Bundle Health Board 15 July 2021

AGENDA

9.30am via Zoom public session

1 MATERION AGORIADOL A LLYWODRAETHU EFFEITHIOL / OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 09:30 - 21.108 Sylwadau Agoriadol y Cadeirydd / Chair's Introductory Remarks - Mark Polin

To record:

1\. Health Board Chair's Action was completed on 27\.5\.21 regarding the tender for the redevelopment of the Critical Care Unit at Wrexham Maelor
2\. Dual F&P Committee and Health Board Chair's Action was completed on 15\.6\.21 regarding the recommissioning of orthodontic services in Penrhyndeudraeth
3\. Health Board Chair's Action completed on 23\.6\.21 to endorse SRG election of Chair and Vice Chair\, to allow Ministerial approval to be obtained for Chair position
4\. Health Board Chair's Action completed on 3\.6\.21 to approve acceptance of the recommended tender for the reinstatement works following the decommissioning of Ysbyty Enfys Llandudno
5\. Dual F&P Committee and Health Board Chair's Action completed on 21\.6\.21 to approve contract with Lightfoot Solutions to provide healthcare consultancy and specialist technology services\, to aid Winter Planning and delivery and ongoing support\.
6\. Health Board Chair's Action completed on 25\.6\.21 for authority to settle a claim over £1million
7\. Health Board Chair's Action completed on 5\.7\.21 for approval of acceptance of the recommended tender for the reinstatement works following the decommissioning of Ysbyty Enfys Deeside

1.2 09:35 - 21.109 Ymddiheuriadau am Absenoldeb / Apologies for Absence

Adrian Thomas
Sue Green - Lesley Hall deputising

1.3 09:36 - 21.110 Datganiadau o Fuddiant / Declarations of Interest

1.4 09:37 - 21.111 Cofnodion Drafft Cyfarfod y Bwrdd Iechyd a gynhaliwyd yn gyhoeddus ar 20.5.21 er cywirdeb ac adolygu'r Cofnod Cryno o Weithredoedd / Draft Minutes of the Health Board Meeting held in public on 20.5.21 for accuracy and review of Summary Action Log

21.111a Minutes Health Board 20.5.21 Public V0.02_English.docx

21.111b Summary Action Log Public_v220.doc

1.5 09:47 - 21.112 Adroddiad y Prif Weithredwr / Chief Executive's Report - Jo Whitehead

Recommendation:
That the Health Board notes the report of the Chief Executive

21.112a CEO report_English.docx

21.112b CEOs report appendix 1 Joint Committee Briefing 11.5.21v1.0.pdf

21.112c CEOs report appendix 2 SSPC Assurance Report 20.5.21.doc

1.6 09:52 - 21.113 Diweddariad Pandemig Covid-19 Pandemic Update - Gill Harris

Recommendation:
The Board is asked to note the report and supporting presentation which will be given at the Board meeting and endorse decisions made by the Executive Incident Management Team.

21.113a Covid update v1.docx

21.113b Covid-19 update slides_bilingual.pptx

2 10:12 - EITEMAU AR GYFER CYDSYNIAD / ITEMS FOR CONSENT

2.1 21.114 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) - Arpan Guha

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

21.114 Section 12(2) Doctors_English.docx

2.2 21.115 Dogfennau a Arwyddwyd dan Sêl / Documents Signed Under Seal - Louise Brereton

Recommendation:
The Board is asked to note the list of documents signed under seal.

21.115 Documents Signed Under Seal v1.0_English.docx

2.3 21.116 Adroddiad Blynyddol ac Ch4 Iechyd a Diogelwch 2020-21 / Health and Safety Annual and Quarter 4 Report 2020-21 - Lesley Hall

Recommendation:
The Board is asked to note the position outlined in the Annual and Quarter 4 Report support the recommendations identified within the findings:
1. Implement year 2 of the Occupational Health & Safety (OHS) Strategy.
2. Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
3. Ensure adequate staff and premises to provide Manual Handling training
4. Establish a permanent fit test program
5. Develop further policies and safe systems of work to provide evidence of practice.
6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators.
7. Train senior leaders and develop further competence in the workforce at all levels
8. Learn lessons from incidents and develop further the risk profile

21.116 Health and Safety Annual and Q4 update Report_Final V2.docx

2.4 21.117 Buddsoddiad Cronfeydd Elusennol Polisi Moesegol / Updated Ethical Charitable Funds Investment Policy - Sue Hill

Recommendation:
The Board is asked to review and approve the update to the Ethical Charitable Funds Investments Policy.

21.117a Ethical Investments Policy v2.1.docx

21.117b Ethical Policy - Appendix 1 Summary Paper.pdf

3 I'W DRAFOD / FOR DISCUSSION

3.1 10:22 - Gwelliant Wedi'i Dargedu / Targeted Improvement

3.1.1 21.118 Diweddariad Fframwaith Gwella Ymyrraeth wedi'i Dargedu / Targeted Intervention Improvement Framework Update - Jo Whitehead

Recommendation:
The Board is requested to note the progress in delivering Targeted Improvement.

21.118 TIIF update 1.02.docx

3.1.2 21.119 Grp Llywio Fframwaith Gwella Ymyrraeth wedi'i / Targeted Intervention Improvement Framework Steering Group - Jo Whitehead

21.119 Chair's Assurance Report TIIF Steering Group 1.6.21 v2.0_English.docx

3.2 10:32 - 21.120 ITEM WITHDRAWN

3.3 10:52 - 21.121 Tasg Fasgwlaidd a Diweddariad Grwp Gorffen / Vascular Task and Finish Group Update - Arpan Guha

Recommendation:
The Committee is asked to receive the update from the Vascular Task and Finish Group

NOTE - a number of background documents contained within Appendix 2 have been provided for Members information only

21.121a Vascular Report template.docx

21.121b Vascular Appendix 1 activity.pdf

21.121c Vascular Appendix 2 RCS plan v2.pdf

3.4 11:12 - 21.122 Gwella Gofal ar Frys / Urgent Care Improvement - Gill Harris

Recommendation:
The Board are asked to note:
1. concerns raised by Emergency Department Clinical Leads in correspondences dated 10th December 2020 and 17th June 2021
2. update on the Urgent and Emergency Care improvement programme of work

Dr Chris Subbe to attend

21.122 Urgent Care Final approved v1.docx

3.4.1 11:32 - Egwyl / Comfort Break

3.5 11:42 - 21.123 Adroddiad Ansawdd a Pherfformiad / Quality & Performance Report - Mark Wilkinson, Arpan Guha, Gill Harris

Recommendation:
The Health Board is asked to scrutinise the report and if required to request the provision of further assurance relating to any specific areas which have not achieved national or locally agreed performance measures.

21.123a QP Report template v0.6_English.docx

21.123b QP Report Appendix 1 v0.8.pdf

3.6 11:57 - 21.124 Adroddiad Cyllid Mis 1 Finance Report Month 1- Sue Hill

Recommendation:
It is asked that the report is noted

21.124 Finance M1_English.docx

3.7 11:59 - 21.125 Adroddiad Cyllid Mis 2 Finance Report Month 2- Sue Hill

Recommendation:
It is asked that the report is noted

21.125 Finance M2_English.docx

3.8 12:09 - Adroddiadau Sicrwydd Cadeiryddion y Pwyllgorau a'r Grwpiau Cynghorol / Committee and Advisory Group Chair's Assurance Reports

21.126 Audit Committee 10.6.21 (Medwyn Hughes)
21.127 Quality, Safety & Experience Committee 4.5.21 (Lucy Reid)
21.128 Finance & Performance Committee 24.6.21 (Mark Polin)
21.129 Charitable Funds Committee 11.6.21 (Jackie Hughes)
21.130 Mental Health Act Committee 25.6.21 (Lucy Reid)
21.131 Remuneration & Terms of Service Committee 22.4.21 & 7.6.21 (Mark Polin)
21.132 Strategy, Partnerships & Population Health Committee 17.6.21 (Lyn Meadows)
21.133 Digital & Information Governance Committee 18.6.21 (John Cunliffe)
21.134 Stakeholder Reference Group 28.6.21 (Mark Wilkinson)
21.135 Healthcare Professionals Forum 4.6.21 (Gareth Evans)
21.136 Local Partnership Forum 13.4.21 (Jo Whitehead)

21.126 Chair's Assurance report Audit 10.06.21_V1.0_English.docx

21.127 Chair's Assurance Report QSE 4.5.21 v1.0_English.docx

21.128 Chair's Assurance Report FPC 24.6.21 V1.0_English.docx

21.129 Chair's Assurance Report CFC 11.06.21 v1.0_English.docx

21.130 Chair's Assurance Report MHAC 25.6.21 v1.0_English.docx

21.131 Chair's Assurance Report RTS 22.4.21 7.6.21 v1.0_English.docx

21.132 Chair's Assurance Report SPPH 17.6.21 V1.0_English.docx

21.133 Chair's Assurance Report DIGC 18.6.21 V1.0_English.docx

21.134 Chair's Report SRG 28.06.21 V1.0_English.doc

21.135 Chair's Report HPF 4.6.21 V1.0_English.doc

21.136 Chair's Report LPF 13.4.21 v1.0_English.doc

3.9 12:24 - 21.137 Adroddiad Blynyddol Arolygiaeth Gofal Iechyd Cymru / Healthcare Inspectorate Wales Annual Report - Gill Harris

To follow once received from HIW colleagues

3.10 12:39 - 21.138 Adroddiad Diweddariad Arolwg Staff GIG Cymru 2020 / NHS Wales Staff Survey 2020 Update Report - Lesley Hall

Ellen Greer and Nia Thomas to attend

Recommendation:
Members of the Board are asked to note the content of this update report

21.138a NHS Wales Staff Survey 2020 Report to Board_final v0.5.docx

21.138b NHS Wales Staff Survey 2020 Question Set Appendix 1.docx

21.138c NHS Wales Staff Survey Our Reflections Our Decions Our Future - Prompt for conversations Appendix 2.pdf

3.11 12:54 - 21.139 Cofrestr Risg Corfforaethol / Corporate Risk Register Report - Gill Harris

Recommendation:
The Board is asked to review and note the progress on the management of the Corporate Tier 1 Operational Risk Register.

21.139a CRR Report template V2.1.docx

21.139b CRR Appendix 1.docx

4 I'W BENDERFYNU / FOR DECISION

4.1 13:04 - 21.140 Fframwaith Sicrwydd y Bwrdd : Prif Risgiau / Board Assurance Framework : Principal Risks - Louise Brereton

Recommendation:
It is recommended that the Board:
(1) Agree the updated Principal Risks as set out in the Board Assurance Framework (BAF); and
(2) Note the remapping of BAF risks to the revised Annual Plan 2021-22 and updated key field guidance.

21.140a BAF report template.docx

21.140b BAF Appendix 1 Principal risks V2.0.pdf

21.140c BAF Appendix 2 remapping BAF risks to Annual Plan.pptx

21.140d BAF Appendix 3 key field guidance updated.docx

4.1.1 13:14 - Cinio / Lunch break

4.2 13:34 - 21.141 Strategaeth a Pholisi Rheoli Risg y Bwrdd Iechyd wedi'u diweddaru / Updated Health Board Risk Management Strategy & Policy - Gill Harris

Recommendation:
The Board is requested to ratify the approval of the revised Risk Management Strategy and Policy by the Audit Committee.

21.141a Risk Management Strategy report template V0.2.docx

21.141b Risk Management Strategy and Policy RM01 v7.0 Appendix 1.docx

21.141c Risk Management Strategy EQIA v2.1_Appendix 2.doc

4.3 13:44 - 21.142 Cynllun Blynyddol 2021-22 / Annual Plan 2021-22 - Mark Wilkinson

Recommendation:
The Board is asked to approve the plan.

21.142a Annual Plan report template.docx

21.142b Annual Plan refresh 080721_Appendix 1.docx

21.142c Annual Plan Programme action plan Appendix 2.pdf

21.142d Annual Plan Summary Plan Content V2 updated Appendix 3.docx

21.142e Annual Plan EqIA Screening Appendix 4.docx

21.142f Annual Plan Socio-Economic Assessment 08-07-21 Appendix 5.docx

4.4 13:59 - 21.143 Safonau'r Gymraeg Safon 37 : Cyfieithu Papurau'r Bwrdd : Diweddariad Chwe Mis / Welsh Language Standard 37 : Translation of Board Papers : Six month update - Teresa Owen

Recommendation:
The Board is asked to:
(1) note the six-month update relating to the translation of specific Board papers following the decision at the Health Board meeting held on 12 November 2020.
(2) approve next steps in line with progressing compliance with Standard 37 of the Welsh Language Standards.

21.143 Welsh Language Standard 37_English.docx

4.5 14:14 - 21.144 Fframwaith Llywodraethu Integredig / Proposed Integrated Governance Framework - Gill Harris

Recommendation:
The Board is asked to approve the suite of documents for implementation from September 2021

21.144a Integrated Governance Framework 1.00 report template QAd.docx

21.144b Integrated Governance Framework v1.18 Appendix 1.docx

21.144c Integrated Governance Framework Appendix 2 - Audit draft Terms of Reference 1.01.docx

21.144d Integrated Governance Framework Appendix 3 - Charitable Funds draft Terms of Reference 1.00.docx

21.144e Integrated Governance Framework Appendix 4 - MHCC draft Terms of Reference 1.01.docx

21.144f Integrated Governance Framework Appendix 5 - PFIG draft Terms of Reference 1.01.docx

21.144g Integrated Governance Framework Appendix 6 - PPPH draft Terms of Reference 1.01.docx

21.144h Integrated Governance Framework Appendix 7 - QSE draft Terms of Reference 1.01.docx

21.144i Integrated Governance Framework Appendix 8 - RaTS draft Terms of Reference 1.01.docx

21.144j Integrated Governance Framework Appendix 9 -Equality Impact Assessment Governance Framework v0.02.docx

4.6 14:29 - 21.145 Cynllun Busnes Rhaglen Tomograffi Gollyngiad Positron Cymru Gyfan / All Wales Positron Emission Tomography Programme Business Case

Sian Lewis (Managing Director, WHSCC) and Sarah McAllister (Programme Manager, WHSCC) to attend

Recommendation:
The Board is asked to approve the Programme business case for an all-Wales Positron Emission Tomography (PET) Service, including the spending objectives, scope, and resource requirements as set out in the financial case.

21.145a PET Report template.docx

21.145b PET Business Case Appendix 1.pdf

21.145c PET EQIA Appendix 2.docx

5 14:39 - ER GWYBODAETH / FOR INFORMATION

5.1 21.146 Crynodeb o Fusnes Heb y Cyhoedd y Bwrdd i gael ei adrodd arno'n gyhoeddus / Summary of Private Board business to be reported in public

Recommendation:
The Board is asked to note the report

21.146 Private session items reported in public_English.docx

6 MATERION I GLOI / CLOSING BUSINESS

6.1 21.147 Dyddiad y Cyfarfod Nesaf / Date of Next Meeting

Annual General Meeting 29.7.21
Health Board Meeting 23.9.21

7 21.148 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
on 20th May 2021 over Zoom conferencing

Present:

Mark Polin	Chair
Louise Brereton	Board Secretary
Nicky Callow	Independent Member ~ University (part meeting)
Cheryl Carlisle	Independent Member
John Cunliffe	Independent Member
Morwena Edwards	Associate Member ~ Director of Social Services
Gareth Evans	Chair of Healthcare Professionals Forum
Sue Green	Executive Director of Workforce & Organisational Development (OD)
Arpan Guha	Acting Executive Medical Director
Gill Harris	Executive Director of Nursing & Midwifery / Deputy CEO
Sue Hill	Executive Director of Finance
Jackie Hughes	Independent Member
Medwyn Hughes	Independent Member
Eifion Jones	Independent Member
Lyn Meadows	Independent Member
Teresa Owen	Executive Director of Public Health (part meeting)
Lucy Reid	Vice Chair
Chris Stockport	Executive Director of Primary and Community Services
Adrian Thomas	Executive Director of Therapies & Health Sciences
Linda Tomos	Independent Member
Jo Whitehead	Chief Executive
Mark Wilkinson	Executive Director of Planning & Performance

In Attendance:

Kate Dunn	Head of Corporate Affairs (for minutes)
Jody Evans	Corporate Governance Officer (for livestreaming support)
Ann Llwyd	Translator
Llinos Roberts	Executive Business Manager – Chair's Office (for livestreaming support)

Agenda item	Action by
21.73 Chair's Introductory Remarks **21.73.1** The Chair welcomed everyone to the meeting and confirmed that proceedings were again being live streamed to enable members of the public to observe the meeting in real time. Members were invited to contribute in the language of their choice. **21.73.2** The Chair also recorded in public that the following Chair's Actions had been agreed since the last meeting: 1. To agree the Stroke Improvement Plan Phase 1 2. Approval of a range of Section 12(2) doctors 3. Approval of acceptance of the recommended tender for the reinstatement works following the decommissioning of Ysbyty Enfys Brailsford, Bangor	

4. Contract Award for the Testing, Maintenance & Repair of Community Equipment 5. Approval of the award of GMS Contract for St George's Surgery, Wrexham	
21.74 Chief Executive's Report **21.74.1 It was resolved that** the Health Board note the report of the Chief Executive.	
21.75 Apologies for Absence **21.75.1** It was noted that Prof Nicky Callow would need to leave the meeting at midday.	
21.76 Declarations of Interest **21.76.1** None declared.	
21.77 Draft Minutes of the Health Board Meeting held in public on 11.3.21 & 30.3.21 for accuracy and review of Summary Action Log **21.77.1 It was resolved that** the minutes of the Trustees Health Board meeting held on the 11.3.21, the Health Board meeting held on 11.3.21 and the Health Board meeting held on 30.3.21 be approved as accurate records. **21.77.2** Updates were noted against the summary action log.	
21.78 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) **21.78.1 It was resolved that** the Board ratify the 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.	
21.79 Covid-19 Pandemic Update **21.79.1** The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper and highlighted a reduction in frequency of Executive Incident Management Team (EIMT) meetings. She confirmed that appropriate arrangements were in place for any key decisions required in between meetings. Secondly she highlighted that BCUHB was now seeing the return of some planned surgery including orthopaedics which was significant to report given the numbers of patients now waiting. **21.79.2** A presentation was then delivered which set out: • That a significant reduction in Covid levels was now being seen across North Wales in terms of both community and hospital levels; • That there was a notable growth in testing opportunities; • Testing activity had decreased generally but this was expected given the current situation and was not currently a matter of concern; • The number of indexed contact cases had reduced and the situation was being carefully monitored as restrictions were lifted; • A number of community projects were underway on the 'protect' activity; • Work was underway to respond to variants of concern and responding to risks around returning travellers;	

• A number of outbreaks had previously been recorded and there was a clear ambition to learn from these and avoid further outbreaks; • The Safe Clean Care (SCC) programme had been refreshed in support of a zero tolerance approach to Health Care Associated Infections, upholding the value of do no harm; • SCC workstreams were led by senior leaders and there was currently excellent clinical engagement. • Vaccination delivery and uptake continued to be excellent and the organisation had been able to respond collaboratively to changes in national clinical guidance; • BCUHB was currently on target for the remainder of the vaccination cohorts; • Work continued with Local Authorities to consider plans for the future of the vaccination programme including sustaining some elements of the Mass Vaccination Centres and planning for booster vaccination requirements. **21.79.3** A discussion ensued. An Independent Member sought clarification on the current figures for hospital in-patients particularly in the West and the Executive Director of Primary Care and Community Services confirmed that the current total was 44 with 25 confirmed Covid in-patients in the West. Another Independent Member indicated she would wish to see more communications and publicity around the success of the vaccination programme in Wales compared to other parts of the UK. The Chief Executive wished to acknowledge the support from retired and redeployed colleagues to the vaccination programme, and the efforts of many volunteers and primary care colleagues. The Independent Member went onto enquire how travellers returning from amber areas and into quarantine were picked up in terms of tracking. The Executive Director of Public Health confirmed there were currently over 3000 travellers isolating in Wales and there was a significant associated piece of work both with the national arrivals team for Wales and with regional and local tracing links. Where necessary there would also be work with enforcement organisations. **21.79.4** An Independent Member enquired as to planning for the autumn flu vaccination programme in the context of Covid. The Executive Director of Nursing and Midwifery / Deputy Chief Executive reported that a range of scenarios were being considered with partners to take into account a Covid booster programme being run alongside the seasonal flu programme. The Executive Director of Public Health agreed to provide more information within the Covid update at the next Health Board meeting. **21.79.5** In response to a question regarding the communication plan and timescale for vaccine passports in Wales, the Executive Director of Nursing and Midwifery / Deputy Chief Executive confirmed there was a dedicated webpage maintained by Welsh Government with the latest information. She undertook to check and confirm that the BCUHB website directed patients to this resource. **21.79.6** The Chair enquired if it could be estimated when the remaining second doses would be completed within North Wales. The Executive Director of Nursing and Midwifery / Deputy Chief Executive was not in a position to confirm this but stated that Wales was still working within the principle of a 12 week interval between doses. In terms of longer term vaccination delivery plans it was confirmed these were being worked up and once a paper was taken to the Executive Team it would be shared with Board members. **21.79.7 It was resolved that** the Board note the report and presentation and endorsed the decisions made by the Executive Incident Management Team.	TO GH GH
21.81 Infection Prevention Annual Report	

21.81.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the annual report and noted that it also incorporated some future steps relating to Safe Clean Care. She highlighted:

- Her personal thanks to all involved in developing learning and bringing Infection Prevention Control (IPC) to the forefront.
- That the report noted a range of innovative work including a move to the use of clear face masks in recognition that the use of facemasks resulted in the loss of the personal touch in the delivery of care.
- That a general improvement in overall infection rates could be noted and BCUHB was one of the better performing areas in terms of MRSA MSA infections with this learning being embedded more widely through the principle of harm-free care.
- The work of the health and safety and organisational development teams in supporting the infection prevention and control programme was acknowledged, in terms of fit testing and reaching out to colleagues across the organisation.
- The launch of the Stronger Together programme would also be instrumental in moving forward the infection prevention programme, recognising the estates challenges around isolation and de-camp facilities to allow for deep cleaning of environments.

21.81.2 The Vice Chair referred to the behavioural elements set out within the report and felt that these applied equally to everyone. She also suggested that the lessons learned as set out in the report were more contributory factors to the outbreaks which would need to be addressed to ensure that lessons were actually learned. She also referred to the RIDDOR reportable Covid infections and suggested that whilst there were common findings identified these were not lessons learned, and also sought clarification how the stated remedial action would be monitored. Finally she queried the exclusion of reference to the Health and Safety Executive (HSE) notices that the Board had received as a result of Healthcare Acquired Infections (HCAIs). The Executive Director of Workforce and OD confirmed that work was ongoing with the Health and Safety teams to ensure delivery could be demonstrated against actions. The HSE had recently advised that HCAIs should only be reported through RIDDOR if the organisation was able to demonstrate a direct link. In terms of the improvement notice issued for Ysbyty Glan Clwyd around the level and nature of fit testing training, this had now been fully complied with. The Executive Director of Nursing and Midwifery / Deputy Chief Executive added that the Quality, Safety and Experience (QSE) Committee had recently received a presentation from the Ysbyty Gwynedd Hospital Management Team and in terms of lessons learnt from the site outbreak this had enabled a helpful reflection on human factors and behaviours.

21.81.3 In response to a question around a dip in compliance score for the national cleaning standards in December 2020, the Executive Director of Nursing and Midwifery / Deputy Chief Executive indicated there were challenges within audit programmes and that work was ongoing with informatics colleagues to ensure data could be captured in real time. Teams had also been reminded of the requirement to undertake the audits and to release staff to participate.

21.81.4 The Chair suggested that the scale of the effort and achievement in terms of maintaining IPC across the three Rainbow Hospitals and the Mass Vaccination Centres, and the commendable performance in terms of infections when compared to other Health Boards should have been more widely acknowledged and celebrated within the report. He also noted a reference within the report to increasing the number of staff within the corporate IPC team and asked if the Executive Team were confident that this additional capacity would be sufficient to deal with any future waves alongside the routine IPC workplan. The Executive Director of Nursing and Midwifery / Deputy Chief Executive responded that this was ongoing and the recruitment of an IPC Lead would be key to moving forward. The critical aspect for

IPC was of course that it became everyone's business and was owned across the organisation.

21.81.5 The Chair sought confirmation that the mortality reviews were being suitably responded to. The Acting Executive Medical Director confirmed that his office and that of the Executive Nurse Director were working closely to ensure that the review of mortality contributed to enhanced learning. He indicated that the importance of this subject was such that an all Wales process was being determined which would be beneficial in terms of providing a uniform framework for learning.

21.81.6 The Chair noted the target date of December 2021 to have a zero tolerance approach to HCAIs seemed a long way into the future and sought assurance that this was an indicative target which would be brought forward if possible. The Executive Director of Nursing and Midwifery / Deputy Chief Executive confirmed that the ambition to deliver this earlier was currently being applied but again relied on IPC becoming part of every single individual's behaviours.

21.81.7 In response to a question regarding the commissioning of an independent review of HCAIs which would inform the action plan, the Executive Director of Nursing and Midwifery / Deputy Chief Executive confirmed this would be reported to the QSE Committee and to Board. In the meantime she was arranging to meet with the report author to identify any early lessons.

21.81.8 It was resolved that the Board receive the Infection Prevention & Control annual report for assurance.

21.82 Targeted Intervention Improvement Framework : Chair's Report from Steering Group

21.82.1 The report was received

21.83 Targeted Intervention Improvement Framework

21.83.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the paper and confirmed that engagement remained ongoing in terms of sharing the principles of Targeted Intervention. Indicative scoring had been checked with Independent Member colleagues and across other parts of the organisation with a focus on ensuring that where Executive Leads felt there was progress, this was also recognised across the wider organisation and by partners. The Chief Executive confirmed there was a sound process for the involvement of Local Authorities.

21.83.2 The Executive Director of Public Health provided an update against the mental health maturity matrix. She welcomed the support and scrutiny from the Independent Member 'buddies' in developing the matrix which was in three parts – children's services, adult services and the transition period. The matrix had been developed in the context of shaping priorities for mental health services and focusing on development work to ensure Welsh Government requirements could be met. She also wished to highlight to the Board that was ongoing with the Concordat for Crisis Care which would enable key strands of activity to be brought together. An Independent Member welcomed the focus on transition and wished to emphasise that the matrix was at a baseline starting point, acknowledging the improvements to be made.

21.83.3 The Executive Director of Planning and Performance provided an update against the strategy, planning and performance maturity matrix. He confirmed that its development was being shared with performance and planning teams to ensure local ownership. He drew members' attention to a proposed addition to the matrix regarding the development of a medical and health sciences school for north Wales as it was felt this provided evidence of the organisation's increasing maturity and was a key strategic issue for the Health Board. An Independent Member indicated she had been impressed with how teams had mobilised at short notice to support the matrix and she was supportive of the methodology with a focus on improvement and progression. **21.83.4** The Executive Director of Workforce and OD provided an update against the leadership matrix which she felt cut across all other domains in terms of organisational development programmes and 'resetting' the organisation. She highlighted that the matrix had been refreshed in light of the Socio-Economic Duty to ensure it reflected the Board's commitment to providing services across communities and the promotion of equality. **21.83.5** The Executive Director of Nursing and Midwifery / Deputy Chief Executive provided an update against the engagement matrix which she also felt was a cross-cutting area. She referred to current conversations around the ability to listen effectively and to engage fully. She confirmed that stakeholder mapping would include the public who were essential to the effective co-design of services. **21.83.6** An Independent Member made reference to the engagement and communications work undertaken to date but was concerned that this was restricted to stakeholders and needed to be widened to engage and consult with patients and staff to ensure they understood the Targeted Intervention process and how it differed to Special Measures. She felt that this was a broader task outside of the leadership domain. The Executive Director of Workforce and OD indicated she would always apply the principle of working to deliver what was right for the organisation and ensuring ownership to that work – with Targeted Intervention almost being a by-product of that. She would wish to see an environment for engagement that was accessible and appropriate. The Chief Executive referred to the ongoing engagement piece with Local Authorities which was resulting in an emerging approach for other partners. In terms of staff communications she noted that this was very often weaved in with other opportunities she was minded to think through how the organisation could consider patient and public involvement and encouraging co-design work. **21.83.7** The Chair made reference to a comment from the Chief Executive of NHS Wales recently on the positive nature of the tri-partite meeting arrangements and the approach being taken. He asked that the approved matrices be shared with the partners within that tri-partite arrangement. **21.83.8 It was resolved that** the Board: 1. Note the progress to date. 2. Agree the Matrices – including the addition of reference to the development of a medical and health sciences school for north Wales to the Strategy matrix 3. Agree the initial baseline scoring for each matrix. 4. Agree the Targeted Intervention Improvement Steering Group Terms of Reference	GH
21.84 Committee and Advisory Group Chair's Assurance Reports **21.84.1** The Audit Committee Chair presented the report from the meeting held on 18.3.21 and highlighted the impact of the pandemic on the internal audit plan, and the continued concern around the pace of improvement around governance arrangements within the Mental Health and Learning Disabilities Division following a limited assurance audit report. The	

Health Board Vice-Chair added that she had been disappointed to receive this limited assurance report however she was confident that the findings would be addressed and that the refresh of the Together for Mental Health Partnership Board would support this. The Board also noted the schedule of approved financial claims that were linked from the report, and endorsed that the Risk Management Strategy and Policy remain extant pending the annual review in June/July. **21.84.2** The Quality, Safety & Experience (QSE) Committee Chair presented the report from the meeting held on 2.3.21 which was received. The Committee Chair provided a verbal update from the QSE meeting held on 4.5.21 highlighting that the vascular report was taken in private session due to pre-election Purdah requirements and she was pleased to see it in the public session on the Board agenda. She also noted that representatives of the Hospital Management Team in Ysbyty Gwynedd (YG) had attended the QSE Committee to present regarding the Covid-19 outbreak. Whilst numbers had now reduced considerably it had emerged that learning from outbreaks on other hospital sites had not been fully embedded. An external independent review into the outbreak would provide valuable information in due course. **21.84.3** The former Finance & Performance (F&P) Committee Chair presented the report from the meeting held on 25.3.21 which was received. **21.84.4** The F&P Committee Chair presented the report from the meeting held on 29.4.21 and highlighted the positive year-end position in terms of a small surplus. He also noted that performance on savings was better than expected given the impact of Covid. Finally he acknowledged the challenge around waiting lists and the lengthy recovery timeframe. **21.84.5** The Charitable Funds Committee Chair presented the report from the meeting held on 9.3.21 which was received. **21.84.6** The Mental Health Act Committee Chair presented the report from the meeting held on 12.3.21 which was received. **21.84.7** The Remuneration & Terms of Service Committee Chair presented the report from the meeting held on 1.2.21 which was received. **21.84.8** The Strategy, Partnerships & Population Health (SPPH) Committee Chair presented the report from the meeting held on 15.4.21. She highlighted the progress with developing the Stronger Together Programme which would be a fundamental element of improving culture and behaviours. The Committee had suggested that the Health Board should receive staff survey data and the Executive Director of Workforce and OD undertook to share the headlines and associated actions from a recent survey undertaken in the autumn of 2020 at a future Health Board meeting. **21.84.9** The Digital & Information Governance Committee Chair presented the report from the meeting held on 26.3.21 and highlighted the Committee's concern around risks to the Digital Strategy relating to national systems. **21.84.10** The report from the meeting of the Stakeholder Reference Group held on 22.3.21 was received and it was noted that the election process was ongoing to identify a new Chair and Vice Chair. **21.84.11** The Healthcare Professionals Forum (HPF) Chair presented the report from the meeting held on 5.3.21 and was pleased to note that feedback from the HPF had been incorporated into the Targeted Intervention maturity matrices. The Executive Director of	SG

Therapies and Health Sciences extended thanks to Professor Michael Rees whose tenure as Vice-Chair had ended recently. The Executive Director of Workforce and OD added that she had met with HPF colleagues recently around organisational development and ensuring appropriate representation on tactical delivery groups. **21.84.12** The Executive Director of Workforce and OD presented the report from the Local Partnership Forum held on 19.1.21 and wished to record her thanks to Trade Union partners for their significant support over the period of the pandemic. The Health Board Chair noted reference in the report to a lack of managerial representation and it was confirmed that attendance had been challenged over the past year but had improved at the April meeting.	
21.85 Operational Plan Monitoring Report Q3 and Q4 **21.85.1** The Executive Director of Planning and Performance confirmed that the report had been agreed by the Executive Team and scrutinized at the F&P Committee. In addition the SPPH Committee had received a supplementary report against any undelivered actions and how these were being carried forward into 2021-22. The Chief Executive reminded members that the process for reviewing all Board and Committee reports was being strengthened and the Executive Team intended to refresh the process for gleaning performance data from frontline colleagues. She assured members that the aim was to ensure reporting was as complete and accurate as possible. **21.85.2** A discussion ensued. An Independent Member made a general observation that the report could be improved by more clarity being evident around the percentage of completion against projects which would provide a snapshot view of how well the organisation was doing. The Executive Director of Planning and Performance indicated he would be happy to look at this if specific examples could be provided. **21.85.3** In response to a point raised regarding a limited pilot around virtual out-patient appointments the Executive Director of Nursing and Midwifery / Deputy Chief Executive acknowledged that the narrative could have been clearer in terms of confirming that this had moved on in some areas. The Executive Director of Planning and Performance also accepted that para 4.3 could have been expressed more effectively and he confirmed the intention to reflect that there was now a separate Digital Services Strategy which would crucially link into the separate emerging Clinical Services Strategy. **21.85.4** Whilst acknowledging the ongoing work to address formatting and content of this report the Vice-Chair felt there was a lack of transparency and the paper did not meet the objective of providing an update against key actions in the annual plan. She made reference to the Digital Health Record target and that to a member of the public reading the report it would appear this was completed, whereas the Board was aware it was not. She was also disappointed that similar concerns had been raised for the last year. The Executive Director of Planning and Performance confirmed that as a Q3/4 report progress had been scored on whether the output for the reporting period had been achieved, not the overall delivery. **21.85.5** The Executive Director of Public Health referred to the mental health section and acknowledged that interpretation of data to provide a status update was key and would be improved for the future. **21.85.6** The Audit Committee Chair expressed his concern at the level of assurance that the paper provided in that actions had been reported as on track for several months and then suddenly changed to red status but the narrative did not support this. He used the business case for the North Wales Medical School as an example. The Executive Director of Planning	

and Performance stated that the Q3/4 plan was developed in October when the timeline was to produce a business case by the end of March, however, timelines had subsequently been revised with Welsh Government. **21.85.7** The Chair sought assurance that these concerns would be resolved before the next meeting both in terms of the accuracy of the description of progress, and the level of confidence in the processes to ensure the data as depicted in reports is signed off and accurate. The Chief Executive undertook to ensure this happened with immediate effect. **21.85.8 It was resolved that** the Health Board note the report. *[Teresa Owen left the meeting]*	JW MW
21.86 Quality & Performance Report **21.86.1** The Executive Director of Planning and Performance presented the report. He highlighted there had been less progress than hoped with regards to Child & Adolescent Mental Health Services (CAMHS) and access to neurodevelopment assessments, and confirmed that these aspects featured in the organisation's plans for investment in 2021-22. Pressures continued to be seen within unscheduled and urgent care with increased attendances at both Emergency Departments (EDs) and Minor Injury Units (MIUs) which were now affecting the four hour target and ambulance handover. He concluded by noting a positive trend in staff sickness rates which was one of the best in Wales. **21.86.2** The Vice Chair noted that the report indicated there were CAMHS recovery actions set out on page 28 however there was no reference to these on that page nor in the wider report. The Executive Director of Planning and Performance apologised for this error which he would rectify outside of the meeting. **21.86.3** In terms of unscheduled care the Executive Director of Nursing and Midwifery / Deputy Chief Executive reported that the Health Board was working with Welsh Government to devise a whole systems approach improvement plan involving primary care, Local Authorities and Ambulance Services. With regards to planned care, Welsh Government had identified funding to target the long waiters. The Executive Director of Therapies and Health Sciences added that cancer lists were running about 1000 above pre Covid levels but it was positive to see patients now presenting. **21.86.4** The Chair noted that several of the risks and barriers identified within the report related to informatics/IT, capacity, workforce and estates and he suggested that an assessment be undertaken as these were key enablers to deliver many of the organisation's aspirations. The Chief Executive noted that the organisation was due to refresh its workforce strategy in 2021/22 which would provide an opportunity to ensure the workforce was in line with identified service needs. In addition a conversation had commenced around ensuring informatics support to prioritise the digital requirements. In response to a question regarding robotic surgery it was confirmed that Community Health Council colleagues had been updated on the procurement process and it was hoped that BCUHB would take delivery of the robot by early July. **21.86.5 It was resolved that** the Health Board scrutinise the report and request any further assurance relating to any specific areas which have not achieved the required performance measures. [*Nicky Callow left the meeting]*	MW

21.87 Finance Report M12

21.87.1 The Executive Director of Finance presented the report, highlighting that the Board had set a plan for £40m deficit based on £45m savings and that the plan had been revised in-year in line with Welsh Government guidance. She was pleased to report that the Month 12 position was a surplus of £0.4m and extended her thanks to colleagues for their commitment during the year. It was reported that the surplus was achieved following receipt of £51m strategic support from Welsh Government of which £10.3m was utilised for performance improvement and £0.7m for additional capacity and capability. In terms of costs relating to the pandemic response these totalled £172m and had been covered by Welsh Government. The Executive Director of Finance highlighted significant elements of this response such as the temporary hospitals (£31m), Test Trace & Protect (£13m) and Personal Protective Equipment (£5m). Members' attention was also drawn to other elements such as block contracts with NHS England against which a refund of £1.5m was anticipated following a revision of the contract during the second part of the year. The overall savings delivery within the Covid context was £18.4m of which £11.3 was recurrent. It was reported that cash and capital targets and payment of non NHS invoices were all met. Finally the Executive Director of Finance confirmed that Audit Wales had commenced their review of the organisation's financial accounts and the Board was asked to delegate approval of the accounts to the Audit Committee as in previous years.

21.87.2 The F&P Committee Chair wished to add his thanks to the teams for their achievements over the past year. He felt that continued monitoring of any additional funding and savings would be key going forward but recognised that the organisation would continue to incur Covid related costs in 2021/22. The Chair referred to a communication from the Chief Executive of NHS Wales regarding £19.9 additional allocation and the Chief Executive confirmed that the requirements set out within that letter were being addressed, along with ensuring that monies were aligned to the Board's operational plan and appropriately endorsed by the Health Board. The Executive Director of Finance confirmed that the draft 2021/22 plan quantified the financial risk to breakeven as £28.2m but that was prior to the announcement regarding further recovery monies. She added that the Month 1 position had now been finalised and was in line with the draft plan which would be refreshed by the end of June.

21.87.3 It was resolved that:
1. The Board note the draft financial position for 2020/21
2. The Board delegate authority to approve the 2020/21 audited annual accounts and returns to the Audit Committee.

21.88 Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016

21.88.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive presented the annual report which had previously been scrutinized by the QSE Committee. She highlighted that the Board was complying in terms of the information it collated. The report incorporated a triannual review to align harm against staffing levels and also outlined the extraordinary year which had affected staffing levels due to redeployment and absences/shielding.

21.88.2 It was resolved that:
1. The Board note and support the following next steps which are incorporated into the overall Health Board recruitment and retention programme:
 a. Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally
 b. Succession planning for the future, ensuring we are developing our next generation

leaders c. Creatively co-designing our post graduate programmes as key attractors d. Analysing workforce data to better inform Nurse recruitment and retention initiatives e. Review of implementation of new roles to support the nursing recruitment pipelines f. Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach g. Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time h. Further analysis of deviations from previous reporting periods and analysis of the first triennial reporting period of the Act 2. The Board support the sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments as presented	
21.89 Mental Health and Learning Disabilities Division Targeted Interventions Progress Update **21.89.1** The Vice Chair suggested that the report provided more granularity to support the Targeted Intervention maturity matrix and highlighted the importance of establishing a baseline. She indicated that the areas requiring most improvement were children's and adult mental health services, but that positive improvements had been made in terms of aligning the governance structures with wider arrangements. The Chief Executive drew members' attention to areas of early progress as set out in Table 1 whilst acknowledging there was much work still to be done. **21.89.2 It was resolved that** the Board note the work undertaken by the Mental Health and Learning Disabilities (MHLD) Division in the self-assessment process against the maturity matrix, which supports the Welsh Government Targeted Interventions Framework.	
21.90 Primary Care Update and the response to the Covid-19 pandemic **21.90.1** The Executive Director of Primary Care and Community Services presented the paper and highlighted a range of ways in which the pandemic had affected general practice – both adversely and positively. He suggested there was a perception across the UK that general practice had not widely been providing a service over the past year when in reality it had never been busier. He reminded members that the majority of people who had contracted Covid had not accessed secondary care services but had been treated and supported within a primary and community setting. In addition the suspension of much secondary care activity had had a knock on effect to primary care. The Executive Director of Primary Care and Community Services outlined how challenging infection prevention and control requirements had been in that much of the primary care estate was not built to deal with the sort of situation that had been faced during the pandemic. He noted that whilst many consultations had commenced virtually, face to face care had very often taken place where appropriate to ensure the best intervention and outcome. He felt there was a need to establish a longer term balance between alternative digital technology and face to face consultations. **21.90.2** The Vice Chair acknowledged the challenges that primary care had faced and welcomed the innovative approach that had been demonstrated in many areas. She noted that the paper reported an increase in activity within general practice and suggested that some of these contacts would be from patients enquiring around delays in diagnostics or referral to treatment appointments. She asked whether the Board could be more proactive in sharing messages around planned care to assist primary care colleagues. The Executive	

Director of Nursing and Midwifery / Deputy Chief Executive indicated that a letter had been drafted for patients on waiting lists and for General Practitioners and she would confirm when this would be ready for circulation. An Independent Member noted reference to an online self help service "Econsult" and wondered if ultimately this would result in an increased demand on services. Another Independent Member was aware that NHS England had written to GPs instructing that patient preferences for face to face consultations should be reflected in how services were provided. The Executive Director of Primary Care and Community Services confirmed that there was no equivalent directive for Wales but the fundamental position remained that virtual consultations had an important role to play but should never be at the expense of the ability to do a better assessment via another means. **21.90.3** The Chair noted there had been a great deal of media coverage about pressures within primary care and he asked whether BCUHB was doing enough to communicate effectively as to the situation in North Wales and the actions being taken. The Executive Director of Primary Care and Community Services confirmed that BCUHB was contributing to national work to ensure consistency of messaging, however, he undertook to follow this point up locally with the corporate communications team. **21.90.4 It was resolved that t**he Board note: 1. the delivery of services across primary care during the pandemic and significant contribution by all contractors; 2. the growing demand for services and backlog of care in primary care services; 3. the need to continue to address the sustainability of primary care services.	GH CS
21.91 Vascular Services **21.91.1** The Chair introduced this agenda item by stating it was important to recognise that the report had been commissioned by the Health Board itself following concerns being raised over the impact of centralising the service. The Chief Executive indicated she fully understood the disappointment amongst Independent Members in terms of progress, and confirmed the current position that the case note review was ongoing, and that the findings would be shared openly and with the organisation's external healthcare regulator. **21.91.2** The Acting Executive Medical Director presented the paper. He reminded members that the Board took a decision in May 2020 to establish the Task and Finish Group and to commission an independent review from the Royal College of Surgeons (RCS). The first element of the review had concluded and was an assessment based on interviews and review of documentation, with the second part relating to the review of 50 sets of clinical notes. This element had been delayed due to the pandemic but the RCS had now confirmed that they would be willing to undertake site visits to review the notes. **21.91.3** The Acting Executive Medical Director accepted there had been a lack of pace in terms of demonstrable progress in implementing the recommendations. The report identified 9 areas that required immediate improvement in order to reduce any impact on patient safety and other areas where further improvements in the service model were also recommended. These were now all reflected in the refreshed action plan. The Acting Executive Medical Director indicated he wished to seek the Board's approval to invite the RCS back to undertake a repeat review. He felt it was important to state at this stage that although the review had identified areas for improvement, there were also notable positive observations such as acknowledgement of the valuable framework of clinical expertise, and an overwhelming commitment from staff to work together to improve services for patients. He went on to describe that the alignment of pathways was now being pursued with pace, which would require a number of data sets to be gathered and analysed. To support this, a	

multidisciplinary group had been established, led by one of the national leads in diabetic footcare and further supported by a diabetologist. The group also had carer and patient representation and its remit was to develop a single unified and agreed pathway based on most recent clinical evidence. The Acting Executive Medical Director added that other pathway work was also progressing with some having been completed. In terms of communication and engagement the process was broadly positive with a patient safety culture survey having been commissioned. Once the complex data had been reviewed it would also be incorporated into the overall improvement plan.

21.91.4 A discussion ensued. The Audit Committee Chair expressed disappointment at the pace of progress in implementing the recommendations which he felt caused a degree of concern for the population and a reputational issue for the Board. He queried why the areas for improvement had only now been highlighted given the assurances the Board was given prior to the decision to centralise the service. The Acting Executive Medical Director responded that when the service began there would have been agreement around the target model, but there had been poor progress. He suggested this lack of progress was in part due to the ability to operationalise some aspects during the pandemic. He felt that with the additional recommendations now incorporated, the improvement trajectory would move forward at pace. He confirmed his personal commitment to follow this through, although much of the history predated his role on the Health Board. The Chief Executive confirmed the organisation's commitment to ensure demonstrable progress as it moved out of the pandemic.

21.91.5 The F&P Committee Chair accepted the complexities around the pathway work but was disappointed that some were not concluded after two years. The Acting Executive Medical Director reiterated that he accepted progress had been poor generally, however, some pathways were developing well and had been submitted to the Clinical Advisory Group and were awaiting implementation.

21.91.6 An Independent Member welcomed the intention to invite the RCS to undertake a follow up review. He alluded to a viewpoint amongst some stakeholders that vascular services should be reorganised further. The Acting Executive Medical Director stated that in his opinion the evidence around the service model did not support anything other than a hub and spoke model, and he noted that clinical evidence in a number of documents clearly articulated the benefits of a centralised service. Personally he was of the view that the Board should focus on moving the agreed model forward not starting again.

21.91.7 In response to a query around the 9 urgent recommendations and whether the service was currently safe, the Acting Executive Medical Director indicated that the RCS opinion on surgical clinical outcomes found no red flags in respect of indicators such as mortality rates, length of stay and readmissions and the 9 recommendations were identified as having the potential to impact on patient safety. The Acting Executive Medical Director indicated he would personally be confident to access the service himself but he accepted this was a subjective view. The Independent Member enquired as to resources and capacity to implement the 9 urgent recommendations and it was confirmed that whilst support had been forthcoming it had been identified that more resources would be required.

21.91.8 An Independent Member asked how members of staff working within the service would be advised about the report and the associated recommendations. The Acting Executive Medical Director confirmed that the service was being supported to be able to respond to the required actions. Once the improvement plan was accepted by the Board then an engagement programme would commence including a specific event with staff. The Chair asked that a date for this event be confirmed outside of the meeting. AG

21.91.9 The QSE Committee Chair set out her view that the inability to evidence progress on occasions came down to the granularity of the actions themselves, and that a number were too vague to be able to effectively monitor and evidence progress against them – in particular those relating to pathways. The Chair asked that the Acting Executive Medical Director meet with the QSE Committee Chair separately to refine and agree the narrative as appropriate. The QSE Committee Chair went on to suggest that any findings from the imminent case note review would need rapid and robust response. *[Prof Nicky Callow rejoined the meeting]* **21.91.10** The Executive Director of Workforce and OD noted that whilst the Acting Executive Medical Director was the lead on vascular services, there was a collective responsibility on the wider Board in terms of executing service change to deliver improved outcomes. The Chair felt that the Board was right to seek assurance that the Executive Team remained committed to the original decision around the model of care. He noted that two previous Medical Directors had provided assurances around the pathway development which did not correlate with elements of the review that was now being presented. He noted that the Executive Team were considering investment of resources to enable progress to be made and he asked for clarification outside of the meeting as to when this would be done. The Chair also set out his expectation that the Board receive an update at each subsequent Health Board meeting until satisfied that appropriate progress had been made. **21.91.11 It was resolved that** the Board: 1. note the update and the recommendations following the receipt of the first part of the Royal College of Surgeons' report 2. note and endorse the revised improvement plan as detailed in the action tracker	AG JW
21.92 Review of NHS Wales Local Health Board Model Standing Orders and Standing Financial Instructions **21.92.1 It was resolved that** the amendments to Standing Orders and Standing Financial Instructions be adopted with effect from the end of the Health Board meeting on 20th May 2021.	LB
21.93 Pharmaceutical Needs Assessment **21.93.1** The Executive Director of Primary Care and Community Services presented the paper, highlighting a change in legislation which required all Health Boards to develop a pharmaceutical needs assessment by October 2021. He extended his thanks to the team for delivering on this ask during very pressured times. The document would be subject to a 60 day consultation and Board Members would be invited to contribute as part of that process. **21.93.2** The Chair noted that the document identified some gaps in service provision and the Executive Director of Primary Care and Community Services confirmed this was apparent across the cluster footprint, and the shortfalls would be addressed on the ground with individual localities. In the longer term as contracts came up for new renewal the approach to dealing with them would also be informed by the needs assessment. **21.93.4 It was resolved that** the Board: 1. Approve the draft Pharmaceutical Needs Assessment 2. Approve the commencement of the statutory 60-day consultation process from the beginning of June 2021	

21.94 Ysbyty Gwynedd Hospital – Fire Safety and Infrastructure Compliance Programme Business Case

21.94.1 The Executive Director of Planning and Performance presented the paper which related to the completion of business case work across the three main District General Hospital sites following the identification of technical infrastructure issues in relation to fire safety although he assured the Board that these did not impair the continued use of the hospital. Individual detailed cases would be developing following this strategic business case. In terms of the strategic context for the Ysbyty Gwynedd site a hospital would be envisaged on that site for at least the next 30 years and it therefore made sense to complete this much needed update and address some of the estates issues that had been identified during the pandemic. The Executive Director of Planning and Performance confirmed that the matter had received support at the F&P Committee.

21.94.2 It was resolved that the Health Board approve the Ysbyty Gwynedd Hospital - Fire Safety and Infrastructure Compliance Programme Business Case for submission to Welsh Government.

21.95 Diagnostic Treatment Centre Strategic Outline Case

21.95.1 The Executive Director of Planning and Performance presented the paper and highlighted that the F&P Committee had considered an earlier version of the Strategic Outline Case at its March meeting. The proposal remained as an innovative one seeking to separate out elective care from unscheduled care and ensure that the Board was more easily able to maintain the flow of elective work irrespective of pressures within unscheduled care or future pandemics. The proposal would reduce waiting lists by improving productivity and efficiency, and improve clinical outcomes and patient standards through the application of consistent clinical standards. It would also be expected to reduce time to first appointment through proactive clinical triage. The Executive Director of Planning and Performance noted that since the F&P Committee meeting a change had been made to amplify the organisation's commitment to explore the full range of options at the Outline Business Case stage which could include innovative approaches to funding and delivery of services that could see a greater role for the private sector.

21.95.2 The F&P Committee Chair confirmed he would be supportive of the change to explore further options. He sought clarity around the related strands of work and the Executive Director confirmed these were the refresh of Living Healthier Staying Well, the Clinical Services Strategy and refresh of the Estates Strategy.

21.95.3 The Executive Director of Nursing and Midwifery / Deputy Chief Executive wished to support the exploration of further options such as the private sector which had not been made explicit in the original business case. She noted that all board members were acutely aware of the long waits being experienced by patients for diagnostics and elective surgery. The Chief Executive confirmed the commitment to work hard to progress this matter in partnership with Welsh Government.

21.95.4 It was resolved that the Board:
1. note the change made to the SOC previously approved by the Finance and Performance Committee and approve it as the basis for subsequent discussions and progression with Welsh Government
2. support the development of the Outline Business Case (OBC), which will incorporate the progression of a managed service option which would have the potential benefits of being quicker to implement and require less burdensome capital requirements

21.96 Digital Strategy : Our Digital Future **21.96.1** The Executive Director of Primary Care and Community Services presented the paper and highlighted two key risks. Firstly in terms of digital exclusion he confirmed that the team were taking an active interest in what they can do to contribute to addressing this risk. Secondly in terms of the resources required he confirmed that by the time work on developing the strategy had concluded, the risk had reduced as a range of strands of work had been brought together which would enable prioritisation and articulation of cases for investment. **21.96.2** The Digital and Information Governance Committee Chair confirmed that the Strategy had been supported at Committee and he wished to commend the team on an excellent piece of work which he felt provided a route for the way forward and opportunities for prioritisation of investment. **21.96.3** The Associate Member (Director of Social Services) welcomed the development of the Strategy but would wish to see a stronger narrative and vision around Welsh language aspects and that linguistic requirements were considered at the outset of any developments. She suggested that the "More Than Just Words" forum could be a useful vehicle for discussion. The Executive Director of Primary Care and Community Services welcomed this offer and undertook to ensure a better read across in terms of the Welsh language. The Associate Member (Director of Social Services) then went on to refer to digital exclusion and suggested there were opportunities for discussion with Local Authority colleagues regarding interventions with individuals in communities. **21.96.4** The Vice Chair was supportive of the Strategy and noted how the pandemic had demonstrated the positive effect that digital services could have on healthcare. She observed whether there was an opportunity to encourage more of a focus at an all Wales level to inform key areas such as electronic prescribing. The Chair referred to a recent conversation with the Chair of the new Digital Health and Care Wales organisation and suggested that a collective engagement approach around digital services would be helpful. He would arrange this through his office. **21.96.5** The Chair welcomed the provision of a Socio-Economic Duty impact assessment against this key strategy. He also sought assurance that once approved as a strategy the many ambitions and intentions would be reviewed and prioritised. The Executive Director of Primary Care and Community Services confirmed this was the case. **21.96.6 It was resolved that** the Health Board approve the Digital Strategy.	CS MP
21.97 Maintaining Good Governance During Covid **21.97.1** The Board Secretary presented the paper which provided an update to similar submissions over the past year, recognising the need to balance reducing the burden of corporate meetings whilst ensuring good governance and appropriate decision making mechanisms. **21.97.2 It was resolved that** the Board: (1) note and support the update outlining the governance arrangements now in place; and (2) support the proposal to formally step down the Cabinet meetings at this time, acknowledging that the Cabinet could be stood up again if required in due course.	
21.98 Board Cycle of Business	

21.98.1 The Board Secretary reported that this report would normally have come to Board for approval by this time however it had been deferred to align with the outputs of the governance review and would be considered as part of that suite of documents in July.	
21.99 Summary of Private Board business to be reported in public **21.99.1 It was resolved that** the Board note the report	
21.100 Collaborative Leadership Forum Minutes 1.12.20 Noted	
21.103 Date of Next Meeting 15th July 2021	
21.104 Exclusion of Press and Public **21.104.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

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 30.3.21				
C Stockport	21/66.2 Further reflect on communication messages given at point of delivery of vaccination to maintain public confidence and to reduce complacency.	May 2021	13.5.21 National communications and local messaging have continued to reinforce the positive impact of the vaccination programme alongside the need to maintain strict compliance with social distancing requirements in accordance with current alert levels, notwithstanding an individual's vaccination status. In view of the proportion of people who are still unvaccinated, and whilst the efficacy levels of the vaccines are proving to be extremely good, some individuals may still be susceptible to infection. **20.5.21** L Reid wished to clarify that the concern raised related to communication messages given to patients at the point of vaccination around the levels of protection following the vaccination. C Stockport confirmed this had been addressed and acknowledged this was not clear within the update.	Closed Closed
Actions from Joint Board to Board 22.4.21				
G Harris	**B21/3.3** Follow up suggestion that communications could be improved with patients regarding planned care - particularly around initial referral to first appointment perhaps via a confirmatory text message	22.5.21	22.6.21 Text messages are sent to patients as a support to the booking process. Within the modernisation of OPD we are looking over the next 6 months at the ability to instigate multi text message support so a patient will be able to accept, change or decline using such platforms. We are also exploring the possibility of full	Closed

			electronic booking from lessons learned from the pandemic but this solution could be 12-18 months away and requires further Informatics infrastructure.	
G Harris	**B21/8.4**. Follow up the current position for national and local stroke data with the Acting Executive Medical Director and his team.	22.5.21	22.6.21 The stroke outcome data has been affected due to key members of staff being reallocated to other duties as part of the Covid 19 response. This is being reversed, and with the approval of the Stroke Business Plan recently, it is anticipated that a positive impact will be seen.	Closed
Actions from Health Board 20.5.21				
T Owen	**21.79.4** The Executive Director of Public Health agreed to provide more information on the seasonal flu programme and wider covid vaccination boosters within the Covid update at the next Health Board meeting.	July Board	Will be addressed in presentation of slides	Closed
G Harris	**21.79.5** Check and confirm that the BCUHB website directed patients to the dedicated WG webpage regarding vaccine passports.	27.5.21	Clarified during latter part of meeting	closed
G Harris	**21.79.6** In terms of longer term vaccination delivery plans and estimations around completion of second doses it was confirmed these were being worked up and once a paper was taken to the Executive Team it would be shared with Board members.		22.6.21 Current planning on known Vaccine supply and uptake rates has us completing 2nd Vaccines by the end of September, this is in line with current required gap of 8 and 12 weeks and Milestone 3 being completed (1st dose) by end of July.	
G Harris	**21.83.7** Share the approved matrices with the partners within that tri-partite arrangement.	3.6.21	22.6.21 Approved matrices shared with tri-partite with covering letter from CEO	Closed

S Green	**21.84.8** Share the headlines and associated actions from a recent survey undertaken in the autumn of 2020 at a future Board meeting	July	6.7.21 Paper on July Board agenda	Closed
J Whitehead M Wilkinson	**21.85.7** Ensure that concerns are resolved by the next 0PMR report around the accuracy of the description of progress, and the level of confidence in the processes to ensure the data as depicted in reports is signed off and accurate.	July Board	6.7.21 The Executive Team have discussed this report and committed to strengthening the quality of it. For 21/22 annual plan monitoring, and following anticipated plan approval in July, it is intended to bring the first plan monitoring report to the relevant Committees in August and thereafter to board and committees aligned to their bi-monthly meeting frequency	closed
M Wilkinson	**21.86.2** Explain and circulate issue around CAMHS recovery actions which were reported as being set out on page 28.	27.5.21	21.5.21 Updated information circulated	Closed
G Harris	**21.90.2** Confirm when the letter to patients on waiting lists and for General Practitioners will be ready for circulation	27.5.21	20.5.21 Confirmed during latter part of meeting that the letter should be ready within next 10 days. 22.6.21 Letters now circulated	Closed
C Stockport	**21.90.3** Follow up issues around messaging regarding primary care pressures with the corporate communications team.	3.6.21	22.6.21 Followed up with Communications Team and with WG Communications Team	Closed
A Guha	**21.91.8** Confirm a date for staff engagement event on RCS vascular report.	3.6.21	Event arranged for 15.6.21	Closed
A Guha	**21.91.9** Meet with the QSE Committee Chair separately to refine and agree the narrative and granularity of actions particularly around pathways.	27.5.21	Meeting convened	Closed
J Whitehead	**21.91.10** Clarify as to when investment of resources would be	3.6.21	22.6.21 The Operational Lead (Neil Rogers) has been appointed	Closed

	confirmed to assist in response to vascular report.		7.7.21 Patrick Johnson undertaking Vascular Programme Lead	
L Brereton	**21.92.1** Ensure new Standing Orders and Standing Financial Instructions be published following adoption by Board.	10.6.21	Published to public facing website	Closed
C Stockport	**21.96.3** Ensure a better read across within the Digital Strategy in terms of the Welsh language, and liaise with Morwena Edwards regarding discussion at the More Than Just Words forum.	June	Meeting arranged between Morwena Edwards and Andrea Williams on 7.7.21 to take this forward	Closed
M Polin	**21.96.4** Arrange further meeting with Bob Hudson regarding collective engagement approach around digital services.	27.5.21	Meeting arranged for 20.7.21	Closed

V220

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15 July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Chief Executive's report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Jo Whitehead, Chief Executive
Awdur yr Adroddiad **Report Author:**	Louise Brereton, Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Jo Whitehead, Chief Executive
Atodiadau **Appendices:**	Appendix 1 : Welsh Health Specialised Services Committee Chair's assurance report from 11.5.21 Appendix 2 : The NHS Wales Shared Services Partnership Committee Chair's assurance report from 20.5.21

Argymhelliad / Recommendation:

That the Health Board notes the report of the Chief Executive.

Please tick 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**	✔

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

Sefyllfa / Situation:

The purpose of this report is to keep the Board up to date with key issues affecting the organisation and highlights topical areas of interest to the Board.

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

Cefndir / Background:

This report seeks to update Board members on the activities, engagements and key meetings undertaken by the new Chief Executive during induction and an overview of local and national developments of interest.

Asesiad / Assessment & Analysis

Chief Executive's meetings and events

Over the last couple of months, I have continued to meet and engage with colleagues and other stakeholders. In May, Mark Polin and I attended the unveiling of the Awyr Las charity commissioned artwork at Ysbyty Glan Clwyd. This is a really remarkable piece of artwork seeking to acknowledge the huge efforts of all BCU colleagues throughout the Covid 19 pandemic. We also went along to Ty Doctor in Nefyn and enjoyed meeting the practice team. I also joined some virtual workforce and organisational development session as part of our Mewn Unod Mae Nerth/Stronger Together approach which is progressing at pace and is enabling some dedicated reflection time for colleagues to consider what they see, feel and experience as part of the organisation.

In June, Mark and I visited Wockhardt UK Ltd in Wrexham who have played a leading role in the production of Covid 19 vaccinations. I also recently visited our Acute Medical Unit (AMU) Clinical Support Workers to hear about their support roles and in particular how important these have been to us in managing the impact of Covid 19. More recently, I went along to Roseneath Medical Practice in Buckley and heard about their role in the vaccination programme in the north-east of the patch as well as all of their usual services. Lastly, I was very interested to receive a tour of the Ysbyty Gwynedd Radiology Department and to meet Dr Kakali Mitra.

We have also had the pleasure in hosting two ministerial visits in the last few weeks. We were delighted to welcome Eluned Morgan, Minister for Health and Social Services to North Wales on Friday 18 June where she met colleagues from Wrexham ophthalmology services, vascular and planned care services in addition to a visit to Plas Madoc vaccination centre. On Wednesday 30 June, Lynne Neagle, Deputy Minister for Mental Health and Wellbeing joined us at the North Wales Adolescent Service (NWAS) unit in Abergele for a tour of the unit and met with colleagues and young people and later visited 'ICAN' in Flint.

Following the recent Senedd elections, we continue to meet our local incumbent and new Senedd Members, along with Members of Parliament (MPs) to keep them informed of service delivery, plans and to discuss any live issues.

Local updates

- **Management of COVID-19 Pressures**

At the time of writing, the UK is in the pre-peak stage of a third wave involving the Covid 19 delta variant and on the 18 June 2021, the First Minister announced that Wales was in the early stages of a third wave of COVID-19 infection. All North Wales counties have seen an increase in community infection rates over the last few weeks, with evidence of community transmission of the virus evident, and North Wales incidence rates exceeding the all Wales average. The repeated experience of the last fifteen months has been that a rise in community transmission rates has been associated with a rise in hospital admissions and nosocomial spread of COVID-19. While we hope this association has been weakened by vaccination, we continue to be vigilant in our preparedness for any future surge and in maintaining our systems to protect hospitals. In addition to the emergence of the third wave of COVID-19 infections, we are also now experiencing a surge in other respiratory viruses and there is potential for this to increase above usual seasonal rates. A further report on the Health Board's ongoing response to COVID-19 pressures is included on the Public Board agenda which discusses this and the ongoing vaccination programme further. I continue to extend my personal thanks to all staff at BCUHB for their ongoing work to keep our communities and colleagues safe.

- **North Wales Medical & Health Sciences School**

Following the submission of a Strategic Outline Case in July 2020, a Welsh Government Task & Finish Group chaired by Professor Elizabeth Treasure was set up last autumn to progress recommendations for Medical & Health Sciences School capacity on an all Wales basis. The group has membership from across Wales and includes the Chair and Chief Executive of BCUHB and Vice Chancellor of Bangor University. This work continues pace in Phase 2 with an objective of achieving final proposals to the Minister for Health and Social Care by the end of July 2021.

- **NHS 111- North Wales launch**

NHS 111 launched in North Wales on 22 June 2021. This enables patients in North Wales to be able to call111 for free access to urgent out-of-hours medical care and round-the-clock health support and guidance. Supported by the national team, the local launch involved a significant piece of awareness raising including radio coverage, press releases, an online toolkit with resources for partners and the public, display materials circulated to all hospital sites, GP and community pharmacies, and information for all staff on the BCUHB intranet.

- **PROMs-led Virtual Orthopaedic Follow-Up Model**

Wrexham Maelor Hospital have recently bid for a Health Service Journal award in respect of their local PROMs-led Virtual Follow-Up Pathway. This is a project which uses 'Oxford Hip and Knee scores' and x-ray to determine the clinical need for face-to-face follow-up. This was a pathway which was designed by our clinical team in Wrexham and implemented by the local Hospital Management Team. The project commenced last year and has found that 90% of follow-up hip and knee patients do not need further face-to-face consultation after their immediate 6-12 week wound check and can be virtually monitored or discharged. The level of activity undertaken in a virtual PROMs clinic is significantly higher than within a traditional Out Patient Department (OPD) clinic with increased value for money as a result.

- **HEIW (Health Education & Improvement Wales) Education Commissioning and Training Plan 2021/22**

Following submission of the HEIW 2021/22 Education Commissioning and Training Plan, it was confirmed by the Minister for Health and Social Services on the 7th December 2020 that funding would be provided to create additional medical training placements across Wales starting in August 2021, alongside increased funding for health professional education and training in other areas. Over the past 6 months the HEIW team have been supporting the national recruitment process and working to identify suitable training environments for these additional posts. Due to COVID, the UK recruitment process this year has been delayed but offers have continued to be issued to maximise fill rates across the UK. As part of the allocation of new posts from August 2021 BCUHB will be receiving 11 medical training placements across the region. Colleagues will be aware that recently Dr Emma Hosking was appointed to the new role of Associate Medical Director for Professional Development and will oversee the placement programme.

- **Armed Forces Covenant – North Wales Veterans Collaborative**

The Armed Forces Covenant is a pledge that together we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives. The Queen's Speech in May 2021 set out that the Armed Forces Covenant will be enshrined in law including around the delivery of the care and support from the NHS and Local Authorities. A bid to develop a North Wales Collaborative to respond to the requirements of the Covenant and to provide the very best health and mental health support to Veterans and their families to enable their ongoing valuable contribution to our communities has been made to the Covenant support fund. If successful, the programme would include the appointment of a dedicated lead to represent the voice of Veterans and their families and to ensure the Health Board meets the commitments of the covenant while creating a Veteran aware exemplar health service that responds to the needs of Veterans and their families. Ian Donnelly, Acute Director at Wrexham Maelor Hospital is leading this submission supported by Prof Arpan Guha, Acting Executive Medical Director and we look forward to the outcome of the submission in due course.

National updates

- **A Fit for the Future Programme for Government – Future Generations Commissioner**

Launched on 24 June, the Future Generations Commissioner, Sophie Howe, has set out the Fit for the Future programme, which seeks to ask Welsh Government to use progressive ideas and to collaborate with under-heard voices in order to help people into the secure and fulfilling work needed for Wales to recover from the COVID-19 pandemic. The programme can be found here - A Fit for the Future Programme for Government – The Future Generations Commissioner for Wales

- **Joint Committee reporting**
  - The Welsh Health Specialised Services Committee (WHSSC) met on 11 May 2021. The Chair's assurance report is included at appendix 1.
  - The NHS Wales Shared Services Partnership Committee (NWSSC) met on 20 May 2021. The Chair's assurance report is included at appendix 2.

Strategy Implications
There are no specific strategy implications within this report.

Options considered
There are no further options for consideration.

Financial Implications
There are no specific financial implications within this report.

Risk Analysis
The risk implications referenced within this report are covered in greater depth by supporting reports on the Public Board agenda.

Legal and Compliance
There are no specific legal and compliance implications within this report.

Impact Assessment
An impact assessment is not required to support this report.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – MAY 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 11 May 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:
https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

Minutes of Previous Meetings
The minutes of the meeting of 9 March 2021 were taken as read and approved.

Action log & matters arising
Members noted there were no outstanding actions or matters arising.

Chair's Report
The Chair's Report referred members to the forthcoming early retirement of Kevin Smith, Committee Secretary, on 31 May, and his return part time for around five weeks from 7 June, and the appointment of his successor, Jacqueline Evans, from 1 June 2021.

The Report also referred members to the Chair's Actions taken to approve the appointment of Professor Ian Wells as an Independent Member of the Joint Committee with effect from 1 May 2021 for an initial term of two years.

In addition, the Chair reported that Emrys Elias had tendered his resignation with effect from 31 May 2021 and that a nomination had been received for a successor, whose appointment would be dealt with later in the week by Chair's Action.

Members (1) noted the contents of the report; (2) ratified the appointment of Jacqueline Evans as Committee Secretary with effect from 1 June 2021; and (3) ratify the Chair's Action appointing Prof Ian Wells.

Managing Director's Report

The Managing Director's report, including updates on:

- Opening of the interim Mother & Baby Unit at Tonna Hospital;
- The south Wales Thoracic Surgery Strategic Outline Case (SOC);
- The PET Programme Business Case;
- The status of the audit of the 2020-21 Accounts;
- De-escalation the SBUHB TAVI service from level 3 to level 2;
- Removal of the CVUHB Paediatric Intensive Care service from escalation; and
- Removal of the SBUHB Soft Tissue Sarcoma service from escalation,

was taken as read.

It was agreed that SBUHB would circulate the Thoracic Surgery SOC to members.

South Wales Major Trauma Network (SWMTN) Update

Members received a presentation on the work of the SWTN from its opening in September 2020 to March 2021, which included a summary of the Delivery Assurance Group report. Members noted the content of the presentation and discussed elements of it in detail.

A further update will be provided to the Joint Committee meeting in six months' time.

Neonatal Transport Service for South and Mid Wales

Members received a paper that proposed a project structure and governance assurance framework as requested following Joint Committee's decision regarding the establishment of an Operational Delivery Network Transport Service for mid, west and south Wales in April 2021. It was noted that the proposed structure borrowed many features from the SWMTN model, which was regarded as exemplary.

Members noted (1) the proposed project management process and associated timeline; and (2) the draft commissioner assurance process, recognising that this would be subject to further discussion in the 'In Committee' section of the meeting and with the programme team.

Revised Risk Management Strategy

Members received a paper that presented the revised Risk Management Strategy (RMS) for WHSSC for approval and shared the latest version of the Corporate Risk Register for information.

Members (1) approved the revised Risk Management Strategy; (2) noted the latest version of the Corporate Risk Register; and (3) noted that further work is on-going to develop risk reporting in line with the RMS.

Activity Reports for Months 11 and 12 2020-21

Members received papers that highlighted the scale of the decrease in activity levels during the COVID-19 period, and whether there are any signs of recovery in specialised services activity. These activity decreases are shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements.

The Month 12 report been restructured from previous format to deal with specialties/areas on an all-Wales basis and would be developed further based on feedback received.

Members noted the information presented in the reports.

