months of the year.

Due to the uncertainty around the impact of Covid-19 and the clinical and operational consequences of managing the pandemic response, forecasting a position for 2020/21 remains extremely difficult. The Health Board is currently anticipating that the plan of a £40m deficit will be achieved. This is based on the assumption that all Covid-19 costs will be funded by Welsh Government although this remains a significant risk to the financial plan.

Asesiad / Assessment:

1.0 Strategy Implications

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.

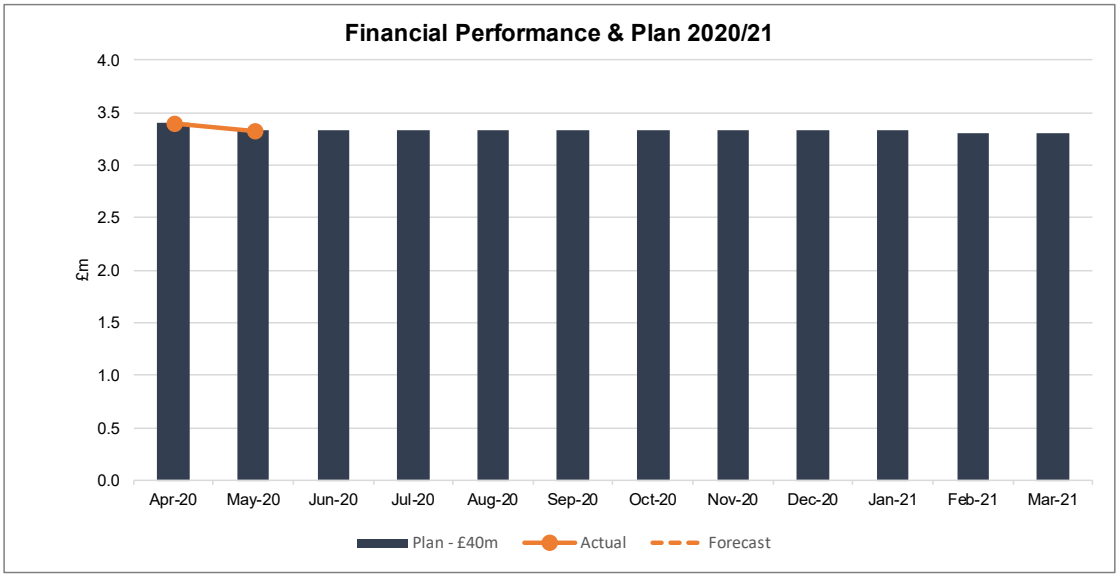
2.0 Options considered

Not applicable – report is for assurance only.

3.0 Financial Implications

3.1 Summary

Current Month		Year to Date		Full Year Forecast	
Plan	£3.3m Deficit	Plan	£6.7m Deficit	Plan	£40.0m Deficit
Actual	£3.3m Deficit	Actual	£6.7m Deficit	Forecast	£40.0m Deficit
Variance	Balanced	Variance	Balanced	Variance	Balanced



Achievement Against Key Targets

Revenue Resource Limit	✓	Public Sector Payment Policy (PSPP)	✗
Savings & Recovery Plans	✗	Revenue Cash Balance	✓
Capital Resource Limit	✓	Medium Term Plan	✗

3.2 Overview

- In month: The £3.3m in-month deficit is in line with the plan for Month 2. This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The cost of Covid-19 in May is £5.1m and anticipated income from Welsh Government has been included in the position to match this cost.

- Year-to-date: The Health Board is overspent by £6.7m, which is in line with the financial plan. The cost of Covid-19 is £36.9m, of which £1m has been funded through the Intermediate Care Fund (ICF) monies. Welsh Government income of £35.9m has been anticipated to fund the remaining balance. The value of Welsh Government funding available for Covid-19 has not yet been

confirmed, although some funding was received in June, and is therefore a significant risk to the financial position. A summary of the financial position of the Health Board, including divisions is included as Appendix 1.

	M01 £m	M02 £m	YTD £m
Covid-19 spend (incl. Field Hospitals)	28.8	3.7	32.5
Lost income	1.0	1.4	2.4
Non delivery of savings	3.7	3.6	7.3
Elective underspend	(2.4)	(2.9)	(5.3)
Total Covid-19 costs	**31.1**	**5.8**	**36.9**
ICF Funding	(0.3)	(0.7)	(1.0)
WG anticipated Covid-19 funding	(30.8)	(5.1)	(35.9)
Impact on position	**0.0**	**0.0**	**0.0**

- Forecast: Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year remains extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

- Savings: The financial plan for 2020/21 is based on delivering savings of £45m. Savings not delivered in Month 2, due to the impact of Covid-19, were £3.6m (£7.3m for the year to date). The Health Board is now moving into the second phase of its plan to respond to the pandemic and considering how best to balance managing Covid-19 patients and elective activity whilst adhering to social distancing rules and the needs to protect staff and patients. The crisis has provided opportunities to push through changes at pace, work with partners effectively and consider how the Health Board can transform in the future, learning from new ways of working and delivering services. Following the suspension of the Recovery Programme in March, the Health Board is now considering how best to resume the savings plans that began development in 2019/20. We have undertaken a desktop review of the programme that was under development and a thorough review of the potential for in-year savings delivery.

3.3 Covid-19 Impact

- Expenditure relating to Covid-19, including the Field Hospitals, is £3.7m in May. This includes £0.7m of CHC placements to create acute capacity funded from ICF monies, leaving a net cost of £3.0m. In addition there is £1.4m of lost income and £3.6m of undelivered savings, offset by elective care savings of £2.9m. The net impact of Covid-19 in May is therefore £5.1m and income from Welsh Government to match this cost has been anticipated in the position.

- Further details on the cost and impact of Covid-19 are included in Appendix 2 and an update on the Financial Governance Controlled Self-Assessment Project is included in Appendix 6.

3.4 Income and Expenditure

	M01 £m	M02 £m	Cumulative Budget	Cumulative Actual £m	Variance £m
Revenue Resource Limit	(154.7)	(128.5)	(283.2)	(283.2)	0.0
Miscellaneous Income	(9.7)	(9.8)	(21.4)	(19.5)	1.9
Health Board Pay Expenditure	65.0	66.1	131.3	131.1	(0.2)
Non-Pay Expenditure	102.8	75.5	180.0	178.3	(1.7)
Total Against Plan	**3.4**	**3.3**	**6.7**	**6.7**	**(0.0)**

- Income: Most of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). Confirmed allocations to date are £1,522m, with further anticipated allocations in year of £161.4m, a total forecast RRL of £1,683.6m. £128.5m has been profiled into May. The Health Board is anticipating income to cover the costs of Covid-19 for 2020/21 but this has not yet been confirmed and is therefore listed as a significant risk to the financial position.

- Pay expenditure: Health Board pay costs in May are £66.1m, an increase of £1.1m from last month. This includes £2.0m of pay costs directly related to Covid-19, which is a £0.9m rise from April. Total variable pay has increased by £0.3m to £8.2m. This includes rises in agency costs of £0.3m and locum costs of £0.5m, whilst other non-core costs have reduced by £0.3m.

- Non-pay expenditure: Costs this month are £27.3m less than in April at £75.5m. £25.0m of the reduction is due to the Field Hospital commissioning costs that were included in Month 1. Both Primary and Secondary Care Drug costs have reduced in May by £0.7m due to fewer prescribing days and a reduction in planned care activity. In addition, savings due to the reduction in elective care activity across the Health Board are £0.5m higher in May at £2.9m. Month 2 non-pay costs include £1.8m directly related to Covid-19.

- Further details on expenditure are included in Appendix 4.

3.5 Balance Sheet

- Cash: The closing cash balance for May was £9.5m, which included £1.7m of cash held for capital expenditure. The revenue cash balance of £7.8m was within the internal target set by the Health Board. The cash flow forecast is currently reporting a shortfall of £38.7m at the end of the year. The Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required.

- Capital: The Capital Resource Limit (CRL) for 2020/21 is £22.7m. Actual expenditure up to May was £1.9m, which was £0.9m ahead of plan. This is primarily due to Covid-19 expenditure (£0.8m). The CRL includes the capital element of the Welsh Government Digital Priorities Investment Fund. Details of the schemes, totalling £1.75m, are included in Appendix 7.

4.0 Risk Analysis

There are four risks to the financial position detailed in Appendix 5.

5.0 Legal And Compliance

Not applicable.

6.0 Impact Assessment

Not applicable.

Appendix 1 – Summary of Position by Division

	M01 Actual £000	M02 Actual £000	Cumulative Budget £000	Cumulative Actual £000	Variance £000
WG RESOURCE ALLOCATION	(154,715)	(128,474)	(283,189)	(283,189)	0
AREA TEAMS					
West Area	13,969	13,417	26,280	26,647	367
Central Area	18,101	17,247	34,223	34,615	392
East Area	19,908	19,137	37,507	38,155	648
Other North Wales	364	2,706	5,292	5,427	136
Field Hospitals	25,037	(539)	24,502	24,502	0
Commissioner Contracts	17,951	17,816	36,033	35,766	(266)
Provider Income	(1,170)	(1,252)	(3,409)	(2,422)	987
Total Area Teams	94,160	68,532	160,427	162,690	2,263
SECONDARY CARE					
Ysbyty Gwynedd	8,248	8,076	16,194	16,323	129
Ysbyty Glan Clwyd	10,151	10,259	20,740	20,410	(330)
Ysbyty Maelor Wrexham	9,054	8,930	17,696	17,984	287
North Wales Hospital Services	8,520	8,074	16,586	16,594	8
Womens	3,404	3,514	6,473	6,918	445
Total Secondary Care	39,377	38,853	77,690	78,229	539
Total Mental Health & LDS	10,920	10,773	21,560	21,693	133
CORPORATE					
Chief Executive	213	209	347	421	75
Estates & Facilities	4,729	4,564	9,242	9,293	51
Utilities & Rates	1,508	1,409	2,617	2,916	300
Executive Director of Finance	739	761	1,483	1,500	17
Executive Director of Nursing & Midwifery	1,074	1,041	1,979	2,189	210
Executive Medical Director	1,760	1,839	3,425	3,625	200
Executive Director of Workforce & OD	1,068	1,157	2,022	2,226	204
Director of Planning & Performance	159	229	423	388	(35)
Executive Director of Public Health	135	88	241	223	(18)
Director of Corporate Services	0	0	0	0	(0)
Office to the Board	162	98	202	187	(15)
Director of Therapies	54	28	68	56	(12)
Executive Director of Primary Care & Comm Services	66	64	167	130	(37)
Director of Turnaround	98	98	302	196	(106)
Total Corporate	11,765	11,585	22,516	23,350	833
Total Other Budgets incl. Reserves	1,897	2,059	7,678	3,956	(3,722)
TOTAL	**3,404**	**3,329**	**6,683**	**6,729**	**46**

Appendix 2 – Covid-19 Impact

Covid-19 Expenditure

Type	M01 £'000	M02 £'000	Total £'000
Other Income	(30)	30	0
Total Income	**(30)**	**30**	**0**
Additional Clinical Services	170	357	527
Administrative & Clerical	166	427	593
Allied Health Professionals	22	50	72
Estates & Ancilliary	(15)	36	21
Healthcare Scientists	10	34	44
Medical and Dental	437	648	1,085
Nursing and Midwifery Registered	313	383	696
Professional Scientific & Technical	0	18	18
Total Pay	**1,103**	**1,953**	**3,056**
Primary Care	131	392	523
Primary Care Drugs	0	10	10
Secondary Care Drugs	129	51	180
Clinical Services & Supplies	1,129	580	1,709
General Services & Supplies	786	662	1,448
Healthcare Services Provided by Other NHS Bodies	0	10	10
Establishment & Transport Expenses	66	92	158
Premises and Fixed Plan	25,352	(522)	24,830
Other Non-Pay	133	480	612
Total Non-Pay	**27,725**	**1,755**	**29,480**
Total	**28,798**	**3,737**	**32,536**

Funded via ICF	**338**	**669**	**1,007**
Funded by Welsh Government	**28,459**	**3,068**	**31,527**

Appendix 2 – Covid-19 Impact

Type	M01 £'000	M02 £'000	Total £'000
Field Hospitals	25,041	(539)	24,502
Area Teams	607	947	1,555
Secondary Care	2,133	2,033	4,166
Mental Health	289	427	716
Corporate	728	868	1,596
Total	**28,798**	**3,737**	**32,535**

- Pay costs are for additional work that is directly related to Covid-19. This includes agency costs, additional hours, overtime or enhancements over and above normal costs. Pay costs do not include the cost of staff that have been redeployed to help with the pandemic response.

- The full set-up costs of the Field Hospitals were accrued in April at a cost of £25m. The accrual has been reviewed and refined in May, resulting in a reduction in the contract forecast costs. This has resulted in negative expenditure of £0.5m in Month 2. The final valuation is dependent on final sub-contractors' costs and any potential retention or contingencies that may change the final outturn cost for the project.

- In addition to these costs, other areas are also being impacted by Covid-19. This includes General Dental Services (GDS) contractor payments, General Medical Services (GMS) contracts and payments and Commissioning contracts, which have been agreed on a block contract basis at a national level.

Covid-19 Lost Income

	£m
Dental patient charges	0.6
Non-contracted activity (NCAs)	0.4
Private patient income	0.3
Other non-contracted income	0.1
Total	**1.4**

Appendix 2 – Covid-19 Impact

- There is a significant loss of patient related income for General Dental Services (GDS) as few patients are currently being treated.

- Non-Contracted Activity (NCAs): Due to the restrictions on travel, it is anticipated that English NCA income for May will be much lower than usual, as this arises from treatment of out of area patients.

Forecast

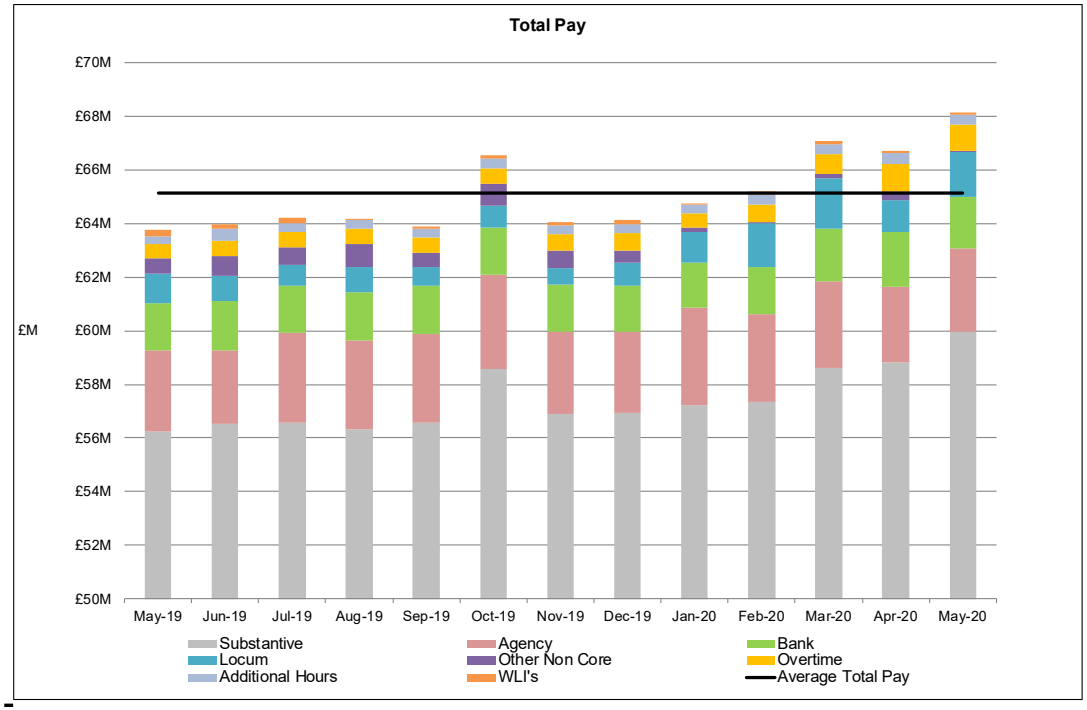
- The forecast costs and expenditure relating to Covid-19 will be reviewed and revised as the Health Board develops and adjusts the plan.

- Specific assumptions made are:

  - The overall cost of Covid-19 to the Health Board will be fully funded by Welsh Government.
  - Savings delivery for the year will be reduced against the plan of £45m.
  - Field hospital costs in April and May relate to the commissioning of the hospitals. Running costs have been estimated at this stage, based on 50% capacity from the start of July to the end of March 2021. This is reviewed on an ongoing basis.
  - Costs for decommissioning the field hospitals are currently estimated at £2.2m, to be incurred in March.
  - Elective under spends will continue for the rest of the year. Some elective work has commenced in May and it is expected that activity will increase over future months, but full capacity will not be reached in 2020/21 due to the requirements of social distancing for staff and patients. The Health Board is continuing to use the local private hospital to support elective activity.

Appendix 3 – Expenditure

Pay Expenditure

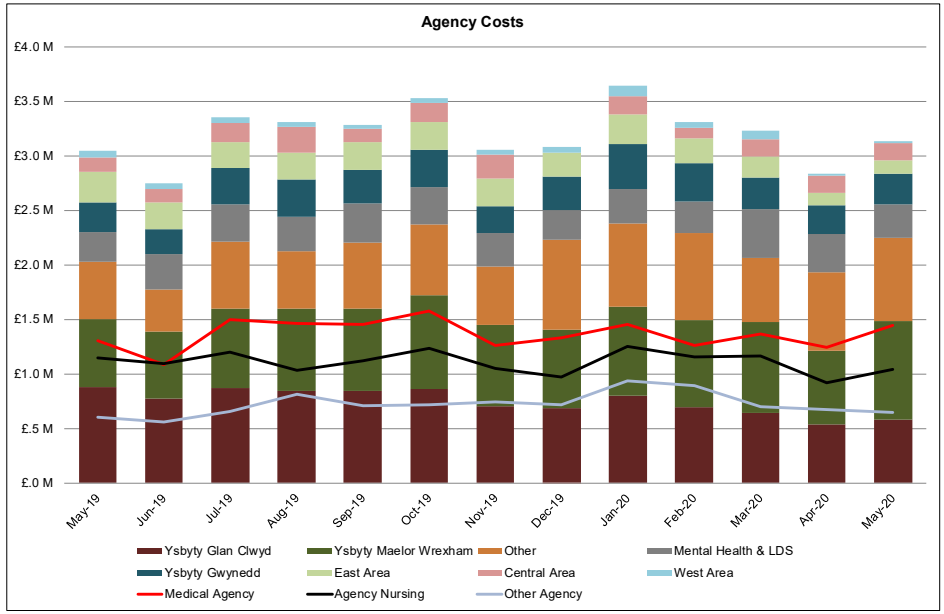


	2019/20 Average £m	M01 Actual £m	M02 Actual £m	Cumulative YTD Budget £m	Cumulative YTD Actual £m	Cumulative YTD Variance £m
Administrative & Clerical	8.3	8.6	8.8	18.3	17.4	(0.9)
Medical & Dental	14.8	15.2	15.6	29.3	30.8	1.5
Nursing & Midwifery Registered	20.2	20.6	20.8	43.6	41.4	(2.2)
Additional Clinical Services	8.9	9.4	9.5	17.4	18.9	1.5
Add Prof Scientific & Technical	2.8	3.1	3.1	6.3	6.2	(0.1)
Allied Health Professionals	3.7	3.8	3.8	7.5	7.6	0.1
Healthcare Scientists	1.2	1.1	1.2	2.4	2.3	(0.1)
Estates & Ancillary	3.0	3.2	3.2	6.5	6.4	(0.1)
Students	0.0	0.0	0.1	0.0	0.1	0.1
Health Board Total	**62.9**	**65.0**	**66.1**	**131.3**	**131.1**	**(0.2)**
Primary care	2.0	1.7	2.1	3.2	3.8	0.6
Total Pay	**64.9**	**66.7**	**68.2**	**134.5**	**134.9**	**0.4**

Appendix 3 – Expenditure

Month 2 Variable Pay	£'000
Agency	3,136
Overtime	989
Locum	1,659
WLIs	82
Bank	1,912
Other Non Core	49
Additional Hours	380
Total	**8,207**

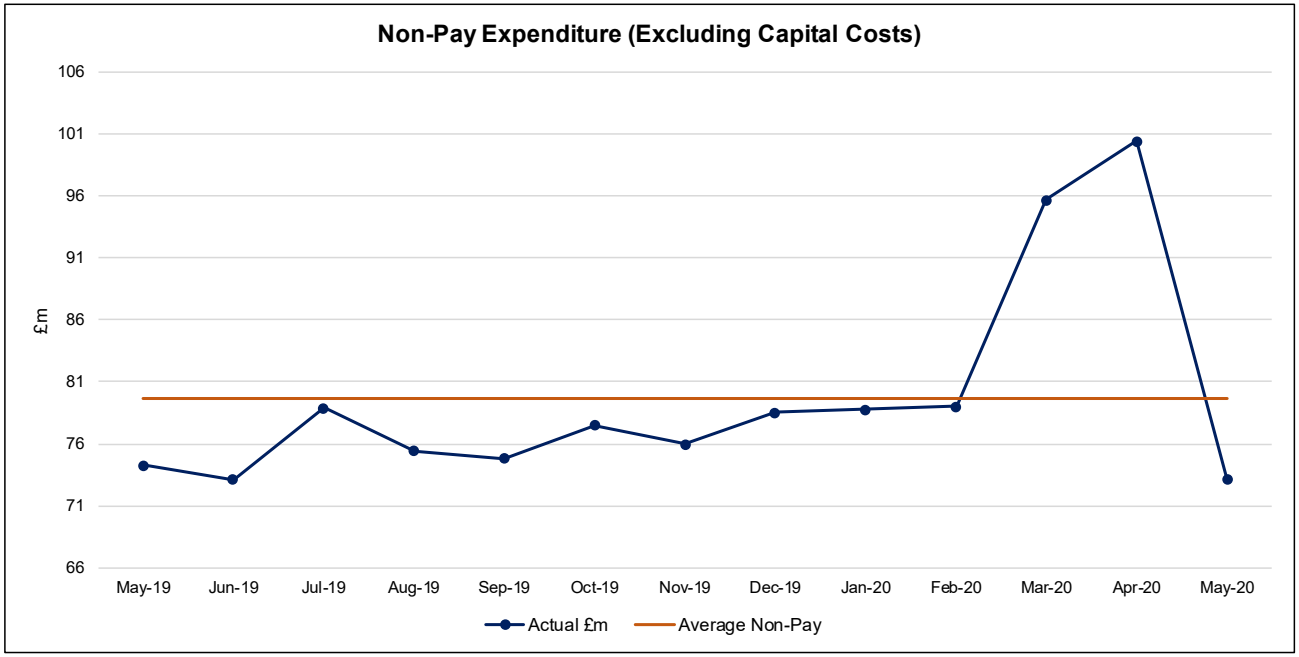
- Total variable pay in May was £8.2m (12.6% of total pay). This is £0.3m more than in April and £0.5m above the average for 2019/20. Increases have been seen particularly in locums (by £0.5m) and agency (by £0.3m), whilst there was a £0.2m decrease in other non-core.



- Agency costs for Month 2 are £3.1m, representing 4.6% of total pay, an increase of £0.3m on last month. Agency spend related to Covid-19 in May was £0.5m compared to £0.2m in April.
- Medical agency costs have increased by £0.2m to an in-month spend of £1.4m. The additional costs incurred in May are all directly related to Covid-19.
- Nurse agency costs totalled £1.0m for the month, £0.1m higher than in April. These costs include £0.1m relating to Covid-19.
- Other agency costs remained at £0.7m for May and mainly arise from Admin and Clerical (£0.4m) and Allied Health Professionals (£0.2m).

Appendix 3 – Expenditure

Non-Pay Expenditure



	2019/20 Average £m	M01 Actual £m	M02 Actual £m	Cumulative YTD Budget £m	Cumulative YTD Actual £m	Cumulative YTD Variance £m
Primary Care	17.7	17.2	17.5	35.5	34.7	(0.8)
Primary Care Drugs	9.0	8.9	8.6	16.3	17.5	1.2
Secondary Care Drugs	6.0	5.4	5.0	11.3	10.4	(0.9)
Clinical Supplies	5.9	4.8	3.6	11.5	8.4	(3.1)
General Supplies	3.7	2.7	2.6	5.7	5.3	(0.4)
Healthcare Services Provided by Other NHS Bodies	21.7	22.7	22.7	45.3	45.4	0.1
Continuing Care and Funded Nursing Care	8.1	8.4	8.2	17.0	16.6	(0.4)
Other	5.8	30.3	4.9	32.7	35.2	2.5
Non-pay costs	77.9	**100.4**	**73.1**	**175.3**	**173.5**	(1.8)
Cost of Capital	6.8	2.4	2.4	4.7	4.8	0.1
Total non-pay including cost of capital	**84.7**	**102.8**	**75.5**	**180.0**	**178.3**	(1.7)

Appendix 3 – Expenditure

- Primary Care drugs: Costs in May have decreased compared to April as there are less prescribing days – 19 in May versus 22 in April. This gives April an average cost per prescribing day of £0.406m, increasing to £0.451m in May. Therefore, overall the trend is still one of rising average costs. The Health Board is working through the forecast for the year and this is a potential risk in 2020/21.

- Secondary Care drugs: Costs are £0.4m lower than in Month 1, with reductions seen across Secondary Care due to lower patient activity. Covid-19 spend on drugs was £0.1m in May (£0.2m year to date).

- Clinical and General Supplies: Clinical Supplies costs include £0.6m relating to Covid-19, a decrease of £0.5m from April. Additionally, cost reductions due to reduced planned care activity are higher in May than in April. Similarly, General Supplies costs include £0.7m relating to Covid-19 (£1.4m year to date).

- Healthcare Services Provided by Other NHS Bodies: Due to the agreement to maintain payments to other NHS organisations via block contracts, there is no reduction in costs, despite those organisations not undertaking work on behalf of the Health Board.

- Other non-pay expenditure: The £25m cost of commissioning the Field Hospitals was included in the Month 1 position. In May there has been a reduction of £0.5m in these costs, which is offsetting other Covid-19 expenditure resulting in a nil cost for the month. The £2.5m year-to-date overspend relates to the non-delivery of savings, offset by under spends due to reduced elective activity and in other areas impacted by the pandemic, including travel (£0.3m), training (£0.2m), printing and stationery (£0.1m).

Appendix 4 – Financial Risks and Opportunities

	Issue	Description	£m	Key Decision Point & Summary Mitigation	Risk Owner
1	**Risk:** WG Covid-19 funding	– Income is anticipated for the estimated cost of Covid-19 for 2020/21. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The operational plan is still being developed and so all costs are only indicative at this stage.		– The Health Board is working with Welsh Government regarding funding for the Covid-19 response. – As the operational plan is developed, there will be greater confidence around the assumptions within the current forecast and any potential mitigating actions can be agreed.	Sue Hill, Acting Executive Director of Finance
2	**Risk:** Welsh Risk Pool (WRP) Risk Share	– The projected increased cost of the Welsh Risk Pool (WRP) Risk Share is a risk to the Health Board's forecast for 2020/21.	0.1	– The cost is being monitored and all-Wales discussions taking place through Deputy Director of Finance meetings.	Sue Hill, Acting Executive Director of Finance
3	**Risk:** Junior Doctor monitoring	– There was a significant test legal case focusing on how NHS organisations should address monitoring for junior doctors.		– It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.	Sue Green, Executive Director of Workforce & Organisational Development
4	**Risk:** Holiday pay	– NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement are ongoing and the outcome of the Supreme Court appeal is awaited.		– The Health Board is monitoring the situation.	Sue Green, Executive Director of Workforce & Organisational Development

Health Board

23rd July 2020

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Audit Committee
Meeting date:	29th June 2020
Name of Chair:	Medwyn Hughes, Independent Member
Responsible Director:	Dawn Sharp, Acting Board Secretary
Summary of business discussed:	• In Committee items from previous meeting reported in public • Committee Breach Log Report • Risk Management Strategy/Policy • Schedule of Financial Claims • Internal Audit, Internal Audit Opinion and 2020-21 Plan • Final Internal Audit Report – Deprivation of Liberty Safeguards • Wales Audit Office, Review of Audited Accounts and Financial Statement, Auditor General and Audit Wales Director letters on COVID-19 impact • Wales Audit Office, Findings from the Auditor General's Sustainable Development Principle Examinations (Wales First "Future Generations Report") • Executive Director Briefing on 2019-20 Financial Statements • Annual Accounts 2019-20 • Remuneration Annual Report 2020 • Financial Conformance Report • Annual Governance Statement (AGS) • Audit Committee Annual Report, Terms of Reference and Cycle of Business • Quality, Safety & Experience Committee Annual Report, Terms of Reference and Cycle of Business • Counter Fraud Annual Report 2019/20 • Financial Governance During COVID-19 Report • Internal and External Audit Tracker
Key assurances provided at this meeting:	• Members were pleased to receive the first iteration of the **Committee Breach Log Report** that provided oversight of breaches of publication of Committee papers not in accordance with the Standing Orders. • Three recommendations for the **Interim Staffing Review** had been agreed and progress would be monitored via the Audit Tracker • The **Risk Management Strategy/Policy** was approved. • The **Schedule of Financial Claims** was received and approved

	• Members were pleased to note a positive (reasonable assurance) opinion in the **Head of Internal Audit Opinion and Annual Report.** • Members were pleased to note the positive engagement from the Safeguarding team and progress already made against the **Final Internal Audit Report – Deprivation of Liberty Safeguards** • Members received the **Health Board's 2019/20 Annual Financial Statements, including the Remuneration Report** that noted the Health Board had achieved the capital resource performance target as well as the Public Sector Payment Policy target. The report had been published with no specific issues with regard to local preparation notwithstanding the COVID-19 pandemic. • Members received the **Financial Governance during COVID-19 Report** and were pleased to note that a Financial Governance Review was shortly to commence with representation from both Internal Audit and Wales Audit Office. • Members noted that the requirement to complete **Committee Annual Reports for all Committees** had been reinstated. The outstanding reports would be received at the September Audit Committee
Key risks including mitigating actions and milestones	• **COVID-19** continued to represent a significant risk to both the Health Board's financial position and ability to progress business as usual. • Members approved the **Risk Management** Strategy/Policy though remained concerned as to the ability to successfully implement and whether the target dates were achievable. Members agreed that this would be the subject of further discussion at the impending Risk Management Workshop. • Members noted that, due to the COVID-19 pandemic and auditor's ability to conduct site visits, there was a risk that it may not be possible to fully implement the **Internal Audit Plan.** • The **All-Wales report on the Well-being of Future Generations** highlighted that significant challenges still existed and would not be easy to resolve. • The **Health Board's financial duties** to balance income with expenditure over a three-year rolling period and to prepare a rolling three-year integrated medium term plan had not been met. • Members noted that there had been an **Independent Member vacancy** since December 2019 which increased pressure on the remaining nine Independent Members. • COVID-19 had impacted the progress made against recommendations in the **Audit Tracker.**

Special Measures Improvement Framework Theme/Expectation addressed	Governance and Leadership
Issues to be referred to another Committee	• **Internal Audit, Deprivation of Liberty Safeguards limited assurance report** to be referred for information to the Quality, Safety & Experience (QSE) Committee noting that the progress of specific recommendations will be monitored by the Audit Committee via the Internal & External Audit Tracker.
Matters requiring escalation to the Board:	• That the **Risk Management Strategy/Policy** was approved in principle pending further assurance in terms of implementation dates. • That the **Head of Internal Audit Opinion (reasonable assurance) and Annual Report** for 2019/20 was received • That the revised **Internal Audit Plan** 2020/21 which has been updated for COVID-19 impact was approved. • To receive the Audit and Quality, Safety and Experience Committee Annual Reports ▪ Audit Committee: https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/audit-committee/audit-committee-annual-report-2019-20-v1-0/ ▪ Quality Safety & Experience Committee: https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/quality-safety-and-experience-committee/quality-safety-and-experience-committee/committee-annual-report-v2-0-final-approved/ • Following a request by the Board to receive an update on the implementation of the Structured Assessment 2019 recommendations Members reviewed the position. Further discussions between Members of the Executive Team and Auditors are to take place to agree a way forward in terms of capturing progress on all Tracker recommendations. In terms of the recommendations relating to Clinical Audit, Members will be aware of the previous reports to Board, Quality, Safety and Experience Committee and Joint Audit, Quality, Safety and Governance Committee. Whilst progress on Clinical Audit has been made, due to COVID 19 there is currently no clinical audit activity being undertaken at present and the national programme has also been suspended. Clinical Audit will be discussed further at the QSE Committee scheduled for October at which point a detailed plan is to be presented.
Well-being of Future Generations Act Sustainable Development Principle	In summary, 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 gives consideration to 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:	As a consequence of the ongoing and developing Covid-19 situation, Committee meetings are operating on a reduced agenda basis. A review of mandatory and urgent matters will need to be considered and confirmed.
Date of next meeting:	17th September 2020 (subject to review due to COVID-19) with an extraordinary meeting to be held at the end of July (date to be confirmed) to receive the Auditor General's report on the refurbishment of Ysbyty Glan Clwyd.