Financial Performance Report – Month 12 2020-21

Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position at was an under spend of £12.03m after making prudent provisions.

The under spend relates mainly to months 1-12 under spend on the pass through elements of NHS Wales provider SLA's, NHS England anticipated underperformance against agreed block contracts where provider activity is forecast at >20% below agreed baseline and Q1 – Q4 2020-21 development slippage. Owing to uncertainty regarding the pace of activity, recovery and timing of information flows from NHS England providers, WHSSC has adopted a prudent approach to providing for expenditure reductions that may arise from under-performance.

Members noted the content of the report.

Other reports

Members also took as read the update reports from the following joint Sub-committees and Advisory Groups:

- Management Group;
- All Wales Individual Patient Funding Request Panel;
- Quality & Patient Safety Committee; and
- Integrated Governance Committee

Standing Orders (SOs) and Standing Financial Instructions (SFIs)

The Committee Secretary reported that revised Model SOs and SFIs had recently been received from Welsh Government and that work was underway to review the WHSSC SOs and SFIs to propose any necessary changes. It was agreed that these would be the subject of a Chair's Action.

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	20 May 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Presentation on IP5

The Programme Director provided an update on the facility at Imperial Park, Newport (IP5). The building was originally purchased to provide contingency for a no-deal BREXIT but has proved to be invaluable in responding to the challenges provided by COVID and in developing additional services. The site was formally acquired by NWSSP in March 2019 and the original business case (prior to COVID) envisaged a number of services moving into the facility. Many of these have been achieved (Relocation of the Cwmbran Store and the HCS South East Regional Hub; Temporary Medicines Unit and the development of office space which is now being used by the Medical Examiner Service). Some planned developments have been either delayed or abandoned due to the impact of COVID (Theatre Kitting; WEQAs; Health Incubators and Baby Bundles). A number of services that were never envisaged prior to COVID have now been established in IP5 (Production of PPE Packs for Primary Care; Storage of Lateral Flow Test Kits; Storage of Renal Fluids and Pulse Oximeters; Medical Records Storage; establishment of the Temporary Medicines Unit; Picking of PPE and Diluent Packs for the Vaccination Programme and more recently the collation of support for India). Members were very appreciative of the presentation, and of the efforts of staff at the site, in supporting NHS Wales and the wider public sector over the last 12 months.

Presentation on Primary Care Services

The Director of Primary Care Services provided a presentation on how NWSSP could better support the objectives of the Strategic Programme for Primary Care. Traditionally, NWSSP Primary Care Services has been largely a transaction-based service but recent months and years have seen the development of a number of expert services. Focusing on Cluster development, the Director highlighted a number of recognised issues including governance and IT issues, evaluation of performance, and support for development. He saw a number of opportunities where NWSSP could assist further with Clusters, including governance and

workforce support, data management and Shared Care Interface. NWSSP would be acting on behalf of Health Boards in helping to drive this agenda, rather than looking to replace them, and could utilise standard systems and processes to tailor solutions to local circumstances. SSPC members were appreciative of the presentation and were particularly focused in ensuring that NWSSP made use of the data at its disposal to benefit the wider NHS community.

Managing Director's Report – the main issues noted were:

- Engagement with the Foundational Economy One of the key priorities in this year is to build opportunities for strengthening our engagement with the foundational economy in supply chain and procurement. Our Procurement Strategy embraces the Wales First principles nurturing local supply chains and provides opportunities via competitive tendering to promote economic regeneration, by ensuring equal opportunities via local, regional, and national strategies on all contracts for goods and services. By adopting these principles this improves the Welsh economic operators' abilities to access and realise opportunities, which in turn also provides significant environmental benefits by sourcing locally. We are continuing to engage with stakeholders and the market to enable foundational economy outcomes from our procurement processes.
- HCS – Electrification of Fleet - Our Health Courier Services recently took delivery of six fully electric vans that are the first in a number that have been ordered and which will be a key component in the implementation of our Decarbonisation Strategy.
- Annual Plan - Positive feedback has been received following the submission of the Annual Plan to Welsh Government and we are currently awaiting official feedback.
- Quality and Safety Committee - Arrangements have now been finalised with Velindre regarding the establishment of the Quality and Safety Committee which enables us to discharge the (Partnership) Committee's resolution on this matter from last September.
- TRAMS - We are in the process of appointing a Director of Pharmacy Technical Services to help manage the Transforming Access to Medicine Service. A revised Programme Board will also be established to drive forward both the OBC and FBC. The role of the SRO is likely to be held jointly between the NWSSP Managing Director and the Chief Pharmacy Officer, Welsh Government.

Items Requiring SSPC Approval

Scheme of Delegation

The Director, Legal & Risk Services presented a paper to request changes to the Scheme of Delegation in respect of the Existing Liabilities Scheme. The paper also covered a request to further extend the COVID expenditure limits to the end of September and to increase the ESR recharge limit from £750k to £1m. The SSPC ENDORSED these requests.

Legal & Risk Case Management System

The Director, Legal & Risk Services, presented a paper on the award of a Case Management System. Implementation of this system will deliver a host of benefits for NHS Wales, including enabling more administrative tasks to be undertaken by junior staff, and thereby freeing up the time of senior lawyers, and also providing an easier route for Health Boards to access information on cases relevant to them. The SSPC NOTED and ENDORSED the contract award.

PPE Strategy

The Director of Finance & Corporate Services introduced this item which included the recent Audit Wales review into the procurement and delivery of PPE which concluded positively, and particularly when compared to the NAO report into the arrangements in England. The task now is to deliver a longer-term strategy for PPE provision. The aim is to have the plan in place with effect from September 2021.

Oracle Finance and Procurement System Upgrade

The Director of Finance & Corporate Services provided a verbal update on progress with the new Oracle upgrade. It was noted that an update on the results of the User testing would be presented at a STRAD meeting later that day and a decision to progress with the update would be made once the results from the user testing had been reviewed.

Annual Governance Statement

The Head of Finance & Business Development presented the final draft Annual Governance Statement which will be formally approved at the end of June Audit Committee. The statement is largely positive, reflecting the challenging year of working in a pandemic, and for which external and internal audit reports have demonstrated that systems and controls have largely been maintained, whilst measures implemented in direct response to the pandemic (e.g. PPE provision and site safety) have been successful. There were no limited or no assurance reports and only a very small number of control weaknesses identified, which had previously been reported to the Committee. There are still a few aspects of the statement which are still in draft. The Committee ENDORSED the statement for formal approval at the June Audit Committee.

Service Level Agreements

The Head of Finance & Business Development presented a paper on changes to the SLAs in place between NWSSP and health organisations across Wales for provision of services. The SLAs require formal annual review and approval by the SSPC. It was noted that both Digital Health and Care Wales and Health Education and Improvement Wales became full members of the Partnership Committee with effect from 1 April. The SSPC APPROVED the updated SLAs.

Audit Committee Terms of Reference The Head of Finance & Business Development presented an updated Terms of Reference for the Shared Services Audit Committee which the Committee APPROVED.
Finance, Workforce, Programme and Governance Updates
Laundry Services - Three of the current five NHS laundries in Wales transferred over to NWSSP on 1 April 2021 as planned. Work is now on-going to improve the facilities and arrangements for each of these laundries, and to implement the operational SLAs that have previously been agreed at Committee. Further work is being undertaken with Cwm Taf Morgannwg UHB and Hywel Dda UHB to enable the two remaining laundries to be transferred later in the year. Project Management Office Update – The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed. Finance and Workforce Report – The final position for 2020/21 was that all financial targets had been met and NWSSP achieved planned surplus of £21K (after a £2m distribution to Health Boards and Trusts), subject to external audit. The total expenditure for Welsh Risk Pool for 2020/21 was £123.8m and the Risk Share agreement was invoked at the IMTP value of £13.8m. Corporate Risk Register – there remain one red risk on the register, relating to the replacement of the NHAIS system. A new risk has been added following a number of attempted bank account mandate frauds in March, but procedures have been further strengthened to protect against this. Issues and Complaints 2020/21 Annual Report – The report highlighted a slight drop in the number of complaints and an improvement in response times. Finance Monitoring Reports – the Committee were provided with the monitoring returns for Months 12 and 1 for information. Audit Committee Assurance Report – the report relating to the Audit Committee held on 20 April was provided for information.
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to NOTE the work of the SSPC and ensure where appropriate that Officers support the related work streams.
Matters referred to other Committees
N/A

Date of next meeting	22 July 2021

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Covid-19 Pandemic Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Sally Baxter
Craffu blaenorol: **Prior Scrutiny:**	This paper has been approved by the Executive Director of Nursing and Midwifery / Covid-19 Gold executive lead.
Atodiadau **Appendices:**	-

Argymhelliad / Recommendation:

The Board is asked to note the report and supporting presentation which will be given at the Board meeting and endorse decisions made by the Executive Incident Management Team (EIMT).

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**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

The paper provides an update report on previously established Covid-19 response mechanisms.

Sefyllfa / Situation:

This report provides a supplementary brief to the Covid-19 Pandemic update presentation, which will be given at the Board meeting of 15 July 2021.

The paper also notes key decisions taken by the Executive Incident Management Team since the previous Board update, which have been presented to Executive Team and to the Board members through verbal and written briefings.

Cefndir / Background:

The Board has received previous presentations and reports setting out the Health Board's approach to ensuring the appropriate level of oversight and scrutiny in the discharge of its responsibilities whilst responding to the ongoing Covid-19 Pandemic.

The Executive Incident Management Team was established to ensure Executive oversight of key programmes of activity, direction and support for actions at tactical and operational level, and ensure issues are escalated as required and key decisions recorded. Issues relevant to collaborative working with partners have also been reported through the Strategic Co-ordinating Group of the North Wales Local Resilience Forum, which has now been stood down. Ongoing partnership work is continuing through the Recovery Co-ordinating Group.

Asesiad / Assessment & Analysis

The Welsh Government (WG)had been easing the Covid restrictions in place in Wales, in response to the improving position in terms of community transmission, hospital admissions and deaths, alongside the excellent progress being made with the vaccination programme. The revised Coronavirus Control Plan set out how WG will move through alert levels and plan for the future. Currently Wales is moving in a phased approach from alert level 2 to level 1.

However, over recent weeks there has been a rapid increase in Covid-19 incidence in the community, linked to the Delta variant. In particular, incidence in North Wales has surged, ahead of the rest of Wales, linked to clusters and incidents related to returning travellers and cross-border flow as well as local transmission. The situation has now moved to a control scenario as broader community transmission is occurring.

Revised scenario modelling was issued in June 2021 to take account of the impact of Delta variant, predicting a peak in cases by end of July and a peak in hospitalisation by August (all Wales projections.) As at 02 July, notwithstanding the increased levels of community transmission, the levels of hospital admission have not increased significantly. This will however require close monitoring and rapid response if the position changes. The impact on communities however is not insignificant, and demand on the testing and tracing teams has escalated.

Regional and national response forums had reduced in frequency and scope, with the North Wales Strategic Co-ordinating Group having stood down at the end of April, with the Recovery Co-ordinating Group (RCG) recommencing. The RCG is maintaining close surveillance on the situation.

In response to the general stabilisation, EIMT reduced in frequency of meetings and has been meeting weekly. EIMT is currently maintaining a fortnightly meeting, and continuing the monitoring and surveillance role on Covid transmission, and impact of any significant incidents or outbreaks, for escalation as required.

As confirmed previously, a detailed decision log is maintained within the suite of EIMT documentation.

Since the previous update to the Board on 20 May 2021 the following key decisions have been recorded:

- Approval of Standard Operating Procedures (SOPs) for the Covid-19 vaccination programme
- Approval of proposals for future use of Ysbyty Enfys Deeside and alternative vaccination centre premise in other areas
- Approval of revised maternity visiting guidance, including implementation of Lateral Flow Device (LFD) testing for visitors

Strategy Implications
All proposals are considered in terms of the overall strategic implications and consistency with the level of Covid escalation at the time.

Options considered
Proposals for significant change have included high level assessment of potential options, proportionate to the scale and impact.

Financial Implications
EIMT has noted where there are financial implications arising from proposals, which are managed through divisional budgets or through specific programmes (such as the vaccination programme, or the planned care delivery programme.)

Risk Analysis
Risk assessment is provided to support specific proposals referred to EIMT. A risk log is kept of significant programme risks overall. All risks are entered on Datix and the Health Board's Risk Management Group maintains oversight of this.

Legal and Compliance
Any specific legal implications would be recorded within the EIMT documentation.

Impact Assessment
Impact assessment is part of the process of development and submission of proposals. Any potential impact on patient care and outcomes is identified within risk assessment. Welsh language and equality impact screening has been undertaken in relation to the overarching programmes in the Covid response (such as Test, Trace and Protect, and the Covid vaccination programme.) The socio-economic duty will also be addressed in any future significant strategic programmes or proposals.

Diweddariad Covid-19 Update

Gorffennaf 15 July

2021

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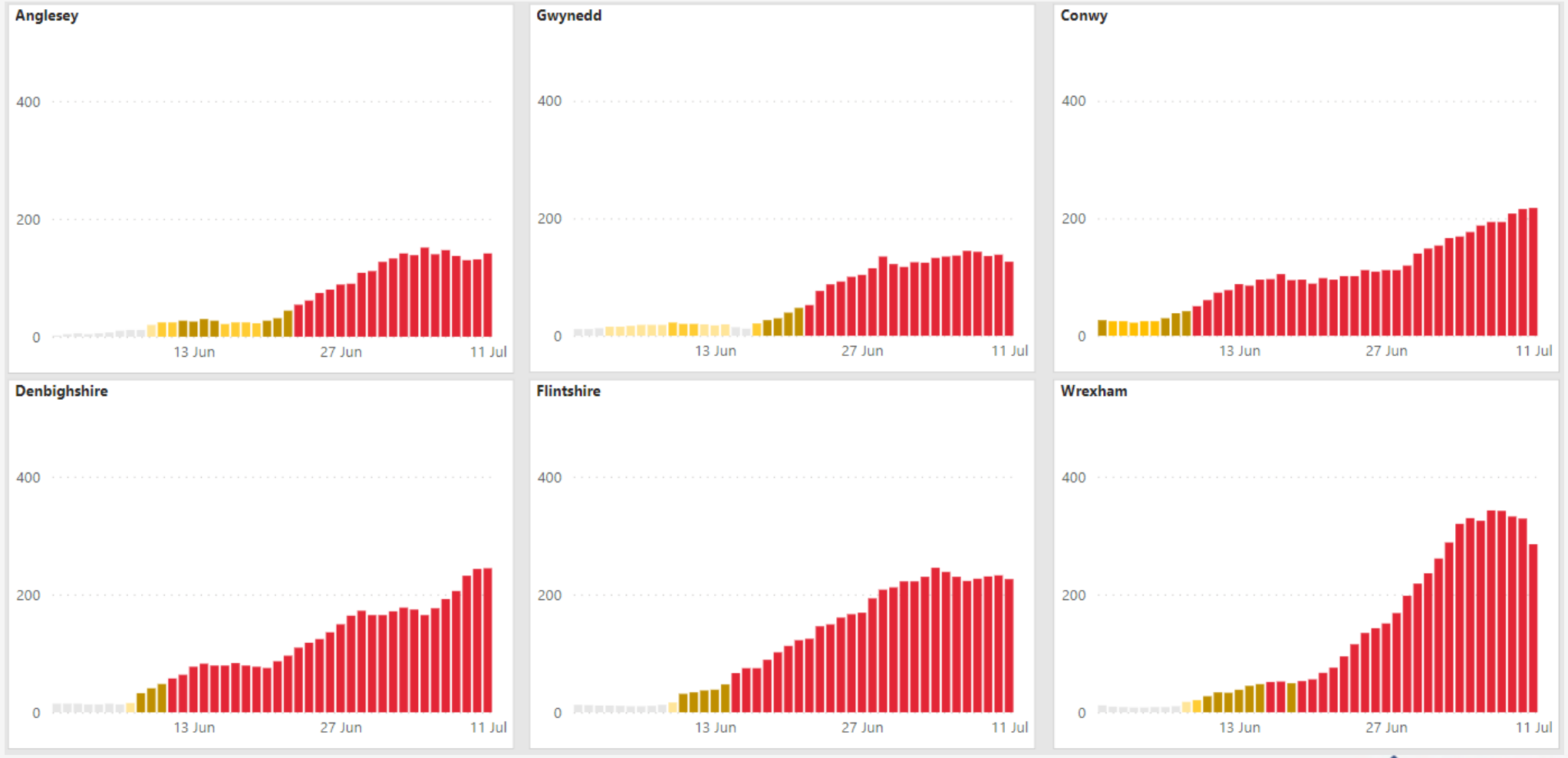
Amlder ac Effaith

Prevalence and Impact

Lefelau yn y Gymuned

Community levels



31 Mai / May 2021 – 11 Gorffennaf / July 2021

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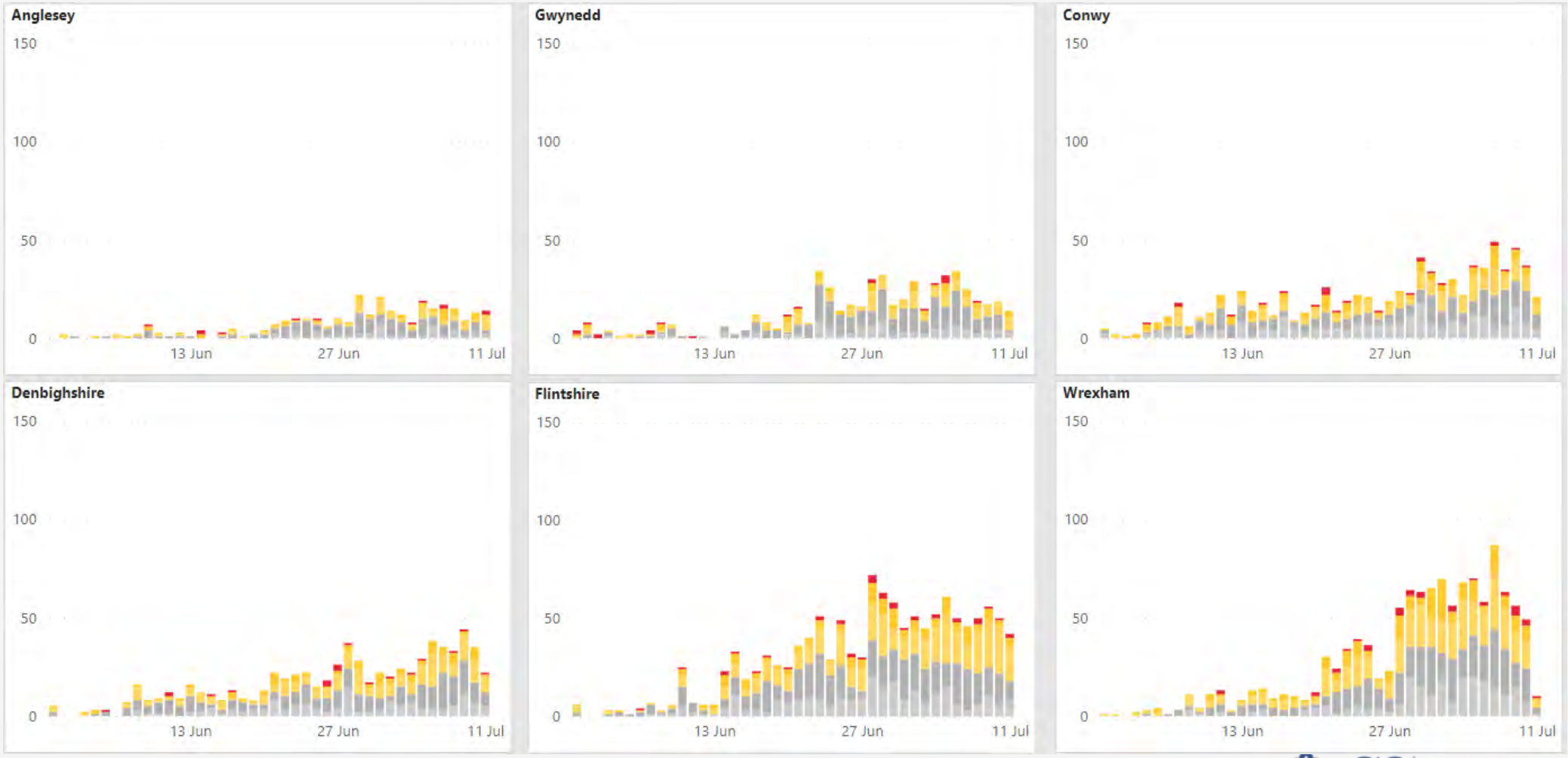
Achosion wedi'u cadarnhau yn ôl oedran

Confirmed cases by age



Age: 0-15, 16-29, 30-49, 50-69, 70 and over

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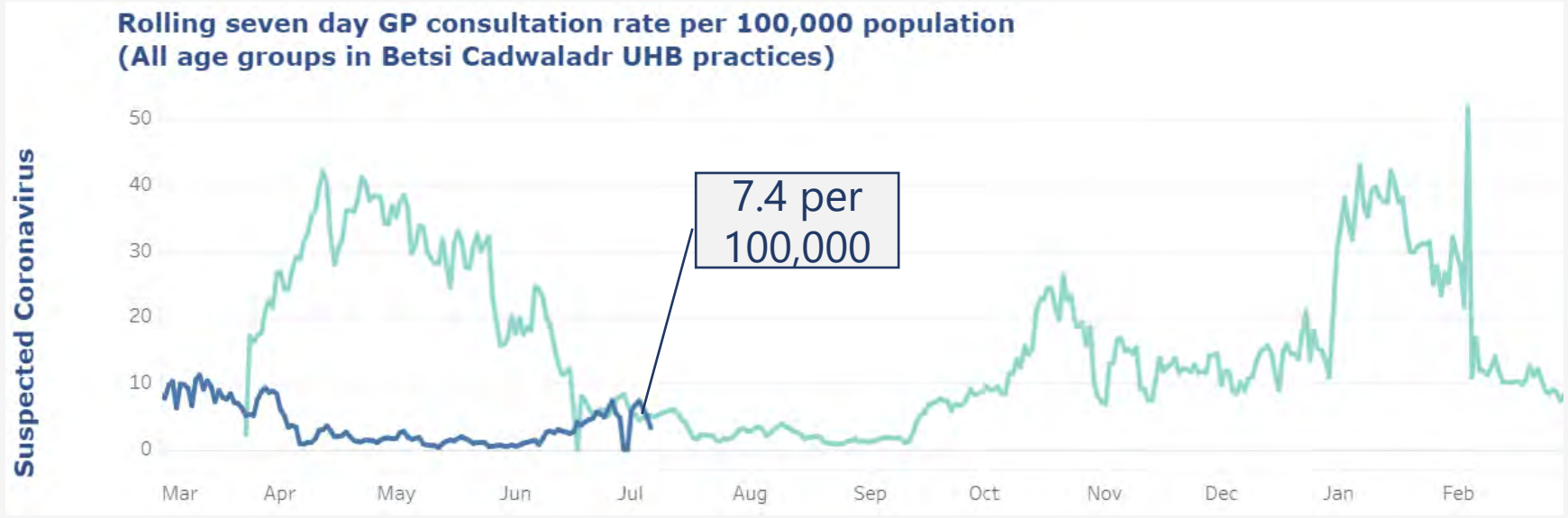
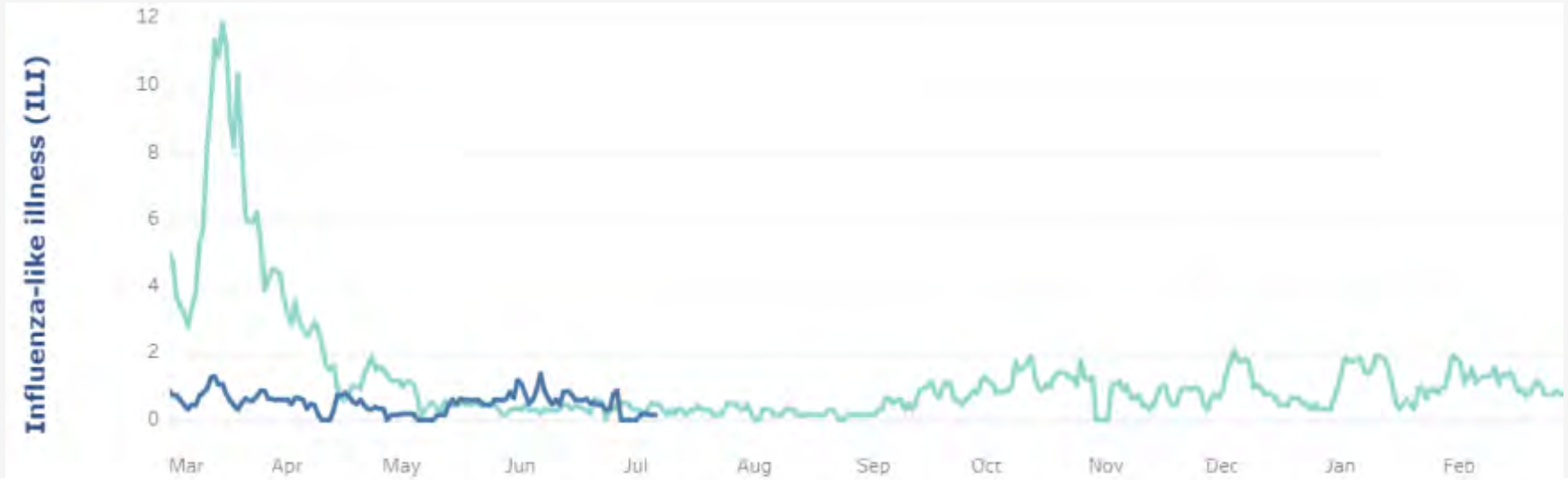
Gofal Cychwynnol - Meddygon Teulu

Primary Care - General Practitioners





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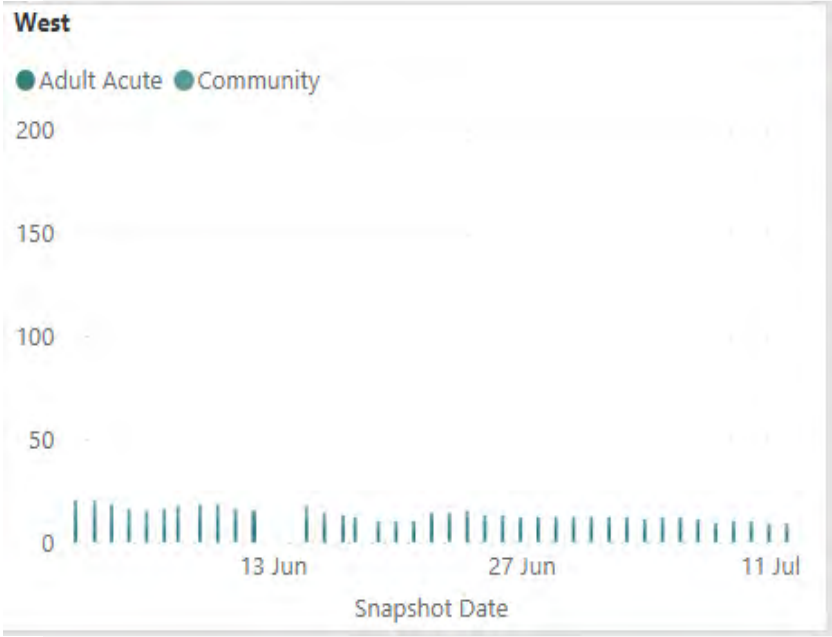
Gofal Cychwynnol

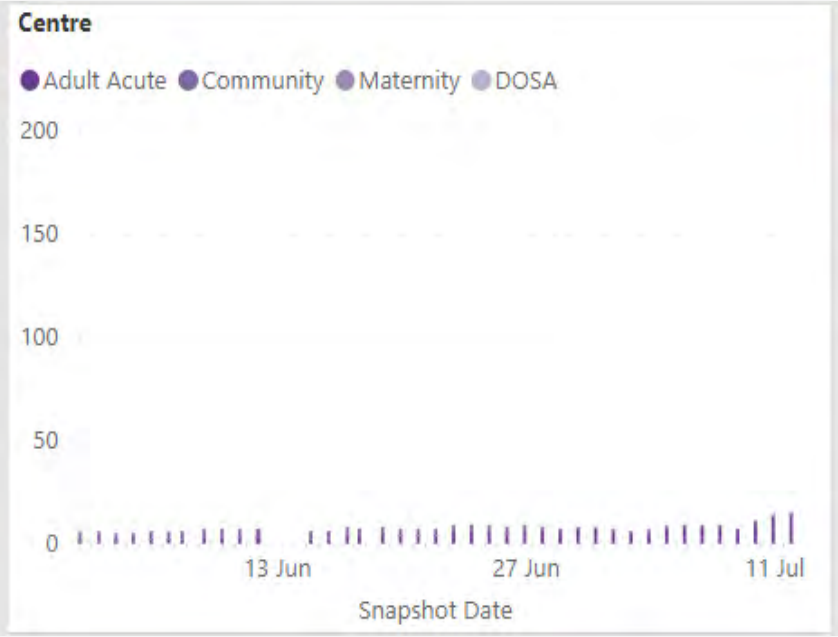
- Mae ymgynghoriadau wyneb yn wyneb wedi parhau ochr yn ochr â chynnydd mewn ymgynghoriadau rhithwir ar gyfer meddygfeydd MT – gymaint ag 20% o gynnydd mewn gweithgaredd
- Heriau sefydlogrwydd a chynaliadwyedd meddygfeydd wedi'u gwaethygu gan effaith Covid
- Fferyllfa yn darparu gwasanaethau cynyddol o dan y Cynllun Cyflyrau Cyffredin a mynediad at brofi a brechu.
- Heriau ar gyfer gwasanaethau deintyddol ac optometreg oherwydd lle ac awyru, defnydd o ymgynghoriadau rhithwir, ac ôl -groniad mewn galw am ofal arferol.

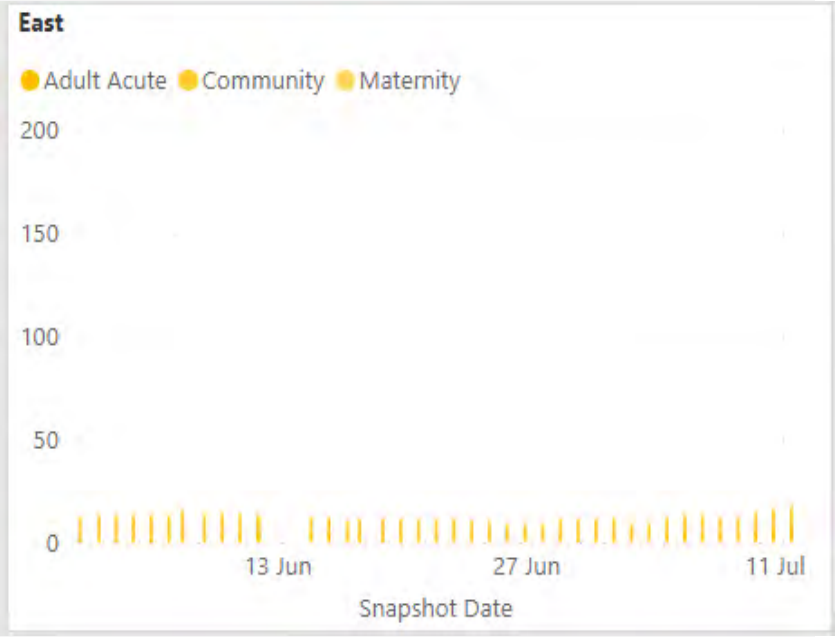
Primary Care

- Face-to-face consultations have continued alongside increase in virtual consultations for GP practices – as much as 20% increase in activity
- Practice stability and sustainability challenges exacerbated by Covid impact
- Continued support to deliver the Covid vaccination programme
- Pharmacy providing increased services under Common Ailment Scheme and access to testing and vaccination
- Challenges for dental and optometry services from space and ventilation, use of virtual consultation, and backlogs in demand for routine care

Cleifion Mewnol Ysbytai - Covid-19 - Hospital Inpatients







41 o gleifion mewnol
41 inpatients

11.07.21

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Haint a gafwyd yn yr Ysbyty

- Cyhoeddi achosion yn Uned Heddfan, Wrecsam, ar 29 Mehefin 2021
- Un ward, Hydref wedi'i effeithio
- Cyfanswm cronnol o 9 o gleifion a 4 staff, HCAI tebygol neu bendant fel ar 11 Gorffennaf.
- Aros am gadarnhad o achos cyfeirio

Healthcare Acquired Infection

- Outbreak declared at Heddfan Unit, Wrexham, on 29 June 2021
- One ward, Hydref, affected
- Cumulative total of 9 patients and 4 staff probable or definite HCAI as at 11 July
- Awaiting confirmation of index case

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Risgiau a materion ar y cyfan

- Effaith ar gapasiti gwasanaethau cychwynnol a chymunedol
- Absenoldebau staff cynyddol posibl
- Arweiniad ymweld â'r ysbyty gan gynnwys ymweld â'r adran famolaeth
- Risg cynyddol o drosglwyddiad nosocomiaidd gyda digwyddiadau cymunedol cynyddol
- Parodrwydd – cynlluniau uwchgyfeirio ar gyfer bob gwasanaeth gan gynnwys gofal critigol

Overall risks and issues

- Impact on primary and community services capacity
- Potential increasing staff absences
- Hospital visiting guidance including maternity visiting
- Increased risk of nosocomial transmission with increasing community incidence
- Preparedness – escalation plans for all services including critical care

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Profi, Olrhain, Diogelu

Test, Trace, Protect

Diweddariad TTP

TTP Update

Profi: galw cynyddol ar draws Gogledd Cymru. Amser cael canlyniadau yn oddeutu 92% ar gyfer Gogledd Cymru. Cynlluniau profi ychwanegol wedi'u cwblhau

Olrhain: Achosion cyfeirio yn parhau i gynyddu: 1,390 mewn 7 diwrnod hyd at 3 Gorffennaf; cysylltiadau 5,533 ar gyfer yr un cyfnod

Amddiffyn: pedwar Hwb Cefnogi Covid wedi'u sefydlu a phumed i fod yn weithredol o 12 Gorffennaf

Risgau: Capasiti ar gyfer profi ac olrhain fel mae busnes arferol yn dychwelyd; effaith symptomau estynedig ar gyfer profi Covid

Testing: increased demand across North Wales. Testing turnaround time is around 92% for North Wales. Surge testing plans completed

Tracing: index cases continuing to increase: 1,390 in 7 days to 3 July; contacts 5,533 for the same period

Protect: four Covid Support Hubs established and fifth to be operational from 12 July

Risks: capacity for both testing and tracing as business as usual returns; impact of extended symptoms for Covid testing

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Rhaglen Brechu

Vaccination programme

Brechlynnau

Hyd at 5 July, rydym wedi rhoi dros 878,000 brechlyn Covid-19 yng ngogledd Cymru

Mae hyn yn cynnwys bron i 380,000 ail ddos

Vaccinations

As at 5 July, we have given over 878,000 Covid-19 vaccines in North Wales

This includes nearly 380,000 second doses

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Carfannau JCVI

JCVI Cohorts

Carfan		Cohort	Dos 1af / 1st dose	Ail ddos / 2nd dose
Preswylwyr cartrefi gofal pobl hŷn a'u gofalwyr	1	Older adult care home residents and their carers	106% - 92%	96% - 85%
Pawb sy'n 80 oed a hŷn a staff rheng flaen iechyd a gofal cymdeithasol	2	All those 80 years of age and over and frontline health & social care workers	99% - 99% - 101%	95% - 94% - 99%
75 oed a hŷn	3	75 years of age and older	99%	96%
70 oed a hŷn	4a	70 years of age and older	98%	95%
16 – 64 oed gyda chyflyrau iechyd gwaelodol a gofalwyr di-dâl cymwys	4b	16 – 64 years with underlying health conditions and eligible unpaid carers	97%	92%
65 oed a hŷn	5	65 years of age and older	96%	94%
Oedolion yn wynebu risg cymedrol o dan 70 oed	6	Moderate risk adults under 70 years of age	91%	82%
Gweddill y rhai 60 oed a hŷn	7	Remaining 60 years of age and over	92%	88%
Gweddill y rhai 55 oed a hŷn	8	Remaining 55 years of age and over	91%	84%
Gweddill y rhai 50 oed a hŷn	9	Remaining 50 years of age and over	93%	84%
Gweddill yr oedolion dan 50 oed	10	Remaining adults aged under 50	84% - 70% - 78%	42% - 18% – 22%

Brechlynnau – symud ymlaen

- Mae pob oedolyn 18 oed a throsodd wedi cael cynnig brechiad
- Trefnu apwyntiadau ar lein nawr ar agor i bawb
- Targedu grwpiau a lleoliadau risg uchel
- Gostwng y bwlch o 8 wythnos rhwng brechiadau
- Terfynu trefniadau'r Canolfannau Brechu Torfol ar gyfer y cam nesaf
- Cyfathrebu cenedlaethol a lleol yn targedu pobl iau – mae cyfraddau brechu carfan 10b (30-39 oed) yn parhau i fod yn is nag oedrannau eraill
- Mae JCVI wedi cadarnhau y bydd carfannau 1-9 yn gymwys ar gyfer y rhaglen atgyfnerthu, ynghyd ag unrhyw un 16-49 oed sy'n gymwys ar gyfer y brechiad ffliw blynyddol

Vaccinations – going forwards

- All adults aged 18 and over have been offered a vaccination
- Online booking now open to all
- Targeting high risk groups and settings
- Reduced interval of 8 weeks between vaccinations
- Finalising Mass Vaccination Centre arrangements for the next phase
- National and local communication targeting uptake in younger people – cohort 10b (30 – 39 year olds) continues to have a lower take-up rate than other ages
- JCVI have confirmed that cohorts 1 – 9 will be eligible for the booster programme, together with anyone aged 16 – 49 entitled to the annual flu vaccination

Canolfannau Brechu

Gorllewin
- Eglwys Gadeiriol Bangor
- Canolfan Tennis Caernarfon
- Canolfan Hamdden Dolgellau
- Ysbyty Alltwen
- Ysbyty Penrhos Stanley

Canol
- Canolfan OpTic (*13 Gorffennaf ymlaen*)
- Venue Cymru (*hyd at 31 Gorffennaf*)
- Ffordd Argyll, Llandudno (*4 Awst ymlaen*)
- Canolfan Adnoddau Cymunedol, Bae Cinmel
- Canolfan Cymuned Ffordd Wellington, y Rhyl
- Eirianfa, Dinbych
- Coed Pella, Bae Colwyn

Dwyrain
- Canolfan Hamdden Glannau Dyfrdwy
- Canolfan Catrin Finch, Wrecsam
- Canolfan Hamdden Plas Madoc
- Canolfan y Lleng Brydeinig, Llai

Vaccination Centres

West
- Bangor Cathedral
- Caernarfon Tennis Centre
- Dolgellau Leisure Centre
- Ysbyty Alltwen
- Ysbyty Penrhos Stanley

Centre
- OpTic Centre (*from 13 July*)
- Venue Cymru (*until 31 July*)
- Argyll Road, Llandudno (*from 4 August*)
- Community Resource Centre, Kinmel Bay
- Wellington Road Community Centre, Rhyl
- Eiranfa, Denbigh
- Coed Pella, Colwyn Bay

East
- Deeside Leisure Centre
- Catrin Finch Centre, Wrexham
- Plas Madoc Leisure Centre
- British Legion Centre, Llay

Hefyd rydym yn defnyddio 4 uned symudol, a chanolfannau codi dros dro.

We are also using 4 mobile units, and temporary pop-up centres.

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COVID Hir

Long-COVID

COVID-Hir: Modelu Data

- Gradd uchel o ansicrwydd o hyd o gwmpas COVID-Hir, yn nhermau symptomau, nifer y cleifion, amserlenni a gofynion cefnogi
- Tystiolaeth gychwynnol yn awgrymu fod cyffredinrwydd o leiaf un symptom am12 wythnos neu fwy yn amrywio o 2% i 10% mewn samplau cymunedol, i dros 70% mewn pobl sydd wedi bod yn yr ysbyty.
- Mae Adran Gwybodeg BIPBC yn dadansoddi data cleifion o amryw o ffynonellau i ddeall yn well pwysau cyfredol a disgwyliadwy o COVID-Hir ochr yn ochr â chyflyrau iechyd gwaelodol cyfredol.
- Mae dangosyddion cynnar yn awgrymu y dylem ddisgwyl 3,000 – 4,000 o gleifion COVID-Hir ar draws Gogledd Cymru a fydd angen cefnogaeth a therapïau dros y flwyddyn sydd i ddod ac o bosib y tu hwnt i hynny.

Long-COVID: Data Modelling

- Still a high degree of uncertainty around Long-COVID, in terms of symptoms, volume of patients, timescales and support requirements
- Initial evidence suggests that prevalence of at least one symptom for 12 weeks or more ranges from around 2% to 10% in community samples, to over 70% in people who have been hospitalised.
- BCUHB Informatics are analysing patient data from various sources to better understand current and anticipated emerging demand pressures of Long-COVID alongside existing underlying health conditions
- Early indications suggest we should expect 3,000 - 4,000 Long-COVID patients across North Wales requiring support and therapies over coming year and possibly beyond.

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Llwybrau Gofal Cleifion COVID-Hir

- Mae'r ffrwd gwaith hwn wedi mabwysiadu egwyddor gref o gyd-ddylunio gan weithio'n agos gydag arbenigedd cleifion trwy grwpiau profiad ac ymarferwyr clinigol i ddylunio llwybr gofal i gwrdd ag anghenion a disgwyliadau'r boblogaeth.
- Aliniad gyda Llwybr Gofal Cymunedol Cymru gyfan a strategaethau cenedlaethol a lleol perthnasol i gyflawni 'gofal yn agosach i gartref' a grymuso a chefnogi ein cleifion i hunan reoli cyflyrau lle bynnag bo'n briodol a phosibl.
- Cynllun Busnes yn cael ei ddatblygu ar gyfer Timau Aml-ddisgyblaethol COVID-hir rhanbarthol i gynnwys: Meddyg ac Uwch Nyrs Ymarferydd i wneud archwiliadau meddygol a diogelwch, Seiciatrydd Clinigol, Ffisiotherapydd, Therapydd Galwedigaethol, Dietegydd, Therapydd Iaith a Lleferydd a chefnogaeth weinyddol bwrpasol.

Long-COVID Patient Pathways

- This workstream has adopted a strong principle of co-design working closely with patient expert by experience groups and clinical practitioners to design a pathway to meet needs and expectations of the population.
- Alignment with All-Wales Community Pathway and relevant national & local strategies to deliver 'care closer to home' and empower & support our patients to self-manage conditions wherever appropriate & possible.
- Business Case in development for regional Long-COVID Multi-Disciplinary Teams to include: Medic and Advanced Nurse Practitioner to carry out medical & safety checks, Clinical Psychiatrist, Physiotherapist, Occupational Therapist, Dietician, Speech & Language Therapist and dedicated Admin support.

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Rhaglen Addysg ar gyfer Cleifion

- Mae BIPBC yn falch o fod wedi datblygu'r Rhaglen Hunan-Reolaeth EPP cyntaf yn y DU wedi'i deilwra'n benodol ar gyfer cleifion sy'n dioddef o COVID-Hir
- Mae'r 3 charfan cyntaf wedi cwblhau'r cwrs gyda 55 o fynychwyr wedi cofrestru. Mae 4ydd carfan ar y ffordd gyda 10 claf arall ac mae'r cyrsiau nesaf wedi'u trefnu i ddechrau ym mis Awst a Hydref 2021.
- Mae adborth ar yr arddull, cyflwyniad a'r cynnwys wedi bod yn hynod o bositif – mae grwpiau cleifion wedi nodi y byddent yn argymell hwn ar gyfer bob claf sy'n dioddef o COVID-Hir
- Mae capasiti EPP ychwanegol yn cael ei gynnwys yn ein Cynllun Busnes ar gyfer gwasanaethau COVID-Hir

Education Programme for Patients

- BCUHB are proud to have developed the first EPP Self-Management Programme in the UK specifically tailored for patients suffering with Long-COVID
- First 3 cohorts have completed the course with 55 registered attendees. A 4th cohort is underway with a further 10 patients and next courses scheduled to commence August & October 2021
- Feedback on the approach, delivery & content has been overwhelmingly positive – patient groups have indicated that they would recommend this approach for all patients suffering from Long-COVID
- Additional EPP capacity is being included in our Business Case for Long-COVID services

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National progress updates

Diweddariadau cynnydd cenedlaethol

Ar gyfer Cleifion:

- Mae'r ap COVID-Hir cenedlaethol wedi cael ei lawr lwytho 6,000 o weithiau ar draws Cymru
- Mae llawr lwythiadau yn cael eu mapio ac ymddengys eu bod yn cydberthyn i heintiau COVID -19 ar draws Cymru – datblygwyr yn paratoi data manwl yn ôl ardal Awdurdod Lleol i alluogi Timau Gwybodeg i ddadansoddi fel bydd angen

Ar gyfer Clinigwyr:

- Sefydliad Gwyddorau a Thechnoleg Clinigol wedi lansio canllaw Cymru gyfan ar gyfer COVID-Hir 18.06.21
- Gwybodaeth yn cael ei ddiweddaru'n rheolaidd ar wefan ICST i gefnogi ymarferwyr clinigol. https://allwales.icst.org.uk/guidelines/all-wales-guideline-for-the-management-of-long-covid

For Patients:

- National Long-COVID app has been downloaded over 6,000 times across Wales
- Downloads are mapped and appear to correlate with COVID-19 infections across Wales - developers preparing detailed data by Local Authority area to enable Informatics Teams to analyse as required

For Clinicians:

- Institute of Clinical Science and Technology launched all-Wales guidance for Long-COVID 18.06.21
- Information kept updated regularly on ICST website to support clinical practitioners https://allwales.icst.org.uk/guidelines/all-wales-guideline-for-the-management-of-long-covid/

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Betsi Cadwaladr
University Health Board

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
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:**	Professor Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Heulwen Hughes, All Wales Approvals Manager for Approved Clinicians and Section 12(2) Doctors
Craffu blaenorol: **Prior Scrutiny:**	N
Atodiadau **Appendices:**	**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 **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 approvals and removals to the All Wales Register of Section 12(2) Doctors and the Register of Approved Clinicians

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

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

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.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / 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.

Opsiynau a ystyriwyd / Options considered

This is a factual report for ratification purposes.

Goblygiadau Ariannol / Financial Implications

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

Dadansoddiad Risk / Risk Analysis

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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

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

Asesiad Effaith / 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 2021 – 22nd June 2021		
	AC	**S12 (2)**
Approvals and Re-approvals	14	3
Removed – Expired	2	0
Approvals suspended	0	0
Approvals re-instated – returned to work in Wales	0	0
Approval Ended	0	0
Retired	3	1
Removed – AC approved	N/A	2
No longer registered		0
Transferred from AC register	N/A	0
Approval Ended as no longer working in Wales	0	2
Registered without a licence to practice	0	0
RIP	0	1

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 2021 – 22nd June 2021

Approvals and Re-approvals – 14

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Odume	Anthony Nketatabuife	Bro Hafren Community Mental Health Team, Back Lane, Newtown SY16 2NG	03 May 2026	Yes
Marshall	Derek John	Elysium Healthcare, Cefn Carnau, Thornhill, Caerphilly, CF83 1LX	31 January 2022	Yes
Dhadesugur	Seshadri	Ysbyty Cwm Cynon, New Road, Mountain Ash, CF45 4BZ.	03 February 2025	Yes
Adrover-Amengual	Maria del Mar	Hafod Y Wennol A&T Unit, Hensol Suite, Pontyclun CF73 8YS	09 May 2026	Yes
White	Colin	Ablett Unit, Ysbyty Glan Clwyd, Sarn Lane, Boddelwyddan, Rhyl LL18 5UJ	17 May 2026	Yes
Turic	Dragana	YOD Team, Cariad, Barry Hospital, Colcot Road, Barry, CF62 8YH	18 May 2026	Yes
Price	Jonathan Raymond	Hergest Unit, Ysbyty Gwynedd, Bangor LL57 2PW	19 May 2026	Yes
Callaghan	Rhiannon	MHSOP, Llanfar Unit, University Hospital Llandough, Penlan Road, Llandough, Cardiff CF64 2XX	19 May 2026	Yes

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Collins	Ann Louise	Block D, Neath Port Talbot Hospital, Baglan Way, Port Talbot, SA12 7BX	27 May 2026	Yes
Bugelli	Tania	Liaison Psychiatry Department, Ablett Unit, Ysbyty Glan Clwyd, Sarn Lane, Boddelwyddan, Rhyl LL18 5UJ	31 May 2026	Yes
Dojcinov	Ivana	Pinetree Court Hospital, 904 Newport Road, Rumney, Cardiff CF3 4LL	01 June 2026	Yes
Koumaris	Vasileios	SBUHB, Orchard Centre, Trinity Place, Swansea SA1 5DR	10 June 2026	Yes
Graver	Faye Helen	Substance Misuse Service, 5-7 Brighton Road, Rhyl, Denbighshire LL18 3EY	14 June 2026	Yes
Melichar	Jan Krzysztof	Dispensing and Treatment Team, (DATT), Angove Unit, Longcross Street, Cardiff CF24 0SZ	20 June 2026	Submitted 24.6.21

Approvals re-instated – 0

Surname	First Name	Workplace	Date Approval Expires

Approvals expired – 2

Surname	First Name	Workplace	Date Approval Expires
Sullivan	Gary	Trealaw Resource Centre, Brynteg Terrace, Trealaw, Tonypandy CF40 2PD	30 May 2021
Hussain	Basit	The Priory Hospital Church Village, Church Road, Tonteg, Pontypridd CF38 1HE	12 May 2021

Approvals Suspended – 0

Surname	First Name	Workplace	Date Approval Expires

Retired – 3

Surname	First Name	Workplace	Date Approval Expires
Hailwood	Rhoswen	Y Bwthyn Cottage Hospital, Hospital Road, The Common, Pontypridd CF37 5AL	10 May 2021
Ames	Samantha	Neath Port Talbot Child and Family Clinic, Children's Centre, Neath Port Talbot Hospital, Baglan Way, Port Talbot SA12 7BX	16 February 2022
Foster	Sarah	Fan Gorau, Montgomery County Infirmary, Llanfair Road, Newtown SY16 2DW	13 April 2025

No longer Registered – 0

Surname	First Name	Workplace	Date Approval Expires

No longer working in Wales – 0

Surname	First Name	Workplace	Date Approval Expires

Approvals Ended – 0

Surname	First Name	Workplace	Date Approval Expires

APPENDIX 2

Mental Health Act 1983

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

29th April 2021 – 22nd June 2021

Approvals and Re-approvals – 3

Surname	First Name	Workplace	Date Approval Expires	Chair's Action
Wortelboer	Yvonne Marie	CMHT. Central Clinic, 21 Orchard Street, Swansea, SA1 5AT	9 May 2026	Yes
Barkouk	Haitham	Caswell Clinic, Pen-y-fai, Bridgend CF31 4LN	19 May 2026	Yes
Ulfin	Yesupalan Rajam	DOLS Team, Vale of Glamorgan Council Dock Office, Subway Road, Barry Docks, Barry CF63 4RT	18 June 2026	Submitted 24.6.21

Expired – 0

Surname	First Name	Workplace	Date Approval Expires

Ended - 0

Surname	First Name	Workplace	Date Approval Expires

AC approved – 2

Surname	First Name	Workplace	
Heke	Sian	Orchard Centre, Trinity Buildings, Swansea SA1 5DL	20 August 2023
Price	Jonathan	Hergest Unit, Ysbyty Gwynedd, Bangor LL57 2PW	7 September 2025

No longer registered – 0

Surname	First Name	Workplace	Date Approval Expires

Transferred from AC Register – 0

Surname	First Name	Workplace	Date Approval Expires

No longer working in Wales – 2

Surname	First Name	Workplace	Date Approval Expires
Okigbo	Susan	Hergest Unit, Ysbyty Gwynedd Hospital, Penrhosgarnedd, Bangor, Gwynedd LL57 2PN	20 July 2021
Vikram	Udaya	Liaison Psychiatry, Ablett Unit, Glan Clwyd Hospital, Sarn Lane, Bodelwyddan, Nr Rhyl LL18 5UJ	1 February 2024

RIP – 1

Surname	First Name	Workplace	Date Approval Expires
Jones	David Alun	Private Address	2 December 2025

Retired – 1

Surname	First Name	Workplace	Date Approval Expires
Jones	Heledd Mair	Garngoch Hospital, Garngoch, Swansea SA4 4LH	13 January 2022

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Documents signed under seal 1.1.21 – 31.5.21
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Liz Jones, Assistant Director, Corporate Governance
Craffu blaenorol: **Prior Scrutiny:**	All the documents signed under seal listed have followed the appropriate approval route prior to sign-off.
Atodiadau **Appendices:**	A list of documents signed under seal processed during the time period 1.1.21 – 31.5.21 is presented at appendix 1.

Argymhelliad / Recommendation:

The Board is asked to note the list of documents signed under seal.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**No**

Not applicable to an update of this type.

Sefyllfa / Situation:

The Board is presented with a list of documents signed under seal at least twice per year, to comply with Standing Order 9.1.1.

Cefndir / Background:

Legal documents such as contracts, leases, land transfers, remedial works, licenses and deeds are required to have the Health Board's seal applied at the time of signing. Standing Orders require the Board to be sighted on the relevant list of documents.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Strategy implications would have been considered at the time that the business listed was originally approved via Board, Committees or Executive Team.

Opsiynau a ystyriwyd / Options considered

Not applicable to an update of this type.

Goblygiadau Ariannol / Financial Implications

Financial implications would have been considered at the time that the business listed was originally approved via Board, Committees or Executive Team.

Dadansoddiad Risk / Risk Analysis

Risks would have been considered at the time that the business listed was originally approved via Board, Committees or Executive Team.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Legal and compliance issues would have been considered at the time that the business listed was originally approved via Board, Committees or Executive Team.

Asesiad Effaith / Impact Assessment

Impact assessments would have been considered at the time that the business listed was originally approved via Board, Committees or Executive Team.

Appendix 1

Document	**Date of processing**
Licence for Works - Land on the South-East side of Grove Road, Wrexham	22.1.21
Lease of Land - South East side of Grove Road, Wrexham	22.1.21
License to Occupy on Short Term Basis - Unit D2, Parc Menai, Bangor	22.1.21
Lease Part of Penrhos Stanley Hospital, Penrhos Beach Road, Holyhead	22.1.21
HM Land Registry; Transfer of part of registered title TP1 re. Mount Street Clinic, Ruthin	10.3.21
Refurbishment Works at Mesen Fach & Bryn Enfys Building, Bryn y Neuadd Hospital	29.4.21
Installation of Door Top Alarms & New Nurse Call at Kestrel Ward (CAMHS), Abergele	29.4.21
Remedial Works at Tan Y Coed, Bryn y Neuadd	29.4.21
Improvement Works at Ty Llewelyn, Bryn y Neuadd	29.4.21
Deed of Release and Grant of Easement Land at Bron Ardd, Station Road, Llanfairfechan, Conwy	13.5.21

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Health and Safety 2020/21 Annual and Quarter 4 Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad **Report Author:**	Pete Bohan, Associate Director of Occupational Health, Safety & Security Sue Morgan, Head of Health and Safety
Craffu blaenorol: **Prior Scrutiny:**	Strategic Occupational Health and Safety Group 25th May 2021 Quality, Safety & Experience Committee 6th July 2021
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Board is asked to note the position outlined in the Annual and Quarter 4 Report support the recommendations identified within the findings:

1. Implement year 2 of the Occupational Health & Safety (OHS) Strategy.
2. Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
3. Ensure adequate staff and premises to provide Manual Handling training
4. Establish a permanent fit test program
5. Develop further policies and safe systems of work to provide evidence of practice.
6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators.
7. Train senior leaders and develop further competence in the workforce at all levels
8. Learn lessons from incidents and develop further the risk profile

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

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:

The Annual and Quarter 4 report provides an update on the work undertaken by the Corporate Health and Safety (H&S) Team during the period between the 1st of April 2020 and 31st of March 2021 with an overview of Q4 1st of January to the 31st of March 2021. The 2019/20 annual report identified that the BCUHB Health and Safety (H&S) Strategic approach still required considerable work. With the onset of the COVID-19 pandemic in March 2020 the proactive work being undertaken to progress the 3-year strategy was refocused to support staff and patients during this challenging period.

Cefndir / Background:

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health & Safety (OHS) within BCUHB. The OHS Team developed a

comprehensive action plan to identify and mitigate the risks identified. This action plan included key areas of risk such as, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. These actions will still need to be completed to ensure BCUHB is fully compliant with legislation.

Asesiad / Assessment & Analysis

Strategy Implications

BCUHB are in the process of implementing the OHS 3-year Strategy. The priority being wherever practicable to eliminate or minimise hazards based on the Health & Safety Executive (HSE) Safety Management System HSG65 and principles of Plan, Do, Check, Act. The process described in the Policy will not only help to reduce the likelihood of accidents and ill health, it will also help to improve time for staff to give care to patients. It will also reduce financial waste and improve the quality of care and quality outcomes given to clinical services and non-clinical support services. We are now in the second year of the plan which has been delayed due to Covid 19 work over the past 12 months. We collect credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to enable change. The changes outlined in this report due to the COVID-19 pandemic will impact on achieving all elements of the OHS 3-year Strategy

Options considered

There are limited alternative options than compliance with legislation. These are the minimum criteria and recommendations identified within the gap analysis and business case provided to the Executive Team that require implementation. Failure to implement recommendations may result in criminal proceeding against the body corporate or individuals.

Financial implications

There are significant budgetary implications, which are currently not funded. A business case is being further developed and will be shared with the relevant Executive Directors. The major financial implications include staffing for Security and Health and Safety, Training packages include the Institute of Occupational Health (IOSH) Director/Leading Safely and Managing Safely programmes and fit testing staffing. Estates related software includes MiCad for schematic drawings of the estate and SHE for managing contractors, Sypol for Control of Substances Hazardous to Health, water safety findings and asbestos management plan with the implementation of risk assessment findings for fire and compartmentation particularly in Bangor Hospital and health surveillance systems for staff.

Risk analysis

The significant risks have been escalated to the Board Assurance Framework and were previously agreed by QSE. These include Leadership of OHS, Security Management. The specific Estates related risks including Contractor Management and Control, Asbestos, Legionella and Fire Safety are now on Tier 1 Estates will directly manage these with OHS support.

Legal and compliance

Failure to comply with Health and Safety legislation can lead to the increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims.

Impact Assessment

The impact of non-compliance with Health and safety legislation described will have a detrimental effect on staff health, safety and wellbeing at work this includes both physical and mental health.

1. Health and Safety Gap Analysis Action Plan

The full gap analysis action plan was put on hold at the start of the COVID-19 pandemic. In Q2 a Health and Safety workshop was held to recommence the work required to ensure compliance with H&S legislation. Due to the increased workload at this time for the Corporate H&S team the action plan required priorities reallocating. Those areas that sit with Estates including fire safety, asbestos, control of contractors, working at height, electricity and water management will remain under review by the Estates team. Authorisation was given to recruit a temporary H&S Advisor specifically to support this work with the Estates Team with a dedicated 15 hours per week. In Q4 a detailed review of Water Safety was undertaken and a comprehensive report has been provided to the Estates Team with recommendations and an action plan. Work has now commenced on a detailed review of Electrical Safety with a draft report for Estates in the West completed. Further work to be undertaken for Central and East areas.

To support the additional work required for the gap analysis, a list of H&S policies, procedures and guidance documents have been collated. The team are working through updating these, with all of the guidance documents now completed.

2. Corporate Health and Safety Team Site Visits

With the onset of the Coronavirus (COVID-19) pandemic in March 2020 and the subsequent government advice to ‘stay at home’ on the 23rd of March 2020, the Corporate H&S reviews were placed on hold. With changes in restrictions of movement since this date the H&S team primarily focused on supporting the Hospital Management Teams and department managers with site visits to support with the ‘social distancing and staying safe’ program and later with undertaking risk assessments for staff returning from shielding. In Q4 a further 127 social distancing and staying safe visits were undertaken bringing the total for the 2020/21 year to 431. The Key Performance Indicator implemented in January 2021 is for one of the team to attend within 2 weeks of the request being made. All visits in Q4 were within this timescale.

The team also reintroduced on a small scale the formal Corporate Health and Safety reviews in Q3 as part of the BCUHB auditing process. In Q4 48 H&S reviews were undertaken giving an overall total of 85 Corporate Health and Safety reviews undertaken in 2020/21.

3. Corporate Health and Safety Team COVID-19 specific guidance

Along with the site social distancing visits, the team have provided guidance documents since the beginning of the pandemic for all staff with advice on staying safe and keeping well. To date there have been 20 short guidance documents produced which have been regularly updated in line with Welsh Government guidance changes. These guidance documents included advice for staff working from home and particularly the use of laptops, mobile phones and tablets and guidance for additional controls for staff at increased health risk from COVID-19 as examples. The guidance documents are stored on the Corporate H&S team webpage and are linked into the team’s Frequently Asked Questions (FAQs) document. This document was first produced on the 27th of March 2020 and to date there have been a total of 14 versions updated onto the webpage.

4. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

4.1 Q4 RIDDOR incidents reported to the Health and Safety Executive

In Q4 the following RIDDORs have been reported:

Area	COVID-19 RIDDORs	Non-COVID-19 RIDDORs	Total Q4	Comparison total Q4 2019
East	40	7	47	3
Central	18	4	22	11
West	56	5	61	9
Total	114	16	130	23

4.2 2020/21 RIDDOR incidents reported to the Health and Safety Executive

For 2020/21 there have been 820 reports made to the HSE under RIDDOR, compared to the same period in 2019-2020, when 105 reports were made to the HSE. The significant increase is predominantly due to the numbers reported as Occupational Diseases following the requirement to report a person at work who has been diagnosed as having COVID-19 attributed to an occupational exposure to coronavirus. When comparing the non-COVID-19 related incidents reported under RIDDOR against the 2019-2020 figures, there has been a decrease of 30, with only 75 reports being made during this period. This is discussed in more detail further on in this paper.

Annual RIDDOR information from April 1st 2020 to March 31st 2021 compared with 2019/20

Report breakdown	**2020/21 Total**	**2019/20 Total**
COVID-19 related	745	0
Staff Injuries	57	88
Patient Injuries	18	17
	820	105

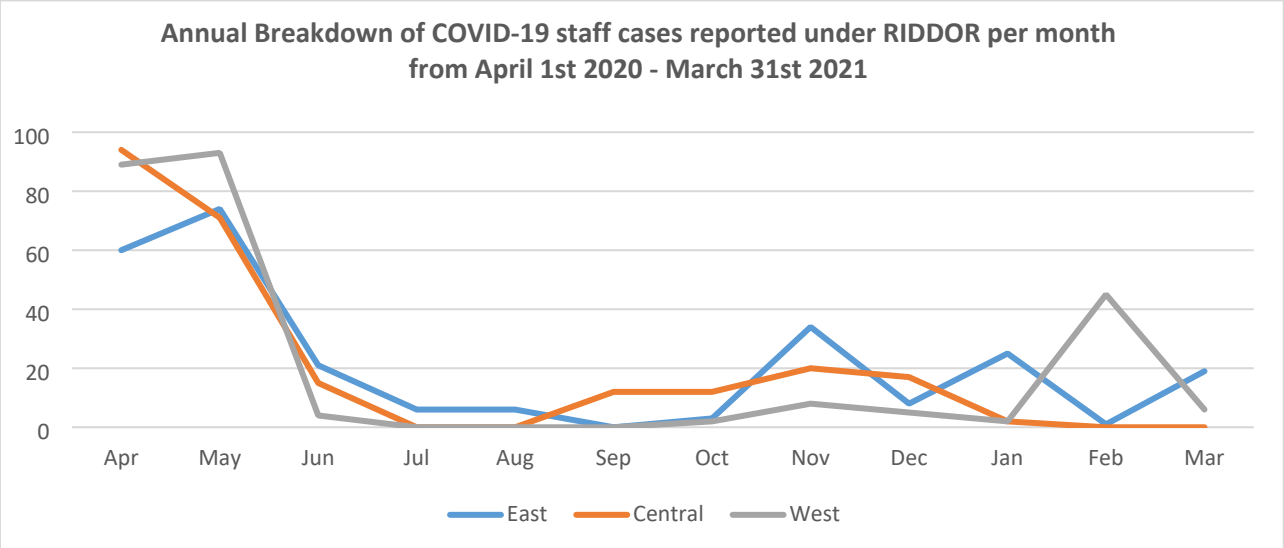
4.3 COVID-19 Staff Cases reported to the Health and Safety Executive

In the period 1st April 2020 to 31st March 2021, there have been 732 COVID-19 staff diagnosis reported as occupational diseases to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

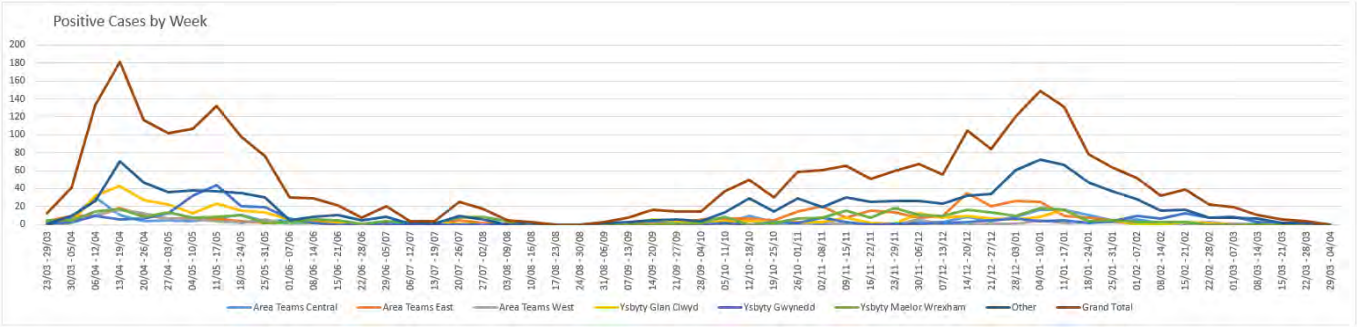
These break down into 86 identified COVID-19 staff clusters:

- 32 in East involving 235 staff,
- 31 in Central involving 243 staff and
- 23 in West involving 254 staff.

There were a 13 further COVID-19 related RIDDOR reportable incidents reported under the category of Dangerous Occurrences. Dangerous occurrences are unintended specified events that have the potential to cause harm and with COVID-19 the incident must or could have resulted in the release or escape of coronavirus leading to a possible or actual exposure to it. As an example all early staff COVID-19 clusters were reported as a Dangerous Occurrence under advice from the HSE and were later reported individually as Occupational Diseases when the guidance changed.



The total number of positive cases by week has been provided by the Workforce Information teams below:



The Corporate Health and Safety Team supported the three area COVID-19 Outbreak Incident Management Teams (2 in East and 1 in Central). In July 2020, the team implemented a 72-hour review form to enable managers to collate the information required in a more structured way for reporting under RIDDOR to reduce the number being reported outside of the statutory timescale. The Corporate H&S team check all of the 72-hour reviews attached to Datix records to determine if the incident is reportable as an occupational disease.

In conjunction with the 72-hour reviews, the joint 'Make It Safe' (MIS) investigations that are held in conjunction with Clinical Services, Infection Prevention and Control (IPC), Public Health Wales (PHW) and H&S on all related COVID-19 outbreak clusters have identified a number of potential transmission sources.

These include:

- Potential breaches of Personal Protective Equipment (PPE) when providing hands on care, which includes caring for challenging patients
- Donning and doffing of PPE that is not of an appropriate standard
- Shortages of PPE in work areas
- Cramped staff rest/welfare areas making social distancing difficult
- Inadequate ventilation and air movement in work environments
- An absence of adequate changing facilities for staff

- Non-adherence to social distancing or the mandatory wearing of face coverings by both staff and patients
- Non-compliance with the Welsh Government recommendations regarding bed spacing
- Ineffective/insufficient cleaning regimes for high touch surfaces and equipment
- Inadequate COVID-19 Workplace or Workforce risk assessments for night and roaming staff
- Lack of supervisory visits and audits of PPE and social distancing compliance during all shifts

For these clusters, remedial action has been recommended and implemented to prevent reoccurrence. It is also now a mandatory requirement to have a COVID-19 Workplace Risk Assessment in place. A template has been developed by the Corporate H&S team to support managers for BCUHB wide communication and implementation. This is in addition to and compliments the All Wales COVID-19 Workforce Risk Assessment.

4.4 COVID-19 related Dangerous Occurrences reported to the Health and Safety Executive

In 2020/21 there have been 13 COVID-19 related Dangerous Occurrences reported to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

At the beginning of the pandemic advice from the HSE was to report staff clusters as a Dangerous Occurrence. The advice was later changed and the staff involved in these clusters were later reported individually as occupational diseases, this considerably increased the workload for the H&S Team.

Annual break down of COVID-19 related Dangerous Occurrences reported under RIDDOR from April 1st 2020 – March 31st 2021

Incident details	**Total**
Staff clusters reported as Dangerous Occurrences	4
Inappropriate PPE worn by staff or failure of PPE	7
Incorrectly packaged or stored coronavirus contaminated samples/equipment	2
	13

4.5 COVID-19 Sharps related incident reported to Health and Safety Executive

In 2020/21, there has been one sharp related incident reported as a Dangerous Occurrence to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The appropriate Occupational Health management was followed and a Root Cause Analysis undertaken. The action implemented from this investigation was that an audit of compliance to the 'Insertion of a Central Line Checklist' will be undertaken. This action is ongoing.

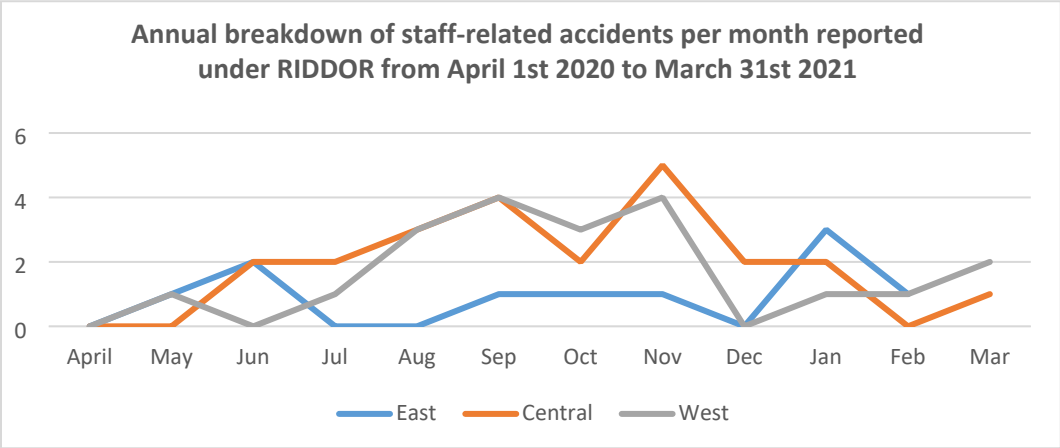
4.6 Non-COVID-19 related incidents relating to staff reported to the Health and Safety Executive

In 2020/21, there have been 57 incidents relating to staff reported to the HSE under RIDDOR. This is a marked decrease of 53 compared to the same period in 2019-2020 when 110 reports were made. This can be attributed to an number of factors relating to the coronavirus pandemic; a reduction of staff at the work-place, lack of capacity in operational services to report incidents on Datix and a pre-occupancy of focus on COVID-19.