Health Board

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Committee Chair's Report

Name of Committee:	Quality, Safety and Experience (QSE) Committee
Meeting dates:	17th March, 5th May and 3rd July 2020
Name of Chair:	Lucy Reid, Independent Member
Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Summary of business discussed:	As a result of COVID-19, the QSE Committee met in March and May with reduced attendance and a more focussed agenda. This was to release officers, in particular the Executives, to prioritise the response to the pandemic. This approach was agreed with members as being proportionate to the situation whilst enabling the Committee to maintain oversight on quality and safety issues across the Health Board. Meetings were held via WebEx. • Infection, Prevention and Control reports were provided and discussed at both meetings; • Ward Accreditation update was received with a focus on hotspots across the Health Board and action being taken; • The Serious Untoward Incidents report provided an update on reporting trends and revised reporting arrangements to Welsh Government during the pandemic; • The update on the Psychological Therapies Services review included the Terms of Reference for the programme group, clarification of membership and how the plan for reviewing and implementing the recommendations arising from the review. It was also noted that the programme group meetings had been deferred due to the pandemic but that it would be progressed as part of Phase 2 of the COVID-19 plan; • A pandemic planning report was provided at each meeting providing an update on key areas including the continuation of essential services, workforce position, revised clinical pathways in response to COVID-19 and reporting lines; • A report on post-partum haemorrhage rates and the associated improvement plans were received from the Women's Services Directorate; • An update on stroke care services was provided including the latest national performance information. The stroke rehabilitation service is being reviewed by the Clinical Pathways Group;

	• A number of other items were deferred including clinical audit report, thematic review of suicides, primary and community care quality assurance report and an update on postponed procedures; It should be noted that the full meeting of the QSE Committee on 3rd July was postponed until 29th July 2020 to enable the Executive Team to complete the Quarter 2 Plan for submission to the Welsh Government. However, the Committee met briefly to consider the Nurse Staffing Annual Assurance Report and the Safeguarding Annual Report https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/quality-safety-and-experience-committee/ to enable these reports to be submitted to the July Board Meeting. In addition the Committee considered and made suggested improvements to the Putting Things Right Annual Report.
Key assurances provided at this meeting:	• The Committee received an update on the partnership working with Local Authorities to support the care home sector and the arrangements for testing residents and care home staff. A care home cell had been established to lead on the support arrangements and the impact of the discharge policy on bed capacity; • The Director of Midwifery and Women's Services provided a report on the service's actions to address the high rates of post-partum haemorrhage cases in the Health Board. An improvement plan identified the steps being taken within the service including changes in clinical practice in line with the NICE guidance. The Committee also received the Health Board's response to the HIW report on Maternity Services, which specified the action being taken including CTG training for midwives; • The ward accreditation report included the triangulation of findings from the assessments and the improvements being made as a result. It was noted that 27% of the white wards were in Ysybty Glan Clwyd. The report highlighted the need to build on shared learning;
Key risks including mitigating actions and milestones	A number of quality and safety risks were highlighted and discussed at the meetings: • There is a reduction in urgent and suspected cancer referrals and reduced access to screening and diagnostics, in particular endoscopy, as a result of COVID-19. Cancer teams are working with patients to provide support for patients. The Committee will receive an update on services at the next meeting as plans for Phase 2 are reviewed; • It was noted that the backlog of waiting lists is increasing as a result of non-essential services being suspended as a result of the pandemic. Although this is a national issue being experienced by all health services, the Committee has sought

	assurance that the Health Board is utilising every opportunity to maximise capacity as part of the Phase 2 planning; • Concern was raised with regard to the number of avoidable infections and cluster outbreaks of COVID-19 amongst staff. The Committee requested that lessons identified as part of the cluster investigations be disseminated as a matter of urgency to ensure that they are communicated across the Health Board and all areas including primary care and care homes; • The need to be able to undertake robust investigations and rapid reviews for serious incidents and demonstrate learning arising from these was identified. It was noted that a review is being undertaken of the investigation processes to ensure focus on human factors and organisational learning; • The Committee received a verbal update on the Vascular Services review and CHC report. The report has been discussed with the CHC and would be presented to the May Board. The importance of a robust implementation plan with critical oversight was agreed and the Committee would submit questions to the Executive Medical Director upon reviewing both reports; • A report was provided on the current status of ophthalmology services and performance against the eye care measure. It was noted that the risk stratification process undertaken for this patient cohort had identified a significant number of patients at high risk of eye sight loss. Work was underway to manage the urgent eye care pathway with optometrists to reduce the potential risk of harm. This had been affected by the pandemic; • A number of concerns were highlighted in relation to the corporate risks allocated to the Committee for oversight including the need for a clear audit trail for updates and changes and clarity of scoring. The Committee noted the review of the risk register and related strategy that was currently underway;
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance
Issues to be referred to another Committee	• It was noted that the Corporate Risk Register was being reviewed by the Audit Committee.
Matters requiring escalation to the Board:	• None
Well-being of Future Generations Act Sustainable	The Committee gave due consideration to the sustainable development principles.

Development Principle	
Planned business for the next meeting:	The meeting to be held on 29th July 2020 will receive a range of items deferred from the 3rd July together with a Health and Safety update on current issues and priorities, and an Infection Prevention report.
Date of next meeting:	29 July 2020

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Health Board **23.7.20**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*
Committee Chair's Report	

Name of Committee:	Finance and Performance Committee
Meeting date:	4.6.20
Name of Chair:	Mr Mark Polin, BCUHB Chairman
Responsible Director:	Ms Sue Hill, Acting Executive Director of Finance
Summary of business discussed:	The following items were discussed • Corporate risks assigned to the Committee • Annual plan 2019/20 monitoring report • Operational plan 2020/21 Q 1 monitoring report • Month 1 Quality and Performance report • Referral to Treatment update • Unscheduled care and building better care update • Month 1 Finance report • Savings programme 2020/21 report *Private session:* • Recovery programme report • Approval of the new contractor to take over a GP contract and merge provision of GMS services
Key assurances provided at these meetings:	• The new format of the quality and performance report was commended • A task and finish group had been instated to address potential patient harm due to unavoidable appointment delays caused by the Health Board's response to COVID-19 (C19) • Planned care activity was being reinstated within the organisation. An Acute Services Group was exploring different ways of working given the continued presence of C19 • The Committee was pleased to note the level of clinical engagement reported in respect of digital platforms introduced, albeit that further evaluation would be required • Positive ways of working differently introduced within ED to enable fast tracking of patients to specialists and also dealing with patients potentially infected with C19 were welcomed • In month £3.4m deficit was in line with month 1 plan, assuming total C19 cost would be met by WG – see significant risk below • Financial self-assessment group had been established to formally review governance arrangements in respect of C19 income and expenditure

	• Innovative practice had been adopted during the response to C19, which should improve patient outcomes and drive efficiency and this is being exploited in terms of the savings programme
Key risks including mitigating actions and milestones	• Concerns regarding the Corporate Risk Register were discussed, including the lack of alignment to the organisation's plan. A Board workshop session was agreed to be scheduled for further discussion and inclusion of all Board members and to incorporate the impact of C19 on the corporate risks • Noting that the executive review had not taken place regarding the assessment of the Annual Plan monitoring report, it was agreed that an update be prepared for the next meeting • Concern with capacity planning and availability of resources was agreed to be addressed at a future Board workshop • Concerns regarding staff testing and mental health were agreed to be explored further in C19 board briefing session. • Whilst the Q1 operational plan had not involved approval by all the Board members, the Chairman advised plans would be put in place for scrutiny of the Quarter 2 Operational plan prior to Welsh Government submission • Backlog appointments were increasing at the rate of 4,000 patients per month, however actions were outlined to mitigate harm in a staged approach. • Potential implications of 14 day isolation policies on services were highlighted as well as C19 testing and staff protection. • Significant risk to the financial plan regarding unknown WG funding response to C19 pandemic. • Month 1 savings requirement £3.7m was not delivered due to organisation's focus on response to C19 pandemic. Further work to ascertain achievability of identified schemes, given pandemic conditions, was requested to be undertaken. • As a consequence of the refocusing of management capacity and the redeployment of the Programme Management Office (PMO) resource to support the C19 response, work on savings was halted in March 2020. A briefing on PMO capacity was requested.
Special Measures Improvement Framework Theme/Expectation addressed	Leadership and Governance Strategic and Service Planning Financial sustainability
Issues to be referred to another Committee	-
Matters requiring escalation to the Board:	• Performance Planned Care, RTT and Unscheduled Care • Financial position 2019/20 • Financial Plan 2020/21 position

Well-being of Future Generations Act Sustainable Development Principle	The Committee gave appropriate consideration to the sustainable development principles.
Planned business for the next meeting:	A range of regular finance and performance reports plus • Primary and Community services sustainability and transformation • Annual plan 2019/20 reconciliation • Unscheduled care report
Date of next meeting:	16.7.20

Health Board **23rd July 2020**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Remuneration & Terms of Service Committee
Meeting dates:	15.6.20
Name of Chair:	Mark Polin, Chair
Responsible Director:	Sue Green, Executive Director of Workforce & Organisational Development
Summary of business discussed:	The Committee considered the following issues in public on 15.6.20: • Minutes of the previous meeting, the updated action tracker and the list of agenda items considered in private at the last meeting In private session, the Committee discussed: • The draft Remuneration & Staff Report 19/20 – the Committee approved the report for submission to the Audit Committee. • Executive Team acting appointments • Search and appointment process for the Chief Executive
Key assurances provided at this meeting:	• Appropriate governance processes are being followed in respect of remuneration/staff annual reporting requirements, and very senior manager appointments.
Key risks including mitigating actions and milestones	• Risks and mitigating actions were covered during discussion of in committee items.
Special Measures Improvement Framework Theme/Expectation addressed	• Leadership and Governance.
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None.
Well-being of Future Generations Act Sustainable	*1.Balancing short term need with long term planning for the future* – consideration of substantive appointments *2.Working together with other partners to deliver objectives* –working with recruitment partners

Development Principle	*3. Involving those with an interest and seeking their views – via* consultation with trade union partners *4. Putting resources into preventing problems occurring or getting worse* – consideration of senior roles *5. Considering impact on all well-being goals together and on other bodies* – noted.
Planned business for the next meeting:	Range of standing items plus – Nursing and Medical revalidation report, Senior role updates, GP updates and R&TS Committee Annual Report.
Date of next meeting:	20.7.20

Health Board 23.7.20	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Strategy, Partnerships and Population Health Committee
Meeting date:	9.6.20
Name of Chair:	Mrs Lyn Meadows, Acting Chair Strategy, Partnerships and Population Health Committee
Responsible Director:	Mr Mark Wilkinson, Executive Director Planning and Performance
Summary of business discussed:	The Committee discussed the following at the meeting held on 9.6.20 • Corporate Risk Register – risks assigned to the Committee • Phase 2 transition to sustainable service delivery • Committee Cycle of Business • Annual Equality report 2019/20 • International Health Group (IHG) 2019/20 annual report • Update on Covid19 communications and engagement activity • Annual Plan 2019/20 progress monitoring report • Current agreed Covid 19 forecast position
Key assurances provided at this meeting:	• Approval of the Annual Equality report 2019/20 which cited numerous excellent practices and awards. Whilst noting that the 4 yearly review of the Strategic Equality plan had taken place to agree objectives, it was acknowledged that some would require reprioritisation following the C19 pandemic as areas of inequality had arisen. https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/strategy-partnerships-and-population-health-committee/ • The communications engagement strategy put in place by BCU's communications team had been critical to the efficacy of responding to the C19 pandemic. The excellent effort and commitment of the team was commended. • The International Health Group (IHG) 2019/20 annual report demonstrated a breadth of work being undertaken in this arena.
Key risks including mitigating actions and milestones	Concern was raised on • Research and Innovation activity especially in relation to Covid 19 and also the need to provide an update on the Health Board's University status, a paper was requested to be prepared. • Emergency preparedness to meet the C19 pandemic major incident response, a paper was requested to be prepared

	• Not all corporate risks were able to be scrutinised due to the unavailability of necessary executives and issues around the new format were also raised. It was understood that these would be raised at a Board workshop – date to be agreed. • Preparedness and involvement with development of the Quarter 2 operational plan. It was understood that Board members would be provided with an opportunity to contribute, acknowledging that C19 had impeded involvement with Quarter 1. • In respect of monitoring the end of year 2019/20 annual plan a paper was requested to address the objectives which had not been achieved, including consequent impacts and how benefits realisation would be demonstrated to provide confidence on the delivery stated.
Special Measures Improvement Framework Theme/Expectation addressed	• Leadership and Governance • Strategic and Service Planning
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	• The Annual Equality report 2019/20 was approved on behalf of the Board
Well-being of Future Generations Act Sustainable Development Principle	The Committee gave consideration to the following sustainable development principles: *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;* *5.Considering impact on all well-being goals together and on other bodies*
Planned business for the next meeting:	Range of regular reports plus:- • Transformation fund updates : Children and Young People, Mental Health, Learning Disabilities, Community Services • Public Health update on TTP • Digitally enabled Clinical Services strategy progress update • Research, Innovation and University status update • Strategy focus : Estates • Transformation Fund Updates • Children's services update • Welsh Language 2019/20 annual report • Update on reporting of partnership funding and arrangements • Draft Committee annual report 2019/20 • Terms of Reference and Cycle of Business reviews
Date of next meeting:	13.8.20

Health Board **23rd July 2020**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Charitable Funds Committee
Meeting date:	25 June 2020
Name of Chair:	Ms Jackie Hughes
Responsible Director:	Mrs Sue Hill, Acting Executive Director of Finance
Summary of business discussed:	• The committee noted and discussed the Covid-19 Appeal Update Report. • The committee discussed at length and approved a number of 'Future Plans', such as: o Staff Lottery Business Case o Covid-19 Second Phase Fundraising & Grant Giving o Prioritisation Criteria for Awyr Las Covid-19 Grant Applications o Awyr Las Digital Devices Grant Scheme o Virtual Hospital Scoping Project o Awyr Las Charitable Funds Advisory Group o The BCUHB Use of Premises Paper o The Staff Development Fund o Covid-19 Staff Wellbeing Fund o Accepting Public Health Funds o Impact Reporting o Wales NHS Charities National Working Group
Key assurances provided at this meeting:	• As a result of the pandemic the approval of all charity grant applications is taking place outside of Committee meetings, to ensure funding can be accessed on a timely basis. However, the same level of approval is required, as per the scheme of delegation, and this has been maintained throughout the Covid-19 response period.
Key risks including mitigating actions and milestones	• There are risks related to gambling in establishing a staff lottery. These will be mitigated where possible with caveats such as only two plays per week maximum. The proposal has been to a Local

	Partnership Forum committee meeting, where it was accepted by Trade Union representatives.
Special Measures Improvement Framework Theme/Expectation addressed	• Not Applicable
Issues to be referred to another Committee	• Not Applicable
Matters requiring escalation to the Board:	• Not Applicable
Well-being of Future Generations Act Sustainable Development Principle	• Developing a strategy for legacies and donations in line with the Health Board's identified priorities supports the WBFGA long term planning priority. • Working together with partners lies at the very heart of fundraising, particularly with volunteers, fundraisers and other charities through Joint Working Agreements • The Advisory Group is a good working example of involving those with an interest as part of decision making when allocating grant funding. • Charitable Funds are a driver in supporting the prevention agenda through funding opportunities and by alignment with Health Board LHSW priorities.
Planned business for the next meeting:	Standing agenda items, plus: • Strategy session after committee meeting (Invite IM & Exec leads for the strategic priorities, Head of Communications and all Charity Support Team members)
Date of next meeting:	10 September 2020

Health Board **23rd July 2020**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Digital & Information Governance Committee
Meeting date:	19.06.2020
Name of Chair:	Mr John Cunliffe, Independent Member
Responsible Director:	Dr David Fearnley, Executive Medical Director
Summary of business discussed:	The Committee considered the following items: • **Finance and Performance Committee referral (ref: FP20/24 2019/20 APPMR-Digital Health Programme)**. Chair to discuss further and clarify points with the Finance and Performance Committee Chair. • **Digital Operational plan – year end report** The Committee reviewed and noted the report. Most activity delivered fully or partially. All initiatives impacted by COVID-19 in the last two months. Health Board broadly on track and work continues with planning processes and to deal with barriers. • **Covid on Informatics and Health Records - verbal update** Members noted the verbal update and presentation on the COVID 19 impact upon informatics - March to May 2020. • **Informatics Quarterly Assurance Report** The Committee noted compliance with legislative and regulatory responsibilities which related to the Informatics Services and advised the service of the additional metrics required to improve assurance. Impacts of COVID-19 were highlighted along with the increasing demand for informatic services. For example paper printing of results have been turned off but until the Results Management Project concludes with a fit for purpose system some targeted paper results will be turned back on. It was noted that the full impact of the pandemic would need further work and analysis within the forthcoming months. • **Information Governance Quarterly Assurance reports - Q3 and Q4 for 2019/20.**

	The Head of Information Governance presented the quarter 3 and 4 KPI reports for 2019/2020. The Committee received and noted the assurance provided in compliance with the Data Protection and Freedom of Information Legislation. In addition, delays within the reporting period which related to COVID-19 activity were highlighted and acknowledged. • **Corporate Risk and Assurance Framework Report.** The Committee considered the relevance of the current controls and actions in place, along with the consideration of the risk scores:- o **CRR10a National Infrastructure and Products** o **CRR10b Informatics - Health Records** o **CRR10c Informatics infrastructure capacity, resource and demand.** Actions to further mitigate risks which had been put on hold due to the COVID-19 pandemic were raised. It was noted that the Risk Management Group were imminent to meet and that the Committee would welcome further update surrounding the impact upon risks from the COVID-19 pandemic, the Committee were content with the risks to date as recorded, and would await feedback. • **Performance against the Board approved 2019/20 annual plan - verbal update** It was noted that the item ***- Covid on Informatics and Health Records - verbal update*** covered the performance update item accordingly.
Key assurances provided at this meeting:	• Progress against Informatics Operational Plans. • Continued progress on good Information Governance.
Key risks including mitigating actions and milestones	• Major risks covered by CRR10a, 10b and 10c. Feedback on the impact of Covid-19 from the Risk Management Group awaited.
Special Measures Improvement Framework Theme/Expectation addressed	• Governance.
Issues to be referred to another Committee	N/A
Matters requiring escalation to the Board:	N/A

Well-being of Future Generations Act Sustainable Development Principle	The Committee is content that these principles are taken into account as part of its core business and in the consideration of papers.
Planned business for the next meeting:	Range of regular reports.
Date of next meeting:	25.9.2020

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Health Board

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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Advisory Group Chair's Report

Name of Advisory Group:	Healthcare Professionals Forum (HPF)
Meeting date:	19.06.20
Name of Chair:	Mr Gareth Evans, Therapies representative
Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies & Health Science

Summary of key items discussed:

- The Chair wished it to be noted that the HPF meeting was held via Skype

- **H20/17 Clinical Services during COVID-19 & Future of the Clinical Pathways Group**

The Deputy Medical Director and Secondary Care Medical Director presented to the members by way of an update on the progress of the Clinical Pathways Group. A presentation was circulated prior to the meeting.

The presentation included the following slides:

- Clinical Pathways Group plan on a page
- What we are trying to achieve
- Examples of Pathways
- Next steps

- **H20/18 Chair's and members' written updates**

The forum noted the written updates received from the following representatives:

H20/18.01 a) HPF Written Summary – Optometry
H20/18.02 b) HPF Written Summary – Midwifery
H20/18.03 c) HPF Written Summary – Dental
H20/18.04 d) HPF Written Summary – Therapy Services / HPF as Associate Board Member
H20/18.05 e) HPF Written Summary – Healthcare Science
H20/18.07 g) HPF Written Summary – Primary Care and Community Medical
H20/18.08 h) HPF Written Summary – Pharmacy & Medicine Management

Verbal updates were received from the following representatives:

H20/18.08 Nursing

	H20/18.09 Community Pharmacy
Key advice / feedback for the Board:	**H20/19 Summary of key advice to be included in Chairs report to the Board** • **H20/17.01 Clinical services during COVID-19 and clinical pathways.** HPF members support the clinical pathways approach as a vehicle to improve services, noting the considerable work undertaken during the Covid 19 period. • The HPF advice is that pathways are best developed end to end, with multi professional engagement using the best science and information available. The use of tools such a workstations can increase support and engagement of staff. • **H20/18 Members reports.** The HPF noted the use of technology to support new ways of working during the Covid 19 pandemic and advise that this should continue to be an enabler to change within the organisation. • **H20/18.03 Member report Dental.** The HPF advise the Board to support new and innovative ways of workforce planning as result of the Covid 19 pandemic, to ensure a continued recruitment pipeline for a well-trained workforce in North Wales. • **H20/18.03 Member report Hospital and Primary care Pharmacy.** The Board should note reports that returning staff wishing to work for BCUHB during the Covid 19 period have not found the process easier to navigate. • **H20/18.06 Member report Secondary and Tertiary care Hospital.** The HPF members reported on a range of experiences about staff wellbeing, noting how resilient and adaptable the workforce have been during the pandemic. The Board is advised to continue to support the wellbeing of staff well into any recovery period and a return to business as usual.
Planned business for the next meeting:	Range of standing items plus: • Performance Director – Performance Focus
Date of next meeting:	2nd October 2020

Health Board **23RD July 2020**	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Stakeholder Reference Group (SRG)

Meeting date:	22 June 2020

Name of Chair:	Mr Ffrancon Williams
Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Summary of key items discussed:	<u>Welsh Ambulance Services Trust – Long Term Strategic Framework</u> Jonathan Sweet, Area Operations Manager from the Welsh Ambulance Services Trust provided a presentation on WAST's long term strategic framework. The primary goals are to help patients to stay heathy, helping people to access services and providing the right care in the right place at the right time. <u>Working with Stakeholders to develop our Quarter 2 Plan</u> Mark Wilkinson, Director of Planning and Performance and John Darlington, Assistant Director of Planning provided a presentation relating to working with Stakeholders to develop our Quarter 2 Plan. Due to the current situation with the Covid Pandemic it has meant that Welsh Government have asked all Health Boards to submit quarterly plans rather than annual plans. <u>Third Sector Priorities / Alignment to BCU Plans</u> Sally Baxter, Assistant Director of Strategy provided a presentation on where we are with the Third Sector Strategy and how this links with the current Health Board plans. There is a need to look at how we can work with the third sector coming out of the pandemic.
Key advice / feedback for the Board:	From the Welsh Ambulance Service Trust's presentation the Chair summarised the discussion which he said gave reassurance that equitable services between rural and urban areas was being addressed. It was pleasing to hear that engagement with the Health Board is good. The Group welcome the direction the strategy is taking and hoped that it would continue to prioritise and develop. It was also reassuring to hear that equitable recruitment is being

	undertaken. From the presentation on the development of the Quarter 2 plan, the Group recognised the importance of communication with patients and families and looking at different ways of doing things. The Health Board are presented with some really difficult messages in a continued challenging environment. The Group welcomed the focus on the plan and the importance placed on working in partnership with all. From the presentation around the third sector work, the Group confirms the importance of the work carried out in this sector and the close links to the Health Board activities and the complexities around co-ordinating the activity. The Group strongly endorsed the creative and responsive work of this sector, which requires resources to get maximum value which the Health Board should consider in its' future Plans. It was also important to flag that future funding of a lot of thire sector organisations will be under threat. There is also a need to ensure the whole sector meet all the safeguarding needs.
Special Measures Improvement Framework Theme/Expectation addressed	Strategic planning Engagement
Planned business for the next meeting:	The following items were agreed for the next meeting: • Digitally Enabled Clinical Services Strategy • Covid response linked to Q3 Plan and winter planning • Special Measures progress • Business Cases as required • Any Annual Reports for information
Date of next meeting:	Monday 28th September 2020

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Services : Update on Independent Review
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Joanne Garzoni, Vascular Network Manager
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group
Atodiadau **Appendices:**	Appendix 1 - Vascular Services Update to the Quality, Safety & Experience Committee (QSE) 3rd July 2020

Argymhelliad / Recommendation:

The Health Board is asked to note the progress made by the Vascular Task and Finish Group.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	**X**	**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	**X**	**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:

This report provides an update to the Health Board on the work undertaken to date by the Vascular Task and Finish Group relating to the external review of the service.

Cefndir / Background:

In July 2019, following the centralisation of the major arterial vascular service in April 2019, it was agreed that a review would be prepared with the principle objective of assessing the impact of the vascular services provided across the North Wales Vascular Network in the post implementation period. The presentation of the report was delayed due to the COVID19 pandemic. This review was presented to the Health Board on 21st May 2020 with recommendations to address areas for improvement.

The Health Board approved the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations. This group would consider the draft action plan to identify any further required actions and

recommend key performance indicators. It was agreed that progress reporting arrangements would be via the Quality and Safety Executive.

Asesiad / Assessment & Analysis

Strategy Implications

This report provides an update of the Vascular Task and Finish Group relating to the proposed external review of the service.

External review of the vascular service

The first Vascular Task and Finish Group was held on 16th June 2020. There was good representation from multidisciplinary team members as well as patient and primary care presence. Following this, the Secondary Care Medical Director and Vascular Network Manager met with the Community Health Council (CHC) Chief Officers and patient and carer representatives on 2nd July to discuss the terms of reference for the external Royal College of Surgeons review. This was a very productive meeting, which agreed the key elements required to be included in the invited review request:

- Quality and safety of surgical care
- Behaviours and team working
- Service / network design
- Clinical Governance
- Communication with patients
- Multi-disciplinary work

A further meeting will be held on 15th July 2020 with the CHC and the Health Board to agree the final terms and to review the actions of the task and finish group prior to the next meeting. The next meeting of the Task and Finish Group will take place on 17th July.

Financial Implications

The scope of this report does not include financial implications.

Risk Analysis

Risk assessments will be undertaken as part of the governance of the Task and Finish Group. A risk register relating to the action plan will be included in the Task and Finish Agenda and be highlighted in the exception report.

Legal and Compliance

There are no legal implications associated with this proposal. The Task and Finish Group will report by exception and the action plan will be tracked through QSE.

Appendix 1

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Services Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Joanne Garzoni, Vascular Network Manager Kate Clark, Secondary Care Medical Director
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group
Atodiadau **Appendices:**	Appendix (i) – Vascular Task and Finish Group Terms of Reference Appendix (ii) – Draft Vascular Network Action Plan v0.3 Appendix (iii) – Vascular Stakeholder Engagement Plan

Argymhelliad / Recommendation:

The Committee is asked to note the progress made by the Vascular Task and Finish Group and approve the draft terms of reference for the Group.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**X**	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	**X**	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

This report provides an update to the Quality and Safety Executive on the work undertaken to date by the Vascular Task and Finish Group.

Cefndir / Background:

In July 2019, following the centralisation of the major arterial vascular service in April 2019, it was agreed that a review would be prepared with the principle objective of assessing the impact of the vascular services provided across the North Wales Vascular Network in the post implementation period. The presentation of the report was delayed due to the COVID19 pandemic. This review was presented to the Health Board on 22nd May 2020 with recommendations to address areas for improvement.

The Health Board approved the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations.

This group would consider the draft action plan to identify any further required actions and recommend key performance indicators. It was agreed that progress reporting arrangements would be via the Quality and Safety Executive.

Asesiad / Assessment & Analysis

Strategy Implications

This report examines the progress of the Vascular Task and Finish Group in implementing the vascular services review recommendations.

Updates to the Group

Good News: Vascular Access

At the National Vascular Access meeting held on 22nd May 2020 the Health Board reported that in June 2019 there were 116 patients awaiting renal access surgery across North Wales. The Vascular Network have reduced the number of patients waiting for renal access surgery to 41 in 11 months; with 9 patients waiting for procedure in Ysbyty Gwynedd, 10 in Glan Clwyd Hospital and 22 in Wrexham Maelor Hospital. The actions required to improve and maintain the service have been jointly led by the renal and vascular services to ensure a unified approach. As a key part of the vascular surgery COVID recovery plan and to ensure the sustainability of the service and safe and timely availability of surgery, the Health Board will continue to provide dedicated vascular access operating lists per week which will be ring-fenced away from the wider vascular surgery lists with no disruption caused by surgical on-call requirements.

https://bcuhb.nhs.wales/news/health-board-news/joined-up-north-wales-vascular-service-cuts-surgical-waits/

Vascular Task and Finish Group

The first Vascular Task and Finish Group was held on 16th June 2020. There was good representation from multidisciplinary team members as well as patient and primary care presence. Terms of reference (Appendix i) was reviewed and are submitted with this paper for approval. The action plan will be tracked through the group with regular updates provided to QSE via exception reporting.

External review of the vascular service

The Royal College of Surgeons will be invited to undertake an external, independent multi-disciplinary assessment of the service. The terms of reference for this review will be drafted by the Secondary Care Medical Director with the Community Health Council (CHC) and patient and carer representatives and this will be brought back to the next meeting.

North Wales Vascular Network Action Plan - Progress against actions within the Vascular Network Action Plan (Appendix ii):

Alignment of vascular inpatient bed base

A review of the capacity and demand for inpatient beds across the service was presented. Further work is required how to understand how the bed base across the Health Board should be distributed whilst ensuring capacity in Glan Clwyd Hospital for major arterial work. It was agreed that the alignment of beds needs to be incorporated into the patient pathway work streams. The lower limb service continues to be delivered across all sites with local access to consultant and MDT review.

Pathways of care

It was agreed that the resource, project leads and time frames for development of pathways would be discussed in the Task and Finish Group and the Clinical Advisory Group (CAG) would provide scrutiny of the pathway. CAG have agreed to facilitate the progress of vascular pathways. There has been progress on the development of pathways highlighted by the service review in relation to the pathway for patients that use drugs intravenously presenting with groin abscesses and for patients post major arterial surgery requiring rehabilitation. The non-arterial diabetic foot pathway requires project management support due to the breadth and complexity of this pathway. Expressions of interest for a clinical lead will shortly be sent out by the Secondary Care Medical Director.

Engagement and Communication

Progress to develop a stakeholder engagement plan (Appendix iii) was presented by the Head of Patient Experience in order to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and learning group. It was agreed that there will be a shared approach with the CHC with patient/carer representation to progress this and explore options for a collaborative approach. There is a review of patient reported outcome measures (PROM) and patient reported experience measures (PREM) in conjunction with existing patient experience data, together with a focus on receiving real time feedback from inpatient and outpatient settings across all sites. Patient information will now be reviewed and developed with the support of the corporate patient experience team and service user involvement through the CHC.

Quality and Safety

A baseline safety culture survey using the Manchester Patient Safety Framework will be undertaken to inform areas for improvement. This will help the service understand their level of development with respect to the value that they place on patient safety.

A draft vascular dashboard was presented to the Task and Finish Group which has been developed to provide assurance of service performance, displaying key metrics and performance indicators. It is aligned to corporate dashboards, and supports the triangulation of complaints, incidents, compliments and lessons learnt trends. This dashboard also provides performance monitoring and includes theatre utilisation, outpatient activity and Referral to Treatment Time and the follow up waiting list, inpatients and outliers, and mortality.

Access to the Service

Further work is required to reduce waiting times and manage the follow up backlog. Recovery plans will continue to require monitoring to ensure improvement. The vascular activity will be separated

from general surgery for reporting purposes and a separate report for vascular will be shared via secondary to the Planned Care Improvement Group for future assurance.

The next meeting of the Task and Finish Group will take place on 17th July.

Financial Implications

The scope of this report does not include financial implications.

Risk Analysis

Risk assessments will be undertaken as part of the governance of the Task and Finish Group. A risk register relating to the action plan will be included in the Task and Finish Agenda and be highlighted in the exception report.

Legal and Compliance

There are no legal implications associated with this proposal. The Task and Finish Group will report by exception and the action plan will be tracked through QSE.

Appendix (i)

Betsi Cadwaladr University Health Board

TERMS OF REFERENCE - DRAFT

Vascular Network Task and Finish Group

Accountability	Quality, Safety and Experience Committee
Remit	The Vascular Network Task and Finish Group will be responsible for implementing the recommendations identified in the Review of the North Wales Vascular Network presented to the Health Board in May 2020. ***The CHC has compiled a report following a series of engagement events with the public and staff. This group will also address any areas for improvement raised within the CHC report.*** The principle objective of the review was to assess the impact of the vascular services provided across the North Wales network and incorporated the following: a) A review of the current provision and delivery of vascular surgery services in North Wales following the implementation of a centralised service in April 2019. b) The safety and accessibility of vascular services for all patients receiving care from the North Wales Vascular Network. c) The risk management and clinical governance arrangements of the North Wales Vascular Network. d) To identify lessons that can be learnt: both examples of good practice and areas where improvement is required e) Clear recommendations for the consideration of the Health Board as to possible courses of action which may be taken to address any specific areas of concern which have been identified. The group will ensure that all relevant stakeholders with a responsibility for planning and delivering services have an opportunity to review/discuss pertinent issues and agree an achievable work plan for delivery of the recommendations. These will include clinical facilities, service delivery, scheduling and risk management issues as well as finance and performance.
Chair	Executive Medical Director

Core Membership	• Secondary Care Medical Director • Executive Nurse Director • Nominated Hospital Director • Clinical Director Vascular Network • Nominated Hospital Medical Director • Nominated Hospital Nurse Director • Chair of the Clinical Effectiveness committee • Primary Care clinician • Consultant Anaesthetist/Critical Care • Clinical Lead for Interventional Radiology • Vascular Network Manager • Community Health Council Representative • Vascular patient and carer representatives • Therapies representative • Communications • Corporate Patients Experience Lead • Informatics • Other members will be co-opted as required and the group develops
Administrative Support	Action log
Attendance	Any clinician, manager or nurse who is not a core member of the group may be asked to attend to discuss specific agenda items within their area of responsibility
Quorum	Greater than five members including the Chair or Vice Chair (Executive Nurse Director) one of which must be in attendance.
Frequency & Venue	Monthly
Proposed Start Date	June 2020
Authority	Quality, Safety and Experience Committee
Functions	The work of the Group will address the recommendations from the finalised action plan**:** • Alignment of vascular inpatient bed base

	• Pathways of care • Engagement and communication • Quality and Safety • Access to the service
Outputs	An up to date action log will be maintained and circulated to agreed stakeholders after each meeting. The Group will provide a monthly report to the Quality, Safety and Experience Committee.
Reporting	The Chair may raise specific matters at the meeting for information, discussion or approval. All members may submit items for discussion to be brought to the meeting. Agenda and supporting papers will be circulated one week prior to the meeting. The Group will provide a monthly report to the Quality, Safety and Experience Committee.
Communication	Each member has a role that involves communicating and disseminating information.
Escalation	Escalation of issues to the Quality, Safety and Experience Committee

Appendix (ii)

Draft Vascular Service Improvement Plan

Recommendation	DRAFT ACTION	Suggested lead	When
Alignment of vascular inpatient bed base	• Review of the capacity and demand for inpatient beds across the service. • Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Vascular Manager	16/06/20 16/06/20
Pathways of care	• Develop the non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines • Review and refine angioplasty pathway • Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses • Review and refine pathway for patients post major arterial surgery requiring rehabilitation • Refine and review pathway for non-surgical arterial condition for	Clinical Advisory Group Clinical Advisory Group Clinical Advisory Group Clinical Advisory Group Clinical Advisory Group	16/6/20 16/6/20 16/6/20 16/6/20 16/6/20

	‘palliative’ patients, in conjunction with palliative care team		
Engagement and communication	• Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Comms lead	16/6/20
	• Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Secondary Care Nurse Director	Review at all meetings of Vascular Task and Finish Group
	• Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	Executive Medical Director	October 2020
	• Development of a stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board’s Listening and learning group	Corporate Lead for Patient Experience	16/6/20
	• Review of PROM/PREM measures to improve patient experience	Corporate Lead for Patient Experience	16/6/20

	alongside existing patient experience data • Review of patient information and accessibility (including travel) with the support of the patient experience team	Corporate Lead for Patient Experience	16/6/20
Quality and Safety	• Baseline Safety culture survey to be undertaken to inform areas for improvement. • Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning • Explore the potential to work with a high reporting service to share good practice • Development of quality and safety E-Dashboard, aligned to corporate dashboards, triangulation of complaints, incidents, compliments and lessons learnt trends to provide assurance from ward to board. • Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures • Training Needs Analysis to be undertaken to support the	Corporate Quality lead Corporate Quality lead Corporate quality lead Corporate Improvement Team Vascular network lead in partnership with Workforce lead Service clinical leads	16/6/2020 July 2020 16/5/2020 July 2020 July 2020 August 2020

	emerging clinical pathways and future workforce model		
	• Issues of significance report from vascular Task and Finish group to Quality, Safety and Experience Committee	Chair of the T&F Group	16/06/20
	• Consider all opportunities for national/international benchmarking including the National Vascular Registry and national audits to assess, evaluate and review opportunities and improve the service	Chair of Clinical Effectiveness Committee	16/06/20, and review monthly
Access to the service	• Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	Executive Medical Director	16/06/20
	• Monitor vascular waiting times	Head of Planned Care	16/06/20
	• Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified.	Secondary Care Medical Director	16/6/20

This action plan will reviewed and updated at the first Task and Finish Group meeting on 16/06/20			

Vascular Task and Finish Group – actions and preparation for 16 June Meeting.

Aims: Engagement and communication:

Review of PROM/PREM measures to improve patient experience, in conjunction with existing patient experience data
Review of patient information and accessibility (including travel) with the support of the patient experience team

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
PREMS				
1. Review secondary data relating to complaints, real-time feedback, care2shares and patient comments.	Exploratory Data Analysis to include, where possible, statistical comparison of Q1&Q2 2019/2020, compared with Q3&Q4 2019/2020. To include thematic comparison of qualitative feedback to identify any trends or inferences post and pre reconfiguration of vascular services. The methodology will use 'vascular speciality' to scope patients and location exact = Dulas YG and Ward 3 YGC.	PM and AD	2nd June	Completed  Review of secondary care com
2. Identify active outpatient clinics for the next 6 weeks.	Table of OPD clinics and contacts in order that Patient Experience Coordinators are able to approach staff to hand out questionnaires and/or use smart devices to collect the data.	JG	5th July	YG: Wed AM YGC: Wed PM WMH: Friday AM, Wednesday AM, Thursday AM

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
3. Review and if necessary amendment of patient feedback (PREMS) questionnaire. To include any additional items related to access to and coordination of the service identified as reported issues within the CHC report.	Validation of patient experience questionnaire. At the vascular task and finish group meeting meeting the request was discussed, requesting CHC and patient/carer representaion from the group to review our form. There was agreement from patient and carer representation present that it was of benefit to request via CHC.	PM	2nd June	Completed  Microsoft Word Document
4. Utilise amended questionnaire in real time within active OPD and within Vascular Wards (3)	Real/Near Time from OPD clinics and vascular ward – where activity exists and access is possible[1] (*Data collection to commence 15th June – and coded and analysed 'manually' using coded template for weekly reporting*).	PM/PALS Officers AD/EY	15th June	YG Data Collection commenced within YGC and YG week beginning the 15/06/2020 weekly Excel Template developed for reporting.
5. Develop a sampling frame for retrospective audit of Vascular patients. Register as Tier III audit.	Agreed that Ward 3 YGC would be utilised in the first instance, and consenst obtained to participate within Care2Share interview prior to discharge and Datix PALS utilised to store and code the interviews.	JG/PM with support from IM&T	15h June	Participant information and consent form developed and shared with PALS officers and Patient Experience Managers.
6. Develop question stems for Care2Share in order to collect primary feedback in relation to the reported issues within the CHC report.	Tested Care2Share interview pro-forma	PM/PALS Officers	15th June	Participant Information Sheet developed by Summer Intern – PM/AD to validate. Share approach with CHC and patient represenative See Above

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
6a. Share Approach with CHC	Share approach with CHC and patient representation and explore options for a collaborative approach	PM/CO	Review date	CHC aware of the proposed approach and collaborative approach offered and explored operationally..
7.Utilise sampling frame to invite patients to take part in retrospective audit. (5, 6 & 6a))	Agree dates and time for care2share telephoned interviews. Utilise mailing list for patient experience survey. Additionally ensure that the survey is available on the internet.	PALS Officers	19th June	Documentation to be delivered to the Wards by 18th June 2020, and first interview to be undertaken by 25th June 2020. Request if CHC can support exploration.
8.Utilise a combination of care2share and/or amended patient experience survey to collect data. (7)	Retrospective review of patient experience for vascular patients using NHS Inpats Questionnaire – complete audit report and recommendations.	PM/PALS Officers	20th July	Request for sampling frame forwarded to IM&T – based on the same procedure as for INPATS
PROMS				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1.Determine if PROMS data set exist	Undertake analysis of PROMS data set for Varicose Veins. Incorporate into version 0.2 of patient experience report – see 1 above	PM	5th June	There are no PROMS data sets currently in existence within BCUHB.  RE Re Query around PROM - Vari

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
2.If PROMS data set does not exist – decide at what points in the pathway the ED5 questionnaire can be utilised (1)	Identify patient groups, and 2 points in the pathway or determine if it can be utilised post recovery for retrospective patients.	JG and nominated clinical leads	TBC following outcome of meeting on 24/06/20	Meeting with the chair of the clinical effectiveness group, secondary care medical director, vascular manager and clinical director on 24/06/20 to ensure effective collaboration
3. Develop protocol for administering PROMS Questionnaire (1 & 2)	Establish PROMs Data set for identified Vascular Patient Groups	JG and nominated clinical leads	TBC	Link with chair of the clinical effectiveness group to ensure effective collaboration. Meeting on 24/06/20.
PATIENT INFORMATION				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Website and leaflets	Scope information available on the internet/intranet to ascertain what information is presently available to patients in relation to their vascular procedures, literature etc. Contact the vascular clinics on sites to scope and identify all written information given to clinic attenders, and those discharged from the vascular wards. Scope what information is given to vascular patients following rehabilitation therapy (physio/ OT).	CO/JO	12th July	Initial review undertaken, 12th June. PT INFORMATIO LEAFLET SCOPE.docx 2nd stage required to identify information in use.

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
1a. Reviewing Written Information.	Ensure that CHC representation is mandated within the readers/review panel for Written Patient Information Guidance Policy ISUE01 explicitly states this.	CO/JO	12th July	Request CHC engagement to review revised guidance and review vascular health information samples.
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1b Create Validated Library of Vascular Patient Information in line with ISUE01 policy guidlines	Pilot the reviewed procedures within ISUE01 by creating a Vascular Patient Information Library.	CO/JO	12th July	Engage with CHC to review,
2. Complaints	Repeat query used to compile information informing the Vascular report, for the period November 2019 to March 2020.	YW	25th June	
DASHBOARD				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
3. Dashboard	The group discussed dashboards and shared information. JG has a meeting on 5 June and will forward any useful information after that.	JG	17th July	Full draft dashboard shared with Medical Director, Sec Care Medical Director, Patient Experience Lead and Clinical Director for comment. Presented to T&F on 16/06/20. Further developments in progress for presentation at July meeting

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
3a Dashboard and Performance Metrics	Agree Minimum Data set for Vascular dashboard and ensure that Patient Experience Data (legacy and prospective) is linked.	JG/PM/CO	20th July 2020	Work Stream needs to be aligned with PID1 and reported to the Concerns Management and Quality Systems Group (CMQSG) – PM/CO to report on progress at the 01/07/2020 meeting.
IMPROVEMENT PLAN – ENGAGEMENT & COMMUNICATION				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Engagement plan developed which clearly identifies stakeholders, communication channels, purpose of communication and anticipated impact on proposed change, Engagement Plan to include clear frameworks and mechanisms for staff to raise a concern(s) taking into account the current policy trajectory.	CO	20th July 2020	CO to e-mail CHC to ensure representation, see also actions above relating to CHC review of patient information and care2share methodology. RC to scope – task initiated
2. Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Ensure that change framework includes a baseline evaluation of patient experience, a 'Voice of the Customer' type matrix and a post implementation evaluation of patient experience. PM to develop potential framework by the next Vascular Task & Finish Group	CO/JO	22nd July	Initial discussion in relation to proposed methodology, the utilisation of PREMs measures identified above pre and post change cited as essential.

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
3. Development of a stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and learning group	See 1 & 2 above. Progress towards archivement of the aims and objectives of the engagement plan to monitored by the Listening and Learning Group (Patient Carer Group).	RC		
IMPROVEMENT PLAN – QUALITY & SAFETY				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Baseline Safety culture survey to be undertaken to inform areas for improvement	Ensure that BCUHB has permission to utilise the Manchester Univesrity Pt Safety Evaluation framewok – although this should be open source as developed by the NPSA, and develop a framework for its application within BCUHB – to be reviewed at next Vascular Task & Finish Group Meeting.	JG/JWJ	22nd July 2020	
2. Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Secondary data analysis of Complaints and Incidents in relation to lessons learnt for specialy='Vascular' and identify any trends in relation to training and/or service improvement. Plan for introducing You Said/We Did to Incidents & Complaints – development of SOP, using PALS You Said/We Did Pro-fomra	CO/YW CO/JWJ	22nd July 2020 TBD	

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes (*embeds available on request)*
3. Review Service Risk Register	Complete review of risks and controls, determine if controls are adequate, identify any further service developments or training which is required to reduce the mitigated risk score further and/or to remove the risk from the register.	MJ and CO to work with JG	TBD	

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Healthcare Inspectorate Wales (HIW) National Review of Maternity Services
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Deputy CEO/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience and Erika Dennis Business Manager, Corporate Nursing
Craffu blaenorol: **Prior Scrutiny:**	Monthly HIW reports submitted to the Quality Safety Group (QSG) HIW Inspection Reports are reported to the Quality Safety & Experience (QSE) Committee ad hoc Scrutiny is also received at a Directorate level
Atodiadau **Appendices:**	Appendix 1 standard operating procedure Appendix 2 Progress against HIW recommendations Appendix 3 Terms of Reference for the review

Argymhelliad / Recommendation:

The Board are asked to receive this report for information regarding the HIW Maternity Review, and to note for assurance:

1. The action progress made by the Health Board in response to inspections undertaken during phase 1 and phase 2 of the review, and that no actions are overdue
2. The arrangements in place for coordination of the Board member interviews in phase 2
3. The readiness of the Health Board to coordinate the patient engagement and community clinic inspections expected in phase 2

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	**X**	**Er gwybodaeth** **For Information**	**X**

Sefyllfa / Situation:

The purpose of this paper is to inform the Board of the background to the HIW National Review of Maternity Services across Wales and to provide with Board with assurance in relation to progress made as part of the review, and the next steps.

As outlined in the background section of this report, there are two phases to the review. Phase 1 is complete, and the Health Board are entering Phase 2 which includes Governance Interviews, visits to Community Sites and visits to Focus Groups.

Phase 1

In relation to the inspection of Maternity Units which took place as part of Phase 1, the following units have been inspected with focus on; Quality of Patient Experience, Delivery of Safe and Effective Care and Quality of Management and Leadership. All inspection reports have been reported to QSE.

1. **Hospital Inspection (Unannounced), Ysbyty Glan Clwyd – Maternity Services**
   Inspection date: 16 -19 September 2019
   Publication date: 19 December 2019

2. **Hospital Inspection (Unannounced), Ysbyty Gwynedd – Maternity Services**
   Inspection date: 25 – 27 November 2019
   Publication date: 28 February 2020

3. **Hospital Inspection (Unannounced), Wrexham Maelor Hospital – Maternity Services**
   Inspection date: 07 – 09 January 2020
   Publication date: 10 April 2020

Immediate Assurances (areas of concern which could pose an immediate risk to the safety of patients), were issued around;

- Managing Risk and Promoting Health and Safety,
- Medical Devices Equipment and Diagnostic Systems
- Medicines Management
- Safe and Clinically Effective Care

This related to checks of equipment used in a patient emergency which were insufficient. This is because checks were inconsistent and not recorded as being carried out on a daily basis. HIW found this specifically in relation to neo-natal resuscitation equipment. In addition, medication cupboards were left unlocked and doors left open to medication rooms. HIW also recommended that the Health Board ensure that PROPESS is administered in line with the Health Board's policy and NICE guidelines.

All HIW recommendations from inspections (including immediate assurances) and the Health Board's actions are captured via HIW improvement plans. These are incorporated into the HIW Corporate Tracker Tool in line with **Appendix 1** (SOP), which monitors progress against the actions agreed and assists with reporting in terms of assurance and escalation.

All completed improvements plans were accepted by HIW as providing sufficient assurance. It is also important to note that good progress has been made by the service (**Appendix 2)** with no actions overdue.

Phase 2

HIW inspected the following birth units / home from home units on Tuesday 21 January 2020; Dolgellau, Tywyn and Bryn Beryl Hospital. The inspection report has previously been reported to QSE:

1. **Hospital Inspection (Announced), Community Hospital Free Standing Birth Units**
   Inspection date: 21 – 23 January 2020
   Publication date: 26 June 2020

Immediate Assurances were issued around; Managing Risk and Promoting Health and Safety, Medical Devices and Safe and Clinically Effective Care. As above, all actions are captured in the HIW Corporate Tracker tool and progress reflected in **Appendix 2**.

Governance Interviews
Following the site inspections of maternity services, the second phase of the review will look at our governance arrangements. To do this HIW will hold a series of interviews with the following key staff within the Health Board; Chairman, Interim Chief Executive, Executive Director of Nursing / Deputy Chief Executive and Executive Medical Director.

The interviews are scheduled for week commencing 3 August 2020. These were initially scheduled for March 2020, however were placed on hold due to Covid-19.

The interviews will look at how our governance arrangements promote safe and effective care covering areas such as;

- Issues and themes arising from the inspections of maternity services within the health board
- reporting and management of concerns
- risk management
- workforce
- quality governance arrangements (ward-to-board) for maternity services

HIW will also look at supporting governance documentation which was previously provided to them in March 2020.

In preparation for the interviews, a briefing pack will be provided to staff selected for interview which will aid discussion and assist with providing assurance to HIW.

Community Clinics

HIW have informed the Health Board on 6 July 2020, another aspect to Phase 2 which will consist of patient engagement and inspection visits to community clinics across Wales. HIW have requested information in relation to our community clinics which will inform them of which community clinics are currently in use across the Health Board. Once this information is received from the Health Board, HIW can progress with their plans and the next steps.

Cefndir / Background:

HIW inspect the NHS in Wales, from general practices to hospitals. HIW assess compliance based on the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation. The Health Board's internal Standing Operating Procedure can be found at **Appendix 1.**

In its 2019-20 operational plan, Healthcare Inspectorate Wales (HIW) committed to a programme of national reviews which included maternity services.

The review is a nationally important piece of work exploring the quality and safety of maternity services in Wales. HIW's decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the concerns in Cwm Taf Morgannwg University Health Board maternity services highlighted by HIW in their maternity inspection in Royal Glamorgan Hospital in October 2018 and the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives in April 2019.

HIW's national maternity review intends to provide a national picture of the quality and safety of NHS maternity services across Wales. This work will provide public assurance and help to improve services for women and their families.

The HIW review is split into two phases:

Phase 1 (June to December 2019)

- Unannounced inspections of maternity units (24 hr)
- Public survey
- Maternity staff survey

Phase 2 (January to March 2020 – now extended due to COVID)

- Inspections of home from home-maternity-units (not 24 hrs)
- Interviews with key personnel with-in each health board
- Face to face engagement with women

Phase 2 (January to March 2020 – now extended due to COVID) has been informed by the work undertaken during Phase 1. This will involve interviews with key personnel within each health board regarding the quality safety and governance of maternity services. HIW will also seek face-to-face engagement with women to understand their experiences in greater detail.

The review will run from June 2019 to summer 2020 when HIW will publish an all-Wales report. The Terms of Reference for the review can be found at **Appendix 3**.

Asesiad / Assesent & Anaysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board's Quality Improvement Strategy (QIS), and Living Healthier Staying Well. These are part of our overall key objectives.

Financial Implications

Costs will be incurred in each service / area and will differ depending on HIW recommendation / Health Board action, and some costs will be part of the maintenance / refurbishment programme. Failure to provide safe care, can result in a complaint, claim and compensation of which there can be significant financial implications.

Risk Analysis

There is a risk of harm to staff if the estate or facilities is not fit for purpose. If staff are unable to provide suitable care, there is a risk of harm to the patient. There is also a reputational risk, particularly in terms of the press following any negative reports and immediate concerns.

Financial risk is associated with costs of any claims.

There is a risk of non-compliance with regulations. When standards are not met, HIW make recommendations for improvement, these feed into the NHS Wales Escalation and Intervention Arrangements. In addition, if HIW do not receive sufficient assurance that action has been taken to address issues, they can take enforcement action.

Legal and Compliance

There is a risk of non-compliance with regulations as per the risk analysis

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required. At present, Covid-19 has placed a significant impact on the work carried out by HIW and as such, all routine inspections and scheduled reports have been placed on hold.

STANDARD OPERATING PROCEDURE (SOP)

SOP No: V1

SOP Title: HIW Management Plan

SOP Number **V1**

SOP Title

Health Inspectorate Wales (HIW) Management Plan

	NAME	TITLE	SIGNATURE	DATE
Author	Diane Read Alison White	Head of Transforming Care (TC) Team Senior Project Support Officer, TC Team		
Reviewer	Deborah Carter	Associate Director Of Quality Assurance		
Authoriser	Gill Harris	Executive Director of Nursing & Midwifery		

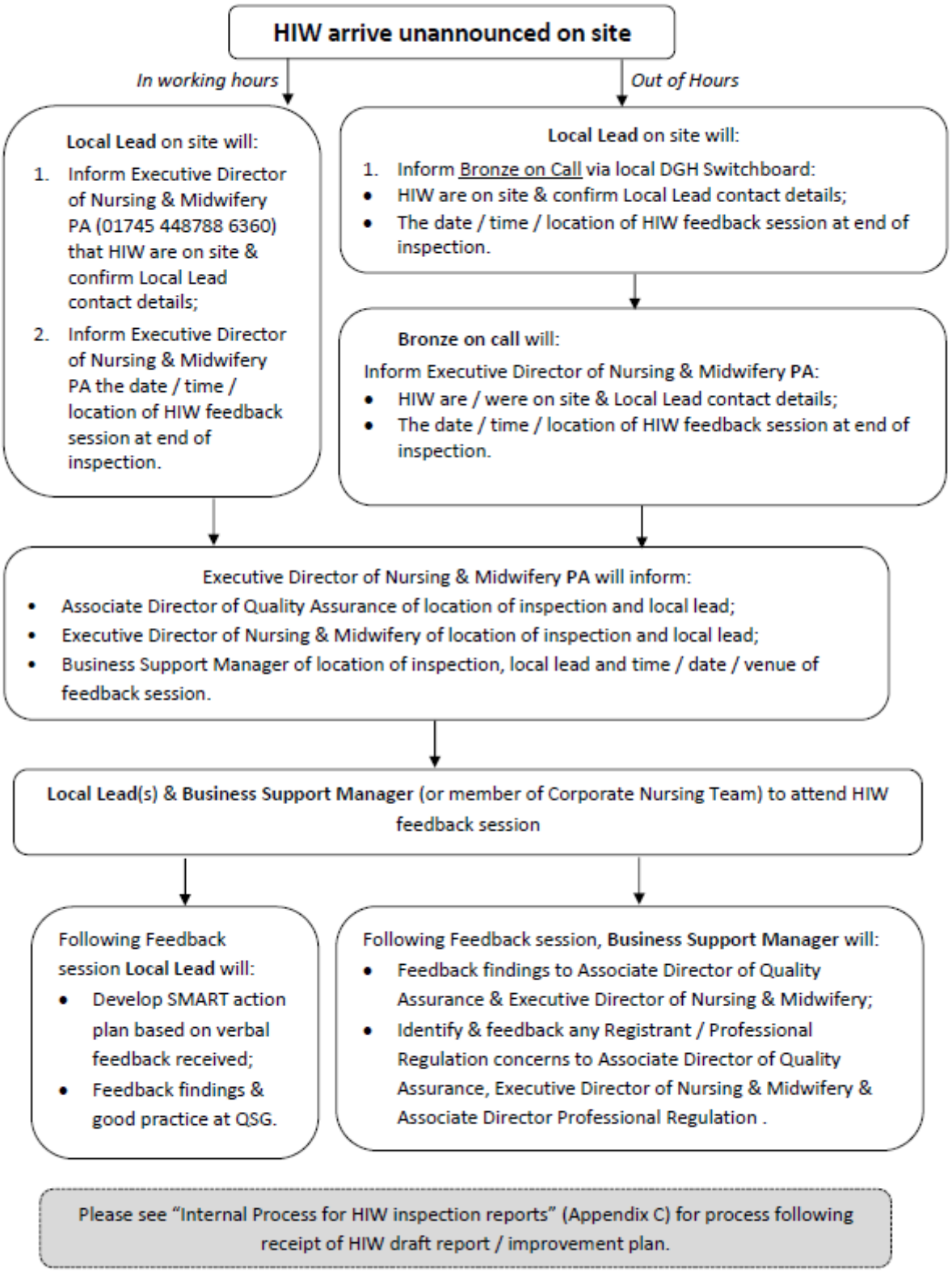
Effective Date:	**18th June 2018**
Review Date:	**18th June 2020**

Committees reviewed / approved by:	
Quality & Safety Group	13th June 2018

Review History:

SOP number	Page(s)	Changes made with rationale and impact	Date
V0.1	2	Associate Director of Professional Regulation & out of hours contact added.	15.06.18

BCUHB – HIW Inspection Process (June 2018)



1.0 PURPOSE & SCOPE

This document provides an overview of the HIW process across BCUHB including the management and support of inspections, developing SMART action plans and the process for correspondence between BCUHB and HIW.

2.0 RESPONSIBILITIES

Chief Executives Office	Assign a 4 digit BCUHB reference to all HIW correspondence. Responsible for returning all BCUHB correspondence to HIW via the secure portal.
Corporate Nursing	Manage all HIW correspondence. Quality Assure all HIW correspondence. Manage the HIW Tracker Tool and expedite actions / updates from Divisions. Act as the conduit between BCUHB and HIW (e.g. enquiries, deadlines etc). Prepare monthly exception reports for Quality & Safety Group.
Divisions / Local Leads	Responsible for managing local action plans (post HIW inspection). Ensure actions are completed and sustained and fed back to QSG accordingly. Sharing of lessons learnt both locally and BCUHB wide. Celebrating good practice.

3.0 HOW HIW INSPECT

When deciding when and where to inspect, HIW consider all the evidence and intelligence they have about an organisation built up over time. This includes:

- Information from previous HIW inspections or reviews;
- The vulnerability of the patient group or the complexity of the service;
- Specific data available to HIW;
- Issues and concerns shared by partner organisations;
- Concerns raised by patients and staff (see our website for further details raising concerns);
- National priorities, new standards or quality requirements;
- Blind spots[1].

4.0 UNNANOUNCED INSPECTIONS

Please see appendices A for the process to follow when HIW arrive on site.

HIW complete the majority of their inspections unannounced (GP Practice inspections are always announced). When the HIW Inspection Team arrive on site they will report to the main reception and ask to speak to the person in charge.

The HIW Inspection Team includes at least one HIW inspector and at least one clinical peer reviewer who is a person who has specialty expertise in the area they

[1] HIW – How we inspect

are inspecting. The number of inspection team members will differ depending on the size and complexity of the service visited.

HIW use the Health & Care Standards as the foundation of their inspection, please see appendix B for details of what HIW will look for during their inspection(s).

4.1 POST INSPECTION

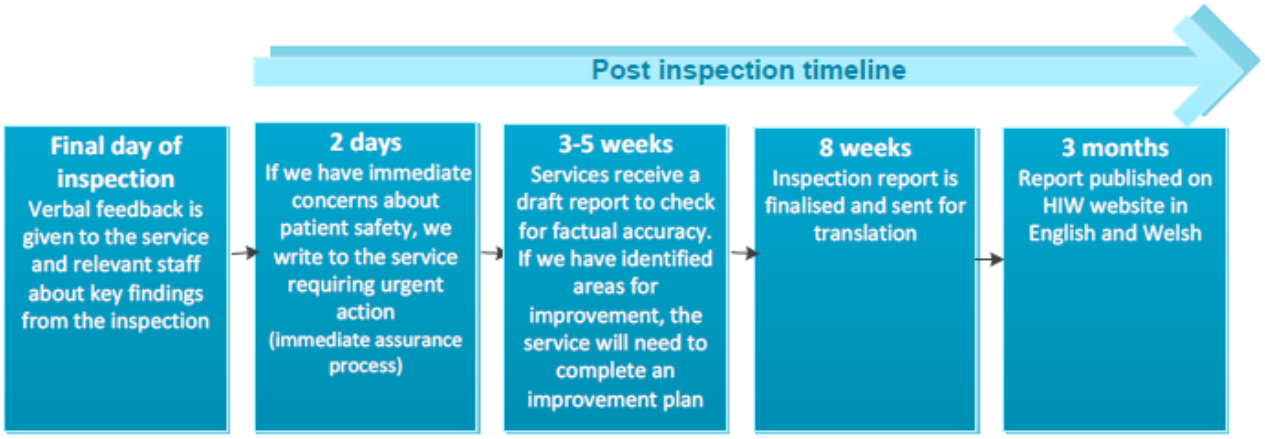


Figure 1 - HIW "How we inspect"

4.1.1 FEEDBACK SESSION

At the end of the inspection, HIW will meet with local leads and Business Support Manager / member of the Corporate Nursing Team to provide verbal feedback of the key inspection findings and areas of good practice.

The Business Support Manager / member of the Corporate Nursing Team in attendance will feedback to both the Executive Director of Nursing & Midwifery and Associate Director of Quality Assurance the:

- Headlines / findings;
- Any Registrant / Professional Regulation concerns / issues raised.

Divisions will commence remedial actions based on the HIW findings (as highlighted during the feedback session) as soon as HIW leave site rather than awaiting receipt of the draft report / action plan.

4.1.2 IMMEDIATE ASSURANCE

If an immediate concern[2] is raised by HIW this will be highlighted during the feedback session and a formal letter advising of these will be received by the Health Board from HIW within 48 hours post inspection.

The Health Board will have approximately 5 working days to introduce corrective action and respond to HIW with a formal action plan / assurance.

[2] *Such as poor medication practice which HIW deem could lead to patient harm*

4.1.3 INSPECTION REPORT

Please see appendix C for the specific process for management of HIW correspondence.

The Health Board will receive the draft inspection report from HIW within 3 to 5 weeks post inspection.

Local Leads / Area Director who will have approximately 7 to 10 days to populate the action plan. The Local Lead / Area Director will also have opportunity to comment on / question factual accuracy via the HIW pro forma (received with the draft report).

HIW will review our draft action plan / factual accuracy response and if acceptable the report will be published on the HIW website (http://hiw.org.uk/?lang=en) approximately 3 months post inspection.

If BCUHB miss the HIW submission deadline, HIW will publish the report minus our populated action plan which will be published as a separate appendices. Therefore, it is imperative that the Health Board respond to HIW by the deadline.

There may be exceptional circumstances where the service is unable to meet the HIW deadline, in such cases the Health Board (Business Support Manager) will approach HIW to request a short extension to the deadline.

4.1.4 ACTION PLANS

Local Leads / Area Directors are responsible for completing the action plans in response to HIW inspection findings. The action plan(s) must be developed using the SMART methodology as follows (please also see appendix D for a quick reference guide):

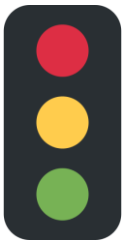
Specific	Does the action describe **how** you will achieve an outcome? *Be clear and specific about what and how you will accomplish the action. For example, if we state that we are going to monitor compliance, how often and for what period of time will be monitor this (and who will do it)?*
Measureable	Can you provide **evidence** that the action is complete and the outcome achieved? *Ensure that the action can be measured / how will we know when the action has been achieved / completed? I*
Achievable	Are you able to **achieve** the outcome following completion of the actions? *Is the action realistic but more importantly sustainable?*
Relevant	Are the actions going to **improve** the finding / issue raised? *Is the action relevant to the HIW finding? Will our action rectify the concern raised by HIW?*
Timely	Realistically, when can the actions be **completed** by? *Ensure we provide a realistic date for completion. For example, if the action is to recruit a new staff member, will you need 4 or more realistically 12 weeks to complete this action?*

Local Leads / Area Directors **must** ensure that leads / person(s) are not allocated actions without being informed to ensure the actions are owned, managed and delivered as confirmed on the action plan.

5.0 HIW TRACKER TOOL

All HIW actions (post inspection) are tracked on an Excel "tracker tool" (managed by the Corporate Nursing - Business Support Manager). Local Leads / Area Directors will provide regular updates for all open actions in their Division to the Business Support Manager to ensure the Tracker Tool is kept up to date. The Tracker Tool records / monitors actions as follows:

- **GREEN** – Action complete / closed;
- **AMBER** – Action being completed within the date communicated to HIW;
- **RED** – Action not completed by the date communicated to HIW.



The Tracker Tool is used to develop the monthly exception reports which is taken to QSG (please see section 6.1 for further detail).

6.0 ASSURANCE

6.1 Quality & Safety Group (QSG)

QSG will monitor the HIW process to ensure actions are being managed, controlled and sustained at local level.

A monthly exception report is presented to QSG which includes the number of amber and red actions (as noted on the Tracker Tool) plus details of thematic reviews and outstanding matters.

Local Leads / Area Directors should escalate to QGG if they are aware that an action cannot be completed by the deadline communicated to HIW (e.g. funding required to implement the action but none available at time of request). QSG will then offer / identify support and agree if the completion date can / should be extended. This decision will be noted on the QSG minutes / Tracker Tool.

5.2 HIW WALK ROUNDS

The Corporate Nursing Team will complete regular announced HIW walk rounds (with the local lead) to areas who have been inspected typically 6 months post HIW inspection with the aim to validate that actions have been completed, sustained and to review/support any outstanding actions.

The walk round Lead will receive the appropriate extract from the Tracker Tool (via the Business Support Manager) to refer to during the walkaround applicable to identify the findings and subsequent actions post HIW inspection.

The outcome of walkarounds will be recorded on the Tracker Tool and fed back to QSG as part of the HIW exception report.

6.3 WARD ACCREDITATION

If a Ward / Unit being accredited has had an HIW inspection in the last 12 months, the inspection report and action plan will be included within the Ward Accreditation data pack provided to reviewers on the day of the ward / unit accreditation.

7.0 THEMATIC & SPECIAL REVIEWS

HIW will complete a Special Review / Investigation when there are serious issues with a healthcare service to help the service learn from what has gone wrong.

HIW sometimes undertake Special Reviews or Investigations of healthcare organisations or services in response to concerns arising from a particular incident or incidents. This depends on the seriousness of these issues and/or frequency of occurrence.

HIW may consider investigating issues that suggest either systemic issues within a service, or alternatively wider failings within the NHS.

A decision to undertake a Special Review or Investigation may also be influenced by intelligence either collected by HIW or by other audit, regulation and inspection bodies.

Welsh Government also commissions HIW to undertake a review when a homicide of an adult is committed by an individual known to adult mental health services.