Each incident was deemed to be a 'work-related accident'. This means that the way the work was carried out, the machinery, plant, substances or equipment used or the condition of the site or premises where the incident happened was a contributable cause to the accident.

Annual Breakdown of staff-related incidents reported under RIDDOR from April 1st 2020 – March 31st 2021

	BCUHB Central	BCUHB East	BCUHB West	Total
Abuse of staff by patients	6	0	4	10
Musculoskeletal	6	6	5	17
Slip, Trip, falls of staff	6	5	10	21
Collisions	0	0	2	2
Equipment failure	1	1	5	7
Total	19	12	26	57



4.7 Root Cause Analysis

A Root Cause Analysis (RCA) is required to be carried out by the operational service for every incident that is reported to the HSE under RIDDOR. This is to identify the root causes of an incident and to ensure any lessons are identified and remedial action implemented to prevent a further occurrence.

Out of the 57 staff-related accidents reported to the HSE under RIDDOR from April 1st 2020 to March 31st 2021, 38 had RCAs completed. Similar to 2020-2021 the quality of the RCAs carried out were generally poor, which affected identification of lessons learnt. Closer scrutiny of RIDDORs is required and work continues to improve the RCA process and provide investigation training in order to improve overall safety within BCUHB.

4.8 Non-COVID-19 related RIDDOR incidents relating to patients reported to the Health and Safety Executive

In the period 1st April 2020 to 31st March 2021, there have been 18 incidents relating to patients reported to the HSE under RIDDOR. Each of these incidents involved a patient fall in which a specified injury was sustained. Each incident was deemed to be a 'work-related accident', either because there

had been insufficient assessment of the risk of falls, or non-compliance with identified control measures to mitigate against the risk of falls.

Annual break down of patient related incidents reported under RIDDOR from April 1st 2020 – March 31st 2021

Area	Total
BCUHB Central	4
BCUHB East	7
BCUHB West	7
	18

Just to note, the investigations relating to these accidents are undertaken by the Operational Governance Teams and scrutinised by the Patient Safety and Patient Experience Team, with identified lessons-learnt shared across the organisation

5. HSE investigations 2020/21

5.1 HSE investigations Q4, Notification of Contravention

On the 23rd of February 2021, the HSE issued a Notification of Contravention letter to BCUHB. This letter identified contraventions of health and safety law identified during an investigation the HSE undertook following a staff member who contracted COVID-19 and sadly passed away. Although it could not be confirmed where the staff member may have contracted COVID-19, material breaches were identified that BCUHB are now required to rectify. A Task and Finish group was established to primarily complete an action plan based on seven overarching recommendations. The requirements include implementing a recorded daily monitoring system to ensure that staff have had a fit test, that they are fitted to the mask they have available and that they understand what can impact the fit so they know when to have another fit test. A suggested way of completing this was to use Fit Test Identification Cards and a trial is due to start on the week commencing 19th of April in three departments across BCUHB. A further requirement is to ensure that the controls implemented following the completion of the COVID-19 Workforce Risk Assessment are suitable and sufficient. A response to the HSE is required on the 14th of April 2021

5.2 HSE Improvement Notice

A RIDDOR report of a Dangerous Occurrence was sent to the HSE on the 28th of May 2020 relating to the partial failure of an FFP3 mask. This report led to an HSE investigation and subsequently BCUHB received an Improvement Notice on the 24th of August 2020. Details have been given in previous quarterly H&S reports but in brief the Respiratory Protective Equipment Task and Finish Group undertook a significant action plan to completely change the Fit Testing Program in BCUHB. Fit testing is now only undertaken using the Quantitative method using PortaCounts, 18 had been purchased by the end of October 2020 and in March 2021 a further six were purchased. There is an interim Fit Testing Co-ordinator team in place and all fit testers have undertaken the Competent Fit Testers training by an Accredited Fit2Fit trainer. The Fit Testing Protocol has been written to replace the original guidance document and is due to go for final ratification in the Strategic Occupational Health Group in May 2021. Training for the fit testers is recorded on the Electronic Staff Record (ESR) and the work is progressing on recording all staff who have had an appropriate fit test on ESR as well.

The HSE have now confirmed that BCUHB have complied with the conditions set out in the Improvement Notice which relates to Ysbyty Glan Clwyd (YGC). The refitting of all staff in high risk areas was delayed due to the shortages of the 1863 respirator stock and no other viable alternative at that time. The stocks of the 1863+/9330+ are stable and there are enough to undertake the full refit program.

5.3 Additional HSE investigations

The HSE have requested information on three COVID-19 staff clusters during 2020/21 and reports were provided for these. The team have also been required to collate further information for two patients who had falls working closely with clinical teams and the Patient Safety and Experience Team. One of the patient falls was in Wrexham and the other relates to two falls for the same patient in the West area.

The HSE have also undertaken an investigation into two staff members who contracted COVID-19 and sadly passed away. A full H&S investigation has been undertaken by the Corporate H&S Team and information passed to the HSE.

6. Datix incidents (Personal Injury)

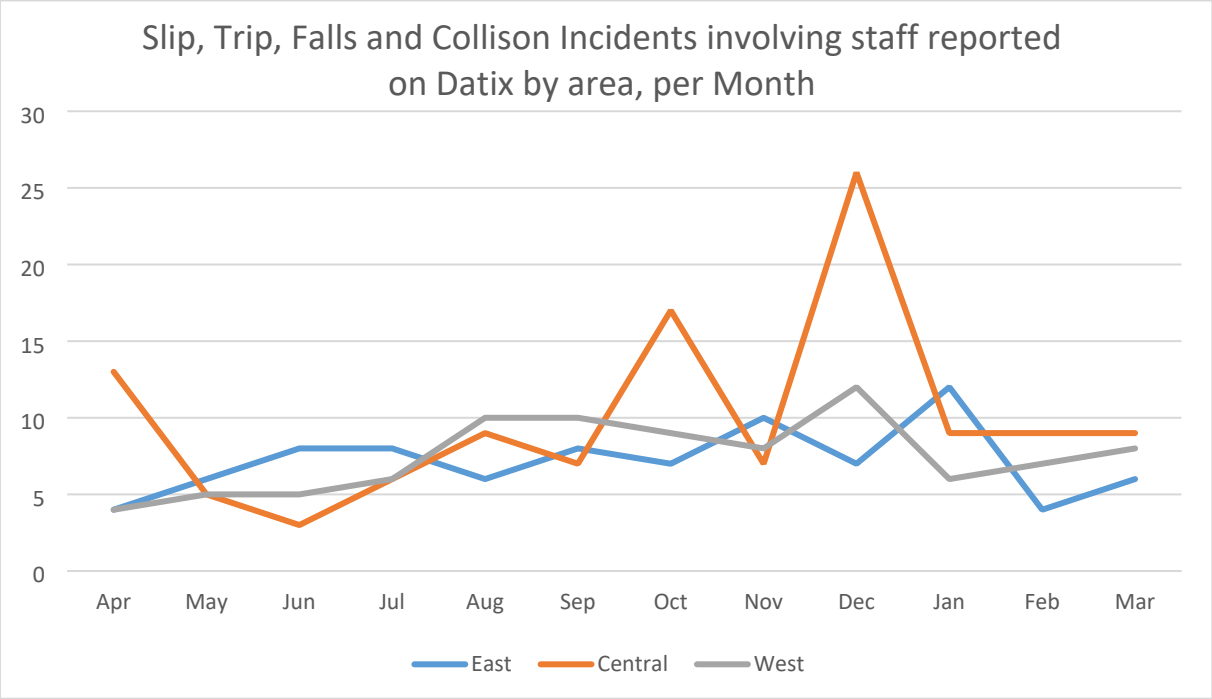
A total of 2,309 incidents were reported in Q4 under the datix category ‘Accident that may result in personal injury incidents’. The figures for COVID-19 related have marginally dropped in Q4 from Q3 along with the non COVID-19 related.

	01.04.20 – 30.06.20 (Q1)	01.07.20 – 30.09.20 (Q2)	01.10.20 – 31.12.20 (Q3)	01.01.21 -31.03.21 (Q4)
Total	2,122	1,867	2,260	2,309
Staff	770	431	791	733
	257 Non C19	301 Non C19	375 Non C19	331 Non C19
	513 C19 related	130 C19 related	416 C19 related	402 C19 related
Patients	1,328	1,403	1,432	1547
Other	24	33	37	29

6.1 Breakdown of incidents by category

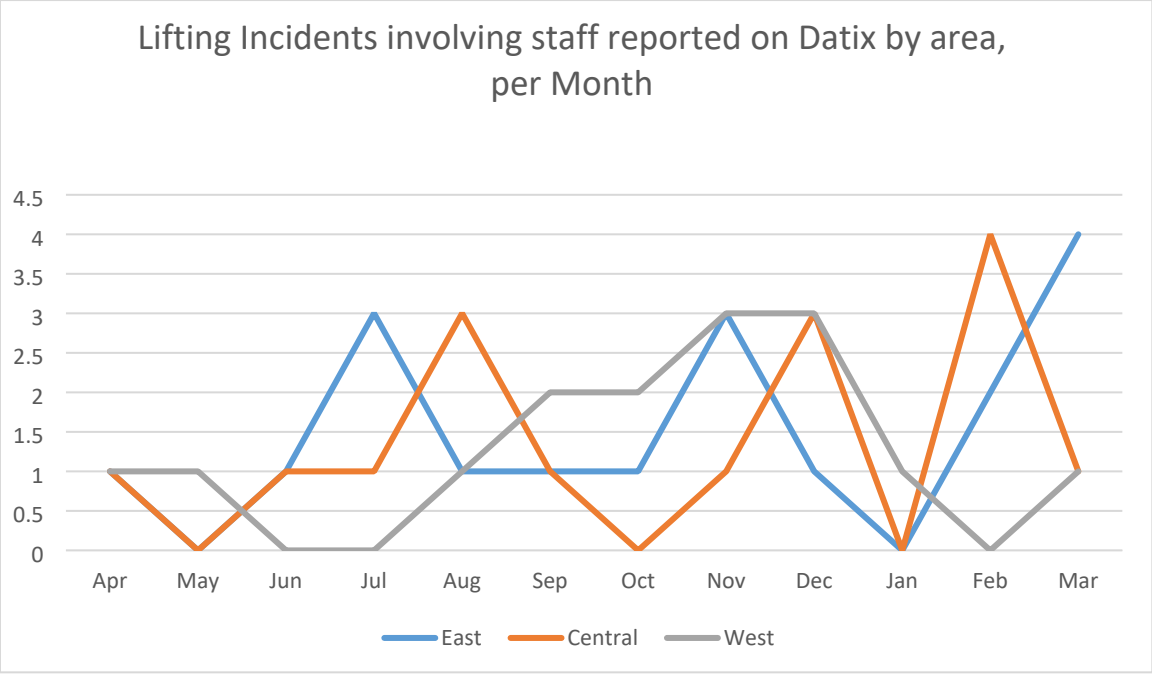
Slip, Trip, Fall and Collison Incidents involving staff reported via Datix
In 2020/21 there have been 296 slip, trip, fall and collision incidents involving staff reported via Datix.

BCUHB East	86
BCUHB Central	120
BCUHB West	90



Lifting Incidents involving staff reported via Datix
In 2020/21 there have been 49 lifting incidents involving staff reported via Datix.

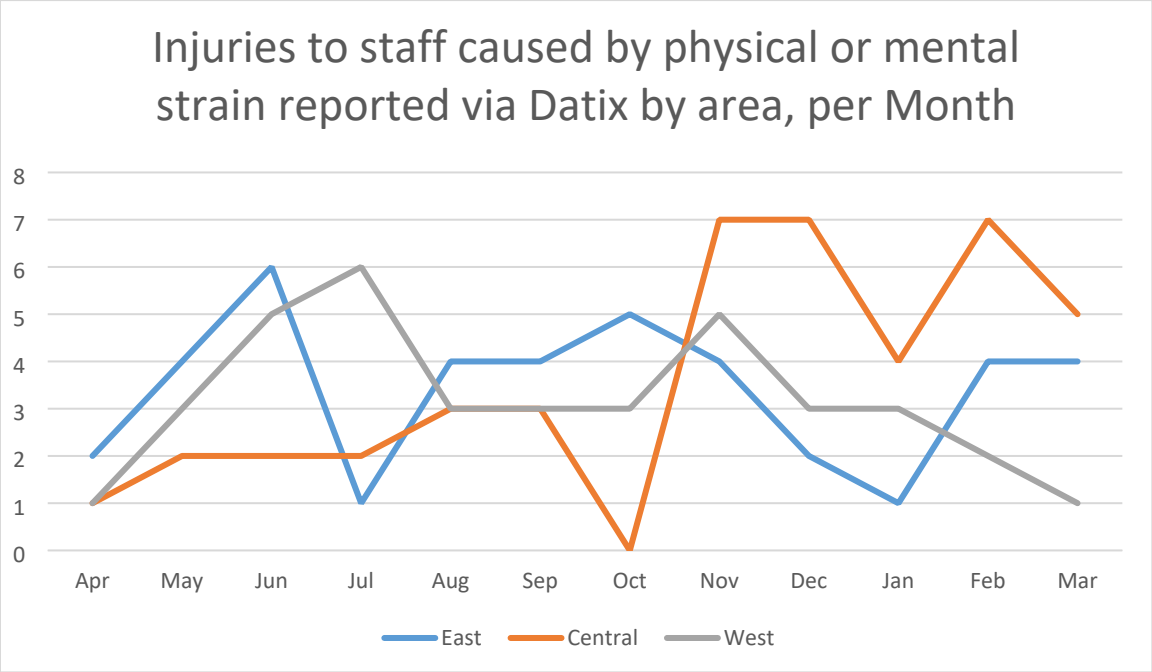
BCUHB East	18
BCUHB Central	16
BCUHB West	15



Injuries caused by physical or mental strain involving staff reported via Datix

In 2020/21 there have been 124 injuries caused by physical or mental strain involving staff reported via Datix.

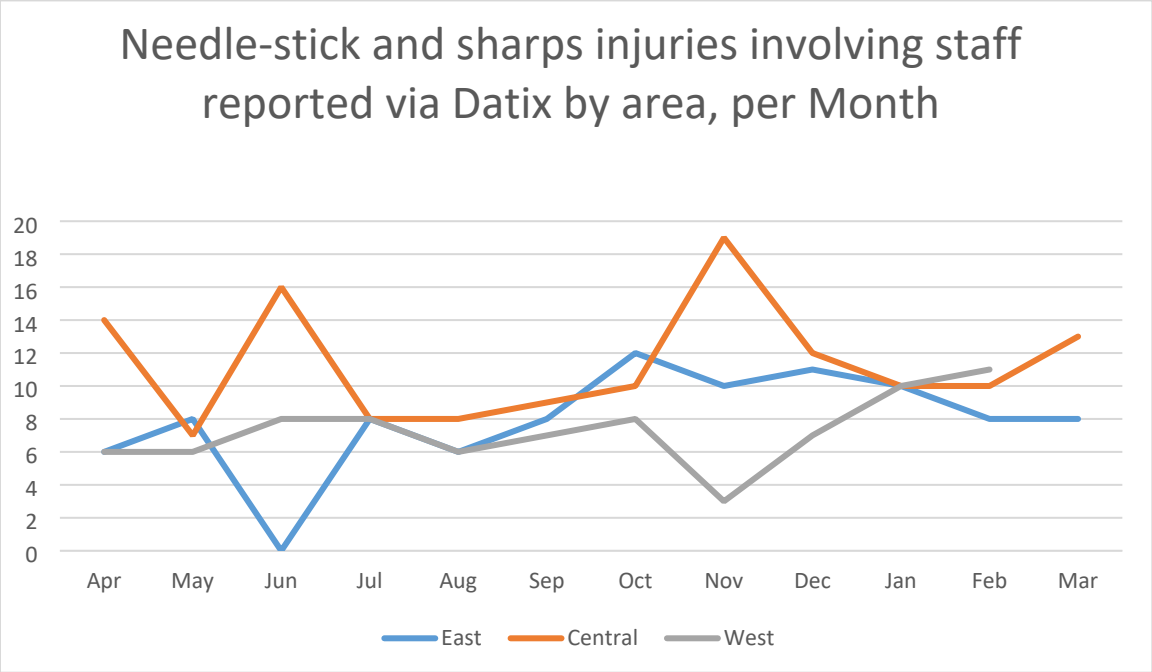
BCUHB East	42
BCUHB Central	44
BCUHB West	38



Needle-stick or sharps injuries caused involving staff reported via Datix

In 2020/21 there have been 320 needle-stick or sharps injuries involving staff reported via Datix.

BCUHB East	95
BCUHB Central	136
BCUHB West	89



7. Security

Effective security provision within BCUHB remains a significant challenge as reflected by its scoring within the risk register. Roles and responsibilities for service providers as well as individual job roles are unclear, however progress has been made with the development of a Business Case, which identifies and proposes strategies to address those concerns. Progress has been made with increased hours for security guard deployment at all three district general hospitals to allow for 24/7 cover to be achieved. The construction of three temporary hospital sites has required the deployment of security guards on those sites. There have also been a small number of guards required for local vaccination centres based in the community.

7.1 Reported incidents of Violence/Aggression & Security

During the period 1st April 2020- 31st March 2021 there were 3,479 incidents of violence & aggression recorded on the Datix system; there were 3,983 incidents the previous year.

V&A incidents by Category (date range 01/04/20-31/03/21)

Category	Number	Previous Year
Aggressive Behaviour	**1441**	1680
Verbal Abuse	**231**	286
Assault	**622**	940
Threatening Behaviour	**278**	225

835 incidents were recorded as 'other and unreported'. Aggressive Behaviour, Assaults and Verbal Abuse have fallen from previous year and could be explained by the fall in "footfall" onto hospital site during lockdown periods.

V&A Incidents by Result (date range 01/04/20-31/03/21)		
Result	Number	Previous year
Personal Injury	**739**	1116
No Injury or Harm	**2015**	2141
Near miss with intervention.	**573**	570

Near miss no intervention	**82**	106
Damage to Property	**49**	49

V&A Incidents "affecting staff"	
1st April 2020-31st April 2021	1st April 2019 - 31st March 2020
1668	**2257**

14 RIDDORs were reported compared to 22 in the previous year.

340 Incidents indicate that police were called increasing from 157 in the previous year.

Security Incidents	
1st April 2020-31st March 2021.	1st April 2019 - 31st March 2020
912	**1084**

The security Datix report will be reviewed during 2021-2022 to explore if more detailed data can be extracted similar to that of Violence/Aggression reports.

From the 16th of November 2020 all Violence/Aggression & Security datix incidents have been reviewed thanks to the additional staff resource of the Security/V&A advisor. 92% of all reported incidents indicate a review by Security/V&A advisor.

7.2 Obligatory Responses to Violence in Healthcare

The Obligatory Responses to Violence in Healthcare status was due to be enhanced by the issue of a Welsh Health Circular during 2019 supported by Welsh Government. This has been delayed due to Brexit and COVID-19 pandemic with an expected date due in spring 2021. Due to the pandemic, the information sessions with North Wales Police to promote the Obligatory Responses process were suspended but arrangements have been made to recommence in April 2021.

The Obligatory Responses to Violence in Healthcare process has had a significant positive impact upon those incidents in which persons with mental health issues engage in violence towards staff. There are continued attempts by Violence and Aggression Case Management to highlight the need for engagement within those areas which are volume generators of violent incidents where staff are victims. Information is now posted upon the Health Board's intranet system and automated links have been set up within the Datix incident reporting system in an attempt to signpost staff to support when required. It was hoped that information would be supplied during V&A training from April 2020 however; this has been delayed due to the pandemic.

7.3 Personal Safety Markers

Communicating a patient's past behaviour in relation to violent/threatening incidents is fundamental to reducing the risk of further violence. To this end, the aim of a personal safety marker is to assist in early alerting of individuals who pose a risk of violence towards BCUHB employees. Early identification and communication of this risk should assist in measures being taken to enhance safety. A BCUHB Working Group, chaired by Informatics Head of Clinical Systems, has been established, to explore the possibility of Personal Safety Markers (and Alerts/Allergies) being established across the Health Board using the electronic patient record systems. The Personal Safety Marker (for Violence/Aggression) is yet to be adopted, largely due to infrastructure and compatibility issues surrounding the electronic patient note system. Work in this area has remained static over several years due to the compatibility

issues experienced by the electronic note system. There continues to be no BCUHB Violence & Aggression Alert system in place. Attempts to incorporate an alerts system within the electronic patient notes will recommence in financial year 2021-2022

7.4 Changes in Legislation

The Welsh Government continues to review section 119 & 120 of the Criminal Justice and Immigration Act 2008, which makes causing a nuisance or disturbance on NHS property an offence and gives powers of removal using reasonable force to NHS employees. This may have training implications for BCUHB staff and potentially contracted security staff. The review was delayed by the pandemic and the Senedd will re-explore this aspect of legislation in the 2021-2022 financial year.

7.5 Policy/Procedure development/reviews

BCUHB procedure HS02 Procedure & Guidance Protecting Employees from Violence and Aggression has been reviewed and distributed for consultation and should be finalised by the end of April 2021. The CCTV and Security policies have been drafted and were due to be presented to the Strategic Occupational Health & Safety Group. This had been delayed due to the pandemic and changes to the proposed business case for security. The CCTV policy has been drafted but will require extensive review due to changes in CCTV equipment that will allow for Ysbyty Glan Clwyd to act as a “central hub” for CCTV monitoring/management from other sites and awaiting an extensive review of all CCTV systems by an external consultancy contractor as arranged by BCUHB Estates & Facilities division.

7.6 Resources

BCUHB security management service for consists of,

1x Fulltime Head of Health & Safety

1x 0,8WTE Violence & Aggression Manager/Security Manager

From October 26th 2020 this was complemented by

1x fulltime Security/V&A advisor on a Bank staffing basis

8. Manual Handling

8.1 Training

Access to training rooms has been the greatest challenge faced this year over the three main sites, this is having an effect on accessibility for staff. This is particularly the case in the West due to a larger geographical area and no training room provision since January 2021. The nearest training location for these staff is in the Llandudno General Hospital. Temporary rooms were set up in all 3 Field Hospitals, along with empty ward spaces available due to COVID-19 displacement, to alleviate poor room accessibility and provide a service. The manual handling team remain under resourced from a combination of reduced working hour requests, shielding due to Covid-19 and maternity leave temporary Bank provision has supported the service.

At the start of 2020/21 the delivery of Manual Handling training changed. The department provides patient handling training for both BCUHB employees and Health Science Students from Universities and a total of 29 patient handling refresher courses (348 places) were cancelled. The team concentrated on Back to Floor sessions and completed 40 of these before being redeployed. At the end of June the team were brought back together and recommenced training using strict Standard Operating Procedures and under risk assessment. This year they have offered 544 refresher classes (3,624 places) however the Did Not Attend rate is around 35% for courses booked and many have had to be cancelled. The main reasons given for not attending have including concerns with travelling to training rooms and staff shortages meaning they are not able to be released. The current compliance in BCUHB for patient handling refresher training has decreased throughout this year and is now at 59%.

In addition to the patient handling refresher courses the team have provided 213 full day Foundation patient handling courses to complete the All Wales Manual Handling Passport. They have also provided videos on the most commonly used Patient Handling techniques used to support staff through the pandemic and introduced workbooks that can be completed prior to attending the courses.

Load handling training previously attended through mandatory training days in lecture theatres has stopped with no further plans from Workforce & Organisational Development (WOD) to reinstate following COVID-19. Whilst 11 Load Handling Workbooks have been marked and staff updated, a new interactive Microsoft Teams course has been

created to fill the void with 340 places through 18 classes provided and positive feedback received.

Manual Handling Champions course recommenced towards the end of the financial year, this 2-day course offered 26 places through the 6 courses, where staff are upskilled to ensure gold standard manual handling occurs in their workplace, reduce MSK's and Datix, and update peers. During this financial year the current Champions have updated a total 1,280 staff in their workplace, however due to resources the provision of regular support and group meetings for the existing Champions has not taken place.

8.2 Datix (Manual Handling)

There have been 115 Datix incidents where the incident relates to manual handling that affects staff. These are targeted to be answered within 7 days, advice offered and those highlighted with any training issues have direct input from the department, further training given and followed up to ensure targeted intervention provided is effective. There was a noticeable lull of reporting during the early months of the pandemic, during the last quarter the Datix numbers have increased, but are unlikely to be a true reflection of the actual number of incidents.

8.3 Assessments

The pandemic and lockdown caused disruption in the beginning of the year, where previously assessments were all undertaken in person, with the majority being performed through interactive means this year. All assessment requests are received via email and are answered within 7 days and the person is seen for an assessment within 4 weeks, with the exception of staff returning to work (seen within 7 days). During this financial year 134 assessments have been carried out, 86% of which are relating to DSE, this has increased due to agile working and a service set up for those struggling with their workstations whilst working from home has begun.

9.0. Recommendations

- Implement year 2 of the OHS Strategy.
- Ensure adequate staffing is available to provide an appropriate H&S security function to BCUHB.
- Ensure adequate staff and premises to provide Manual Handling training
- Establish a permanent fit test program
- Develop further policies and safe systems of work to provide evidence of practice.
- Establish monitoring systems from the Divisions and HMTs to measure performance including clear KPIs.
- Train senior leaders and develop further competence in the workforce at all levels
- Learn lessons from incidents and develop further the risk profile

The Board is requested to note the position outlined in this report and support the recommendations.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15 July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Updated Ethical Charitable Funds Investment Policy
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	John Baker, Interim Charity Accountant
Craffu blaenorol: **Prior Scrutiny:**	Charitable Funds Committee and Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Ethical Investments Policy Update

Argymhelliad / Recommendation:

The Board is asked to review and approve the update to the Ethical Charitable Funds Investments Policy.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact (EqIA) and a socio-economic (SED) impact assessment is not applicable.

Sefyllfa / Situation:

The investment management contract was awarded to Brewin Dolphin in 2020 and the investments are in the process of being transferred over (95.8% as at 30 June 2021). The key objective of the investment portfolio is to preserve and grow its value in 'real' terms, in order to increase charitable distributions over the long term.

Cefndir / Background:

Many of the donations and legacies that the charity receives are not immediately spent, as they need to be combined with other charitable funds to support the most appropriate purchases. These donations are therefore invested to generate income and protect their value in real terms.

As part of the transfer of the portfolio to Brewin Dolphin, the Charitable Funds Committee reviewed the existing Ethical Investment Policy to discuss whether it was still relevant and whether any changes were required. Brewin Dolphin provided the Charitable Funds Committee with a discussion paper on how the policy could be improved, using best practice guidance and based on their knowledge of the charity. Following discussions at the March 2021 Charitable Funds Committee and the Health Board

Workshop in April 2021, Brewin Dolphin provided an amended proposal. This was submitted to, and approved by, the Charitable Funds Committee on 11 June 2021 and is outlined in Appendix 1.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
Aligned to the Awyr Las Charity Strategy.

Opsiynau a ystyriwyd / Options considered

Not applicable – paper is for information on the financial position of the charity.

Goblygiadau Ariannol / Financial Implications

The final proposal for the charity's Ethical Investment Policy is included in Appendix 1.

In summary, the policy will state:

It is recommended that there is negative exclusion of investment in companies involved in the manufacturing and distributing of:

- Alcoholic products [10% of turnover];
- Tobacco products [10% of turnover];
- Armaments or civilian firearms [10% of turnover]
- Adult entertainment [5% of turnover]
- Gambling [10% of turnover]

Investment in companies which have a poor record in human rights and child exploitation should not be permitted [controversy risk mitigation as defined by VE software as being "weak" or "limited"].

In addition, investment in companies that demonstrate compliance with the principles of the Equality Act 2010 should be supported.

The Board is asked to approve this Ethical Policy summary paper.

Dadansoddiad Risk / Risk Analysis
Not applicable – the Charity Risk Register is reported separately.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

Ethical Policy Summary Paper - Betsi Cadwaladr UHB Charity
May 2021

Background

Prior to the Board workshop held on 8 April 2021, we had provided an ethical policy discussion paper which demonstrated the implications of a number of potential exclusions which we felt may be of interest to the Trustees in constructing an ethical policy.

This included the issues currently specified in your current policy (i.e. alcohol, tobacco, human rights and child exploitation), and proposed further issues to clarify which other products may or may not be considered in conflict with the Health Board's activities.

Your Current Ethical Investments Policy

'It is recommended that there is negative exclusion of investment in companies manufacturing and distributing:

- *Alcoholic products;*
- *Tobacco products; and*
- *Any products which may be considered in conflict with the Health Board's activities.*

Investment in companies:

- *Which have a poor record in human rights and child exploitation;*
- *Which derive their profits from countries with poor human rights records*

should not be permitted.

In addition, investment in companies that demonstrate compliance with the principles of the Equality Act 2010 should be supported.

Board Workshop Discussion

In summary, at the Board workshop there was acceptance of the straightforward proposed implementation for alcoholic products and tobacco products.

It was deemed that the suggested issues of armaments, civilian firearms, adult entertainment and gambling fell within the definition of being in conflict with the Health Board's activities and should be specified as such and implemented as proposed.

Issues suggested around obesity and fossil fuels were not to be included at the present time.

There was clarification on the issues of human rights and child exploitation and we resolved to consider an appropriate means of implementation to give effect to your intentions. Ethical screening of these categories is more difficult to analyse as materiality can't be measured in financial terms like the criteria above and therefore a high degree of subjectivity is introduced. Instead, we refer to news flow.

Our recommendation is to use our screening software (VE) to identify alleged breaches of fundamental human rights from verified sources. VE provide a 'Controversy Risk Mitigation' rating, ranging from weak, limited, robust to advanced. These ratings are based on frequency of breaches, severity of the allegation and responsiveness to the problem. We would suggest a 'weak' rating captures the sorts of companies deemed to be repeat offenders involved in high severity issues.

Proposed Revised Policy Wording

We would therefore suggest the wording be revised as follows. The following criteria exclude 46 companies in the FTSE All Share, or 32.2% of the market, which we are comfortable with implementing at the present time.

It is recommended that there is negative exclusion of investment in companies involved in the manufacturing and distributing of:

- *Alcoholic products [10% of turnover];*
- *Tobacco products [10% of turnover];*
- *Armaments or civilian firearms [10% of turnover]*
- *Adult entertainment [5% of turnover]*
- *Gambling [10% of turnover]*

Investment in companies which have a poor record in human rights and child exploitation should not be permitted [controversy risk mitigation as defined by VE as being "weak"].

In addition, investment in companies that demonstrate compliance with the principles of the Equality Act 2010 should be supported.

Supporting Documentation

The following supporting documents provide further background information about our approach to implementing your criteria and to responsible investment issues more widely:

- **21 05 25 Ethical Paper**
- **21 05 25 Responsible Investment Paper**

Cyfarfod a dyddiad: Meeting and date:	Health Board 15th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Targeted Intervention Improvement Framework - update
Cyfarwyddwr Cyfrifol: Responsible Director:	Jo Whitehead, Chief Executive
Awdur yr Adroddiad Report Author:	Simon Evans-Evans, Interim Director of Governance
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Board is requested to note the progress in delivering Targeted Improvement.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The Health Board continues to develop the approach to Targeted Improvement, which will enable the Board to monitor progress of the transformation programme and provide robust assurances against the commitments made to, and expectations of, the Minister for Health and Social Care as detailed within the Targeted Intervention Improvement Framework (TIIF).

Cefndir / Background:

The Welsh Government placed the Health Board into Special Measures on 8 June 2015 with the intention that we would be able to demonstrate progress and move down through the four 'escalation' levels:

Whilst the Welsh Government provided the areas of concern (domains) and expected outcomes the Health Board has developed and own the details within four matrices, which the Board agreed on 20th May and has subsequently shared with colleagues in Welsh Government, Health Inspectorate Wales and the Audit Wales "the Tripartite". The matrices have been published in Welsh and English on the Health Board's website (Ymyriad wedi'i Dargedu - Bwrdd Iechyd Prifysgol Betsi Cadwaladr (gig.cymru))

.

The four matrices cover:

- Mental Health Service Management (adults and children).
- Strategy, Planning and Performance.
- Leadership (including Governance, Transformation, and Culture)
- Engagement.

Summary progress so far

The focus on delivery for this quarter are

Priorities for mental health for the next quarter

- Engage and communicate internally within the divisions, and with partners and stakeholders on the Maturity Matrix approach (Child, Adolescent Mental Health - CAMHs and Adult Mental Health - MH).
- Progress the joint working between CAMHs and Adult MH, with a focus on financial allocations and the transition pathway. (CAMHS and Adult MH).
- Establish the improvement and development group to support the CAMHs programme delivery (CAMHS).
- Review the Mental Health Learning Disabilities (MHLD) leadership structure, with leads identified to support the key delivery areas (Adult MH).
- Progress the crisis concordat activity to support our clinical pathway focus (Adult MH).

Priorities for engagement for the next quarter:

- Undertaking a stakeholder mapping exercise and develop a relationship management approach to relevant stakeholders in the domains of patient, partners, staff and public.
- Consolidate a team for engagement across the four engagement domains, drawing from best practice.
- Use the development of key strategies (i.e. Living Healthier, Staying Well and Clinical Service Strategy) as a Plan, Do, Study, Act (PDSA) exercise to improve engagement process and outcomes.
- Develop an engagement process to encourage openness, transparency and trust with our citizens.

Leadership priorities for the next quarter:

- Ensuring executive, senior leadership and partner ownership and engagement in the delivery of Discovery phase of Mewn Undod mae Nerth/Stronger Together.
- Aligning the Board Development programme with Mewn Undod mae Nerth delivered by the King's Fund with additional support from the Good Governance Institute.
- Reviewing clinical leadership support structures and resources to improve multi professional clinical engagement.
- Mobilising additional capacity and capability to support transformation, organisational and system development, engagement and governance

Strategy and Planning -priorities for the next quarter:

- Using the refresh as the basis for our Clinical Services Strategy implementation plan.
- Starting the refresh of Living Healthier Staying Well.
- Develop a revised planning process to allow for a draft approvable Integrated Medium Term Plan (IMTP) to be agreed for 2022-25.
- Implement and embed the Performance and Accountability Framework including regular reviews, appropriate escalation, and revised performance reporting.

Integration

Whilst Targeted Improvement is a program of work within its own right, operationally the intention is to make deliver the program as much as business as usual as possible. Work is currently underway to flag elements of the annual plan, and local delivery plans that will directly affect the attributes within each Maturity Matrix. This will enable integrated reporting of Targeted Improvement within the quarterly Annual Plan progress report as well as allowing specific progress reports to be pulled. Gap analysis is also planned to identify any attributes within the matrices that require but do not have actions attached

Engagement

We are gathering evidence of internal and external engagement activity across the Domains, particularly in relation to Mental Health, Strategy (in the development of Living Healthier Staying Well and Leadership (in the discovery phase of Mewn Undod mae Nerth / Stronger Together). The next meeting of the TIIF Steering Group will focus on Engagement as a cross-cutting theme to consider the effectiveness and consistency of engagement within the Targeted Improvement Program.

Governance

The Governance framework for Targeted Improvement is being implemented. The Executive Director of Therapies and Health Sciences will chair the Evidence Group, and the Acting Executive Medical Director will chair the Outcomes Group. These groups are integral to providing assurance of both action and impact to support the Board in the self-assessment process (next due in November 2021). Both of these groups draw membership from within and without the Health Board. The Targeted Improvement Support function is currently working with operational teams to ensure that evidence of action and impact can be captured, recorded, presented, challenged and assured with the minimal administrative burden on the teams as possible. The inaugural Evidence Group meeting took place on 1 July. The Targeted Intervention Improvement Framework Steering Group will meet on 12 July 2021.

Welsh Government Oversight

Informal fortnightly meetings are being held with the Welsh Government lead for TI. The next formal TIIF oversight meeting will be held with The Director General of Health and Social Services/Chief Executive NHS Wales and colleagues on 28 July 2021.

Health Board

15th July 2021

To improve health and provide excellent care

Chair's Report

Name of Committee:	Targeted Intervention Improvement Framework (TIIF) Steering Group
Meeting date:	1.6.21
Name of Chair:	Gill Harris, Deputy Chief Executive/ Executive Director of Nursing & Midwifery
Responsible Director:	Gill Harris, Deputy Chief Executive/ Executive Director of Nursing & Midwifery
Summary of business discussed:	• Consideration of correspondence from Welsh Government following the Targeted Improvement (TI) meeting held on 7.5.21 – the Steering Group noted the priority actions listed for the next quarter; the Health Board had given an undertaking to deliver these. • Discussion on the finalisation of the Maturity Matrices for submission to Welsh Government; the final versions would be translated and posted on the Health Board's TI web pages • It was agreed that there would not be a separate set of plans for TI – the improvement actions would instead be cross-referenced within the annual plan as part of business as usual, and thus aligned to normal governance and quarterly reporting arrangements. • Arrangements for the inaugural meetings of the Evidence Group and Outcomes Group were in hand; the evidence required to demonstrate success would be determined from the outset, alongside finalisation of the maturity matrices.
Key assurances provided at this meeting:	• Governance arrangements are in place to monitor TI progress via Steering Group oversight • Teams are working to deliver improvements, to augment maturity levels ahead of the next self-assessment to be brought before the Board in public at its November meeting.
Key risks including mitigating actions and milestones	• There is a risk of insufficient progress on the improvement journey; the oversight of the Steering Group and added scrutiny from IM Link buddies will mitigate this.

TIIF Domain addressed	• All
Issues to be referred to another Committee	-
Matters requiring escalation to the Board:	-
Well-being of Future Generations Act Sustainable Development Principle	*Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.* *1. Balancing short term need with long term planning for the future* – covered by the strategy, planning and performance domain. *2. Working together with other partners to deliver objectives* – covered by the engagement work *3. Involving those with an interest and seeking their views* – covered by the engagement work; *4.Putting resources into preventing problems occurring or getting worse* – via WG funding allocation; *5. Considering impact on all well-being goals together and on other bodies* – covered by engagement work.
Planned business for the next meeting:	• More detailed discussion on priorities for the next three months • Plans for partnership engagement across each of the matrices (particularly Mental Health/CAMHS) will be covered at the next meeting'.
Date of next meeting:	12.7.21.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Task and Finish Group update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Professor Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Patrick Johnson, Vascular Programme Lead
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group [improvement plan] Acting Executive Medical Director Chief Executive Quality, Safety & Experience (QSE) Committee 6th July 2021
Atodiadau **Appendices:**	Appendix 1 - Vascular service provision Appendix 2 - Vascular Task and Finish Group Action Plan Tracker

Argymhelliad / Recommendation:

The Committee is asked to receive the update from the Vascular Task and Finish Group.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	**X**
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**N**	

Sefyllfa / Situation:

This report provides an update to the Board on the work undertaken to date by the Vascular Task and Finish Group following the Royal College of Surgeons' [RCS] review of the vascular service.

The Task and Finish group last met on 28th June 2021.

Cefndir / Background:

As part of assessing the potential for improving the vascular services following centralisation of arterial services in North Wales in 2019, the Health Board commissioned an external and independent review of the vascular service from the Royal College of Surgeons of England (RCS) which has been now been partially completed. The first part of the report, based on stakeholder interviews and examination of documents, was provided to the Health Board in March 2021.

The second part of this review, based on the analysis of 50 case notes, will commence on the 19th of July and is anticipated to conclude in 8-10 weeks.

Asesiad / Assessment & Analysis

Strategy Implications
This report reports on the progress of the refreshed improvement plan following the RCS report and has been approved by the Board.

A report has also been provided to the Quality, Safety and Experience Committee held on 6th July 2021.

As noted above the Task and Finish group last met on 28th June 2021.

In addition an extraordinary meeting of the Task & Finish Group was held on 7th June 2021 at which the first part of the RCS report was the sole item on the agenda. There was a good range of representation from multidisciplinary team members as well as patient and Community Health Council (CHC) presence. The original action plan is being tracked by the Group with regular updates provided to QSE and Welsh Government.

The first part of the RCS report was provided to the Executive Medical Director in March 2021. The case note review will now take place on 19th July 2021 and the RCS have advised that the second part of the report will be received by the Health Board between eight and ten weeks after the case note review takes place – this will be mid to late September 2021.

The report detailed nine urgent recommendations that may impact on patient safety and two for service improvement.

The report has highlighted that several of the actions require a response across the BCUHB system [e.g. the diabetic foot pathway, which is a pathway largely driven by diabetes care and not a vascular only pathway] involving operational improvement plans across several clinical areas across primary, community and secondary care. As this work is more complex than previously appreciated, some of the completion dates will require amendments.

RCS urgent recommendations to address potential patient safety risks

- Agreed pathway for timely and effective treatment at the hub site
- Vascular bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub site
- More effective use of the hybrid theatre
- Vascular consultant presence to enable patient review within 24hrs at spoke sites
- Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation
- Develop non-arterial diabetic foot pathway
- Finalise other pathways currently in draft
- Confirm pathway for non-complex/low risk vascular interventions at spoke sites
- Improve effectiveness of clinical governance process

Recommendations for service improvement

- Clarify phase 2 of centralisation plans (services accessible at spoke sites)
- Improve communication and team working across hub and spoke sites

Patrick Johnson at Ysbyty Glan Clwyd (YGC) is supporting the Acting Executive Medical Director as a member of the Task and Finish Group to deliver the vascular action plan.

Following the receipt of this feedback the structure and function of the Task and Finish Group, including the terms of reference, have been reviewed to address the internal and external concerns raised. The revised terms of reference which have been reviewed at the Task and Finish Group in May and were finalised at the Task and Finish Group meeting on 28th June 2021.

The key proposed change is that the Task and Finish Group is now designated as a steering group with subsidiary Task and Finish Groups to address specific topics such as the diabetic foot pathway.

The vascular services currently provided at Wrexham Maelor Hospital (WMH) and Ysbyty Gwynedd (YG) comprise outpatient clinics, day case surgery and provision of reviews for patients referred via the Emergency Department or from inpatient settings. The provision is detailed in Appendix 1.

All inpatient activity is currently carried out at YGC. It had been identified previously that there were around 300 patients per annum whose condition would be best treated in the specialist hybrid theatre created at YGC with the supporting infrastructure in place. It is now necessary to strengthen the provision of the spokes service at Ysbyty Wrexham Maelor and Ysbyty Gwynedd, which is also highlighted in the RCS review.

Vascular Task and Finish Group

Appendix 2 - North Wales Vascular Task and Finish Group Action Plan is attached and each of the recommendations that are summarised below are included in the tracker.

Develop the non-arterial diabetic foot pathway.

Whilst this pathway is covered under the RCS review of the North Wales Vascular Service, it is not a vascular led service. Vascular input is required if a patient's foot has deteriorated to the point where surgical input is required. That input will vary on a case by case basis but might be from either vascular or orthopaedic surgery or a combination of the two.

The diabetic and podiatry teams are at the head of this pathway and our review has shown that both those services require additional resources to deliver a fully effective service. This has been compounded by a shortfall in the availability of orthopaedic capacity which will need to be addressed via the Area Teams and Secondary Care governance mechanisms.

There are documented pathways in both primary and secondary care which comply with NICE guidelines. However, an analysis has shown that the knowledge and availability is not uniform

across BCUHB and work is currently underway with the GP lead and lead podiatrist to resolve the situation in primary care to obtain uniformity and an updated pathway. Agreements on principles of care are being achieved across the District General Hospital (DGH) sites for the secondary care pathway and key meetings are in place during the week of the 7.7.21 to resolve any additional issues. The time taken reflects the multiple professions that need to be fully engaged in the process.

Pathways and alignment of vascular inpatient bed base

The progress is described in the action tracker.

A review of the capacity and demand for inpatient beds across the service was completed at the commencement of the Task and Finish Group. It has been agreed at the Task and Finish Group that this will be reviewed again once all the pathways have been agreed.

All pathways have been agreed with the exception of the Intravenous Drug User Pathway at YG, and it is anticipated that YG will adopt the same pathway as has been adopted at WMH and YGC in early July. The pathway is led by general surgery and only by clinically identified exceptions is input from the vascular team required.

A snapshot audit on three different days and several weeks apart shows a potential of up to 10 vascular inpatients on any given day at YGC could have been treated at their local hospitals if there were designated vascular beds available. This total is split evenly between WMH and YG. A further review of the number of beds and theatre lists required will be completed and agreed in July 2021.

The above figure doesn't include the number of orthopaedic beds that will be required at all three hospitals as a result of providing a more robust service rather than relying upon a single surgeon.

More effective use of the hybrid theatre

A number of actions have been identified that will be taken to improve theatre utilisation. Standard operating procedures have been agreed and operational implementation awaited. This is indicated on the action tracker.

These have been identified as a result of discussions with the Surgical Clinical Director at YGC along with the theatre manager and the Vascular Clinical Lead. These actions include

- Changes to the day the weekly Multidisciplinary Team (MDT) and theatre scheduling meeting take place to reduce the current high risk of disruption and cancellations at the beginning of the week. This will have a knock on effect as to how other clinical sessions are provided in the week.
- Alternatively to change how the theatre is used on different days.

Vascular consultant presence to enable patient review within 24hrs at spoke sites

The RCS report has prompted a further detailed examination of how the medical workforce is deployed across the network to ensure that the agreed hub and spokes model is strengthened. A revised rota has improved the situation, with presence across all sites on all five days of the week. Access to a Consultant of the week and an on call consultant is always ensured.

The Clinical Lead is now completing a detailed review of all job plans to ensure there is greater resilience around physical presence at all three hospitals but also to address the re-localisation of some of the patient pathways. This review will be completed in July 2021.

There is a round of substantive Consultant appointments being planned once the exact requirement is defined.

Communications plan

To support the North Wales vascular service and highlight the progress being made, a communications plan is in development and will be completed by Friday 9th July. The key elements of this are to build confidence in the service by showcasing innovation and staff achievements, highlight positive patient experiences, outline progress against the improvement plan that has been approved by the Board and clearly communicate next steps.

The dedicated vascular services page on our website will be developed to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available. This work is underway and will be completed by the end of July.

A regular supply of press releases will be delivered which will also be shared on our website and on our social media channels. Opportunities will also be taken to include positive key messages in any reactive media statements we issue on the service.

An action plan will be agreed in July between the Communications team and the vascular service with details, following a meeting facilitated by the Executive Director of Workforce and the Acting Executive Medical Director.

Opsiynau a ystyriwyd / Options considered

Next steps

- The exceptions to planned progress are being addressed.
- Recruitment to the Vascular Network Manager role is vital. Further interviews are planned for w/c 12th July 2021. Additional support for the implementation of the Royal College of Surgeons report has also been made available.

Goblygiadau Ariannol / Financial Implications

It is evident from the above narrative that the operational changes needed for improvement may require financial outlay, which will be quantified by the service as part of the implementation plan.

Dadansoddiad Risk / Risk Analysis

There is a need to review the risk register for the service within the remit of the Task and Finish Group terms of reference. This will be done at the next meeting on 26th July 2021.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

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

Asesiad Effaith / Impact Assessment

Impact assessments will be completed as part of the development and approval of clinical pathways as required by the Clinical Advisory Group.

Appendix 1

YG			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	• Dialysis access formation (Fistulas and PD catheters) • Minor vascular procedures including minor amputations, foot debridement • IR procedures including angioplasty / stents • Varicose vein procedures (open, ednovenous)
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews • Urgent patients are referred to the vascular consultant on call in YGC
Inpatient care	vascular inpatient beds	vascular inpatient beds	No vascular inpatient beds

WMH			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	• Dialysis access formation (Fistulas and PD catheters) • Minor vascular procedures including minor amputations, foot debridement • IR procedures including angioplasty / stents • Varicose vein procedures (open, ednovenous)
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews • Urgent patients are referred to the vascular consultant on call in YGC
Inpatient care	vascular inpatient beds	vascular inpatient beds	No vascular inpatient beds

YGC			
Date	**pre 2015 (3 site model)**	**2015-2019 (2 site model)**	**Current (YGC vascular hub, WMH and YG as vascular spoke sites)**
Procedures	all major and minor vascular procedures	all major and minor vascular procedures	all major and minor procedures
Outpatients	Vascular outpatient clinics	Vascular outpatient clinics	Vascular outpatient clinics
Referrals/reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews	• Inpatient and AE referrals • Inpatient reviews
Inpatient care	vascular inpatient beds	no vascular inpatient bed	Vascular inpatient beds as vascular hub

CONTENTS

Vascular Task and Finish Group Action Plan and

Recommendations following the Royal College of Surgeons Invited Service Report Report - Part One

Immediate Royal College of Surgeons actions (embedded documents available to members on ibabs)

Recommendations for service improvement

Additional recommendations

Vascular Task and Finish Group Action Plan

Royal College of Surgeons (March 2021 report) recommendations to address patient safety risks

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone	Assurance
1.0	Agreed pathway for timely and effective treatment at the hub site	There must be an agreed pathway which is clear to all staff to ensure the timely and effective treatment at the hub site for patients requiring specific arterial surgery and complex endovascular interventions. This should include but is not limited to: (i) Appropriate and timely MDT review at both the hub and spoke sites. At the spoke sites, this should, wherever possible, be undertaken by the consultant vascular surgeon assigned to the spoke site, when available (see 4 below). When the on-site consultant vascular surgeon is unavailable, the on call arrangement will be used. (ii) Diagnostic and assessment services should be available in a timely manner at both the hub and spoke sites. This should include non-invasive imaging (CT and MRI) and, if available, cardiorespiratory work up. (iii) A repatriation protocol, including timescales, for admission to hub from a spoke site should be introduced. Treatment plans for transfer must include a robust mechanism to ensure that the medical and any non-vascular clinical needs of patients are communicated to the appropriate specialist teams at the hub site. Renal patients with dialysis needs, is highlighted specifically including that renal function assessment needs are met prior to undergoing vascular surgery.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	31/05/2021	Completed		The vascular recovery plan was drafted based on national guidance and approved by the Clinical Advisory Group and Executives on 25/09/20. This provides timelines for the assessment and management of patients with vascular conditions. This recovery plan has been updated during May 2021 and circulated to all three Hospital Medical Directors for dissemination. Communication to all senior management teams at all three hospitals will be ongoing during Q2 2021/22 to ensure that it is fully understood and embedded. A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients. Diagnostic services are available at all three hospitals. The Clinical Lead for Radiology has confirmed that this is the case though there are some capacity constraints which will require investment to address. Assessment and management of renal patients with dialysis needs has been discussed in a meeting with renal and vascular leads and a draft route into the hub dialysis ward proposed. Further meeting held on 21/05/21 with Acute Care Director, Head of Nursing for Medicine, CD for Medicine and Vascular Network Manager at which requirements were agreed. .	\\cymru.nhs bcu\wmh\hc Pa214822\
2.0	Vascular bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub site	Admission should be to a vascular ward and where this is not possible and vascular patients are admitted under a different specialty, robust arrangements must be in place to ensure appropriate review by the vascular multi-disciplinary team (MDT) and continuity of care.	Site Hospital Directors/ Site Nurse Directors	Chief Operating Officer	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting		Prior to the centralisation of major arterial vascular surgery, the lower limb service at Ysbyty Gwynedd admitted patients from across North Wales, managing the care for patients with diabetic foot disease and difficult to manage lower limb tissue loss and limb ischaemia. Post centralisation, these patients would continue to be managed at Ysbyty Gwynedd (although lower limb surgical arterial procedures would be performed at the hub). Maintaining this model of care in Ysbyty Gwynedd, an analysis of the caseload by patient episode indicated a bed requirement of 15 beds. However, this was based on 2015/16 coded data and did not take into account the increase in demand from East and Central. There were also plans to implement a community hub and spoke model with community beds to allow a reduction in the number of these beds. The Health Board's plans to retain beds in Ysbyty Gwynedd for the lower limb salvage service had to be severely curtailed due to the resignation of senior clinicians and resultant staff shortages. This has provided the opportunity to review and determine the most appropriate pathways for vascular related patients across North Wales in line with national guidance. The NICE guidance for the management of patients with diabetic foot problems recommends that each hospital should have a care pathway for people with diabetic foot problems managed by a multi-disciplinary foot care service. There is now work underway through the Diabetic Foot Task and Finish Group to agree the pathways for the assessment and management of patients including patient requiring admission. A full audit of beds used since centralisation is underway and once the pathways and the audit are completed a recommendation will be made on the number of beds required at each of the three hospitals will be made. **Delivered under the remit of the Vascular Task and Finish Group:** A new calculation of the beds required at each of the three hopsitals will be undertaken when all pathways have been determined and an audit of actual bed usage since April 2019 is completed.	
3.0	More effective use of the hybrid theatre	The potential capacity of the hybrid theatre at the hub could be more effectively utilised by (but not limited to): (i) Ensuring that only cases requiring hybrid theatre facilities (as opposed to regular theatre) are undertaken there. (ii) Commencing lists on time and introducing a "golden patient" initiative for each theatre list (with beds ring-fenced for these patients). (iii) Avoiding any vacant sessions by ensuring that consultant surgeon cover is in place. (iv) Introducing three session lists to allow more flexibility and less 'overloading' of lists. (v) Addressing other factors which have contributed to cancellation of cases. These include: Considering alternative appropriate options to ITU beds where there is not availability, such as post-anaesthesia care unit (PACU) and high dependency unit (HDU). (vi) Anaesthetist involvement in the Friday theatre meetings to help avoid cancellation of cases 'on the day' due to anaesthetic concerns.	Theatre Manager/ Critical care lead YGC	Chief Operating Officer	01/04/2021	28/05/2021	Completed		• ToR for local Task and Finish group involving the CD for surgery, vascular and operational leads. The duties of the Task and Finish Group: - • Agree allocation of operating lists in accordance with schedule in a timely manner working towards 6 week review. • Ensure that processes conform with what is outlined in the Operating Department Standard Operating Procedure 3 – Operating List Management • Agreement of process for cancellation and subsequent relocation of operating lists. • Agree and promote robust method of communication with regard to the above to reduce communication errors. • Analysis of cancelled sessions, monitoring trends and agreeing action points • Ensuring that only cases requiring hybrid theatre facilities (as opposed to regular theatre) are undertaken there. • Commencing lists on time and introducing a "golden patient" initiative for each theatre list (with beds ring-fenced for these patients). • Addressing other factors, which have contributed to cancellation of cases. These include considering alternative appropriate options to ITU beds where there is not availability, such as post-anaesthesia care unit (PACU) and high dependency unit (HDU). • Anaesthetist involvement in the Friday theatre meetings to help avoid cancellation of cases 'on the day' due to anaesthetic concerns." . • Theatre utilisation to be reported to site Q&S	C:\Users Pa214822\De TOR Hybr C:\Users Pa214822\De ODSOP
4.0	Vascular consultant presence to enable patient review within 24hrs at spoke sites	Regarding the vascular surgical presence at the spoke sites: (i) This should ensure consultant review of patients within twenty four hours. (ii) The on-site consultant vascular surgeons should be accessible to all relevant specialties, including but not limited to: Diabetology, Orthopaedics and Endocrinology. (iii) The availability of and means of accessing the consultant vascular surgeons at the spoke sites needs be made clear to all staff who require their input for review of patients.	Vascular Network Manager	Clinical Director - Vascular	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	First analysis shows presence at WMH and YG not certain due to annual leave/sickness. Though as an example the rota for the next two weeks has presence every weekday.	• (i). Gap analysis undertaken and proposal for any resource to be presented to the Secondary Care Medical Director in July 2021. • (ii). Local meetings with diabetology, endocrinology, podiatry and orthopaedics have taken place on all sites as part of the development of a diabetic foot pathway and this includes the means to access vascular support (further detail in recommendation 6 update). • (iii). The vascular rota is circulated across sites, specialties and teams. The rota also includes the allocation of surgeons and the site, together with the contact details.	

5.0	Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation	The draft pathway for the management of patients post major arterial vascular surgery29 needs to be agreed and finalised. It should ensure that communication from the hub to spoke sites and community services regarding discharge and follow up is improved and standardised. This should include but is not limited to: (i) Rehabilitation needs are assessed by the relevant clinical teams prior to discharge and appropriate rehabilitation services accessed locally, wherever possible. (ii) All relevant clinical services at both hub and spoke sites are aware of the pathway and that robust mechanisms are established to ensure that discharge plans (including rehabilitation) are communicated to the relevant teams.	Vascular Network Manager	YGC Medical Director	22/05/2020	27/01/2021	Completed		**Delivered under the remit of the Vascular Task and Finish Group**: Approved at CAG on 27/01/21. Implemented. Focus now on communication of the process across sites and teams. • (i) The process details the referral pathway and includes the access to assessment by the clinical specialty locally as required to ensure rehabilitation needs are appropriately assessed. • (ii). This pathway has now been discussed with the acute care directors and includes transfer within 24 hours of acceptance and the patient being medically fit and the escalation process.	
6.0	Develop a non-arterial diabetic foot pathway	The milestone identified in the Vascular Task and Finish Group to develop the non-arterial diabetic foot pathway should be progressed urgently with the involvement of representatives from all relevant clinical teams. This should include but is not limited to: (i) Assessment protocols by a member of the diabetic team (identified consultant, podiatrist or clinical nurse specialist). (ii) Identifying a diabetic foot lead within the consultant vascular surgeon team, ideally for the entire network to support consolidation of pathways and protocols. (iii) A robust MDT approach across the vascular network with input from relevant clinical specialities, including (but not limited to): Anaesthetics, Podiatry, Diabetology, Microbiology, orthopaedic surgery, prosthetic limb and specialist vascular nursing. This should include: ⍰ Establishing a foot MDT for each spoke site. ⍰ The re-introduction of MDT clinic sessions. Podiatry and Diabetology should be central with input from other relevant clinical specialities, including (but not limited to): Microbiology, orthopaedic surgery, prosthetic limb and specialist vascular nursing. (iv) Patients at spoke sites diagnosed with diabetic foot sepsis with no arterial compromise, should be treated at the spoke site where possible. If it is not possible, a protocol should be in place for urgent transfer to the hub. (v) Clear admission arrangements at spoke sites, including the specialty the patient is admitted under, which allows for input from vascular surgery. Admission responsibilities need to be included in job planning for the admitting consultant(s). (vi) Robust mechanisms should be established to ensure that discharge plans are communicated to the relevant teams. In particular, communication with CNS/ANP, vascular outreach nursing and podiatry should be addressed. **See also additional recommendation number 15**	Senior Diabetic Clinician	Secondary Care Medical Director	01/04/2021	30/06/2021(+E9:G10)	In progress but not on track/overdue/late starting	Due to the multi-professional nature of management of these pateints, and the need for uniformity across the sites, there is a need for further clinical discussion based on some core pathway documents that have been designed. This will be agreed in July 2021.	Some of the principles pf the secondary care diabetic foot pathway has been agreed. (The one page vers attached). Each hospital/areas has then produced a gap analysis highlighting the resources that are requ to have a sustainable service. The gaps are mainly human resources but there also some physical space i to be addressed. A weekly meeting is held between Centre and East / West so that relevant information their patients that are being discharged to include: 1 Date and location of vascular follow up 2 Antibiotic plan for the patient 3 Offloading plan 4 Date podiatry review required For consistency, this information is also required for central patients being discharged	C:\Users\Pa214822\Desktop\OUTPATIENT MDET C:\Users\Pa214822\Deskt Central Outpatie C:\Users\Pa214822\Desk West Outpatie C:\Users\Pa214822\Desk East Outpatie C:\Users\Pa214822\Desk 20210604 Daily C:\Users\Pa214822\Desktop\Diabetic Foot C:\Users\Pa214822\Desk ToR Diabetic Fo
7.0	Finalise other pathways currently in draft	The review team noted that in addition to the two clinical pathways referred to in recommendations 5 and 6, the Vascular task and Finish Group have identified actions in respect of a further three pathways. It is recommended that these are agreed, finalised and implemented and that relevant clinical services at both hub and spoke sites are made aware of the pathways.	Clinical Lead for General Surgery	Secondary Care Medical Director	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	Final sign of pathway required by Vascular Clinical Lead or deputy in his absence.	• IVDU pathway outstanding. Secondary Care Medical Director is determining best practice and will facilitate a meeting with all stakeholders with the intention that the pathway is appropriately led by General Surgery. • Acute Care Director (YGC) met with the Hospital Medical Director (YG) on 25/05/21 to understand the local issues. **Delivered under the remit of the Vascular Task and Finish Group:** • The day case vascular angioplasty pathway was approved by Clinical Advisory Group and the executives in January 2021 and has been implemented. • The pathway for the management of patients post vascular intervention at Glan Clwyd Hospital was approved by the Clinical Advisory Group in January 2021 and has been implemented. • The pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team was incorporated into the agreed pathway for the management of patients post vascular intervention at Glan Clwyd Hospital and was approved by the Clinical Advisory Group in January 2021 and has been implemented.	C:\Users\Pa214822\De Managing I
8.0	Confirm pathway for non-complex/low risk vascular interventions at spoke sites	Pathway/pathways is/are needed to enable non-complex/low risk peripheral vascular interventions to be undertaken (in line with VSGBI guidelines), mainly as day cases at the spoke sites. This should involve discussions between the hub and spoke Medical Directors and will need to include, but is not limited to: (i) Agreement regarding interventions undertaken at the spoke sites in line with VSGBI. (ii) Details for inpatient responsibility for patients requiring admission following general anaesthesia, which includes input from vascular surgery. The potential inpatient responsibilities could include (but are not limited to): general surgery, general medical, diabetes or orthopaedics. (iii) A mechanism in place for timely transfer to the hub site should the need for complex vascular intervention arise.	Clinical Leads for East and West - Vascular	Clinical Director - Vascular	01/04/2021	30/06/2021	In progress but not on track/overdue/late starting	It is necessary to secure the required theatre sessions and access to beds before this can be progressed further. At Wrexham a full day elective orthopaedic list has been made available so that patients requiring urgent surgery can be prioritised away from the daily trauma lists.	The vascular recovery plan was drafted based on national guidance and approved by the Clinical Advisory Group and Executives on 25/09/20. This provides timelines for the assessment and management of patients with vascular conditions. This recovery plan has been updated during May 2021 and circulated to all three Hospital Medical Directors for dissemination. Communication to all senior management teams at all three hospitals will be ongoing during Q2 2021/22 to ensure that it is fully understood and embedded. It is agreed which vascualr procedures can be carried out at WMH and YG as well as any orthopaedic interventions. Changes haven't yet been implemented as discussions are ongoing regarding theatre availability and where necessary, inpatient beds. Expectation is that from Q3 that changes will be fully implemented. The main reason for caution now is that there is severe pressure on all three hospitals for elective capacity and inpatient beds as a result of high non-elective demand, primarily medical.	

9.0	Improve effectiveness of clinical governance process	Improvements are required in respect of the effectiveness of the clinical governance processes. This includes, but is not limited to: (i) Steps taken to ensure that there is confidence in the independence of the sign off on Datix reports as part of clinical governance and feedback. (ii) Consideration given to appointing an external chair (for an agreed defined period) for clinical governance meetings to (remotely) oversee the process. This could be considered in conjunction with expert support/input for vascular MDT meetings [see recommendation 12 (i)]. (iii) A mechanism in place to ensure that agreed changes to clinical practice arising from shared learning are clearly identified and effected. (iv) Addressing any concerns regarding the submission of Datix reports as a method of complaining about colleagues. In addition, all staff should be made aware of the Health Board policy/guidelines in respect of Datix submissions and the other appropriate process(es) in place for raising concerns. Alignment with these policies/guidelines/process(es) should be managed by the Medical Director. (v) Clarifying the requirements for undertaking root cause analyses (RCAs) for all major amputations, and that processes are in place to ensure any requirements are met.	Vascular Clinical Governance Lead	Secondary Care Medical Director	01/04/2021	28/05/2021	Completed		• This feedback was provided to the vascular team for their reflection and ideas for improvement following the publication of the report on 13/05/21. • Meeting held on 20/05/21 with the vascular governance lead, vascular network manager, CD for vascular and acute care director for YGC to discuss actions for improvement. • Support will be provided from a specialty with a well established governance process. • Proposals for improvement to be presented to the site Q&S. • (i). The vascular service complies with the approved Health Board concerns and incident process. • (ii). Appointment of the Secondary Care Medical Director as Chair of the vascular clinical governance meetings to oversee the process. • (iii). The service now ensures that actions from goverance meeting including sharing of learning are now documented and tracked in an action log. • (iv). Clinical Director presented to the Vascular Clinical Governance meeting on 22/04/21 on civility and partnership working. An Anaesthetic consultant will also attend Vascular Clinical Governance meetings as well as General Surgery consultant on an as required basis.	 S:\Concerr Concerns pro BCUHB.incid

Royal College of Surgeons (March 2021 report) recommendations for service improvement

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
10.0	Clarify phase 2 of centralisation plans (services accessible at spoke sites)	Given the focus on the establishment of the provision of arterial and complex vascular surgery service at the hub site as the primary phase of centralisation, a clear action plan should be put in place (as phase 2 of centralisation) to enable the return of spoke services within accepted guidelines.	Acute Care Director	Chief Operating Officer	01/04/2021	30/09/2021	In progress and on track		There is a comprehensive review of all pathways underway under the remit of the Vascular Task and Finish Group and subsequent communication which will result in a clear understanding of what services are to be provided in spoke sites. This will affect patients who are currenty transferred to YGC that should be treated closer to home.
11.0	Improve communication and team working across hub and spoke sites	Support should be provided to improve and facilitate communication and team working across hub and spoke sites to reflect a network approach, which supports spoke services. This could include agreed non-patient facing job plan time timetabled at the spoke sites, which could also help maximise the availability of vascular clinical expertise there.	Vascular Network Manager Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	30/06/2021	In progress but not on track/overdue /late starting		▪ Review of consultant presence and any resource gaps to be identified and proposal to be presented to the Secondary Care Medical Director has not fully completed by the deadline but will be completed in July 2021. ▪ SPA on-site presence is currently within existing job plans.
12.0	Improving clinical leadership	The potential for improving clinical leadership should be explored. This should include but is not limited to: (i) Formalising a complex case MDT and governance process (with Liverpool suggested as the nearest major centre) by establishing a model for the vascular network to enable joint supra-regional MDT and case sharing. (ii) Establishing a clinical lead for each spoke site to enable and support: ▪ Local MDT working; ▪ Improved communication between the vascular surgery service and an appropriate member of the spoke management team that the vascular team can meet with regularly to consider local issues and service development.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	31/08/2021	In progress and on track		(i) Vascular CD / governance lead to contact the Liverpool Lead to initiate discussions for formalising a complex case MDT and governance process by the end of August 2021 (ii) CD for vascular has established a clinical lead for each spoke site
13.0	Improving effectiveness of mortality and morbidity discussions and shared learning	Review of a number of issues relating to M&M meetings to improve their effectiveness in enabling comprehensive MDT discussion and shared learning, is recommended. These should include but are not limited to: (i) The timing of meetings to enable anaesthetists to attend. (ii) A system to ensure that discussion items that are not able to be discussed at a meeting are carried forward to the next. (iii) A robust system to record and share all agreed actions.	Vascular Clinical Governance Lead	Secondary Care Medical Director	01/04/2021	01/07/2021	Completed		(i) The timing of meetings to enable anaesthetists to attend has been initially discussed with the Directorate General Manager and the governance lead for anaesthetics - attendance to be timetabled in line wtih current dates. This has already been established with general surgery. Vascular Network Manager met with the clinical goverance lead for anaesthetics and agreed joint sessions throughout the year. (ii) The service is drafting a cycle of business for clinical governance that will be presented to the clinical effectiveness group and quallity and safety for approval in the June 2021 meetings (iii) Actions are now tracked in a separate rolling action log implemented in April 2021.
14.0	Progression of clinical audits within the department	The six audits identified by the vascular task and finish group to be undertaken utilising National Vascular Registry (NVR) data should be progressed as part of assessment, evaluation and shared learning.	Vascular Clinical Audit Lead	Secondary Care Medical Director	01/04/2021	31/08/2021	In progress and on track		The identified clinical audits are now timetabled for discussion at vascular clinical governance meetings and two audits were presented at the last two governance meeting in March and April 2021. The next governance meeting is 15/06/21.

15.0	Further actions to progress the non-arterial diabetic foot pathway	Following (and to support) recommendation 6, the following requires consideration: (i) The need for an additional consultant diabetes physician to the YG spoke site (including non-consultant grade support) to ensure capacity to meet the workload requirements. This would enable ward beds to be hosted by a consultant diabetes physician and to play a key role in vascular care. (ii) The provision of a diabetic foot clinic by consultant vascular surgery in partnership with podiatry at all three sites. (iii) A network wide appointment in podiatric surgery, or an orthopaedic surgeon with special interest in vascular, to support the foot salvage service on all three sites with the in-house teams. (iv) A lead vascular surgery clinician for foot salvage across three sites to support the spoke teams and standardise care and pathways.	Senior Diabetic Clinician	Secondary Care Medical Director Area Medical Director	01/04/2021	28/01/2022	In progress and on track		▪ The Diabetic Foot Pathway Task and Finish Group is a subsidiary of the Vascular Task and Finish Group. ▪ See recommendation 6 update.
16.0	Improved communication across nursing teams	Regular vascular nursing staff meetings should be established to support this and enable effective discussion and communication. These time slots will need to be protected in order to enable attendance by all vascular nursing staff.	Head of Nursing - all sites	Secondary Care Nurse Director	01/04/2021	30/06/2021	Completed		There are now established weekly vascular nurse and podiatry meetings on a Monday (Centre and East) and Thursday (Centre and West) to enable improved communication across sites. Work is ongoing to coordinate a single meeting.
17.0	Deanery and non-training grade surgeons at the spoke sites	Additional Deanery and non-training grade vascular surgeons are needed to allow both for support for learning opportunities at the spoke sites and to take the reliance on general surgery trainees out of the on call process.	Educational Lead for Vascular	Secondary Care Medical Director	01/04/2021	04/08/2021	In progress and on track		Discussions with the West general surgical team to look at getting a general surgical trainee to rotate into vascular. The East have appointed a middle grade and SHO level non-training grade doctors, both of these doctors have now commenced in the service.
18.0	Developing working relationships between vascular surgery and interventional radiology at spoke sites	The Health Board should maintain and develop the working relationships between vascular surgery and interventional radiology (IR) at spoke sites to ensure timely intervention in line with the VSGBI quality improvement framework for lower limb ischaemia.	Clinical Leads for East and West - Vascular IR Lead for Vascular	Secondary Care Medical Director Clinical Director for Radiology	01/04/2021	30/06/2021	Completed		There is a weekly MDT pan BCU which is attended by the Interventional Radiologists and Vascular Consultants. Weekly local MDTs with IR and Vascular input are also undertaken. Vascular Network Manager met with the Vascular IR lead radiologist on 13/05/21 to understand areas for potential improvement. Consensus that the relationship between the vascular service and interventional radiology is developing well now.
19.0	Developing nurse outreach services	The service expansion plan for the vascular nursing outreach team at YG spoke site, which was reported to have been prepared prior to centralisation of the vascular service, should be re-visited.	Vascular Network Manager	Secondary Care Nurse Director	01/04/2021	30/06/2021	In progress but not on track/overdue /late starting	scheduled with YG Vascular Outreach Nurse on	Will be considered as part of overall resource plan for pan BCU rather than in isolation.