HIW special reviews and investigations provide an opportunity for services to learn when something has gone wrong[3].

8.0 OUTSTANDING MATTERS

HIW write to the Health Board on a monthly basis to request updates in relation to open / ongoing concerns brought to HIW by both patients, public and staff.

Upon receipt of the outstanding matters letter, the Business Support Manager will contact the relevant local lead for an update on the concern / matter. These updates will then be combined and a response returned to HIW.

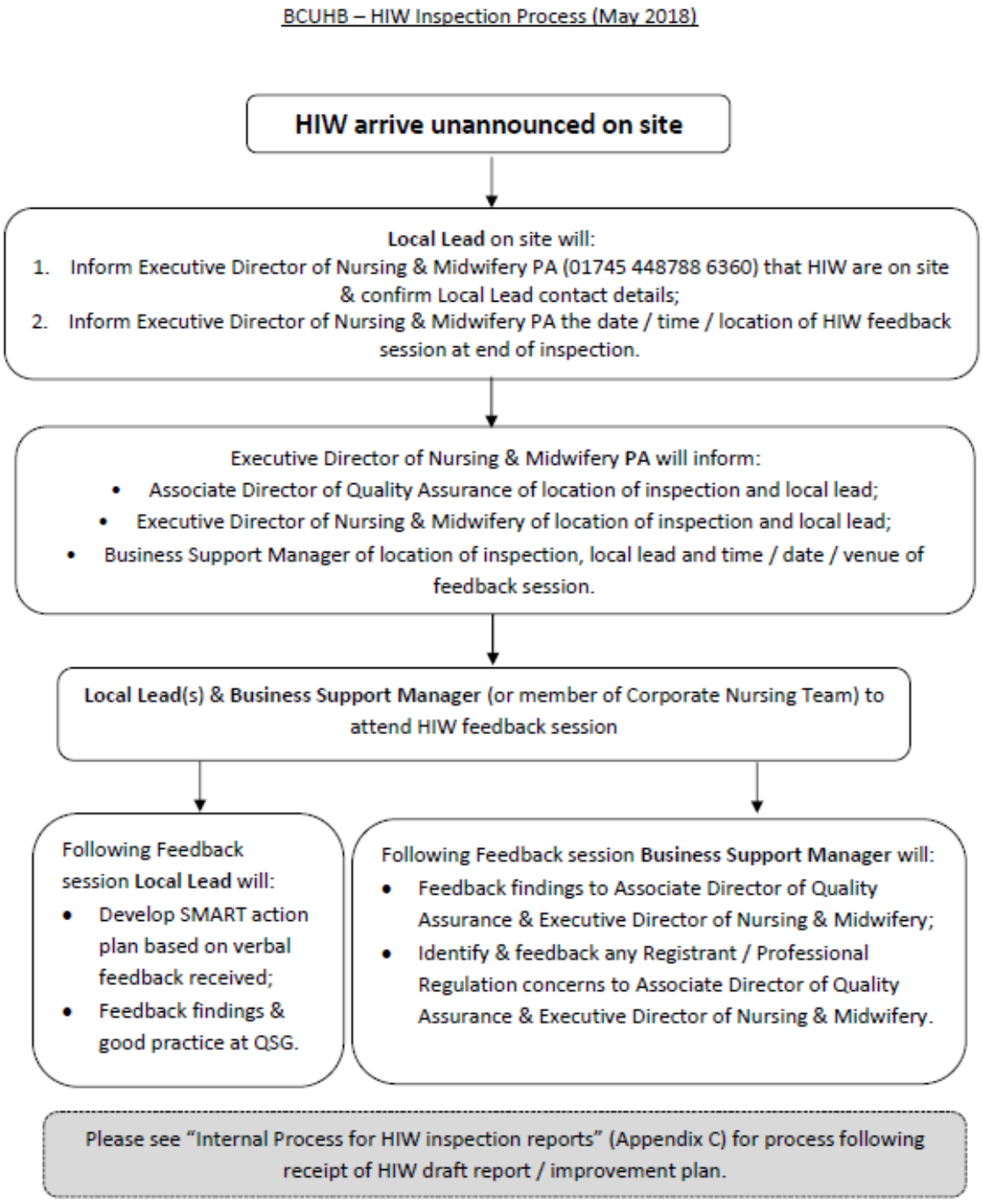
Divisions / Departments should inform the Business Support Manager of any concerns taken to HIW. The Business Support Manager will then record on the Tracker Tool in anticipation of an update on the status of the concern being requested by HIW via the monthly outstanding matters request.

9.0 FORMS/TEMPLATES TO BE USED

Appendix A	BCUHB – HIW Inspection Process (May 2018)
Appendix B	What HIW look at during their inspections
Appendix C	BCUHB – Internal process for HIW Inspection Reports (May 2018)
Appendix D	Creating SMART Action Plans

[3] http://hiw.org.uk/reports/special/?lang=en

Appendix A


BCUHB – HIW Inspection Process (May 2018)
HIW arrive unannounced on site
Local Lead on site will:
1. Inform Executive Director of Nursing & Midwifery PA (01745 448788 6360) that HIW are on site & confirm Local Lead contact details;
2. Inform Executive Director of Nursing & Midwifery PA the date / time / location of HIW feedback session at end of inspection.
Executive Director of Nursing & Midwifery PA will inform:
• Associate Director of Quality Assurance of location of inspection and local lead;
• Executive Director of Nursing & Midwifery of location of inspection and local lead;
• Business Support Manager of location of inspection, local lead and time / date / venue of feedback session.
Local Lead(s) & Business Support Manager (or member of Corporate Nursing Team) to attend HIW feedback session
Following Feedback session Local Lead will:
• Develop SMART action plan based on verbal feedback received;
• Feedback findings & good practice at QSG.
Following Feedback session Business Support Manager will:
• Feedback findings to Associate Director of Quality Assurance & Executive Director of Nursing & Midwifery;
• Identify & feedback any Registrant / Professional Regulation concerns to Associate Director of Quality Assurance & Executive Director of Nursing & Midwifery.
Please see "Internal Process for HIW inspection reports" (Appendix C) for process following receipt of HIW draft report / improvement plan.
BCUHB – HIW Inspection Process (May 2018) - V0.1

Appendix B

What HIW look at during their inspections

HIW inspections capture a snapshot of the standards of care patients receive. They may also point to wider issues associated with the governance of healthcare services provided.

The following table shows each of the Health and Care Standards we consider, what we are looking for during the inspection and how we do this.

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
Quality of patient experience	Staying healthy		
	1.1 Health promotion, protection and improvement	• Patients should be supported to look after their own health and well-being • Patients should know what care and support services there are to help them • Patients should be supported to make choices about their own health and	• Discussions with patients; family; friends, advocates and carers • Discussions and interviews with staff • Observations • Review of available patient information

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		wellbeing	• Responses within completed HIW patient questionnaires
	Dignified care		
	4.1 Dignified Care	• Patients should be treated with dignity, respect and kindness • Patients should have their needs are met whatever your religion, language, culture or feelings	• Responses within completed HIW patient questionnaires • Observations of interactions between staff and patients • Discussions with patients; family; friends, advocates and carers
	4.2 Patient Information	• Patients should have good information about their care that is easy to understand • Patients should be supported to make choices about their care	• Review of patient information • Discussions with patients; family; friends, advocates and carers • Discussions and interviews with staff • Review of available patient information • Responses within completed HIW patient questionnaires
	3.2 Communicating effectively	• Patients should have their communication needs met	• Discussions with patients; family; friends, advocates and carers

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		• Patients should be able to understand information about their care and health • Patients are able to tell health services about what they need or what they think	• Responses within completed HIW patient questionnaires • Discussions and interviews with staff • Responses within completed HIW patient questionnaires
	Timely care		
	5.1 Timely access	• Patients should have the right care at the right time in the right place with the right staff	• Discussions with patients; family; friends, advocates and carers • Responses within completed HIW patient questionnaires • Discussions and interviews with staff • Observations • Examination of a sample of patient medical records
	Individual care		
	6.1 Planning Care to promote independence	• Patients should be supported to look after their own health and well-being • Patients should be able to make	• Discussions with patients; family; friends, advocates and carers • Responses within completed HIW

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		choices about their care	patient questionnaires • Review of available patient information • Examination of a sample of patient medical records
	6.2 Peoples rights	• All health services must understand and support equality and human rights for everyone	• Discussions with patients; family; friends, advocates and carers • Examination of a sample of patient medical records • Review of staff training records • Observations • Discussions and interviews with staff
	6.3 Listening and Learning from feedback	• Patients and their families should be able to tell health services about the care they get from health services • Health services should know what is working well and what is not working well • Health services should be open and honest with patients when they tell	• Discussions with patients; family; friends, advocates and carers • Responses within completed HIW patient questionnaires • Review of feedback systems including complaints policy and procedures • Observations

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		them that something has gone wrong • Health services should learn from what patients tell them and make services better	• Information held by HIW • Interviews with senior management
Delivery of Safe and Effective Care	Safe Care		
	2.1 Managing risk and promoting health and safety	• Health services must look after patient's health and safety and make sure that any risks are managed as well as they can	• Review of policies and procedures • Observations • Discussions and interviews with staff • Interviews of senior management
	2.2 Preventing pressure and tissue damage	• Patients should be helped to look after their skin • Health services should make sure that patients do not get sore skin from sitting or lying down for too long	• Review of documentation e.g. audits, risk assessments • Examination of a sample of patient medical records • Observations • Discussions with patients; family; friends, advocates and carers • Discussions and interviews with staff
	2.3 Falls Prevention	• Health services should check if patients	• Review of documentation e.g. audits,

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		are likely to fall • Health services should do everything they can to stop people from falling and hurting themselves	risk assessments • Examination of a sample of patient medical records • Discussions with patients; family; friends, advocates and carers • Discussions and interviews with staff
	2.4 Infection Prevention and Control (IPC) and Decontamination	• Health services should involve everyone in helping to control and stop infections so that people do not get ill	• Review of documentation e.g. audits, risk assessments, policies and procedures • Observations • Discussions and interviews with staff
	2.5 Nutrition and Hydration	• Patients should be supported to eat and drink so that they can get better quicker	• Review of documentation e.g. audit and monitoring processes • Examination of a sample of patient medical records • Discussions with patients; family; friends, advocates and carers • Discussions and interviews with staff • Observations

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
			• Responses within completed HIW patient questionnaires
	2.6 Medicines Management	• Patients should get the right medicine at the right time	• Review of documentation – e.g. audits, medicines management policy and procedures • Examination of a sample of patient medical records • Discussions and interviews with staff • Discussions with patients; family; friends, advocates and carers • Observation of medicines administration and storage
	2.7 Safeguarding children and adults at risk	• Health services must support and protect all children and any adults who are vulnerable or at risk	• Review of staff training records • Discussions and interviews with staff • Scrutiny of safeguarding policies and procedures • Review of Deprivation of Liberty Safeguards (DOLS) and Mental Capacity Act assessments in patient medical records where appropriate

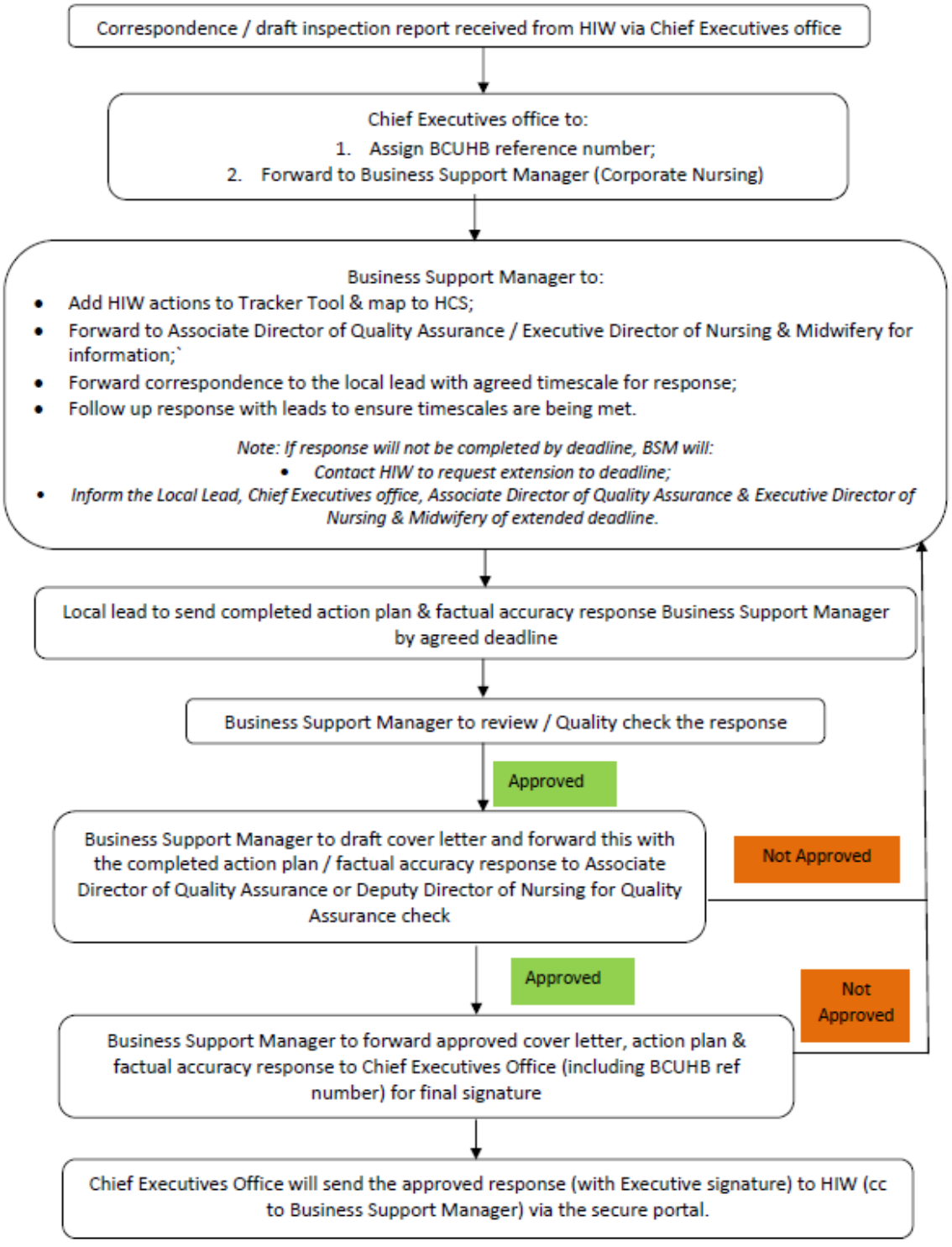
HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
	2.8 Blood management	• Patients should be able to get blood when they need it	• Review of policies and procedures • Staff training records • Discussions and interviews with staff • Interviews with senior staff
	2.9 Medical devices, equipment and diagnostic systems	• Health services must make sure that all the equipment they use is safe and works well	• Discussions and interviews with staff • Interviews with senior staff • Review of documentation e.g. servicing and installation
	Effective Care		
	3.1 Safe and Clinically Effective care	• Patients should get the right care and support for their needs • Health services should know the best ways to care and support patients	• Examination of a sample of patient medical records • Discussions and interviews with staff • Review of documentation e.g. audits, risk assessments, monitoring processes • Responses within completed HIW staff questionnaires
	3.3 Quality Improvement,	• Health services should look at different	• Interviews with senior management

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
	Research and Innovation	ways to make services better based on good research	• Review of documentation e.g. audits, quality improvement initiatives • Responses within completed HIW staff questionnaires
	3.4 Information Governance and Communications Technology	• Health services should have the right information and make sure this information is shared safely	• Interviews with senior management • Review of documentation e.g. policies and procedures • Discussions and interviews with staff
	3.5 Record keeping	• It is very important that health services keep good records to make sure patients get the right care • Health services must follow the rules about how to record information and keep it safe	• Examination of a sample of patient medical records • Discussions and interviews with staff • Review of documentation e.g. audits
Quality of Management and Leadership	**Governance, Leadership and Accountability**	• All health services should be person centred. They should focus on patient's needs and listen to them • Health services should do the right things well, know how well they are doing, be open and honest in	• Interviews with senior management • Discussions and interviews with staff • Review of documentation e.g. policies and procedures, audits, future plans • Information held by HIW

HIW inspection theme	What Health and Care Standards apply?	What are we looking for?	How do we do this?
		everything they do, be caring and kind and work hard	• Responses within completed HIW staff questionnaires
	Staff and Resources		
	7.1 Workforce	• Health services should have enough staff with the right skills and training to be able to give patients the best care	• Responses within completed HIW staff questionnaires. • Discussions and interviews with staff • Review of documentation e.g. rotas, staff training records, recruitment procedures • Observation

Appendix C

BCUHB – Internal Process for HIW inspection reports (May 2018)



BCUHB – HIW Internal Process (May 2018 – V0.2)

Appendix D

CREATING SMART ACTION PLANS

1. SPECIFIC

Does the action describe **how** you will achieve an outcome in detail?

2. MEASURABLE

Can you provide **evidence** that the action is complete and the outcome achieved?

3. ACHIEVABLE

Are you able to **achieve** the outcome following completion of the actions?

4. RELEVANT

Are the actions going to **improve** the issue raised?

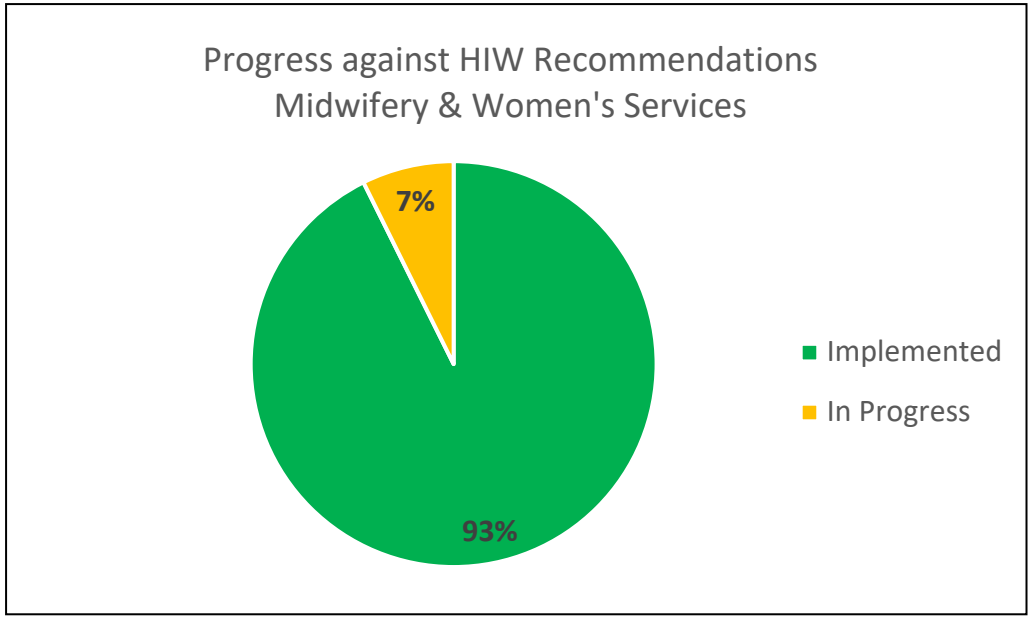
5. TIMELY

Realistically, when can the actions be **completed** by?

Appendix 2: Midwifery & Women's Services

Progress against HIW Recommendations, National Maternity Review 2019/20

Status	**Midwifery & Women's Services**
Implemented	177
In Progress	14
Overdue	0
Grand Total	**191**
Note: 10 recommendations from those in progress have revised completion dates due to COVID which have been agreed corporately.	



Healthcare Inspectorate Wales

National Review of Maternity Services 2019-20

TERMS OF REFERENCE

Background

In its 2019-20 operational plan, Healthcare Inspectorate Wales (HIW) committed to a programme of national reviews which included maternity services. Our decision to undertake this review was based on a number of concerns relating to the pressures around maternity services in Wales, including the issues identified during HIW's inspection of maternity services in the Royal Glamorgan Hospital in the former Cwm Taf University Health Board in October 2018[1].

The Royal College of Obstetricians and Gynaecologists and Royal College of Midwives were commissioned by Welsh Government in October 2018 to carry out an independent review of the patient care provided by the former Cwm Taf University Health Board[2]. This followed serious concerns that initially came to light as a consequence of the under reporting of serious incidents in maternity services. The report published in April 2019 raised a number of significant concerns around staffing, processes and the underlying culture in maternity services which have compromised care. This resulted in the maternity services in the health board being placed in special measures in April 2019.

Following its publication and given the seriousness of this situation, the Minister for Health and Social Services, Vaughan Gething AM, required health boards to consider their own services in the context of the recommendations of the report and to provide immediate assurances in this regard.

Welsh Government is working with heads of midwifery, clinical directors and user led maternity service liaison committees to ensure that the learning from this report informs the actions for Wales in the development of a new five year vision for maternity services[3].

[1] https://hiw.org.uk/sites/default/files/2019-06/210119royalglamorganmaternityen.pdf
[2] Since 1 April 2019, Cwm Taf University Health Board became Cwm Taf Morgannwg University Health Board following the incorporation of the Bridgend area within the health board.
[3] https://gov.wales/written-statement-publication-maternity-care-wales-5-year-vision-future

In April 2017, under a new model for clinical supervision, the health boards took responsibility for the supervision of midwives practicing in Wales (previously undertaken by the Local Supervising Authority for Midwives). Since this change, there has not been a national overview of the delivery of midwifery supervision across Wales. Therefore, an independent review of maternity services is now timely.

HIW's national maternity review will provide a national picture of the quality and safety of NHS maternity services across Wales. This work will provide public assurance and help to improve services for women and their families.

Scope and methodology

Our national review will explore:

- The experiences of women, their partners and families.

It will also explore the extent to which health boards across Wales:

- Provide safe and effective maternity services
- Understand the strengths and areas for improvement within their maternity services.

The journey from early pregnancy to birth and following the birth is an important time for both the mother and the baby and is often complex. We will listen to the accounts of women, their partners and families to gain their opinion of the services they received before giving birth and the support provided after the birth whether these have been low risk or high risk pregnancies and births. The national review will collect evidence in a number of ways over the next year.

Phase I (June to December 2019) will consider the evidence and any themes that emerge from a programme of unannounced inspections of maternity units across Wales. The focus will be on the care provided in maternity units[4] up to the point of discharge plus some aspects of antenatal care provided in the community.

The inspection teams will consist of:

- At least one HIW inspector
- At least one midwife peer reviewer
- One obstetrician peer reviewer
- One lay reviewer.

HIW will tailor its approach to review the care provided within stand-alone midwifery led units (home from home units) which are not permanently staffed.

[4] Home from home units, free standing midwife led units, alongside midwife-led units and obstetric units

In the autumn 2019, HIW will launch a national maternity survey, developed with input from the Community Health Council. The survey will gather the experiences of maternity services from a broad range of women, their partners and families across Wales. The survey will cover experiences during pregnancy, birth (whether at home or in a maternity unit), and after the birth.

The survey will be published on HIW's website and a variety of communication tools and channels will be used to raise awareness of how people can take part in the survey, including seldom-heard from groups.

A separate national survey will be launched to capture the views of multi-disciplinary staff working in maternity services. This will also be published on HIW's website and shared with each health board in Wales for dissemination to staff.

Phase II (January to March 2020) will be informed by the work undertaken during Phase I. This will involve interviews with key personnel within each health board regarding the quality safety and governance of maternity services. We will also seek face-to-face engagement with women to understand their experiences in greater detail.

Work by other organisations

As part of our scoping for the review, we will identify and liaise with other organisations who have recently conducted or plan to conduct work in relation to maternity services.

HIW will work with a range of stakeholders, including the Community Health Councils and third sector organisations, in order to engage with women, their partners and families to understand their experiences of maternity services across Wales.

HIW will liaise with these stakeholders at key intervals throughout the review to share plans and ensure any joint working opportunities are explored to avoid unnecessary duplication of efforts and to share findings following completion of fieldwork.

Planning

HIW will establish a maternity stakeholder reference group to inform the review. The Terms of Reference for the stakeholder reference group once finalised will be made available on HIW's website.

HIW will also form an advisory panel which will consist of a small team of obstetricians, anaesthetists and midwives whose role will be to provide additional support and advice to HIW's internal project board on the day to day implementation of the review. The Terms of Reference, when once finalised will be made available on HIW's website.

To inform the review, HIW has gathered intelligence relating to maternity services across Wales. This work includes:

- A range of information, data and national audits regarding maternity services across Wales, including any concerns intelligence held by HIW and the Welsh Government
- Information provided by each health board to the Welsh Government regarding the safety of maternity services, following the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives report on maternity services at the former Cwm Taf University Health Board
- Maternity information and self-assessments from each health board requested by HIW.

Timescales

The following table includes estimated project timeline for the review.

Task	Timing
Researching and scoping	May 2019 – June 2019
Local Health Board self-assessment	June 2019
Planning of fieldwork	January 2019 – June 2019
Fieldwork Phase I	June 2019 – December 2019
Fieldwork Phase II	January 2020 – March 2020
Report publication and engagement	Summer 2020

Analysis and reporting

A report will be produced following each maternity inspection between June and December 2019. In line with HIW's inspection processes, any urgent concerns will be raised immediately with the health boards and the Welsh Government[5].

If we identify areas for improvement, health boards will be required to complete an improvement plan which describes how the service will address the findings. All inspection reports will be published on HIW's website three months after the date of inspection. Health boards will receive a draft inspection report to check for factual accuracy, prior to its publication.

The review will conclude with the publication of a national maternity services report in summer 2020. The final report will highlight key themes and recommendations identified from our fieldwork. The report may make recommendations for health boards and Welsh Government to consider and act on.

[5] Further details on how HIW inspects the NHS can be found on our website https://hiw.org.uk/sites/default/files/2019-05/170328inspectnhsen_0.pdf

Publication and engagement

All the reports will be published on HIW's website and a communication strategy will be developed to enhance exposure.

A dedicated webpage for the maternity review will be created on HIW's website with updates on the key findings from the review. We will also use different communications tools and channels to raise awareness of how people can take part in the national survey and engagement activities. Following the publication of the final national report, follow-up, engagement and learning events will be considered.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quarter 2 Plan
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Mr John Darlington, Assistant Director - Corporate Planning.
Craffu blaenorol: **Prior Scrutiny:**	The BCU Planning Workstream has overseen the development of the Q2 plan. Priorities for action have been discussed with partners in the Stakeholder Reference Group (SRG). The draft plan was discussed at the Executive Management Group (EMG) and Board workshop on 1st July. The Chief Executive agreed the final draft plan on 3rd July.
Atodiadau **Appendices:**	Appendix 1: Betsi Cadwaladr University Health Board Quarter 2 Plan - Sustainable Service Delivery

Argymhelliad / Recommendation:

It is recommended that the Board:

1. Receive and approve the draft Q2 plan to support service delivery during the Pandemic.
2. Provide feedback as to what they would wish to see covered in the Q3 plan.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval *	√	**Ar gyfer Trafodaeth For Discussion***	√	**Ar gyfer sicrwydd For Assurance***	√	**Er gwybodaeth For Information***	√

Sefyllfa / Situation:

The quarter 2 plan describes what we aim to achieve as a Health Board in the 12 weeks starting on 1st July to 30th September 2020. It is a plan for the full range of our responsibilities including mental health services, our physical health services from primary to tertiary care, and including the critical enablers of care: workforce, digital, and estates. It is an integrated plan aligning service, workforce and financial planning.

Cefndir / Background:

The purpose of the plan is to ensure a single service plan exists across the Health Board which will begin to balance COVID 19 and Non COVID 19 demands.

The plan sets out the actions that we are taking with our partners in quarter two and builds upon the decisive actions that we took within quarter one through making changes at pace to meet the first peak of COVID-19.

Our priority for quarter 2 is to continue to respond to the pandemic and to balance managing COVID-19 patients with the provision of other essential services whilst adhering to social distancing rules and the needs to protect our staff and patients.

We will achieve this through ensuring that safe operating environments are in place, for example through established technology enabled clinical pathways to manage COVID-19 and non COVID-19 patients.

The initial modelling of demand for the pandemic suggested an intense period of activity requiring significantly enhanced capacity; the emerging picture is that of a less intense, but prolonged period of activity with potential peaks which will require surge capacity. We will therefore continually review our planning assumptions throughout the year working with our partners.

Our underlying approach is to continue to proceed with caution given the uncertainty around future COVID-19 demand. The focus of this plan is therefore to ensure delivery of essential NHS services, to meet unscheduled care demand and other urgent services based on an assessment of safety, workforce, capacity, clinical support requirements and patient risks.

Our plans have been re-set to align to this 'new normal' and the need to consider four types of harm, and address all of them in a balanced way

We need to provide treatment for an increasing number of patients who are waiting for diagnosis and treatment, recognising that demand for primary and secondary care services will further increase in the future as the population begin to recognise the need to present with non COVID symptoms.

The current pandemic and its impact on the care sector reinforced the need for system wide partnership working which we will continue to build into Q2 and Q3.

Asesiad / Assessment

There is agreement across the system that we need to ensure that we are able to deliver essential health services for our population and where possible recommence more routine care. However we need to do this progressively, and with caution, through short planning cycles that maintain the flexibility and agility we have demonstrated over recent months.

On 18th June, we received the NHS Wales COVID 19 Operating Framework – Quarter 2 framework reflecting the continued need to maintain essential NHS services, to meet unscheduled care demand and other urgent services based on an assessment of safety, workforce, capacity, clinical support requirements and patient risks.

Our draft Q2 plan was submitted to Welsh Government (WG) on 3rd July in response to the operating framework . The plan is attached in Appendix 1 for approval covering the period 1st July - 30th September 2020.

This represents a dynamic and rolling plan which will be continually reviewed and refreshed alongside our continued response to Covid-19.

Whilst this plan specifically relates to the second quarter, we recognise the importance of preparing for the rest of the year and the additional risks associated with the winter period. The preparatory work required ahead of the third quarter is therefore described within the plan alongside the work we are doing with partners to consider how we can transform for the future, learning from new ways of working and delivering services.

Betsi Cadwaladr University Health Board

Sustainable Service Delivery Plan for Quarter 2

1st July - 30th September 2020

Version 1.3

7th July 2020

Summary of our Plan for Q2

This plan describes what we plan to achieve as a Health Board in the 12 weeks starting on 1 July, as part of a planning approach to 2020/21 including the critical winter period.

It is a plan for the full range of our responsibilities including mental health services, our physical health services from primary to tertiary care, and including the critical enablers of care: our workforce, digital technology, and estates. It is an integrated plan aligning service, workforce and financial planning.

On COVID-19, we will continue to promote good health by supporting the government's behavioural and social interventions. Through Test Trace and Protect, we will seek to slow the spread of COVID-19.

Our primary care services will build on work in the first quarter, supporting patients to access safe and effective care through triage and assessment through maximising the potential of digital technology. We will promote the availability of our services and communicate to the public about new models, access and self-care.

For our hospital services, we will maintain a high state of readiness to respond in a timely way to COVID-19, fulfil our obligations to deliver 'essential services', and restart as many of our remaining services as we can using the principles of harm reduction.

Key elements of our clinically led approach include:

- Each hospital site uses its available capacity providing essential services locally where appropriate.
- A BCU wide risk stratification approach is applied to patients waiting to access outpatients or inpatients / day cases to ensure that the highest priority patients are offered appointments at the soonest opportunity.

The following demand assumptions underpin this plan:

- Current demand levels for COVID-19 care will continue.
- Emergency / unscheduled care demand continues to increase to pre COVID-19 levels.
- We will deliver all essential services and some other planned care.

By far the most significant variable in our demand modelling is unscheduled care demand.

Demand for our beds may be higher because of the requirement to safely discharge patients into the care sector, and the challenges facing the care sector in responding to COVID-19. Our 'functional' capacity is reduced by environmental guidance and workforce availability. These scenarios have been modelled at a high level and do not fundamentally change our central conclusion.

To maintain safe and appropriate hospital bed occupancy levels, we will commission some of our planned surge capacity whether in our acute or community hospitals. We do not expect to open our Temporary Hospitals to any significant extent, unless there is a significant second wave of COVID-19 during Q2.

We note Welsh Government guidance and are planning that a reasonable worst-case second COVID-19 peak acute bed demand should assume 1,100 beds would be required. We have plans available should the need arise including the use of temporary hospitals.

Full delivery of 'essential services' will be supported by work to re-design and re-model services and (in some areas) additional investment. It will be supported by a pan BCU pathway approach.

It is both necessary and possible to make progress in a number of other key priority areas, for example, we will continue to develop our mental health services and seek to progress strategic priorities such as the acute Digital Health Record.

In our mental health services, we will prioritise improvements to primary care, rehabilitation, crisis care and psychological therapies service delivery. To support this, we will progress at pace with work to ensure that our staffing structures are best placed to support the future service delivery model.

The Q1 workforce plan very much focused on ensuring that staff were supported with safe working conditions, provided with the correct and appropriate guidance regarding COVID-19, including the implementation of the BAME guidance and relevant support for this staff group. The Health Board also made sure that all workforce planning was directly linked to the revised clinical pathways, supporting the reintroduction of essential services whilst maintaining flexible and innovative working practices across all relevant staff groups, such as remote working, development of key transferable skills and redeployment where applicable. Our workforce plan aims to ensure that the key workforce strategic themes set out for 2020/21 are adhered to whilst ensuring the work commenced in Q1 to specifically support COVID-19 is continued.

Our digital plan includes those objectives that have continued into this year, as well as those that are directly aimed at supporting COVID-19 and our response. We are prioritising delivery of support for virtual consultation and need to ensure this does not detract from longer-term priorities. Many of our Q2 objectives support the ability to allow staff to work more flexibly and to minimise the need for patients to visit sites.

Our estates plan sees us taking forward the programme of work needed to ensure the continued safe delivery of services at the Wrexham Maelor, creation of the North Denbighshire Community Hospital, Ablett mental health unit reprovision, Ysbyty Gwynedd statutory compliance and residential accommodation for our staff.

The financial plan for 2020/21, approved by the Board, was to deliver a deficit of no more than £40m and was based on delivering savings of £45m. The plan did not take into account the impact of COVID-19, and the Q2 plan has been updated to reflect the anticipated impact, although there is a significant variable element to the assumptions, given the potential of a second COVID-19 wave. It is clear that expenditure will be significantly higher than planned due to the pandemic response, and as operational and clinical teams are focused on both COVID-19 and essential services, savings delivery has been particularly impacted.

The current forecast reflects a gross deficit of £178.2m, which after assumed COVID-19 additional Welsh Government funding of £138.2m leaves the Health Board with a net deficit in 2020/21 of £40.0m. £60m of the COVID-19 expenditure relates to the three temporary hospitals we have established in North Wales, which are providing circa 1,000 beds across three locations, in Llandudno, Bangor and Wrexham.

We are working closely with our partners as we plan how we will deliver services for north Wales in a challenging year. This document sets out the key actions the health board will take in the next three months. A plan for the remainder of the year will be developed over the summer so that we are prepared for the winter.

Contents

Chapter 1 Introduction

Our plan sets out the actions that we are taking in quarter 2, working closely with our partners. The plan builds upon the decisive actions that we took within Q1 through making changes at pace to meet the first peak of COVID-19.

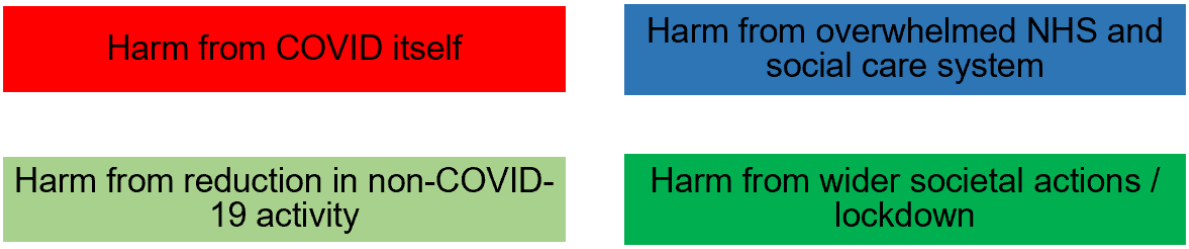
Our priority for Q2 is to continue to respond to the pandemic and to balance managing COVID-19 patients with the provision of other essential services whilst adhering to social distancing rules and the need to protect both our staff and our patients.

Responding to the changing environment requires a focus on safety, consistency and sustainability. We will achieve this through ensuring that safe operating environments are in place, for example through technology enabled clinical pathways to effectively manage COVID-19 and non COVID-19 patients.

We will continue to implement evidence based clinical pathways and clinically led service change based on national and professional guidance and overseen by our clinical pathways work stream. This work aligns well with our pre-COVID-19 plans to develop our digitally enabled clinical strategy. We have seen this work accelerated and intend to continue to take this forward in quarter 2.

Our underlying approach is to continue to proceed with caution given the uncertainty around future COVID-19 demand. The focus of this plan is to ensure delivery of essential NHS services, to meet emergency / unscheduled care demand and other urgent services based on an assessment of safety, workforce, capacity, clinical support requirements and patient risks.

Plans have been re-set to align to this 'new normal' and the need to consider four types of harm, and address all of them in a balanced way:



Whilst this plan specifically relates to Q2, we recognise the importance of preparing for the rest of the year and the additional risks associated with the winter period. The preparatory work required ahead of Q3 is described within the plan alongside the work we are doing with partners to consider how we can transform for the future, learning from new ways of working and delivering services.

Chapter 2 Forecast Demand and Capacity for Hospital Beds

2.1 Demand

This section outlines some of the key demand and capacity assumptions and judgements that underpin the plan. The analysis focuses on bed-based capacity and activity:

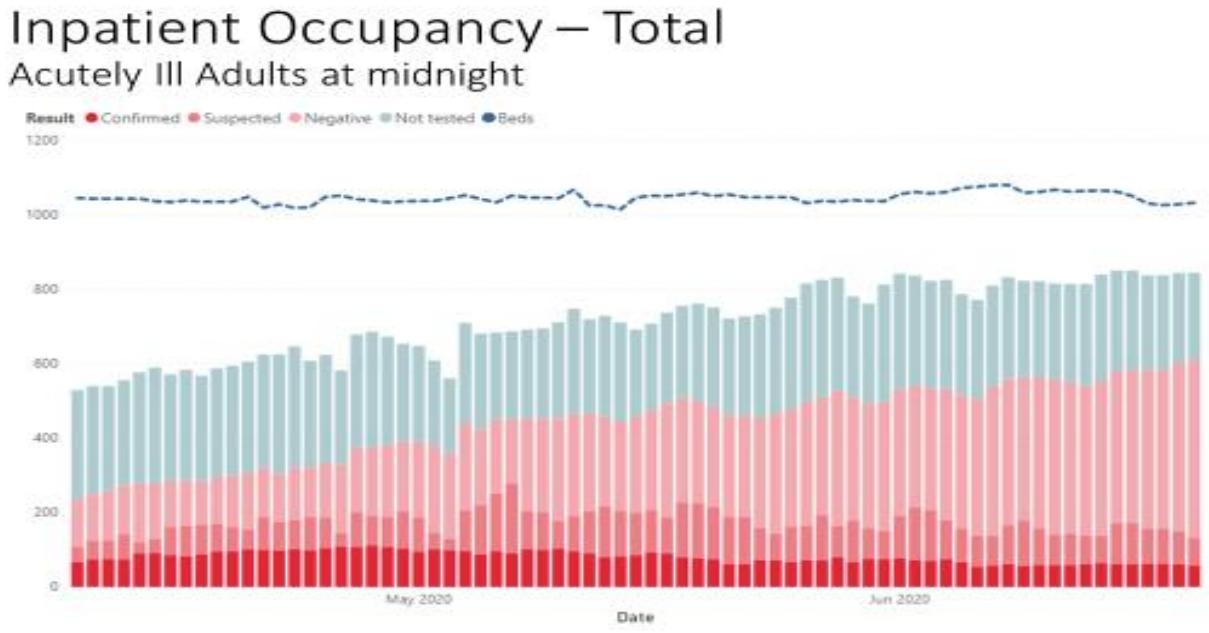
- critical care beds
- outpatients
- key elements of diagnostics

As is outlined in the national planning guidance, capacity plans need to be reviewed to respond to a reduced but more sustained pressure because of COVID-19. The analysis of demand and supply also addresses the increase of non COVID-19 emergency activity towards pre COVID-19 levels, the need to deliver all essential services, and the cautious re-introduction of routine services.

It is important to be clear about the nature of the supply and demand forecasting in this plan. The key point is that this is a highly uncertain environment. The limitations of forecasts COVID-19-related demand, including the scale and timing of any second peak in demand, have been well rehearsed. There are also significant uncertainties about the speed with which non COVID-19 demand may return to pre COVID-19 levels, as well as other elements such as the ability of the care home sector to admit patients and the resultant impact on acute and community hospital lengths of stay.

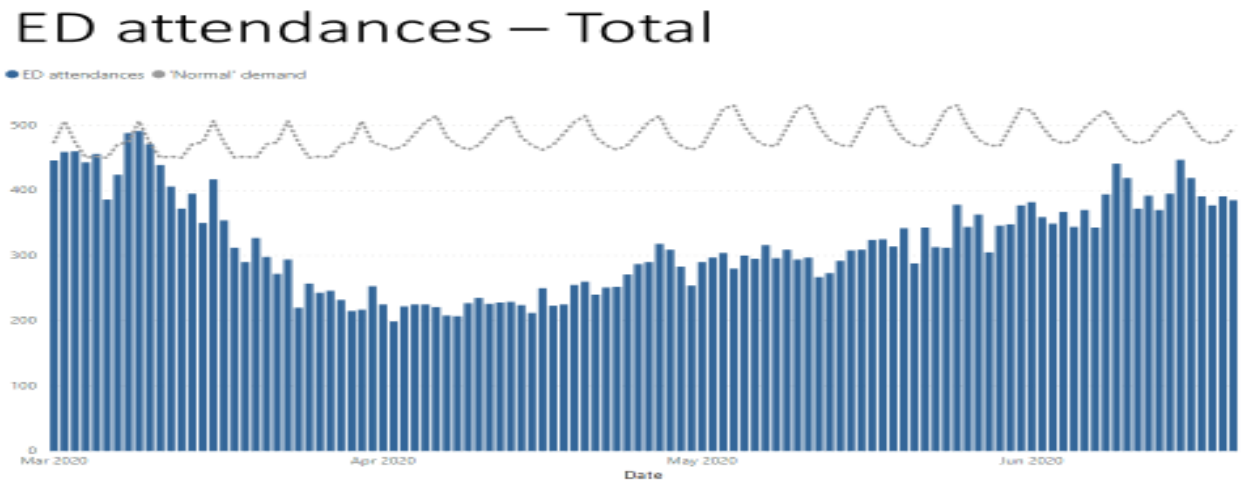
It is clearly important to have a reasonable estimate of levels of demand to inform decisions. However these forecasts must be regarded as giving a broad indication of the capacity required and the speed with which it will be needed, and the position may change materially (in either direction) in a short space of time. Very short-term forecasts (2-4 weeks) are far more likely to be valid than a longer-term view, and decisions may need to be adjusted frequently.

The overall position across BCU is one of COVID-19 demand broadly stable, while non COVID-19 demand for unscheduled care is returning rapidly to pre COVID-19 levels. The following charts give an overview of demand for emergency acute hospital beds, and the trends in attendances at the Emergency Departments:



Week	13-Apr	20-Apr	27-Apr	04-May	11-May	18-May	25-May	01-Jun	08-Jun	15-Jun
Confirmed	101	112	116	106	96	77	76	72	64	65
Suspected	67	76	79	128	113	122	96	109	93	91
Negative	139	152	207	229	272	297	348	362	413	445
Not tested	296	301	269	248	252	266	293	284	268	252
Total	**604**	**640**	**671**	**712**	**733**	**762**	**812**	**827**	**838**	**852**

There are some important geographical differences within this picture, with COVID-19 admissions in Bangor at a very low level, and overall occupancy relatively low. By contrast bed occupancy at Glan Clwyd is running particularly high. This is reflected in the supply and demand analysis below.



As regards second quarter demand and the basis of this plan, an indicative realistic scenario has been developed for planned and unscheduled care. In terms of unscheduled care, it makes the following key assumptions:

- Demand for COVID-19 beds will continue based on current trends during the second quarter i.e. a slight decline with no second wave before the end of September.

- Non COVID-19 emergency activity will rise at the current rate, but will plateau at pre COVID-19 levels.

For elective care, the bed requirements have been calculated for essential services and the additional elective activity, which is planned for the period. A significant factor that may increase demand on both acute and community hospital beds is the impact of regulations in relation to admissions to care homes.

- The requirement for patients to test COVID-19 negative prior to discharge means there will be a number of patients whose discharge pathway will be extended if they have tested COVID-19 positive. Current estimates are that this could require 24 beds, primarily in community hospitals.

- The fact that care homes cannot take admissions until they have not had a new case for 28 days will also result in delayed discharges. It has been estimated that this may affect 112 patients at any

one time. Further work is being undertaken to establish the extent to which these two factors are already reflected in current occupancy levels, and what may be an additional pressure.

This gives rise to the following forecast demand for beds for acutely ill patients, excluding the two factors above:

Week	**29 Jun**	**6 Jul**	**13**	**20**	**27**	**3 Aug**	**10**	**17**	**24**	**31**	**7 Sep**	**14**	**21**	**28**
Non COVID-19 emergency	795	819	844	869	894	918	943	962	991	995	1000	1006	999	983
COVID-19 emergency	59	56	54	51	48	46	43	41	38	35	33	30	28	25
Essential Services	23	23	23	23	23	23	23	23	23	23	23	23	23	23
Additional planned work	11	11	11	11	11	11	11	11	11	11	11	11	11	11
Beds required at 92% occupancy	**964**	**989**	**1,013**	**1,087**	**1,061**	**1,085**	**1,109**	**1,127**	**1,156**	**1,157**	**1,159**	**1,163**	**1,152**	**1,143**

2.2. Capacity

The following table outlines the available hospital beds for acutely ill adults[1] at the three main acute hospitals. It also describes the available beds in community hospitals and the potential surge capacity available in acute, community hospitals, temporary hospitals.

	Time to Open	**Acute Hospitals**			**Community Hospitals**	**Temporary Hospitals**			**Total**
		Ysbyty Gwynedd	**Glan Clwyd**	**Wrexham Maelor**		**Ysbyty Enfys Bangor**	**Ysbyty Enfys Llandudno**	**Ysbyty Enfys Deeside**	
Acute Hospital beds		333	360	386					1,079
Community Hospital beds					465				465
Surge beds: Hospital and Community	24 hours	28	40	18	45				131
	1 to 7 days	29	20	58	53				160
	After 7 days	0	123	70	165	223	314	420	1,315
Total		**390**	**543**	**532**	**728**	**223**	**314**	**420**	**3,150**

There are three key factors that may reduce the above bed availability during the second quarter:

[1] Note that this is the bed pool for acutely ill adults only. This is more meaningful than the Sitreps figures which include the specialist "bed pools" in Mental Health, Coronary Care, & the Cancer Treatment Centre (i.e. beds which can only be occupied by specific types of patients), as well as general adult acute beds, and treat them as a single entity.

Workforce availability: Significant work has been undertaken to develop workforce modelling and scenario planning tools to support assessment of priorities for deployment of staff in event that surge capacity is required, or resources are impacted by infection/unavailability e.g. Test, Trace and Protect (TTP). In addition, a clinical deployment dashboard has been developed to provide a transparent mechanism for clinical teams to assess need and deploy resources in a safe way. Any decision to mobilise surge capacity would be balanced against the resources available both existing core workforce and additional flexible workforce. Work will continue to build upon the significant improvements in the level of flexible workforce availability.

The division of capacity into COVID-19 and non COVID-19 areas: the division of the acute hospitals into Red and Green areas means that the adult medical and surgical beds are no longer operating as a single bed pool. This is also true of the community hospitals. This reduces flexibility and means that there may be a shortage of Red or Green beds even when the overall occupancy is not particularly high. The impact of this is currently being modelled.

Environmental requirements: an assessment is currently being carried out of the impact of meeting environmental guidance. There is a risk that this will result in a reduction in available beds, though a preliminary view is that this impact will be marginal.

2.3. Assessment

Our preferred sequence of capacity use is as shown below. This reflects the agreed clinical model and the overriding importance of delivering safe care.

1st	Existing acute and community hospital beds in line with our normal practice.
2nd	Surge beds on existing acute and community hospital sites.
3rd	Ysbyty Enfys (Temporary Hospitals).

Combining demand and capacity, it becomes clear what will be needed in the second quarter.

Week	**29 Jun**	**6 Jul**	**13**	**20**	**27**	**3 Aug**	**10**	**17**	**24**	**31**	**7 Sep**	**14**	**21**	**28**
DEMAND														
Beds required at 92% occupancy	964	989	1,013	1,087	1,061	1,085	1,109	1,127	1,156	1,157	1,159	1,163	1,152	1,143
CAPACITY														
Acute hospital beds	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079	1,079
Surge beds opened						6	30	48	77	78	80	84	73	64
SURPLUS / (SHORTFALL) AFTER SURGE	**115**	**90**	**66**	**42**	**18**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Remaining surge capacity	**649**	**649**	**649**	**649**	**649**	**643**	**613**	**565**	**488**	**410**	**330**	**246**	**257**	**266**

Note - this analysis assumes our current community hospital occupancy percentage is appropriate.

The table above demonstrates that the current bed base (excluding surge capacity) will be insufficient to keep occupancy below a reasonable 92%, if non-COVID-19 emergency activity continues to rise.

This is the case even with COVID-19 activity remaining relatively low and static, and elective work continuing to be well below pre-COVID-19 levels. This position would clearly deteriorate further if the number of available beds are reduced because of workforce factors, and if the impact of regulations on care homes result in a significant number of delayed transfers of care.

Therefore, we expect to open additional surge beds in the second half of the second quarter, although this modelling does not suggest we will need to use our Temporary Hospitals.

Welsh Government guidance[2] is that planning for a potential second peak acute bed demand should assume 1,100 beds would be required for COVID-19. As stated in the guidance, this is 'not because we envisage the levels of COVID-19 activity reaching the volumes stated in the short term but to ensure we are collectively prepared if a second peak were to materialise, particularly as we head to a winter period'. In this 'Reasonable Worst Case' scenario, the Health Board would clearly need to utilise some Temporary Hospital capacity.

2.3. Demand and Capacity for Critical Care

Predicting Critical Care demand

Anticipating critical care demand is difficult. Estimates are provided for non COVID-19 activity based on 50% elective activity admitted to critical care and 67% of baseline emergency activity. Estimates of COVID-19 activity are provided in accordance with most recent admission frequency and duration.

Existing Critical Care bed configuration

Ordinarily we have the highest number of annual critical care episodes in Wales, at around 2100 per year. This is achieved with a baseline provision of 36 critical care beds (including 19 Level 3 beds) which provide invasive ventilation to sedated patients).

Assessment

Our projected total second quarter demand of 2691 L3/2 bed days is within our current capacity. In terms of planning for a second COVID-19 peak, it is noted that Welsh Government have advised that 78 critical care beds may be needed across North Wales. We are refining our existing surge plans to deal with these anticipated levels of demand.

[2] COVID Capacity Planning letter from Director General Health and Social Services to Chief Executives – NHS Local Health Boards 24 June 2020.

Chapter 3 COVID-19 Test, Trace, Protect (TTP) Delivery Plan including Antibody Testing

The Test, Trace and Protect programme (TTP) is a national response to the COVID-19 pandemic and introduces measures aiming to reduce the spread of the virus and support the easing of lockdown measures.

TTP is in the early stages of establishment and has four main components, antigen testing, antibody testing, tracing and protecting. Through this period, and in partnership with North Wales local authorities and Public Health Wales, the testing and tracing service will be developed further.

Currently tracing relates to COVID-19 cases only and in the autumn, this will be extended to symptomatic cases. The Protect component of the programme is in the early stages of discussion and will be develop during Q2. Establishing a robust and sustainable service will be essential in preparation for the onset of winter.

This programme will continue into 2021 and potentially beyond until the introduction of a vaccine.

Chapter 4 Service Delivery Plans to meet COVID-19 / Non COVID-19 patient needs

4.1 Promoting Health & Well-being

Promoting health and well-being as well as taking preventative measures will be an integral part in both establishing recovery and future resilience of care on behalf of the North Wales population.

Our plans for example to improve access to children's weight management specialist services were paused due to the Covid-19 pandemic and this important work will resume in quarter 2.

4.2 Essential Services Summary Delivery Plan

Primary, Community and Hospital Services

Q1 has demonstrated our ability to deliver essential services based on the National Essential Service Guidelines and we have identified and are supporting challenged areas to continue to deliver care for our highest risk patients.

Innovations such as Consultant Connect, Attend Anywhere and primary care digital processes are enhancing the efficient and innovative delivery of services.

In Q2 we will continue to deliver Essential Services, expanding the delivery of these to support patients with the greatest clinical needs, for example through re-establishing the second catheter laboratory and additional CT capacity to support care pathways for patients waiting cardiac diagnostics.

Clinical pathways have been designed to take into account the latest advice on PPE for staff and patients, providing confidence to our population in accessing our services. This is being overseen by our strategic PPE Group, which operates to ensure a BCUHB-wide approach to guideline adoption and providing patient care in accordance with estates and social distancing measures.

All clinical pathways have been endorsed by the BCU Clinical Advisory and Pathways Group and incorporate the latest UK and international clinical evidence to ensure safe delivery of services in the COVID-19 19 environment

There is also alignment with test, trace and protect strategy as well as an approved pathway for pre-admission and emergency COVID-19 testing.

We are seeking to capture all learning from patient experiences to improve how we can deliver care. Initial learning from our communications task group has completed in Q1 and recommendations will be implemented for Q2.

Using regular review and early warning triggers, we will continue to flex our available capacity to support the needs of patients at highest risk of harm.

We will ensure available capacity is used across North Wales and within our commissioned services to minimise the need to escalate patients i.e. moving to treat patient prioritised as P3, (requiring treatment within 3 months).

We will continue to use the facilities at the Spire Hospital to provide Essential Services and diagnostic capacity.

We will expand the availability of diagnostic services beyond the Essential Services through use of additional equipment such as the gantry CT scanner and insourcing of additional staff to reduce delays along the patient pathways.

A number of projects are being bought together aligned and under one programme and aligning the long term strategy with the all Wales "*Transforming the way we deliver outpatients in Wales, a three year strategy and action plan 2020-2023".* This is to improve further both the patient experience, patient care and efficiency and with this it is essential that we utilise our outpatient capacity in the most appropriate manner, which this programme supports.

Q2 sees the implementation of our Outpatients Improvement Programme, which will focus on quality of care, follow-up backlog review and to ensure effective scheduling and treatment of patients in order of clinical priority.

Products such as Consultant Connect are supporting a reduction in new referrals to secondary care by offering and supporting advice and guidance, reducing follow-up referrals and supporting primary care clinical decision making.

Products such as Attend Anywhere will reduce patient travel and the logistics and cost associated with this with our efficiency project enabling us to see more patients thus improving the time from referral to consultation.

Summary of our Priorities for Primary, Community and Hospital Care

- Maintain delivery of the current Essential Services and planning for the new additions (for example, Paediatric Diabetic service)
- Roll out of clinical pathways across primary and secondary care, through for example the use of Consultant Connect and Attend Anywhere working with Cluster leads.
- Focus on the immunisation programme and its delivery adaptation in the new environment of schools post return in September
- Working towards full restart of Healthy Child Wales Programme and Flying Start services, with school nursing supporting schools and C&YP on return in September
- Restarting CAMHS intervention work via both Attend Anywhere (trial starting at end of July)
- Progress the eye care plans and electronic patient record
- Support to manage diagnostic capacity constraints, specifically to develop sustainability plans for:-
    - Cardiology
    - Endoscopy
    - Radiology
    - Phlebotomy services
- Support for stroke rehabilitation care as a priority

Specialist Services and NHS England Providers

Specialist services for the population of BCUHB are provided by BCUHB, C&VUHB and across various NHS England providers. BCUHB also hold contracts with various NHS England providers for secondary care services.

In response to the Welsh Government published Guidance *Coronavirus: ethical values and principles for healthcare delivery framework*. Welsh Health Specialised Services Committee are working collaboratively with Betsi Cadwaladr University Health Board to review how safe services can be

delivered for Welsh patients and staff in view of the COVID-19 pandemic for all specialist care and in all NHS England providers.

We have canvassed all providers for details of their current positions and plans to deliver safe services for our population. BCUHB/ WHSSC Contract Review and Governance meeting will continue to oversee this work throughout 2020/21 to gain assurance on delivery of specialist services and NHS England providers on delivery of essential services and progressive implementation of recovery and transformation plans.

4.3 Primary Care

Primary care responded rapidly in Q1 to minimise the spread of COVID-19 infection, continue to provide essential services and allow the sector to cope during a surge of cases. Change has been implemented at pace, enabled by workforce and digital technology innovation.

Our contractor services have established measures in place to support business continuity including separation of COVID-19 and non COVID-19 patient flows including the establishment of hubs for urgent and emergency care, for GP practices, optometry and dental service provision. All services have been supported to put in place arrangements to adhere to social distancing and infection control requirements through both physical measures and rapid rollout of remote consultation working.

Q2 Primary Care Operating Framework

Alongside other Health Board primary care teams, we have actively contributed to the 'Primary Care Operating Framework for Recovery – Q2 and beyond' and will be applying the Framework across our primary care services throughout Q2. The Framework includes actions that allow us to transition the return all components of our primary care services that are currently 'red' or 'amber' towards a 'green' status.

Technology

GMS contractors in particular have embraced different ways of working in response to the COVID-19 pandemic, and in Q2, we will support the retention of the best of this whilst also enabling contractors to return to providing more face-to-face care. BCU GMS contractors have had the highest take-up of remote desktop and mobile technology to support care delivery. Take-up of 'Attend Anywhere' video consultation software has been good but not as high as some areas in Wales, although this is in part due to the use of an equivalent product embedded within EMIS (which unlike the rest of Wales is our predominant primary care IT system). We now wish to embed this use of technology with a number of contractors and have identified IT literacy support requirements which we will support through our Primary Care Academy during Q2 and Q3.

Use of the eConsult online platform has also been helpful in Q1, with 48,000 patient episodes in BCU across 53 practices. Of these 1463 were able to use the self-help functions, and 422 able to go directly to the Pharmacy for self-help. We recognise that this is a technology that we also wish to retain and further embed.

Immunisation Plans

During Q2, we will be prioritising focused support to GMS and Community Pharmacy contractors to support immunisation planning:

- We will work through an action plan to support families that decided to delay or miss childhood immunisations during Q1 in order to bring those children back to a full immunisation status.

- We are progressing action plans through Q2 with contractors to support them to deliver what will undoubtedly be a challenging flu immunisation programme this year, due to system pressures, staff self-isolation, potential increased demand and the challenges of social distancing.

- We will support practices to begin to consider how a flu immunisation programme could be adapted to meet the needs of a coronavirus immunisation programme when and if the need arises.

Primary and Community Care Academy (PACCA)

Our Primary and Community Care Academy is key to achieving longer-term Primary Care sustainability, and during Q2, we will fully resume the pace of developments that were underway prior to the pandemic. These include the finalisation of a recruitment programme for GPs wanting to work in rural North Wales, a training enhanced service to support the increased multi-professional training placements that we require, and the progression of innovative training programmes for advance practitioners in primary care settings. Q2 and Q3 will see the expansion of the Academy beyond General Medical Practice contractor settings.

Contractor specific recovery plans

- GMS

In Q1, the clusters have led the development of the Local Assessment Centres (red hubs). In Q2, the continued segregation of patients will be managed via these hubs where there is an ongoing or resumed need, alongside ensuring that practices can safely manage Covid-19 related activity where clusters have stepped down their LAC.

Whilst GMS activity in early weeks of the pandemic saw a clear reduction in contacts, later weeks have seen demand upon GMS contractors increase, with greater consultation frequency occurring. We anticipate that this will continue, with potential additional consultations from individuals who have delayed presenting. This will need careful support. Recent weeks have seen stable practice 'escalation' returns with all of our practices reporting being at Level 1 or 2, and we will be working with practices during Q2 to maintain this through the continued use of (appropriate) alternative working methods.

The appendix includes detail of component actions in Q2 that we will be prioritising to support GMS to deliver the Q2 Primary Care Operating Framework referenced above.

- Dental

Work is underway to progress the implementation of the WG Dental Recovery plan, which will see de-escalation of red phase activity during Q2. Alongside this, a resumption of our longer-term priorities will occur in this quarter, with continued support to practices to adopt the contract reform programme and to progress the delivery of a dental training unit in Bangor.

- Community Pharmacy

We experienced an unprecedented increase in prescription volume and attendance within community pharmacy at the beginning of the pandemic. In line with WG guidance, a range of measures were introduced to work differently and ensure business continuity, including a change to opening hours, a review of dispensing arrangements, using appointments to minimise unplanned demand and telephone consultations.

The majority of community pharmacies have reverted to pre COVID-19 opening hours and demand for enhanced services is increasing but some will require further support during Q2 to do so. Where it is possible to do so, we will 'return to normal levels' for the Common Ailments Service, Emergency Contraception and Smoking Cessation Levels 2 and 3 during Q2.

Preparations for flu immunisation includes community pharmacy but has been addressed above.

- Optometry

In line with WG guidance, in Q1 essential patients were seen in 15 Optometry Practice Hubs in the community to replace the 80 practices normally open. The WG Optometry Recovery Plan is now being implemented with the recent move from a Red to Amber phase, which will see all Practices reopen.

Practices are ensuring social distancing can be maintained including restricting the number of patients in a practice at any one time, ensuring social distancing and reducing face-to-face consultation time with patients.

The expected WG / Royal College of Ophthalmology guidance to stratify the backlog of primary care activity will be used in Q2 to support Optometrists risk stratify their patients, and prioritise those most in need and those most likely to achieve biggest impact.

The service will also support the delivery of reinstated secondary care pathways e.g. Glaucoma, Wet AMD, ODTC and assist in the prioritisation of eye care patients and develop options for the delivery of activity in community settings as appropriate.

We plan to restart the Eye Health Examination Wales (EHEW) and the Low Vision Service during Q2.

- GP out of hours

During Q2, we will embed changes in practice within OOH services that have seen a wider MDT approach, and supported video consultations.

In Q2, we will be implementing a programme board to oversee the rollout of 111 in BCUHB and the transfer of IT systems from Adastra to SALUS.

Supporting delivery plans include detail of component actions in Q2 that we will be prioritising.

4.4. Community Care

Health and Social Care Partnership Plans (including care home and domiciliary care resilience)

Community and Social Care priorities for Q2 include consolidation of safe and effective management of the COVID-19 outbreak and improving the delivery of care across partner organisations. This involves working with partners across BCU and other bodies with ‘home first’ principles, to effectively manage step-up, step-down care and rehabilitation, ensuring safe environments, testing and infection management for patients and staff, enhancing best practice opportunities to progress the management and quality of care, including lessons learned from our response to COVID-19 and the development of system resilience.

Good progress, associated with maturing relationships with partners, was occurring prior to the pandemic in delivering our health and social care partnership plans. Formal project activity across the Community Services Transformation programme largely halted because of COVID-19, with resources and in some cases funding, being re-allocated to support Area Integrated Service Boards (AISBs) in their management and response to the pandemic.

Driven by necessity, the pandemic has moved forward the plans at a much greater pace in a number of areas. We are now reinstating the formal project management of our partnership community transformation plans, beginning with a review and refresh to capture the areas where progress has in fact occurred at expedited pace.

Community and Social Care priorities for Q2 therefore include both a consolidation of safe and effective management of the COVID-19 outbreak and reinstating a programme of steps towards the greater integration of services between partners.

Significant components of this will relate to domiciliary care and rehabilitation, both significantly affected by the Covid-19 pandemic. Considerable progress has been made in working more efficiently together during Q1 and we will retain this focus as we progress the work in Q2. Our partnership working in respect to care homes will continue to specifically respond to both national patient discharge guidance and the fragility of the local care home sector across North Wales. We are currently reviewing service models to meet patients' needs within the community taking into account the expected increase in demand for rehabilitation.

It is therefore important that in seeking to move forward with the Community Services Transformation Programme that we do not lose sight of these developments and that we build upon the positive advancements made. To that end, a facilitated workshop will be held in July 2020 in order to bring together strategic leads from across the Health Board and six North Wales Local Authorities. The workshop will be to take stock of the work undertaken pre COVID-19, as well as the achievements made during the pandemic. The vision for the programme will then be reviewed in light of lessons learnt during COVID-19, and priorities for moving forward will be refreshed.

Funding for the programme is expected to cease on 31st March 2021 but it is hoped that Welsh Government can commit to an extension of both programme term and funding. During Q2, we will work with partners to assess those elements of transformation and integration that can be delivered within the original timeframes, along with what elements of the programme can be deferred until after March 2021, in order to meet with programme term and funding profile available, once this is better understood.

4.5 **Mental Health & Learning Disabilities**

The COVID-19 pandemic has provided an opportunity for us to review the way in which we deliver mental health services to patients. We are accelerating our pathway approach to service delivery going forward, which is one of our key commitments in our *Together for Mental Health Strategy*.

Pathways have also been the focus of work within the Division as part of the Quality and Workforce Groups for the past 18 months.

During phase 1, services have focussed on cohorting admissions to inpatient units and remodelling community services to focus on the most complex, high risk and vulnerable patients identified through a RAG methodology suggested by the Royal College of Psychiatrists.

A lot of emphasis is being placed on rapid response to emergencies and collaboration with the voluntary sector. Direct feedback from clinicians, partners and patients has also helped to identify the weaknesses and what needs to be improved for phase 2 in delivering essential services; managing COVID-19; and developing services, in line with our previously agreed strategy.

Our key priorities for action for the next 3 months are set out below:

Sustain

We will maintain cohorting of inpatient admissions and where appropriate identify more local treatment green wards.

Our community services will continue to develop Community Hubs with a single point of entry and stepped approach, focusing on the most complex and risky patients. This will include integrating newly formed services such as early intervention in Psychosis and Community Rehabilitation Teams.

Learning Disabilities and Substance Misuse Services will continue with the plan developed during phase 1 and progress, which has been made so far.

Our commitment to the delivery of high quality, co-produced services remains a key priority.

The clinical leadership that has served to deliver service improvements across the Division will continue.

Commence

We will commence our programme of wider engagement with partners and stakeholders on phase 2 and 3 of the plan

We will reopen the Psychiatric Intensive Care Unit, temporarily used as a red ward

Targeted engagement with primary care will commence (GPs, clusters, managed) to work on the improved offer, including the implementation of the Primary Care Liaison Service, Consultant Connect and unified offer of interventions from the Local Primary Care Mental Health teams under part 1 of the Mental Health Measure

Older People's Mental Health Services will increase their community offer through intensive treatments targeting residential care. We will also re-instate Memory Services.