Royal College of Surgeons (March 2021 report) recommendations for the healthcare organisation to consider as part of its future development of the service:

Ref	Recommendation	Detail	Action by	Owner	Start Date as per report date (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
20.0	Vascular on-call for vascular surgical trainees	Including vascular surgical trainees in the vascular on-call to enable exposure to more complex procedures.	Clinical Director - Vascular	Secondary Care Medical Director	01/04/2021	30/06/2021	**In progress but not on track/over due/late starting**		There is currently one HEIW general surgical trainee on rotation in vascular. From August 2021 there will be an additional HEIW vascular trainee. These trainees are on the general surgical on-call. The possibility of involvement in the vascular on-call will be explored and a proposal made to the Secondary
21.0	Tenure of clinical leadership / management roles	Having agreed guidelines for the length of tenure of clinical leadership/management roles to facilitate rotation of the roles, and thereby, support the potential for new ideas and leadership styles.	Secondary Care Medical Director	Executive Medical Director	01/04/2021	30/06/2021	Completed		Discussions have taken place regarding rotating leadership roles and creating asdtional roles, such as resaerch leadership to strnthen the service. A balance will be struck between stability and managing change accordingly.
22.0	Recruitment and retention of clinicians	The development of an action plan designed to maintain stability and attract further clinicians, given the relatively rapid turnover of vascular surgeons within the service.	Secondary Care Medical Director	Executive Medical Director	01/04/2021	28/01/2022	Completed		The action plan includes highlighting the potential for increased academic activity within the vascular service and the potential of contribution to the emerging medical and health sciences school in North Wales. Agreement has been reached with

Vascular Task and Finish Group Review Action Plan

Ref	Recommendation	Actions	Action by	Owner	Start Date as per PID (for tasks only) DD/MM/YYYY	End Date for milestones (as per PID) and tasks DD/MM/YYYY	Revised Start Date DD/MM/YYYY*	Revised End Date DD/MM/YYYY* Reason for revision	Actual End Date DD/MM/YYYY*	Task Status - *this will autopopulate once the start/end dates are inserted*	If overdue, task status	*Notes - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone	Addresses RCS recommendations	Assurance
1.0	**Alignment of vascular bed base**	**Milestone 1 - Alignment of vascular bed base**												
1.1		Review of the capacity and demand for inpatient beds across the service.	YGC Site Hospital Director/ YGC Nurse Director	Chief Operating Officer	22 May 2020	16/06/2020		01/01/2021 Amended to 30/09/21 in line with Diabetic Foot pathway deadline		**In progress but not on track/overdue/late starting**		Agreed by T&F group to re-assess the requirement for inpatient beds as part of the finalisation of clinical pathways. The pathways will determine the bed requirement and alignment. A new calculation of the beds required at each of the three hospitals will be undertaken when all pathways have been determined and an audit of actual bed usage since April 2019 is completed. All pathways need to be finalised before a definitive calculation can be made. A review of the patients under vascular care at YGC has shown that there are around 8 patients who could have had their care at WMH or YG. In addition there are diabetic foot patients who will under orthopaedic care at all three hospitals.	Safety: 1, 2, 5, 8 Service: 1, 2	Audit of bed occupancy and capacity and demand has been done on three separate dates and it shows that there are between 8 and 10 patients who could have been treated locally.
1.3		Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Vascular Network Manager	Secondary Care Medical Director	22 May 2020	16/06/2020		01/01/2021		Completed		Agreed by T&F group to review as part of the development of clinical pathways. The pathways will determine the bed requirement and alignment. The service continues locally with consultant reviews, clinics and daycase procedures. Changes to this provision will be determined by any changes resulting from the development of the diabetic foot pathway.		
2.0	**Pathways of care**	**Milestone 2 - Pathways of care**												
2.1		Develop the non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines	Senior Diabetic Clinician	Secondary Care Medical Director	22 May 2020	30/04/2021		30/06/21 with timeframes detailed in pathways of care tab		Completed		June 2021: • One secondary care diabetic foot pathway agrred for all three hospitals.Approprate orthopaedic input has now been identified at all three hospitals. Gap analysis completed for each location. In the East there is a requirement for an additional seesion from diabetes. The centre.	Safety: 1,4,5,6,7,8,9	National Diabetic Foot Audit

2.2		Review and refine angioplasty pathway	Vascular Network Manager	Clinical Director for Radiology	22 May 2020	09/10/2020		30 November 2020		Completed		**Update February 2021:** Approved at CAG on 20/01/21.	Safety: 1,4,5,6,7,8,9	Audit of day-case angioplasty procedures in line with national standards. To be presented to Vascular Clinical Governance 15/06/21
2.3		Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses	Clinical Lead for General Surgery	Secondary Care Medical Director	22 May 2020	02/11/2020		30/11/2020 Amended to 31/07/21 as further discussions between clinicians and site medical director at YG is required.		**In progress but not on track/overdue/late starting**		**Update June 2021:** Secondary Care Medical Director has agrred with WMH and YGC that current pathway led by general surgery is appropriate. Meeting still to occur at YG.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken once pathway agreed
2.4		Review and refine pathway for patients post major arterial surgery requiring rehabilitation	Vascular Network Manager	YGC Medical Director	22 May 2020	02/11/2020		30 November 2020		Completed		**Update February 2021:** Approved at CAG on 27/01/21.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken
2.5		Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	Vascular Network Manager	YGC Medical Director	22 May 2020	23/10/2020				Completed		**Update February 2021**: Approved at CAG on 27/01/21.	Safety: 1,4,5,6,7,8,9	Audit of compliance to the pathway to be undertaken
3.0	**Communication and Engagement**	**Milestone 3 - Communication and Engagement**												
3.1		Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Communications Officer	Assistant Director Of Communications And Engagement,	22 May 2020	16/06/2020		01/09/2020 Revised as the initial deadline was the first T&F group meeting date	01/09/2020	Completed		Draft communication plan shared and approved on 13/08/20 Vascular T&F Group meeting	Service: 1, 2 Safety: Indirectly supports all recommendations	
3.2		Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22 May 2020	Ongoing		01/09/2020 Revised as the initial deadline was the first T&F group meeting date	01/09/2020	Completed		Plan detail in the Communication & Engagement section	Service: 1, 2 Safety: Indirectly supports all recommendations	Patient evaluation of ward patient information undertaken December 2020 - completed
3.3		Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	Executive Medical Director	Executive Medical Director	22/05/2020	15/10/2020		01/11/2020 Revised as the initial deadline was the first T&F group meeting date		Completed		Update from AG that review of process for freedom to speak up is underway to create a BCUHB policy. To be brought to the group once finalised.	Service: 1, 2 Safety: Indirectly supports all recommendations	
3.4		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	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22/05/2020	16/06/2020			16/06/2020	Completed on time		Sent out by CO 23/06/20	Service: 1, 2 Safety: Indirectly supports all recommendations	Ongoing patient experience feedback with support of the corporate team
3.5		Review of patient information and accessibility (including travel) with the support of the patient experience team	Head Of Patient & Carer Experience	Head Of Patient & Carer Experience	22/05/2020	16/06/2020			16/06/2020	Completed on time			Service: 1, 2 Safety: Indirectly supports all recommendations	
4.0	**Quality and Safety**	**Milestone 4 - Quality and Safety**												

4.1		Baseline Safety culture survey to be undertaken to inform areas for improvement	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	17/07/2020		30/10/2020 This was extended due to the logistics of undertaking the survey across the Health Board. 15/04/21 Closing period for survey extended due to poor response in the first round. Results being presented 15/04/21		Completed		**Update February 2021**: Interim organisational report drafted. Segmentation not granular enough to identify vascular services. Chair has commissioned a targeted sample to those who work in vascular services. To be sent out 08/02/21 for 3 weeks. **Update March 2021**: Survey had been out for 3 weeks. Feedback that there have not been sufficient responses to anaylse (n=10). Analyst advised keeping it open for another week. As at 09/03/21 there were n=28 responses. Awaiting analysis of this. **Update April 2021:** Report circulated to Task and Finish Group and presented to the group by Peter Morris, Patietn, Safety and Experiecnce Business Analyst on 15/04/21.	Safety: 2,3,4,5,6,7,9 Service: 2	Repeat survey at a time determined by the T&F group
4.2		Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	17/07/2020		20/08/2020 Deadline extended as team unable to provide the anaylsis for original date.	13/08/2020	Completed		Action plan updated for 17/09/20 meeting and plan detail in the Communication and Engagement section	Safety: 2,3,4,5,6,7,9 Service: 3	Discussion and sharing of learning at Clinical Governance
4.3		Explore the potential to work with a high reporting service to share good practice	Head Of Patient & Carer Experience	Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience	22/05/2020	01/09/2020		01/09/2020	15/10/2020	Completed		Action plan updated for 17/09/20 meeting and plan detail in the Communication and Engagement section	Safety: 2,3,4,5,6,7,9 Service: 4	
4.5		Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures	Vascular Network Manager	Vascular Network Manager	22/05/2020	17/07/2020		17/09/2020	30/09/2020	Completed		Workforce indicators identified and discussion with Information whether these can be incorporated on the dashboard.	Safety: 2,3,4,5,6,7,9 Service: 5	Workforce indicators to be reviewed in Q&S
4.6		Training Needs Analysis to be undertaken to support the emerging clinical pathways and future workforce model	Service Clinical Leads	Service Clinical Leads	22/05/2020	13/08/2020		27/11/2020 - complete for all pathways except the non-arterial diabetic foot pathway. Extended to 30/06/21		**In progress but not on track/overdue/late starting**		Work ongoing with pathways prior to this being actioned. As delay on IVDU conclusion and finalisation of diabteic foot pathway is close to the June month end this action won't be completed on time but can be done in July 2021. June 2021: Learning needs to be identified post IVDU pathway meeting with Secondary Care Medical Director. Learning needs associated with the diabetic foot pathway will be developed as part of the gap analysis by the Diabetic Foot Pathway TFG.	Safety: 2,3,4,5,6,7,9 Service: 6	
4.7		Issues of significance report from Vascular Task and Finish group to Quality, Safety and Experience Committee	Secondary Care Medical Director Vascular Network Manager	Executive Medical Director	22/05/2020	Ongoing		01/09/2020	01/09/2020	Completed on time		Regular reports to QSE and Welsh Government on progresss.	Safety: 2,3,4,5,6,7,9 Service: 7	

5.0	**Clinical Effectiveness**	**Milestone 5 - Clinical Effectiveness**

5.1		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	Clinical Director - Vascular	Secondary Care Medical Director	22/05/2020	16/06/2020		17/09/2020 Revised as the initial deadline was the first T&F group meeting date	17/09/2020	Completed		Presentation at July T&F group on data bases to develop benchmarking information. This included antibiotic resistance presentation. September 2020: Detailed update on the audits currently underway within the service and the opportunities to benchmark provided	Safety: 9	Compliance with Tier I-III audits
5.2		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	Head Of Patient & Carer Experience	Secondary Care Medical Director	22/05/2020	17/07/2020		17/09/2020 Revised as the initial deadline was the first T&F group meeting date	08/10/2020	Completed		Patient experience data to be incorporated. Further workforce metrics to be reviewed and included as data available. Development team continuing to work on accessing data. Workforce indicators monitored through accountability with DGM and HoN. Dashboard in use by the service.	Safety: 9	
5.3		Review of PROM/PREM measures to improve patient experience alongside existing patient experience data	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	16/06/2020			16/06/2020	Completed			Safety: 9	
5.4		Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	Ongoing		01/03/2021		Completed		Regular reports to QSE and Welsh Government on progresss.	Safety: 9	
5.5		Monitor vascular waiting times	Vascular Network Manager	Chief Operating Officer	22/05/2020	Ongoing		17/09/2020		Completed			Safety: 9	Monitoring via the vascular dashboard
5.6		Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified	Vascular Network Manager	Secondary Care Medical Director	22/05/2020	16/06/2020			16/06/2020	Completed on time		Kate Clark to re-circulate reporting template. Action closed.	Safety: 9	

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15.07.2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Urgent Care Improvement
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing & Midwifery / Deputy CEO
Awdur yr Adroddiad **Report Author:**	Claire Brennan, Head of Office Roshan Robati, Programme Director for Unscheduled Care (USC) Dr Chris Subbe, Senior Clinical Lead for USC
Craffu blaenorol: **Prior Scrutiny:**	Review by Executive Director of Nursing & Midwifery / Deputy CEO
Atodiadau **Appendices:**	*n/a*

Argymhelliad / Recommendation:

The Board are asked to note:

1. concerns raised by Emergency Department Clinical Leads in correspondences dated 10th December 2020 and 17th June 2021
2. update on the Urgent and Emergency Care improvement programme of work

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This report provides an update to the Health Board on the improvement programme of work for the whole urgent and emergency care system that will ultimately avoid harm, ensure delivery of high clinical standards and quality of care, improved patient outcomes and provide a better experience for patients and staff. This focused improvement programme of work is in recognition of the ongoing unprecedented challenges on the urgent and emergency care system, which have also been escalated by Emergency Care clinicians and seeks to support and enable staff to effectively and safely deliver the necessary services to meet the demand of our population.

Cefndir / Background:

Emergency Department (ED) Performance

The Health Board's 4 hour ED performance has remained below the 95% standards for some considerable time and is one of the key indicators of the daily pressures across the urgent and emergency care system where patients are experiencing unacceptable delays in the department due to lack of flow across the whole system and an inability to offload patients from ambulances.

Whilst the usual demand on our EDs eased during the first phase of the lockdown in April and May 2020 when there was a significant drop in the number of attendances, the number of people presenting to our EDs is comparable to pre-covid levels in 2019. This increase in attendances, alongside the reduced capacity in our EDs to ensure adherence to social distancing and the need to continue with the separation of red and green pathways, means that overcrowding in ED is felt more acutely. Whilst the rate of new Covid-19 infections is reducing, challenges remain within EDs in the unpredictable shift in green and red patients who continue to present to the departments and this year this is exacerbated by an increased number of tourists to the North Wales area due to the international travel restrictions. The acuity of patients presenting to EDs has remained high over recent months.

In addition to the aforementioned challenges, the reduction in bed base across the Health Board, in order to comply with social distancing requirements (circa.10% reduction in bed base), delays in specialty bed waits as well as swabbing delays for direct admission has further impacted on flow across the whole system resulting in delays in admitting patients from the EDs. Our capacity is further impacted by the number of staff who have to self-isolate, which further reduces the capacity.

In support of improving flow, work has been undertaken to mobilise surge capacity across North Wales with criteria that meets the current clinical needs of patients 'waiting' to return to Care Homes or needing packages of care. Furthermore, Home First Bureaus are established in each health community, to support the timely and appropriate transfer of patients from acute and community hospitals back to their own homes, existing care home or new placement. Working across Health and Local Authority processes they co-ordinate and manage patients with more complex discharge planning arrangements on Hospital Discharge Pathways 3 and 4, focusing primarily on internal systems that concentrate on acute and community hospital patient discharges. We are actively exploring with the Welsh Government the options to utilise nursing home unused capacity to improve flow out of hospital. Specifically in the West health community, there are discussions underway to block purchase beds within a nursing home to support discharge of medically fit patients who awaiting their preferred home or package of care with a view to rolling this out across wider homes.

There is also a proposal to expand the Hospital at Home model which has proved successful in Anglesey to other areas in North Wales. This will support admission avoidance, provide rapid response and support discharge pull of patients from hospital, with specified referral criteria.

For the six months from January to June 2021, the Health Board has reported a total of 104 instances when sites reported escalation level 4, this is split per site as follows; Ysbyty Gwynedd 13, Wrexham Maelor 25 and Ysbyty Glan Clwyd 66.

The following graph at Figure 1 below depicts the Health Board's ED monthly data for 4 hour performance, the number of attendances, admissions and Wales Ambulance Services Trust (WAST) arrivals for the period from April 2019 to June 2021.

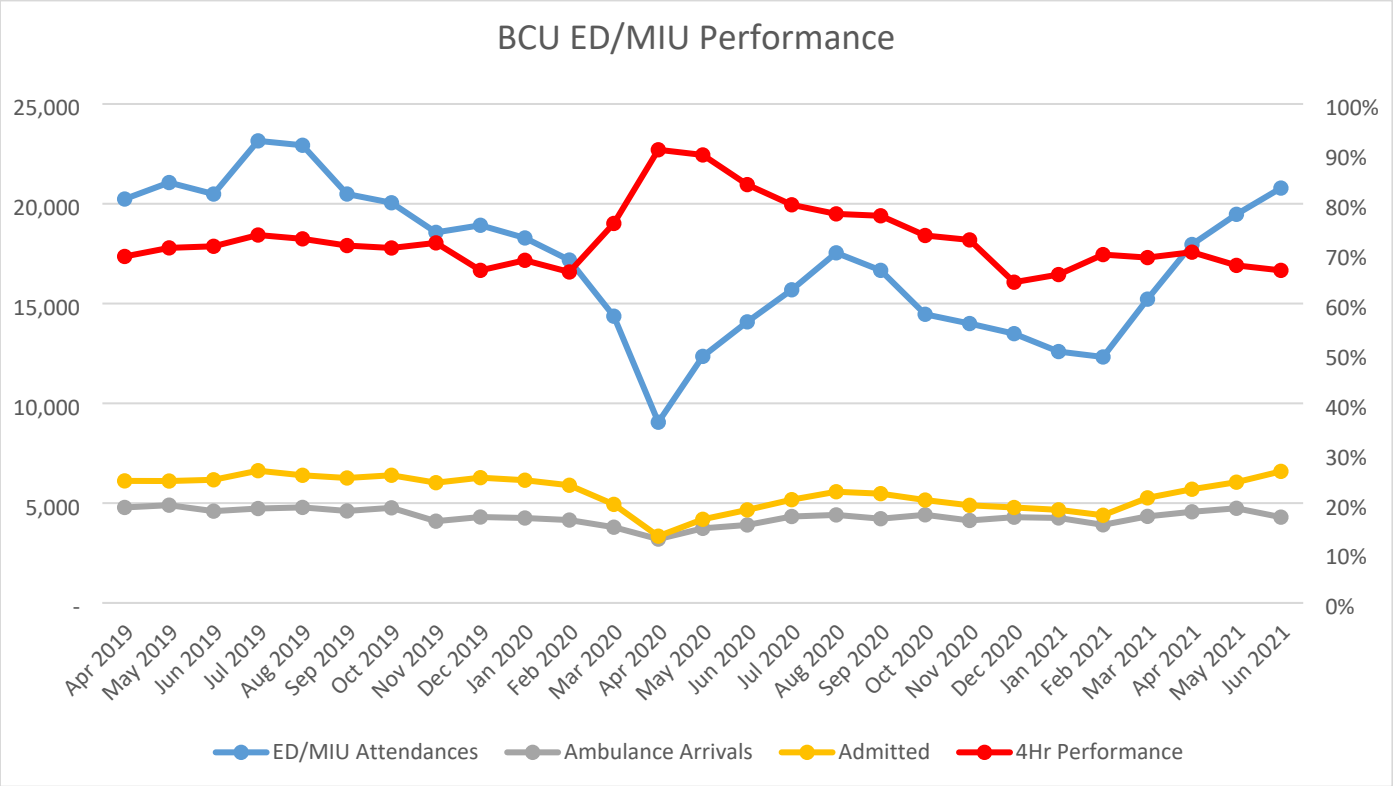


Figure 1: ED / Minor Injury Unit (MIU) performance

Primary Care

All GP practices have remained open during the pandemic, with some clusters also developing Local Assessment Centres or 'red hubs' during in the initial wave, to care for suspected covid-19 patients away from the main surgery sites.

Within primary care, high levels of demand and activity are now being reported across GP practices, with new ways of accessing services implemented to continue to safely support and socially distance patients during the pandemic. Additional contact activity provided using on-line platforms, email, telephone and video consultations is noted, with an indicative study suggesting that activity in GP practices has increased as much as 20%, and this is expected to continue.

A GP practice with a patient population of approximately 16,000 collated data to demonstrate the significant demand increases. The data highlighted the average monthly activity managed by reception staff. Notably incoming telephone calls nearly doubled, with a 66% increase in emails and over 100% increase in eConsult queries. Total GP consultations (face-to-face and telephone combined) have also increased. Practices also continue to contribute significantly to the Covid-19 vaccination programme, as well as support patients who are waiting for secondary care treatments or have delayed contacting their GP with a concern. Furthermore, as in secondary care, GP practices also have a backlog of planned care to address in supporting patients with chronic conditions.

Emergency Department pressures

ED Clinical Leads wrote to the Acting Chief Executive on 10th December 2020, regarding the significant levels of overcrowding in EDs and highlighted their concerns around the impact on their ability to deliver safe, effective care and the subsequent consequences on patient safety and staff

wellbeing. The Chairman and Acting Chief Executive met with ED Clinical Leads on 15th December to discuss the concerns they raised in the letter and the necessary actions required to ensure that improvements are delivered to ensure patient safety, reduce harm and support staff to be able to deliver the high standards of clinical care they aspire to. A further letter was received from the ED Consultants at Ysbyty Gwynedd to the Chief Executive and Chairman dated 17th June 2021, following a critical incident in an ambulance with a patient who they unable to offload at the site which reiterated their concerns. The Chief Executive, Chairman with the Deputy CEO are scheduled to meet with the Clinical Lead from Ysbyty Gwynedd on 14th July 2021.

A Health Board wide learning lessons event will be held in August, bringing together all the Emergency Departments to reflect and share the outcomes of serious incident investigations across the three sites. This will be a clinically led, open, and supportive event to allow key learning to be shared in order to improve patient safety and patient experience constancy across the Health Board. The event is the first of what will become a regular programme to support cross-site/division learning.

The Health Board have recognised the need for improvement across the urgent and emergency care system and the Acting Chief Executive facilitated a scoping review on 11th December with consultants and senior nursing colleagues from EDs, as well as wider senior acute and area team colleagues. The National Director for Unscheduled Care / Chief Ambulance Service Commissioner, attended the event. The purpose of the session was to review and refresh the urgent and emergency care programme in recognition of the ongoing pressures and increasing demand, whilst also considering the new ways of working as a result of the impact of Covid-19. It was also to ensure that any revised programme captures a system wide, sustainable response in future plans, with full local ownership.

Our plans will align to the six goals for urgent and emergency care, articulated within the Welsh Government framework, set out in Figure 2 below;

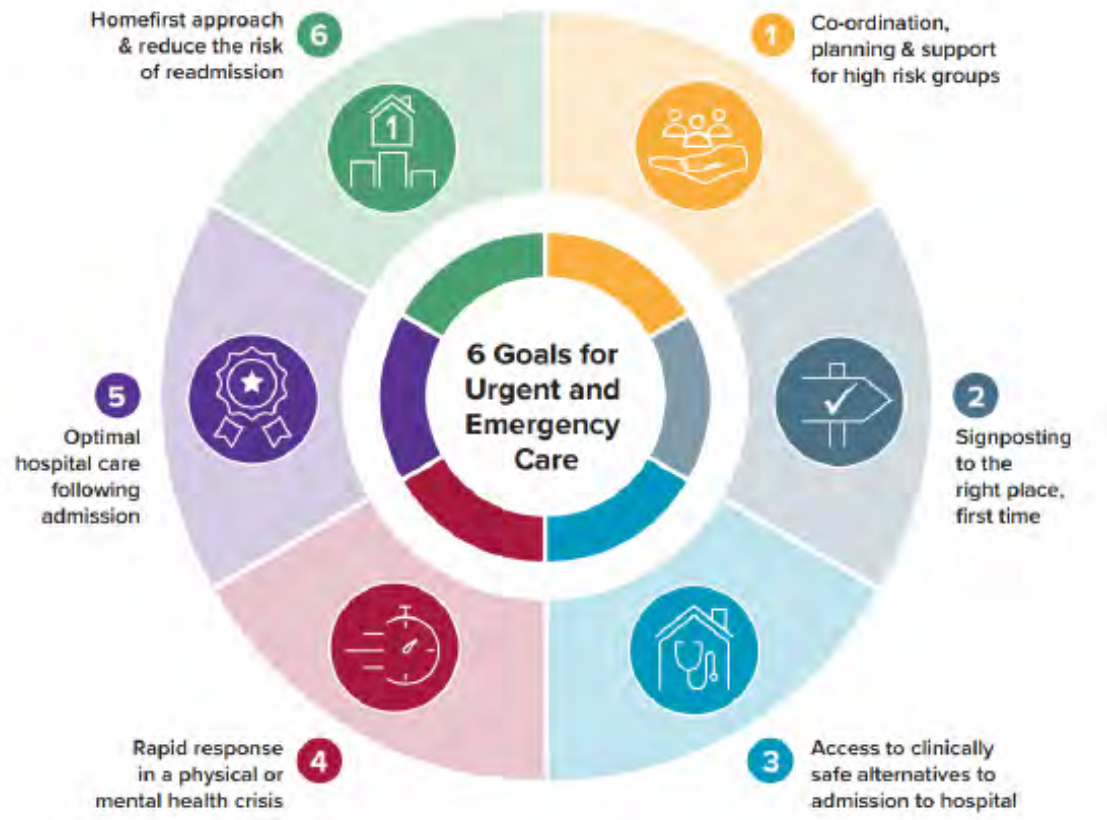


Figure 2: WG 6 goals for urgent and emergency care

Urgent and Emergency Care Improvement Programme

A schedule of support for improvement has since been confirmed by Welsh Government allowing the National Collaborative Commissioning Unit (NCCU) to work with the Health Board to assist with the development of the strategy for unscheduled care and help shape the immediate programme of work. This package will include support to the clinical and management teams with their plans, facilitating the local ownership necessary for the successful delivery and sustainability.

The Health Board has received confirmation from Welsh Government that for the next 2 years there will be targeted additional funding directed at policy goals 2 and 3 (namely signposting people to the right place first time and developing clinically safe alternative pathways to admission), which the Health Board is progressing bids against.

The NCCU support is being provided by the Programme Clinical Lead and Deputy Clinical Director for the National Programme for Unscheduled Care (Dr Ruth Alcolado) and the Programme Director / Assistant Director of Unscheduled Care (Kath McGrath). The NCCU have proposed that the programme presents a number of opportunities recognising that the BCUHB is both a Health Board and a region which could lead to exemplar status for a number of processes and the opportunity for investment for whole system transformation of patient centred care that aims to:

- reduce harm,
- improve patient outcomes
- improve patient and staff experience
- secure partnership working with WAST, Local Authorities and the Third Sector.

The Health Board welcome the NCCU commitment to providing longer term support over the next 18-24 months, which is essential for the sustainable implementation of plans and support for change management, as it is recognised that the scale of change required for this transformation work for urgent and emergency care is a longer term improvement programme and will take time to deliver in its entirety and will continue to evolve.

A further follow up meeting was held on 20th January 2021 with ED Consultants, Secondary Care Medical Director, Secondary Care Nurse Director, Interim Director of Unscheduled Care, Kendal Bluck and colleagues from the performance and communications team facilitated by the Deputy Chief Executive and led by the National Director for Unscheduled Care and Deputy Clinical Director. This meeting was to discuss the development of the improvement programme of work with the NCCU.

Asesu a Dadansoddi / Assessment & Analysis

The collaborative NCCU / BCUHB programme of support commenced in March 2021 with the NCCU Programme Clinical Lead and NCCU Programme Director undertaking visits to each of the 3 localities in East, Centre and West. These visits provided an opportunity to speak with a range of staff across various disciplines to hear their experiences and views as well as seek their input and ideas for the urgent and emergency care system. This included, clinicians, staff from wards, site management, ED, discharge teams, therapy teams, community, pharmacy and mental health. Further follow up meetings have been held with the acute and area senior management teams to initially feedback and then further support the development of the programme structure, including prioritisation and implementation of local plans shaped around a range of projects and initiatives within a whole system change programme with agreed outcome measures. The programme forms part of and aligns with the overall transformation ambitions being led by the Executive Director of Primary Care.

The NCCU team have also met with the six North Wales Local Authority Adult Heads of Service to discuss the improvement programme of work and emerging plans which received very positive feedback and this programme will continue in partnership with social care colleagues and other wider stakeholders including WAST and the Third Sector.

Following extensive engagement between clinical and managerial colleagues and the NCCU, the Urgent and Emergency Care Improvement Programme has been agreed and defined (Figure 3). This is an extensive long term transformational work that requires commitment from colleagues at all levels across the Health Board and in close working with other partners such as local authorities, Welsh Government and others.

A fundamental aspect to the success of the delivery of the programme is building trust both within the Health Board and across the health and social care systems in North Wales. The following principles will be adhere to and the programme will be:

- Clinically led and evidenced based
- Delivering solutions that are right for patients and staff
- Locally owned
- Informed and driven by data and intelligence

The improvement work going forward will be clinically led, which is a key factor to the delivery of the programme, and Dr Chris Subbe has been appointed to the post of Senior Clinical Lead and will be key to driving this work forward, working closely with staff including clinical colleagues, partners and

wider stakeholders to facilitate, implement and embed change, supported by the NCCU. He will be supported by the new Programme Director for Unscheduled Care who commenced on 1st July, alongside a programme manager and analytical support. The Deputy CEO will be the Senior Responsible Officer (SRO) for the programme.

The overarching emerging plan is set out within the diagram at Figure 3 below, which sets out 4 key workstreams and a range of illustrative supporting projects and key enablers with equivalent enabler plans also in the process of being developed around workforce, training, technology, finance and communications. All localities have agreed the importance of patient flow being a system wide responsibility and the need for it to be embedded into business as usual across the system, ensuring that local plans are integrated with effective inpatient ward processes with systems that empower nursing and medical staff.

Workstream 1 will look at reducing demand on hospital and EDs including primary care capacity, 111 First and ambulance / minor injury unit pathways. Workstream 2 focuses on hospital front door and Emergency Department Quality Delivery Framework (EDQDF) and acute models including Same Day Emergency Care (SDEC). The focus of Workstream 3 will be on internal hospital processes including improving patient flow, whilst Workstream 4 will improve the interface with community and Local Authorities to facilitate timely discharge and optimising community step down capacity.

As well as the work underway to develop long term sustainable plans to embed the transformational changes needed across the whole patient pathway, the urgent need to address the serious issues raised by clinical colleagues is recognised and accepted. Improved clinical outcomes for patients and strong clinical engagement and leadership are fundamental to the success of the improvement programme. There are opportunities to improve patient flow and manage demand across the whole system, this is fundamental to addressing some of the root causes of the issues raised. Implementation plans for the East, West and Central areas of the Health Board are being finalised and managing flow and system escalation 24 hours a day 7 days a week will be included as key immediate priorities within those plans. The plans will need to demonstrate effective communication, engagement and commitment from staff at all levels across the system. Additionally, they will need to describe how capacity plans will be developed, managed and refined at times of escalation. They will also need to explain how key basic aspects of patient flow management will be introduced managed and monitored in a timely and effective manner.

The improvement programme aims to implement whole system transformation in response to the recognised challenges that will also address the serious concerns raised by our ED colleagues and build on the national EDQDF programme that sets out to define '*what good looks like'* for patients accessing ED, with agreed care standards, a uniform approach to measuring activity and a nationally agreed model of care for Emergency Departments to enable optimization of clinical outcomes and patient and staff experience. Teams on each of the 3 sites have continued to work closely with clinical and management colleagues to support and facilitate numerous improvement projects across our three Emergency Departments. Project Managers have been involved with a variety of schemes, all ultimately with a focus on improving patient experience, staff experience and patient outcomes, aligning with the EDQDF principles and objectives. Engagement throughout the Health Board has been excellent, particularly from our clinical colleagues, and we will build on these strong working relationships as the programme progresses.

The programme of work will be overseen by an Urgent & Emergency Care Improvement Group chaired by the Senior Clinical Lead. It will follow a standardised agenda, monitoring progress of plans aligned with agreed patient focused outcomes, identifying opportunities for improvement and

learning to reduce risk and improve service delivery. In addition, the programme team comprising of the Deputy Chief Executive (Programme SRO), Senior Clinical Lead and Programme Director will hold regular meetings with the Acute Directors and Area Team Directors of the three health communities to ensure operational delivery of the Urgent and Emergency Care priorities.

A framework is now being developed to finalise plans and priorities for the forthcoming 30, 60, 90 days and beyond. Priority focus within the first 30-day-plan will include a mapping exercise against key targets, available data sources and agreeing a hierarchy of performance data as well as extensive communication and engagement with acute and area teams to identify deliverables and milestones for each workstream and associated projects, how the work is going to be prioritise and to socialise the plans with the wider teams.

The detailed focus on data analysis is fundamental and will form a significant piece of work within the initial 30 days to understand the root causes behind existing demand and performance as well as identify specific data requirements to inform the modelling of potential solutions and areas for improvement. This will also include reviewing and building on existing data analysis work undertaken within previous improvement programmes. In addition, we have commissioned a piece of work from Lightfoot to be able to access and interrogate views of cross organisational information and pose useful questions of patient pathways and clinical decision-making.

We will also work with stakeholders to ensure detailed plans are in place to commence the transformation of work to understand the prioritisation of interventions to be implemented within subsequent 30 day development and implementation phases and identify what additional support is needed from programme team, executive team and the NCCU. The longer term plans for 90 days and beyond will secure wider engagement with clinicians to co-design interventions and issuing of regular feedback to clinical teams.

Conversations have commenced regarding redesigning and mapping of skills within the multidisciplinary teams against organisational priorities. Engagement with Kendall Bluck has recommenced to focus on the system wide workforce required to deliver the plans which go beyond the immediacy of the Emergency Departments and include direct referral models.

There will be a focus around management of system-wide escalation and processes for providing mutual aid to improve flow within the whole system.

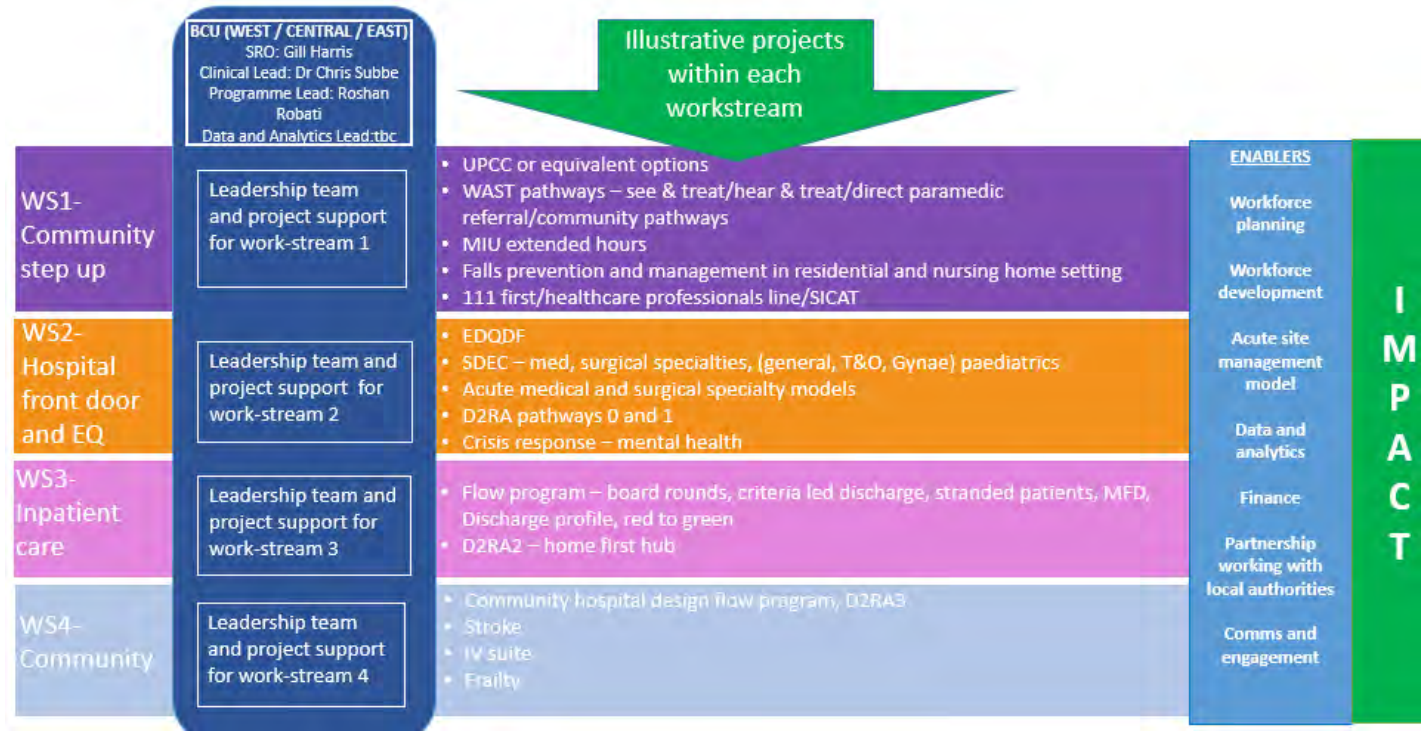


Figure 3: Emerging Plan for Urgent and Emergency Care

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

Bids are in place for relevant projects against the Welsh Government £25m for Urgent and Emergency care in line with the 4 key deliverables: Contact First, Urgent Primary Care Centres, Same Day Emergency Care models and Remote clinical support and optimising conveyance as well as funding for programme management support.

Dadansoddiad Risk / Risk Analysis

Board Assurance Framework (BAF) 20-02 for Safe and Effective Management of Unscheduled Care within strategic priority 1 for Safe Unscheduled Care, describes the risk that "…*the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided*". Mitigating actions to reduce harm, improve patient outcomes and better patient and staff experience across the urgent and emergency care system are in the process of being confirmed in line with the improvement programme of work and revised governance and reporting arrangements.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

N/A

Asesiad Effaith / Impact Assessment

N/A

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quality and Performance (QaP) Report – Position as at 31st May 2021
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Kamala Williams, Interim Director of Performance Edward Williams, Head of Performance Assurance
Craffu blaenorol: **Prior Scrutiny:**	The data and information in this report has been scrutinised by the Finance and Performance Committee on 24th June 2021 and Quality, Safety and Experience Committee on 6th July 2021.
Atodiadau **Appendices:**	1. QaP data report

Argymhelliad / Recommendation:

The Health Board is asked to scrutinise the report and if required to request the provision of further assurance relating to any specific areas which have not achieved national or locally agreed performance measures.

Please tick as appropriate

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

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

Sefyllfa / Situation:

It should be noted that publication of the NHS Wales Delivery Framework for 2021-22 has been delayed due to the ongoing consequences of the COVID-19 pandemic. Welsh Government have advised that Health Boards should continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until further notice.

The Report includes RAG rated trend arrows that identify the direction of travel of performance over the previous 6 months.

The Board are asked to note the following:

Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout Quarter 4, 2020/21 at 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of MMR vaccinations by age 5.

In comparison to the same period of 2020/21, there has been a fall in the number of most infection types across Wales and the Health Board. There has been a rise in the rate of C.Difficile infections

across Wales. However, BCU currently has the lowest C.Difficile rate of all the Health Boards in Wales.

The infection prevention and control teams continue to work on reducing the number of infections alongside their work on COVID-19.

For Adult Mental Health there was a dip, as expected, in performance compared to last month, with the percentage of adults assessed within 28 days of referral at 61.99%. This was due to an increase in referrals in March and issues with capacity in East, which has a waiting list larger than West and Central combined. The number of patients starting therapy within 28 days of assessment remains above the 80% target at almost 80.9%.

Performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 23.68%, and starting therapy within 28 days of assessment at 19.64%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy at 70.67% in May 2021 from a low of 20.1% in September 2020.

Whilst the number of patients experiencing delayed transfer of care (DToC) within our mental health services has increased slightly at 15 in May 2021 (compared to 13 in March 2021), the length of stays has continued to fall at 565 (compared to 631 in April 2021). The service is working to resolve issues that lead to DToC and it is expected that the number and length of DToCs will fall over the coming months.

Performance against the 26 week target for children awaiting neurodevelopment assessment remains poor at 26.84%, however it is a slight improvement on the 23.82% reported previously. It is expected that plans recently approved will enable us to increase capacity to see 120 children per month and this will translate to a much improved performance.

Pressures upon the unscheduled care system continues in light of COVID-19. Performance in our Emergency Departments fell in May to 67.65% of patients seen within 4 hours compared to 70.3% in April. However, there was a marked increase of attendances. The number of patients waiting over 12 Hours in our Emergency Departments increased again to 2,118 compared to 1,749 in April (1,618 in March 2021). The number of patients experiencing ambulance handover delays of an hour or more also increased in May at 1,331 compared to 1,190 in April and 939 in March 2021.

Performance against the stroke care measures improved in May with 27% of patients admitted to a Stroke Assessment Unit within 4 Hours compared to 21% in April 2021 (against a target of 59%). The rate of patients reviewed by a Stroke Consultant within 24 hours improved at 82% in May 2021 (against a target of 85%) compared to 54% in April 2021, with significant improvement against this measure across all three acute hospitals with the biggest improvement in West.

As in the rest of the UK, the disruption caused by COVID-19 continues to severely impact upon our capacity to deliver planned care services at the pre-COVID-19 rates result in increased waiting times. However, in May 2021 the number of people waiting over 36 weeks and 52 weeks fell at 52,706 and 42,034 compared to 53,076 and 43,567 respectively in April 2021. This is the first reduction in numbers of over 36 weeks and over 52 weeks waits reported since December 2019. The number of patients waiting over 8 weeks for diagnostic tests (6,934) and the number waiting for

therapy (1,040) continued to fall in May 2021 compared to 7,441 and 1,153 respectively in April 2021.

For April 2021, against a target of 75%, 67.0% of patients started treatment within 62 days of suspicion. Although below the target rate, BCU remains one of the best performing Health Boards in Wales in terms of the Suspected Cancer Pathway.

At 180,572, the total number of patients waiting on the 'Follow Up' waiting list, rose for the second month in May 2021. The number of those patients that are more than 100% overdue their follow up date rose for the first time in 8 months, at 54,146 at the end of May 2021, compared to 53,173 in April 2021.

Performance against the eye care measure has remained static at 44.23% in May 2021 compared to 44.97% in April. The predicted continuous improvement is not occurring at the expected pace.

The trend for staff sickness rate over the last 6 months (October to March) has been one of improvement and the May rate is 5.27%, and remains lower than at the same period in 2020. COVID-19 related sickness also fell from 0.4% to 0.1%.

PADR (Performance Appraisal Development Review) rates have continued to increase month on month with 71.3% completed by end of May 2021.

There were 3 New Never Events reported in May 2021. These were a second dose of Methotrexate within 48 hours, a wrong side chest-drain insertion and a wrong side ankle block. Investigations into all three incidents remain underway.

Crude Mortality (under 75 years old) has decreased to 1.01%. The mortality rate for BCU is lower than the Wales average of 1.13%.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments and the Office of the Medical Director is currently reviewing this. Reporting is expected to recommence by end of August 2021.

Reducing spend on agency and locum staff continues to be a priority for the Health Board. In May the combined Agency and Locum cost was 7.2%, 0.1% down on April 2021.

The Quality & Performance Report is currently being redesigned with a view to presenting a new Integrated Quality & Performance Report to the Health Board and its committees in Quarter 3 of 2021-22.

A Quality Surveillance Group (incorporating, performance, corporate, medical and nursing services) has been established (first meeting held on 14th June 2021) to review quality and identify hotspots and risks.

Cefndir / Background:

Our report outlines the key performance and quality issues that are of priority for the Health Board. The summary of the report is now included within the Executive Summary pages of the QAP and demonstrates the key measures contained within the 2020-21 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

COVID-19 is now subject to a separate report to the Board and is therefore no longer included in the Quality & Performance report.

Asesiad / Assessment & Analysis

Strategy Implications
The performance measures within the report are aligned with the National Delivery Framework.

Options considered
Not Applicable

Financial Implications
The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on the financial recovery plan of the Board.

Risk Analysis
The present pandemic has produced a number of risks to the delivery of care across the healthcare system.

Legal and Compliance
This report will be available to the public once published for the Health Board

Impact Assessment
The Report has not been Equality Impact Assessed


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Quality and Performance Report
Health Board
Performance to 31st May - Presented on 15th July 2021
Put patients first • Work together • Value and respect each other • Learn and innovate • Communicate openly and honestly

About this Report

The NHS Wales Delivery Framework for 2021-22 has not yet been published, Welsh Government have advised that Health Boards should continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until further notice.

Report Structure

The format of the report reflects the published National Delivery Framework for 2020-21. This aligns to the Quadruple aims contained within the statutory framework of A Healthier Wales.

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.

This report contains data showing the impact of the pandemic on referrals, planned care activity and waiting lists.

COVID-19 is now subject to a separate report to the Board and is therefore no longer included in Quality and Performance report.

Performance Monitoring

This report uses the Key Performance Indicators agreed by executives as the key indicators of performance aligned to the Board's operational plan and risks reportable to Welsh Government under the NHS Wales Delivery Framework and have been scrutinised by the Finance & Performance Committee and the Quality, Safety & Experience Committee.

Performance is measured via the trend over the previous 6 months and is represented by arrows as shown below.

↑	Performance has improved over the last 6 months
↓	Performance has got worse over the last 6 months
→	Performance remains the same

Ongoing development of the Report

A new Integrated Quality and Performance Report (IQPR) is currently in development and will replace the Quality and Performance report in its current format.

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Executive Summary (1)

The Board are asked to note the following:

Quadruple Aim 1:Prevention

Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our childhood immunisation programmes have continued to deliver throughout Quarter 4 of 2020/21 with 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of MMR vaccinations by age 5.

Quadruple Aim 2: Infection Prevention

In comparison to the same period of 2020/21, there has been a fall in the number of most infection types across Wales and the Health Board. There has been a rise in the rate of C.Difficile infections across Wales, however, BCU currently has the lowest C.Difficile rate of all the Health Boards in Wales.

The infection prevention and control teams continue to work on reducing the number of infections alongside their work on COVID-19.

Quadruple Aim 2: Unscheduled Care

Pressures upon the unscheduled care system continue in light of COVID-19. Performance in our Emergency Departments fell in May with 67.65% of patients seen within 4 hours compared to 70.3% in April. However, there was against a marked increase in attendances. The number of patients waiting over 12 Hours in our Emergency Departments increased to, 2,118 compared to 1,749 in April and 1,618 in March 2021. The number of patients experiencing ambulance handover delays of an hour or more also increased in May at 1,331 compared to 1,190 in April and 939 in March 2021.

Performance against the stroke care measures improved in May with 27% of patients admitted to a Stroke Assessment Unit within 4 Hours compared to 21% in April 2021 (against a target of 59%). The rate of patients reviewed by a Stroke Consultant within 24 hours improved at 82% in May 2021 (against a target of 85%) compared to 54% in April 2021, with significant improvement against this measure across all three acute hospitals with the biggest improvement in West.

Quadruple Aim 2: Planned Care

As in the rest of the UK, the disruption caused by COVID-19 continues to severely impact upon our capacity to deliver planned care services at the pre-COVID-19 rates result in increased waiting times. However, in May 2021 the number of people waiting over 36 weeks and 52 weeks fell at 52,706 and 42,034 compared to 53,076 and 43,567 respectively in April 2021. This is the first reduction in numbers of over 36 weeks and over 52 weeks waits reported since December 2019.

At the end of May the number of patients waiting over 8 weeks for diagnostic tests was 6,934 and the number waiting for therapy was 1,040 this compares to 7,441 and 1,153 respectively in April 2021.

Cancer performance measures are reported a month in arrears for April 2021 67.0% of patients started treatment within 62 days of suspicion of cancer, against the national suspected cancer target of 75%. Although below the target rate, BCU remains one of the best performing Health Boards in Wales in terms of the Suspected Cancer Pathway.

Performance against the eye care measure has remained static at 44.23% in May 2021 compared to 44.97% in April. The predicted continuous improvement is not occurring at the expected pace.

At 180,572, the total number of patients waiting on the 'Follow Up' waiting list, rose for the second month in May 2021. The number of those patients that are more than 100% overdue their follow up date rose for the first time in 8 months, at 54,146 at the end of May 2021, compared to 53,173 in April 2021.

Whilst remaining poor at 26.84%, performance has continued to improve against the measure for the percentage of children and young people waiting less than 26 weeks for a neurodevelopment assessment (25.98% in March 2021).

Executive Summary (2)

...continued from overleaf

Quadruple Aim 2: Mental Health

For Adult Mental Health services there was a dip in performance compared to last month, with the percentage of adults assessed within 28 days of referral at 61.99%, this compared to 85.48% in February which was reported in the last Health Board report. The reduction in performance was due to an increase in referrals in March and capacity issues in the East, which currently has a waiting list larger than the West and Central services combined. The number of patients starting therapy within 28 days of assessment remains above the 80% target at 80.9%.

Performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 23.68%, and starting therapy within 28 days of assessment at 19.64%.

Service change and additional staffing have delivered a sustained and significant improvement in the percentage of adults waiting less than 26 weeks to start psychological therapy with 70.67% achieved in May 2021 from a low of 20.1% in September 2020.

Whilst the number of patients experiencing delayed transfer of care (DToC) within our mental health service has increased slightly at 15 in May 2021 (compared to 13 in March 2021), the associated total number of bed days has continued to fall at 565 (compared to 631 in March 2021). The service is working to resolve issues that lead to DToC and it is expected that the number and length of DToC's will fall over the coming months. Mental Health DToCs continue to be impacted by the bespoke needs of patients with combined complex mental and physical health needs.

Quadruple Aim 3: Quality & Safety

There were 3 New Never Events reported in May 2021. These were a second dose of Methotrexate within 48 hours, a wrong side chest-drain insertion and a wrong side ankle block. Investigations into all three incidents have commenced.

Quadruple Aim 3: Workforce

The trend in staff sickness rate over the last 8 months (October to May) has been one of improvement, the May rate was 5.27% which is lower than at the same period in 2020. COVID-19 related sickness has also fallen from 0.4% to 0.1%.

PADR Rates have continued to increase month on month with 71.3% completed by end of May 2021.

Quadruple Aim 4: Mortality and Timely Interventions

Crude Mortality (under 75 years old) has decreased to 1.01%. The mortality rate for BCU is lower than the Wales average of 1.13%.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments and the Office of the Medical Director is currently reviewing this. It is expected that reporting will recommence by end of August 2021.

Quadruple Aim 4: Agency /Locum Spend

Reducing spend on agency and locum staff continues to be a priority for the Health Board. In May the combined Agency and Locum cost was 7.8%, 0.1% down on April 2021.

Performance management

A Quality Surveillance Group (incorporating, performance, corporate, medical and nursing services) has been established (First meeting held on 14th June 2021) to review quality and identify hotspots and risks.

Development of a new Integrated Quality and Performance Report (IQPR) to replace the current Quality and performance report has commenced.

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 lives. 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

- Uptake levels of childhood immunisations have remained high in North Wales over the course of the pandemic
- BCUHB is the only Health Board in Wales to achieve 95% 2 doses of the MMR Vaccine for children aged <= 5
- BCUHB the second best performing Health Board in Wales for '6 in 1' Hexavalent vaccine by age 1

Measures

Committee	Period	Measure	Target	Actual	Trend
QSE	Q4 20/21	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	>= 95%	95.40%	↑
QSE	Q4 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	95.20%	↓

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.

Key Messages

- Recovery Programme commenced and most planned care services have restarted
- Plan to recommence all orthopaedic inpatient services in June
- Impact of COVID continues to present performance challenges across the system

Top 5 Measures (based on movement up or down)

May 21	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time.	>95%	**27.00%**	↓
May 21	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	0	**59.40%**	↓
May 21	Number of Ambulance Handovers over 1 Hour	0	**1,331**	↓
May 21	Number of patients waiting more than 8 weeks for diagnostic test	0	**6,934**	↑
May 21	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	0	**54,146**	↑

Quadruple Aim 2: Infection Prevention Measures

Committee	Period	Measure	Target	Actual
QSE	May 21	Cumulative numberof MRSA cases	**0**	0
QSE	May 21	Cumulative number of C.difficile cases	**0**	22

Quadruple Aim 2 : Infection Prevention

Issues Affecting Performance

- Infection Prevention & Control Team requires a multidisciplinary Team (MDT) approach utilising expertise from Anti-Microbial Pharmacists (AMPs), senior qualified Infection Prevention and Control leads, project managers and quality improvement leads to provide the skillsets needed to support the frontline staff in reducing incidences, transmission, and risks of infections. Although funding for additional Infection Prevention Control (IPC) staff was agreed several months ago, some vacancies remain un-recruited to, hindered by the by the complex nature of the recruitment processes.
- The increasing need to bring more people (patients and visitors) into hospital during a pandemic without expanding the facilities/redesigning how we deliver care.
- Isolation is the key control mechanism in infection prevention and control, this includes isolating suspected and know infected patients, physical distancing and sterile/effective fomite cleaning to stop the spread of infection.
    - We do not have enough appropriate facilities to provide rapid effective isolation for our suspected and confirmed infected patients.
    - We do not have enough people available to ensure effective fomite cleaning efficiently e.g. in between every contact.
    - How we use our facilities prevents us from maintaining enough physical distance to reduce the risk of infection transmission.
- Inability to find appropriate decant space to run a routine deep clean programme throughout our facilities.
- Inappropriate antimicrobial/Proton Pump Inhibitor (PPI) prescribing.
- Having the time to complete care bundle paperwork effectively upon insertion and maintenance of devices.
- Inability to have the information/intelligence needed at our fingertips to understand and minimise risk.
- Time it takes to get test results back - from test taken to results being acting upon. The national target is that tests be turned around within 12 hours and currently over 99% of tests meet this timeframe. However, we are proposing an ambitious project to significantly reduce the average test turnaround times. This work could form part of the improvement works of the laboratories and completion of the end-to-end process mapping of tests. The Executive Director for Public Health is overseeing the possibility of linking these two work-streams.

Actions and Outcomes

- Developing the Board Assurance Framework (BAF) to show short/medium and long term actions to drive performance improvement.
- Safe Clean Care Harm Free programme begin mobilised to support pan Health Board transformation and behavioural change, developing a bid for capacity and capability funding to provide full time support to drive improvements.
- Safe Clean Care Harm Free has six underpinning work streams Safe Place, Safe Space, Safe Action supported by Informatics, Communications and Staff Engagement to release time to deliver harm free care through mobilising the underpinning 38 projects.
- Second round of HARMs self assessment to see how the divisions are embedding the changes required to achieve the national IPC guidance and the remaining gaps.
- Accountable areas Infection Prevention Plans on a Page developed to set the road map for 2021/22 to reduce harms fostering an approach of zero tolerance to Health Care Associated Infections.

Timeline for delivery of improvement

April 2022

Risks and Mitigations

- Risks are set out on the corporate risk register and the Board Assurance Framework (BAF).
- New risk to flag is opening up our facilities to more visiting could significantly increase our risk of possible infection transmission and Health Care Associated Infections (HCAI).

Quadruple Aim 2 : Unscheduled Care Measures

Committee	Period	Measure	Target	Actual	Trend
F&P	May-21	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	>= 65%	**59.40%**	↓
F&P	May-21	Number of Ambulance Handovers over 1 Hour	0	**1,331**	↓
F&P	May-21	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	>95%	**67.65%**	↓
F&P	May-21	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	**2,118**	↓
F&P	May 21	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time.	>= 59%	**27.00%**	↓

Quadruple Aim 2: Emergency Departments & Minor Injuries Units (1)

Key Drivers of performance

1. Pre-hospital demand –

- High ambulance conveyance rates across North Wales (adjusted to per 100,000 population).
  - Disproportionate demand for patients arriving by ambulance leading to protracted length and number of ambulances delayed at handover.
  - Increased risk to our communities due to limited availability of ambulances to respond to calls.
  - Allocation of calls pan North Wales.

2. Demand and Capacity in Emergency Departments (ED) –

- Variance in green and red patients presenting to ED – challenge to sustain flow through both pathways which results in:
  - Delays in ambulance handover.
  - Flow out of EDs due to speciality bed waits and COVID-19 restrictions.
  - Lengthy waits for patients in our EDs resulting in poor patient experience and outcomes.

3. Flow and discharge –

- Overcrowding in EDs due to upstream capacity challenges, impacted further by red v's green capacity. This results in:
  - Risk of nosocomial transmission.
  - Ability to safely offload patients from ambulances.
  - Long waiting times to be seen by an ED doctor.
  - Poor patient experience and outcomes as well as increased stress and anxiety to staff.

Actions being taken

1. Pre-hospital demand –

- Increase Single Integrated Clinical Assessment and Triage (SICAT) capacity to maximise all opportunities for conveyance and admission .
- Good progress being made on the rollout of Same Day Emergency Care (SDEC) services with the addition in May of support from the National Collaborative Commissioning Unit (NCCU) team.
- Further development on acute medical model of care, frailty services and direct access pathways. This work will gather pace over the next 3 months with a target date of October 2021 for implementation and embedding of pathways across the 3 health communities.
- Implementation of the Health Board's Contact First service is on track to deliver the 'Healthcare Professionals Line' by 22nd June. This is phase 1 of a 2 phase rollout which will see the Contact First service become directly patient facing as part of the 2nd phase rollout of 111 in North Wales.

Actions continued overleaf...

Quadruple Aim 2: Emergency Departments & Minor Injuries Units (2)

Actions being taken continued...

- Work on the Kendall Bluck staffing review of EDs has been reviewed and revised to reflect post COVID-19 ways of working, taking into account the planned changes to acute pathways i.e. implementing an Acute Medical model and Frailty services; direct access pathways to specialities through SDEC roll out and the pre-hospital demand management work (which is likely to negate the predicted 5–15% increased USC demand over the coming 5 years). The revised workforce model reflected in a revised business case will be complete by June 30th with the plan to progress through approval and implementation by October 2021 (pre-winter). In the interim, teams are working on ensuring the Health Board offer for urgent and emergency care demand have the capacity to meet the predicted increases over the summer period where we anticipate up to a 15% increase due to the 'staycation' affect on tourism across North Wales.

2. Demand and capacity –

- Forward planning introduced in early February with revised data based on the Swansea University Reasonable Worse Case (RWC) scenario modelling.
- Projections have been adjusted to BCUHB to support sites to pre-plan the capacity needed for COVID-19 and non-COVID demand through our EDs. This data suggests a further surge in Q3 – and though predicted numbers are unlikely to reflect the second wave, the Health Board processes and infrastructure will be required to ensure safe and effective Infection Prevention & Control arrangements continue.
- Access to point of care testing and increased rapid swabbing capacity is planned to be delivered by July 2021 and this will be key to maintaining timely flow through EDs.

3. Flow and discharge –

- Use of revised capacity and demand data from in-patient bed modelling linked to Health Board surge planning. Enhanced intelligence data designed to help teams to plan surge capacity days in advance (acute and community sites), and offer opportunity to better mitigate unexpected outbreaks or staffing challenges which results in reduced bed availability. Also review of site surge planning for Red and Green pathways to maintain flow.
- Work continues to deliver the recommendations in the Kendall Bluck staffing review of EDs. This will address, in part, the current challenges in staffing number and skill mix across 2 of the 3 EDs.
- Mobilising surge capacity across North Wales with criteria that meets the current clinical needs of patients waiting to return to Care Homes or needing packages of care.
- Ongoing work with partners and Care Home sector to support key homes and services experiencing difficulties as a result of COVID-19.

Timelines to delivery of Improvements:

- Reduction in number and length of ambulance handover delays – ongoing.
- Implementation of Kendall Bluck recommendations – June 2021.
- Partnership working with Welsh Ambulance Services Trust (WAST), Local Authorities (LAs) and Care Homes – ongoing.
- Delivery of Contact First/111 – June 2021.

Quadruple Aim 2: Emergency Departments & Minor Injuries Units (3)

Actions being taken continued...

In addition to the above specific actions, the BCUHB collaboration with the National Collaborative Commissioning Unit (NCCU) is now well underway, with NCCU colleagues working closely with the locality teams and across partner organisations. A meeting has been held with the six Local Authority colleagues across North Wales – this was an incredibly productive, interactive session and offered up lots of opportunity to improve the partnership working across Health and Social Care. The NCCU team presented to the Health Board in June and provided details of the progress made to date on the work being progressed with teams across the 3 Health Communities on shaping the local plans for unscheduled care, which will inform the overarching BCUHB strategy for urgent and emergency care. The Board supported the direction of travel for the programme of work which will be clinically led with the NCCU continuing to provide leadership and support over the next 18-24 months. A Senior Clinical Lead has been appointed to drive this programme forward and further supporting appointments including clinical, operational and analytical leads are being progressed.

Risks to delivery:

Workforce – inability to recruit to
i) implement the full recommendations of the Kendall Bluck ED Review.
ii) deliver Contact First/111.

Financial – insufficient funding to deliver the 2021/22 USC plans.

Technology – inability to mobilise the digital technology to deliver Contact First/111; delivery of the Welsh Patient AdminstrWPAS across all sites.

Quadruple Aim 2: Stroke Care

Key Drivers of performance
- Access to Stroke Co-ordinators.
- Timeliness of referrals for CT scan – requires above.
- Availability of beds on Acute Stroke Unit (ASU).

Actions being taken
- WEST established team including Heads of Nursing (HoN) Medicine, Directorate General Manager (DGM) Emergency Care, Prysor Ward Manager, Stroke Specialist Nurse, Occupational Therapy, Physio Therapy, Operational Management and Improvement Leads to review all breaches.
- Unscheduled care pressures across the system remain a challenge and recovery of planned care activity has increased acute flow challenges on all sites.
- Pathway work with Emergency Department (ED) and work on referral pathways when Stroke Co-ordinators not available.
- EAST - Breach analysis reports sent to Stroke Multi-disciplinary team (including ED, Acute Medical Unit (AMU) and ASU managers).
- Work with Site Management re adherence to retaining beds on ASU a key element of daily Safety Huddles. Sisters on ASU identifying patients each morning that can be transferred to other medical wards to create stroke beds for acute admissions.
- Business plan progressing for funding to support service improvement and early supported discharge to support ASU.
- Refresh of local Stroke Delivery Meetings and BCU wide Stroke meeting re-established.
- Work on referral pathways when Stroke Co-ordinators not available continues with junior medical staff.

Action to be completed by
- Stroke business plan approved with Site leads for Stroke, supported by Medical, Nursing and Therapy teams. Appointed ex-Directorate General Manager for Stroke to manage phase 1 of revised business plan.

Risks
- Recruitment plan for resources identified in Business Plan.
- Lack of Stroke Co-ordinators to cover in the week and weekends, impacted more so by sickness within the team and Co-ordinators being allocated to ward numbers due to nursing staff shortages.
- Stroke Consultant support due to Covid-19 rota, reduced ASU / Stroke Rehabilitation Unit (SRU) beds in YGC, no Early Supported Discharge (ESD) service, COVID-19 pathways affecting flow, swabbing delays.

Stroke Care – April 2021 Performance

4Hr – Admission to ASU – Challenge across all 3 sites – 21% - unscheduled care pressures and loss of ASU beds at YGC.

CT Scan – 52% - not a capacity issue, this will improve with 4th stroke coordinator.

The Formal Swallow target was a data error for WEST, this has been reviewed by Therapies and should be 89%.

Quadruple Aim 2 : Planned Care Measures

Committee	Period	Measure	Target	Actual	Trend
F&P	Apr 21	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	**95%**	67.00%	↓
F&P	May 21	Number of patients waiting more than 8 weeks for a specified diagnostic	**0**	6,934	↑
F&P	May 21	Number of patients waiting more than 14 weeks for a specified therapy	**0**	1,040	↑
F&P	May-21	Percentage of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments	**>= 95%**	44.23%	↓
F&P	May-21	Number of patients waiting more than 36 weeks for treatment	**0**	52,706	↓
QSE	May 21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	**>= 80%**	26.84%	↑
F&P	May-21	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	**34,721***	54,146	↑

Quadruple Aim 2: Cancer

Cancer reporting is a month in arrears

Issues Affecting Performance

- In April 2021, 240 out of 358 (67%) of patients were treated in target. Main reasons for patients not being treated in target were:
  - Complex diagnostic pathways (9%)
  - Delay to first outpatient appointment, primarily breast and colorectal (16%)
  - Delay to other diagnostics, primarily on urology pathway (34%)
  - Delay to endoscopy (12%)
  - Delay to surgery (12%)
  - Patient related reasons e.g. patient unavailability for next stage of pathway (12%)

Actions and Outcomes

- Additional outpatient capacity has been created in both breast and colorectal in order to meet demand and reduce delays. A business case has been submitted to the Executive Team for an additional four rapid access breast clinics each week in order to ensure patients are seen in a timely manner.
- Endoscopy insourcing continues to reduce waiting times; a full endoscopy business case for a sustainable service has been submitted.
- Surgical delays have reduced significantly as COVID pressures have eased; outsourcing of urology procedures continues pending a decision re the robot procurement for North Wales.
- Business cases being developed for one stop neck lump clinic and vague symptoms rapid diagnosis clinics to reduce pathway waits.

Timeline for delivery of improvement

- All business cases to be completed by end of June with implementation in autumn.

Risks and Mitigations

- Cancer diagnoses are approximately 400 less (April 2020-March 2021) compared to 2019/20. There may be an increase in patients presenting at later stage which would place pressure on oncology services; currently seeing expected numbers of stage 4 cancer presentations but reduction in stage 1 presentations. Risk escalated to Health Board and business case for additional oncology support developed.
- Currently, approximately 500 patients still active on a suspected cancer pathway over day 62 due to pathway delays above (note majority will not have cancer but pathway has not yet been completed; conversion rate from referral is approximately 10%). All delays escalated to operational managers.

Quadruple Aim 2: Cardiology

Key Drivers of performance:

- The impact of COVID-19 has resulted in reduced capacity to allow for social distancing and Infection Prevention and Control (IPC) measures. This has impacted on waiting times for patients being longer than the 8 week target.
- There are national recruitment challenges specifically for cardiac diagnostics staff which is affecting some of our sites.
- Department growth has resulted in restrictive footprints creating infrastructure and estates difficulties.
- Potential capacity challenge for the service regardless of COVID impact which will need to be addressed.

Actions being taken:

- The demand and capacity exercise for cardiac physiology is nearing completion which will form part of a North Wales wide workforce and service development plan.
- There is additional activity being undertaken across North Wales, primarily to support echocardiography waiting lists, these include; Waiting List Initiatives, locum working and shared resources across North Wales.
- A scoping project to look at insourcing/outsourcing for echocardiography has commenced.
- Within cardiac physiology we have successfully recruited to 2 Practitioner Training Posts (PTPs) and 3 Scientist Training Posts (STPs). Recruitment of these post plus support from Band 7 training posts will support much needed succession planning, however, in the interim the training requirements of these posts may impact on activity if additional funding for Band 7 training posts is not successful.

Timelines:

- Demand and Capacity exercise completion by end of Quarter 2 of 2021/22 .
- Above feeding into 3 to 5 year service development plan for Cardiac Physiology Services.
- Additional activity on-going – no end dates currently.
- Recruitment of STP posts end of April and will be in post in Quarter 3 2021/22.

Risk

- Workforce restrictions – to include succession planning, sickness and expansion.
- Demand & Capacity – complexity proving difficult and a risk of the data not being as meaningful as first thought.
- Continuing Pandemic implications.

Quadruple Aim 2: Endoscopy Diagnostics

Key Drivers of performance:

- Lack of capacity to meet the demand, resulting in long waiting times for patients. Current waiting times show that 65% of Diagnostics waits and 33.71% of our surveillance patients are overdue. This equated to 2,540 and 1,880 patients respectively.
- Impact of COVID – reducing capacity to approximately 60%, resulting from downtime requirements through enhanced infection control policies. Procedures have been limited to urgent suspected cancers and urgent patients due to available capacity.
- Recruitment challenges resulting in vacancies and staff that do not have the required competencies.
- Poor estate and IT infrastructure, resulting in inefficiencies. i.e. labour intensive processes due to poor IT, limitations in capacity, high risk processes i.e. decontamination.

Actions being taken:

- Business case is in its final draft to expand endoscopy capacity, which will resolve issues of the backlog and reduce the demand and capacity gap. The case has been supported by the Planned Care Board. To be submitted to the Business Case Group and Executive Team. £8.2M has been secured, from the £100M national funding pot. Insourcing has been procured until March 2022. Currently undergoing financial scrutiny.
- Outsourcing forms part of the business case, with the proposal for a modular build on Ysbyty Glan Clwyd (YGC).
- A review of the endoscopy ventilation systems is still in progress, which will enable the productivity to be improved.
- An IT system dedicated to endoscopy has been agreed by the planned care board, which will contribute to the resolution of some of the inefficiencies. A business case has been submitted to the digital team and a capital request has been identified. A Project Manager has now been appointed.

Timelines:

- Timeline for the business case is dependent upon outcomes of review at Business Case Group and Executive Team.
- Insourcing is showing positive results but will need to continue for 2021/22, for Q1 and Q2. A business case is in draft to support substantive recruitment, which will need to be agreed to enable backlog to be resolved by December 2021. This case was presented to the Planned Care Board on 26th March 2021.

Risk:

- Further waves of pandemic may impact recovery.
- IT capacity to support the implementation of an endoscopy IT system and the capital funding required.
- Capital funding for estate improvement for endoscopy and decontamination.

Quadruple Aim 2: Radiology and Neurophysiology Diagnostics

Radiology

The number of patients waiting over 8 weeks for radiology diagnostics is currently 2,261, an improvement of 1,916 from the end of March 2021 position. Further imaging capacity is now on-line and with additional non-recurrent funding to meet anticipated increased demand. We are continuing to use a combination of additional hours and insourcing to help address the capacity gap. Although future referral rates are uncertain, we anticipate the downward trend in waiting list size to continue. A profile forecast for the non-recurrent funding has been developed and shared with the Executive Team.

Neurophysiology

There are 401 patients waiting over 8 weeks, a decrease of 13 from the end of March 2021 position. Consultant-led in-sourcing activity of 123 patients in May 2021, along with overtime within the small team has maintained the overall position. A new tender for insourcing will be progressed in June 2021. We are seeking a locum physiologist to reduce the Nerve Conduction Studies (NCS) backlog over the next 3-6 months.

Quadruple Aim 2: Eye Care Measures (1)

Key Driver:
- Utilisation of agreed Glaucoma, Diabetic Retinopathy and COVID Cataract Pathway (integrated delivery between Primary and Secondary Care).
- Key enabler of above is National Digital Electronic record & E-Referral Programme, see Eye Care slide (2).

Benchmarking
- National/BCU benchmarking/learning inbuilt into MDT/pan-organisation engagement/pathways/performance reports: via: Webinars/Eye Care Collaborative group (ECCG)/Local eye groups (LEGs).
- Waiting times is main concern trend (historic/backlog due to COVID-19).
- Pan BCU risk stratification established.

Actions:
- Identify delivery targets for high risk specialities (Glaucoma/Diabetic Retinopathy/Age related Macular Degeneration - AMD). e.g. Primary care data gathering for later medical virtual review.
- Review/agree Key Performance Indicators (KPI) for AMD targets in reference to updated National pathway.
- COVID Cataract pathway: Clinical Lead informing Regional Cataract Centre planning.
  Progression of Business Case opportunities to utilise primary care to support Pathway transformation.
- Ongoing work to confirm Cataract current delivery plan (Glaucoma/Diabetic Retinopathy KPI implementation plans including outcome from BC support).