Our inpatient rehabilitation service will develop in line with the previous agreed strategy to focus resources in fewer units for the most vulnerable population and avoiding out of area placements.

Our organisational change process will commence in support of these priorities.

Complete

We will complete joint lessons learnt on Phase 1 with partners and stakeholders within and external to the Health Board.

Detailed programme plans will be completed for our service improvement priority areas, specifically, Primary Care, Rehabilitation and Crisis Services.

In line with wider Health Board requirements we will complete changes to governance structures and establish a central business function.

In this quarter, we will clarify the governance arrangements as well as giving additional clarity on individual's roles and responsibilities. We will also be explicit regarding managerial responsibilities and accountabilities for the delivery of services during this phase in order to avoid any confusion, duplication and omissions. This will require us to review our current governance structures and senior leadership structures.

To ensure we meet these complex challenges across the Division we recognise that additional support and expertise will be needed and we are developing a plan to identify the scale of the 'ask' in early July.

4.6 **Acute Hospitals Delivery Plan**

Our aim is to ensure safe, effective and equitable care for patients across North Wales supported by digital technology operating consistently across all our acute hospitals.

We will use quality outcome measures and patient experience to inform our learning and innovation to ensure more seamless care is delivered for our patients.

We have developed our plan both in support of this aim and in support of building upon the rapid progress made in Q1 through the development and delivery of consistent clinical pathways of care across North Wales.

The following section summaries the operational plans to deliver our clinically led response to the impact of COVID, together with changes we will make to operational delivery, quality and performance monitoring and our governance systems.

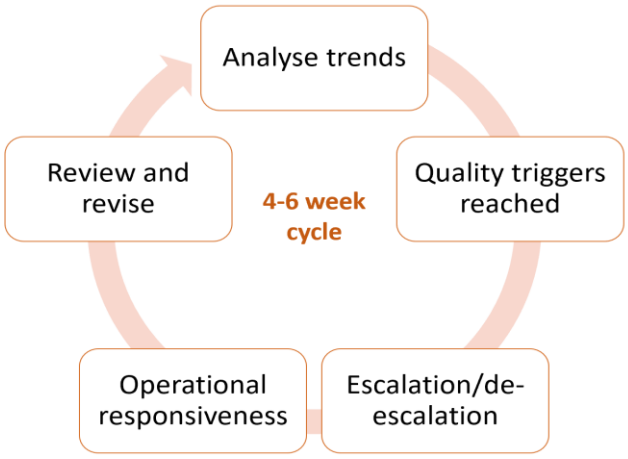
Building on Progress in Q1

Creation of red and green zones and new emergency pathways have enabled us to remain responsive to changes in activity. As a result of the presence of COVID-19, additional measures have been implemented to safeguard staff and patients.

Guidance has been provided by national, international and professional bodies to support clinical decision-making and delivery of all components of healthcare. There is also specific reference to planned care in consideration of the delivery of Essential Services. All these factors combined, means a new approach to delivering responsive care that can:

- Protect planned capacity, by continuing virtual working and non-face to face delivery, including buiding upon developed community pathways.
- Maximise throughput given the imposed limitations of the COVID-19 restrictions.
- Respond to patient restrictions such as pre-operative isolation and rapid testing.
- Be able to reduce the risk for both patients and staff of potential cross infection.
- Deal with phase 2 and 3 of the planned care recovery.
- Respond to further surges of non COVID-19 emergency and elective activity.

Acute Operational Service Model



Our acute hospital services operational model as illustrated above is summarised below and operates around the following key principles, including:

- Safe Care: focus on reducing risk and harm
- Equity of access for all our population across North Wales: ‘attend anywhere’ principle.
- A focus upon patient experience and outcomes
- Introduction of a ‘Once for North Wales’ model
- Maximising capacity by implementation of 7 day working where feasible

- Resources aligned to patient need / follow the patient

Actions in Quarter 2

In quarter 2, we will maximise use of all available capacity (including use of Spire) providing essential services locally where appropriate.

Planning cycles of 4-6 week cycles will be adopted with service models reviewed to respond to changes in quality triggers. We are data driven and will make use of data to recognise system and quality triggers for escalation and de-escalation.

We are adopting a North Wales regional and networked approach to risk stratify patients waiting for access to elective care to ensure timely intervention.

Our work aims to identify and embed the improvements introduced during the initial COVID-19 response. This work will be clinically led through pathway development and implementation.

In order to achieve this each hospital site has invested in their health community to build relationships and develop pathways to support patient experience. This relationship needs to continue to be developed to encourage future pathways which focus on 'care closer to home', whilst maximising the opportunity of a single Health Board in delivering care.

For high-risk patients who require diagnostics or surgical intervention our services are developing a once for North Wales approach which is clinically led. This will support movement of patients or clinical teams to ensure that the next available appointment is allocated on clinical priority not post code. It also enables us to flex capacity depending on the extent of COVID-19 activity in each of our sites to support essential services and highest clinical need. This is already in place for endoscopy services and further services are implementing this approach including urology.

We will deliver, as appropriate and where possible, a 'prehabilitation' programme, designed to support our surgical and orthopaedic pathways. This will enable us to manage patients appropriately in their homes or primary care while they await their surgery. This will facilitate an evidence-based reduction in length of stay and early discharge home, which is even more desirable during COVID-19. This will also promote patient engagement and confidence.

We will initially focus on services considered highest priority either due to risk of potential harm to patients waiting or insufficient resource to meet their needs. This includes the zoning of areas to deliver elective services with COVID-19 light principles and the use of the Spire Hospital to support surgical and diagnostic activity on a needs based rotating 6 week cycle. We will utilise Abergele as the single North Wales Eye hospital, supplemented with risk-stratified activity as appropriate.

Unscheduled Care Plan

Our unscheduled care model, which we developed in Q1, will continue to facilitate streaming of patients, with focus on direct to speciality.

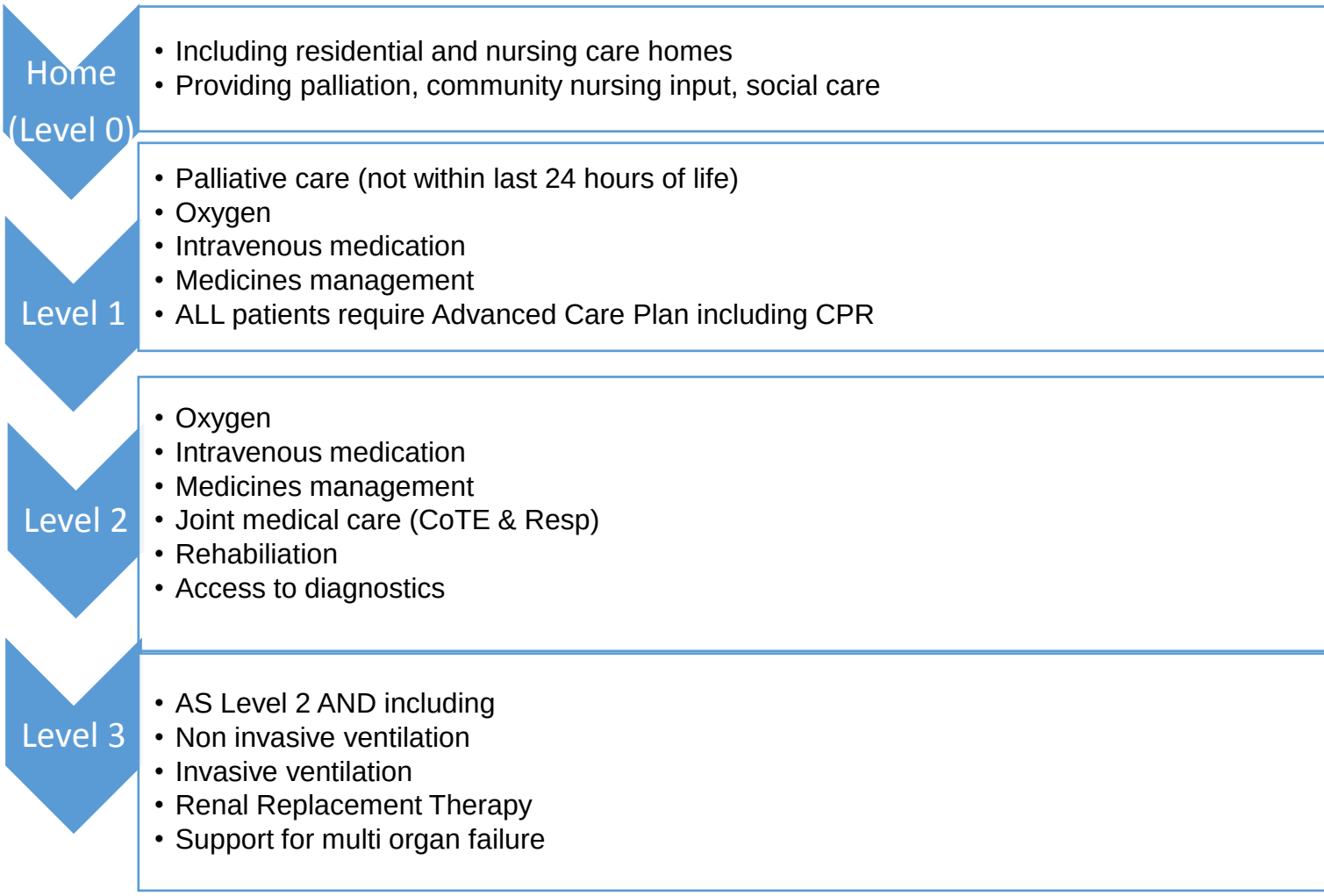
The option to use our SICAT facility will be explored to further support the triage of patients to manage flow and demand to our Emergency Departments, optimising an appointment system where feasible.

The volatility of activity we can anticipate within Q2 is fully recognised and plans are in place to surge capacity across the system in line with demand (see following section on surge planning).

4.7 **Surge Planning**

Our plan and forecasting work highlights that this is a highly uncertain environment including the limitations of forecasts for COVID-19 related demand and the likely scale and timing of any second peak in demand. There are significant uncertainties about the speed with which non COVID-19 demand may return to pre COVID-19 levels, as well as other elements such as the ability of the care home sector to admit patients and the resultant impact on acute and community hospital lengths of stay.

We continue to base our surge planning and delivery around our high level COVID-19 clinical pathway, responding appropriately to patient acuity.



Our data driven approach supports the management of clinical risk and our surge capacity for activation together with escalation plans to manage capacity in a flexible and responsive way.

We have established in Q1 key triggers to support our ability to flex and expand our capacity including critical care, temporary hospital and independent sector capacity.

Welsh Government guidance is that planning for a potential second peak acute bed demand should assume 1,100 beds would be required for COVD-19. As stated in the guidance, this is 'not because we envisage the levels of COVID-19 activity reaching the volumes stated in the short term but to ensure we are collectively prepared if a second peak were to materialise, particularly as we head to a winter period'. In extremis and worst-case scenario, we would clearly need to utilise the Temporary Hospitals.

These forecasts must be regarded as giving a broad indication of the capacity required and the speed with which it will be needed, and the position may change materially (in either direction) in a short space of time. Very short-term forecasts (2-4 weeks) are far more likely to be valid than a longer-term view, and decisions may need to be adjusted frequently.

Work will continue to review our approach and plans across adult and children services to address both the current levels of COVID-19 demand and a potential second peak. This work is being led by the Director of Nursing & Midwifery with operational teams including Area and Hospital Directors to ensure that responsive surge arrangements are in place including outlining the facilities suitable for which patients and their needs.

4.7.1. Surge Planning in Primary Care

During Q2, we will build upon our surge planning capability within primary care, recognising that the ongoing presence of additional Covid-19 peaks will create challenges for all primary care contractors.

Plans are being enhanced during Q2 to rebalance activity towards more elective primary care activity, recognising that this may need to be rapidly re-profiled again if a surge of Covid-19 activity occurs, and not necessarily on a whole Health Board basis.

As we move through Q2 into Q3, activity in primary care typically increases, with the onset of mass flu vaccination, and an increase in infective illness. Specific work is underway to ensure that our flu vaccination programme this year, which will be challenging (see the primary care section earlier), is adequately resourced, since this will reduce the impact of surge activity for the rest of the year.

Where individual clusters stand down Local Assessment Centres (LACs) in Primary Care, it will be on the basis that they can be rapidly re-opened should local demand require.

We have a well-embedded escalation tool in place for general medical service contractors in BCUHB, and we will continue to use this, alongside our established communication channels with practices to proactively measure capacity within primary care. Recent weeks have seen consistent scores of Level 1 or 2 across all practices, but we do expect a changing profile as catch-up, elective, and flu season work impact further. A community pharmacy escalation tool has been created and is being rolled out in BCU during Q2.

Chapter 5 Enabling Plans

5.1 Workforce

In quarter 1 our workforce plans were aligned to the clinical pathways for repurposing of capacity and capability to meet changing demand; being "ready" to resource additional capacity commissioned within the Health Board and supporting partners in health and social care to manage risks associated with outbreaks or clusters impacting upon staffing.

A number of enabling/supporting measures were mobilised, including for example:

- Workforce Support Hubs aligned to the operational localities.
- Wellbeing Hubs to provide focussed support services for staff.
- Dedicated Resourcing Teams supporting retraining; repurposing; redeployment of our own staff; recruitment and getting new staff and volunteers "work ready".
- Developing workforce planning and response models for temporary hospitals; internal surge capacity; Test, Trace and Protect; care home support etc.
- Dedicated Occupational Health and Safety Teams to support testing, result management for staff and key workers across North Wales as well as making sure our staff and services are operating safely to mitigate the risks associated with virus transmission.

Key achievements

Recruited additional 1700 workers	Wellbeing Hubs seen over 1500 staff	Supported over 700 Risk Assessments for BAME staff members	Established Workforce Support Hubs staffed 7 days within 2 week period	Returned to work 6100 members of staff absent due to COVID-19
Engaged 700 additional volunteers	Occupational Health supported antigen testing for over 10,000 staff across BCU and partners	Developed workforce models for 3 temporary hospitals with capability to "step up" resources as capacity is required	Developed suite of accessible guidance, advice and resources in partnership with trade union partners	

Moving into Q2, each of these measures remains as relevant now as during the period that saw higher levels of COVID-19 activity.

They provide the tools for us to continue to deliver in a context requiring shorter term planning cycles; agile decision making based upon both modelling, but importantly key triggers that show us when and where we need to flex delivery/capacity and as a result our workforce.

The systems in place led by the Workforce Support Hubs to ensure appropriate staff (and household members) are tested, responded to and supported to return to work when safe provides us with timely information to support the new Clinical Deployment Dashboard and tool for clinical managers to enable safe and prioritised deployment.

The Dashboard also draws through specific competencies required for COVID-19 zones in the event additional or flex capacity is mobilised.

Additional staff and volunteers have and continue to be deployed and refresher training and orientation plans are in place and continue to be delivered

The workforce planning and modelling tools developed are in place to enable us to see the impact of different triggers e.g. community or staff cluster; changing patterns of patient presentation, need to switch on switch off or move activity. These tools are key enablers to the planning of care delivery and the decisions required by clinical teams.

Staff Wellbeing

Our staff health and wellbeing is of upmost importance especially as we move through the potential uncertainty and apprehension associated with release of the "lockdown" measures. The Health Board has been actively listening and proactively enabling facilities and resources to support staff and teams.

We recognise going forward into the next period it is vitally important we continue to care for ourselves and keep each other well. The safety of our workforce is fundamental to our organisation. A risk assessment process is in place for all staff to ensure staff are not placed at greater risk through their deployment in the organisation. This risk assessment reflects the additional risk factors for BAME and other vulnerable members of staff. This is particularly important as we move as a nation from formal shielding of clinically extremely vulnerable people and the additional protections provided by "lockdown" for those in other vulnerable groups e.g. over 70's; pregnant women etc.

We have been actively monitoring absence levels within the organisation and continue to work with staff to ensure they are supported when they are sick; able to return to work after a period of illness and supported to undertake homeworking if they are able to. In addition, we have been actively monitoring cases of staff clusters and the risks associated with nosocomial infection.

Informed by this, we have taken the decision to continue to restrict the numbers of staff attending the workplace, particularly in health care settings and have plans in place to continue to support staff who are able to undertake their role remotely either in full or part to do so. This includes working with our staff and trade union partners to listen to the lived experiences of staff who have been working remotely and those who have not, to understand how this has felt and what we need to do to support this moving forward.

These steps, together with the measures in place are being further enhanced to ensure working environments are "COVID-19 Safe", are intended not only to keep our staff safe, but also to enable greater reliability in our planning as we increase the delivery of key and essential services over the coming months.

Longer term planning and resilience

There is unlikely to be a hard stop to the COVID-19 related activity, however, it is important that as well as managing delivery in Q2, there are measures in place to continue to renew and refresh for the remainder of this year and into the next.

This workforce plan aims to ensure that the key workforce strategic themes set out for 20/21 are adhered to whilst ensuring the work commenced in Q1 to specifically support COVID-19 is continued.

Specific actions, which will support this delivery, are outlined below.

- Establish a revised workforce governance and performance management structure to facilitate improvement at strategic, tactical and operational level.

- Ensure effective national and local social partnership working arrangements are in place to support delivery of the continued COVID-19 response; recovery and Workforce Strategy objectives.

- Continue the development and delivery of an integrated workforce offer to support clinical and operational teams in an agile way across all levels of the organisation.

- Ensure a robust integrated workforce model is in place with Local Authority partners for specific projects, to support the development of a health and social care model across the wider health community.

- Ensure workforce optimisation plans are in place to support the delivery of safe care and mitigate the impact of COVID-19, the TTP programme on staff and the Health Board's adjusted surge capacity plans.

- Ensure all key workforce indicators are in place and monitored robustly to support all surge and essential services delivery.

- Develop and implement the leadership plan at both clinical and operational levels to support the revised clinical pathways and complex operational conditions across the Q2 period and beyond.

- Working with the Clinical Advisory Group ensure Postgraduate and Undergraduate education and training activities are fully restored in the second quarter.

- Ensure agile and new ways of working deployed in order to maintain safety for staff and patients as a result of COVID-19 are optimised and embedded.

- Ensure a staff wellbeing policy and infrastructure are in place to ensure wellbeing and psychological support is accessible to all staff.

- Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance.

- The Health & Safety Improvement Plan is implemented to ensure that staff are proactively protected, supported and safe, including BAME, older colleagues, those with underlying health conditions and pregnant workers and that all environmental and social impacts are monitored and complied with. The business case associated with the Improvement Plan is a key element of our delivery and will be submitted for approval during this period.

- The Strategic Equality Plan revised year 1 actions are implemented to help ensure that equality is properly considered within the organisation and influences decision making at all levels.

5.2 **Digital**

As health and social care services move towards empowering users, carers and staff, data remain the key underlying essential component. Transforming raw health and social care data into information that enables safer patient care and better decision making is a key challenge in Q2. This is because the demand for better information and faster and safer communication, at new levels due to COVID-19, is exceeding the informatics capacity available to enable this continued transformation. This is perhaps the biggest digital problem facing the Health Board.

Our Q2 plan will address this by focussing action on the following areas:

- Support further organisational effectiveness and efficiency through the scale up of Office 365 – including the migration of all mail boxes to cloud and implementation of Teams across 50% of the workforce.

- Support essential information infrastructure development:
    - mitigating the COVID-19 caused delay in WPAS Phase 3 implementation with renewed effort on the West implementation with particular focus on data migration in Q2
    - Seek approval for funding for WEDS implementation

- Obtain approval for the business case for a digital health record and mobilisation of the project ready for implementation from Q3.

- Deliver clinical letters with the Digital Dictation and Speech Recognition Project, across the Health Board over 2 years starting July 2020.

- Digitised patient results process, improving the assurance of results management and standardising good practice.

- Development of sustainable digital health care enabling platforms, including:
    - video consultations, offering greater access and care closer to home.
    - Medicines Transcribing and E-Discharge Service (MTED) for safer and more effective management of medicines following discharge from hospital.
    - continue development of plans for pharmacy related technologies e.g. e-prescribing.
    - mobile working in community, accelerating agile working to support care closer to home.
    - business intelligence, developing learning from COVID-19 to gather, analyse and communicate.

- COVID-19 hardware response – meeting demand for equipment e.g. over 950 laptops.

- 40% of informatics staff remain focused on supporting COVID-19 in Q2, including contact tracing, increased mobility, ward moves and shift back to normal.

In addition, a review of the informatics resources will occur during Q2 to assess capacity and capability for continued support for transformation. This analysis will be shared with the Health Board as part of a further discussion about building sustainable enablement.

5.3 **Estates / Capital**

The Estates Strategy provides a vision and framework for the future development and utilisation of our estate, outlines an initial pipeline of priorities and describes how we will seek to work with partners to maximise the benefits of our collective property portfolios.

The strategy must be flexible to respond to the changing needs and priorities of the Health Board. It was confirmed that the strategy would be subject to annual review as part of an iterative process to reflect and respond to the challenges faced by the Health Board. From a recent review of the progress to date, the following were noted:

- The work in developing the infrastructure programme for Wrexham Maelor Hospital signposted similar concerns with respect to resilience and compliance at Ysbyty Gwynedd
- Our developing understanding of the needs of the emerging integrated health and social care localities has instigated a review of the primary care pipelines and the future configuration of health and well-being hubs
- During the year, the Health Board has engaged with partners in developing a range of collaborative solutions. This work has highlighted the complexity of managing significantly different governance

and financial regulatory arrangements between the NHS, Local Authorities and third sector partners. However, notwithstanding these complexities it is clear that collaboration offers potential opportunities

The Estates Improvement Group (EIG) have identified key strategic themes for potential estates savings as follows:

- Estates Disposals.
- Withdrawal from leased premises.
- Review of office accommodation.
- Large site rationalisation.
- Investment in non-compliant estate.

In going forward the Estate Strategy will need to reflect the future design of services as determined by the emerging digitally enabled clinical strategy and successful delivery will be dependent upon focusing on a small number of priorities that deliver maximum benefit.

Refreshing the Estate Strategy

In response to the above the EIG have identified a structure for the Estate Strategy and the process to develop and implement the required change. The Strategy will provide a delivery framework for the future development and utilisation of the estate. This framework will comprise a series of inter-related programmes that will be defined within supporting programme business cases. Each programme business case will comprise a series of inter-dependent projects defining the priorities for change. This approach is advocated by the Welsh Government and allows the Health Board to clearly articulate our estate priorities and their inter-dependencies to provide a complete picture.

The programmes will be shaped by the clinical strategy, which will define the estates requirements within our acute hospitals but also our integrated community primary, and social care services including mental health.

Following on from the Wrexham Maelor Hospital continuity business case, separate programmes will be developed for Ysbyty Gwynedd and Ysbyty Glan Clwyd. It is noted that while there are challenges with respect to electrical capacity at Ysbyty Glan Clwyd, this can be managed in the medium term. The integrated area plans will support changes within our acute hospitals and define the requirements within our community, primary care and mental health estate.

The clinical support programme will define the estates needs within diagnostic, pharmacy and cancer services together with sterile services and medical engineering. The programmes will also be required to demonstrate how we will deliver our strategic saving themes.

We will continue to work with partners to seek opportunities to develop collaborative solutions and make best use of our collective property assets.

Programmes leads will be identified for each of the programmes and delivery groups established to deliver the agreed objectives. For each area, this will be delivered through the HEEGs and the chair of each will be the senior responsible officer.

During 2020/21, we will continue to take forward the plans to deliver the following:

- Wrexham Maelor continuity programme
- North Denbighshire Community Hospital
- Ablett Mental Health Unit
- Llandudno Junction/Conwy Primary care resource centre
- Project Paradise

In addition the EIG and HEEGs will focus upon the following priority programmes:

- Ysbyty Gwynedd compliance
- Health Economy programme business cases
- Review of accommodation in Central Area
- Relocation of services from Abergele hospital
- Rationalisation of Bryn y Neuadd
- Office accommodation (linked to 4 and 5 above)
- Residential Accommodation

The above priorities will in all likelihood require additional resources to drive them forward at pace. The EIG will scrutinise, monitor the progress of the above, and provide an update report as part of the Annual Plan Monitoring Report. The Estate Strategy will be refreshed to reflect the revised delivery framework and proposed next steps.

5.4 **Financial Plan**

Context

The financial plan for 2020/21, approved by the Health Board, was to deliver a deficit of £40m and was predicated on delivering savings of £45m. The plan did not take into account the impact of COVID-19, and the Q2 plan has been updated to reflect the anticipated consequences, although there is a significant variable element to the key financial assumptions, given the potential of both a second COVID-19 wave and the effect of the Test, Trace and Protect programme.

It is clear that that expenditure will be significantly higher than planned due to the Health Board's response to the pandemic and as operational and clinical teams are focused on both COVID-19 and essential services, savings delivery has been particularly impacted. The current forecast reflects a gross deficit of £173.9m, which after assumed COVID-19 additional Welsh Government funding of £133.9m leaves the Health Board with a net deficit in 2020/21 of £40.0m. £59.1m of the COVID-19 expenditure relates to the three Temporary Hospitals we have established in North Wales, which are ready to provide circa 1,000 beds across three locations, in Llandudno, Bangor and Wrexham.

Summary Financial Plan for Q2

	Apr-20 £m	May-20 £m	Jun-20 £m	Jul-20 £m	Aug-20 £m	Sep-20 £m	Q2 £m	20/21 £m
Resource Allocation	-146.86	-128.34	-128.34	-128.34	-128.34	-128.34	-788.54	-1,541.6
less Expenditure	154.01	135.49	135.49	135.49	135.49	135.49	831.44	1,626.6
plus £45m Savings	-3.75	-3.75	-3.75	-3.75	-3.75	-3.75	-22.50	-45.0
Deficit Plan 2021	-3.40	-3.40	-3.40	-3.40	-3.40	-3.40	-20.40	-40.00
Non delivery of Savings	-3.70	-3.63	-3.10	-2.93	-2.93	-2.92	-19.21	-34.1
Elective underspend	2.30	2.88	2.29	1.82	1.78	1.76	12.83	20.4
Lost income (NHSE / GDS)	-1.00	-1.40	-1.38	-1.38	-1.38	-1.38	-7.93	-9.2
Slippage on Investments	0.23	1.23	0.23	0.17	0.17	0.17	2.19	2.2
C19 expenditure	-3.59	-4.69	-4.38	-4.14	-4.03	-3.75	-24.57	-43.0
Test, Trace, Protect	0.00	-0.01	-1.10	-1.10	-1.10	-1.10	-4.40	-11.0
Field Hospital costs	-25.06	0.57	-0.58	-0.56	-0.56	-0.56	-26.76	-59.1
Gross Deficit	-34.23	-8.45	-11.41	-11.52	-11.45	-11.17	-88.24	-173.9
Assumed C19 Funding	30.84	5.11	7.92	8.10	8.03	7.76	67.77	133.9
Net deficit	-3.38	-3.35	-3.49	-3.42	-3.42	-3.42	-20.48	-40.0

Underlying Position

The underlying position brought forward from 2019/20 was a deficit of £57.7m, with an opening plan of £40m deficit.

Q2 Planning Assumptions

The Health Board is now moving into the second phase of its plan to respond to the pandemic and considering how best to balance managing Covid-19 patients and elective activity whilst adhering to social distancing rules and the need to protect our staff and patients.

The crisis has provided opportunities to push through changes at pace; work with partners effectively, and consider how the Health Board can transform in the future, learning from new ways of working and delivering services.

Savings

Following the suspension of the savings programme in March, the Health Board is now considering how to resurrect the savings plans that began development in 2019/20. The current assumptions on the delivery of savings for Q2 and 2020/21 are shown in the table below:

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Forecast year-end position £'000
Non delivery of Savings	3,700	3,634	3,098	2,927	2,927	2,920	19,208	**34,106**

A high-level review of the savings pipeline has been undertaken to inform the Month 2 reporting. A detailed review of the programme is underway to ensure movement of schemes into amber and green and a thorough reassessment of the potential for in year savings delivery. The outcome of this review work will be set out in the Month 3 Return. A summary of the red pipeline schemes is shown overleaf.

Savings Theme	Recurrent Savings £000	Non-Recurrent Savings £000	Annual Forecast £000	FYE of Savings £000
Care Closer to Home	0	150	150	0
Continuing Health Care	1,614	0	1,614	2,028
Estates	50	350	400	50
Medicines Management	1,945	15	1,960	1,945
Planned Care	72	0	72	143
Procurement	2,375	0	2,375	2,524
Transactional	173	0	173	321
Workforce	1,860	548	2,408	1,893
Total	**8,089**	**1,063**	**9,152**	**8,905**

With the focus back on business as usual the development of savings plans for 2020/21 has become a priority and what we currently have is only an initial view and which will expand.

Elective Underspends

Elective under spends will continue for the rest of the year. Some elective work has commenced in May and it is expected that activity will increase over future months, but full capacity will not be reached in 2020/21 due to the requirements of social distancing for staff and patients. The Health Board is continuing to use the local private hospital to support elective activity; the cost is estimated to be £4.8m and is included in the forecast from July.

Elective underspends are anticipated to generate a surplus of £12.83m for Q2.

Income

The impact of Covid-19 has estimated a loss in income of £7.93m up to the end of Q2, which includes £2.7m of General Dental Services (GDS) patient income and £4.4m of English Non-Contracted Activity (NCA) income.

Expenditure

Slippage on Investments

As a result of the suspension of business as usual slippage on new investments of £2.2m have been identified.

COVID-19 Expenditure

It is forecast that total expenditure directly related to Covid-19 up to the end of Q2 will be £24.57m, of which £12.3m is pay and £12m is across non-pay expenditure categories. An analysis of the pay items is in the table below.

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Forecast year-end position £'000
Pay								
Establishment & Bank	**814**	**1,499**	**1,522**	**1,581**	**1,720**	**1,734**	**8,868**	**17,700**
Agency	**278**	**333**	**408**	**378**	**378**	**378**	**2,153**	**4,572**
Returners	**30**	**81**	**112**	**112**	**112**	**98**	**545**	**1,013**
Students	**0**	**69**	**234**	**252**	**207**	**15**	**777**	**867**
Other	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	1,122	**1,982**	**2,276**	**2,323**	**2,417**	**2,225**	**12,343**	**24,152**

Non pay includes £3.5m to cover the licence to occupy charges for the three Temporary Hospital sites.

Test, Trace and Protect

Test, Trace and Protect consists of the tracing teams, Antigen testing and Antibody Testing. In total, this programme is estimated to cost £4.4m in Q2 (£11m in 2020/21).

	HB In Year £000	HB FYE £000
TTP Teams - mimimal model		
Equipment	630	840
Staff	630	840
Antigen testing		
Medicine	495	660
Staff	2,250	3,000
Overheads	549	732
	3,294	4,392
Antibody testing		
Medicine	3,375	4,500
Staff	675	900
Point of Care	1,500	2,000
Reagents	1,500	2,000
	7,050	9,400
Total	10,974	14,632

Temporary Hospital Costs

Temporary Hospitals set up costs of £23.29m are included; this is a reduction of circa £1.7m in line with the final cost schedules.

In addition it is estimated that based on an assumption of 64% capacity utilisation for the period October 2020 to the end of March 2020, the running costs of the Temporary Hospitals will be £3.46m for the period up to the end of Q2 (£35.9m for 2020/21), as illustrated in the following table:

	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Q2 £'000	Forecast year-end position £'000
Temporary Hospitals								
Set Up	**25,037**	**(1,742)**	**0**	**0**	**0**	**0**	**23,295**	**23,295**
Pay	0	0	0	0	0	0	0	25,199
Non Pay	25	1,174	577	562	562	562	3,462	10,652
Running Costs	**25**	**1,174**	**577**	**562**	**562**	**562**	**3,462**	**35,851**
Total	**25,062**	**(568)**	**577**	**562**	**562**	**562**	**26,757**	**59,146**

Note: Running costs at 100% utilisation are currently costed at circa £7.5m / month

Income Assumptions

The original plan was against a resource allocation for the year of £1,541.6m. Confirmed allocations to date are £1.522m, with further anticipated allocations in year of £161.4m, a total forecast Revenue Resource Limit (RRL) of £1,683.6m for the year.

Activity Planning Assumptions

The assumptions made in the Q2 plan are based on a 50% utilisation of the Temporary Hospitals with effect from July 2020, and the continuation of current activity levels across secondary and community care. To date the Health Board has not been able to describe how it intends to bring back elective activity and what is expected to be the on–going impact of COVID-19 because of the number of unknown variables as lock-down is eased.

Chapter 6 Risk to Delivery

6.1 Risk and Mitigation

The Health Board recognises the need to continue to improve its risk management culture and this will be further supported by the implementation of the revised Risk Management Strategy following Board ratification in July. The Health Board`s Risk Management Improvement Plan has also been updated to reflect recent changes whilst the organisation has realigned resources to support the management of the COVID-19 Pandemic response, so that it aligns with the new Risk Management Strategy and Policy.

The plan going forward is to continue to develop and build staff capacity and capability in risk management, support Directorates to review all risks on their risk registers with focus on narrative and accuracy in scoring in view of the launch of the new Risk Management Strategy planned for 1st October 2020. Work will continue to ensure compliance after this date due to the Health Board continuing to resume a level of business as usual post the first phase of our response to the COVID-19 pandemic. Training will also support staff member's ability to manage risks and clarify the distinctions between a risk and an issue as well as controls and actions/further actions implemented in mitigating risks.