Key Risks/Opportunities for change
- Clinical & Operational Senior Leadership constraints/conflicting COVID-19 priorities impacting on engagement re: implementation/monitoring.
  >Redress: a. Reset of ECCG Governance framework (achieved) b Sites progressing/leading LEG meetings.
- KPI Data Quality gaps adversely impacting on establishing dashboards/ demand & capacity analysis/ recovery and delivery trajectories/KPI monitoring.
  >Redress: Pan BCU Data Standard Operating Procedure/Root-cause redress actions (Achieved). Redress of gaps rollout on track/in progression.
- Delay in sites formulating/delivering local implementation plans.

>Redress: a. Escalated to Senior leaders b. All sites reporting exception/recovery plans ECCG, June 2021.
- Significant opportunities to reduce Inequity of wait times. Pan BCU Cataract PTL (Patient Treatment List) is key equity enabler with reduced uptake/transfer of patients.
  >Redress: a. Exploring through planned care (Once for North Wales) b. Sites confirming/progressing site utilisation/supporting Data Quality Assurance development needs, June 2021.
  c. Establish Pan BCU operational/monitoring process, July 2021.
- Significant under performance against High risk (R1 risk stratification) patient pathway targets.
  >Redress. Progressing for backlog reduction April 21 (Glaucoma: Central & West progression against trajectory. Diabetic Retinopathy: East achieving).
- Reduction in Cataract delivery Pan BCU due to COVID-19.
  >Redress. Options in development to progress recovery of activity and backlog. Cataract Regional Centre & Mitigation planning in progression.

Escalation:
Risks/opportunities and Monthly reports shared/escalated to Senior Managers/Clinical Lead (via Monthly ECCG Meeting/Highlight & KPI reports/Action Logs.

Quadruple Aim 2: Digital Eye Care (2)

Ophthalmology Performance Digital Programme

Key Driver:

- Delivery of National Digital Programme (Key Enabler of National Pathways).
- Electronic Patient Record (EPR) implementation.
- E-Referral Implementation.

Benchmarking

- National Programme: Shared via Wales Ophthalmology Planned Care Board (WOPCB).
- Equipment training commenced March, EPR Equipment Webinars in April 21 plus EPR system training from Welsh Government (WG), April 2021

Actions:

- Arrive/install Welsh Government funded (£1.3M equipment by close March 2021: (Achieved March 2021).
- Site/Clinician training in Zeiss equipment, April-June 2021 rolling (On track).
- Server delivery (Zeiss & IT partnership), June 2021 (on track for completion).
- Establish Electronic Patient Record (EPR)/E-Referral Implementation team/delivery plan (Established Feb 2021/Digital Sub-Group Updating Plan, June 2021).
- Progression of Business Case to resource BCU Digital implementation/sustainability. WG funded posts progress.

Key Risks/Opportunities for change

- Clinical/Operational/Informatics constraints/conflicting priorities impacting on engagement.

> Redress: a. Reset of Governance/communication framework. Digital Programme sub-group of ECCG (Achieved Jan 21 with ongoing priority to sustain).

- Establish Electronic Patient Record (EPR)/E-Referral Implementation team/delivery plan.

> Redress: Funding approval for Regional/programme (WG Capital) posts confirmation (Achieved). Recruitment meetings with support of Informatics/Pan BCU Clinical -- Lead/ Site.

Key Barrier Trends:

Business Case progressing positively and plans in readiness stage for implementation following approval.

Escalation:

Escalation of Risks/opportunities and Monthly reports shared/escalated to Senior Managers/Clinical Lead (via Monthly ECCG Meeting) and Planned Care Transformation Group, Secondary Care Group and BCU Performance Group.

Quadruple Aim 2: Referral To Treatment

Issues Affecting Performance

The COVID-19 pandemic has left a backlog of over 42,034 patients waiting over 52 weeks as at the end of May 2021. All sites and areas are undertaking re-start of their services for planned care, with the exception of orthopaedic in-patients at Abergele and West site. The risk stratification process is underway to treat the back logs using a cohort Methodology.
The plan is to achieve cohort 1 (pre-COVID-19 backlog with the exception of orthopaedics by March 2022) followed by the COVID-19 backlog (cohort 2) from March 2022.

Actions and Outcomes

- Additional clinical sessions have commenced along with validation of patients on waiting lists, specification for outsourcing and insourcing are going through internal governance process prior to procurement.
- Business case being developed for modular wards and theatres for orthopaedics expected to be completed in July 2021.
- This will contribute to the reduction of both cohorts.

Timeline for delivery of improvement

- Outsourcing should be available in August/September subject to procurement.
- Cohort 1 and 2 numbers are reducing this month through validation.

Risks and Mitigations

- Inpatient beds - being mitigated by modular ward and “green pathways”.
- Medical cover at Abergele - vacancies are out to agency to support staffing.
- Further disruption from COVID-19.
- Unscheduled Care - Sites are working closely with unscheduled care to ensure winter plans are aligned.

Quadruple Aim 2: Neurodevelopment

Key Drivers of performance

- Current waiting list 2,110 a slight decrease of 54 on the March 2021 position. There are currently 1,634 children waiting over 26 weeks.
- Referrals into the service remain slightly lower than pre-COVID-19 activity, however, this is starting to see an increase following pre-COVID-19 trends
- Activity from within establishment remains below trajectory.

Actions being taken

- Waiting list validation exercise commencing at the end of June 2021.
- External provider remains on target with current trajectory. Discussions taking place with regards to increasing the trajectory. Early indications show that the provider could deliver 1,104 assessments by end of March 2022.
- Private Provider has offered to deliver between 1,500 and 1,700 assessments by year end, however, which will require further investment/funding and a remodelling of MDT's due to the internal capacity that the model will require. Work is underway on this.

Timelines

- Internal capacity to undertake assessments expected to be at pre COVID-19 level by Quarter 2 2021/22.

Risks

- Internal staffing capacity will present a risk to increased levels of internal activity if projections are revised as it will currently require work in addition to current job plans which may then negatively impact upon other assessments and interventions offered by the service.
- Additional activity from external providers will require additional funding, as well as confirming that they can provide that activity, which is a fluctuating situation.
- If staffing levels decrease internally, including clinical/admin, this may place external contract could be placed at risk due to the collaborative and interwoven approach between external and internal provision, e.g. with joint Multidisciplinary Teams (MDTs).
- Future demand following full opening of all schools may see referrals increase. We are working with Local Authorities (LAs) and schools to improve clarity regarding expectation and appropriateness of referrals.

Quadruple Aim 2: Follow Up Outpatient Waiting List

Issues Affecting Performance
- Weekly / bi weekly Access meeting have ceased over a number of months, these were instrumental in the provision of assurance/reassurance of delivery to national targets.

Actions and Outcomes
- Administration Validation (ongoing).
- Clinical Validation (ongoing).
- Virtual Consultations – the restart of the provision of a video consultation platform (Attend Anywhere).
- Pathways - See on Symptoms/ Patient Initiated Follow Up (SOS/PIFU) – review of historic SOS/PIFU for clinical discussion on discharge.
- Outpatients Efficiency Programme.
- Launch of video group consultation.
- Speciality focus on efficiency.

Timeline for delivery of improvement
- Administration Validation (ongoing).
- Clinical Validation (ongoing).
- Virtual Consultations: the restart of the provision of a video consultation commenced June 2021.
- Pathways: review of historic SOS/PIFU for clinical discussion on discharge commenced June 2021.
- Outpatients Efficiency Programme: ongoing with delivery dependant on support.
- Launch of video group consultation: commenced June 2021.
- Speciality focus on efficiency: commenced June 2021.

Risks and Mitigations
- Securing resource for delivery of the Outpatient Efficiency Programme.
- Management willingness to support delivery / culture change.
- Clinical decision making pace.
- Weekly Accountability framework.

Quadruple Aim 2: Mental Health Measures

Committee	Period	Measure	Target	Actual	Trend
QSE	Apr 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	>= 80%	61.99%	↓
QSE	Apr 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment	>= 80%	80.90%	↓
QSE	May 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	70.67%	↑
QSE	Apr 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)	90%	92.10%	↑
QSE	Apr 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	23.68%	↓
QSE	Apr 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	>= 80%	19.64%	↑
QSE	May 21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	15	↓
QSE	May 21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	565	↑

Quadruple Aim 2: Adult Psychology

Issues Affecting Performance

- Capacity/demand mismatch.
- Sickness and vacancy.
- COVID-19 restrictions.

Actions and Outcomes

- Stepped Care Initiative support to offer input during maternity leave of clinician in Wrexham (now returned April 2021).
- Stepped Care Initiative supported increased provision from MDTs (as per Matrics Cymru) through supervision & training.
- Digital adaptations increasing online clinician supported delivery of CBT, DBT, and Coping Skills group and individuals.
- External support waiting list initiative (now ended) in Wrexham has increased compliance significantly.
- Compliance significantly improved over last year due to combination of above actions.

Figure 1: May 2021 Target Compliance BCUHB

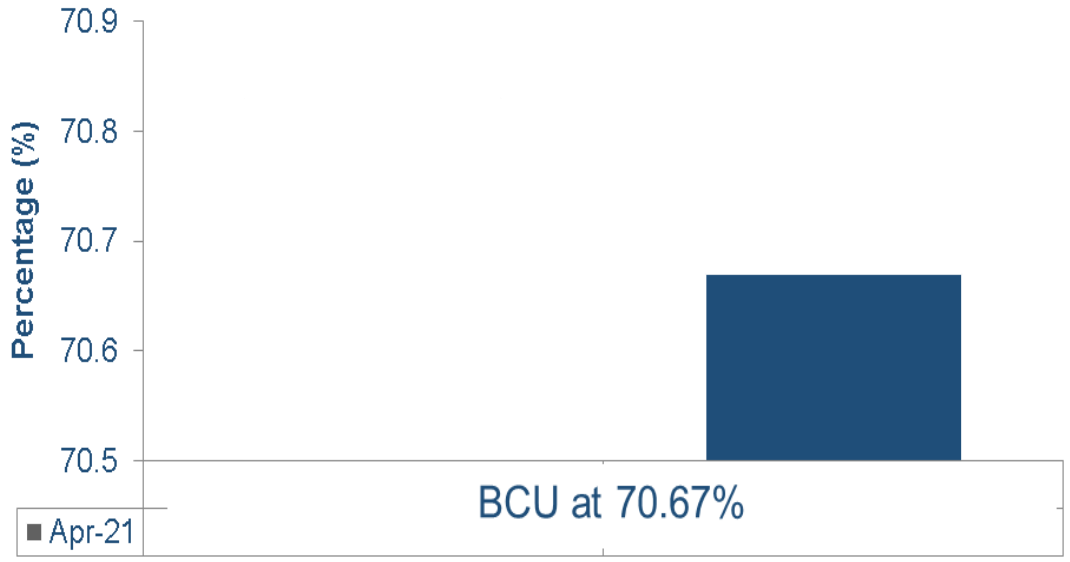
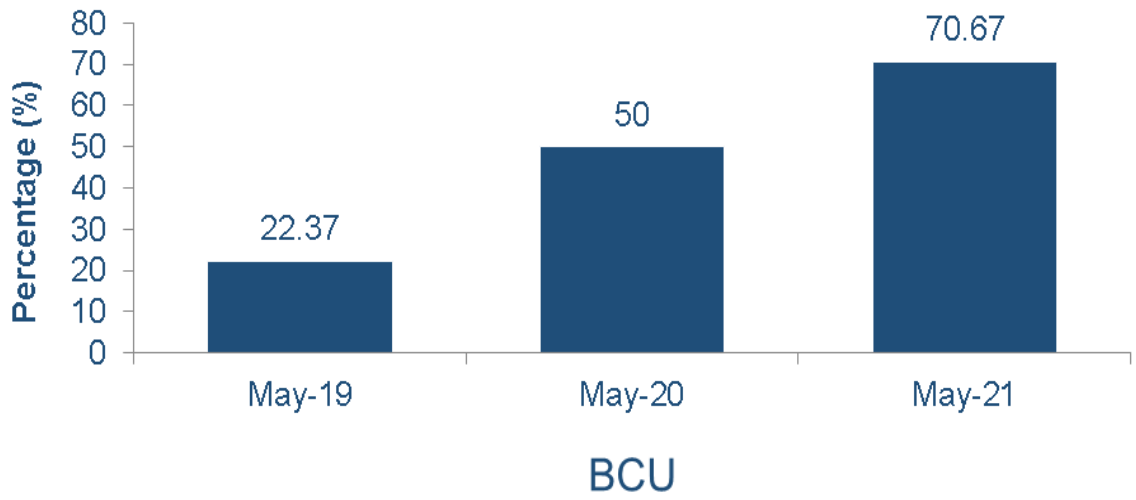


Figure 2: Target Compliance BCUHB May 2019, 2020 & 2021



Quadruple Aim 2: Children's & Young Adult Mental Health Services (CAMHS)

Issues Affecting Performance

- Increased referral numbers in last couple of months since return to schools.
- Children & Young People (C&YP) presenting with elevated acuity and complexity in Community teams and to Crisis teams, requiring additional capacity and support**.**
- Reduced efficacy of evidenced based treatments delivered remotely leading to increased new to follow up ratio.
- Reduced capacity within the teams – the current vacancy rate stands at 23.75%.
- Reduced physical capacity within CAMHS accommodation due to social distancing requirements.

Actions and Outcomes

- Targeted Interventions maturity matrix completed with 12 separate work streams. Leads identified for each work stream and Project Initiation Documents (PIDs) produced priorities and timelines to be finalised.
- Regional infrastructure posts to support Performance delivery, governance and service development identified, to be recruited to.
- Bids submitted for Service Improvement funding for Eating Disorders, Psychological Therapies, Crisis services and Specialist CAMHS including Outreach team.
- Funding secured for roll-out of Schools In-Reach project, options appraisal to be finalised.
- Workforce plan to include recruitment strategy and training and development plan to be completed, additional HR support requested. Workshop to be arranged.
- Single Tender waivers for private providers to increase assessment and therapy submitted by each Area – awaiting approval with Contracting team.
- Tender for private provider for assessments and therapy to be renewed, Ministerial approval being sought by Procurement colleagues.
- Health Education & Improvement Wales (HEIW) allocated one training number for commencement in August 2021 and a further two training numbers for commencement in August 2022, BCU support in Annual Plan.
- Attend Anywhere being utilised in all teams – video contacts constituted 17.22% of total attendances in April 2021.
- Ongoing discussions regarding access to additional accommodation for clinical contacts including discussions with schools to support remote appointments.

Timeline for delivery of improvement

- Targeted Intervention priorities and timelines to be agreed by July 2021.
- Workforce plan to be finalised, timeframe to be confirmed. Workshop to be held late June/early July 2021.
- Tender process to be completed with contract in place by December 2021.
- Single tender waiver arrangements to be made by respective teams by end of June 2021, dependent on approval to proceed received.

Risks and Mitigations

- Current vacancies and additional posts cannot be recruited to - to be supported by workforce plan.
- Demand for services and acuity and complexity increases – Service Development funding to target.
- Non-delivery on Mental Health Measures (MHM) targets included on service risk register – reviewed regularly at local meetings and CAMHS Service Improvement Group.

Quadruple Aim 2: Adult Mental Health Delayed Transfers of Care (DToC)

Since February 2021, the Mental Health and Learning Disabilities (DToC) performance has improved significantly on a weekly basis both in patient numbers and bed days lost and we expect this to be our regular position aside from some issues out of our control, such as, the availability of low secure beds across the UK and nursing homes being red due to COVID-19.

The current performance is where we expected for April and May 2021, and if the recommendations from the DToC Review report are progressed and implemented there should be further improvements.

Issues Affecting Performance
- Continuation of weekly divisional scrutiny panel, supported by Heads of Nursing (HON's) and senior staff, Community Health Council (CHC) and Finance.
- Analysis of weekly figures, barriers to change, appropriate coding of registration, actions and reduction/ increase in DToC for that period.
- National database updated and all related training given, this is now single source of DToC information, to allow parity and consistency across division.
- Estimated Discharge Date (EDD) requested for all registrations to allow monitoring of process and appropriate actions.

Actions and Outcomes
- Policy and process reviewed to ensure accuracy and consistency across BCUHB Mental Health & Learning Disabilities (MH&LD) Division.
- Divisional scrutiny panel weekly data considered, barriers identified and support and guidance offered by panel members.
- Delayed Transfer of Care Review Report presented to MH&LD, Speech & Language Therapy (SALT) with recommendations.
- Significant reduction in registered DToC's since scrutiny process enabled- **Overall reduction 83%** since inception of process.
- Since the review commenced **reduced bed days lost to DToC from 3,000 to 498** – a further reduction of 38% since March report completed.

Timeline for delivery of improvement
- National database updated for weekly scrutiny and recommendations. Process enabled 5.2.21 and ongoing.
- Scrutiny panel supported by HONs, CHC and Finance, continues weekly to date.
- Weekly report to Gold Command on progress with recommendations, and highlighting good/effective practice in planning.
- Delayed Transfer of Care Report completed April 2021, awaiting implementation of recommendations.

Risks and Mitigations (What are the key risks to improving performance and have they been escalated? If so where to?)
- All risks managed through weekly scrutiny panel review and reported to divisional leads, with mitigation plans. Timelines, and Estimated Discharge Dates.
- All significant barriers identified and reported to Command meeting, where additional senior support is identified as a need to ensure timely resolution.

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.

Key Messages

- Staff health and well-being remains a key priority for the Health Board
- Staff have responded well to the demands placed upon them
- Slight increase in agency/ locum spending in a challenging environment

Measures

Committee	Period	Measure	Target	Actual	Trend
QSE	May 21	Number New Never Events	0	**3**	↓
F&P	May 21	Percentage of sickness absence rate of staff	< 5%	**5.27%**	↑
F&P	May 21	Personal Appraisal and Development Review (PADR)	>= 85%	**71.30%**	↑
F&P	May 21	Percentage compliance for all completed level 1 competencies of the Core Skills and Training	>= 85%	**83.23%**	↓

Quadruple Aim 3: New Never Events

There were **3 Never Events** reported in May 2021. Investigations remain underway, however, immediate actions are as follows:

Second dose of Methotrexate within 2 days of previous dose.
Actions:
- Methotrexate policy and Patient Safety Alert circulated across the Health Board.
- Cross reference to previous learning from 2018 as part of the investigation.
- Yellow Methotrexate Alerts to be visible and in place within the clinical environment.

Wrong side insertion of chest drain.
Actions:
- BCUHB Local Safety Standards for Invasive Procedures (LocSSIPs) library launched 14th June 2021 – LocSSIPs to be used for any invasive procedure.
- Mandated nursing staff in attendance when undertaking chest drain insertion.
- Internal auditing of LocSSIP compliance within clinical areas underway.

Wrong side ankle block.
Actions:
- 'Stop Before you Block' posters and protocols reinforced to all staff across Health Board.
- Anaesthetist to verbalise 'Stop Before you Block' prior to administering a block.
- Reinforcing staff responsibility to speak-up and raise concerns.
- 'Stop Before you Block' stickers now in place on nerve stimulators and ultrasound machines.
- Safety Alert distributed across Health Board.

In addition, a report is being presented to the Patient Safety and Quality Group outlining the findings of work to assess the external review of a Never Event in urology against the action plan put in place to identify any further actions needed.

Quadruple Aim 3: Personal Appraisal & Development Review (PADR)

Key Drivers of performance

- PADR Compliance for May was 71.26%, a 0.97% increase since April. As a comparison, PADR compliance in May 2020 was 66.81%.
- Only 3 divisions out of 22 have seen a decrease in compliance this month, this is an improvement as there are usually more than three divisions who see a drop in compliance each month.

Actions being taken

- Detailed reports and tailored support to be offered to the 3 divisions that have seen a decrease in compliance. This tailored support has proven to be effective and impact positively on compliance in other divisions. For example, since supporting and attending Estates & Facilities Senior Leadership Team meetings, they have seen an increase of 4.6% in compliance.
- Bespoke PADR training sessions to be held with managers and supervisors in Estates & Facilities as a result of discussions at Senior Leadership Team meeting.
- League tables to be shared with senior managers across the organisation with tailored reports being offered to support line managers to take corrective action to increase compliance.

Timelines

- Detailed reports and offer of tailored support to be offered by 8th June allowing time for planning and improvements to take place. Any other requests for detailed reports to be provided as and when requested.
- Bespoke PADR training sessions to be held with managers and supervisors in Estates & Facilities on the 14th and 23rd June
- League tables to be shared with senior managers across the organisation by 4th June

Risk

- Although COVID-19 related activity may now start to reduce, the risk remains that the pressure on increase in activity to achieve performance targets may take the focus away from conducting PADRs.

Quadruple Aim 3: Mandatory Training

Key Drivers of performance

- Mandatory training compliance at level 1 reduced across all Mandatory training subjects in April 2021 by 0.44% to 82.63%. A key factor in this is a fault in the E-learning functionality with the E-Learning modules being offline from the 6th to the 21st April 2021. Mandatory training compliance has increased to 83.19% (as of 26th May) following restoration of the E-Learning functionality.
- BCU has the highest compliance with mandatory training of all Health Boards in Wales with its current compliance of 83%.
- A further extension of temporary contracts within vaccination centres has been implemented from the end of June 2021 to the end of October 2021. This will continue to affect overall compliance as staff working solely in vaccination centres are not required to complete all attached competencies of Level 1 Mandatory training.
- Completion of Mandatory training remains low for Estates and Facilities and for Medical & Dental staff.

Actions being taken

- During the downtime of the E-learning programmes, close monitoring of the training completions took place with an increase of compliance as noted taking place with a current compliance figure of 83.19%, an increase of 0.56%.
- Following investigation, it is not possible to remove specific Mandatory training compliance for staff allocated to contracts within the mass vaccination centres, therefore, compliance figures for particular mandated subjects will continue to be affected until at least October 2021.
- A revision of the ESR function for completing E-learning has taken place between ESR functionality managers and representation from ESR systems, Organisational development and the Office of Medical Director to agree a 'simpler user process' for accessing E-Learning related training. Following rollout of the new revised process, compliance will be monitored for Estates and Facilities and Medical and Dental staff to assess the impact of the revised process on improving completion of mandatory training for these two staff groups.

Timelines

- Weekly monitoring of compliance figures will continue and will be reviewed at the next exception report completion.
- A review of requirement to complete all level 1 Mandated subjects for staff pertaining to temporary contracts within vaccination centre temporary contracts will be taken before 31st October 2021.
- An Implementation plan for the rollout of revised E-learning training to be rolled out by 30th June 2021.

Risk

- COVID-19/Business as Usual (BAU) related work impacts upon training delivery.
- Social distancing restrictions affects delivery of training within existing training buildings, this affects the safe 'face to face' classroom occupancy for specific courses.

Quadruple Aim 3: Sickness Absence

Key Drivers of Performance:

- COVID-19 related sickness absence has dropped further to 0.3% (0.4% in April). This reflects a further reduction in staff testing positive, which totaled just 5 in May (a significant drop from 65 during March and 15 in April).
- Non COVID-19 related sickness absence increased by 0.6% to 5% (which is the same as January).
- Stress related absence remains the biggest cause of absence with approximately 4 times more days lost than the 2nd largest cause (infectious diseases). It is the biggest cause of absence by a considerable margin for all areas. As previously stated, the incidence of colds / flu has been much lower this year, due to the successful flu campaign and social distancing.
- The highest levels of sickness absence are in Additional Clinical Services, Estates and Ancillary and Nursing and Midwifery. Nursing sickness levels are high on all 3 secondary care sites – 6.66% to 7.71%. Hotspots for Additional Clinical Services are Mental Health and Learning Disabilities (MH&LD), East and West Area and Ysbyty Glan Clwyd (YGC).

Actions Being taken:

- Work is ongoing to strengthen control measures to reduce transmission, including booking systems for areas where social distancing is otherwise not possible and reinforcing messages on remote working.
- Psychological / Emotional Health and Wellbeing support to staff has been strengthened, and is being further developed.
- Workforce and Organisational Development (OD) continue to support hotspot areas.
- Further invites are being sent out in June to staff in priority groups 1 – 4 who have not previously taken up the offer of vaccination.
- Joint task and finish group is in place to support processes to support shielding staff with a return to work (now approximately 35 who have not yet been able to return in some capacity).

Timelines:

- Further offer of vaccination in June 2021.

Risk:

- Further increase in stress related absence.

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 focuses on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This brings individuals to the fore and considers the relative value of different care and treatment options. Research, innovation and improvement activity will be brought together across regions and public sector bodies. 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.

Key Messages

- At 1.01%,the crude mortality rate for BCU is lower than the Wales average.
- Increased system working to link Health and Social Care Data
- Sepsis Six Bundle reporting to recommence following period of non-reporting due to COVID-19

Measures

Committee	Period	Measure	Target	Actual	Trend
F&P	May 21	Agency spend as a percentage of total pay bill	Reduce	**7.20%**	↓
QSE	Apr 21	Crude hospital mortality rate (74 years of age or less)*	Reduction	**1.01%**	↑
QSE	May 21	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	**No Data**	

Quadruple Aim 4: Agency and Locum Spend

Key Drivers of Performance

- Non-core agency, bank and overtime pay spend saw a slight decreased in May from £8,801,000 to £8,493,000.
- Agency spend is down by £363k at £3,472,595 (4.8% of total pay); Locum spend is down by £143k at £1,775,593 (2.4% of total pay); WLI spend is up by £66k at £188,254; Bank spend is down by £75k at £1,976,771. There is a general trend of decreased spend except across agency and WLI which can be linked to the increase in activity across Planned Care as the recovery programme is started.
- Medical Agency spend is up from £1.38m to £1.43m month on month with a corresponding decrease in locum and bank spend. The increase in agency spend can be linked to the increase in activity across Planned Care as the recovery programme is started.
- Nursing Agency spend is up from £1.2m to £1.4m and bank spend has seen a corresponding decreased by £120k and overtime by £186k. The increase in agency spend can be linked to the increase in activity across Planned Care as the recovery programme is started.

Actions being taken

- Proactive recruitment drives for Medical and Dental staff are being developed and work to secure a number Physicians Associates and ST 1 doctors is being taken forward, this correlates to number of other workforce optimisation initiatives that are being mobilised to support reduce the Health Boards reliance on temporary staffing.
- The focus on Nursing recruitment is increasing as capacity is released from COVID-19 response with overseas nurse programmes underway and looking to be expanded, with new initiatives such as Clinical Fellowships being developed to increase nursing capacity and support progression and retention across the nursing workforce.
- Support is in place to focus on increased recruitment to hotspots with the development and implementation of the recruitment pipeline report.

Timelines

- Refreshed clear medical and nursing recruitment plans now in place and being rolled out across identified areas such as band 5 nursing hotspots.
- Enhanced temporary staffing service process developed and now in place.

Risk

- The service delivery model and replication of predominantly bed-based services will continue to result in challenges in respect of rotas.
- It is acknowledged that there is a UK shortage of nurses (band 5 in particular), therefore, recruitment campaigns will reduce rather than eradicate the vacancy levels.
- Quarantine rules for overseas travel may reduce the run rate of overseas nurses commencing employment.
- The lack of shielding staff being able to return to clinical posts and the effects Long COVID-19 on staff could result in being unavailable to work for longer periods of time.

Quadruple Aim 4: Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the peer group (1.01% v 1.13% (Other Welsh HBs ex Powys) to April 2021). This has reduced during the last quarter as the second COVID-19 surge has receded. The highest number of deaths was in those patients admitted with COVID-19 (136) , Sepsis (82) and unspecified pneumonia (74).

Key Drivers of performance (for year to April 2021 against other Welsh health boards excluding Powys reported by CHKS)

- Crude mortality- overall (2.33% v 2.65%) this is similar to the pre second surge level.
- Mortality- sepsis (18.2% v 20.4%) remains below the peer; however, this has increased compared to the previous years crude rate.
- Mortality- cerebrovascular disease incl. stroke (12.3% v 13.3%) variation seen over the past year is common cause with mortality "as expected" overall.

Actions being taken

- Implementation of DATIX mortality module to support learning from deaths has been delayed due to reduced training capacity within the team. However, this has recommenced and DATIX is being used across all sites.
- The roll out of the Medical Examiner continues to be delayed until we can provide scanned notes; funding has been agreed and the recruitment process has started. This will support our decision to undertake further review and highlight any emergent themes for action. Processes have been piloted at Wrexham and Bangor to ensure smooth introduction to the service.
- Hospital Acquired COVID-19 reviews are continuing. Additional support has been agreed in principle as part of the wider review process and a paper has been developed to support this.
- BCUHB clinical mortality lead to work with OMD to increase local ownership and enhance learning – advertised 18/06/21.
- Supporting Delivery Unit with developing All Wales Learning from Deaths Framework and the mortality process review. Visits and discussions have been taking place with other services within and external to Wales to inform our developing policy.

Timelines

- DATIX mortality module – aim to be paperless for in-patients by April 2022. Acute site roll out complete by August 2021; Community beds by April 2022.
- Medical Examiners– aim all deaths on acute sites will be scanned by August 2021.
- Healthcare Associated Infections (HCAI)COVID-19 deaths - Sites have lists of all deaths for review; process in place to update monthly. Review process has started to roll out on all sites. Completion date will depend on resources available and cannot be confirmed at this time. Ysbyty Gwynedd will have completed death reviews by the end of June 2021.
- Clinical Mortality Lead - Job description written and funding agreed – aim to be appointed by July 2021.
- Learning from Deaths Policy – on hold pending the appointment of the Clinical Lead.

Risk

- The COVID-19 pandemic has reduced the capacity for staff to undertake routine mortality reviews. This, together with the need to complete HCAI death reviews, has led to a backlog of stage 2 reviews. Nursing colleagues have been identified on all sites to support mortality reviews. Additional resources are required to ensure these are completed. Other health boards in Wales are in a similar position. Failure to complete these in a timely way may impede safety and also cause reputational damage to the Health Board. A proposal document has been written for Executive review.
- Lack of agreed mortality review process across all acute sites may result on the three areas working differently. Mitigation - all sites are using the same tools.

Quadruple Aim 4: Sepsis

Issues Affecting Performance

- There has been a significant reduction in data collection across all sites since the COVID-19 pandemic. This is in absolute numbers of patients audited and the completion of the bundle data such that the levels of compliance are unreliable.
- YG have noted delays in doctor reviews; seeking second checker for antibiotics; ambulance waits and the introduction of Symphony software is contributing to this.

Actions and Outcomes

- All sites are aware of this issue and it has been escalated to Secondary Care division and corporate Clinical Effectiveness Group (CEG).
- YG ongoing unscheduled care improvement work stream will address some process delays; reminding staff to note if entries in Symphony are retrospective and explore whether a prompt can be introduced in to Symphony.
- YGC has identified a new Sepsis lead for the site who is developing a plan.
- YWM has identified sepsis champions for all clinical areas that will start to support a programme led by Acute Intervention Team; sepsis bundle included in local teaching with additional targeted education focussing on new starters.

Timeline for delivery of improvement

- YG by end of August they will define the denominator to enable real time monitoring and reinforcement.
- YWM above actions now in place; improvement is anticipated by September 2021.
- Secondary care have been asked to provide an improvement plan; this will be followed up at secondary care CEG in June 2021.

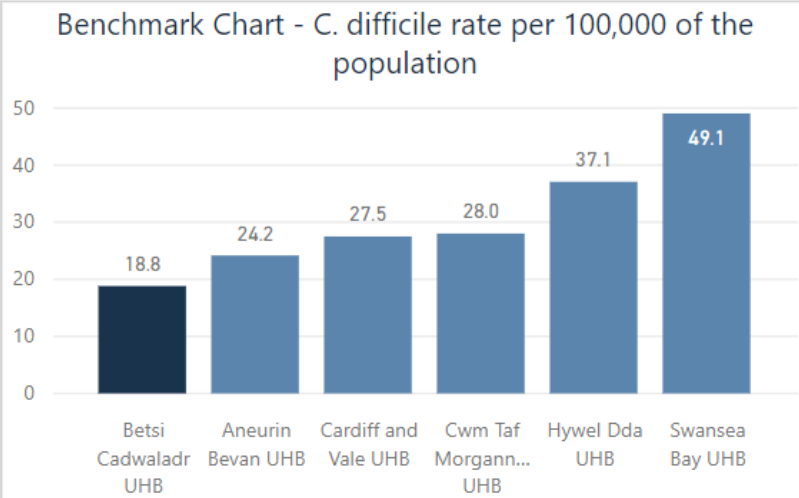
Risks and Mitigations

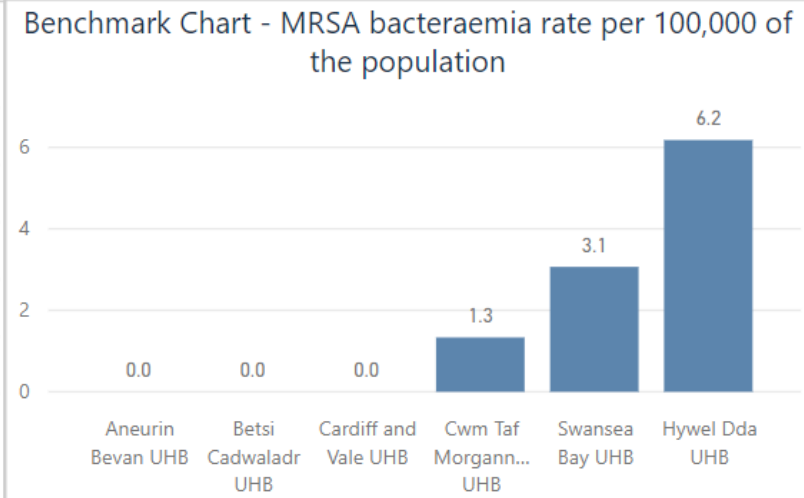
The risk is the organisation is not sighted on Sepsis 6 bundle compliance because of poor data capture. This has been escalated within sites, to Secondary Care Medical Director and CEG and corporate CEG. There is no mitigation in place, although clinical staff are aware of the requirement for this care to be delivered. At the current time mortality from sepsis is within expected limits and below the Welsh average peer group in the Comparative Healthcare Knowledge System (CHKS).

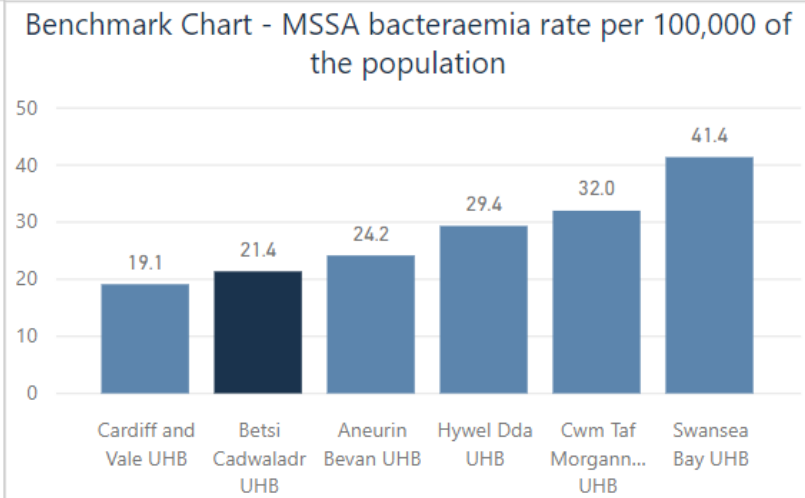
Key: YG = Ysbyty Gwynedd YGC = Ysbyty Glan Clwyd YWM = Ysbyty Wrecsam Maelor

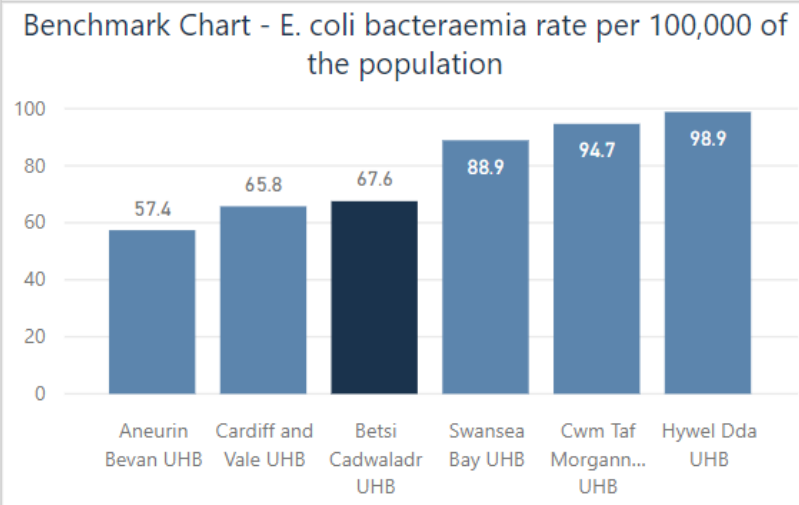
Additional Information

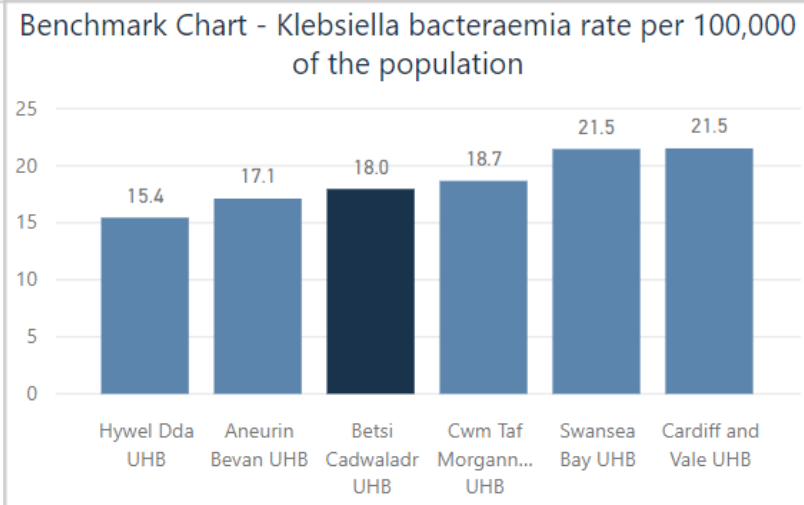
Quadruple Aim 2: Charts Infection Control

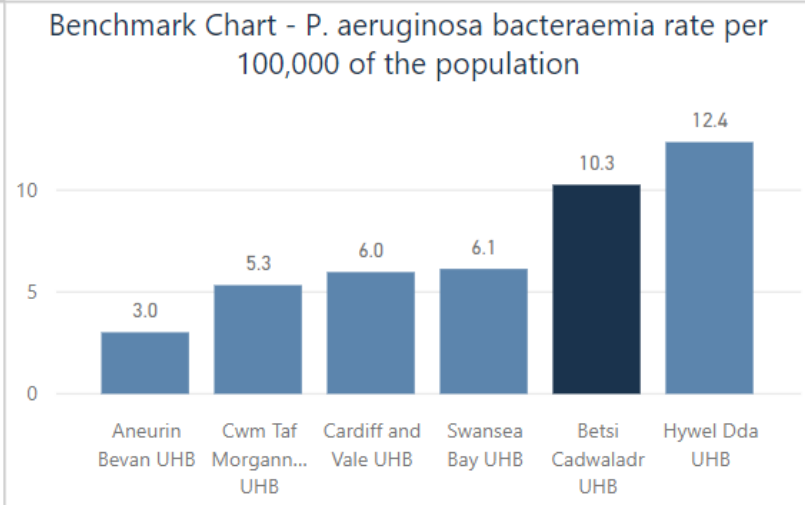






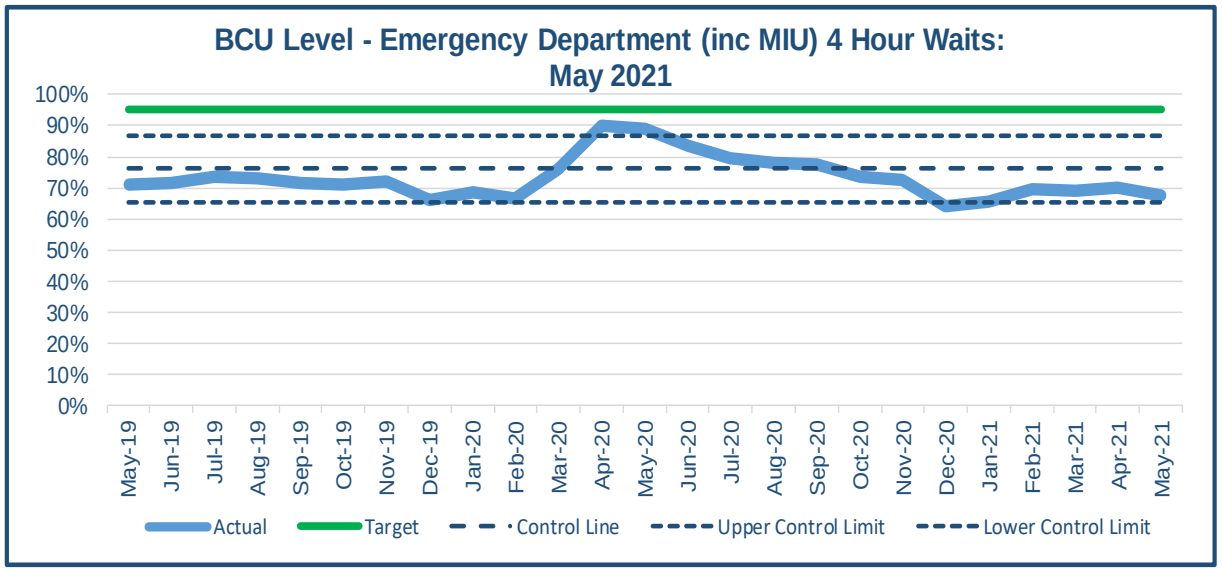


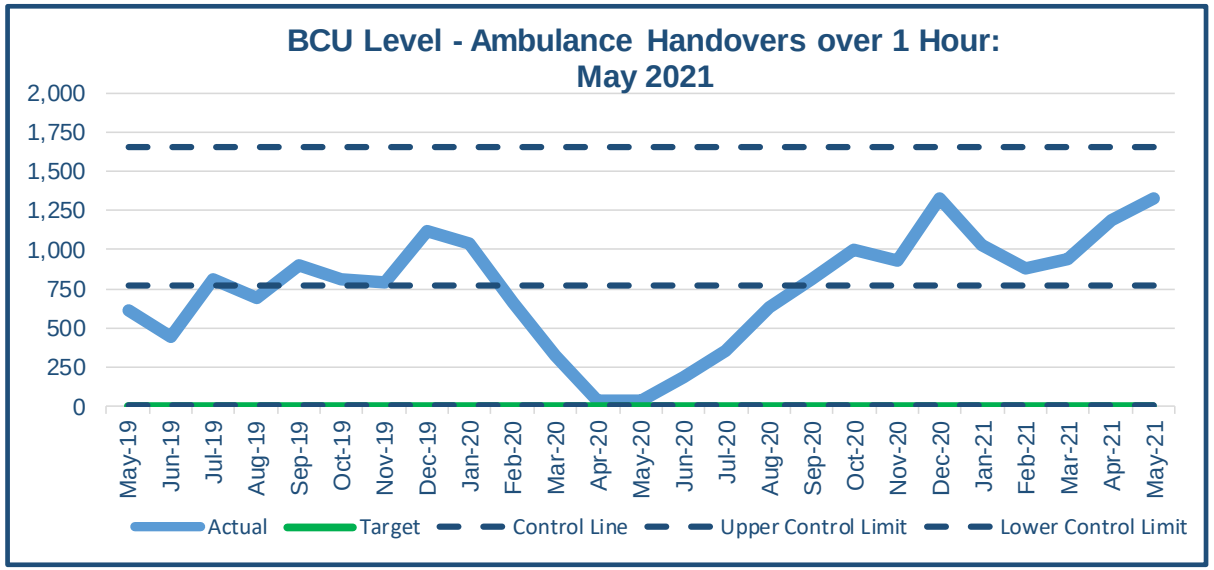


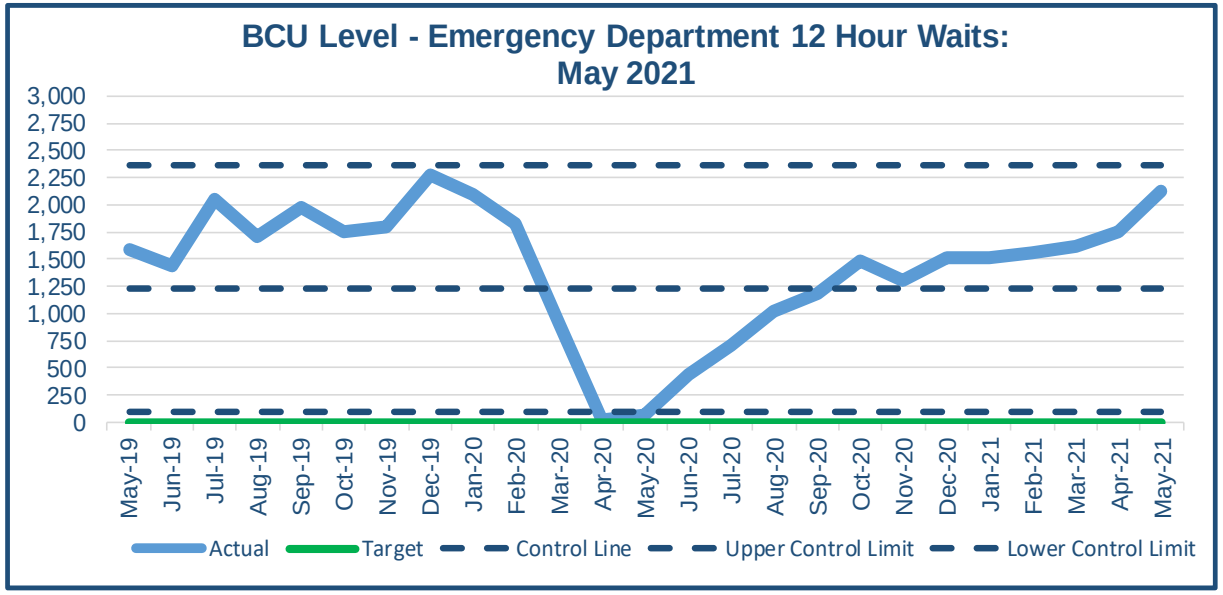


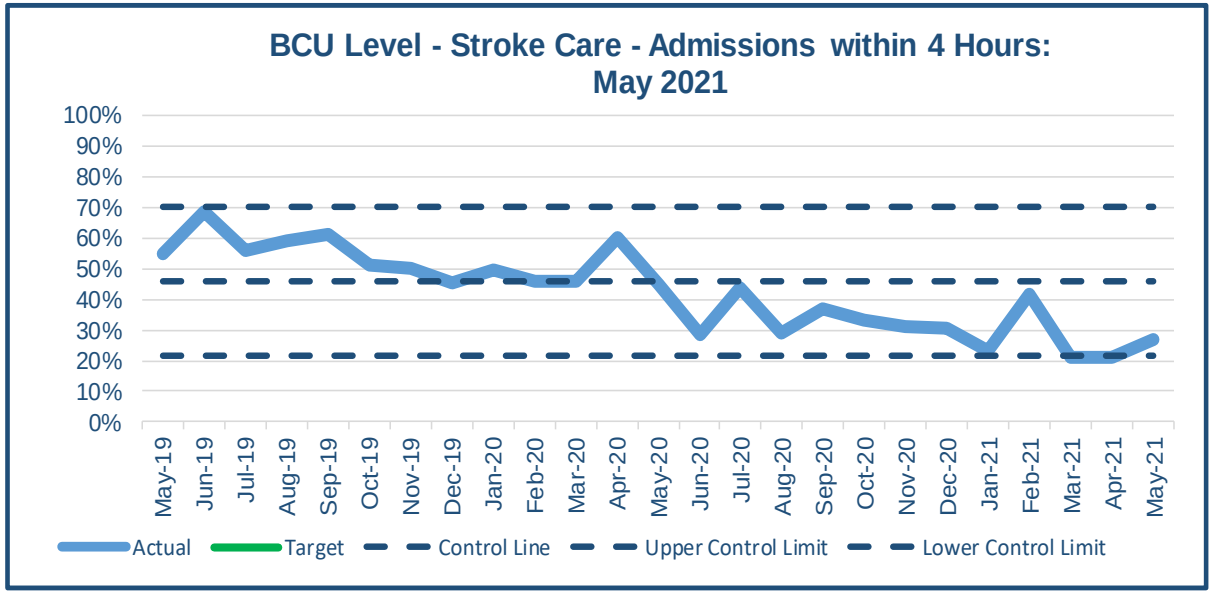
Rolling period refers to Cumulative April 2021 to Date (May 2021)

Quadruple Aim 2: Charts Unscheduled Care

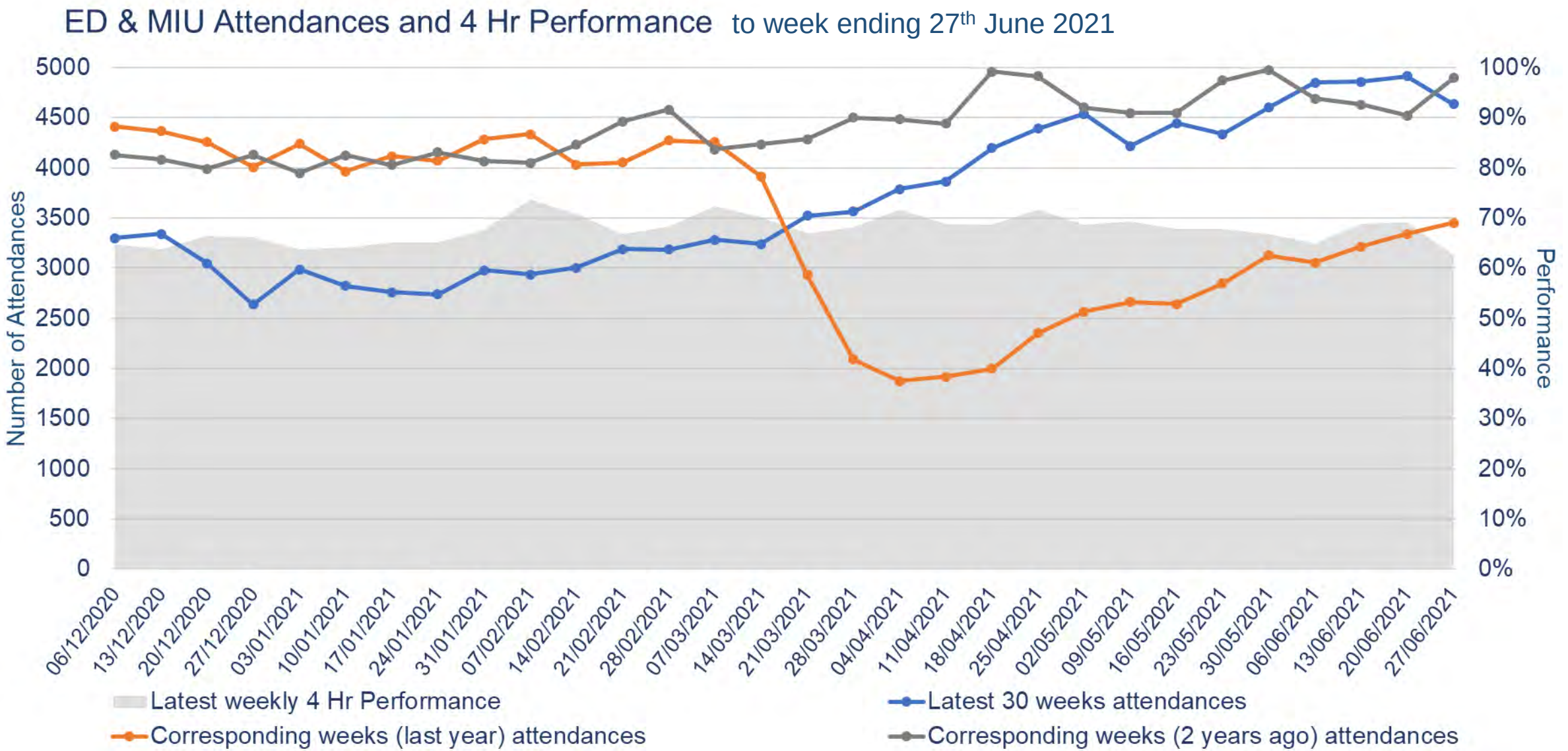




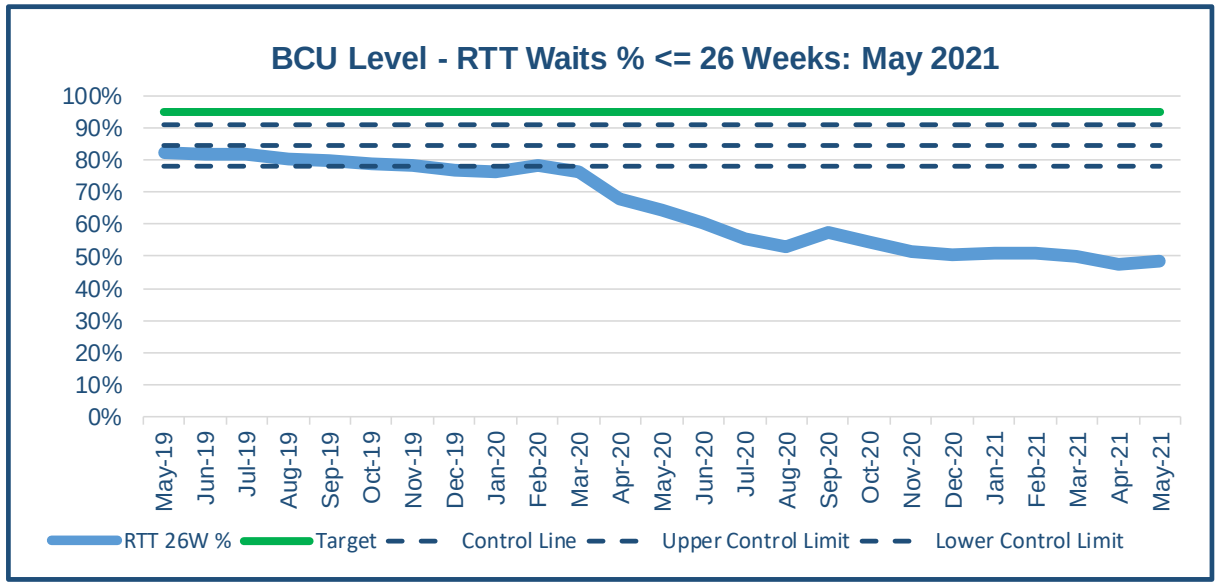


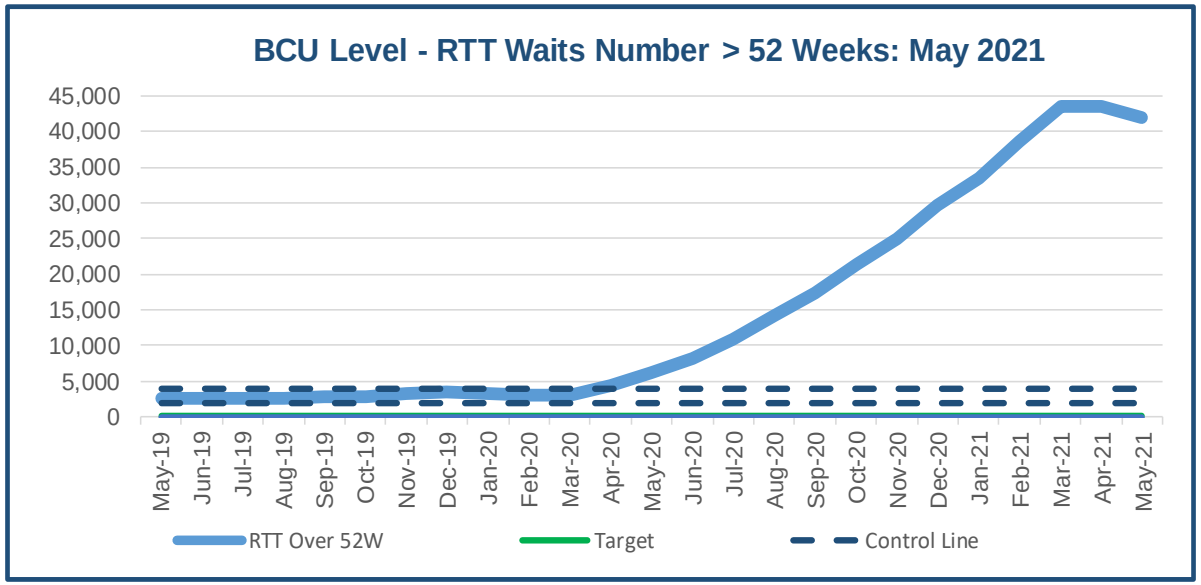


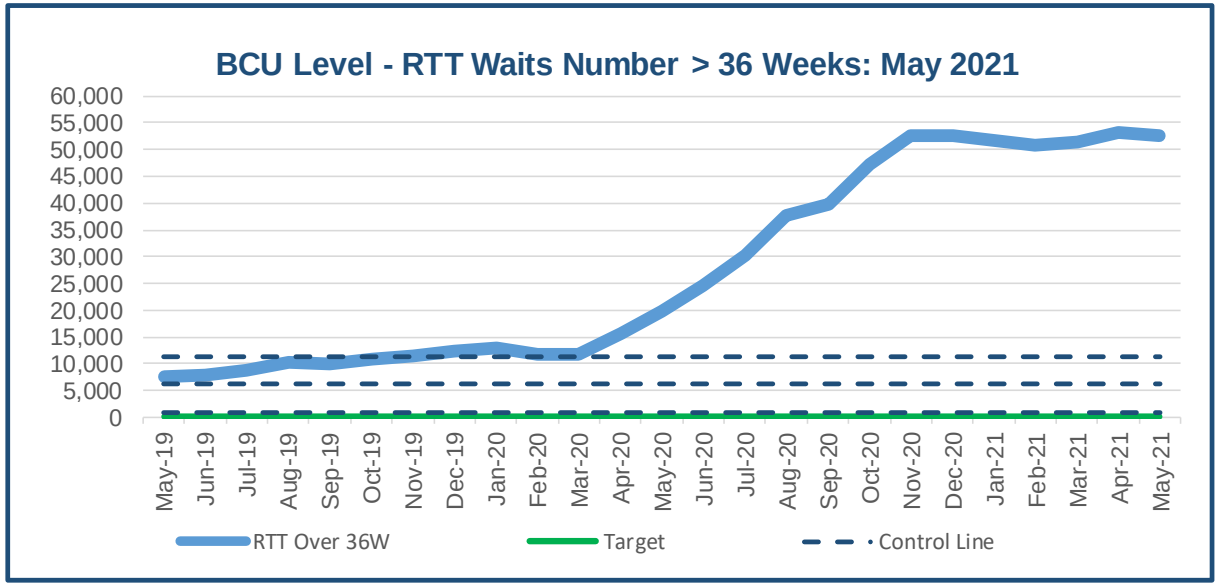
Quadruple Aim 2: Unscheduled Care: Attendances

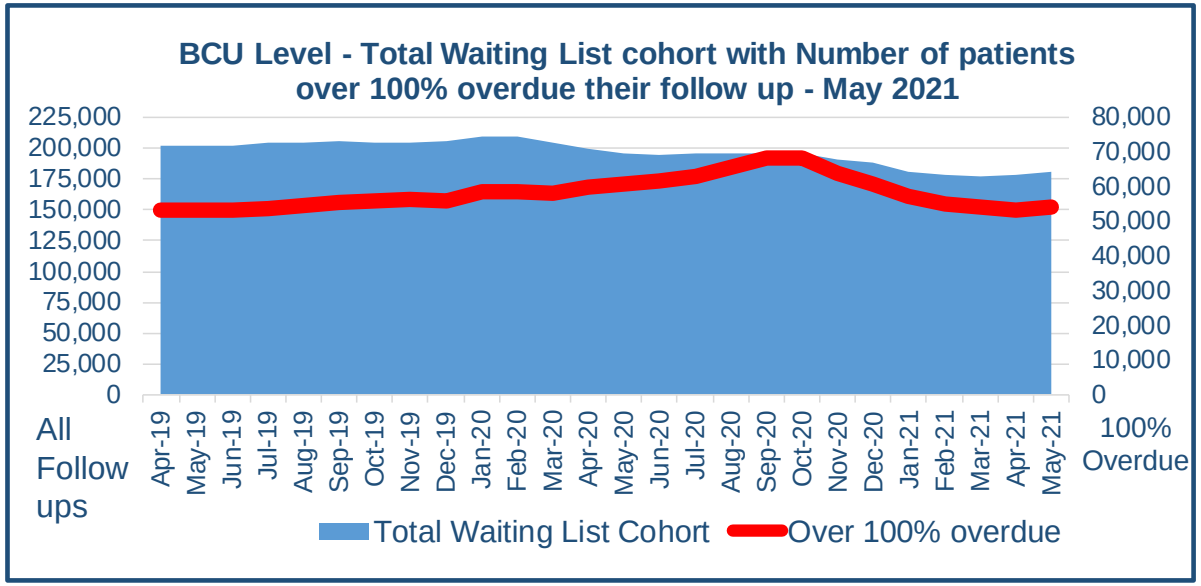


Quadruple Aim 2: Charts Planned Care (1)

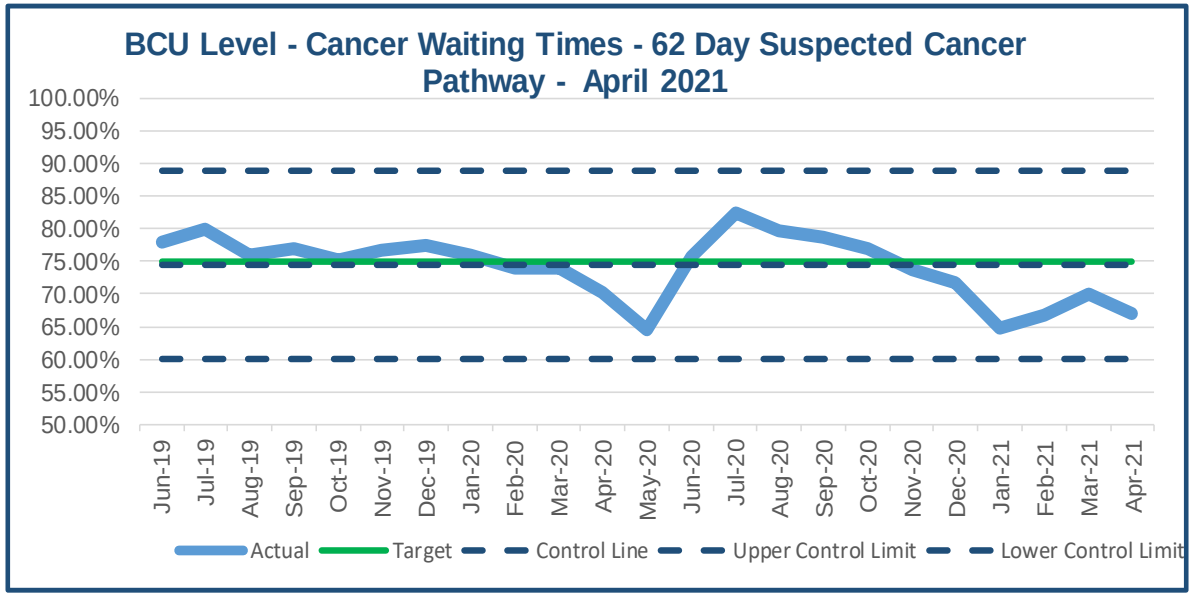


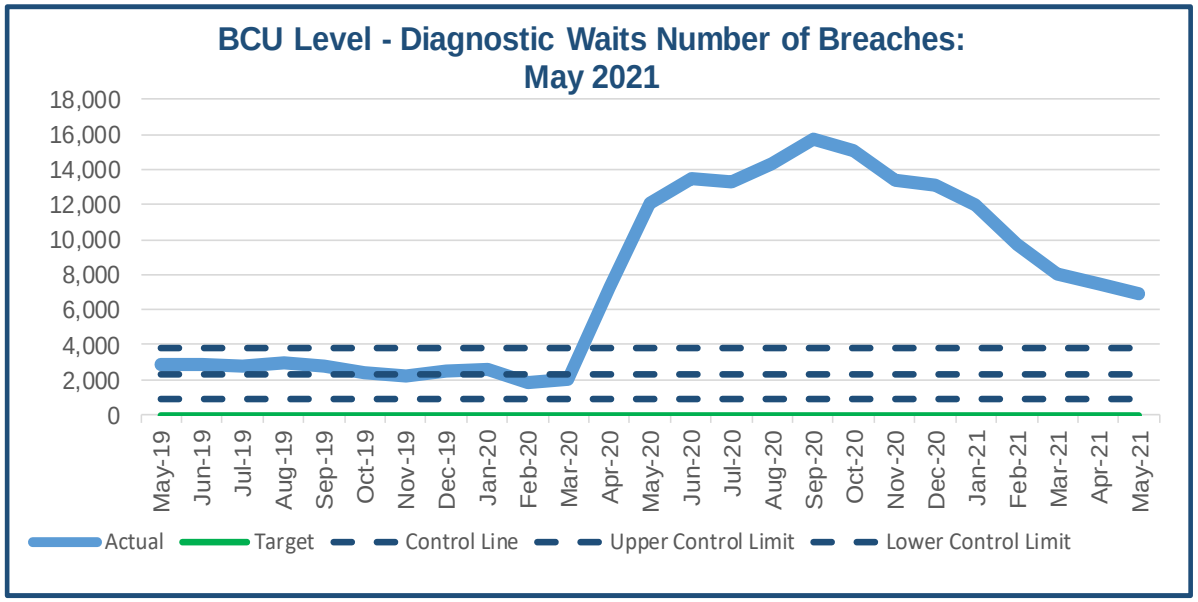






Quadruple Aim 2: Charts Planned Care (2)

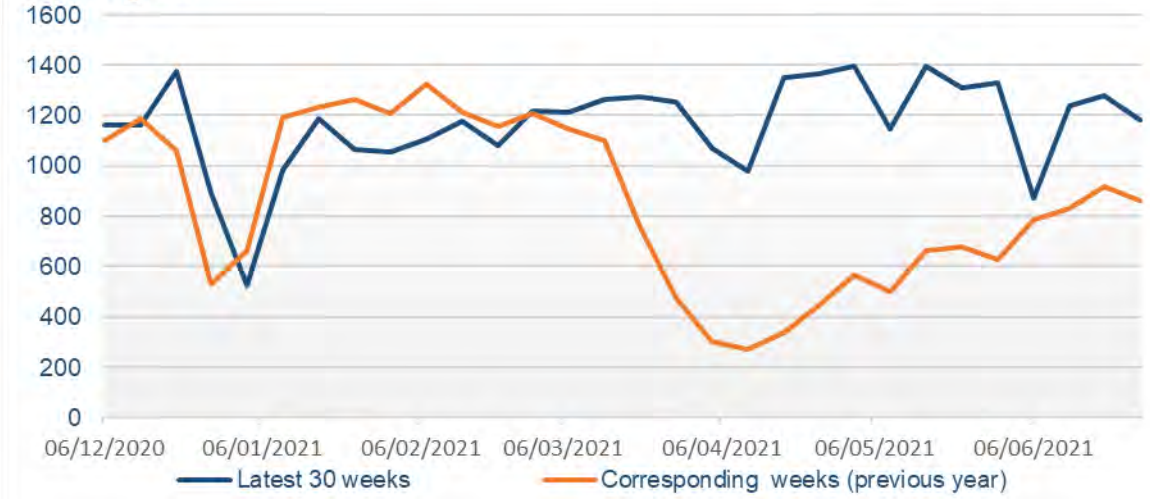




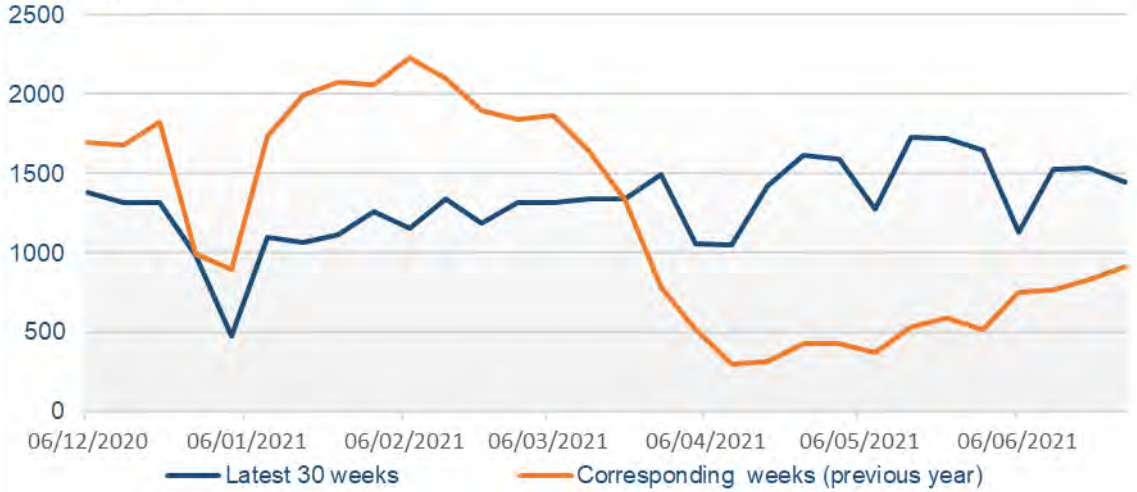
Note: Cancer Data is reported 1 month in arrears

COVID-19 Impact on Planned Care Referrals and Out Patient Activity

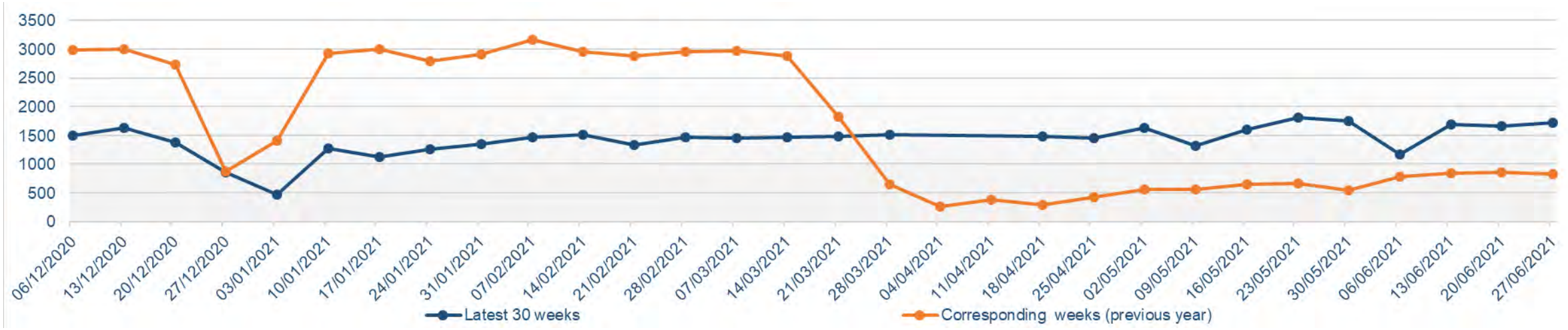
GP Urgent to week ending 27th June 2021



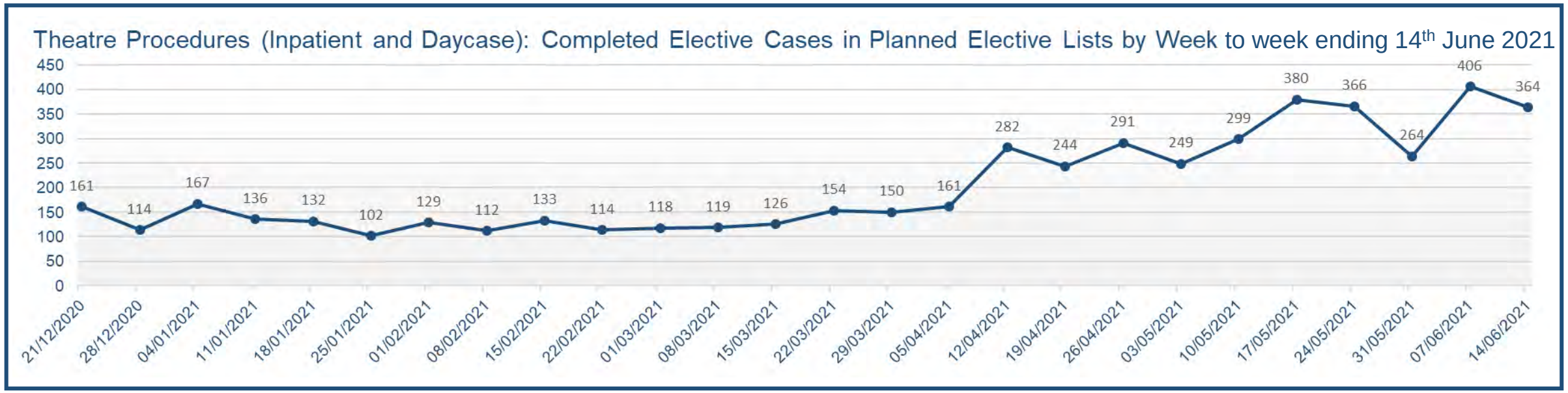
GP Routine to week ending 27th June 2021



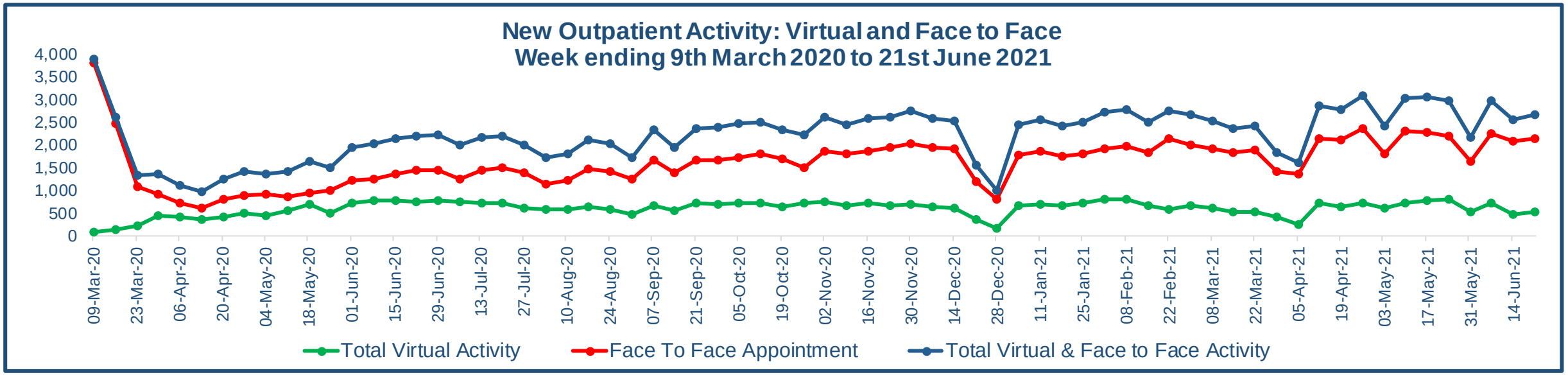
RTT High Level Report – Core Outpatient Activity (New, RTT, Face to Face attended appointments) to week ending 27th June 2021

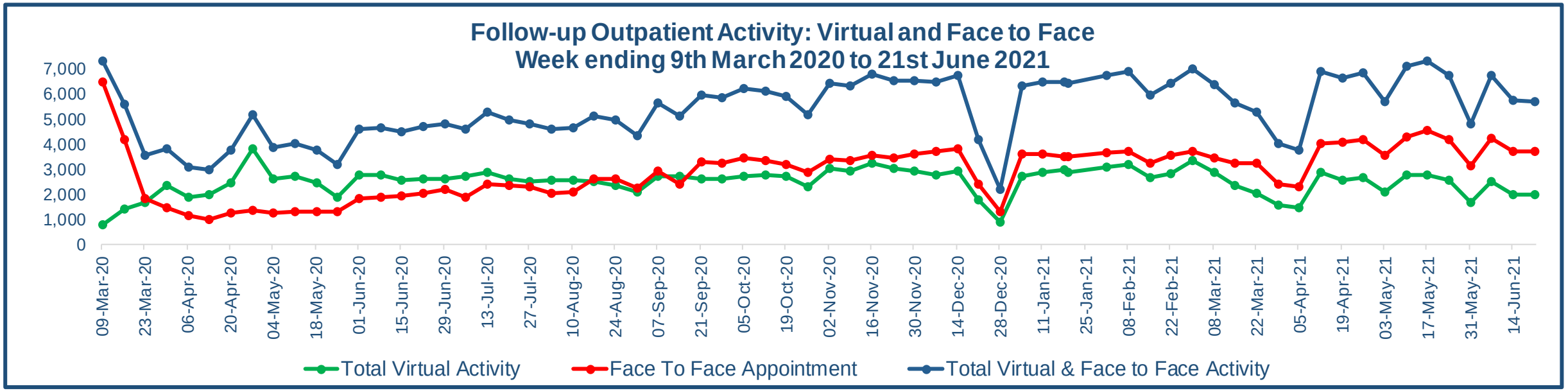


Planned Care Theatre Sessions

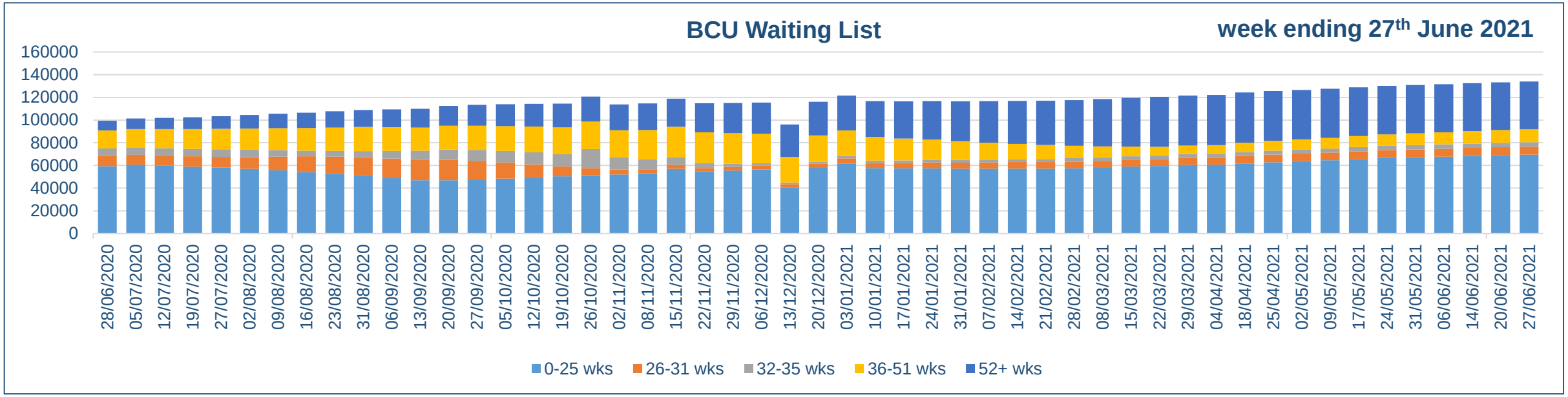


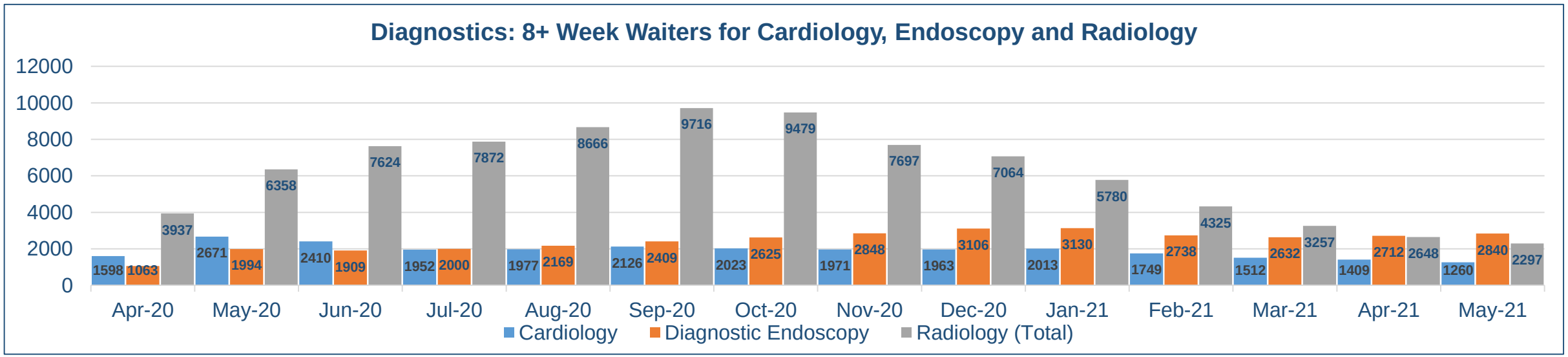
Planned Care New and Follow Up Outpatients (Virtual vs Face to Face)



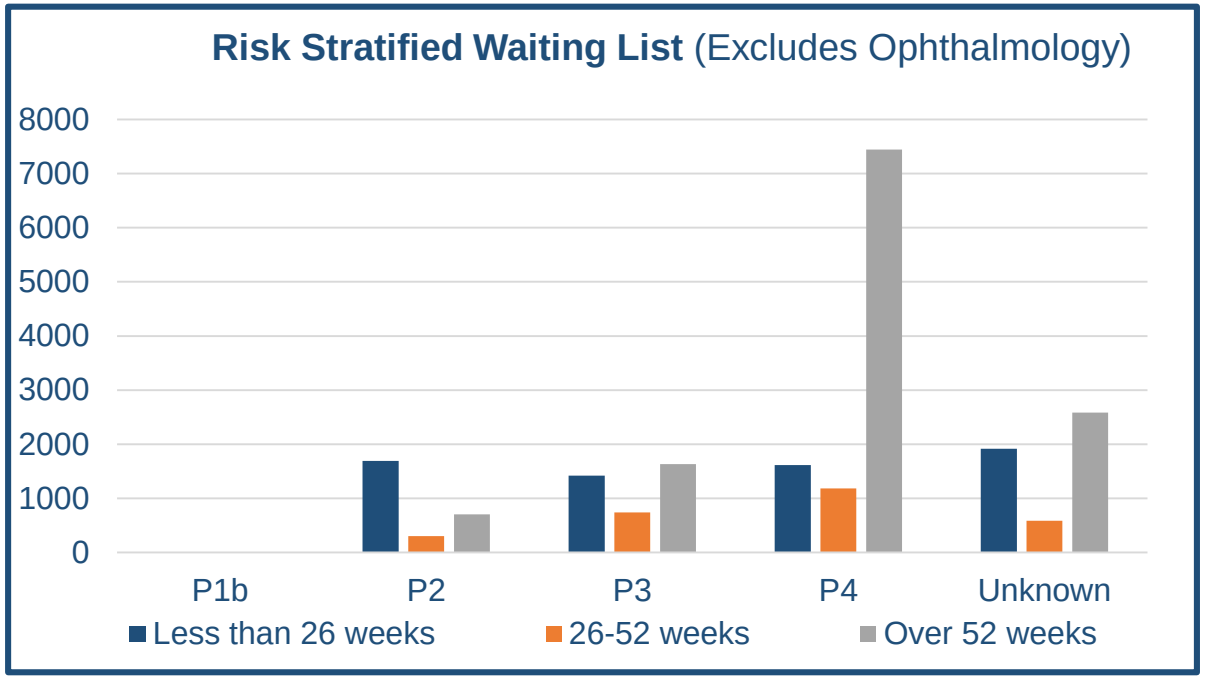


COVID 19 impact on Waiting Lists and Diagnostic Waits

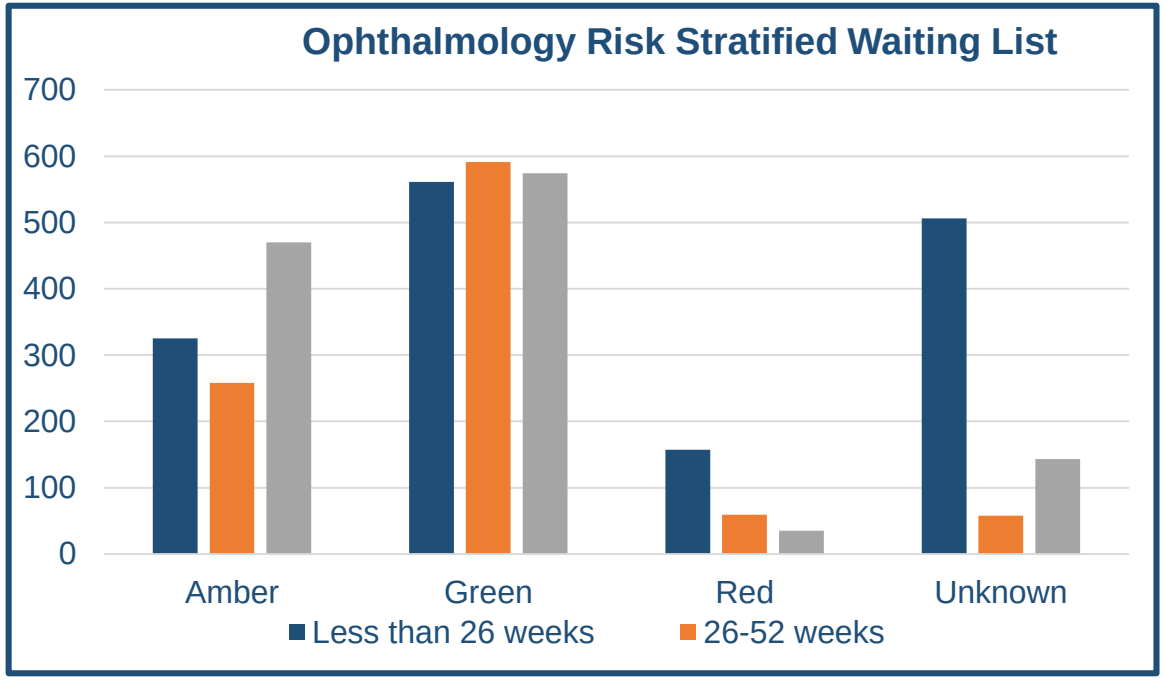




Waiting List by Risk Stratification



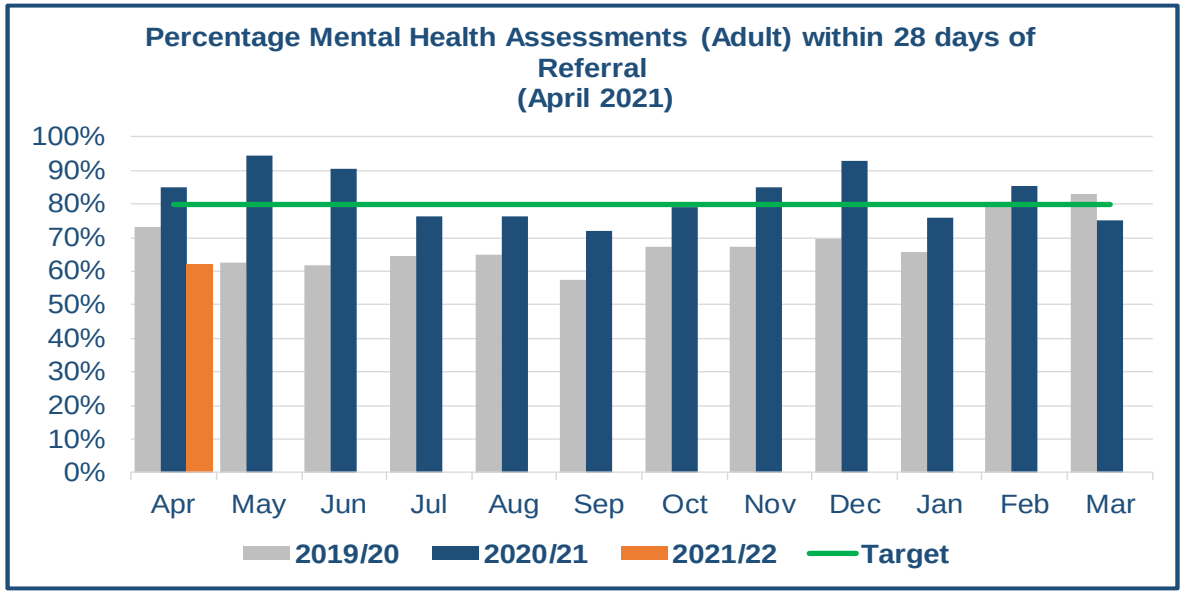
Source BCU HB IRIS : Accessed 15:30pm 28th June 2021
Data includes Admissions Waiting List for all specialties and excludes Endoscopy

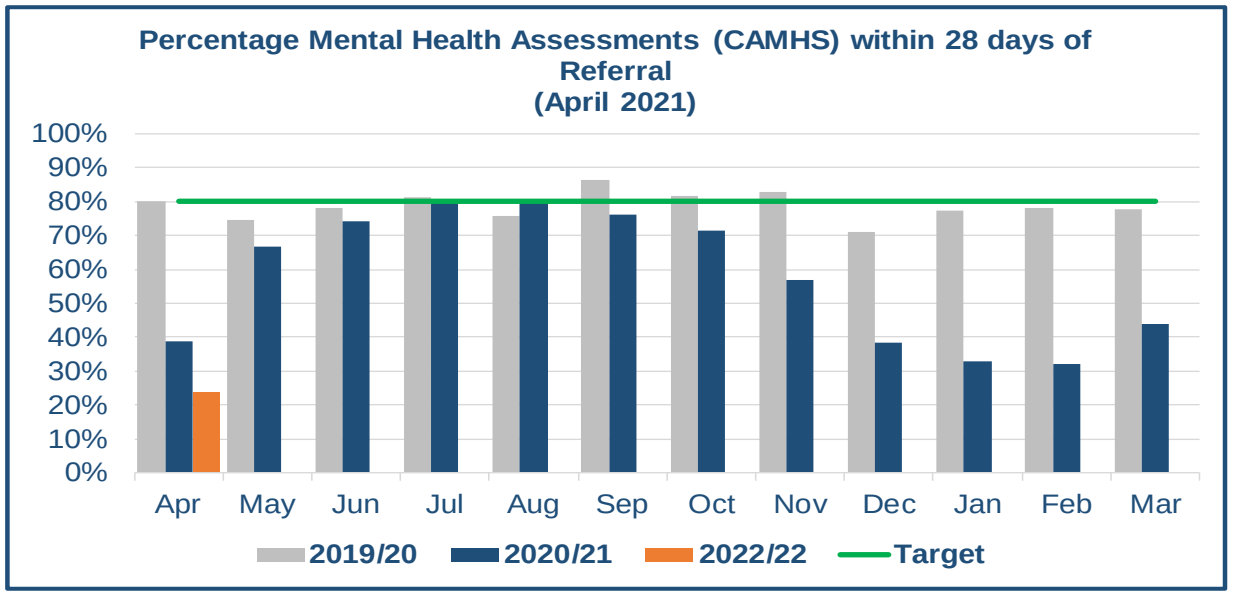


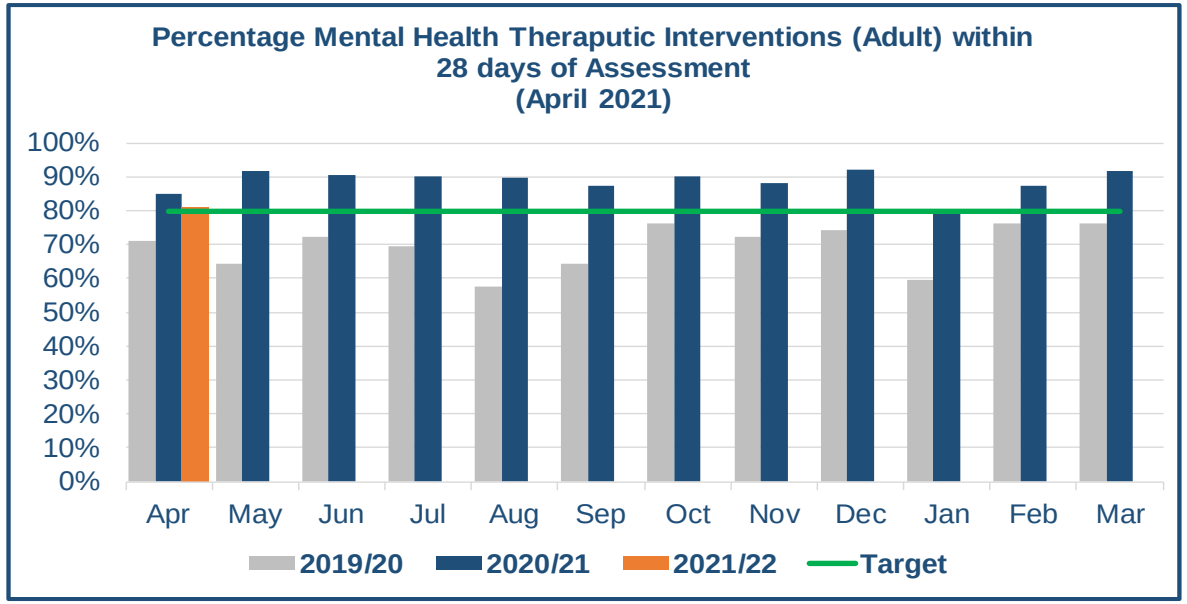
Source BCU HB IRIS : Accessed 15:30pm 28th June 2021
Data includes Waiting List for Ophthalmology Only

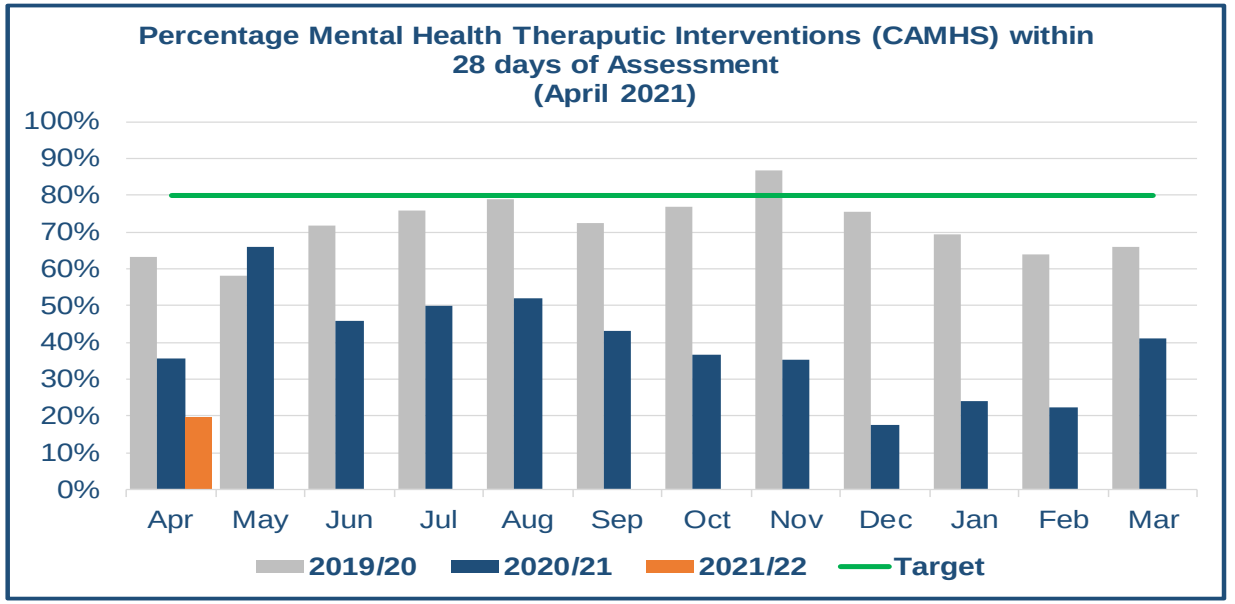
Please Note: Performance, along with colleagues in Informatics and in the services are currently reviewing the data quality for Risk Stratification

Quadruple Aim 2: Mental Health and CAMHS (1)

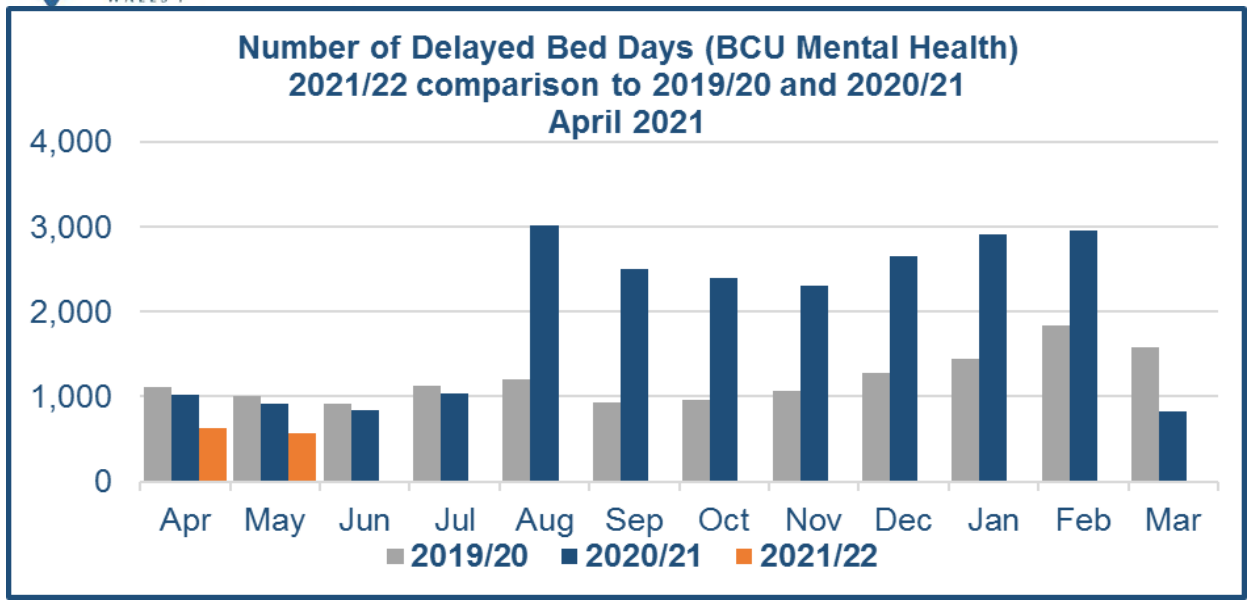


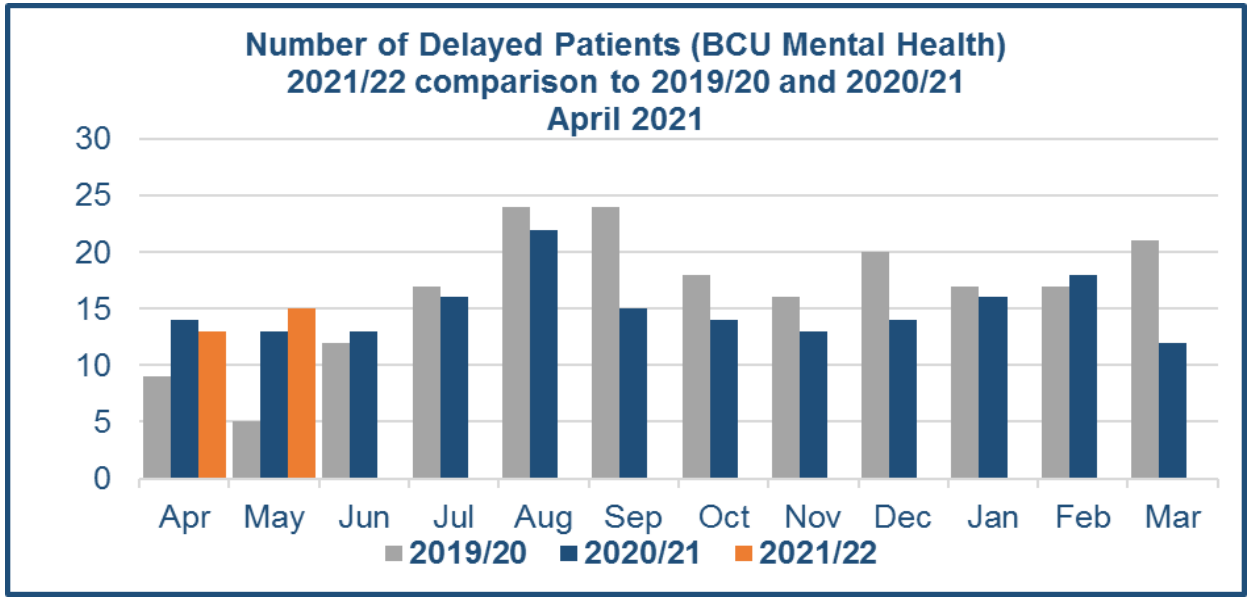






Quadruple Aim 2: Mental Health and CAMHS (2)



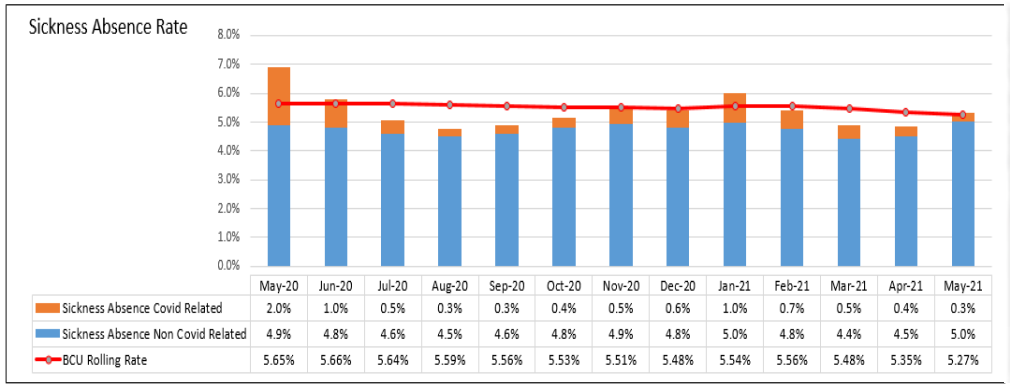


Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	1110	1004	917	1121	1210	927	958	1064	1275	1445	1840	1578
2020/21	1015	921	837	1042	3025	2501	2400	2312	2649	2913	2956	819
2021/22	631	565										

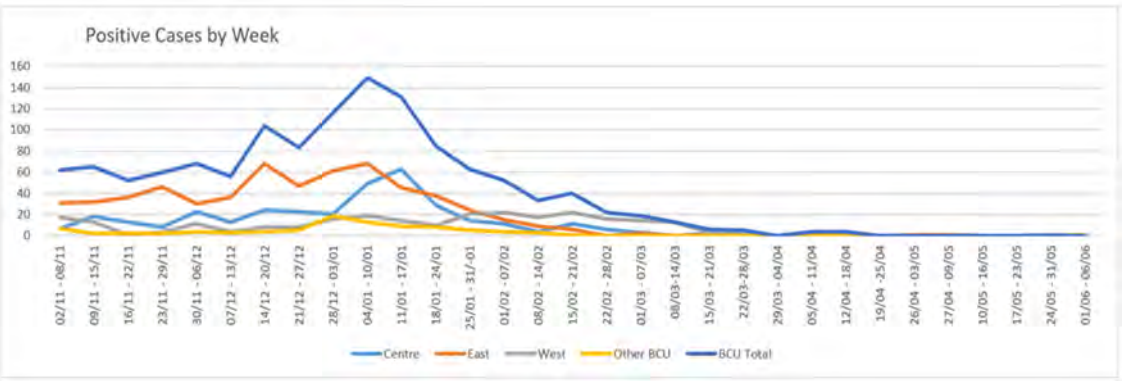
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	9	5	12	17	24	24	18	16	20	17	17	21
2020/21	14	13	13	16	22	15	14	13	14	16	18	12
2021/22	13	15										

Quadruple Aim 3: Workforce

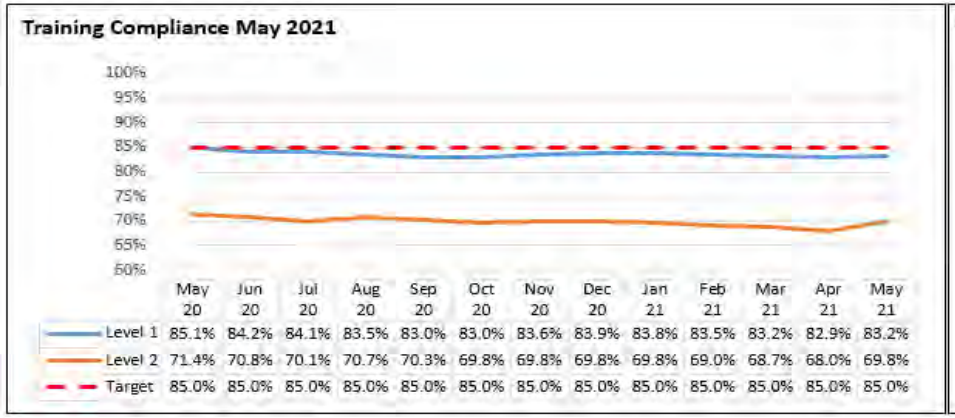
Sickness Absence Rates



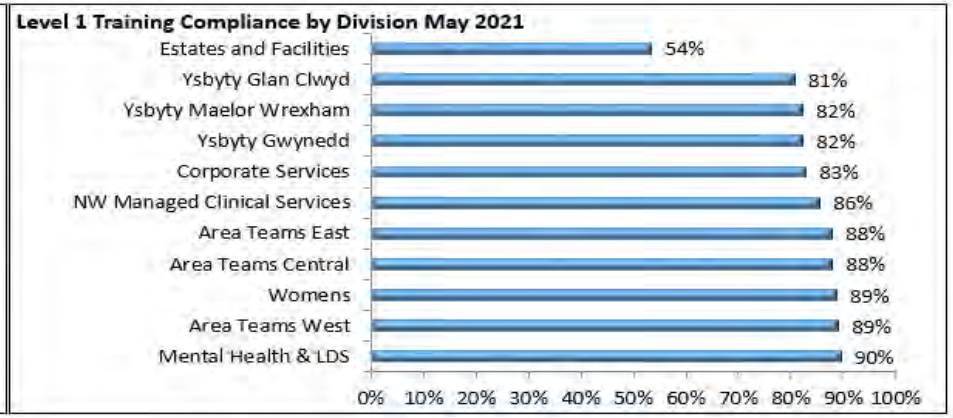
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Sickness Absence Covid Related	2.0%	1.0%	0.5%	0.3%	0.3%	0.4%	0.5%	0.6%	1.0%	0.7%	0.5%	0.4%	0.3%
Sickness Absence Non Covid Related	4.9%	4.8%	4.6%	4.5%	4.6%	4.8%	4.9%	4.8%	5.0%	4.8%	4.4%	4.5%	5.0%
BCU Rolling Rate	5.65%	5.66%	5.64%	5.59%	5.56%	5.53%	5.51%	5.48%	5.54%	5.56%	5.48%	5.35%	5.27%



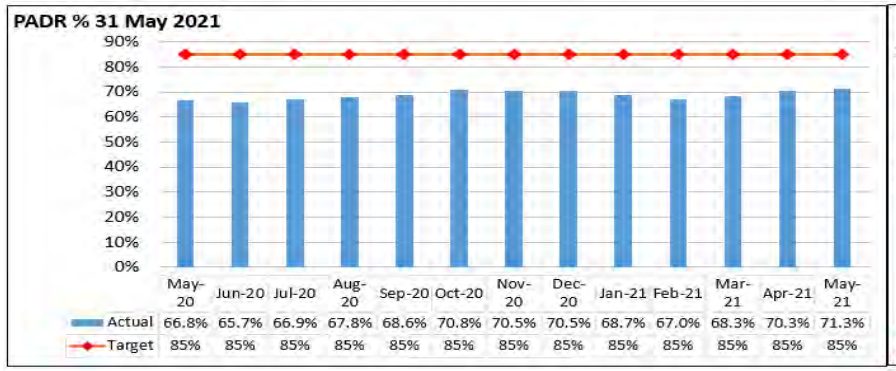
Core Mandatory Training Rate



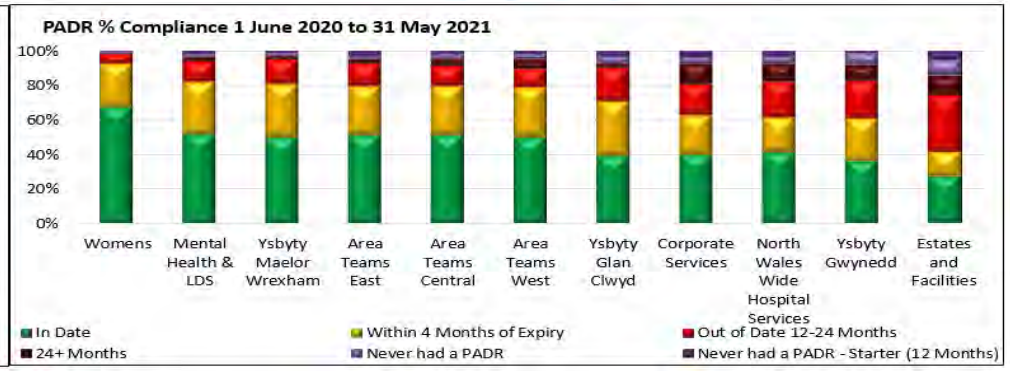
	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Level 1	85.1%	84.2%	84.1%	83.5%	83.0%	83.0%	83.6%	83.9%	83.8%	83.5%	83.2%	82.9%	83.2%
Level 2	71.4%	70.8%	70.1%	70.7%	70.3%	69.8%	69.8%	69.8%	69.8%	69.0%	68.7%	68.0%	69.8%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



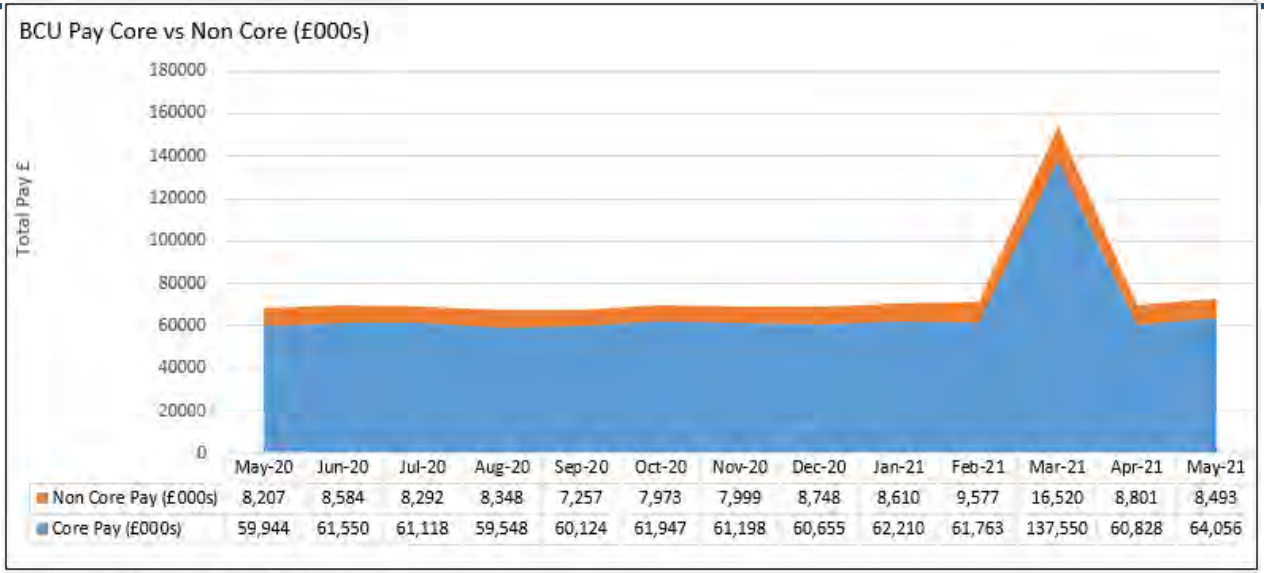
PADR



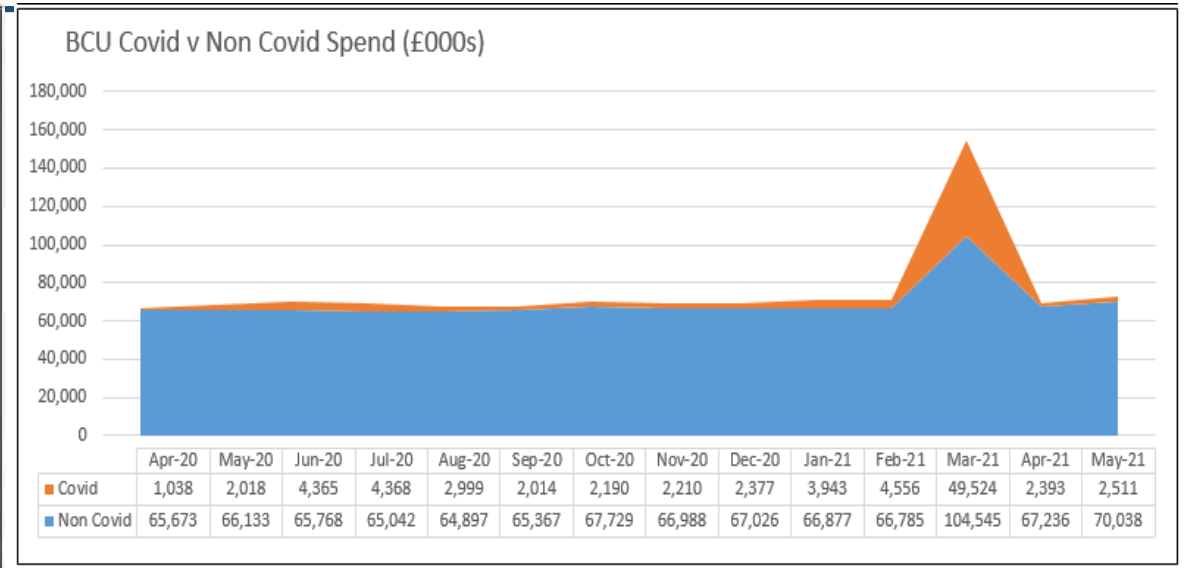
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Actual	66.8%	65.7%	66.9%	67.8%	68.6%	70.8%	70.5%	70.5%	68.7%	67.0%	68.3%	70.3%	71.3%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



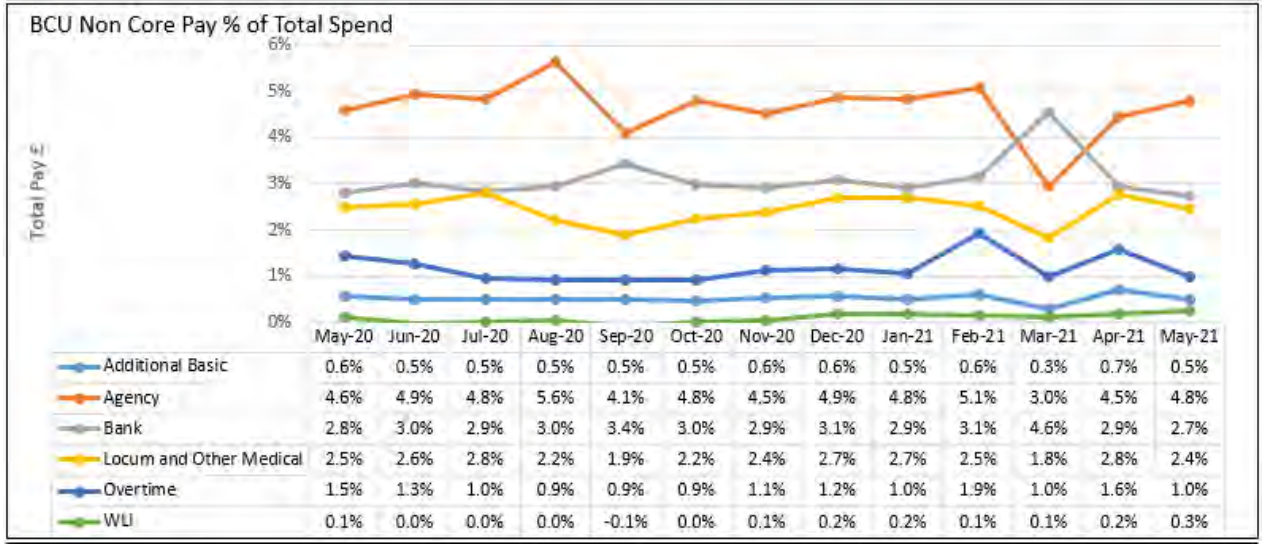
Quadruple Aim 4: Agency & Locum Spend



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Non Core Pay (£000s)	8,207	8,584	8,292	8,348	7,257	7,973	7,999	8,748	8,610	9,577	16,520	8,801	8,493
Core Pay (£000s)	59,944	61,550	61,118	59,548	60,124	61,947	61,198	60,655	62,210	61,763	137,550	60,828	64,056



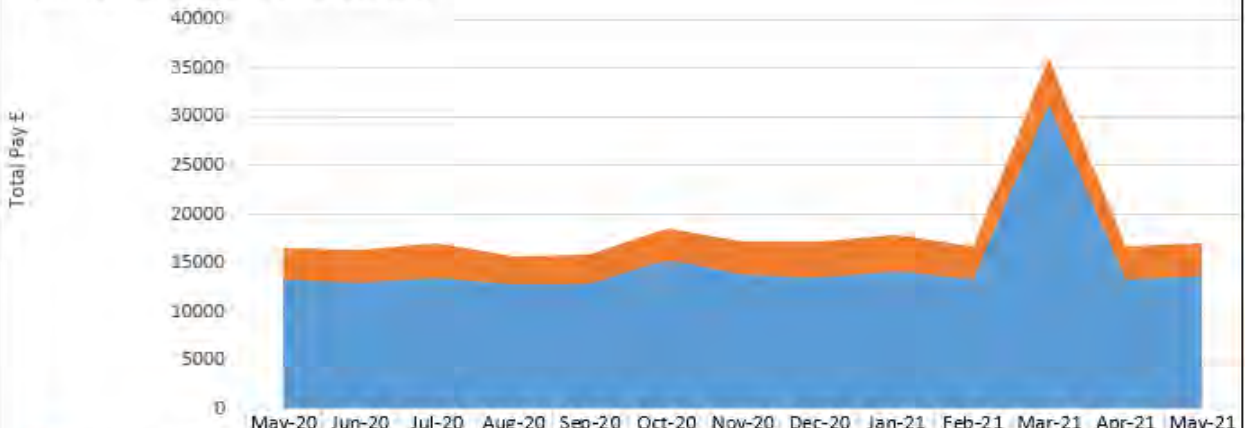
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Covid	1,038	2,018	4,365	4,368	2,999	2,014	2,190	2,210	2,377	3,943	4,556	49,524	2,393	2,511
Non Covid	65,673	66,133	65,768	65,042	64,897	65,367	67,729	66,988	67,026	66,877	66,785	104,545	67,236	70,038



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Additional Basic	0.6%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.5%	0.6%	0.3%	0.7%	0.5%
Agency	4.6%	4.9%	4.8%	5.6%	4.1%	4.8%	4.5%	4.9%	4.8%	5.1%	3.0%	4.5%	4.8%
Bank	2.8%	3.0%	2.9%	3.0%	3.4%	3.0%	2.9%	3.1%	2.9%	3.1%	4.6%	2.9%	2.7%
Locum and Other Medical	2.5%	2.6%	2.8%	2.2%	1.9%	2.2%	2.4%	2.7%	2.7%	2.5%	1.8%	2.8%	2.4%
Overtime	1.5%	1.3%	1.0%	0.9%	0.9%	0.9%	1.1%	1.2%	1.0%	1.9%	1.0%	1.6%	1.0%
WLI	0.1%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.3%

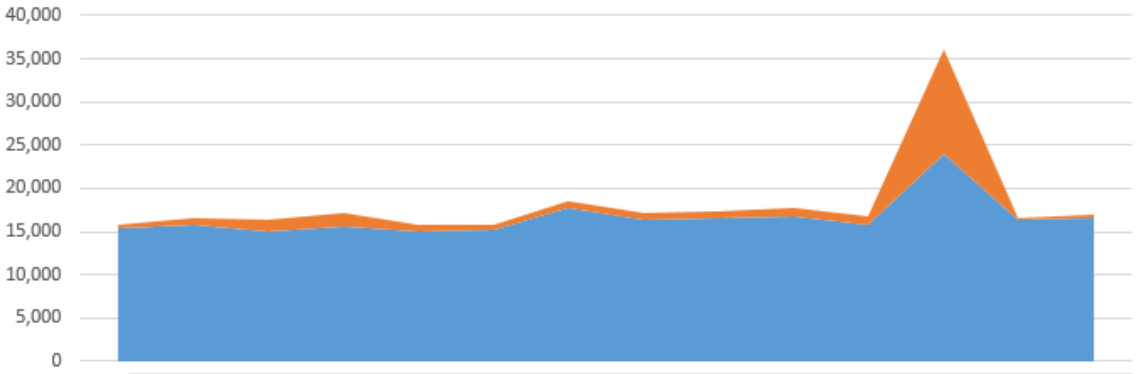
Quadruple Aim 4: Narrative – Locum Spend

M&D Pay Core vs Non Core (£000s))



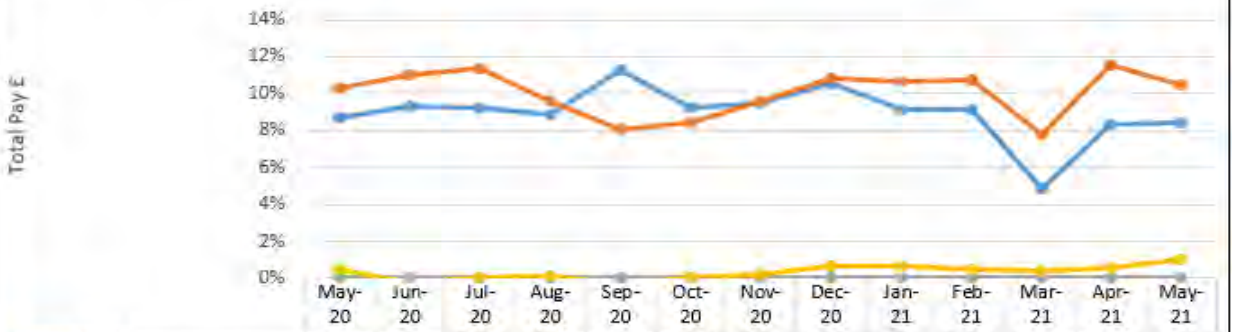
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Non Core Pay (£000s)	3,231	3,281	3,524	2,925	3,028	3,302	3,322	3,825	3,640	3,415	4,708	3,405	3,402
Core Pay (£000s)	13,295	13,026	13,555	12,818	12,849	15,272	13,852	13,446	14,180	13,366	31,307	13,252	13,613

M&D Covid v Non Covid Spend (£000s)



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Covid	372	713	1,255	1,523	681	592	819	761	765	1,065	1,076	12,069	345	522
Non Covid	15,464	15,814	15,053	15,557	15,062	15,285	17,756	16,413	16,506	16,755	15,705	23,947	16,311	16,493

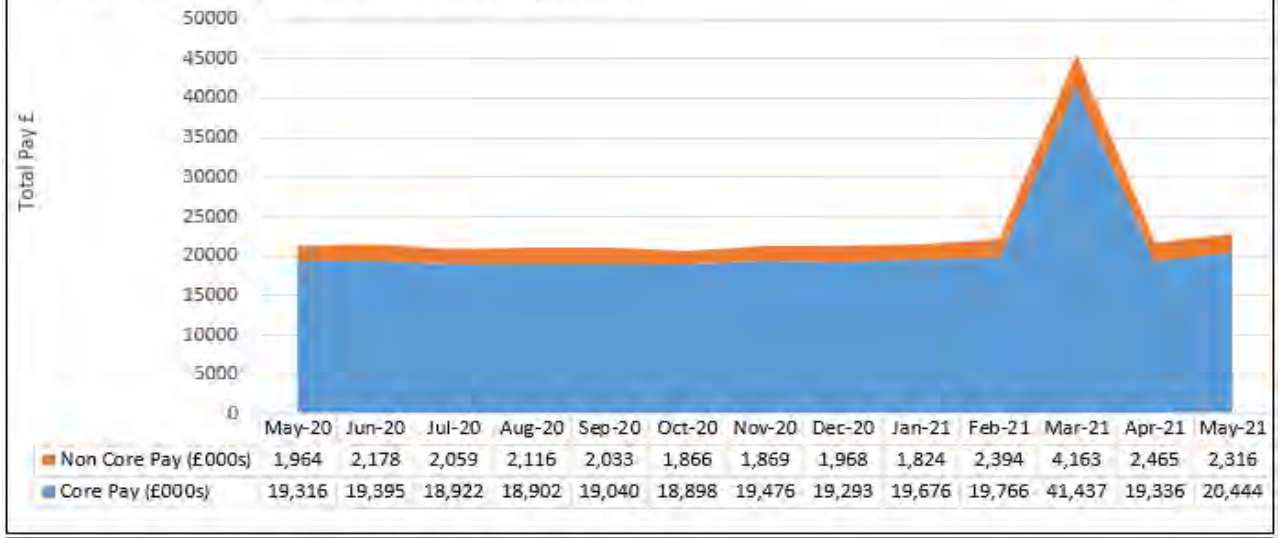
M&D Non Core Pay % of Total Spend



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Agency	8.7%	9.3%	9.2%	8.8%	11.3%	9.3%	9.5%	10.6%	9.1%	9.2%	4.9%	8.3%	8.5%
Locum and Other Medical	10.3%	11.0%	11.4%	9.6%	8.1%	8.5%	9.6%	10.9%	10.7%	10.7%	7.8%	11.5%	10.4%
Overtime	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
WLI	0.5%	-0.2%	0.0%	0.1%	-0.4%	0.1%	0.2%	0.7%	0.6%	0.4%	0.4%	0.6%	1.1%

Quadruple Aim 4: Narrative – Nursing & Midwifery Agency Spend

Nursing & Midwifery Pay Core vs Non Core (£000s)

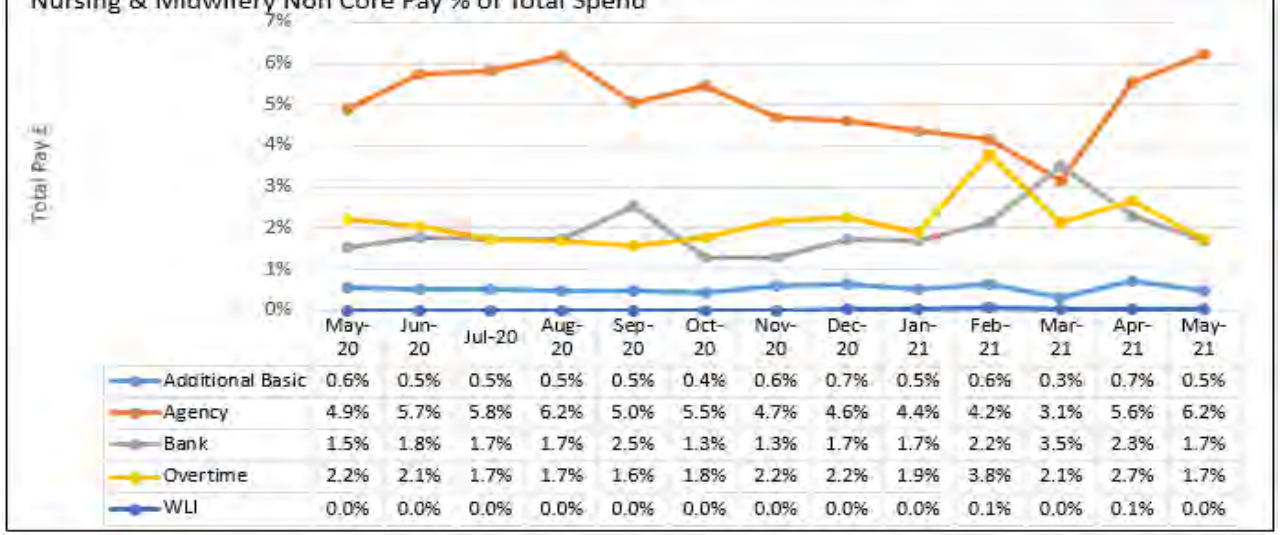


	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Non Core Pay (£000s)	1,964	2,178	2,059	2,116	2,033	1,866	1,869	1,968	1,824	2,394	4,163	2,465	2,316
Core Pay (£000s)	19,316	19,395	18,922	18,902	19,040	18,898	19,476	19,293	19,676	19,766	41,437	19,336	20,444

Nursing & Midwifery Covid v Non Covid Spend (£000s)

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Covid	313	383	558	455	250	415	184	512	644	1,159	1,547	12,788	695	774
Non Covid	20,691	20,897	21,014	20,526	20,769	20,658	20,580	20,833	20,617	20,342	20,613	32,812	21,106	21,985

Nursing & Midwifery Non Core Pay % of Total Spend



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Additional Basic	0.6%	0.5%	0.5%	0.5%	0.5%	0.4%	0.6%	0.7%	0.5%	0.6%	0.3%	0.7%	0.5%
Agency	4.9%	5.7%	5.8%	6.2%	5.0%	5.5%	4.7%	4.6%	4.4%	4.2%	3.1%	5.6%	6.2%
Bank	1.5%	1.8%	1.7%	1.7%	2.5%	1.3%	1.3%	1.7%	1.7%	2.2%	3.5%	2.3%	1.7%
Overtime	2.2%	2.1%	1.7%	1.7%	1.6%	1.8%	2.2%	2.2%	1.9%	3.8%	2.1%	2.7%	1.7%
WLI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%

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.bcu.wales.nhs.uk
- Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb
http://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Finance Report Month 1 2021/22
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Finance Finance & Performance Committee
Atodiadau **Appendices:**	

Argymhelliad / Recommendation:

It is asked that the report is noted.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact Assessment (EqIA) and socio-economic (SED) impact assessment not applicable.

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the financial performance of the Health Board as at April 2021.

Cefndir / Background:

In the second year of its response to the COVID-19 pandemic, the Health Board is now also focusing on implementing significant clinical programmes in order to begin to address the recovery of planned care in order to reduce harm to patients alongside the clear priorities around delivering the related COVID-19 programmes in North Wales. The draft financial plan submitted to Welsh Government at the end of March identified the financial risk for 2020/21 as £28.3m. This is based on a savings delivery target of £17.0m, which is 50% of the savings not delivered last year due to COVID-19. The Health Board received confirmation of a package of strategic support in November 2020, which provided multi-year funding to cover the historic deficit position, to improve performance and to drive a programme of transformation linked to a sustainable clinical model for North Wales. For 2021/22 this support totals £82.0m (£40.0m to cover the deficit and £42.0m strategic support) and has recently been notified of a £19.95m allocation as part of the planned care recovery programme across Wales.

In line with all NHS organisations in Wales, the draft plan is being revised during Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans while maintaining the focus on the six key objectives described in the draft plan.

Asesiad / Assessment:

Goblygiadau Strategol / 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.

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

Goblygiadau Ariannol / Financial Implications

Financial Position

	Month 1 £m	Forecast £m
Actual Position	2.3	28.3
Planned Position	0.0	0.0
Variance	(2.3)	(28.3)

The in-month and cumulative position is a £2.3m deficit. This reflects the £28.3m risk identified in the draft financial plan.

The total cost of COVID-19 in April is £8.3m. Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

	Actual M01 £m	Forecast 2021/22 £m
Testing	0.1	2.8
Tracing	1.1	13.7
Mass COVID-19 Vaccinations	1.7	12.0
Extended Flu Vaccinations	0.0	1.7
Field Hospital/Surge	0.3	1.0
Cleaning Standards	0.0	2.7
Other Costs	4.5	55.6
Total COVID-19 costs	**7.7**	**89.5**
Non Delivery of Savings	0.8	6.6
Expenditure Reductions	(0.2)	(1.2)
Slippage on Planned Investments	0.0	0.0
Total Impact of COVID-19	**8.3**	**94.9**
Welsh Government Funding	(8.3)	(94.9)
Impact of COVID-19 on Position	**0.0**	**0.0**

The forecast total impact of COVID-19 is currently is £94.9m. This is based on the assumption that COVID-19 will continue to have an impact for the first six months of the year, whilst Personal Protective Equipment (PPE), Testing, Tracing, Mass COVID-19 Vaccinations and Cleaning Standards will continue for the whole year. Welsh Government income has been anticipated to fully cover this cost, so there is no impact on the overall Health Board position. As additional modelling data for COVID-19 is received, and in line with the refresh of the financial plan, this forecast will be revised and updated.

Forecast

As noted in the draft financial plan, the financial risk for 2021/22 is £28.3m. This is therefore the forecast position for the year. In order to achieve a break-even position the Health Board would need to reduce planned expenditure by £28.3m, through a combination of the additional delivery of savings, improved productivity and efficiency, or by different choices. An action plan has been developed to address this financial risk.

Forecast expenditure related to the £30.0m funding for the Performance Fund and £12.0m Strategic Support is included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend each month for the first seven months of the year and a continued high level of spend for the remaining five months. This cost profile is dependent on

submitted schemes being approved by the Health Board and operational teams implementing plans at pace. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts.

Dadansoddiad Risk / Risk Analysis
There is one risk to the financial position, but the value of this cannot be currently quantified.

BCU risks are reported separately via the Risk Register.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Finance Report Month 2 2021/22
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Finance Finance and Performance Committee
Atodiadau **Appendices:**	

Argymhelliad / Recommendation:

It is asked that the report is noted.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact Assessment (EqIA) and socio-economic (SED) impact assessment are not applicable.

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board as at May 2021.

Cefndir / Background:

The draft financial plan submitted to Welsh Government at the end of March identified the financial risk for 2020/21 as £28.3m. This was based on a savings delivery target of £17.0m, which is 50% of the savings not delivered last year due to COVID-19. The Health Board has undertaken further discussions with Welsh Government during May and has been notified of additional funding totalling £32.663m to cover the impact of the undelivered savings from 2020/21. This additional funding is anticipated to cover the financial risk for the year and to ensure that the Health Board achieves a balanced position in line with the financial performance in 2020/21. The Health Board's plans for 2021/22 include the £82m strategic support funding notified by Welsh Government last year (£40m to cover the deficit and £42m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

In line with all NHS organisations in Wales, the draft plan is being revised during Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans, while maintaining the focus on the six key objectives described in the draft plan. The Month 2 return incorporates the latest thinking, with further work taking place in June.

Asesiad / Assessment:

Goblygiadau Strategol / 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.

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

Goblygiadau Ariannol / Financial Implications

Financial Position

	Month 2 £m	YTD £m	Forecast £m
Actual Position	(2.3)	0.0	0.0
Planned Position	0.0	0.0	0.0
Variance	2.3	0.0	0.0

The in-month position is a £2.3m surplus, which gives a balanced cumulative position. This reflects the additional funding announced in the recent touchpoint meeting with Welsh Government. This funding, which is to cover the impact of the undelivered savings from 2020/21, means that there is now also a balanced position forecast for the year.

The total cost of COVID-19 in May is £5.5m (£13.8m for the year to date). Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

	Actual M01 £m	Actual M02 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.3	2.8
Tracing	1.1	1.0	2.1	13.5
Mass COVID-19 Vaccinations	1.7	1.5	3.2	12.7
Extended Flu Vaccinations	0.0	0.0	0.0	1.1
Field Hospital/Surge	0.3	0.7	1.0	1.4
Cleaning Standards	0.0	0.0	0.0	2.5
Other Costs	4.5	3.6	8.1	69.3
Total COVID-19 costs	**7.7**	**7.0**	**14.7**	**103.3**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.9)	(2.8)
Slippage on Planned Investments	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**13.8**	**100.5**
Welsh Government Funding	(8.3)	(5.5)	(13.8)	(100.5)
Impact of COVID-19 on Position	**0.0**	**0.0**	**0.0**	**0.0**

The forecast total impact of COVID-19 is currently is £100.5m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to fully cover this cost, so there is no impact on the overall Health Board position.

As additional modelling data for COVID-19 is received, and in line with the refresh of the financial plan, this forecast will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.

Forecast

The forecast position has been updated to recognise the additional funding announced in the recent touchpoint meeting with Welsh Government. This funding, which is to cover the impact of the undelivered savings from 2020/21, means that there is now a balanced position forecast for the year.

Expenditure related to the £30.0m funding for the Performance Fund, the £12.0m Strategic Support and the £19.9m COVID-19 Recovery Plan are included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend each month for the

first seven months of the year and a continued high level of spend for the remaining five months. This cost profile is dependent on operational teams implementing approved plans at pace. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts.

Dadansoddiad Risk / Risk Analysis
There are three risks to the financial position, with a combined total of £6.5m.

BCU risks are reported separately via the Risk Register.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

Health Board 15 July 2021	 *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Audit Committee
Meeting date:	10/06/21
Name of Chair:	Richard Medwyn Hughes, Independent Member
Responsible Director:	Louise Brereton, Board Secretary
Summary of business discussed:	• Minutes and Action log review from previous meeting • Details of Breaches in terms of publication of Board/Committee papers • Noting Chair's action taken to approve revised Model Standing Orders and Standing Financial Instructions and Scheme of Reservation and Delegation as reported to the May Board • Received the Terms of Reference of the Targeted Intervention Steering Group • Received the report on issues discussed in the previous private committee session • Received a progress update report from Audit Wales together with reports on Phase One of the Structured Assessment; Test-trace-protect; Review of Welsh Health Specialised Services Governance; Personal Protective Equipment (PPE) Review; together with the report on the Annual Accounts • Briefing on the Financial Statements provided by the Executive Director of Finance; received the Annual Accounts together with the ISA260 • Received the Annual Report and the Suite of Committee Annual Reports • Internal Audit Report, Annual report and Head of Internal Audit Opinion together with five limited assurance reports covering:- Interim staffing; Security Compliance; Violence and Aggression; Water Management and Control of Contractors. • Clinical Audit Plan • Risk Management Strategy/Policy • Chair's Assurance Report – Risk Management Group • Corporate Risk Register • Board Assurance Framework • Proposed Integrated Governance Framework • Schedule of Financial Claims (Public and Private Session) • Covid-19 Field Hospital Consequential Losses • Financial Conformance Report • Counter Fraud Annual Report

	• Counter Fraud Annual Workplan
Key assurances provided at this meeting:	The Audit Committee: • Approved the Health Board's 2020-21 annual financial statements together with the Letter of Representation following consideration of the Audit Wales Audit of Financial Statements Report and confirmation of the Auditor General's intended opinion on the financial statements. • Received the progress update from Audit Wales together with the individual audit reports as detailed above; together with the report on the annual accounts. • Approved the Health Board's Annual report for submission to Welsh Government; • Approved the suite of Committee Annual Reports; • Received the progress report, together with the Head of Internal Audit opinion and annual report for 2020-21. • Received the Audit Recommendation Tracker and were pleased to note that progress continued to be made against implementation, notwithstanding the operational pressures of the pandemic. • Approved the draft Clinical Audit Plan for 2021/22 noting that the Plan was to be presented to the Quality, Safety and Experience Committee in July at which there would be further discussion on the Tier 2 audits and the learning and communication of learning from Tier 3 audits. *Post Meeting note: Following the meeting the Senior Associate Medical Director advised that she had been informed that Chronic Obstructive Pulmonary Disease (COPD) in Wrexham had not submitted any data (in relation to mandated audits). Arrangements have been made for a plan to be in place within two weeks to rectify the situation.* • Approved the updated Risk Management Strategy and risk appetite for onward submission to the Board. • Noted progress on the principle risks as set out in the Board Assurance Framework together with the management of the Corporate Tier 1 operational risks. • Approved the Counter Fraud Annual Workplan and received the Annual report for 2020-21 • Approved the Losses and Special Payments as detailed within the Conformance report. • Agreed the approach required for the payment of Consequential Losses including the governance behind the payment of Consequential Loss and the evidence required to substantiate any payment.
Key risks including mitigating actions and milestones	Members commented on the themes throughout the Internal Audit Limited Assurance reports regarding health and safety matters, and queried whether the Board was giving them enough attention and resources based on the risks. The Chief Executive agreed to

	take the challenge of resources versus risk back to the Executive Team for review.
Issues to be referred to another Committee	Limited Assurance reports as follows: • Engagement of Interim Appointments – Remuneration and Terms of Service Committee • Security Compliance – Quality, Safety and Experience Committee • Violence and Aggression – Quality, Safety and Experience Committee • Water Management – Statutory Compliance – Quality, Safety and Experience Committee • Control of Contractors – Quality, Safety and Experience Committee
Matters requiring escalation to the Board:	• Schedule of Financial Claims (open session) – to note the schedule of approved claims • To note the Committee's approval of the Risk Management Strategy and Policy including the risk appetite (appears separately on the Board Agenda) • Concerns raised by the Committee in respect of the Interim Staffing Limited Assurance Report - that the report was extremely disappointing given that the issues had been identified more than twelve months earlier and that it was unacceptable that Auditors had difficulty in obtaining information from the Workforce Team • Receive the suite of Committee Annual Reports • Approval of the Integrated Governance Framework (appears separately on the Board Agenda
Well-being of Future Generations Act Sustainable Development Principle	The purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance. As such, the Committee 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:	Range of regular reports including:- • Updated Clinical Audit Plan • Emergency Scheme of Reservation and Delegation • Performance and Accountability Framework • Annual review of gifts and hospitality and declarations of interests register • Legislation Assurance Framework • Post Payment Verification progress report • Dental Assurance report
Date of next meeting:	28/09/21

Health Board

15th July 2021

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Quality, Safety and Experience
Meeting date:	4th May 2021
Name of Chair:	Lucy Reid
Responsible Director:	Gill Harris, Executive Director of Nursing / Deputy Chief Executive
Summary of business discussed:	The Committee received the following: - A patient story about cancer services; - A report on the Covid-19 outbreak in Ysbyty Gwynedd; - An update on Covid-19 transmission rates, vaccination programme and the Test, Trace and Protect programme; - The outcome of the Review of the Discharge of Mental Health Patients During the Covid-19 Pandemic' - An exception report from the Mental Health and Learning Disabilities Division; - The Quality Governance Review report for Ysbyty Glan Clwyd; - An update on Healthcare Inspectorate Wales activity; - The action plan arising from the Healthcare Inspectorate Wales Maternity Review; - The Quality Governance Self-Assessment Action Plan for Maternity Services; - The Patient and Carer Experience Quarter 4 Report; - The Patient Safety Quarter 4 Report; - The Quality and Performance Report for March 2021; - The Board Assurance Framework; - The Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016; - Patient Safety Group Triple A Report; - Committee Annual Report 2020-21 for submission to the Audit Committee; - "Feeling Forgotten – waiting for care and treatment during the coronavirus pandemic" report from the Community Health Council;
Key assurances provided at this meeting:	• The Committee received a report on the progress on the vaccination programme, attempts being made to contact the hard to reach people in the population and plans to use pop up clinics following the decommissioning of the Mass Vaccination Centres;

Key risks including mitigating actions and milestones	• The Committee received an update from the Hospital Management Team for Ysbyty Gwynedd on the Covid-19 outbreak that was declared in February. The team outlined the contributory factors to the outbreak and their response to it. The team committed to embedding and sustaining lessons learnt from the outbreak to prevent recurrence. The Committee reiterated the need for strong leadership and monitoring compliance of controls. An external review has been commissioned and will be presented to the next Committee meeting; • The Committee were concerned about the lack of progress in the development of a plan to address the areas for improvement identified in the Quality Governance Review for Ysbyty Glan Clwyd. The delay had been as a result of the pandemic and the decision to wait for the new leadership team to commence in the hospital. The Committee were informed that a range of immediate actions had been put in place in the meantime. The improvement plan and progress against it would be reported to the next Committee meeting; • The Committee rejected the Corporate Risk Register report due to inconsistencies in the paper that related to the decisions that the Committee were being asked to take. The Chair agreed to discuss this outside of the meeting with the Interim Director of Governance;
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	The vascular report was received in private session due to purdah and was discussed at the public Board meeting on 20th May 2021.
Well-being of Future Generations Act Sustainable Development Principle	The Committee gave adequate consideration to the 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; 4.Putting resources into preventing problems occurring or getting worse; and 5.Considering impact on all well-being goals together and on other bodies)

Planned business for the next meeting:	Range of regular reports plus • Covid report (to include update on external review of YG outbreak, nosocomial action plan, vaccinations, Test Trace Protect and matters escalated from Executive Incident Management Team) • Serious Untoward Incidents • Health and Safety annual report • Combined assurance report for adult and children's mental health • Primary and community care assurance report (focusing on recovery post-Covid) • Clinical audit plan • Mortality annual report • Safeguarding annual report • Update on cancer pathway • Planned care update (focus on highest risk specialties) • YGC Improvement plan
Date of next meeting:	6th July 2021

Health Board

15th July 2021

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Finance and Performance Committee
Meeting date:	24th June 2021
Name of Chair:	John Cunliffe
Responsible Director:	Sue Hill, Executive Director of Finance
Summary of business discussed:	**Chair's Actions** • A range of Chair's Actions were reported to the Committee **Board Assurance Frame Work** • Progress against Principal Risks was noted. Some suggestions were made regarding improvements to definitions, reporting and assessment of current and target risk scores. **Annual Plan 2021-22** • The Committee reviewed the draft refreshed Annual Plan 2021-22 ahead of wider Board discussion at a later Workshop **Quality & Performance Report** • Some performance improvements were noted around Stroke patient reviews and reduction of over 36 and 52 week waits. However, there was a deterioration in performance of Emergency departments and an increase in Follow Up waiting list numbers. **Performance & Accountability Framework** • An implementation report was received with members expressing concern around pace. **Planning Principles 2022-25** • A timetable of planning principles was discussed with members expressing some frustration regarding the approach taken historically. Feedback was received that there were conflicting expectations regarding detail and documentation. It was suggested that a consensus view should be established at a board workshop regarding planning purposes, audiences and detail required by members..