A further workshop with the Board will also be held during July to review and articulate the Health Board's objectives in line with our plans, to review the current Corporate Risk Register whilst ensuring alignment with our objectives and plans.

6.2 Information Governance

Information governance and good data protection practice is key to the delivery of a successful and positive governance culture. The Information Governance (IG) Department has and will continue to deliver an efficient service to provide essential support, advice and guidance to all areas of the Health Board to make sure it meets its statutory and regulatory obligations.

IG will continue to work closely with ICT, Health Records, Senior Information Risk Owner, Data Protection Office and the Caldecott Guardian in order to provide appropriate levels of assurance to the Board.

IG will also continue to work collectively with other Health Boards, National Wales Informatics Service, Public Health Wales and Welsh Government on the implementation of national programmes.

New ways of working have been essential to allow the Health Board to continue to operate its services. This has resulted in a number of new systems being put in place both locally and nationally in a short period of time. The Information Governance Team will continue to work closely with leads locally, other health boards and partners to ensure that the systems put in place have been risk assessed appropriately and that all the necessary due diligence checks have been undertaken for assurance.

A full review of the Data Protection Impact Assessments, Data Sharing Agreements and Data Protection Agreements undertaken since March 2020 will form part of the IG work plan, which will be monitored through the Digital and Information Governance Committee.

IG will ensure patients are made fully aware of ongoing changes through privacy notices and fair processing.

Freedom of Information requests (FOI) and Subject Access Requests (SAR's) will continue to be actioned as a priority to ensure compliance. COVID-19 related requests are increasing and work is underway to ensure that these demands will be met. This will be under constant review as business as usual and escalated where necessary.

Robust monitoring and areas for improvement will form part of the ongoing work within the IG work plan and staff training and guidance will be put in place to improve compliance rates and staff understanding of the importance of meeting the deadlines.

Training will be monitored closely and commenced with Workforce & Organisational Development as and when it is safe to do so. E-learning will continue to be monitored with compliance rates being reported.

The Information Governance Strategy is currently under review and will include the Information Governance priorities for the year ahead and include actions because of COVID-19.

Work/action plans are being put in place to ensure that areas of weakness requiring improvement can be robustly monitored and improvement plans will be put in place, which will be incorporated into the IG compliance checks action log.

Chapter 7 Preparation for Q3 and winter 2020/21

The management of unscheduled care will form a key priority for our Q3 plan. The overall position across BCU is one of COVID-19 demand broadly plateauing, while non COVID-19 demand for unscheduled care returning rapidly to pre COVID-19 levels.

Through our pathway re-design work, we have established urgent / unscheduled care pathways and will continue our work to strengthen arrangements that ensure resilient Urgent and Emergency Care (UEC) capacity is available to meet demand. In addition we will operate within new environmental guidelines and uncertainty that non COVID-19 demand may return to pre COVID-19 levels, as well as other elements such as the ability of the care home sector to admit patients and the resultant impact on acute and community hospital lengths of stay.

Our aim is to reduce bed occupancy levels to a maximum of 92% through acute bed expansions, increasing community care, investment in primary care and improvements in length of stay and admission avoidance.

We will focus our work with our partners including Local Authorities, Third Sector, Independent Sector, Welsh Ambulance Services Trust, our staff and our public to redesign and reduce reliance upon hospital services through better management of patient needs within their own homes and communities.

Building on these partnerships and streamlining our own clinical processes and pathways, we aim to deliver more seamless and safe discharge from hospital to home first wherever possible.

Summary of Unscheduled Care Actions for Q3

Demand

- Work to ensure resilient GP OOH services (in light of delays to national 111 service implementation).
- Improve access to MIUs and determine future strategic vision to support demand.
- Improved access to primary care services.
- Admission avoidance schemes to prevent ED attendance from Nursing / Residential Homes.
- Improve access to Community Resource Teams.

Flow

- Embed Ambulatory / Same Day Emergency Care within acute sites.
- Zero tolerance to ambulance handovers over 60 minutes.
- Zero tolerance to ED delays over 24 hours.
- Reduce medical and nursing vacancies in Unscheduled Care by 50 percent.
- Embed SAFER principles across acute and area sites.
- Pathway development.

- Implement Recurring Miscarriages Services across North Wales (Early Pregnancy Service Review concluded in Year 1 (2019 / 2020).

Discharge

- Reduction in length of stay patients through robust stranded patient review process.
- Improving ‘Discharge to Assess’ model utilising Home First principles.
- Formalising access to Community Hospital.

Chapter 8 Managing Performance against the Plan

We will continue to report daily SITREP reporting and monitor COVID-19 hospital admission numbers/trends including acute bed occupancy, critical care bed occupancy, DToC and workforce capacity including sickness absence.

Alongside this we will ensure that essential Non COVID-19 profiles e.g.: cancer referrals; unscheduled care; referrals to Outpatient Departments (OPD) and take up of OPD consultations via virtual and face to face routes. Mental Health and Learning Disabilities; Child and Adolescent Mental Health services (CAMHs); outpatients; use of private sector and discharges are monitored and constantly refreshed as our 6 week planning cycles progress.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 23rd July 2020
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Risk Management Strategy and Policy
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris Deputy Chief Executive / Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Mrs Justine Parry Assistant Director of Information Governance and Risk Mr David Tita Head of Risk Management
Craffu blaenorol: **Prior Scrutiny:**	The Risk Management Strategy and Policy has been reviewed and discussed previously at the Risk Management Group in April and November 2019, at the Audit Committee workshop in December 2019, with further updates discussed during the meeting in March 2020. Formal approval was agreed by the Audit Committee on the 29th June 2020. In addition significant scrutiny, conversations and updates have been provided by the Audit Committee Chair, the Quality, Safety and Patient Experience Committee Chair and the Chair of the Digital and Information Governance Committee.
Atodiadau **Appendices:**	Appendix 1 – RM01 Risk Management Strategy and Policy Appendix 2 - Revised Equality Impact Assessment

Argymhelliad / Recommendation:

The Board is asked to:

1. Ratify the approval of the revised Risk Management Strategy and Policy by the Audit Committee
2. Note there may be a delay in the 1st October 2020 implementation date from operational teams due to the effect from returning to business as usual following the Health Board's response to the COVID Pandemic arrangements.

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	√	**Ar gyfer Trafodaeth** **For Discussion & Scrutiny**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	

Sefyllfa / Situation:

This paper presents the new Risk Management Strategy and Policy for the Health Board. The new strategy underlines the powerful intention and firm commitment of the Health Board to embark on the implementation and embedding of an Enterprise Risk Management (ERM) Model across all its Services and Directorates from `Ward to Board` in 2020/21.

Cefndir / Background:

This revised Risk Management Strategy and Policy is the product of a series of workshops, meetings and surgeries which were held by members of the Risk Management Team and staff across the Health Board as well as those which were held with the members of the Board and Audit Committee over the last 18 months. The Board is asked to ratify the Audit Committee's approval of this Strategy and Policy on the 29th June 2020.

To further support this implementation, whilst the new Risk Management Strategy and Policy clarifies the governance and escalation process for risks from `Ward to Board`, a risk management training pack and targeted support will be in place to ensure that staff are sufficiently trained, empowered and confident in raising, assessing, capturing and discussing risks at their local governance or Quality and Safety meetings. The Risk Management Strategy and Policy will also be supported by the following documentation:

- RM02 Risk Register Procedure and Guidance
- RM03 Risk Management and Assurance Training Plan
- RM04 Model Risk Management Procedure
- A Risk Management Improvement Plan

Asesiad / Assessment & Analysis

The Health Board recognises the need to improve its risk management culture and the Risk Management Team will support the organisation with the implementation of the Strategy through the delivery of training to build staff capability and capacity.

The Risk Management Improvement Plan has also been updated to reflect recent current changes whilst the organisation has realigned resources to support the management of the COVID-19 Pandemic response, and also to ensure alignment with the revised arrangement in the Strategy and Policy. This was presented to the Audit Committee alongside a paper providing the rationale, process and scrutiny to be followed for the movement from a 5 Tier to 3 Tier risk management model. These additional documents provided a level of assurance to demonstrate delivery of the revised Strategy and the move to an Enterprise Risk Management (ERM) Model. The remaining suite of supporting documentation are in the process of being updated to also reflect the strategy changes.

Plans are continuing to support the development and building of staff capacity and capability in risk management, whilst support provided to Divisions and Directorates with reviewing all risks on their risk registers focussing on the narrative and accuracy in scoring in view of the launch of the new Risk Management Strategy planned for 1st October 2020. Training will also support staff member's ability to manage risks and clarify the distinctions between a risk and an issue as well as controls and actions/further actions implemented in mitigating risks.

Some of the key features of this new Risk Management Strategy and Policy include:-

- A risk management vision statement, which clearly defines our strategic approach to risk management.
- Better clarification and definition of our risk appetite statement.
- Change from the 5 Tiers to a 3 Tier risk management model.
- Articulation of BCU risk management process and governance arrangements for risks.
- Risk management escalation and de-escalation flow chart.
- Brief inclusion of the Board Assurance Framework (BAF) and its link to the Corporate Risk Register (CRR).

- Placing performance measurement and monitoring using Key Performance Indicators (KPIs) at the heart of our risk management culture.

Audit Committee Members expressed a concern with the ability to implement the Strategy and Policy by the 1st October 2020, expressly referring the impact on the Health Board from COVID-19. Adherence to the timeframes in the Improvement Plan will be monitored by the Risk Management Group monthly with updates provided to the Audit Committee Chair at appropriate intervals. However, due to the extension of the current arrangements coming to an end in September, it is advisable to implement the new arrangements ensuring only 1 system and process is in place avoiding any unnecessary confusion with the management of risks at organisational and operational levels.

Consistent reference to the Enterprise Risk Management model throughout the new Risk Management Strategy and Policy demonstrates the Health Board`s commitment to incorporate and embed risk management into its organisational and business planning, objective setting and prioritisation, performance reporting, financial management and the general day-to-day management of its activities and services.

Strategy Implications
The new Risk Management Strategy and Policy provides the organisation's approach to managing risk and its risk appetite. Along with a detailed training programme, it will support the consistent identification, assessment and management of risks and strengthen decision making.

Financial Implications
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 thereby leading to enhanced quality, less waste and no claims.

Risk Analysis
The risk of not having an effective Risk Management Strategy in place or failing to successfully implement it may prevent the organisation from achieving its objectives including impacting upon patient safety.

Legal and Compliance
The Risk Management Strategy supports the Health Board's statutory obligations.

Impact Assessment
Due regard of any potential equality/quality and data governance issues has been addressed within the quality impact assessment and factored into writing this report and the new Risk Management Strategy and Policy. A copy of the revised Equality Impact Assessment is attached as Appendix 2

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version 5.0 & Reference Number: RM01

Risk Management Strategy and Policy

Authors & Titles	David Tita: Head of Risk Management Justine Parry: Assistant Director of Information Governance & Risk.							
Responsible dept / director:	Risk Management Gill Harris: Deputy Chief Executive							
Approved by:	Audit Committee							
Date approved:	29th June 2020							
Date activated (live):	1st August 2020							
Documents to be read alongside this document:	Board Assurance Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Datix Risk Register – Procedure and User Guide (RM02) Model Risk Management Procedure (RM04)							
Date of next review:	March 2021							
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Changes made yes/no:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Contents: Page

PURPOSE	Vision Statement
To provide a framework and structure for the consistent management of both operational and strategic risks as drivers for better decision-making and the provision of high quality personalised patient-centred care and enhanced experience.	**BCU`s vision for risk management is underpinned by Good Governance and a dynamic, proactive, integrated, Enterprise-wide strategic approach which emphasises the appropriate and timely management of risks in order to foster the achievement of its objectives and priority areas as articulated in its 3 Year Plan. The destination of the Health Board`s vision for risk management is an Enterprise Risk Management (ERM) Model which will be rolled out in the 2nd year. BCU`s ambition in the first year of this vision as articulated below will seek to lay down the ground work and foundation on which a robust risk management architecture will be built. The aim will be to fully integrate ERM with strategy and performance.** **First Year – 2019/20: Review of Risk Management Strategy and Policy, Design and delivery of RM training to Senior Managers, undertake a Gap and Training Needs Analysis, Update Risk Improvement Annual Plan and clarification of the Health Board's governance and escalation arrangements for risk management.** **Second Year – 2020/21: Roll out of Risk Management Training and new Risk Management Strategy and Policy, implementation of risk governance and escalation architecture, embedding BCU`s Risk Management strategy and Policy/culture and review of its risk management annual health check as well as implementation of the Enterprise Risk Management Model.** **Third Year 2021/22: Embed Enterprise Risk Management Model while continuously supporting Directorates.**

Our Strategic approach to Risk Management

1. Principles	2. Benefits	3. Realisation
Our approach to risk management is built on the following principles:	**Through our risk management approach, the following benefits will be realised:**	**Realisation of the principles and benefits will be achieved through:**
It is dynamic, open, iterative; transparent, reacts to changes & consistently applied. It triangulates information and intelligence in informing better decision making. It is integrated into our processes and aligns with our objectives. It engineers continuous improvements in patient care and organisational learning. It is wrapped around the values of the Health Board. It is underpinned by staff engagement and informed by innovation and best practice.	Enhance organisational resilience via facilitating continuous improvement and innovation. Strengthen governance to enable informed decision-making. Promote a culture of proactive management of risks and opportunities Improvements in patient care, safety, enhanced experience and flexibility to respond to pressure and challenges. Help in embedding the values of the HB. Stakeholder confidence, empowerment and trust.	Strong risk-focussed leadership that ensures the effective operationalisation of BCU`s Risk Management Strategy. Strong and transparent risk governance arrangements, including reporting and risk escalation. Consistent application of the risk strategy and framework. Clarity in communication of the HB`s risk management approach and better staff engagement. Staff development and continuous support in embedding ERM.

1. Introduction

BCU`s Risk Management Strategy and Policy provides a structured, comprehensive and coherent framework to support staff in identifying, assessing and managing risks arising from its activities as the effective management of risks is an inherent part of its approach to quality improvement and Good Governance. The Health Board is committed to implementing and embedding the robust management of both clinical and non-clinical risks as an integral part of business as usual and its strategic and operational management. Staff are encouraged to integrate BCU`s risk management process into key business/service planning and decision-making in order to effectively and efficiently manage risks in real time and in a dynamic way. This Risk Management Strategy and Policy notes that risk management is everyone`s responsibility across the Health Board.

It draws from best practice, the AS/NZS ISO 31000:2018, policy and legislative instruments such as the National Health Service (Wales) Act 2006, the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999. This strategy and policy underscores the fact that effective risk management is a tool for improving productivity, ensuring business continuity and achieving robust organisational planning and performance reporting. It identifies staff and senior leadership engagement, clarity of roles and responsibilities, consistency, regular monitoring and review of risks including Good Governance, scrutiny and assurance as key drivers for embedding effective risk management across the Health Board.

2. Statement of Intent

The Health Board is committed to implementing effective risk management across all its services through a comprehensive system of internal controls and compliance with this strategy and policy in order to minimise risks to its patients, staff, visitors, contractors and other stakeholders. The Health Board`s approach to risk management is proactive, integrated, enterprise-wide and is informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear. It thus seeks to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving its objectives and priority areas as defined in its 3 Year Outlook and Annual Plan.

Over the next two years, the Health Board`s approach to risk management will progress into an Enterprise Risk Management (ERM) model. This will enable staff to better integrate risk management into how they lead, organise, plan and deliver the Health Board`s business activities while ensuring financial viability and sustainability. This revised Strategy and Policy will support the new “Duty of Quality” outlined within the Health and Social Care (Quality and Engagement) (Wales) Bill by requiring the Health Board to exercise its functions with a view to securing improvement in the quality of health services. This will be achieved and monitored by the implementation of the Health Board’s Clinical Strategy.

The Health Board is keen to ensure that risk management is not seen as an end in itself or a bureaucratic exercise, but as a great managerial tool for enhancing decision-making, the quality of patient care and experience, organisational resilience and raising productivity. This strategy and policy thus signals the Health Board`s commitment to building, implementing and

embedding a proactive risk management culture that maximises opportunities and improves service and health outcomes for our patients and wider community.

3. Definition of key concepts

This Risk Management Strategy and Policy is underpinned and informed by the following definitions: -

Risk: A risk is the uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's objectives and priority areas. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).

Risk Management: The Charted Institute of Internal Auditors (CIIA) defines risk management as "the discipline that identifies, assesses, evaluates and takes actions to influence the likelihood of a risk event occurring or its impact if it does".

Risk Assessment: This is the overall process of risk analysis and risk evaluation. This is achieved by comparing the individual risk against the Health Board's risk appetite.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to manage its risks in order to achieve its objectives of efficiently and sustainably delivering high quality patient-centred care, safety and enhanced experience.

Controls: These are measures being implemented by the Health Board to mitigate the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.

Actions: Actions are steps which the Health Board are required to implement to reduce the likelihood and/or consequence of a risk were it to be realised. Actions are also the things the Health Board is doing or planning to do that will help us achieve the risk target score and thus mitigate the risk in the long run.

Enterprise risk management (ERM) is a process whereby an organisation plans, organises, leads and controls its activities in order to minimise the negative effects of any potential danger (risks) on its operations, business continuity and the achievement of its objectives.

4. Objectives

The main objectives of this strategy and policy are:

- To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks.
- To set out the organisational governance arrangements and responsibilities for risk management.
- To enable staff to understand our risk environment and to use the Health Board`s risk appetite statements to identify and assess risks which cannot be tolerated.

- To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting.
- To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning.
- To enable the Health Board to identify and manage risks emanating from the well-being goals and ways of working included in the Well Being of Future Generations Act 2015. Also, overtime to seek alignment with the risk management approaches used in our key partnership mechanisms e.g. Public Service Boards and the Regional Partnership Board (Social Services and Well Being Act).

5. Scope

Risk management is an intrinsic strand of good management at all levels across the Health Board and sits at the heart of its business continuity, patient safety and values. Staff are encouraged to continuously scan the horizon for emerging risks and to ensure risks are appropriately assessed, mitigated and managed in accordance with this strategy and policy as well as best practice.

This strategy and policy thus clearly defines the Health Board`s vision, approach, objectives, systems and processes for risk management and governance as well as underscores the principles, framework, model, best practice and emerging thinking which underpin and shape its overarching risk management culture. It is applicable to everyone involved in providing services for and on behalf of the Health Board.

6. The Board's Appetite for Risk

Risk appetite is defined as the amount and type of risk an organisation is able to take on in order to achieve its objectives and priority areas while risk capacity refers to the maximum amount of risk that an organisation is able to take on. These are underpinned by the Health Board`s risk capability and the maturity of its risk management culture. The Health Board`s risk appetite for individual risks will thus be different depending on its current performance, strategic objectives or priority areas as defined in the "3 Year Outlook, Annual Plan" and risk maturity level.

The Risk Appetite Statement sets out the amount and type of risks that the Health Board is able to take on in order to achieve its objectives and priority areas. The Board accepts that there is an element of risk in every activity it undertakes from the provision and commissioning of healthcare services and recognises that its risk appetite for any risk will change depending upon the individual risk and current performance. It also recognises that the transformation journey it has embarked on will involve taking on some transformation and project improvement risks which may sit outside its risk appetite. The Board is directly accountable for setting its risk appetite and risk culture.

The Health Board has articulated its risk appetite statement to demonstrate the various range of often complex and complicated risks it may take on or accept in order to achieve its objectives and priority areas. The risk appetite statement will be measurable and shaped by

three key determinants (the risk score, potential impact and type of risk), as these will vary or change over time depending on the context, type and risk environment.

The Health Board`s risk appetite statement aligns with its proactive, inclusive and enterprise-wide approach to risk management as well as its commitment to actively mitigate, control and manage risks which could compromise the achievement of its objectives and priority areas. However, the Health Board realises that in some instances it may have to take on risks which sit outside its risk appetite in order to achieve its objectives and priority areas. It thus recognises that agreement to pursue a risk outside the above risk appetite will be openly discussed at the appropriate governance meeting and a conscious decision made to do so based on the added value. Risk appetite and risk tolerance are thus at the heart of the Health Board`s operational and strategic agendas as the latter implies the amount of risk it can actually cope with.

The Health Board's Risk Appetite Statement is included at Appendix A, and sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds. It is a live document that will be regularly reviewed and modified so that any changes to the organisational strategy, objectives, priority areas or capacity to manage risk are properly reflected.

The risk appetite statement is monitored by the Board to ensure Executive Directors and managers are able to make robust decisions based on the appropriate level of risk for the organisation and/or their potential reward. The risk appetite statement will be communicated and disseminated across the Health Board through a range of mechanisms. These will include training, drop-in sessions, Quality & Safety/ Governance meetings, newsletters, global emails and the weekly bulletins.

7. BCU`s Risk Management Process

The Health Board`s risk management process as shown in the following diagram is informed by the AS/NZS ISO 31000:2018 and the ERM model. It emphasises the need to identify, assess, review, monitor and effectively manage risks within the wider context of organisational business planning/objectives and service priorities while considering the specific risk environment.

This strategy and policy is supported by a suite of procedural documents and guidance as full details on how to articulate controls and assurance can be found in the supporting **RM02 Risk Register Procedure and Guide.**

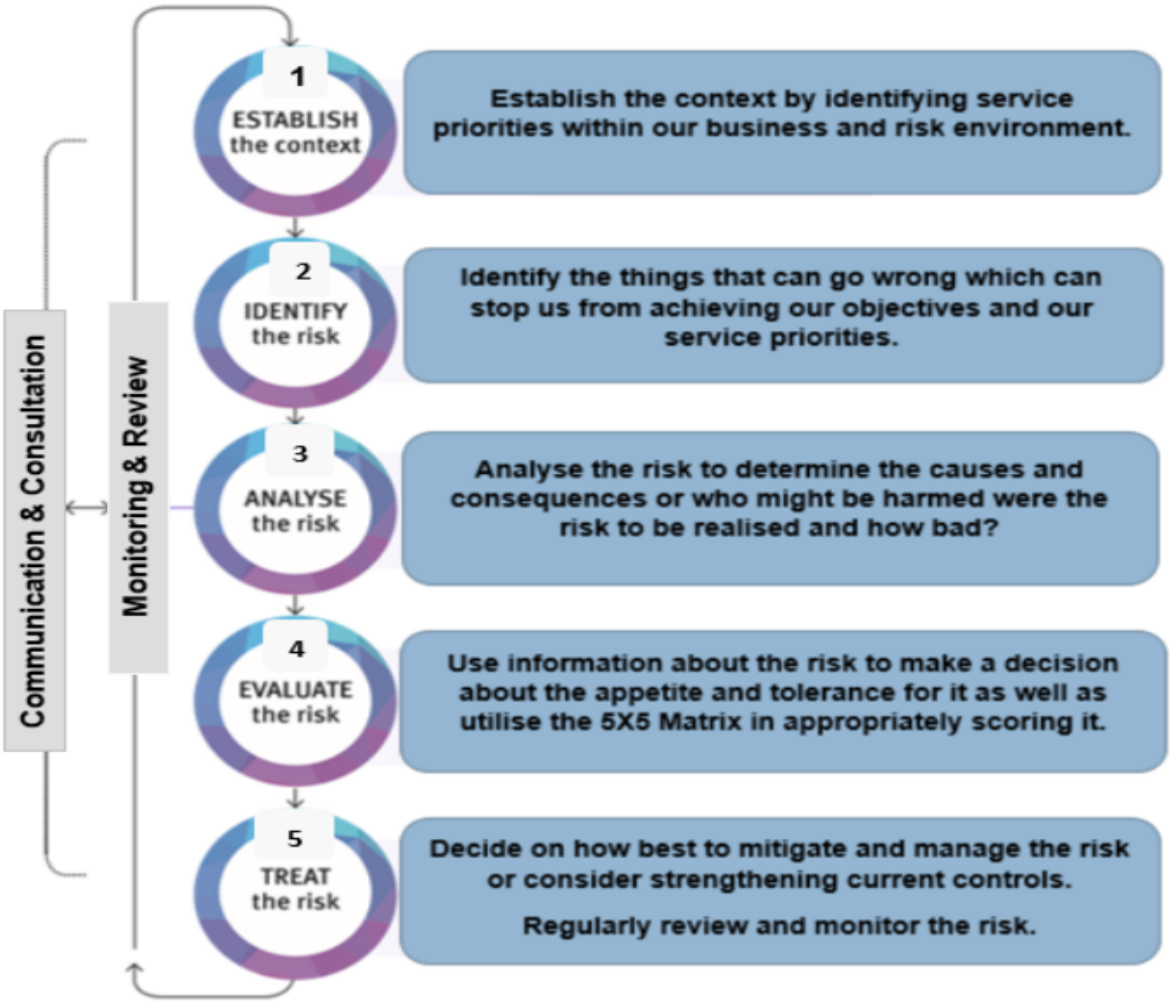

Figure 5 - **BCU`s Risk Management Process**.

Step 1: Establish the context
As the starting point for a robust risk assessment, it important to establish the context by clearly setting out the service objectives and priority areas so as to clearly identify risks which can negatively impact on their achievement.

Step 2: Risk Identification
The focus here is to identify the risk or what can go wrong. A risk can be proactively identified from incidents, complaints, claims, `near misses`, external and internal reports, clinical audits, external visits and Peer Reviews, new service development including service reconfiguration/transformation etc.

The recommended form for risk descriptions is to identify the cause, the event and the effect.

The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public domain with acronyms spelt out in the first instance. When wording the risk it is helpful to think about it in three parts and write it using the following phrasing:

- There is a risk of….if… (this relates to not achieving an objective as intended)
- This may be caused by…….
- Could lead to an impact/effect on …….

An example of this is “There is a risk that patients may not be discharged promptly if medications are not dispensed due to pharmacy delays. This could lead to poor patient experience and delays impacting on bed capacity.”

Step 3: Risk Analysis
Determine the cause and effect and analyse what can happen, where, when, why and decide who might be harmed and how. Consider how the risk could negatively impact on say patient safety, the quality of clinical care, Workforce, Finance, patient experience for example and then decide what needs to be done.

Step 4: Risk Assessment/Evaluation
Evaluate, assess and quantify the risk by deciding on how bad (consequence) and how often (likelihood) if the risk were to be realised. The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix (appendixes C1 and C2) in assessing and scoring the risk.

Step 5: Risk Treatment & Prioritisation
Once you have identified and assessed a risk, you will then need to record your findings, identify appropriate controls to mitigate the risk and then identify further actions which can be implemented to reduce the risk and decide who will lead on each of them. Design and implement an action plan and also decide on how best to manage it.

Step 6: Risk Review and Monitoring
Risk management is a dynamic and iterative process; hence the risk lead/handler will need to periodically review, re-assess and monitor the risk in line with the following timescales, as a minimum to ensure controls are robust and effective in mitigating the risk.

- Risks scored 15 and above should be reviewed bi-monthly
- Risks scored 9-12 should also be reviewed bi-monthly
- Risks scored 1-8 should be reviewed quarterly.

NB: Please note that the above is just a guide and does not replace the timely, dynamic and effective review and management of risks in real time.

8. Three Tier Risk Management Model

Risks within risk registers across the Health Board held on Datix will be categorised and managed within a three tier model as depicted in **Figure 3** below.

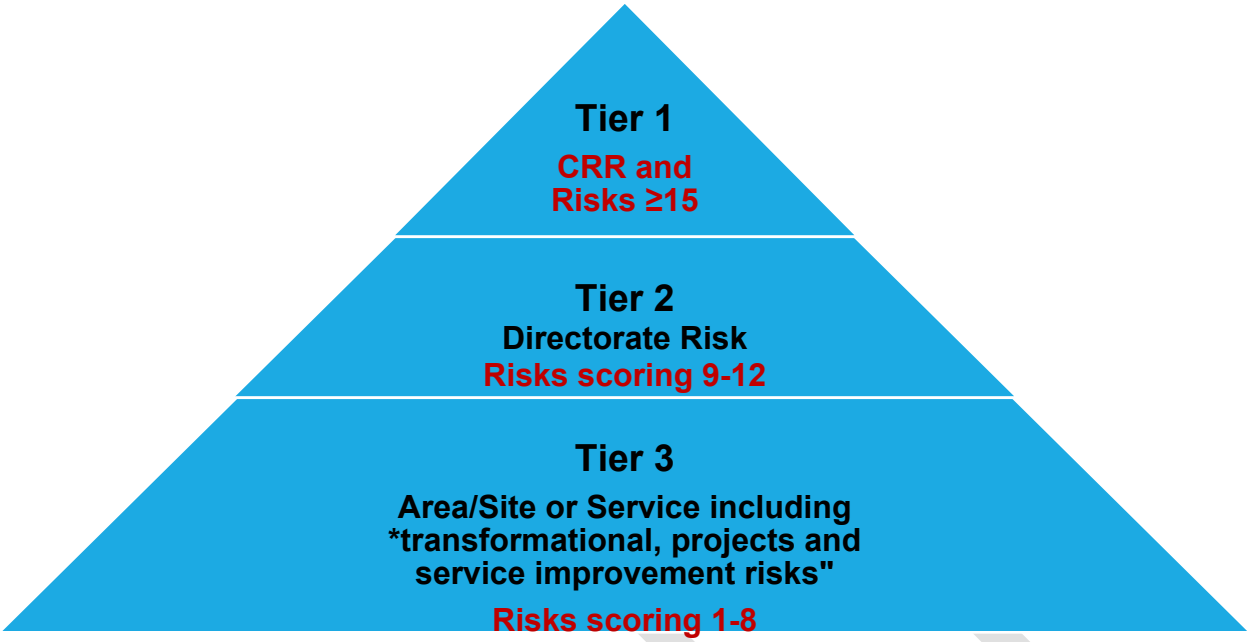

Figure 3 – Risk Management Tiers and oversight.

***Any decision to manage a risk outside the above 3 tier framework (e.g. a risk scoring more than 8 as a Tier 3) must be clearly agreed, regularly reviewed/monitored and minuted at the relevant governance meeting with delegated authority to manage their risks as part of the governance meetings' terms of reference. All risks scoring outside the risk scoring framework will be regularly monitored and reported through the corporate governance structures with oversight at the Risk Management Group. An exception report will be provided to the Audit Committee from the Risk Management Group so that oversight of the appropriate management of these risks and compliance with the Risk Management Strategy is maintained.**

Within the three tier risk model:

- Tier 1 risks will refer to extremely high risks scored ≥15 which have the greatest potential to negatively impact on or disrupt business continuity;
- Tier 2 risks will refer to those scored 9-12 which will also be known as Directorate risks;
- Tier 3 risks will refer to those scored 1-8 and have the lowest potential to disruption our smooth operations or commissioning arrangements.

Determining at which Tier the risk will be managed will be dependent on the assessed score (which takes into account the likelihood, potential impact, size and scope upon the Health Board) should the risk be realised. It is expected that the decision around the appropriate Tier, score, potential impact, risk handler/manager including escalation and/or de-escalation of a risk should be agreed and minuted at the relevant governance meeting.

8.1 Corporate Risk Register (CRR)

There are two determinants either of which can qualify a risk for escalation and approval by the appropriate Committee of the Board for inclusion onto the CRR:

- Such risks associated with the delivery of the Health Board's Integrated Medium Term

Plan (IMTP) and / Annual Plans and/or a risk which threatens the achievement of the Health Board's key deliverables and objectives. It is worth noting that irrespective of its score, such a risk should be escalated and if approved, recommended by the appropriate committee for inclusion onto the CRR with ratification of such a decision awaited from the Board.

- Risks scored ≥15 that are escalated will be reviewed by the relevant Executive Director and must be approved by the appropriate committee, for ratification from the Board for inclusion onto the CRR.

The CRR will thus encompass all risks including those linked to the IMTP/Annual Plan irrespective of their scores and operational risks with scores ≥15 where there is heightened concern of their potential impact on business continuity. **It is the responsibility of very senior managers and Executive Directors to ensure that updates/actions and recommendations from relevant committees and the Board are reflected in the related risk entries on Datix.**

8.2 Directorate Risk Management (Tier 2)

Executive Directors are expected to ensure that there are appropriate processes, systems and governance arrangements in place for regularly reviewing, scrutinising and effectively managing, escalating and de-escalating Tier 2 risks within their Directorate. They will be required to periodically present their Tier 2 risk register and any assurance thereof at the Risk Management Group (RMG)

8.3 Area, Site, Service or Transformational / Improvement Risk Management (Tier 3)

These are risks which score 1-8 and should be regularly reviewed, scrutinised, approved and escalated where appropriate by the relevant governance or Quality and Safety meeting. Extreme and high risks including those with potential high impact should not be held at Tier 3 except where a conscious governance decision and rationale have been made to do so and documented.

9. Source of Risks

Risks can be identified from the following sources as shown in figure 4 below. This list is not exhaustive, but can include:

Figure 4 - Shows some examples of different source of risks.

10. BCU`s Enterprise Risk Management (ERM) Framework

BCU`s approach to risk management will be shaped, informed and underpinned by the ERM Model. This is important as it will provide a framework through which BCU will seek to integrate effective and efficient risk management and governance into performance reporting, business continuity, organisational planning, priority setting and continuous improvements in patient care and journey. It will emphasise the need for open and transparent communication and consultation with all staff or key stakeholders at each stage of the risk management process to ensure engagement, shared understanding and awareness of the intelligence on controls in place. Staff are encouraged to ensure risks are regularly presented at the relevant governance and Quality and Safety meetings for review, scrutiny, approval and assurance.