	Planned Care • An update report was received and noted. In particular that backlog clearance had started. **Unscheduled Care** • Report received and progress on the Urgent and Emergency Care Improvement programme was noted. **Transformation Update** • A verbal update was provided around the transformation agenda. **Capital Programme** • Report received and noted with clarity sought regarding the Medical Device programme changes. **Finance Report** • Reports for Months 1 and 2 received. Some concern noted regarding initial performance against savings but forecast positive **Workforce Performance** • A refreshed workforce performance report was welcomed in terms of improved format. Officers were asked to look into the inclusion of a dashboard 'headline' approach. **Approvals** • The Committee approved: o inflationary uplifts for 2021/22 in relation to Continuing Health Care (CHC) and Funded Nursing Care, and an additional premium to the CHC rate. o to lease surplus land at Cefni Hospital to the Llangefni Town Council. o In private session the Committee approved a range of contractual and tender requests
Key assurances provided at this meeting:	• In private session the Committee were assured that the remaining outstanding recommendations of the *PWC* report into financial recovery would be completed in year.
Key risks including mitigating actions and milestones	**Unscheduled Care** • Continued pressures as reported within the Quality & Performance Report • Compounding factors relating to the need to maintain red and green pathways and comply with social distancing. • The Committee were assured that work continued with regards to improvement plans and that the outcome of bids submitted to Welsh Government should be known within the next three weeks.

	Planned Care • Members acknowledged the work ongoing within planned care however were keen to see capacity maximised through weekend and evening activity. • Assurance was given that insourcing in particular would include weekend work, and that development of modular theatres for orthopaedics was in final stages of completion. Cataract Centre plans and endoscopy business planning processes were however not as well advanced.
Targeted Intervention Improvement Framework Domain addressed	• Strategy, planning and performance • Leadership (including governance, transformation and culture)
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None
Well-being of Future Generations Act Sustainable Development Principle	The Committee gave appropriate consideration to the sustainable development principles.
Planned business for the next meeting:	Range of regular reports plus • Radiology Informatics outline business case • NW Medical and Health Sciences School Business Case • Further business cases and contractual matters as required • Savings programme report • External contracts Q1 report
Date of next meeting:	26th August 2021

Health Board

15 July 2021

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Charitable Funds Committee
Meeting date:	11 June 2021
Name of Chair:	Jackie Hughes
Responsible Director:	Sue Hill, Executive Director of Finance
Summary of business discussed:	• Charitable Funds Finance Report Q4 2020/21 • Charitable Funds Fundraising Update Report Q4 2020/21 • Investment manager's portfolio report & presentation • Third Sector Groups Update Report • Keep The Beats Fund Report • Awyr Las CRM Business Case • Awyr Las Strategic Plan 2021-22 to inform the 3 year 2022-25 Awyr Las Strategy • Summary of Expenditure Approvals • Updated Ethical Investment Policy • Charity Risk Register & Risk Focus • Updated Charity Work Plan for 2021/22
Key assurances provided at this meeting:	**Investment Portfolio** The Charity Accountant informed the Committee that all investments with Rothschild were ready to be transferred to Brewin Dolphin but it had been agreed to hold the transfer until April 2021 in order to streamline the financial year end. It is anticipated that the transfer of the portfolio will be completed by end of July 2021. **Awyr Las Strategic Plan 2021-22 to Inform the 3 Year 2022-25 Awyr Las Strategy** The Head of Fundraising took the Committee through the Awyr Las Strategic Plan advising that a decision had been reached to pause the introduction of a new strategy to the end of the year, recognising that it would need to incorporate a number of changes coming up, both internally and externally. **Updated Ethical Investment Policy** The Charity Accountant advised that Brewin Dolphin had presented an Ethical Policy paper to the Committee in March 2021 and to a Board Workshop in April 2021.Following these discussions, Brewin Dolphin had provided an updated policy. The Charity Accountant asked for the Committee's approval prior to the updated policy being

	submitted to the Board. She confirmed that it would remain a policy of the charity and would be included within the annual report which would be made public and that the next step would be to develop a full investment policy which would expand on the ethical element. The Committee reviewed and approved the policy. **Updated Charity Work Plan for 2021-22** The Head of Fundraising presented the Charity Work Plan to the Committee to request that the budget, which is usually presented annually in March, be presented in December of the previous year in order to be approved in advance of the new financial year, and to include a work plan. The Committee was in agreement with the requested changes.
Key risks including mitigating actions and milestones	• Reduction in donations during 2020/21 • Risks relating to Charitable Funds will be reviewed systematically by the Committee in future meetings
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
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:	Range of regular reports plus • Brewin Dolphin to attend September Charitable Funds Committee to talk through the portfolio and present an initial report. • Head of Fundraising to present an update regarding information, monitoring and evaluation of grants.

Date of next meeting:	16 September 2021

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Health Board 15.07.21	 *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Mental Health Act Committee
Meeting date:	25.06.21
Name of Chair:	Lucy Reid
Responsible Director:	Teresa Owen, Executive Director of Public Health
Summary of business discussed:	The Mental Health Act Committee received updates on the following: • Deprivation of Liberty Safeguards Annual Report; • Hospital Manager's Update Report; • Performance Report on Mental Health Act activity including a deep dive into section 136 performance; • Healthcare Inspectorate Wales Monitoring report and Quality Check Summary for Coed Celyn Hospital; • Section 12 (2) Doctors Recruitment and Action Plan; • Development of the risk register for the Committee; • Reporting plans for clinical audit activity; • Reforming the Mental Health Act White Paper Consultation Responses from BCUHB; • Criminal Justice Liaison Service report; A number of draft policies were also approved.
Key assurances provided at this meeting:	• The Committee noted the number of sections that have been prevented as a result of positive intervention and signposting by the Criminal Justice Liaison Service; • A comprehensive action plan has been developed to address the concerns regarding section 12(2) doctors, which has been a key cause for concern for the Committee;
Key risks including mitigating actions and milestones	• The Committee received an update on the plans for the implementation of the Liberty Protection Safeguards and the impact that this may have on the Health Board. A key risk that has been identified is training and resources, which has been raised with Welsh Government. A Task and Finish Group will be established to support the implementation of the new framework across the Health Board.
Targeted Intervention Improvement	• Mental Health (adult and children)

Framework Domain addressed	
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None
Well-being of Future Generations Act Sustainable Development Principle	Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this. 1.Balancing short term need with long term planning for the future; 2.Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4.Putting resources into preventing problems occurring or getting worse; and 5.Considering impact on all well-being goals together and on other bodies)
Planned business for the next meeting:	The next meeting should be under the revised governance framework and cycle of business.
Date of next meeting:	24th September 2021

Health Board

15TH July 2021

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Remuneration & Terms of Service (R&TS Committee)
Meeting dates:	22.4.21 and 7.6.21
Name of Chair:	Mark Polin
Responsible Director:	Sue Green, Executive Director of Workforce & OD
Summary of business discussed:	The Committee considered the following issues: • R&TS Committee Annual Report 2020/21 – approved • National pay terms and conditions update Items considered in private on 22.4.21: • Managed practices • Disciplinary cases • Senior interims update • Upholding Professional Standards in Wales (UPSW) update • NHS Performers List update • Professional standards case management • Executive and senior appointments • Executive Directors' performance and development review and on 7.6.21: • Remuneration Report 2020/21 – approved.
Key assurances provided at this meeting:	• Appropriate governance processes are being followed and improved
Key risks including mitigating actions and milestones	• Potential risks and mitigations formed part of the discussions in private.
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	None.

Well-being of Future Generations Act Sustainable Development Principle	*1.Balancing short term need with long term planning for the future* – consideration of future processes *2.Working together with other partners to deliver objectives* –working with trade union partners *3. Involving those with an interest and seeking their views – via* consultation with trade union partners and engagement with colleagues *4. Putting resources into preventing problems occurring or getting worse* – plans for management process improvements *5. Considering impact on all well-being goals together and on other bodies* – noted.
Planned business for the next meeting:	A range of standing items plus professional registration annual reports, a tribunal report, senior appointments update, Executive objectives, pay protection and UPSW.
Date of next meeting:	22.7.21.

Health Board

15th July 2021

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Strategy, Partnerships & Population Health Committee
Meeting date:	17th June 2021
Name of Chair:	Lyn Meadows
Responsible Director:	Mark Wilkinson, Executive Director of Planning and Performance
Summary of business discussed:	• Update on proposals to refresh the *Living Healthier Staying Well (*LHSW) Strategy. Discussion focused on engagement plans, timing and mapping against Welsh Government priorities to deliver patient centred not workforce centred services. • Review of Committee allocated risks on the Board Assurance Framework, noting that remapping will be undertaken against risk appetite would be undertaken once revised Risk Management Strategy approved by the Board. • Civil contingency and business continuity progress report including work programme for 2021/22 Available as item 5.3 within agenda pack • The refresh of the Annual Plan 2021/22 was received and members indicated an increased level of confidence, however, a range of comments would be fed into subsequent discussions by Finance & Performance Committee and Board Workshop on 24.6.21. • Endorsement of planning principles and outline timetable for 2022/25. • An update on Mental Health Strategy development and refresh of the partnership board. • Receipt of Equality and Human Rights Annual Report including update against the Strategic Equality Plan. Available as item 6.3 within agenda pack • Update on development of Estates Strategy. • Presentation on workforce strategy development. • Committee supported establishment of a BCUHB decarbonisation programme to respond to the NHS Wales Decarbonisation Strategic Delivery Plan 2021/30. • Receipt of Regional Partnership Board (RPB) minutes. • Progress update for the North Wales Children's and Young Peoples Transformation Programme. • Presentation and report on BCUHB University Status.

	• Research and development update. • Update on Test Trace Protect. • Well Being of Future Generations Auditor General Wales report and BCUHB response • Pandemic learning report • Wales Audit Office Review of Public Services Boards report 2019 • International Health Group Chair's report 2020/21 • Update from Mid Wales Collaborative • In private session the Committee received an update on progress against the development of a North Wales Medical and Health Sciences School.
Key assurances provided at this meeting:	• Assurance given as part of LHSW discussion that an Emergency Department will remain in each of the District General Hospitals. • Members were pleased to note positive approach and improvements with regards to the Mental Health Strategy refresh.
Key risks including mitigating actions and milestones	• Members expressed concern at the ability to test business continuity plans as part of major incident planning. An update was requested for the next SPPH meeting as to which departments had undertaken testing. • The Committee approved the planning timetable for 2022/25 with caveats around confidence in capacity to deliver within timeframes given the Covid context and current lack of an agreed clinical strategy. • The Committee requested that the Committee focus on RPB matters and the transformation agenda be strengthened and the Executive Director of Planning & Performance would take this on board.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	None
Matters requiring escalation to the Board:	• The Board is asked to receive the Executive Summary of the Annual Equality Report (attached)
Well-being of Future Generations Act Sustainable Development Principle	The Committee gave due regard to the sustainable development principles of: 1.Balancing short term need with long term planning for the future; 2.Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4.Putting resources into preventing problems occurring or getting worse; 5.Considering impact on all well-being goals together and on other bodies)

Planned business for the next meeting:	Range of regular reports plus • Public health update • PSB Area Director update • Transformation update Mental Health & Learning Disabilities • Planning Board – Substance Misuse • All Wales strategic programme for primary care • Learning Disabilities Strategy • Third Sector Strategy • Staff surveys • Welsh Language annual monitoring report • Update on business continuity planning testing • Workforce strategy update • University status and links with IMTP planning
Date of next meeting:	12th August 2021

V1.0

Executive Summary Annual Equality Report 2020-21

This Executive Summary report provides an overview of the action we have taken to promote equality during this very challenging year. It is well recognised that Covid-19 has further magnified inequalities for many people with protected characteristics and those who are socio-economically disadvantaged. We have reviewed and communicated this emerging evidence to inform a range of activity that has taken place. We have maintained engagement with communities, individuals and groups, our staff and experts to inform our equality work and are grateful for the insight and support of so many as we work together across North Wales. The full report can be accessed Annual Equality Report.

Equality Key Achievements in 2020-21

- We have continued to advance equality through the delivery of a revised year 1 Strategic Equality Plan.
- We have taken action to understand the impacts of Covid-19 on people with protected characteristics and supported teams to consider the potential impact of equality within their decisions.
- We have delivered new programmes such as Test, Trace and Protect, Virtual Visiting and Attend Anywhere informed by Equality Impact Assessments.
- We have taken action to strengthen equality and human rights scrutiny in governance and decision making structures.
- We have facilitated an equality update for the Board led by the Equality and Human Rights Commission.
- We have maintained and promoted evidence bases to support Equality Impact Assessment (EqIA) and Socio-economic Impact Assessment (SEIA).
- We have prepared for implementation of the Socio-economic Duty.
- We have built upon organisational understanding and capacity by adapting our in-house Equality Impact Assessment training and have delivered this virtually to over 100 staff.
- By December we had achieved 85.5% mandatory equality training compliance.
- We have grown our BCUnity staff support networks for individuals with protected characteristics.
- We have established a network of Equality Champions led by an Independent Member.
- We have improved staff equality monitoring data completion rates.
- We have established a monthly Equality Briefing series and library resource to communicate emerging evidence and key messages widely across the Health Board.
- We have worked with our partners and supported a range of awareness raising initiatives and campaigns including NHS Wales Virtual Pride Week celebrations.

Looking to the Future

We look forward to delivering the second year of our Strategic Equality Plan. We know that the ongoing Covid-19 pandemic will continue to highlight and exacerbate existing health inequalities and it is as important as ever for us to plan and deliver our services from a founding principle of equality.

We will strengthen performance and accountability and apply the Equality Accountability Framework to divisional governance structures. We will continue to build upon progress and ensure that impact assessment informs decision making. In year two we will be focusing on ensuring understanding of and compliance with the Socio-economic duty and signposting leaders to guidance and support in understanding their roles and responsibilities. We will be continuing to build our North Wales Equality Evidence Portal and will further our governance mechanisms to ensure equality and human rights principles are at the heart of decision making at every level. We will continue to ensure robust impact assessment processes are a part of this, key areas of focus include the refresh of the Health Board Strategy 'Living Healthier Staying Well' and the strategic organisational development programme.

We will continue to grow our network of equality champions, celebrate diversity and inclusion with a week of events across the Health Board and continue to produce and disseminate monthly Equality Briefings to raise awareness of key messages. We will promote the Autism Code of Practice when published, the importance of inclusive communications, increasing access and reducing cultural and language barriers. We will continue to train our staff and drive cultural competence and sensory loss awareness. We will optimise the functionality of the new Civica Real-Time Patient Feedback System to strengthen reporting of patient experience information by protected characteristic.

We will work to improve data collection by protected characteristic and improve the identification, reporting and recording of hate crime. We will continue to grow our BCUnity Staff Networks for people with protected characteristics including the establishment of a Women's Network and work to understand the gender equality impact of the pandemic. We will fully support the roll out of the Race Equality Action Plan for Wales.

Finally and most importantly, we will continue to work with our partners, stakeholders and the people of North Wales to advance equality of opportunity and tackle health inequalities.

Health Board

15th July 2021

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Digital & Information Governance Committee
Meeting date:	18.6.21
Name of Chair:	Mr John Cunliffe, Independent Member
Responsible Director:	Dr Chris Stockport, Executive Director Primary & Community Care
Summary of business discussed:	• **Digital Operational plan – Quarterly update** The Committee noted the overview of the quarter 4 report and the key points raised from the report. • **Informatics Annual Operating Plan 2021-2022** The Committee noted the overview of the projects and activities outlined within the Informatics Annual Operating Plan 2021-2022. The content of the report included all Digital Strategy and Corporate Programme Actions. • **Informatics Assurance report – Quarterly update** The Committee received the report and noted the compliance levels and provided advice accordingly. • **Digital Health and Care Wales (DHCW) update report** The Committee noted and accepted the report which had been received from DHCW. • **Information Governance quarterly assurance report (KPI, Lessons learned and compliance report)** The Committee received the detailed overview of the Key Performance Indicators Quarter 4 report. The report provided the Committee with the high-level analysis, demonstrating many of the continuous improvements to date. • **Chair Assurance reports : Information Governance Group** The Committee received the report received and the highlights in relation to key issues taken from the meeting held on the 27th May 2021. Items for escalation to the Board were raised **i**n relation to CCTV and management of keynotes/alerts.

	• **Review of Corporate Risks allocated to the Committee - Corporate Risk Register Report** The overview of the report was presented to the Committee and the Committee reviewed and noted the progress and approval requests. • **Review of Board Assurance Risk allocated to the Committee - Board Assurance Framework (BAF)** The Report and overview was presented to the Committee. The Committee acknowledged the appendices which included details regarding the remapping of the BAF risks to the annual plan, along with the detailed explanations and definitions of assurance levels. The Committee reviewed and noted the progress on the Principal Risks, as set out in the Board Assurance Framework (BAF). • **Periodic updates on Limited Assurance Audit reports** The Committee noted the email circulated on 20.4.21 which included the Final Internal Audit Report - Business Continuity - Informatics. • **Policies: Adoption of All Wales Information Governance Policies** The Committee agreed to endorse the following: Appendix 1 - WIGB202103 BCUHB Policy Letter Appendix 2 - All Wales Internet Use Policy V3 Appendix 2a – All Wales Internet Use Policy EQIA Appendix 3 - All Wales Information Governance Policy V2 Appendix 3a – All Wales Information Governance Policy EQIA Appendix 4 - All Wales Information Security Policy V2 Appendix 4a – All Wales Information Security Policy EQIA • **Training and awareness for staff in relation to cyber security**. It was agreed that the Chair's report to the Board include the need to raise awareness and to highlight the importance of cyber security.
Key assurances provided at this meeting:	• Progress against Informatics Operational Plans. • Continued progress on good Information Governance.
Key risks including mitigating actions and milestones	• **Cyber Security** A new Cyber security risk has been accepted but due to the nature of the topic the content should not be discussed in public session at Committee or at Board.
Targeted Intervention Improvement	• Strategy, planning and performance

Framework Domain addressed	• Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	N/A
Matters requiring escalation to the Board:	• **CCTV** There is no ownership and management of the policy across the Health Board. Consequently there is no compliance with the CCTV Code of Practice. This is currently impacting on the Health Boards ability to act on the: o Prevention or detection of crime or disorder; o Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings); o Health and Safety interest of the public and employees; o The Protection of public health; o Protection of BCUHB property and assets. There have been previous concerns raised about the lack of suitable procedures to ensure the information is being accessed, recorded or monitored appropriately. For example: o An incident in Bangor where there was a failure to assist in the apprehension of a suspect who stole a laptop. There was only a live feed running at the time and no recording taking place. o No monitoring of CCTV systems purchased independently. Leading to multiple systems in place, non-compliance with signage and no appropriate information for patients/visitors on the siting and use of such systems o The Health Board has been unable to assist in SA3 Requests for information from the police to assist with their investigations due to differing management of systems across the Health Board. • **Management of Keynotes / Alerts** There is no ownership and management of the policy across the Health Board. Consequently there is limited compliance with the integrity of the data held within the clinical systems. This is currently impacting the Health Boards ability to fully comply with DPA/UKGDPR legislation in the respect that the data held on systems could be inaccurate. o Keynotes/Alerts in East and Central are not being managed or monitored appropriately. Following data migration to the new PAS system no data cleanse exercise has been carried out.

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:	10.9.21

Health Board **15.07.21**	Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	Stakeholder Reference Group
Meeting date:	28.06.21
Name of Chair:	Clare Budden, Chair Designate of Stakeholder Reference Group (Chair's report agreed with Lead Executive)
Responsible Director:	Mark Wilkinson, Executive Director of Planning and Performance
Summary of key items discussed:	• 2021/22 Annual Plan • Living Healthier Staying Well Refresh and Clinical Services Plan • Dinerth Road Business Case
Key advice / feedback for the Board:	In respect of the 2021/22 Annual Plan, a key priority is recovering access to timely planned care. There is also a need to focus on the existing challenges in relation to unscheduled care and develop organisational capacity and capability through the targeted improvement phase. The SRG : • expressed their need for further understanding in relation to the development of the 'social movement' for change • reflected on the need to include detail in relation to the Race Equality action plan • recognised that there may be an increase in Covid related chest infections and seasonal flu particularly in relation to younger children and queried how the Health Board may respond to those pressures • acknowledged the need for engagement and accountability in terms of staff engaging in delivery of the plan, how the plan is managed and how the Health Board can support a workforce who are tired and exhausted In respect of the Living Healthier Staying Well Refresh and Clinical Services Plan, there is a need to refresh the strategy, address 'A Healthier Wales' and ensure the strategy fits with the partnership

	priorities. The SRG: • identified a broad spectrum of people who could get involved and contribute to the refresh. • discussed the groups who are more challenging to engage with and highlighted a request for these groups to be engaged going forward. • a request for additional time to contribute towards important schemes, such as the refresh in future. In respect of the Dinerth Road Business Case, the development has been proposed as an integrated health and social care facility which will also include a teaching and learning centre. The SRG: • agreed this is an exciting project and requested to be kept informed of any future developments. • highlighted potential issues in relation to staffing in particular attracting and keeping staff in North Wales.
Targeted Intervention Improvement Framework Domain addressed	• Strategy, planning and performance • Engagement (patients, public, staff and partners)
Planned business for the next meeting:	• Mental Health Investment • Socio-economic duty / Race and equality plan • 111 Update • 3 Year Plan / Corporate Planning update • Well-being of Future Generations Act • Third Sector Strategy Update • WAST Presentation The particular agenda items will be selected closer to the next meeting.
Date of next meeting:	Monday 20th September 2021

Health Board 15th July 2021	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:	Healthcare Professionals Forum
Meeting date:	4th June 2021
Name of Chair:	Gareth Evans, Therapy Services Representative
Responsible Director:	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 Microsoft Teams virtual platform.

H21/14 Primary Care & Community Services Update - Clare Darlington, Assistant Director Primary Care & Community Services

The Chair welcomed Clare Darlington (CD) to present an update on Primary Care and Community Services. Clare noted that although the presentation discusses both areas, that there is more focus on the former. The updated slides shared with the Forum members prior to the meeting, covering the following points:

- Covid 19 Response
- The Strategic Programme for Primary Care
- Primary and Community Care Academy
- Looking ahead

A question and answer session ensued. CD welcomed any feedback from the Forum members regarding any specific areas and would be happy to return to the Forum to discuss items in further detail.

The Chair thanked CD very much her time at the meeting and for the informative presentation, which covered a large topic, and noted a couple of aspects to be advised to the Health Board.

H21/17 Workforce & Organisational Development Update - Sue Green, Executive Director, Workforce & Organisational Development

The Chair welcomed Sue Green (SG) to present an update on

	Workforce, and Organisational Development. It was noted that members of the Forum are encouraged to contact SG if they have any concerns regarding a Workforce issue in order to resolve any issues quickly, efficiently and completely. A set of presentation slides were shared with the Forum members during the meeting called Mewn Undod mae Nerth / Stronger Together covering the following points: • Thoughts • Determinants • Characteristics of high-performing Healthcare organisations • Outcomes It was noted that every individual in the organisation must be involved in the process. Further slides were presented showing the detail of a Strategic Organisation & System Development Route Map highlighting the Discovery, Design and Delivery phases and how it will be achieved over the next three years through promotion, prioritising and participation. An interactive discussion ensued around engagement of the strategy and integration of the programme throughout the local health care professions across North Wales. A question and answer session followed. The Chair thanked SG for her time and the informative presentation at the meeting. The Chair also acknowledged the strong level of support to improve the engagement across the network. SG noted that the Workforce Team would be happy to share the slides and to come to discuss the Mewn Undod mae Nerth / Stronger Together presentation to any of the Forum member's and their teams. **H21/18 Chair's and members' written updates** **H21/18.1 HPF Written Summary Update –** Therapy Services / HPF as Associate Board Member **H21/18.2 HPF Written Summary Update –** Nursing **H21/18.3 HPF Written Summary Update –** Optometry **H21/18.4 HPF Written Summary Update –** Dental **H21/18.5 HPF Written Summary Update –** Primary Care and Community Medical **H21/18.6 HPF Written Summary Update -** Pharmacy and Medicines Management **H21/18.7 HPF Written Summary Update –** Midwifery Verbal updates were received from the following representatives: **H21/18.8 HPF Verbal Summary Update** – Healthcare Science

Key advice / feedback for the Board:	**H21/20 Summary of information to be included in Chair's report to the Board** • The Forum noted the ongoing and significant pressure upon primary care, alongside the learning and transformation gained from its response to the pandemic. In particular, positive developments around the role of locality working and the key responsibility of GMS in the immunisation work stream are highlighted. • Secondary care planned care access is identified as a key issue for primary care services with pathways more polarised than the pre-covid state. The Forum advises the importance of primary care involvement and leadership in the planned care transformation programme including the Diagnostic and Treatment centre model. • The Stronger Together work programme is supported by the Forum. Members considered a number of areas to maximise its success. It is advised that independent contractors and their representative groups are included in the work of the programme. This reflects the ambition to acquire a picture of a fully integrated system as part of the learning and feedback. Clarity of what will be different this time to previous attempts to engage was considered important to ensure involvement and participation. Finally it is advised that a process must be identified for separating out the more immediate issues that emerge from the feedback from those that will inform longer term design.
Targeted Intervention Improvement Framework Domain addressed	• Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Planned business for the next meeting:	Range of standing items plus: • Executive Director Public Health – Public Health update
Date of next meeting:	3rd September 2021

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Health Board **15th July 2021**	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:	Local Partnership Forum

Meeting date:	13th April 2021

Name of Chair:	Ms Jan Tomlinson

Responsible Director:	Mrs Sue Green, Executive Director of Workforce & Organisational Development

Summary of key items discussed:	• Gareth Evans, Organisational Development Manager, delivered a presentation on Raising Concerns / Speak out Safely. Following discussion, GE agreed to explore and embed within documentation the difference between TU rep and Champion role. Sue Green, Executive Director of Workforce & Organisational Development, agreed that learning lessons was a key driver for the new arrangements. • Sue Green and Michael Shaw, a Strategic Organisational Development Consultant, provided a presentation regarding the aims of 'Mewn Undod mae Nerth – Stronger Together'. SG acknowledged the significance of the task and the need for some additional expertise and leadership to take the project forward. MS explained that the timeframe for implementation of the scheme would be around three years and talked through the key steps along the way. • Ellen Greer, Acting Associate Director of Organisation Development, introduced an item on Staff Support and Wellbeing. This will be communicated to staff to ensure that they are aware of the support that is available and how to access it. During the ensuing discussion, it was confirmed that support is now being made available to sufferers of long Covid, via the Expert Patient Programme (EPP). Sue Green also confirmed that a paper was going to the Executive Team relating to identifying support for those staff who had been shielding. • Mark Wilkinson (MW), Executive Director for Planning and Performance, presented his Corporate Planning Update, which included the Health Board's Annual Plan. During a discussion, MW acknowledged the long-standing concerns within the dentistry provision and alluded to work being done

	around developing a dental training facility in Bangor. When questioned about the succession planning being considered for existing staff, MW confirmed that he supported an approach of offering opportunities to current staff and that he would like to see less reliance on interim appointments. MW estimated the timeframe for delivery of the Diagnostic Treatment Centre, mentioned in his presentation, to be around four years. • A discussion took place around the LPF Annual Report and it was agreed that the draft presented would be amended to reflect to work undertaken whilst responding to Covid, which would strengthen the section on focus for the next 12 months. • It was agreed that it would be helpful for the Forum to receive an update on Targeted Intervention and that it should be added to future agendas. • Whilst discussing the Welsh Partnership Forum Minutes, continued concern was expressed regarding the organisational readiness for the new Respect and Resolution Policy and Sue Green confirmed that there were some process elements to be worked through.
Key advice / feedback for the Board:	• It was agreed that learning lessons was a key driver for the new Raising Concerns / Speak out campaign. • 'Mewn Undod mae Nerth – Stronger Together' was acknowledged to be a significant undertaking, requiring additional expertise and leadership to take the project forward. • Ellen Greer is undertaking an important piece of work, which will require careful communication to staff to ensure they are aware of the various support available and where to access it. • The Forum was advised that the long-standing concerns regarding dentistry have necessitated the development of a dental training facility in Bangor. • The Forum is to be kept regularly updated on the Targeted Intervention.
Planned business for the next meeting:	Range of standard reports plus: • Verbal update on Targeted Intervention by Jo Whitehead • Welsh Language Standards presentation by Eleri Hughes-Jones • Health and Safety Management Annual Report presentation by Peter Bohan • Mewn Undod mae Nerth – Stronger Together. Presentation by Ellen Greer. • Covid-19. A long journey. Presentation by Cemlyn Roberts. • Staff Lottery. Presentation by Sue Hill • Safe Clean Harm Free. Verbal update from Debra Hickman • Annual Equality Report presentation by Sally Thomas • Update from the Trade Unions Partners' Secretariat. • Strategic Occupational Health & Safety Group (issues of

	significance). • Corporate Risk & Assurance Framework
Date of next meeting:	Monday, 26th July 2021. Virtual via Teams.

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	NHS Wales Staff Survey 2020 Update Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Green, Executive Director Workforce & OD
Awdur yr Adroddiad **Report Author:**	Nia Thomas Head of OD Joy Lloyd Senior OD Manager
Craffu blaenorol: **Prior Scrutiny:**	Strategy, Partnerships & Population Health Committee have received reports on 10th December 2020 and 15th April 2021
Atodiadau **Appendices:**	Appendix 1 – NHSW Staff Survey Question Set 2020 Appendix 2 – Our Reflections Our Decisions Our Future Prompt for Conversations

Argymhelliad / Recommendation:

Members of the Board are asked to note the content of this update report

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This paper provides the Board with an update on the full national NHS Wales Staff Survey undertaken in November 2020. It provides information on how the survey was administered and the way the outputs and feedback is managed. The way the survey was implemented and the subsequent management of feedback is significantly different to previous years so direct comparison of results with the 2018 national survey is less feasible than would have been true between previous national surveys. With this refreshed approach there is a focus on locally managed feedback and engagement of staff in the development of any improvement plans via management structures. This approach encourages conversations at team and department level in order to own the feedback at a local level and involve staff in the development and implementation of improvement plans.

Cefndir / Background:

This paper aligns to the Workforce and Organisational Development strategy 2019-22 and meets the objectives and deliverables outlined within the strategy in relation to staff engagement and listening to staff feedback.

Following the NHS Wales Staff Survey 2018 an Internal Audit review was conducted in 2019/20. 2 recommendations were made from the review, which centred on divisions providing assurance that staff feedback was discussed at a senior level within Divisions along with their improvement plans. Subsequently the Integrated Operational Workforce Groups were established within each of the Divisions (these are now held across a locality as a combined Area and Secondary Care group) with the principal duties being:

• To oversee locality workforce key performance indicators (KPIs), developing and enacting plans to ensure all are 'green' rated; and
• To oversee effective local staff engagement plans resulting in highly engaged workforce as evidenced by improved staff engagement scores in local and national surveys.

In addition to the NHS Wales Staff survey, additional staff feedback has been sought via the BeProud organisational and team level surveys. The BeProud survey differs from the full national staff survey in that it looks at assessing staff engagement enablers which also consists of measuring engagement behaviours and feelings. BeProud Pioneers are nominated from within the teams and they work with their teams to develop improvement plans based on the lowest 3 engagement enablers as identified within their first team survey. Pioneers follow an improvement journey with their teams for a 26 week period. At the end of the programme the teams are re-surveyed to benchmark improvements.

The outputs of the full national NHS Wales and BeProud staff surveys are also being included in the review of documentation/previous staff engagement work undertaken in the Health Board as part of and to help inform the Discovery Phase of Mewn Undod Mae Nerth/Stronger Together. In addition, the outputs have been used to inform the assessment of the Health Board's current position in relation to the Targeted Intervention/Improvement Maturity matrix.

Asesiad / Assessment & Analysis

National perspective

NHS Wales has historically facilitated pan-organisational surveys with broadly comparable questions approximately every 2 to 3 years (2013, 2016 and 2018). These have been overseen by the Welsh Partnership Forum (WPF), funded by the Welsh Government and provided by externally commissioned organisations.

Following the publication of *A Healthier Wales,* the creation of the draft national Workforce & Organisational Development (OD) Strategy and the 2018 survey, there has been a significant review nationally as to the purpose and subsequent approach to staff surveys across NHS Wales with a renewed approach agreed titled **Our Reflections, Our Decisions, Our Future**, the key points are summarised below:

Theme	Detail
Outcomes	To increase colleagues participating in: • Giving feedback (measured by % participation in surveys) • Taking part in making decisions (measured by the question "I am involved in deciding on the changes that affect my work/area/team/ department")
Guiding Principles	• Simplicity – purpose, messaging, questions (fewer, simpler & comparable), results, follow up • Regularity – expectation of habitual recurrence in terms of more frequent pulse surveys • Immediacy – ensuring link between participation and action
Governance	• The Health Minister is ultimately accountable • The Welsh Partnership Forum are the overseeing body • The Welsh Partnership Forum Staff Survey Sub Committee provide operational project reference and accountability

Host/ Facilitate	• It was agreed that Health Education & Improvement Wales (HEIW) would undertake the project management, hosting, facilitation and ensuring widespread partnership/ownership
Technical delivery	• Following a full procurement process, Qlearsite were appointed as the partner organisation for 12 months (with an optional additional 12 months as needed). It is anticipated that the benefits of the NHS Wales Office 365 contract might be fully realised in the future.
Parameters	• Support from Minister, Welsh Partnership Forum and organisational leads • Full cyber security requirements were in place • Confidentiality of reporting (no-one is able to see results where there are less than 11 responses,) • Fully accessible on any web-enabled device (feedback only through on-line approach) • Results fully available for any stakeholder (ideally directly) • Quantitative feedback was screened (for profanity & identifiable information) and then shared. • Identify/create and utilise added valued throughout the project • Maximise economies of scale at every opportunity • All colleagues (including Bank and volunteers) to be included

The national approach adopted for the November 2020 staff survey had the following parameters:

1. **Awareness/marketing:** Maximum stakeholder awareness and ownership for the overall approach; this included appropriate marketing resources (e.g. crowd-sourced video and posters)

2. **Purchase software system:** contract was awarded for a 12-month period to Qlearsite.

3. **Setting up reporting hierarchies/structure:** prepared software/system (including setting up questions, hierarchies, training/awareness for users of the Qlearsite system)

4. **Questions set:** using principles of comparability, these were reduced from 80 to 20 questions, the final question set can be seen at Appendix 1.

5. **2020 Survey Fieldwork:** survey window was identified for 3 weeks

6. **Reporting of results:** results were available at team level following the close of the survey. Results were immediately available for quantitative data with qualitative data available following a short window where screening took place to ensure no profanities or individuals could be identified within the qualitative data.

7. **Create expectation of local discussions:** developed expectation that “local” team/group reflect, discuss & decide improvement actions immediately on receipt of the results

8. **Create expectation of directorate & organisational discussions:** developed expectation that local discussions would lead to aggregated discussions & improvement actions

Implementation from a BCUHB perspective

1. Organisational hierarchies were submitted to HEIW on the 16th October 2020 – there were some restrictions in terms of levels that could be submitted.
2. A communications plan was implemented which included a web page on the intranet, social media posts on the Staff App and BCU Best, posters distributed to departments, a message on the carousel and on the Electronic Staff Record (ESR) banner. The OD team also hosted a number of roadshows at all main Acute Sites over a 5-day period (ensuring compliance with social distancing and infection prevention guidance) with IPad, laptops and phones to encourage participation.

3. The survey opened on the 4th November 2020 for a period of 3 weeks and closed at 11.00 pm on the 24th November 2020. The final response rate at the close of survey was 18%, with the overall national response rate being 20%. Although the BCUHB response rate was low, it is similar to other Health Boards in Wales and BCUHB was second in Wales in terms of the number of staff who completed the survey. It is important to note that this survey was open for 3 weeks as opposed to 8 weeks in 2018. The responses across Wales can be seen in Table 1 below..

Table 1:

NHS Wales | Our Reflections Our Decisions Our Future Survey 2020

FINAL

Response rate as at 11PM 24/11

	TOTAL RESPONSES	PERCENT TOTAL
Betsi Cadwaldar University Health Board (BCU)	3,313	18%
Cardiff & Vale University Health Board (C&V)	3,369	22%
Cwm Taf Morgannwg University Health Board (CTM)	1,548	10%
Health Education & Improvement Wales (HEIW)	268	61%
Hywel Dda University Health Board (HD)	1,759	17%
NHS Wales Informatics Service(NWIS)	452	60%
NHS Wales Shared Services Partnership (NWSSP)	976	31%
Powys Teaching Health Board (PTHB)	701	29%
Public Health Wales (PHW)	453	22%
Swansea Bay University Health Board (SB)	2,365	18%
Velindre NHS Trust (Vel)	422	25%
Welsh Ambulance Services NHS Trust (WAST)	1,375	35%
TOTAL	17,001	20%

4. Staff were invited to complete the survey through a generic email invitation with a link to complete the survey, the link shared was an open link with no unique identifiers used. The survey could therefore be completed anywhere with an internet connection (with Google Chrome preferably) and on any device. The link was shared widely across the organisation through numerous communication channels, e.g. all user emails, targeted emails to low response areas, regular league table updates to senior directors and service managers and via social media.

5. Redaction work was undertaken over 3 days (27, 28 and 30th November) to redact the free text comments from the survey; this included redaction of any identifiable information such as names and expletives. BCUHB Heads of Human Resources (HR) together with divisional leads and trade union partners were asked for their involvement in this process. Members of the Welsh language team also assisted with any Welsh language redactions. The aim of this exercise was to quality assure the data whilst balancing the need to remove explicit or personally offensive references.

Results and Feedback

The first dashboard (quantitative data) was made available to view on the 1st December 2020, with access widely available to all staff. Anyone could request access to the high level dashboard by contacting support@qlearsite.com.

Full access to the results was provided to all senior directors and leaders across the Health Board. Any member of staff could gain access to the interactive (quantitative) dashboard by contacting support@qlearsite.com. The second dashboard (qualitative free text comments) was made available on the 8th December 2020. Directors and Heads of HR were asked to identify staff survey leads from within their division/departments who required access to this dashboard by the 1st December, this was submitted to Qlearsite to enable access to their reporting system in order for local managers to access the feedback relevant to their teams. Managers, trade union colleagues, Workforce & OD teams and local leads/links all have access to this part of the dashboard.

The prompt for local conversations to review the feedback and decide on any improvements that need to be made at a local team level was shared widely and can be seen at Appendix 2.

NOTE: A direct comparison of results cannot be made between the 2018 survey and the 2020 survey as the participation rate, method of completion was different i.e. online survey only available in 2020 and the survey was open for 3 weeks as opposed to 8 weeks in 2018.

Emerging key themes for BCUHB

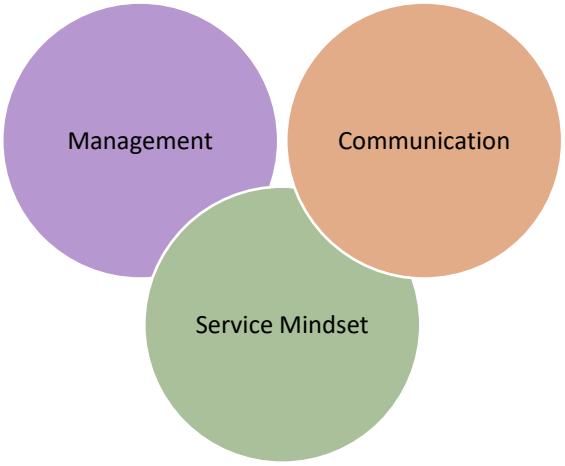
Theme	Question	BCU 2020	BCU 2018	NHS Wales
Engagement Score		73%	75%	75%
Friends and Family	If a friend or relative needed treatment, I would be happy with the standard or care provided by my organisation	59.7%	67%	67.8%
We're Doing Great At				
Engagement	I am enthusiastic about my job	76.8%	73%	76.5%

Engagement	I am happy to go the extra mile when required	89.3%	94%	89.6%
Experience of Work	The people I work with treat me with respect	77.6%	81%	79.5%
Experience of Work	My line manager makes clear what is expected of me	68.7%	75%	70.8%
Bullying, Harassment, Abuse	In the last 12 months have you experienced b/h/a by another manager – (% said No)	88.1%	81%	90.4%
Bullying, Harassment, Abuse	In the last 12 months have you experienced b/h/a by another colleague – (% said No)	79.4%	Combined with above	83.4%
Bullying, Harassment, Abuse	In the last 12 months have you experienced b/h/a by a member of the public – (% said No)	84%	78%	84.8%
Key focus Areas for Impactful Change				
Bullying, Harassment, Abuse	My organisation takes effective action if staff are bullied, harassed, abused by other members	37.9%	48.5%	42.3%
Engagement	I am involved in discussions/decisions on changes in my work/department/team	53.2%	54%	54.9%
Immediate experience of work	Team members take time out to reflect and learn	51.8%	60%	52.1%

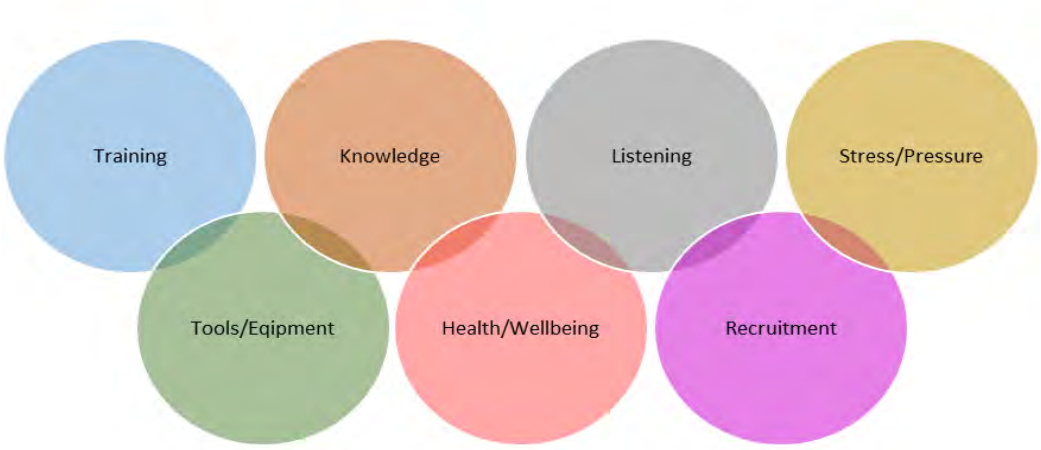
Personal Reflections (Free-Text Comments)

What do we do well?

What things could we do better?



If I could do one thing to improve my work it would be:



Key focus areas for impactful change
There has been significant progress in work linked to the three key areas for impactful change:

1. **Review of Raising Concerns processes.**

Whilst direct comparison of the staff survey 2020 results cannot be made with those of the 2018 survey, the 2020 results may suggest that the % of staff who said they had **not** experienced bullying/harassment /abuse had increased compared to the 2018 staff survey, but that the % of staff who felt the organisation takes effective action where bullying/harassment/abuse occurs has reduced.

A review of how staff could raise concerns safely has been conducted which resulted in a proposal submitted to the Remuneration and Terms of Service Committee in October 2020 with the final proposal approved at its Committee meeting on 1st February 2021. The proposal set out a system around raising concerns that was deemed comprehensive, coherent and capable of delivering on NHS Wales's commitments to provide safe, secure and healthy environments for our staff to work in and for our patients to be treated in.

The proposal and new process established a Speak out Safely Guardian which is due to be appointed shortly. The Guardian will meet regularly with the Chief Executive Officer (CEO) and Vice Chair to share updates and feedback on concerns raised. The new process also includes the establishment of a safe, secure and anonymous portal for staff to raise concerns called Work in Confidence. The portal has an associated Case Management Tool for data capture and for systematic analysis of data for emerging trends and themes that would allow for targeted support in 'hotspot' areas of the organisation.

Additionally, the Work in Confidence platform has functionality to host a range of surveys and staff engagement discussion forums, including on boarding, exit interviews and team and cultural engagement surveys allowing the organisation to better locate and extract data from one site of origin relevant to recruitment and retention activity and monitoring, staff engagement and service improvement and innovation.

The Speak out Safely process will be supported by a group of multi-disciplinary senior managers, Trade union colleagues and a Welsh language representative who will oversee the process and:

- ❖ Provide support, advice and guidance for staff looking to raise concerns
- ❖ Provide information and signposting about the different options and routes staff have available to raise a concern
- ❖ Engage in anonymous two-way conversations with staff members via the Work in Confidence platform
- ❖ Promote Speaking Out Safely in their work areas and with colleagues
- ❖ Liaise with other members of the Speak out Safely multi-disciplinary team in relation to advice, formal investigation and escalation of concerns as the situation requires

IIn addition to the new Speak out Safely process, a new national Respect and Resolution policy has recently been launched, the emphasis of which is to promote and support local conversations between staff and line managers to address concerns quickly and informally to prevent their escalation and the need for a formal route.

2. Mewn Undod Mae Nerth/Stronger Together

Mewn Undod Mae Nerth/Stronger Together is a Strategic Organisation & System Development Route Map. The plan aims to align each & every member of the organisation behind the goal of "one NHS organisation" working with partners and citizens to deliver co-ordinated seamless care for and around the individual patient.

The undertaking of Stronger Together is being done in partnership with our staff so that the problems and solutions are co-produced with people who work in the organisation and understand the challenges we face. The approach is inclusive to ensure that those who contribute are truly representative of our people and wider cultural aspects are taken into account.

Numerous methods are being used in order to ensure that we can connect with staff from all levels in the organisation and all groups. These range from 1:1 interviews, small focus groups(of up to 6 people), virtual workshops, face to face workshops(for up to 12 people), attending staff meetings, conducting a smart survey, providing micro workshops for those who may find it difficult to attend a full workshop, providing weekend and evening access to workshops.

The Discovery phase of Mewn Undod Mae Nerth/Stronger Together and the co-production of the Design phase is a crucial element which will contribute to staff feeing more engaged with discussions/decisions that are made locally and organisationally and also the ability to take time out to reflect on discussions that take place during the Discovery phase and any learning that can be taken forward to the Design phase.

In addition to Mewn Undod Mae Nerth/Stronger Together, other staff engagement activities being undertaken include:

- Ensuring through the Divisional Integrated Operational Workforce Groups that local engagement improvement plans are co-developed with staff which take account of the 2020 national staff survey results from their services/departments
- Re-launching the Be Proud Pioneer programme in March 2021 with 14 teams across BCUHB currently taking part in this 26 week programme. These teams develop engagement improvement plans based on results from surveys undertaken at the start of the programme, with a repeat survey at the end of the programme to measure improvements in engagement within teams.
- Commencing a new Matrons programme at the end of April 2021 with 13 Matrons from across BCUHB. This programme supports Matrons in leading and supporting their teams. This is a year long programme where Matrons complete a QI improvement project, study for an ILM

Level 5 Diploma in Leadership and Management and receive mentorship to support them through their leadership development journey

In addition, the use of online engagement tool is being supported by the Organisational Development Team. The use of on line tools –accessible from work laptops and personal mobile phones – is one of the enablers of staff engagement being everyone's business. These on line tools give line managers and groups of staff interactive and innovative tools to engage with staff who may be spread across a number of locations. Use of tools such as Mentimeter, Kahoot and Padlet enable line managers (and/or groups of staff) to engage with and receive immediate feedback which everyone participating can see. A demonstration of these online tools was recently given to the Safe Clean Care, Harm Free Steering Group members with follow up training sessions also provided to support members of the Steering Group and their teams to engage with their staff to help embed the principles and actions of Safe Clean Care Harm Free across the organisation.

3. Development of an Organisational and Leadership Development Strategy 2022-2025

The organisational Annual Plan details the development of an Organisational and Leadership Development Strategy 2022-2025 which is aligned to Mewn Undod Mae Nerth/Stronger Together. The development of the strategy will be informed by the discovery phase of Mewn Undod Mae Nerth/Stronger Together and will be developed as a key part of the subsequent design phase of Mewn Undod Mae Nerth/Stronger Together. This will ensure the Health Board's organisational design and its leadership are enabled to deliver the Health Board's strategic goals and purpose.

4. Increasing participation

A key area of focus for the 2021 survey will be increasing participation. Due to the change in approach to the survey it is imperative that local teams participate in order to have meaningful feedback which is relevant to them. There is representation from BCUHB at national level at the Staff Survey Group hosted by HEIW who will ensure that adequate notice of an impending survey is key in order to manage organisational communication and promotion of any future survey. The Integrated Operational Workforce Groups, staff networks, staff engagement ambassadors, social media channels, working closely with Communication team colleagues will also be key to dissemination and promotion of the survey.

The agreed approach for the 2021 staff survey from a national NHS Wales perspective includes:

1. Continuing to build stakeholder understanding and local ownership

2. Working closely with the Office 365 Implementation Board to help maximise the benefits of the NHS Wales contract

3. Building NHS Wales capacity/capability to deliver the new approach of regular surveys at a more local level.

4. Creating a timetable of regular short simple quarterly surveys.

5. Supporting NHS Wales and it's component organisations to develop and use people/workforce metrics which are based on colleagues' experiences

Taking account of the national learning from the new 2020 staff survey, the BCU approach includes:

1. More regular opportunities to get involved in giving feedback and having conversations, this will be through shorter and more adaptable pulse surveys. The expectation is that all Health Boards will undertake an annual staff survey as a minimum, but with further flexibility to run more regular quarterly pulse surveys. Pulse surveys can be flexed to suit the needs of the organisation, to include additional or new questions as required. The schedule for pulse surveys can also be flexed according to organisational priorities at the time, with the annual survey taking place in September/October.

2. There is a need to reflect on the implementation of the 2020 survey and make amendments/learning in readiness for 2021 surveys, taking into account the need to increase participation and involving staff in creating the improvements required following feedback.

3. Continue to develop communication plans to encourage local ownership of feedback. Divisions have the staff survey as a standing agenda item on the Integrated Operational Workforce Improvement Groups.

4. Develop a plan to encourage increased participation in future surveys

5. Support Divisional management teams to reflect, encourage participation and develop mechanisms to encourage teams to discuss the feedback and make decisions around any improvements that may be required.

6. The outputs from the survey will be integrated into further evidence for the Mewn Undod Mae Nerth/Stronger Together route map.

Dadansoddiad Risk / Risk Analysis

As the 2020 survey was administered in November 2020, this timeline was close to the second wave of the pandemic, and as such the outputs from the survey may not have been prioritised due to conflicting priorities at the time. However, as noted in this report, the Integrated Operational Workforce Groups established in each area receive an update from local leads on how local teams and departments are managing the improvements required following feedback from the survey.

Asesiad Effaith / Impact Assessment

The impact assessment for the survey is considered at a national level as part of the design and planning of the survey therefore a local EqIA is not required.

Appendix 1: Survey "lay out" & Question Set for 2020

Theme		Question (s)
Engagement Index	1	I look forward to going to work.
	2	I'm enthusiastic about my job.
	3	I would recommend my organisation as a place to work.
	4	I am proud to tell people I work for my organisation.
	5	I am happy to go the extra mile at work when required.
	6	I am able to make improvements in my area of work
	7	I am involved in discussions / decisions on change introduced in my work / department / team.
Friends & Family	8	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.
Bullying Harassment Abuse	9	In the last 12 months, have you personally experienced bullying, harassment or abuse at work? *Branching questions: No – go to Q11; Yes – go to Q10*
	10	Was this from: - Your manager - Another colleague
	11	My organisation takes effective action if staff are bullied, harassed or abused by other members of staff.
Immediate experience of work	12	To what extent do you agree or disagree that your job gives you a feeling of belonging?
	13	Team members take time out to reflect and learn.
	14	My line manager takes a positive interest in my health and wellbeing.
	15	
	16	The people I work with treat me with respect.
	17	I feel comfortable challenging disrespectful behaviour in my team. My line manager makes clear what is expected of me.
Free Text		My team/immediate colleagues:
	18	What do we do well?
	19	What things could we do better?
	20	If I could do one thing to improve my work it would be…
Demo graphics	21	Demographic questions to cover all protected characteristics and "hierarchy" (i.e. which team the person is in)

The key accountability measures are:

- % participation rate in each area/team/organisations
- I am involved in discussions / decisions on change introduced in my work / department / team.

Fforwm Partneriaeth Cymru
Welsh Partnership Forum

GIG Cymru yn Gweithio mewn Partneriaeth
NHS Wales Working in Partnership

NHS WALES GIG CYMRU

Our Reflections
Our Decisions
Our Future

results and how we want things to be better.

We want to have stronger teams; compassionate, healthier, fairer and more collective organisations; better care.

We can all start reflections and conversations anywhere with anyone, and this prompt should be helpful with these.

Our managers should be making time for us to have conversations and make decisions together.

Our Reflections Our Decisions, Our Future:
So now what…

The aims of 2020 are that as many people as possible:

- Take part in giving feedback
- Get involved in discussing the results and deciding what happens next

These simple questions may be useful to help this

How many people took part? How many didn't? Why was this?	
How are we going to get people involved in the discussion/ decisions?	
What are we proud of in these results? What should we be celebrating? Is there anyone/anything we should be highlighting for recognition?	
Where are the things we think we can improve? What do we know? What can we learn more about? What are the things we think we can improve?	
What are the things we can decide/change ourselves? What are we going to do? How are we going to know we have changed things?	
What are the things we need others to change? How are we going to tell them? How will we know that things have improved?	
Is there anything else? How are going to improve participation for next time?	

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery, Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: **Prior Scrutiny:**	Quality, Safety and Experience Committee on the 6th July 2021 Digital and Information Governance Committee on the 18th June 2021 Audit Committee on the 10th June 2021
Atodiadau **Appendices:**	Appendix 1 – Full Corporate Tier 1 Risk Report

Argymhelliad / Recommendation:

The Board is asked to review and note the progress on the management of the Corporate Tier 1 Operational Risk Register.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates and provides assurance that the Health Board is robustly mitigating and managing high-level risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underline their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is now reported separately.

Each Corporate Risk has been reviewed and updated and this report incorporates updates from the different Committees in relation to their risks.

Cefndir / Background:

The implementation of the Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. This includes the evaluation, monitoring and review of progress, accountability and oversight

of the Principal Risks and the high-level operational risks that could affect the achievement of its agreed Priorities.

The Corporate Risk Team continues to facilitate and work with staff and risk owners across the Health Board in regularly updating, reviewing and appropriately managing their risks in line with the Health Board`s Risk Management Strategy and Policy. The Risk Management Group has oversight of all risks on the CRR as these are also scrutinised by the Executive Team, which then makes recommendations and proposals for any changes to the CRR to the Board and Committees. Committees receive a CRR report of their risks on a bi-monthly basis, with the full Corporate Risk Register presented twice yearly to the Board, with oversight of the risk management system and process remaining with the Audit Committee, which also receives an updated CRR report twice a year.

The Corporate Risk Management Team continues to deliver the RM03 - Risk Management Training Plan for 2021/22 that commenced, in line with the plan in April 2021. This training includes the management of risk in line with the Risk Management Strategy for managers and practical training for developing, managing and reporting risks for risk handlers. Following the delivery of the training in quarter 1, feedback has been collated and used to influence further training in June 2021 onwards.

In addition to the above, the Corporate Risk Management Team also plans to attend key meetings and networks in place to deliver the training, for example: Junior Doctors meetings or Consultant's meetings.

A review of the current Corporate Risk Register Template has been completed, Committees will be presented with the new look CRR template from August 2021. This will include the additional fields to capture the gaps in controls, progress of the risk since it was last submitted to the Committee / Board and a target date attached to the target risk score. Each paper submitted will also be accompanied with a Key Definitions document.

This report notes:

1) The QSE at its meetings of 2nd March 2021 and the 6th July 2021 approved two risks for inclusion onto the CRR Tier 1:
   - CRR20-08 - Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients and
   - CRR21-13 - Nurse staffing; continuity of service may be compromised due to a diminishing nurse workforce.

2) The QSE also undertook the following actions which were recommended by the RMG:

   a. CRR20-01 - Asbestos Management and Control – noted the completion of actions ahead of the agreed completion date, so that they can be archived and removed from the next reporting schedule. The Committee also approved the reduction in the target risk.
   b. CRR20-02 - Contractor Management and Control – noted the completion of actions so that they can be archived and removed from the next reporting schedule. The Committee also approved the reduction in the target risk.
   c. CRR20-03 - Legionella Management and Control - The Committee approved the reduction in the target risk.

d. CRR20-05 - Timely access to Care Homes - noted the completion of actions ahead of the agreed completion date, so that they can be archived and removed from the next reporting schedule. The Committee also approved the reduction in the target risk.

3) The DIGC in its meeting held on 18th June 2021 approved two risks for inclusion onto the CRR Tier 1:
   - CRR21-11 - Cyber Security and
   - CRR21-12 - National Infrastructure and Products. It was noted that risk CRR21-12 has been re-opened as it had previously been on the old CRR which was closed and archived. For noting, the graph will only date from 18th June 2021 the point at which it was approved for inclusion onto the CRR in order to align with its re-open date.

4) The DIGC de-escalated CRR20-10 – GP Out of Hours IT System which is now being actively managed by the Executive Director of Primary and Community Care at the Tier 2 level.

5) The DIGC also undertook the following actions which were recommended by the RMG:

   a. CRR20-06 **–** Informatics – Patient Records pan BCU - approved and noted the completion of actions, so that they can be archived and removed from the next reporting schedule. The Committee also recognised that the implementation of the Centralised Access to Health Records Service and the Baseline Assessment Report of Records needed to be captured as controls within the next iteration of the risk. The Committee noted the extension to the timeframe to complete the action 12426, due to the impact from re-aligning resources to support the management of the COVID-19 Pandemic.
   b. CRR20-07 – Informatics infrastructure capacity, resource and demand - approved the completion of actions, so that they can be archived and removed from the next report, recognising that the monitoring and assurance reporting of the implementation of the Digital Strategy will become a control within a future iteration of the risk.

Summary table of the full Corporate Tier 1 Risk Report:
The current Tier 1 Corporate Risks are (full details of the risks and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	Oversight Committee	Movement*
CURRENT RISKS – Appendix 1					
CRR20-01 - Asbestos Management and Control	20	20	8	QSE	Unchanged ⟷
CRR20-02 - Contractor Management and Control	20	20	8	QSE	Unchanged ⟷
CRR20-03 – Legionella Management and Control	20	20	8	QSE	Unchanged ⟷
CRR20-04 - Non-Compliance of Fire Safety Systems	20	20	8	QSE	Unchanged ⟷
CRR20-05 – Timely access to Care Homes	25	20	9	QSE	Unchanged

					⟺
CRR20-06 – Informatics – Patient Records pan BCU	16	16	12	DIGC	Unchanged ⟺
CRR20-07 - Informatics infrastructure capacity, resource and demand	20	16	12	DIGC	Unchanged ⟺
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	25	20	6	QSE	New Risk (March 2021)
CRR20-10 – GP Out of Hours IT System	De-escalated				
CRR21-11 – Cyber Security	25	20	15	DIGC	New Risk (June 2021)
CRR21-12 – National Infrastructure and Products	20	20	12	DIGC	Re-opened Risk (June 2021)
CRR201-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	20	16	6	QSE	New Risk (July 2021)

*movement in the current risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions.

Below is a heat map representation of the current corporate risk scores:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high – 5
Likelihood	Very Likely - 5				CRR20-03 - (QSE) CRR20-04 - (QSE) CRR21-12- (DIGC)	
	Likely - 4				CRR20-06- (DIGC) CRR20-07- (DIGC) CRR21-13- (QSE)	CRR20-01- (QSE) CRR20-02 - (QSE) CRR20-05 - (QSE) CRR20-08 – (QSE) CRR21-11 – (DIGC)
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The implementation of the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Opsiynau a ystyriwyd / Options considered

Continuing with the Corporate Risk Register.

Goblygiadau Ariannol / 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 thus leading to enhanced quality, less waste and no claims.

Dadansoddiad Risk / Risk Analysis

See the individual risks for details of the related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.

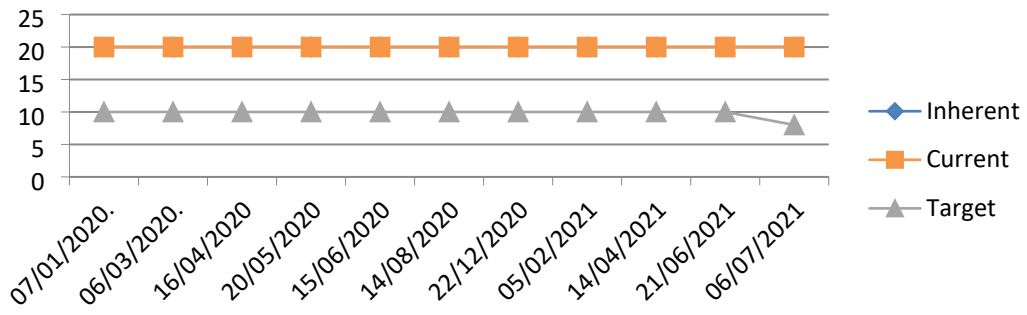
Asesiad Effaith / Impact Assessment

No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the Risk Management Strategy and Policy to which the CRR reports are aligned.

Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1: Full Corporate Tier 1 Risk Report

CRR20-01	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 31 March 2022
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place. 2. A number of surveys undertaken. 3. Asbestos management plan in place. 4. Asbestos register available. 5. Targeted surveys where capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in premises where there is limited clarity on asbestos condition.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

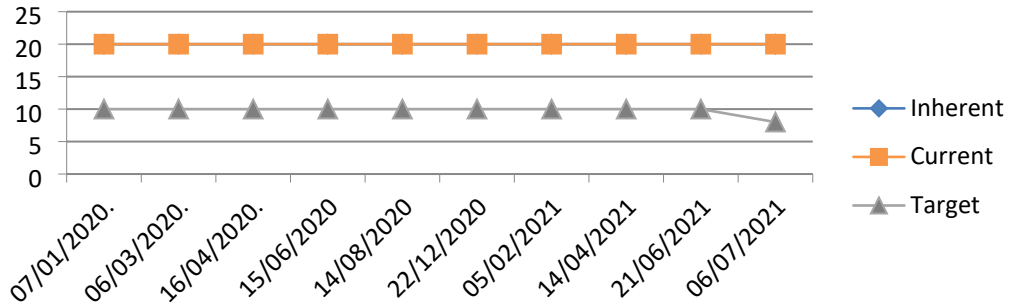
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Re-survey of existing asbestos surveys, sample 10 – complete and assurance provided that surveys are robust. Resampling will be included with the updated management plan as an ongoing compliance work stream. 14.04.2021 (DT, updates from RT/GB) Completion of this action was reported to the asbestos management group in Jan 2021.	Complete
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. This updated policy and plan will ensure consistency across the Health Board in the management of Asbestos and support the mitigation of the risk should it materialise.	Complete

	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On Track
	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Priority assessments and risk reviews – Actions complete and removal / management plan in place.	Complete
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Contractor management and control – actions complete with updated permit to work system and contractor control framework	Complete
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Asbestos surveys – all site have access to site-specific registers (hard copy). Following the roll out of the asbestos management modal within MICAD, all sites will have access to digital register which will improve management and oversight in support of managing the likelihood of the risk materialising.	Complete

	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Annual re-inspections – Asbestos Management Group providing oversight and governance with escalation to SOH&SG. Appointed Independent Asbestos Consultants.	Complete
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing may potential impact.	On Track
	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non-public areas.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Action should be closed as not required as there is no legal requirement none one on grounds of best practice.	Complete
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/21. Corporate Health and Gap analysis – Action plan updated and progress against actions recorded and included within escalation report to SOH&SG.	Complete
	15032	Air Monitoring in all premises where there is limited clarity on asbestos condition.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed - 14/04/2021. Improve safety and ongoing compliance with the Regulations. Action completed.	Complete

CRR20-02	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 30 September 2022
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Control of contractors procedure in place. 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings. 5. Externally appointed CDMC Coordinator (Construction, Design and Management Regulations) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation.	1.Health and Safety Leads Group. 2.Strategic Occupational Health and Safety Group. 3.Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Guidance Document is currently being reviewed and updated.	Complete
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Policy Document is currently being drafted.	Complete

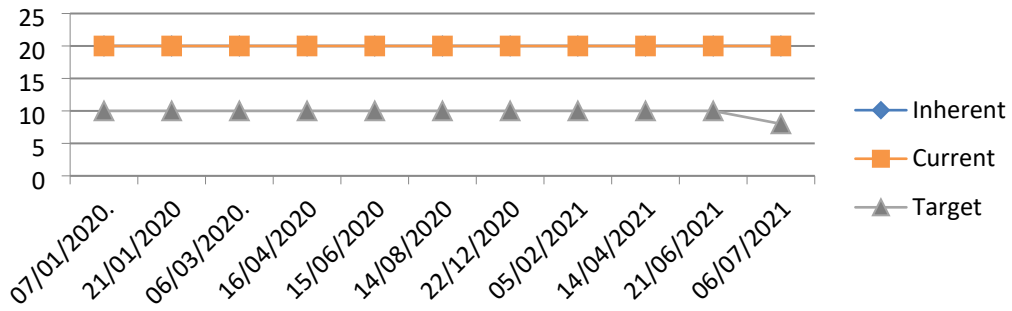
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.	On Track
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board	On Track

					includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	On Track
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board	On Track

					includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	Action Closed - 31/03/2021. The Control of Contractors Guidance Document is currently being reviewed and updated.	Complete

CRR20-03	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2021
	Risk: Legionella Management and Control	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 30 September 2022

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	2	4	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

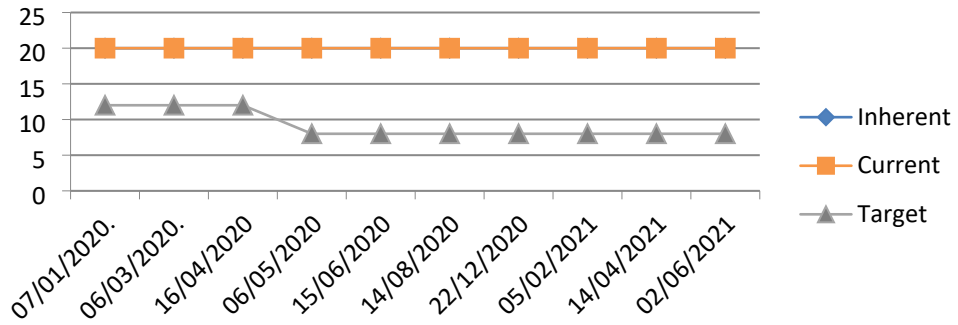
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	On Track
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Dead legs are removed on identification and assessment of risk.	On Track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track

	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	On Track
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.	On Track
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and	On Track

					assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

CRR20-04	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 June 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 30 September 2022

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

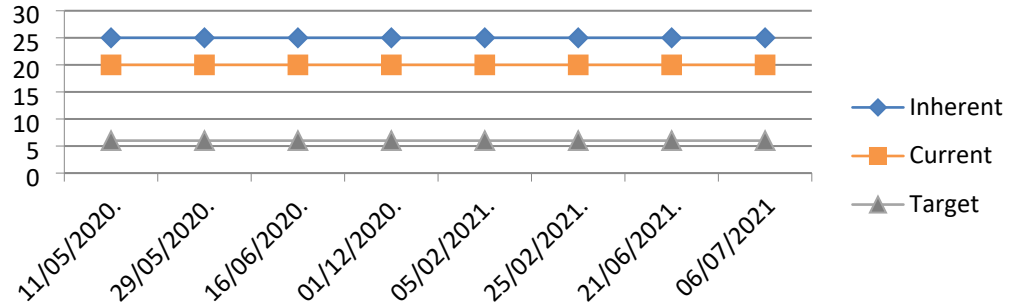
Controls in place	**Assurances**
1. Fire risk assessments in place. 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Governance actions completed and operational elements are captured within the gap analysis areas below.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Complete with escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons.	On Track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Database located within the fire safety files, managed and updated by the fire safety trainer.	On Track
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track

	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team.	On Track
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent, Shared Services (Specialist Estates Services) audits commissioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites.	On Track
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk Assessment process and appropriate action taken.	On Track
	15036	Fire Risk Assessments in place Pan BCUHB	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 31 December 2021
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact a day” data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG. 4. Oversight by the Recovery Group.