The following figure depicts BCU`s Enterprise risk management framework.

Figure 6 - BCU`s Enterprise Risk Management Framework

11. BCU`s Risk Management Escalation and De-escalation Process

Underpinning BCU`s risk management framework is the governance arrangement for escalating and de-escalating risks that staff are advised to adhere to. Each service and directorate within the Health Board is expected to maintain a risk register on Datix and a local risk management procedural document (RM02) which defines how risks are identified, assessed and managed within the service or directorate as these interrelated activities constitute the key building blocks in BCU`s risk management process.

Datix is the sole repository for capturing risks being managed by services across BCU. Staff are not advised to record risks on paper-based systems or spreadsheets.

Extreme operational and strategic risks identified within services and directorates should be escalated via appropriate governance routes for consideration and approval so that such risks can be held at the right Tier and assigned the right profile, handler, manager and resources. It is worth noting that escalation and de-escalation of any risk is based on the following distinct but interrelated criteria:-

- Its potential negative impact were it to materialise.
- Its high score and/or high profile nature.

There are thus two pathways for escalating or de-escalating risks:

- Through appropriate governance or Quality and Safety meetings.
- Through the Senior Management team and/or Executive Director in the case of where an urgent decision is required as the next governance meeting is due in the distant future. Any decision taken will need to be presented at the relevant governance or Quality and Safety meeting for noting and ratification.

Simply put, escalating a risk does not free the service or Directorate where the risk has been identified of the responsibility to appropriately assess, mitigate and manage the risk as risks are locally owned, led and managed. Escalation provides an opportunity for raising the visibility of a risk, requesting for support/resources and keeping the Health Board aware of those which are high profile. The next table depicts BCU`s escalation and risk governance arrangements for risk management.

Tier	Risk Score	Category of risk	Level at which risk is managed	Approval Group or Committee	Escalation and De-escalation
Tier 1 Corporate Risk Register	15-25	Extreme	Risks scored 15 and above, escalated and approved for the CRR will be led on by Executive Directors although responsibility for managing and mitigating them on a daily basis will remain with original owner. **Reviewed bi-monthly**	Board/ Committee Executive Team	Appropriate Committee with the assigned risks on the CRR. Once reviewed, the RMG will have sight of the entire CRR prior to sharing with the Audit Committee / Board.
Tier 2	9-12	High	Managed at Directorate level and led on by Executive Directors with local ownership and input. **Reviewed bi-monthly**	Appropriate Directorate Governance meeting RMG	Risks with a current score 9-12 will be managed under the leadership of an Executive Director. Risks scoring above 12 are escalated to the Executive Team for consideration and approval as Tier 1 risks *CRR.
Tier 3	4-8	Moderate	Managed at local level Area/Site or Service including those for	Relevant group meeting or	Risks with current score 1-8 are managed at local level with

			transformational projects and Service Improvement. **Reviewed quarterly**	local governance meeting.	oversight from relevant local governance meeting. Those which score >8 will be escalated to the local governance meeting for consideration and presentation to the appropriate Executive Director.
	1-3	Low			Risks escalated are still locally owned and managed.

Figure 7 - The Health Board`s escalation and risk governance arrangements for risk management.

*** CRR: Corporate Risk Register**
*The above timescales for reviewing risks are only a guide and do not replace the dynamic and timely review and escalation of risks in real time.

The next figure shows BCU`s escalation and de-escalation route:

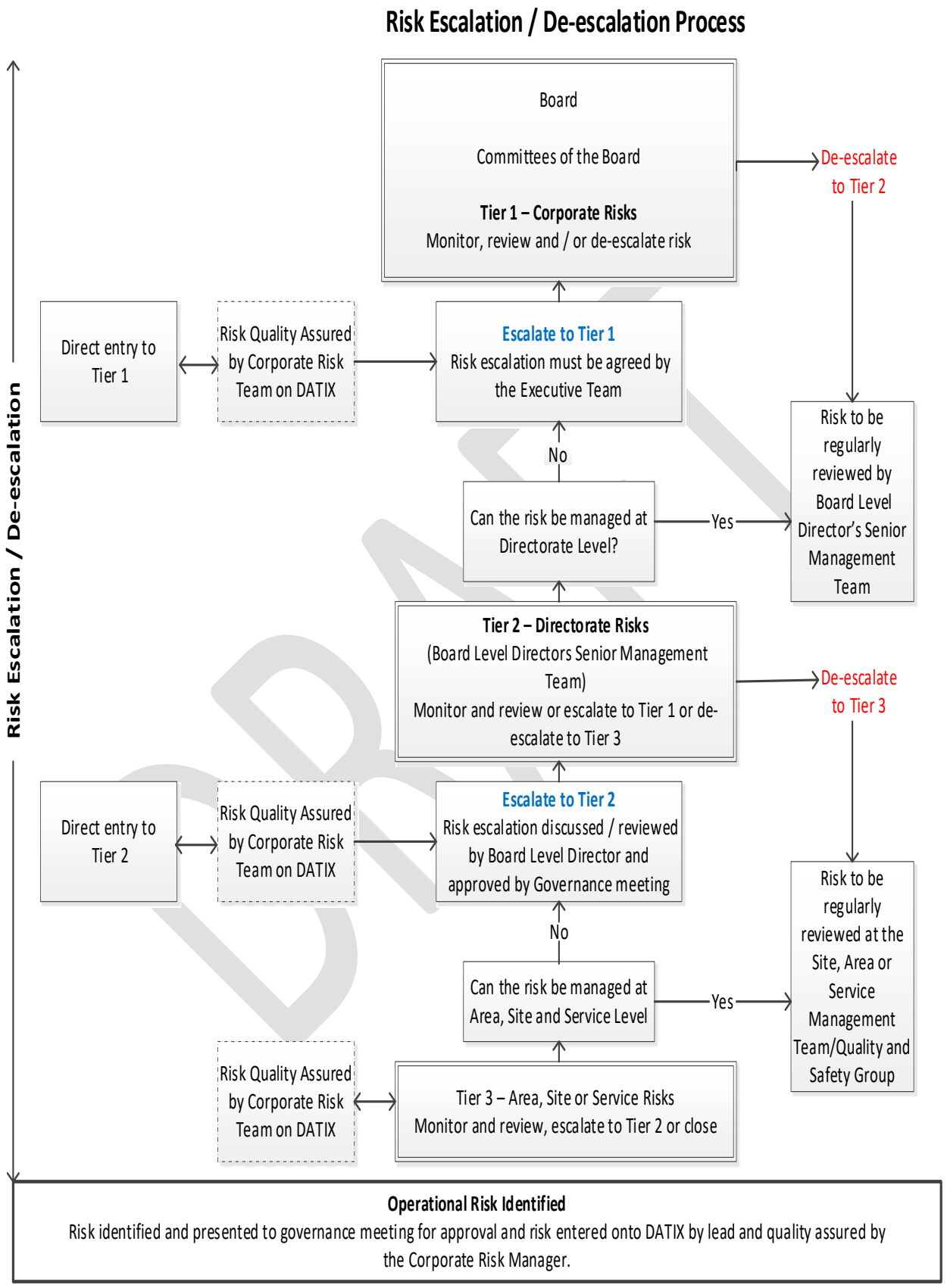

Figure 8 - Escalation/De-escalation route

12. Roles and Responsibilities

The following section provides a synopsis of the roles and responsibilities of individuals, groups and committees in ensuring the timely and effective identification, assessment and management as well as review and scrutiny of risks across the Health Board: -

12.1 The Board

The Board have collective responsibility for the setting and ensuring delivery of strategic objectives and priority areas. Key strategic risks are identified and monitored by the Board. The CRAF provides a central record of risks to the delivery of its strategic objectives and priority areas. The Board is also accountable for setting the risk appetite of the Health Board and in providing scrutiny, oversight and constructive challenge while gaining assurance that the Health Board has robust systems and processes in place to ensure the effective management of risks, associated controls and assurances across its length and breadth.

The Board is also responsible for ensuring that the health board consistently follows the principles of good governance, ensuring that the systems, policies and people in place to manage risk are operating effectively, focused on key risks and driver the delivery and commissioning of the health board's strategic objectives.

In the context of this Strategy and Policy the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of this strategy;
- Ensure, through the Chief Executive that the responsibilities for risk management outlined in this strategy are communicated, understood and maintained;
- Take a lead role in "horizon scanning" for emerging threats/risks to the delivery of the health board's strategic objectives and priority areas and ensuring that controls put in place in response, manage risks to an acceptable level;
- Oversee and participate in the risk assurance process;
- Ensure communication with partner organisations on problems of mutual concern including risks;
- Ensure that appropriate structures are in place to implement effective risk management;
- Commit those financial, managerial, technological and educational resources necessary to adequately control identified risks;
- Ensure that lessons are learned and disseminated into practice from complaints, claims and incidents and other patient experience data;
- Receive reports from the Committees of the Board in line with terms of reference and workplans of those committees.

12.2 Chief Executive

The Chief Executive is accountable for the Board's risk management and governance arrangements and has executive responsibility for ensuring organisational compliance with the Health Board`s risk management strategy and policy. He/she also has responsibility for communicating, implementing and monitoring the Health Board`s risk appetite as delegated by the Board and for ensuring that the Annual Governance Statement aligns with this risk management strategy and policy.

12.3 Deputy Chief Executive

The Deputy Chief Executive has been delegated responsibility by the Chief Executive to develop the governance arrangements and strengthen the Health Board`s risk management systems and processes by:

- Embedding an effective risk management culture throughout the health board;
- Working closely with the Chair, Vice Chair, Chief Executive, Chair of the Audit Committee and Executive Directors to implement and maintain appropriate risk management and related processes;
- Developing and communicating the Board's risk awareness, appetite and tolerance;
- Leading and participating in risk management oversight at the highest level, covering all risks across the health board;
- Leading the development of, and Chair of the Risk Management Group;
- Working closely with the Chief Executive and Executive Directors to support the development and maintenance of the Corporate and Directorate level risk registers;
- Developing and implementing the health board's Risk Management Strategy and Policy.

The Deputy Chief Executive will discharge these responsibilities through the Assistant Director of Information Governance and Risk and the Head of Risk Management.

12.4 Board Secretary

In accordance with the NHS Wales Governance Framework and Guidance from IRM and CIIA, the Board Secretary provides advice and guidance to the Board on all aspects of governance and it is the Board's responsibility to approve the governance framework. The Board Secretary is responsible for designing, developing and maintaining the Health Board`s Board Assurance Framework (BAF).

12.5 Executive Directors

Executive Directors have overall responsibility for the operational management of risk within their portfolios and will be the responsible officer for risks on the Corporate Risk Register. They are also responsible for the effective allocation of resources to timely mitigate risks within their remit, while ensuring prompt escalation and de-escalation of risks where appropriate.

12.6 Independent Members

Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust and effective challenge to the Executive Directors and senior management. The role of Independent Members is not to manage individual risks but to understand and question risk on an informed and ongoing basis.

In addition, Independent Members chair Board level Committees and in line with the relevant committee's terms of reference, should provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board.

12.7 Clinical Executive Directors

The Executive Director of Nursing and Midwifery, Executive Medical Director, Executive Director of Therapies and Health Sciences and the Executive Director of Public Health have collective responsibility for clinical quality governance which includes patient safety, incident management and patient experience and will therefore have a responsibility to ensure that clinical risks are appropriately managed in line with this strategy.

12.8 Senior Information Risk Officer

The Board will nominate an Executive Director as the Senior Information Risk Officer (SIRO) with delegated responsibility by the Chief Executive for ensuring that information risks are treated as a priority for business outcomes.

12.9 Senior Managers (including Directors)

Senior managers take the lead on risk management within their divisions, sites and areas and set the example through visible leadership. They are also responsible for the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit.

12.10 All Staff

All staff including Trade Union colleagues and contractors are required to comply with this Risk Management Strategy and Policy, bring any issues of concern to the attention of their line manager and to appropriately mitigate and manage risks to the best of their knowledge and ability. Controls and actions implemented in mitigating risks must be timely disseminated to all staff involved with the management of the risk were it to be realised. All staff are expected to share intelligence around any potential risks with contractors providing services within and on behalf of the Health Board.

13. Committee Duties & Responsibilities

The key responsibility of committees here is to provide assurance to the Board that there are robust and effective arrangements in place to appropriately identify, assess, review, monitor and manage Tier 1 risks and those on the Corporate Risk Register (CRR) within their portfolio. Each risk on the corporate risk register is aligned to a Committee of the Board which will regularly review and scrutinise their risks prior to the CRR being presented to the Board. With the approval of Executive Directors and ratification by the Board, Committees can recommend risks for inclusion onto the CRR. Committees here include:

- Quality, Safety and Experience Committee (QSE)
- Finance and Performance Committee (F&P)
- Strategy, Partnerships and Population Health Committee (SPPH)
- Digital and Information Governance Committee (DIGC)

13.1 Audit Committee

The Audit Committee is responsible on behalf of the Board for providing oversight and scrutiny of the CRR in order to assure the Board that there are robust processes and systems in place for appropriately managing risks across the Health Board and especially those on the CRR. This involves reviewing how risks which could impact on the achievement of the objectives

and priority areas as noted in the 3 Year Outlook and Annual Plan are being managed and mitigated. The Audit Committee will also review and approve the Risk Management Strategy and Policy annually as required as part of the Health Board's Standing Orders in advance of ratification by the Board.

13.2 The Risk Management Group

The Risk Management Group will maintain oversight of the risk management system and overall governance and reporting arrangements ensuring that it is fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy and Policy. It is also responsible for the oversight and monitoring of risks at Directorate level (Tier 2) and providing oversight of the full Corporate Risk Register prior to review by the Audit Committee. As part of the Health Board governance arrangements, the Risk Management Group will report to the Audit Committee.

13.3 Directorate Risk Management Arrangements

All Directorates must have the necessary arrangements in place for good governance, quality, safety and risk management.

Directorates, through management have the responsibility for risks to their services and for putting in place appropriate arrangements in line with this Risk Management Strategy and Policy and supporting documentation. They are also responsible for developing their local arrangements for monitoring their risks and communicating risk information.

14. Management and Governance of shared risks

The Health Board recognises that there will be instances where the effective management of a risk will require input from other colleagues and stakeholders who may sit outside the area or service where the risk has been identified. For example, a service may identify a risk in their area which requires input from Informatics, Estates and Facilities, Health & Safety etc. In such a situation the Health Board encourages risk handlers and managers to ensure all key stakeholders are involved in the initial discussions, assessment, scrutiny and approval of such risks. This will entail clarity of roles, responsibilities as well as allocation of actions/resources to mitigate the risk.

15. Board Assurance Framework (BAF)

The BAF is a mechanism that should enable the Board to gain assurance that principal risks to the achievement of the Health Board`s strategic objectives and priority areas have been identified, assessed and are properly mitigated and managed in line with best practice. It thus provides a structure and process through which the Health Board can focus on those principal risks which can compromise the achievement of its core objectives as defined in its 3 Year Plan/IMTP and Clinical Strategy.

While the BAF focuses on principal risks to the Health Board`s strategic objectives and priority areas, the Corporate Risk Register on the other hand, will focus on ensuring that extreme risks scored ≥15 and operational risks to the achievement of the organisation`s objectives and priority areas as defined in the 3 Year Plan/IMTP are effectively and efficiently identified, assessed, mitigated and managed. The Health Board`s BAF and CRR will be symbiotically

linked, inform, shape and feed-off each other as both documents will be received, reviewed and scrutinised by relevant committees and the Board each time they sit.

The BAF is thus the main tool that the Board will use in discharging its key responsibility of internal controls and in gaining assurance that objectives are being delivered and that the Health Board is managing its principal risks in accordance with the vision, strategy, process and assurance mapping that informed the design of its BAF.

16. Risk Management Training

As the Health Board embarks on a journey to implement and embed ERM across all its services, it recognises the importance of developing local capacity and capability in risk management as a driver for embedding its risk management culture. Risk management training needs analysis has recently been undertaken across services within the Health Board and its results will help in focusing minds and resources on addressing the gaps and staff risk management training needs identified.

A series of classroom-based risk management training and awareness sessions, Corporate Induction and the delivery of risk management training through existing governance and Quality and Safety meetings will be delivered in supporting the Health Board embed its risk management culture. On the other hand, all staff (including Board Members) will receive training and refreshers in risk management appropriate to their roles and responsibilities at defined and agreed intervals.

17. Equality Impact Assessment

The Health Board has undertaken an Equality Impact Assessment on the implementation of this strategy and policy to ensure that it is inclusive and does not discriminate against any protected characteristics. The assessment has highlighted an equality impact concern regarding the availability of the documentation in a format to address any visual impairment disabilities. Positive action including support and the availability to transcribe the document will be provided to support individuals and the Health Board to positively meet its responsibilities under the equalities and human rights legislation.

18. Performance Measurement and Monitoring of Risk Management Culture

The Health Board will undertake an annual internal audit or health check of its risk management culture through the use of key performance indicators in determining the effectiveness of risk management across all its services. This health check will explore a sample of 20 risks randomly selected from each Directorate risk registers and 10 from the Corporate Risk Register in measuring a set of agreed key performance indicators which will be further developed throughout the year. The below is an example of some of the indicators which will be used (please note this list is not exhaustive):-

Compliance: This will measure whether the Health Board is compliant with its own risk management strategy and policy by evaluating the following components:-

- % of risks in the Directorate reviewed in line with the Risk Management Strategy and Policy;

- % of risks which are in date and/or out of date;
- % of actions linked to Directorate risks which have been completed within set timescales.

Maturity: This measure will focus on evaluating the completeness of risks on risk registers across the Health Board and will concentrate on the following aspects:-

- % of risks with all fields appropriately completed;

Data Quality: This measure will focus on evaluating the accuracy and appropriateness of information captured in the description of risks, their controls, actions and titles. It will consider:-

- % of risks with titles clearly articulated.
- % of risks with appropriate descriptions

19. Conclusion:

The use of ERM will thus provide a framework through staff across the Health Board to timely and proactively identify, assess, manage and mitigate potential events or risks that may compromise the achievement of the organisation`s objectives and Priority Areas as outlined in its 3 Year Plan/IMTP. In conclusion, this risk management strategy and policy will foster standardisation, engagement, consistency and help embed ERM across all services within BCU from `Ward to Board`.

20. References

- WHC(2000)13 – Corporate Governance in the NHS in Wales: risk management and organisational controls.
- AS/NZS ISO 31000:2018 (2018) Risk Management Guidelines. BSI Publication.
- The Good Governance Guide for NHS Wales Boards, second edition 2017.
- Welsh NHS Confederation (2009) The Pocket Guide to Governance in NHS Wales. Good Governance Institute. http://www.wales.nhs.uk/sitesplus/documents/1064/NHS%20Wales%20Confed%20-%20Governance%20Pocket%20Book%20FINAL%5B1%5D.pdf.
- Welsh Government (2015a) Health and Care Standards for Wales.
- www.gov.wales/topics/health/publications/health/guidance/carestandards.
- Welsh Government (2014c) NHS Wales Governance E-Manual, www.wales.nhs.uk/governance-emanual.
- Governance in the NHS in Wales, Memorandum for the Public Accounts Committee April 2015
- NHS Leadership Academy (2013) The Healthy NHS Board 2013 – Principles for Good Governance, www.leadershipacademy.nhs.uk
- IRM (2011) Risk Appetite & Tolerance Guidance Paper
- John, Bullivant (2009) A Simple Rules Guide for the NHS – Board Assurance Framework. Institute of Governance Publication.
- Deloitte (2015) Enterprise Risk Management – A `risk-intelligent` approach. Deloitte Advisory Publication.
- Committee of Sponsoring Organizations of Treadway Commission (2017) Guidance on Enterprise Risk Management – Integrating with Strategy and Performance. https://www.coso.org/Pages/erm.aspx

21. Glossary

Action plan	Sets out the activities that will address the identified gap between the current and acceptable (target) rating of a risk
Assurance	Objective evidence that risks are being managed effectively (e.g. management information, corporate oversight reviews, clinical audit / service evaluation, inspections, etc.).
Control(s)	Processes in place to eliminate, transfer or treat a risk.
Corporate risk register	A record of the risks identified through internal processes that will impact on the delivery of the Health Board's key deliverables and objectives.
Gaps in controls or assurances	Deficiencies, either in current control actions or in the assurances being used to determine the effectiveness of controls, that indicate where an additional system or process is needed, or evidence of effective management of the risk is lacking
Impact	Is the result of a particular threat or opportunity should it actually occur.
Issue	A relevant event that either will happen or is already happening and that requires some management action.
Incident	An untoward event that has occurred and that requires management action.
Likelihood	The measure of the probability that the risk event will happen.
Operational risks	A risk or risks that have the potential to impact on the delivery of business, project or programme objectives. Operational risks are managed locally within teams and significant operational risks are escalated, where appropriate, to the Executive Team via the Divisional senior management team.
Opportunity	An uncertain event that would have a favourable impact on objectives or benefits if it occurred.
Risk	An uncertain event or set of events that, should it occur, may have an effect on the achievement of objectives. A risk can arise from a threat or an opportunity.
Risk Tolerance	A threshold, set by type of risk that, indicates at what magnitude a risk is considered acceptable.
Risk assessment	The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk. The risk is compared against predetermined acceptable levels of risk (tolerances)
Threat	An uncertain event that could have a negative impact on the delivery of objectives or benefits, should it occur.

Appendix A – Risk Appetite Statement – May 2020

The Health Board recognises that risk is inherent in the provision and commissioning of healthcare services, and therefore a defined approach is necessary to articulate risk context, ensuring that it understands and is aware of the risks it is prepared to accept in pursuit of its aims, strategic objectives and priority areas.

The Health Board places fundamental importance on the delivery of its strategic objectives and priority areas and its relationships with its patients, the public and strategic partners in achieving delivery of its "*Living Healthier Staying Well*", 3 year plan.

The Health Board is not open to risks that materially impact on the quality or safety of services that we provide or commission; or risks that could result in us being non-compliant with UK law, healthcare legislation, or any of the applicable regulatory frameworks in which we operate.

The Health Board has the greatest appetite to pursue innovation and challenge current working practices and financial risk in terms of our willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Risk Domains	**Description**
Risk Appetite Category: Cautious (Low Score 1 - 6)	
Patient and Staff Safety	The Health Board consider the safety of patients and staff to be paramount and core to our ability to operate and carry out the day-to-day activities. We have a low appetite to risks that result in, or are the cause of incidents of avoidable harm to our patients or staff. This means we are not open to risks that could result in poor quality care or clinical risk assessment, non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or tasks safely and, nor any incidents or circumstances which may compromise the safety of any staff member or group.
Quality and Patient Outcomes	The Health Board's ambition is to ensure that the health services it provides to individuals, patients and the population improve and achieve desired health outcomes and are informed by current professional and cutting-edge knowledge and best practice. The Health Board recognises that it`s quality risks will include those which relate to clinical effectiveness and patient experience amongst others.

	The provision of high quality services is of the utmost importance to the Health Board and for ensuring value for money in a challenging arena. We therefore have a cautious appetite to risks that impact adversely on quality of care and depending on the circumstances will accept some risks that could limit our ability to fulfil this activity.
Workforce and OD	The Health Board will continue to employ and retain staff that meet our high quality standards and provide on-going training to ensure all staff reach their full potential, always mindful of the professional and managerial capacity and capability of the Health Board. We will also actively promote staff well-being. In certain circumstances we will accept risks associated with the delivery of this activity, however the preference is for safe delivery options with a low degree of inherent risk. There might be occasions as part of a future strategy to meet changing needs that we seek to develop new staffing models, which in their development might require a greater level of risk.
Regulation and Compliance	The Health Board will continue to comply with all legislation relevant to us and will avoid risks that could result in the Health Board being non-compliant with UK law or healthcare legislation, or any of the applicable regulatory frameworks in which we operate.
Risk Appetite Category: Moderate (Moderate Score 8 - 10)	
Reputation & Public Confidence	The Health Board will maintain high standards of conduct, ethics and professionalism at all times, espousing our Values and Behaviours, and will not accept risks or circumstances that could damage the public's confidence in the organisation. Our reputation for integrity and competence should not be compromised with the people of North Wales, Partners, Stakeholders and Welsh Government. We have a moderate appetite for risks that may impact on the reputation of the health board when these arise as a result of the health board taking opportunities to improve the quality and safety of services, within the constraints of the regulatory environment.
Partnership Working	The Health Board will continue to work with other organisations to ensure we are delivering the best possible service to our patients/service users and are willing to accept risks associated with this collaborative approach. Partnership working is a fertile ground for innovation in service delivery, new ways of delivering services and new service models. However, not where this compromises safety and quality of care for patients and service users. This is key to ensuring patients, carers and stakeholders receive

	seamless care from all agencies, especially with regard to legislation such as Social Care and Well Being Act and the Well Being of Future Generations Act, which will support the Health Boards commitment to improving population health and the general well being of local people through the implementation of “Living Healthier Staying Well”.
Finance	The Health Board have been entrusted with public funds and must remain financially viable. We will make the best use of our resources for patients and staff. Risks associated with investment or increased expenditure will only be considered when linked to supporting innovation and strategic change. We will not accept risks that leave us open to fraud or breaches of our Standing Financial Instructions.
Risk Appetite Category: Open (High Score 12 - 15)	
Innovation & Strategic Change	The Health Board wishes to maximise opportunities for developing and growing our services by encouraging entrepreneurial activity and by being creative and pro-active in seeking new initiatives, consistent with the strategic direction set out in the 3 Year outlook, Annual Plan, whilst respecting and abiding by our statutory obligations. We are willing to accept risks associated with innovation, research and development to enable the integration of care, development of new models of care and the use of technology to address changing demands. This will include new ways of working, trials and pilot programmes in the delivery of healthcare.

This Statement will be regularly reviewed and modified so that any changes to the Health Board’s strategy, objectives, priority areas or our capacity to manage risk are properly reflected. It will be communicated throughout the Health Board in order to embed sound risk management and to ensure risks are properly identified and managed.

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

For:	Risk Management Strategy and Policy – RM01 -V4.5
Date form completed:	23rd June 2020

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or 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?	Risk Management Strategy and Policy - RM01 -V4.5
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Re-designing and crafting this new Risk Management Strategy and Policy for Betsi Cadwaladr University Health Board reflects its commitment to place and integrate effective risk management into everything it does including business/operational delivery, objective and priority setting, financial planning and budget setting. The Health Board emphasises the fact that effective risk management is everyone`s responsibility. The main objectives of this strategy and policy are: • To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks. • To set out the organisational governance arrangements and responsibilities for risk management. • To enable staff to understand our risk environment and to use the Health Board`s risk appetite statement to identify and assess risks which cannot be tolerated. • To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting. • To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning.
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?	Gill Harris - Deputy Chief Executive and Executive Director of Nursing and Midwifery.

Part A Form 1: Preparation

4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Yes, • Board Assurance Framework • Health and Safety Policy (HS01) • Risk Assessment Guidance (HS03) • Concerns Policy and Procedure (PTR01 and PTR01A) • Datix Risk Register – Procedure and User Guide (RM02) Model Risk Management Procedure (RM04)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	• Employee's and workers • Patients and service users • The Public and visitors • Contractors • Any persons residing in BCUHB accommodation • Staff side and Trade Unions • All others entering BCUHB premises
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	To support the proposed implementation of the Strategy and Policy: • A clear programme of communication and awareness raising of RM01 • Engagement from all BCUHB employees to implement and support the strategy and policy • A programme of training and training needs analysis to support staff with accessing and robustly utilising the RM01. Potential barriers: • Confidence to manage and comply with the Strategy and Policy • Poor communication or lack of engagement with staff/public • Lack of understanding around the Strategy and Policy requirements.

Part A Form 1: Preparation

7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This Risk Management Strategy and Policy fosters equality and reduces inequality by emphasising the need for staff, contractors and everyone to ensure its appropriate application in embedding an organisation-wide culture of safety and the provision of high quality care to all patients irrespective of their age, sex, ethnicity etc.

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		(+ve)		• This Risk Management Strategy and Policy will prevent any potential discrimination, foster an organisational-wide culture of safety and offer the same level of support regardless of age. https://www.ons.gov.uk/atoz?az=a	Through regular review and audits of the Health Board`s risk management culture.
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	X		(+ve)		• This Risk Management Strategy and Policy ensures the same level of safety prioritisation and appropriate risk management for all staff, patients, visitors, contractors and everyone regardless of disability. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Support will be provided to those with a disability as it is reasonably practicable in appropriately accessing and utilising the Risk Management Strategy and Policy including signposting them to relevant support services within the and outside the Health Board which can enhance and enable them to access and explore this strategy including those with

						dyslexia. It also includes support for colour blindness for interpretation of the RAG ratings by the inclusion of the letters RAG in the column with the colour.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)	X		(+ve)		• This Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of gender reassignment. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their gender reassignment.
Pregnancy and maternity	x		(+ve)		• This Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their pregnancy and maternity status. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their pregnancy and maternity status.
Race (include different ethnic minorities, Gypsies and Travellers)	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their race and/or ethnicity. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their pregnancy and maternity status.

Consider how refugees and asylum-seekers may be affected.						
Religion, belief and non-belief	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their religion, belief and non-belief. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their religion, belief and non-belief.
Sex (men and women)	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff regardless of their sex. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their sex.
Sexual orientation (Lesbian, Gay and Bisexual)	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of their sexual orientation. https://www.gov.scot/publications/equally-well-report-ministerial-task-force-health-inequalities/pages/4/	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their sexual orientation.

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

Marriage and civil Partnership (Marital status)	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of their marriage and civil Partnership (marital status).	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of their marriage and civil Partnership (marital status).
Low-income households	x		(+ve)		• This Risk Management Strategy will prevent discrimination and offer the same level of access and utilisation to all staff irrespective of they being from low-income households.	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because of they being from low-income households.

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		**(+ve)**		• Article 5 Right to liberty and security • Article 8 Right to respect for family & private life	The Strategy will support horizon scanning for emerging risks and their appropriate mitigation and management in providing high quality patient-centred responsive care.	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against.

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

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	X		**(+ve)**		The Strategy will support horizon scanning for any emerging risks which could negatively affect people who use the Welsh language and to appropriately mitigate and manage them.	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because they are a Welsh language speaker.
Treating the Welsh language no less favourably than the English language	X		**(+ve)**		The Strategy will support horizon scanning for any emerging risks which could negatively affect people who use the Welsh language and to appropriately mitigate and manage them as well as ensure that Welsh language is not less favourably treated than the English language.	Will remove any negative impact by undertaking regular monitoring and audit of its implementation to ensure that no one is being discriminated against because they are a Welsh language speaker.

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.	• Workshops have been held with all key stakeholders including staff of the Board and Audit Committee. • Risk management training has also been piloted around the main thrusts of the new strategy and feedback has been received.
Have any themes emerged? Describe them here.	• Collaborative and joined-up working in managing risks. • Risk appetite statement • Embedding risk management • Better and enhanced decision making
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	Yes, • The views of the various stakeholders who have been engaged in crafting this Strategy have shaped and influenced the final version as comments and feedback have been incorporated into the final version.

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)	Risk Management Strategy and Policy - RM01 -V4.5

2. Brief Aims and Objectives: (Copy from Form 1)	Re-deigning and crafting this new Risk Management Strategy and Policy for Betsi Cadwaladr University Health Board reflects its commitment to place and integrate effective risk management into all what it does including business/operational delivery, objective and priority setting, financial planning and budget setting. The Health Board emphasises the fact that effective risk management is everyone`s responsibility. The main objectives of this strategy and policy are: • To provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks. • To set out the organisational governance arrangements and responsibilities for risk management. • To enable staff to understand our risk environment and to use the Health Board`s risk appetite statements to identify and assess risks which cannot be tolerated. • To facilitate the use of risk management as a tool for better decision-making, driving continuous improvements and linking these to organisational planning and performance reporting. • To foster an open, transparent and blame-free culture in driving and embedding an integrated approach to risk management that is intelligence-led, evidence-based and informed by continuous learning.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x

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

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The outcomes from the information provided in forms 2 and 3 indicate that the impact of the implementation of the Strategy will have a positive impact on the protected characteristic groups highlighted within this EqIA. The Strategy will be implemented equally across all protected characteristic groups.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x
	Record Details: No Mitigating issues	
6. Are monitoring	Yes	No x

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arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	How is it being monitored?	The Strategy will be monitored through local team engagement, senior management meetings, Risk Management Annual Health check and Audits.
	Who is responsible?	Gill Harris - Deputy Chief Executive and Executive Director of Nursing and Midwifery.
	What information is being used?	E.g. will you be using existing reports, data etc. or do you need to gather your own information? Feedback from the Board and Audit Committee and consultation with colleagues and risk reports generated for various Quality and Safety and/or Governance meetings.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	As appropriate and in line with the policy review date – July 2021

7. Where will your policy or proposal be forwarded for approval?	The Audit Committee and then ratification by the Board.

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be**	Name	Title/Role
	David Tita:	Head of Risk Management

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undertaken as a group activity Senior sign off prior to committee approval:	Justine Parry: Specialist support from the Equality and Inclusion Manager	Assistant Director of Information Governance & Risk.
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A	N/A	N/A

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	No significant change to procedure	N/A	N/A
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?	Clear communication of the procedure across BCUHB Support for implementation	David Tita Head of Risk Management	31st Oct 2020
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Full implementation and engagement with the new Strategy.	David Tita Head of Risk Management	31st Oct 2020