8. Remote consulting offered by general practice. 9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular formal communication channels with care homes at a local level and across BCU.	

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF21-03

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	14936	Establish separate discharge cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete
	14937	Develop a BCU wide approach to primary care support and intervention, including GPOOH.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will improve communication and support direct admission to care homes.	Complete
	14938	Develop electronic daily reporting metrics.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete

	14939	Complete and implement a North Wales care home escalation and support tool.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occurring.	On Track
	14941	Embed the new ways of working in all home first bureau.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will help eradicate delays in discharge through better co-ordination.	Complete
	14942	Develop communication with care homes at a local level and across North Wales.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14943	Deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This action will support access to care homes.	On Track

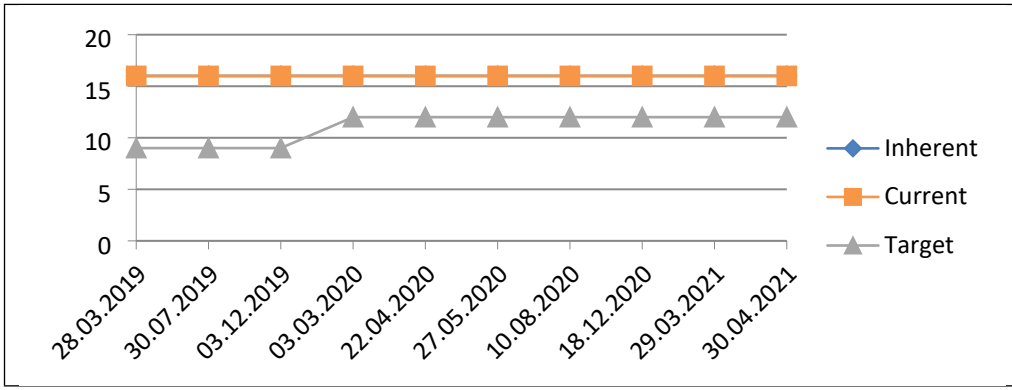
	14944	Adopt care home DES for primary care.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14945	Increasing the frequency for multiagency care home cell.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will improve communication and support direct admission to care homes.	Complete
	14946	Update the 2020 care home monitoring levels and escalation framework.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed -28/05/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14947	Development of proactive risk triggers.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14948	Diversion of CHC priorities.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track

	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14951	Increase MDT Care Home group to weekly or as the need arises due to C-19 pressures.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14952	Implementation of reactive support to in crisis care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Action Closed - 02/06/2021. This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	14954	Contribute to the development and implementation of national guidance.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	15272	Infection Prevention and Control.	Ms Jane Trowman, Care Home Programme Lead	04/01/2021	Action Closed 25/02/2021. Identify outbreaks in care homes at an earlier stage and prevent escalation. Develop triggers which identify which homes are most at risk	Complete

	15273	Vaccination of Care Home Staff.	Ms Jane Trowman, Care Home Programme Lead	30/04/2021	Action Closed 25/02/2021. High uptake of the vaccination will reduce the spread of Covid within the care home, if staff are positive then vaccination will reduce the severity of the illness relieving staffing pressures. Process for new staff to access the vaccine in a timely way.	Complete

CRR20-06	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 30 April 2021
	Risk: Informatics - Patient Records pan BCU	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 30 September 2024

There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).	1. Chairs reports from Patient Record Group. 2. ICO Audit. 3. HASCAS Audit.

Links to	
Strategic Priorities	**Principal Risks**

Effective use of our resources	BAF20-18 BAF20-28

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12422	Enable actions to meet the regulatory recommendations from the ICO, HASCAS/Ockenden and Internal Audit reports.	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	Action Closed - 29/03/2021 All actions are complete. The only recommendation not delivered to the expectation of the ICO is with regards to 'verbal requests' for a patient's information (handling a SAR request from a patient by ANY member of staff working in the Health Board) in the context of a large organisation and the risks this would introduce. Managed and controlled actions have been put in place to meet verbal request in a safe way e.g. directing to the centralised ATHR team where they are handled over the phone rather than a form being sent out; update to web-pages to give advice on recognising a verbal SAR request and signposting to the team to fulfil; new agreement in place to actively encourage the provision of	Complete

					Clinic Letters/Results at the point of patient care when requested (or directly following). Analysis will be undertaken in Q4 to catch any recommendations not already covered.	
	12423	Development of a local Digital Health Records system	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	UPDATE Mar 2021 - Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is established with register baselined; DPIA in place.	On Track

	12424	Improve the assurance of Results Management	Mrs Danielle Edwards, Head of Digital Records	30/09/2021	UPDATE Mar 2021 - (WS1) - WCP 3.11.4 (moved on version) has been through UAT and whilst all showstoppers for RN have been addressed to a level that can be managed through SOPs, there are some other areas of the release that are still being reviewed. Business Case in process of being submitted to secure the funding required to deliver the project. (WS2) - for the 10 users that have the access (provided directly by NWIS which will in future need to come with the Project Board agreement to ensure readiness to govern and support) plans are being formed to test an 'Acceptable Use statement to ensure safe practice. (WS3) ETR - improved forms that have been developed by NWIS with local SME engagement will be available in WCP 3.12. (WS4) Radis 2.4 upgrade planned for later in Spring.	On Track

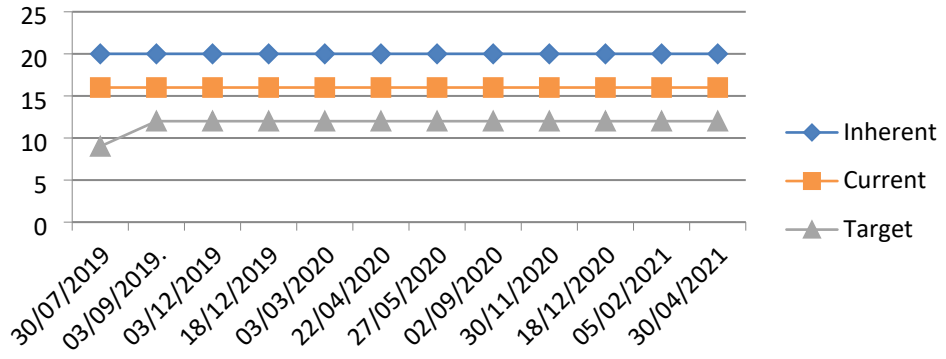
	12425	Digitise the clinic letters for outpatients	Mrs Danielle Edwards, Head of Digital Records	30/06/2021	UPDATE Mar 2021 - Project remains on track - (West) the recovery activity for the PiMs integration is complete with the integration running well. Cancer Services, Pain Team went live 08/03 followed by the Anaesthetics Team on 15/03. The full roll out is in development with the West Operational leads, with an aim to run on a weekly go live schedule. (Central) Care of the Elderly team went live with EPRO on the 25/01, Gastro team on the 02/02, closely followed by Renal team 03/02 and Community Paediatrics planned 12/04. The Project team will take advantage of any gaps to the West roll out plan by seizing the opportunity to address the soft roll out list for Central if and when possible.	On Track
	12426	Digitise nursing documentation through engaging in the WNCR	Mrs Danielle Edwards, Head of Digital Records	31/05/2021	UPDATE Mar 2021 - Due to pressures with the Nursing Lead supporting IPC (Covid) and other competing priorities within the Informatics team this was delayed, however work has picked back up with this to complete over the next few	Delay

					weeks as a draft for review, but will roll into next AOP year.	
	12428	Baseline the; storage, processes, management arrangements and standards compliance	Mrs Danielle Edwards, Head of Digital Records	31/03/2021	Action Closed - 29/03/2021 UPDATE Mar 2021 - The initial report is now complete covering (i) the approach to measuring standards for this priority stage 1 areas and onwards for BAU and (ii) presenting the audit recommendations for Acute, Mental Health, CAHMS. The report has been signed off by the Head of Patient Records & Digital Integration Department and is being reviewed for sign off by the CIO, prior to being presented to the Patient Records Group (PRG), Information Governance Group (IGG) and finally the DIGC (June). This all aligns with the IG toolkit compliance requirements for all NHS providers. Progress against actions will be monitored by the PRG and exception reporting to the IGG and DIGC. This closes this action handing over the ongoing reviews and progress monitoring to the PRG.	Complete

	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Danielle Edwards, Head of Digital Records	31/05/2021	UPDATE Mar 2021 - Meeting to review the status of the Mental Health development business case is planned for April which will inform the next steps for this long standing action.	On Track

CRR20-07	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 30 April 2021
	Risk: Informatics infrastructure capacity, resource and demand	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 15 December 2021

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. For devices/ training and externally from the public, government and regulators e.g. Growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *moderate level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc.	1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to DIGC (for Governance).

5. National Infrastructure Review (Independent Welsh Government Review undertaken by Channel 13).	

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18 BAF20-20 BAF20-28

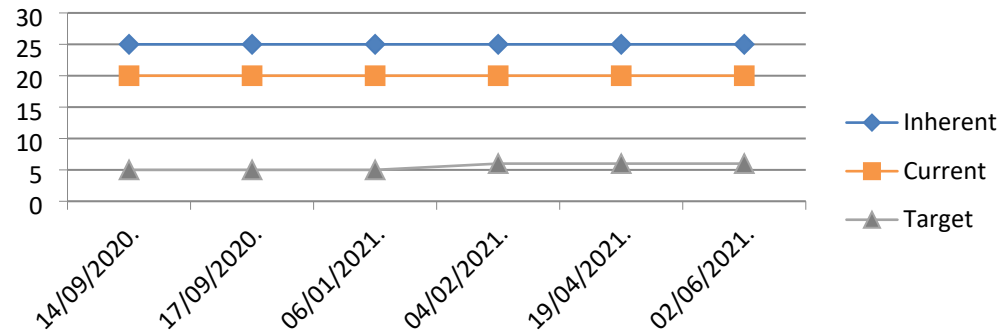
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12379	Review workforce plans and establish future proof informatics/digital capability and capacity.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/09/2021	The development of a Workforce Planning Strategy will take into account the service capability and capacity to deliver on the Digital Strategy.	On Track
	12380	Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	This will be undertaken now the Digital Strategy has been approved and will ensure appropriate governance arrangements are in place to monitor implementation of the strategy.	On Track
	13182	To develop a Digital Strategy	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2021	Action Closed - 31/03/2021 This high level digital strategy will set the strategic direction and support the prioritisation of work which will support	Complete

					and make the case for capacity and resources. It will also influence the governance and mapping to clinical services requirements.	

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02 June 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 28 February 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in – New Risk	New Risk		

Controls in place	**Assurances**
1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 4. More clinic slots are being made available to accommodate clinically pressing patients.	1. Risk is regularly reviewed at local Quality and Safety meetings.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under ‘essential’ services & safe stepping up planned care	BAF21-02 BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14907	Age related macular degeneration – A business case is awaiting approval to increase staffing and treatment capacity. The resources have been identified in the HBs Annual Business Plan for 2021/22 and is being progressed to final approval stages.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to robustly mitigate and manage this risk to its target score.	On Track
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On Track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals are being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On Track

CRR21-11	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 September 2020
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 13 April 2021
	Risk: Cyber Security	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 12 December 2022

REDACTED DUE TO THE NATURE OF THE RISK AT THE REQUEST OF THE DIGITAL AND INFORMATION GOVERNANCE COMMITTEE		Impact	Likelihood	Score
	Inherent Risk Rating			
	Current Risk Rating			
	Target Risk Score (Risk Appetite – *Moderate level)*			
	Movement in Current Risk Rating Since last presented to the Board – New Risk	New Risk		

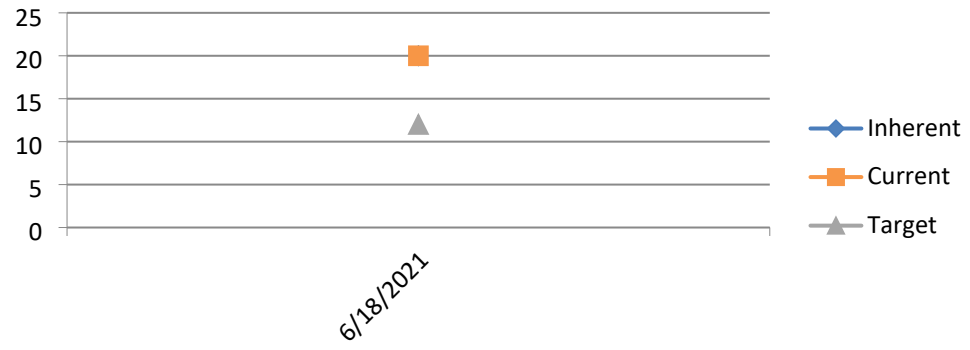
Controls in place	**Assurances**

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF20-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score						

CRR21-12	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 23 October 2017
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 9 April 2021
	Risk: National Infrastructure and Products	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 31 March 2022

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits when planned. This may be caused by
a) a one size fits all approach.
b) products which are not delivered as specified (e.g. time, functionality and quality).
c) the approach of the National Programme to mandate/design systems rather than standards.
d) poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
g) DHCW Lack of alignment with BCUHB planning cycles and an understanding from a DHCW perspective.
This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *Moderate level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in – Re-opened Risk	Re-opened Risk		

Controls in place	**Assurances**
1. Scrutiny of DHCW by DIGC who escalate any areas of concern to the Health Board.	1. Public Accounts Committee Review of NWIS.

2. Project Management Framework with strong governance. 3. Technical Oversight Group for WPAS and other National Programme Groups.	2. Reports from the Digital Transformation Group to IGIC / EMG. 3. WAO - review. 4. National Architecture and Informatics Governance Reviews.

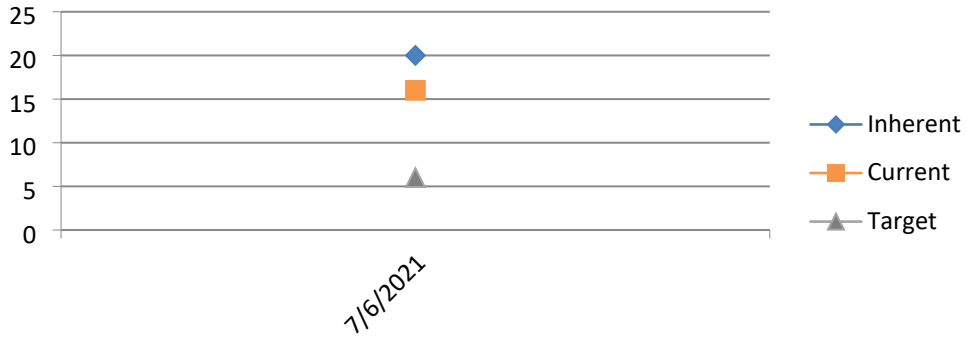
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF20-18

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	15284	A joint digital plan to be developed with Digital Health and Care Wales for 2021/22 which will include all projects and upgrades	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/04/2021	Having an agreed plan in place will enable better monitoring of delivery and scrutiny by DIGC.	Delay
	15285	To meet with DHCW on a quarterly basis to review delivery of agreed plan	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	This will enable performance management of the plan and escalations can be made sooner.	On Track

	15286	Action Plan to be scrutinised by DIGC quarterly	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	Increased performance management of supplier to reduce the likelihood of the risk.	On Track
	15287	To strengthen the governance by agreeing escalation levels within existing and new national projects	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	Having agreed escalation levels will result in issues being dealt with quicker.	On Track
	15474	CCIO & CIO to influence the National Strategic Direction through National Groups	Mr Dylan Williams, Assistant Director of Informatics	31/03/2022	Influencing the National Strategy should increase alignment with BCUHB Digital Plans.	On Track

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 06 July 2021
		Target Risk Date: 30 December 2022

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience.This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.
This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low Level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in – New Risk.	New Risk approved at QSE Committee on the 6th July 2021		

Controls in place	**Assurances**
1. Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. 2. Double sign off of nursing rosters to ensure effective deployment. 3. Nurse staffing policy outlines standards and escalation. 4. Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. 5. District Nursing principle compliance review undertaken bi-annually in line with AW approach.	1. Risk is regularly reviewed and monitored at the Site Quality and Safety meeting. 2. Review exercise of all Nurses working in

6. Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to QSE/Board. 7. Workforce recruitment and retention strategy in place. 8. Recruitment and Retention operational group insitu with HB wide representation. 9. Targeted Recruitment Campaign for Band 5 nurses developed and rolled out. 10. Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information. 11. International Nurse recruitment programme in place informed by data analysis. 12. Clinical Fellows for Nursing programme being rolled out. 13. AND appointment to lead and support nurse recruitment. 14. Workforce/Service planning process to triangulate requirements. 15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable. 16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. 17. MDT staffing support across the Health Board during surge due to inability to respond to demand. 18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity.	corporate services and elsewhere with the Health Board. 3. Risk is regularly reviewed and monitored at the Senior Nursing Meeting.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care Effective use of our resources Safe unscheduled care	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve	15633	Analysis of current vacancy, turnover and recruitment data to better inform recruitment intentions.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/05/2021	Gain a clear understanding of the current position which will help drive the way forwards in terms of mitigating the risk.	Complete

target risk score					A new suite of metrics have been developed that better inform our current vacancies, but also enable us to forecast future trends taking planned recruitment activity into account. In having this information, we can monitor performance on our recruitment campaigns and take timely action when necessary.	
	15634	Development of a clinical fellowship model for nursing.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/05/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This is a further pipeline for staff into the organisation, it is an attraction method which in turn will also support retention.	Complete
	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	01/07/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register.	On Track
	15636	Extension of the International Nurse Programme.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	01/07/2021	The pipeline of international recruits has been developed and strong links with overseas partners have been created. The anticipated approval of extending this programme will see new recruits joining each month through to spring 2022, offering a consistent and	On Track

					manageable number of nurses to integrate into our workforce. This action will assist to create a sustainable workforce in the longer term whilst continuing to recruit nationally.	
	15637	Put in place a targeted specialist recruitment campaign Band 5 nurses.	Mr Nick Graham, Associate Director of Workforce Planning & Performance	31/07/2021	We have enlisted the support of a specialist company to run a comprehensive marketing campaign. To date, the marketing material has been created and the campaign is due to launch in the early July. A further campaign has been initiated for Mental Health and Learning Disability division, which includes CAMHS, to increase our numbers of mental health trained staff, across a range of staff groups. A key factor in this is that a new team will be established which can be mobilised to respond to situations more readily. This action will assist with creating and delivering an innovative, digital attraction strategy and help limit the over-reliance on temporary agency staff.	On Track

					To assist this campaign, a new SharePoint site of online guidance and material has been created that supports our recruiting managers. Moreover, a series of proposals to streamline the recruitment process have been taken forward which will shorten the time it takes to recruit, but also reduce the admin burden on Ward managers.	
	15638	Introduce targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/07/2021	A new suite of metrics are in development to provide a clearer picture of how rosters are being managed, which in turn will enable us to monitor staffing levels for patient safety and staff wellbeing. These metrics will link roster data together with recruitment and temporary staffing information to provide a rounded picture of wards in difficulty. This action will put in place a formal Review and Approve process to maximise e-Rostering efficiency and support the creation of safe and effective rosters in line with Health Board KPIs.	On Track
	15639	Introduction of leadership	Sian Knapper, Senior Organisational	31/3/2022	This action will support retention with providing developing opportunities but	On Track

		development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Development Officer		also aid delivery of the Quality & Safety strategy within the Nursing workforce.	
	15640	Review of band 4 roles across the HB as to maximising opportunity.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/8/2021	This action will continue to further develop career pathway opportunities and aid stability within the current workforce.	On Track

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework (BAF): Principal Risks
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Liz Jones, Assistant Director : Corporate Governance
Craffu blaenorol: **Prior Scrutiny:**	Audit Committee 10.6.21 (Strategy, Planning & Public Health Committee, Digital & Information Governance Committee and Finance & Performance Committee risks subsequently updated)
Atodiadau **Appendices:**	Appendix 1 – BAF Report: Principal Risks Appendix 2 – Re-mapping of BAF risks to revised Annual Plan 2021-22 Appendix 3 - Key field guidance/definition of assurance levels (updated)

Argymhelliad / Recommendation:

It is recommended that the Board:
(1) Agree the updated Principal Risks as set out in the Board Assurance Framework (BAF); and
(2) Note the remapping of BAF risks to the revised Annual Plan 2021-22 and updated key field guidance.

Please tick as appropriate

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

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

N

Sefyllfa / Situation:

The BAF seeks to bring together in one place all relevant information on the risks to the achievement of the Board's strategic priorities. A revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised BAF template reporting arrangements that reflected the work undertaken to support better management of strategic level risks.

This BAF report is the first to be received by the Board in the new reporting format. Further development and refinement of the BAF is ongoing, as it is acknowledged that there is more to do to, particularly in respect of reducing the number of risks. The forthcoming refresh of *'Byw'n iach, Aros yn iach/Living Healthier, Staying Well'(LHSW)* will provide an opportunity to check and challenge the

current risks and ensure that only the Health Board's principal strategic risks are included as part of the BAF going forward. The Good Governance Institute (GGI) will be providing support and guidance on the BAF refinement process.

Each current BAF risk has been reviewed, remapped to the Annual Plan and updated, following consultation with the nominated leads for each risk – all of whom have engaged positively with the process of joint working with the Office of the Board Secretary on the risk ratings, controls, mitigations and progress on agreed actions.

Appendix 1 sets out the Board Assurance Framework principal risks and associated detail
Appendix 2 explains the remapping of the BAF risks to the Annual Plan.
Appendix 3 provides details of the key field guidance (with some re-wording to provide greater clarity on definitions of assurance levels, following discussion at the recent Strategy, Planning & Population Health Committee meeting)

Cefndir / Background:

The design of the new BAF and Corporate Risk Register (CRR) emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, but also highlights their symbiotic relationship as both mechanisms inform and feed off one another. This includes the evaluation, monitoring and review of progress, accountability and oversight of the principal risks and also the high level operational risks which could affect the achievement of the Health Board's agreed priorities. These are being monitored by regular review with respective leads and oversight by the Risk Management Group and Executive Team.

Oversight and co-ordination of the BAF process has transferred from the Corporate Risk Management Team to the Office of the Board Secretary, with the risk management system and process continuing to be managed by the Corporate Risk Team. Reports are provided separately.

Ownership of the BAF rests with the Board, with individual Executives being responsible for the management of their respective risks, and the Board Secretary holding responsibility for managing the underpinning process.

The Board has updated its strategic priorities as set out within the 2021-22 Annual Plan. As a result, some principal risks do not lend themselves to direct mapping, and have subsequently been mapped to an 'enabler' rather than a priority. The remapped BAF risks were endorsed by the Audit Committee on 10th June 2021 and are attached at Appendix 2. The new identifiers (BAF21-01 and so on) have been applied to the BAF risk sheets as presented at Appendix 1.

It is recognised that in respect of a number of risks, the target risk score is above the Board's risk appetite. The reviewed Risk Management Strategy, including a revised risk appetite, is also being presented for approval to this meeting of the Health Board. Following this, risk appetite scoring will then be remapped to the individual risks and the position reviewed with each risk lead. This updated position will be reviewed at the August Risk Management Group meeting.

The BAF is a 'live' document that evolves through engagement and support from the Board. As alluded to earlier, this approach will continue as the Health Board refreshes LHSW and its underpinning strategies. This refresh will necessitate a greater focus on strategic risks in the BAF as the Health Board looks to the future in delivering its strategies. A further revision of the BAF will be

required to reflect the refreshed objectives as defined in LHSW. Operational BAF risks will be managed as part of the Corporate Risk Register going forward.

Key progress on the BAF risks are detailed below (this information is also reflected within the relevant BAF risk sheet at Appendix 1):-

- **BAF21-01 – Safe and Effective Management of Unscheduled Care (USC) (formerly titled Emergency Care Review Recommendations)**

  Key progress since the last review relates to the action concerning a scoping review to develop a strategic blueprint solution for USC – this has now been completed and moved into the mitigation column. At the beginning of June 2021, Executives commissioned further work by Kendall Bluck, to build an acute medical model into the Emergency Department workforce plan, taking into account improved pathways currently being progressed through the USC improvement plan. This is designed to ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. The USC BAF risk is currently subject to review, specifically concerning longer-term action planning and mitigation linked to the winter plan, to include partners such as the Red Cross.

- **BAF21-02 – Sustainable Key Health Services**

  Key progress since the last review relates to the risk description, which has been modified to remove the words 'diminishing capacity' and to reflect the current status as regards demand levels. The scoring, including inherent, current and target risk scores, has been revised to reflect impacts on health. Actions have been reviewed and all dates remain appropriate. There has been an action added in respect of the recovery focus across North Wales and the establishment of the Recovery Co-ordination Group.

- **BAF21-03 – Primary Care Sustainable Health Services**

  Key progress since the last report includes the ‘increase in the number of GP Trainees in north Wales’ action now being a mitigation (a Welsh Government statement in December 2020 stated that GP places would remain at current levels with the ability to over-recruit if needed). The Dental Training Unit contract is currently being advertised. Continuation & roll out of urgent primary care centres (UPCCs) has been prioritised in the Annual Plan, with a view to securing ongoing funding as part of the national programme.

- **BAF 21-04 – Timely Access to Planned Care (reporting to both Finance & Performance [F&P] Committee and Quality, Safety & Experience [QSE] Committee)**

  Key changes since the last review relate to mitigations, gaps and actions being updated to reflect current developments, including extensions to some timelines. Further actions have been added which include additional internal activity above core being mobilised via the recovery plan, development of a business case for an orthopaedic modular ward and theatre on each site, outsourcing of orthopaedic activity being investigated with the independent sector, and capacity planning to understand the clearance times for the over 52 week backlog. Current estimates are that it will take approximately 3-4 years to clear the backlog - orthopaedics being the most significant driver for this lengthy timescale. For this reason, the scoring remains unchanged.

- **BAF21-05 – Mental Health: Effective Stakeholder Relationships**

  Key progress since the last report relates to updated timeframes to reflect the overall progress being made by the Division on partnerships. A review of the terms of reference of the Together for Mental Health Partnership Board (T4MHPB) has taken place, with a number of task and finish groups being established. The revised terms of reference are to be presented to the T4MHPB on 9 July 2021. Monthly meetings between the Child, Adolescent Mental Health Services (CAMHS) and Adult Mental Health Senior Leadership Teams continue, to support joint working and system planning that is both clinically and financially effective. Although engagement with stakeholders is an organisational wide priority, this risk is specifically focused on Mental Health Services where there is a greater need to embed a culture of clear and consistent engagement. The Targeted Improvement programme will be the mechanism used to measure the Division's progress.

- **BAF21-06 – Safe and Effective Mental Health Service Delivery**

  Key progress since the last review relates to addressing the number of interim roles in the Mental Health management structure. An appointment has now been made to the Head of Psychology role, with a start date of 1 July 2021. Other interim senior leadership team roles are also being reviewed.

- **BAF21-07 – Mental Health Leadership Model**

  Key progress relates to the Governance Structures Review, now completed and shown as a mitigation. A new action has been added in respect of the development of a cycle of business to support effective reporting through the revised governance structure.

- **BAF21-08 – Mental Health Service Delivery During Pandemic Management**

  Key progress since the last review relates to completion of the action to procure additional IT equipment for Attend Anywhere. A further implementation action has been added, as this project was initially a proof of concept exercise that demonstrated benefits – as a result of which, the Division decided to implement a wider roll out. This project is also aligned to Information Management and Technology (IM&T) implementation.

- **BAF21-09 – Infection Prevention and Control (IPC)**

  Key progress since the last review relates to additional actions identified. These include ensuring that the most effective control measures are being monitored at local level with assurance reporting to the QSE Committee, the requirement for Safe Clean Care programme support, development of a real time information platform to focus improvement actions, and also the substantive appointment of an IPC Director of Nursing. This risk was the subject of a deep dive at the Risk Management Group meeting on 15 June. At its next review the narrative will be expanded to include more long term strategic controls, to further reduce the risk rating over the coming months.

- **BAF21-10 – Listening and Learning**

Key changes since the last review relate to the updating of target action dates, in acknowledgment of the delay in roll out of the new Datix system. The action in relation to the Quality Dashboard is now shown as complete.

- **BAF21-11 – Culture / Staff Engagement**

  Key changes since the last review relate to the go live date for the new Speak Out Safely process being extended, to allow sufficient time for supporting actions such as the launch of the Work in Confidence platform and the recruitment process for the Speak Out Safely Guardian.

- **BAF21-12 – Security Services**

  Key changes since the last review relate to target dates for the 'security provision systems and staffing' action being updated to June 2021 from May 2021. Scoring remains static. The review of mitigations highlighted the action regarding the commitment from Estates to upgrade CCTV systems on a number of premises. The reference to the temporary hospitals in the control column has been updated to reflect an extension of the requirement to maintain premises during de-commissioning. The security services risk will be subject to a deep-dive review at the August Risk Management Group.

- **BAF21-13 – Health and Safety**

  Key progress since the last review relates to an update on the position as regards the Institute of Occupational Safety & Health (IOSH) Managing Safely and Leading Safely training programme for senior leaders, which will be implemented subject to an approved business case. Welsh Government is expected to provide additional funding for this as a result of the new Fire Bill, in light of the Grenfell disaster. This risk will be subject to a deep-dive review at the August Risk Management Group.

- **BAF21-14 – Pandemic Exposure**

  Key progress since the last review relates to Planning and Estates improvement plans being approved by the Board and currently with Welsh Government awaiting approval, and also to ensuring that fit testing becomes business as usual under continuous review by the Health & Safety Group.

- **BAF21-15 Value Based Improvement Programme**

  Key progress since the last review include actions completed in April being moved to the mitigations column. Executive leadership has changed from the Executive Director of Finance to the Executive Director of Primary Care and Community Services, to align with the overall transformation approach. Job descriptions for Improvement Programme team roles have been drafted, linked to the broader transformation resource. Data collection for initial projects has commenced, with consideration of longer term systems solutions to be progressed as part of a national review.

- **BAF21-16 Digital Estate and Assets**

  Key progress since the last report relates to actions updated to reflect approval of the Digital Strategy by the Board, with an additional action added regarding the formal launch of the Strategy. The date in relation to the Management of Portfolio approach has been amended to align with the proposed Governance Structure Review implementation. Mitigations have been updated to reference regular meetings with Digital Health Care Wales. A resource structure had been developed, however the decision was subsequently taken not to fund cost pressures for additional capacity. This will necessitate a review of existing resources.

- **BAF21-17 Estates and Assets Development**

  Key changes since the last review relate to an extension to the Estates Strategy action, to allow sufficient time to agree the standards for workforce accommodation and for changes in working practices through modern ways of working. The current risk scores will be revisited in September 2021.

- **BAF21-18 Workforce Optimisation**

  Key progress since the last report includes the commencement of the Workforce Service Review Programme and the establishment of Medical Bank via a contract with MEDACS covering 2020-22; both actions are now shown as mitigations.

- **BAF21-19 – Impact of COVID-19**

  Key changes since the last review relate to updated controls, mitigations, actions and timeframes to reflect the current situation. The risk score remains unchanged in light of the potential risks posed by the variants of concern. Executive Lead responsibility for COVID-19 has transferred to the Executive Director of Nursing & Midwifery/Deputy Chief Executive, from the Executive Director of Primary Care and Community Services.

- **BAF21-20 Development of Annual Plan 2021/22**

  Key progress since the last report relates to actions, timelines and scoring updated to reflect that the Plan was supported by the Finance and Performance Committee and was approved by the Health Board for submission to Welsh Government on 30 March 2021. In light of the residual financial gap, and taking into account discussions at the Finance and Performance and Strategy, Planning and Population Health Committees, the scoring of this risk was revised, and increased from 3 to 6.

- **BAF21.21 Delivery of a Planned Annual Budget**

  Key progress highlighted during the review related to a number of actions having been completed and now shown as mitigations, including submission of the Plan as agreed by the Board.

- **BAF21.22 Estates and Assets**

  Key progress highlighted during the review related to the completed action in respect of the approval of the capital programme. This is therefore now shown as a mitigation.

Below is a heat map representation of the current BAF risk scores:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				BAF21-16	BAF21-04
	Likely - 4				BAF21-01 BAF21-11 BAF21-18	BAF21-03 BAF21-06 BAF21-09 BAF21-10 BAF21-12 BAF21-13 BAF21-14
	Possible - 3			BAF21-05 BAF21-08 BAF21-17	BAF21-15 BAF21-19	BAF21-02 BAF21-07 BAF21-21 BAF21-22
	Unlikely - 2			BAF21-20		
	Rare - 1					

Asesiad / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management. The aim is to foster a culture of safety and learning, to support continuous improvements and an enhanced patient experience.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Goblygiadau Ariannol / Financial Implications
The effective mitigation and management of risks has the potential to deliver a positive financial dividend for the Health Board, through better integration of risk management with business planning and decision-making. It will also shape how care is delivered to patients, leading to better quality, less waste and a reduction in claims.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and so additional resources may be required.

Dadansoddiad Risk / Risk Analysis
The individual risks at Appendix 1 include details of the related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework.

Asesiad Effaith / Impact Assessment
No specific or separate EqIA has been carried out for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy, to which BAF reports are aligned. Due regard of any potential equality/quality and data governance issues has been factored into the writing of this report.

Board Assurance Framework 2021/22

Strategic Priority 5: Improved Unscheduled Care Pathways

Risk Reference: BAF21-01		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)									
There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day. 5) Primary Care Urgent Treatment (PCUT) Centre established in East	2	1) Roll out of YGC improvement plan to other sites as appropriate. National support agreed. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with the agreed standards implement a uniform model for patient access to and from EDs. 5)Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. 6) D2R&A (discharge to rehabilitate and assess) - in progress; 7)111 - on track to implement by June 2021 and PCUT to be established in Centre and West.	30 June 2021 30 June 2021 30 June 2021 30 June 2021 30 September 2021 31 December 2021 30 June 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	1)Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer. 2) USC scoping review undertaken to develop strategic blueprint solution for unscheduled care	1	1) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care. 2) Update as of beginning June 2021 - Executives have commissioned further work by Kendal Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care.	30 June 2021 30 June 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	30 June 2021

Review comments since last report: Action in relation to USC scoping review to develop strategic blueprint solution for unscheduled care now moved into mitigation column. Update as of beginning June 2021 - Executives have commissioned further work by Kendal Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. It is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**1 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-02		Risk Rating	Impact		Likelihood		Score		Appetite
Sustainable Key Health Services									
There is a risk that the Health Board may not be able to deliver sustainable key population health services to the wider population of North Wales due to demand exceeding capacity.		Inherent Risk	5	↑	4	↔	20	↑	**Low**
		Current Risk	5	↑	3	↔	15	↑	**1 - 6**
		Target Risk	5	↑	2	↔	10	↑	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health Improvement & Reducing Inequalities Group (HIRIG) provide strategic direction and monitors delivery of the Population Health Services. HIRIG reports to Executive Team.	2	Health Board commitment to establishing priority services including: Programme management and recruitment to posts.	2	1) Fully integrated the Smoking Cessation service. 2) Implement a Tier 3 Childrens Obesity service. 3) Implement a Healthy Weight pathway T1-3. 4) Implement and delivery the Immunisation Strategy. 5) Implement and deliver the Infant feeding strategy. 6) Implement and deliver a suite of Building a Healthier North Wales projects.	30 June 2021 31 August 2021 31 March 2022 31 March 2023 31 March 2023 31 December 2022
Strategy, Partnership and Population Health Committee have oversight via standard reports by exception on progress.	2	Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place.	2	Embed BCUHB North Wales population health priorities within its operational and strategic plans.	1 April 2022
Welsh Government have oversight of Smoking Cessation, Building a Healthier Wales, Infant Feeding, Healthy Weight Healthy Wales, Immunisation programmes and provide an element of funding.	3	HIRIG provide reports nationally regarding expenditure and performance.	3	Standardised reporting and meet submission requirements once national reporting requirements determined.	30 September 2021
The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Local Public Health Team.	2	Regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact.	3	1) Embed Public Health Outcomes approach into local planning through Local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales.	31 March 2022 31 March 2022

Review comments since last report: The risk description has been modified to remove the words 'diminishing capacity' and to reflect the current status on demand levels. The scoring - including inherent, current and target risk scores have been revised to reflect the significant impact on health effects. Actions reviewed, all dates still appropriate. Additional action added in respect of the recovery focus across North Wales and the establishment of the Recovery Co-ordination Group. Action in relation to embedding Public Health Outcomes - wording amended to reflect approach rather than Framework. Population Health is dependent of system wide commitment and actions and therefore the action in relation to embedding Public Health Outcomes and the approach will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Strategy, Partnership and Population Health Committee	**17 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 3: Primary and Community Care

Risk Reference: BAF21-03		Risk Rating	Impact		Likelihood		Score		Appetite
Primary Care Sustainable Health Services									
There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Each Area Team reviews GP practice sustainability and provides bespoke support to individual practices.	1	Regular review of 5 domains matrix. Escalation tool implemented and monitored by the Primary Care Panel, chaired by the Executive Director of Primary and Community Care, with reports provided to Quality, Safety and Experience Committee.	2	Delivery of Quality Assurance Visiting Programme across all contractors, in-depth review/visits which will be supportive for practices where concerns are identified.	31 March 2023
Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care.	3	1)Review of current workforce profiles. 2)Delivery of milestones set by the national strategic programme. Contribution and leadership in the national priorities. 3)Increase in the number of GP Trainees in north Wales. (WG Statement in December 2020 stated that GP places would remain at current levels with the ability to over recruit if needed).	2	1) Primary Care Strategy for north wales embedded in the clinical strategy of BCUHB. 2) Further development of primary care workforce plans, with a further consideration of the impact of the pandemic on assumed GP retirements.	31 March 2022 30 July 2021
Provision of alternative services to increase capacity in GP practices in place.	1	Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services.	1	Full roll out of UPCCs (subject to national evaluation & pathways) (presentation made to Welsh Government on 19 May 2021 to secure ongoing funding for the pathfinders).	31 March 2022
Primary & Community Care Academy (PACCA) in place with further development and roll out planned.	2	Academy work plan 2019/22 in place, monitored by the Strategic Leadership Group for the Academy and as part of the performance monitoring of the Health Board's Operational Plan which feeds through to the Strategy, Partnership and Population Health Committee.	2	1) Increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity. Business case to be presented for consideration. 2) Strengthen coordination and implementation of work placements for training, mentorship and formal internship.	30 September 2021 31 March 2022
The Health Board has committed to work in partnership to develop proposal for a Medical School at the Univeristy of Bangor	1	Review progress in the development of a Medical School with Bangor University with the first commitment being delivery of medical degrees in partnership with Cardiff University (see below).	1	1) Development of a business case	31 July 2021
Delivery of Medical Degrees at Bangor University in partnership with Cardiff University	1	Cardiff University in partnership with Bangor University have 21 students undertaking their medical degree in north Wales. Students spend 12 months in Primary Care as part of their 4 year course	1	1) Ensure sufficient capacity with Primary Care for medical students	01 September 2021
The Health Board continues to work in partnership with local HE providers to secure funding for and delivery of courses and programmes of education to attract and retain the workforce in north Wales	1	The development of the North Wales Dental Academy in partnership with HEIW, WG and Bangor University will provide an essential resource and training environment for the dental practitioners include Dental Hygienists and Dentists.	1	1) Establish Dental Training Unit in Bangor (currently being advertised)	01 April 2022
Cluster working/Health & Social care Localities in place with further development planned, with oversight by Area Teams, Regional Partnership Board Leadership Group and Integrated Care Boards (partnerships).	2	GP clusters have increased maturity throughout Covid-19 with practices working closely together with oversight by the Area Directors.	1	1) Development of broader cluster membership with the further integration with locality services. 2) Establish Cluster Transformation Board to lead the further development of clusters and promote/facilitate innovation and transformation.	30 September 2021

Review comments since last report: Update since the last submission - The following action is now show as a mitigation :-Increase in the number of GP Trainees in north Wales. (WG Statement in December 2020 stated that GP places would remain at current levels with the ability to over recruit if needed. Dental Training Unit contract is currently being advertised - Continuation & roll out of UPCCs prioritised for funding in draft Annual Plan was made to Welsh Government on 19 May 2021 to secure ongoing funding as part of the national programme. It is considered that the following actions will have the most material impact on the risk - Primary Care Strategy for North Wales to be embedded in the clinical strategy of BCUHB; further development of primary care workforce plans, with further consideration of the impact of the pandemic on assumed GP retirements; establishment of the Dental Training Unit in Bangor (currently being advertised); increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Strategy, Partnership and Population Health Committee	**20 May 2021**

Linked to Operational Corporate Risks:
CRR20-05 Timely Access to Care Homes

Board Assurance Framework 2021/22

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04		Risk Rating	Impact		Likelihood	Score		Appetite
Timely Access to Planned Care								
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5	25		Low
		Current Risk	5	↔	5	25	↔	1 - 6
		Target Risk	5		3	15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Finance and Performance Committee. Introduction of further validation staff in Q3/4 non recurring complete.	2	1)Scoping of Artificial Intelligence approach to validation requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan. 2)Validation staff being recruited on a fixed term basis to continue with validation work. 3)Subject matter expert reviewing validation exercises for planned care.	31 July 2021
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1)Ensure the waiting list size is continually validated and patients appropriately communicated with. 2)Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support long waiting patients approved via Single Tender Waiver.	1	1) Introduce a system that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan. 2) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 3) Sites and areas are completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022.	20 June 2021 31 July 2021 31 May 2021
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Chief Operating Officer and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care. Shortlisted candidates, interviews mid May.	31 July 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1)Weekly operational group with Divisional general Managers (DGM's) to ensure operational co-ordination of the once for north wales approach. 2)Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthamology introduced in February. 4) Over 52 week recovery plan for the 2019/20 end of March co-hort as first phase agreed.	1	1) Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times 2) Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Review of Opthamology Business Case in light of Welsh Government Strategy re Cataract Centres. 4) Additional internal activity above core is being mobilised via recovery plan. 5) Business case being developed for orthopaedic modular ward and theatre on each site. 6) Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.	31 July 2021 31 May 2021 20 June 2021 31 July 2021 20 June 2021 20 June 2021

Review comments since last report: Mitigations and Gaps/Actions updated to reflect current developments including extension to some timelines. Further actions added which include:- additional internal activity above core being mobilised via recovery plan; business case being developed for orthopaedic modular ward and theatre on each site; outsourcing of orthopaedic activity being investigated with the Independent Sector; and capacity planning undertaken to understand the clearance times for the over 52 week backlogs. It is estimated to be approximately 3-4 years to clear this activity, orthopaedics being the most significant driver for this length of time. These are the reasons for retaining the current scoring. It is considered that the following actions will have the most material impact on the risk:- Review of Ophthalmology Business Case in light of Welsh Government Strategy re Cataract Centres; Additional internal activity above core is being mobilised via recovery plan; Business case being developed for orthopaedic modular ward and theatre on each site; and Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee and Quality, Safety and Experience Committee	**7 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-05		Risk Rating	Impact		Likelihood		Score		Appetite
Effective Stakeholder Relationships									
There is a risk that our relationships (internal and external) are ineffective. This could be caused by a lack of engagement, poorer communication, a lack of a co-productive approach, lack of direction, shared purpose and culture or insufficient service and organisational development. This could lead to a lack of trust, poor morale, high staff turnover, reduced stakeholder credibility plus reduced staff and public confidence, and an impact on services.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	2		2		4		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Together for Mental Health (T4MH) Strategy implemented with key stakeholders which sets out the direction of travel for Mental Health and Learning Disabilities services.	2	T4MH Partnership Board which oversees implementation of the strategy and includes key partners.	2	1) First meeting held on 22nd January where a number of actions were agreed which consist of a review of the TOR of the T4MHPB and a refresh of the MH Strategy. To deliver this a number of task and finish groups have been established and the revised TOR are to be presented to the T4MHPB on 9 July 2021. 2) Population needs assessment to be undertaken across North Wales which will influence the MH Strategy. 3) Delivery of Targeted Intervention Framework outcomes for Mental Health	31 July 2021 30 September 2021 31 March 2022
Deputy Director attendance at Regional Leadership group with regular feedback into the MHLD Division to ensure two-way communication and engagement.	2	Consistent and regular communication with senior Local Authority partners in relation to service redesign. Feedback to Senior Leadership Team on key issues	2	Ensuring appropriate cover to ensure relevant and appropriate attendance at Regional Leadership Group.	Complete
Divisional CAG meetings whereby senior clinicians and managers discuss and agree service model across the division.	2	Recommendations from meetings presented to BCU Clinical Advisory Group and presented for sign off via Divisional Finance and Performance meeting.	2	To present update of service model to BCU CAG and then to Regional Leadership Group.	30 September 2021
In line with Divisional Wellness, Work and Us Strategy, oversight of all vacancies and sickness overseen by Divisional Workforce Group to ensure any identified demand and capacity pressures.	1	The MHLD division has introduced a workforce group which oversees key actions and identifies and escalates risks to Divisional Directors.	1		
Regular and concise communication with all staff groups across the division.	1	Fortnightly divisional staff engagement newsletter which highlights significant issues/service changes and celebrates staff achievements which reduces the risk of breakdown in communication. This is now embedded practice within the Division.	1	1. Ensure newly formed meeting with Staff Side to discuss key operational and strategic staffing issues continues. 2. Continuation of monthly meetings between CAMMHS and MH Senior Leadership Teams to ensure effective joint working and system planning being clinically and financially effective.	30 September 2021 31 December 2021
Service users, carers and the public to have the opportunity to be involved in the development, planning, design and delivery of the services.	2	Divisional Patient and Carer Engagement Group re-introduced in order to listen better and use feedback from consultation and engagement to make mental health and learning disability services more relevant to service users and carers' needs. We are reviewing the CANIAD contract to ensure integrated working.	2	1) To ensure the review of the CANIAD contract is discussed with the North Wales Leadership group for the joint review. Currently out to procurement for independent review of the CANIAD contract. 2) Address potential gap in advocacy contract arrangements. Curently out to tender.	31 October 2021 31 July 2021
Closer and regular working with North Wales CHC to ensure the population of North Wales have the opportunity to feedback on their experiences of local services and to contribute to the future design.	3	Safe space events started in December 2020 have been set up with CHC to engage with North Wales population to seek views/experiences of MHLD services. Deputy Director & Director of Nursing are attending the CHC AGM.	3	MHLD Division to agree process for sharing feedback from events with staff groups. An action plan is being developed following the Safe Space events facilitated by the CHC.	31 August 2021

Review comments since last report: Key actions updated including timeframes to reflect the overall progress being made in the Division in relation to Partnerships. Review of the Terms of Reference of the Together for Mental Health Partnership Board (T4MHPB) have taken place with a number of task and finish groups being established. The revised Terms of Reference are to be presented to the T4MHPB on 9 July 2021. Continuation of monthly meetings between CAMMHS and MH Senior Leadership Teams to ensure effective joint working and system planning being clinically and financially effective. Although engagement with stakeholders is an organisational wide priority this risk is specifically focussed on Mental Health Services where there is a heightened need to address the risks and embed a culture of clear and consistent engagement. The Targeted Intervention Framework will be the consistent conduit which will be used to measure the Division's progress moving forward. In terms of which actions will have the most material impact on the risk it is considered that the T4MH Partnership Board actions, the action relating to closer working with the CHC and the delivery of the actions and outcomes within the Targeted Interventions Maturity Matrix will have the greatest impact.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Strategy, Partnership and Population Health Committee	**18 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-06		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Mental Health Service Delivery									
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	3		3		9		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly (last met on 9 April 2021). Interim Deputy Director leading this key partnership agenda.	31 December 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2021). The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in partnership and strategy development.	2	1. Work is ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team. 2. Delivery of Targeted Intervention Framework outcomes for Mental Health.	01/09/2021 31 March 2022

Review comments since last report: Action and timelines reviewed which include:- 1. Work ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team.
2. Delivery of Targeted Intervention Framework outcomes for Mental Health - aligned to all TIIF Measures. Ensuring the effective working of the T4MHPB will have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:18 June 2021**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-07		Risk Rating	Impact		Likelihood		Score		Appetite
Mental Health Leadership Model									
There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Interim Senior Leaders in place and working within division. This is alongside other key posts; Interim Director of Nursing and Interim Deputy Directors x2. Each lead specific programmes and will further support and develop leadership, governance and management.	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging it's roles and responsibilities.	2	Stabilise Senior Management with substantive posts. Sustainability needs to reviewed as a matter of priority to ensure continuity.	1 September 2021
Strategy approved and regular updates reported via Targetted Intervention to Welsh Government.	2	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways. There is on-going work to agree plan for 21/22	1 December 2021
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	2	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via the Division Clinical Advisory Group.	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	1 December 2021
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1		
Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1	Finalise all 4 service areas draft Business Continuity Plans for implementation.	01 September 2021
Divisional Quality, Safety and Experience Group meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	1	Division has actively worked to ensure that the Divisions Governance Structure more accurately reflect and is coherent with BCUHB's governance structure		Need to introduce a cycle of business to support effective reporting to the revised governance structure	1 September 2021

Review comments since last report: Actions reviewed and updated to reflect the current position with target dates amended. Action in relation to review of Governance Structures now completed and shown as mitigation. New action in respect of cycle of business to support effective reporting to the revised governance structure. Actions were reviewed and it is considered that the stability of the leadership team will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	**18 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-08		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Mental Health Service Delivery During Pandemic Management									
There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	2		
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scruitinise them through Senior Leadership Team.	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed.	30 August 2021
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	1) Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation. 2)Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	1		
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	1) Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans. 2)Revisit and assess gaps in recruitment processes to support additional staff requirements. 3)Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21	2	Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements.	30 September 2021
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	1) Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group. 2) Process to ensure continuous mapping of staff to enable redeployment decisions.	2		
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1		
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	MH&LD Covid19 Senior Leadership Team briefing meeting in place, currently meeting twice weekly, but flexible and responsive to need, which reports into the Corporate Covid19 meetings.	2		
MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.	1	1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure SOP operationalised	1		
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	1)To source and procure additional IT equipment, primarily laptops, to increase the roll out of Attend Anywhere across the MH&LD Division. All Priority 1 laptops delivered across the MH&LD Division, priority 2 laptops delivery roll out planned ongoing. 2)This project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T) implementation.	Complete 31 December 2021

Review comments since last report: Procurement of additional IT equipment action now shown as complete with a further action added as this project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T). All action dates reviewed and updated. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	18 June 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2021-22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-09		Risk Rating	Impact		Likelihood		Score		Appetite
Infection Prevention and Control									
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		Inherent Risk	5		5		25		Low
		Current Risk	5	↔	4	↔	20	↔	1 - 6
		Target Risk	5		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group. Safe, clean care harm free programme commenced.	2	1) Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. 2) Finalise recruitment to increase IPC Team resource. 3) To develop the leadership to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. 4) IT solution and information leadership required to ensure that the right data is captured which can then be tranformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system). 5) Safe clean care programme support required to support and manage and assure delivery. 6) Substantively recruit into the Director of Nursing IPC role	31 December 2021 30 September 2021 31 December 2021 31 December 2021 31 July 2021 30 September 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee (QSE).	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3	1) Identify decant facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. 3) Development of a real time information platform to focus improvement actions	31 October 2021 31 October 2021 31 October 2021
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	1) Strengthening of effective reporting arrangements through outbreak control groups and IPSG. 2) Ensuring that the most effective control measures are being monitored at a local level and assurance reporting to QSE Committee.	30 September 2021 30 August 2021

Review comments since last report: Additional actions identified including ensuring that the most effective control measures are being monitored at a local level with assurance reporting to QSE Committee; safe clean care programme support required to support and manage and assure delivery; development of a real time information platform to focus improvement actions; and to substantively recruit into the Director of Nursing IPC role. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the action to build or purchase more isolation facilities would have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:14 June 2021**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing focus

Risk Reference: BAF21-10		Risk Rating	Impact		Likelihood		Score		Appetite
Listening and Learning									
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology. This will address aspects 1, 2 and 3 of the risk.	30 September 2021
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better. This will address aspects 1, 2 and 3 of the risk.	31 October 2021
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning. This will address aspects 2 and 3 of the risk.	30 June 2021
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned. This will address aspects 2 and 3 of the risk.	30 September 2021
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2			Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives. This will address aspects 1, 2 and 3 of the risk.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy. This will address aspects 2 and 3 of the risk.	31 March 2022
				Implementation of an organisation-wide integrated Quality Dashboard. This will address aspects 2 and 3 of the risk.	Complete
				Implementation of a new Speak out Safely process for staff to raise concerns. This will address aspects 1, 2 and 3 of the risk.	30 June 2021

Review comments since last report: Target action dates reviewed and updated, acknowledging the delay in roll out of the new Datix system. Action in relation to the Quality Dashboard now shown as complete. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that it is the collective impact of the actions that will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**2 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-11		Risk Rating	Impact		Likelihood		Score		Appetite
Culture - Staff Engagement									
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Revised new Speak Out Safely process agreed by Remuneration and Terms of Service Committee 1st February 2021. Implementation Plan in place, key elements being: 1. External platform commissioned - Work in Confidence - to replace Safe Haven to enable staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardian and/or members of wider Multi-disciplinary Team. 2. Role outline for Speak Out Safely Guardian completed, Guardian will report directly to CEO, with an independent board member now also identified to support and scrutinise Guardian role and new Multi-Disciplinary Team being established, the role of which will be to review concerns raised, agree actions required; and, monitor themes to identify learning; 3. Role outline for Speak Out Safely Champions has been refreshed and network of champions being created 4. Communications and promotion strategy under development with support of corporate communications; 5. WP4a policy (Raising Concerns) has been revised to reflect the transition to the new process	1	1. Launch of Work in Confidence platform now anticipated to be early July 2021, having received approval of DPIA (received Friday 11th June) 2. Advert has been placed to appoint first Speak Out Safely Guardian, closing date of 25th June and interviews during first 2 weeks of July; 3. Full membership of MDT now agreed with first meeting arranged for 29th June; 4. Overarching SOP in development, inclusive of agreed role outlines for Guardian, Speak out Safely Champions and independent member and terms of reference for MDT, with process map for Speak out Safely to be completed to support completion of SOP; 5 Communications strategy includes development of intranet pages. 6. WP4a policy (Raising Concerns) revised to reflect new process; 7. Evaluation metrics to monitor impact of new process under development. 8. On-going concerns raised through Safehaven process being managed to ensure they are not 'lost' during transition phase	31st July 2021
3. Dignity at Work Policy - Now Respect and Resolution Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level.	1	1. Dignity at Work Policy under review at All Wales level. 2. Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.	30 September 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4. Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	30 September 2021

Review comments since last report: Go live date for new Speak Out Safely process has been extended to ensure all supporting actions in place as outlined above. It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	**14th June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-12		Risk Rating	Impact		Likelihood		Score		Appetite
Security Services									
There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1)There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of June 2021 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.	1	Staff Training is in place in certain service areas. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant. Additional Bank staff employed to support Covid vaccination centre work and security review.	2	1) A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. BCUHB requires copies of Security Industry Authority licences. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed. 2) Business case under further review to identify gold standard approach. 3) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas.	30 June 2021 30 June 2021 30 June 2021
There is a Security Group established to review workstreams. Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North Wales Police.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices is required. To ensure appropriate care, this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. The Manual Handling Team require competency training in order to be able to deliver appropriate V&A training.	30 September 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different in many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required. Estates have committed to upgrate CCTV systems in a number of premises.	30 September 2021

Review comments since last report: Scoring reviewed and remains static. Target action dates in relation to line one have been updated to June 2021 from May 2021.
Reference also made to an action regarding Estates, who have committed to upgrade CCTV systems in a number of premises. Additionally the reference in the 'Control' column to the Field Hospitals has been updated to reflect an extension of the requirement to maintain premises during de-commissioning.
- It is considered that the following actions will have the most material impact on the risk: Support for the case for investment and change to improve capacity and quality of the security service and management and Implementation of the gap analysis findings.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	**26 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-13		Risk Rating	Impact		Likelihood		Score		Appetite
Health and Safety									
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented subject to business case approval.	30 September 2021 31 October 2021
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business case to be reviewed. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. (Welsh Government are likely to be providing additional support post 'Grenfell' to support the new Fire Bill.) Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. HSE are scrutinising work activity in many areas, likely to Audit BCUHB for Asbestos and Violence at work shortly. 2)Actions arising from the Legionella review to be implemented.	30 September 2021 31 October 2021
Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews a total of 820 RIDDOR investigations undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak.	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October was lifted at the beginning of April. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 September 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	30 September 2021

Review comments since last report: Actions updated to reference IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented **subject to a business case** and that Welsh Government are likely to be providing additional support post 'Grenfell' to support the new Fire Bill. It is considered that the action that will have the most material impact on the risk is the Competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership and it is anticipated that the necessary funding will therefore be made available.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	26 May 2021

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-14		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Exposure									
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group and reporting through to Quality, Safety and Experience Committee.	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality,Safety and Experience Committee.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group	30 September 2021
Review of all buildings has taken place against new regulations/guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours.	30 September 2021 31 December 2021

Review comments since last report: Actions reviewed and updated:- Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval; and ensuring fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the purchase/building of more isolation facilities will have the most material impact on this risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**8 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key Enabler: Making effective and sustainable use of resources

Risk Reference: BAF21-15		Risk Rating	Impact		Likelihood		Score		Appetite
Value Based Improvement Programme									
There is a risk that the Health Board does not understand or use its resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.		Inherent Risk	4		4		16		Moderate 8 - 10
		Current Risk	4	↔	3	↔	12	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Finance & Performance (F&P) Committee oversight via standard reporting of opportunities and savings delivered.	2	Contribution to national benchmarking programmes, providing detailed analysis of service areas and opportunities.	3	The June refresh of the Annual Plan will provide further clarification regarding the way in which the VBHC Improvement Programme supports the Health Board's transformational approach.	31 July 2021
F&P Committee oversight of benchmarking data & follow up work e.g. Mental Health.	2	Drivers of the Deficit analysis and external benchmarking data used to inform Annual Plan and to identify priorities for tackling efficiency opportunities, linked to service transformation.	1	Staff recruitment to be aligned with Annual Plan and broader transformation programme approach. Job descriptions drafted; banding and recruitment prep to be concluded in June.	30 June 2021
Lessons Learnt analysis from COVID reported to Executive Team, with action to mainstream innovation and value opportunities. Reporting of progress to delivering opportunities to F&P Committee.	2	National efficiency framework analysis to identify opportunities and cascade to Improvement Groups and Divisions.	1	Planning and business case approach to be reviewed to capture VBHC principles. Work ongoing to finalise , adopting learning from other Health Board approaches	30 June 2021
Clinical Effectiveness Group re-established with oversight of Value Based Healthcare within its brief.	1	1) Executive leadership changed to reflect alignment with the broader transformation approach; Director of Primary and Community Care to lead alongside the Director and Finance.	2	Initial priorities identified e.g. lymphodema and orthopaedic services, with projects being established along with reporting arrangements.	30 June 2021
Executive Team reviewing the opportunities analysis produced for Improvement Groups to identify potential areas of inefficiency to be addressed.	2	Finance Delivery Unit of Welsh Government have designed a maturity matrix for VBHC which can be used to guide and inform the programme of work.	2	Steering group to be established to drive the programme of work, supported by the VBHC structure. Progress reports to be provided to the Clinical Effectiveness Group. Initial group established; the approach to be aligned with the overall transformation approach as part of the Annual Plan refresh. The Welsh Government maturity matrix guide for value based healthcare is actively being utilised	31 July 2021
		Direct support secured from the National VBHC Team to support the Health Board in developing and implementating the programme.	2	Initial data capture and reporting systems for VBHC to be developed. Data capture in place for initial projects. Future system requirements under review as part of the national programme	Complete 30 September 2021
		The Draft Plan for 2021/22 confirmed that VBHC is part of the Board's overall transformation approach	2	Programme reporting established to Finance and Performance Committee	31 July 2021
		Resources have been secured from the strategic support allocation to resource the VBHC Team	2	Utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress.	30 September 2021

Review comments since last report: Actions completed in April have moved to mitigations. Status of actions has been reviewed to reflect work undertaken since the last update in April. Executive leadership has been changed (from the Executive Director of Finance to the Executive Director of Primary and Community Services) to align with the overall transformation approach. Job descriptions for team roles have been drafted, linked to the resource available. Data collection in initial projects has started, with consideration of future system needs progressing as part of a national review. The following actions are considered those that will have the most material impact on the risk:- 1) Further clarity within the Plan refresh as to how the VBHC programme supports the Board's transformation approach; 2) Recruitment of the VBHC team, aligned to the broader transformation resource; 3) Clarity on longer term systems solutions to support VBHC; and 4) utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Finance and Performance Committee	**14 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Transformation for Improvement

Risk Reference: BAF21-16		Risk Rating	Impact		Likelihood		Score		Appetite
Digital Estate and Assets									
There is a risk that Informatics cannot implement digital solutions due to available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on compliance with legislation resulting in significant financial penalties.		Inherent Risk	4		5		20		Moderate to High 8 - 15
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Monthly budget reviews take place with finance. Finance attendance at Informatics Senior Management Team (SMT) on a monthly basis as part of the Cycle of Business.	1	Contribution to national informatics programmes through representation both informatics and clinical i.e. Virtual Consultations, Digital Services for Patients and the Public Programme.	3	1) Development of a Digital Strategy - approved by the Board on 20 May 2021. 2) Formal launch of Digital Strategy	Complete 1 September 2021
Quarterly review of Operational Plan at SMT with Digital and Information Governance Committee (DIGC) oversight of the delivery of the Informatics Operational Plan and budget on a quarterly basis.	2	Review of required business cases through the Business Case Review Group and to the Finance & Performance Committee (F&P) Committee for approval.	2	Implementation of the Digital Strategy Year 1 to 2.	1 March 2022
Capital and Revenue Programmes are in place and are reported through the DIGC on a quarterly basis.	2	Resource risks are identified and go through the escalation process as documented in the Risk Management Strategy. This governance includes SMT, DIGC and Risk Management Group.	2	Established resource structure submitted, together with revenue and capital requirements for 21/22 - decision taken by ET not to fund cost presssure for additional capacity. Accordingly a review of the current projects is being undertaken which will be presented in due course to the Executive Team.	30 June 2021
		Programmes and Projects are managed using agreed standard methodologies (Tailored Prince2) and have governance structures.	1	Development of an established resource structure and revenue and capital requirements in line with the strategy delivery from 22/23.	1 December 2021
		Regular meetings with Digital Health Care Wales in place to discuss local and national priorities and challenges.	3	Development a Management of Portfolio approach so that all digital solution change initiatives are well governed, controlled and prioritised. Implementation of the Management of Portfolio Approach.	31 October 2021
				Meeting with Digital Health Care Wales has taken place to discuss the BCUHB Priorities and Risks and plan currently in development to take account of the challenges.	30 June 2021

Review comments since last report: Actions updated to reflect approval of the Digital Strategy by the Board, with additional action added re formal launch of the Strategy. Date in relation to the Management of Portfolio approach amended to align with the proposed Governance Structure Review implementation. Mitigations updated to reference regular meetings with DHCW together with extensions to action timeframes. Implementation of the Digital Strategy together with the resources to deliver it will be the actions that have the most material impact on the risk. Resource structure had been developed however decision taken not to fund cost pressures for additional capacity which will necessitate a review of existing resources against current projects.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Digital and Information Governance Committee	21 May 2021

Linked to Operational Corporate Risks:

CRR20-06 - Informatics - Patient Records pan BCUHB

CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-17		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets Development									
There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy, monitored by Capital Investment Group with oversight at Finance and Performance, and Strategy Partnerships and Population Health Committees and Health Board.	2	Disposal or acquisition of assets are signed off by the Board and Welsh Government in line with the BCUHB Scheme of Reservation and Delegation (SoRD).	3	Health Board through the Workforce Strategy to agree the standards for workforce accommodation and changes in working practices through modern ways of working - Stronger Together.	31 March 2022
Workforce Strategy monitored by the Health Board.	2	Business Case process in place with oversight by the Executive Team, Capital Investment Group, Finance and Performance Committee and onto Welsh Government.	3	Financial Planning to be agreed and secured to support the change in working practices and a digitally enabled workforce.	31 March 2022
		Collaboration on public sector assets/corporate hubs, and regional working across North Wales.	3	Additional Resources for Asset Management function have been identified through the Health and Safety Business Case to be approved by Finance and Performance Committee.	31 March 2022
				Health Board agreed Estate rationalisation programme over three years 2021 to 2023. 2021-22 overview through Finance and Performance Committee and oversite through the Capital Investment Group.	01 June 2021
				Opportunities to progress corporate accommodation hubs in partnership with North Wales Regional Public Service Providers and Local Authorities.	31 March 2022
				Update Estates Strategy to reflect demands for flexible accommodation hubs and review current and future needs for Office accommodation.	01 September 2021
				The Health Board is progressing a Programme Business Case (PBC) to address fire safety and infrastructure compliance for Ysbyty Gwynedd (YG). This PBC will be submitted to the Health Board for approval and progression to Welsh Government for funding approval. The scope of the PBC will address all risks for YG which are listed within the Corporate Risk Register.	20 May 2021
				Development of enabling plans i.e. Finance, Workforce, Digital Strategy together with a refresh of Living Healthier, Staying Well [Digital Strategy now approved as a framework by the Health Board, however there is not currently funding identified for its implementation.]	01 September 2021

Review comments since last report: Updates to actions and review dates with extension to the action in relation to the Estates Strategy and the inclusion of the refresh of Living Healthier, Staying Well. All of the actions collectively have a contributory effect on the impact of the risk and its mitigation. It is not possible at this stage to identify one particular action in isolation due to a number of strategic enablers being progressed currently, e.g. Living Healthier, Staying Well; Digital and Workforce Strategies which will be reflected through an updated Estates Strategy. The current scores will be revisited in September 2021 based upon actions within the themes identified once approved.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**13 May 2021**

Linked to Operational Corporate Risks:
CRR20-07 Informatics infrastructure capacity, resource and demand.

Board Assurance Framework 2021/22

Aligned to Key enabler - Effective alignment of our people

Risk Reference: BAF21-18		Risk Rating	Impact		Likelihood		Score		Appetite
Workforce Optimisation									
There is a risk that the Health Board cannot attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could impact on the Board's ability to deliver safe and sustainable services.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)G=Gap; A=Action*	Date
Establishment Control Policy and system in place. Pipeline reports produced monthly for review and action by managers across the organisation. Roster management Policy. Recruitment Policy. Safe Employment Policy.	2	1. Review of Vacancy control process underway to establish a system for proleptic/proactive recruitment against key staff groups/roles. 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. 3.. Workforce Service Review programme commissioned and commenced.	2	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy including vacancy control and active recruitment pipeline management in place. G. Previous structure for planning and recruitment dispersed across secondary care sites, area teams, MHLD. Once for North Wales approach required. A. Revised delivery group structure developed subject to further refinement and approval. G.Use of technology requires review and improvement A.Scope for review of systems and usage to be drafted.	31/08/2021 31/07/2021 30/06/2021
Workforce plans for each of the core priority programmes: 1. Existing USC delivery. 2. Existing Planned Care Delivery. 3. Existing TTP delivery. 4. USC Surge Plan. 5. Planned Care Recivery Plan. 6. TTP reslience plan. 7. COVID Vaccination Plan.	1	1. Review and development of a clear Workforce planning process. 2. Workforce Service Review programme commissioned and commenced.	1	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy underway.	30/06/2021
Temporary Staffing Policy. Medical Bank Protocol.	1	1. Temporary Staffing Solutions Plan under development. 2.Medical Bank established with contract with MEDACs in place for 2020/22.	1	G. Temporary bank primarily established to support Nursing and Health Care Support. A. Plan to establish BCU Temporary Staffing Solutions under development. Service to cover all staff groups and include "ready to work" pipeline.	31/07/2021

Review comments since last report: Actions and timelines updated. Workforce Service Review Programme commissioned and commenced and Medical Bank established with contract with MEDACs in place for 2020-22, both actions now shown as mitigations. Actions reviewed in terms of which would have the most material impact on the risk. It is considered that the collective impact of the actions will mitigate the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Finance and Performance Committee	**8 June 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-19		Risk Rating	Impact		Likelihood		Score		Appetite
Impact of COVID-19									
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	4	↔	3	↔	12	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place and meeting regularly. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate. EIMT is now phasing down (now meeting fortnightly) as business as usual returns.	2	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity. De-escalation and decommissioning plans are being implemented. Surge plans/winter resilience plans are being tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Updating of business continuity and escalation plans. 2) Decomission Ysbytai Enfys in Bangor and Llandudno. 3) Deeside to be retained as local vaccination centre and for surge capacity.	30 June 2021 31 July 2021 31 March 2022
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group now stood down but reporting continues through EIMT for significant decisions.	2	1)Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Updating of programme plans and development of new plans in response to new Welsh Government guidance as it arises. 2) Prevention and response plan to be refreshed with partners.	31 July 2021 30 June 2021
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2		
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic.	30 September 2021
Executive Incident Management Team has been established and is meeting as required (frequecy dropped since original inception), with formal reporting to the Board as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Board briefings; escalation of matters requiring Board approval.	2	Ongoing work to ensure all records captured and indexed.	30 September 2021
North Wales LRF Strategic Co-ordinating Group has stood down. Recovery Co-ordinating Group remains in place and is continuing surveillance and managing recovery. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis.Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery.	3	1) Prevention response plan to set out remobilisation.	30 June 2021

Review comments since last report: Control, mitigations and action together with timeframes updated to reflect the current position of the pandemic. Current risk score reviewed but remains unchanged in light of the potential risks posed by the Variants of Concern. It is considered that the collective impact of the actions listed will mitigate the risk. Executive Lead transferred to Gill Harris from Chris Stockport.

Executive Lead:	**Board / Committee:**	**Review Date: 28 May 2021**
Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery	Quality, Safety and Patient Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-20		Risk Rating	Impact		Likelihood		Score		Appetite
Development of Annual Operational Plan 2021/22									
There is a risk the Health Board fails to deliver a plan to Welsh Government and remains in breach of its statutory duties whether due to inability to deliver financial balance or to present a plan that delivers key performance targets. This impacts on reputation, and reduces freedom to act.		Inherent Risk	3		3		9		**Low 1 - 6**
		Current Risk	3	↔	2	↑	6	↑	
		Target Risk	3		1		3		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Executive led planning process in place responsible for meeting the Welsh Government requirements for the development / implementation of an operational plan for 2021/22	2	1) Strong corporate, clinical, managerial and partnership engagement / collaboration with established and coordinated communication links including Welsh Government, Public Health Wales, and key internal and external stakeholders, e.g.: Executive led Planning Workstream, Stakeholder Reference Group, Regional Partnership Board. 2) Clear accountability across the organisation - agreed programmes with designated Executive lead, programme lead	2	1) Review of 2021-22 Planning Process to ensure robust arrangements are in place going forward. 2) Development of a 2022-23 plan by December 2021 3) In view of the draft nature of the plan it is expected that the plan will be refreshed during the year. 4) Residual financial gap to be addressed. 5) Plan refresh to Board in July, following Finance and Performance consideration in June. This will reflect the feedback from WG and the further new recovery fund resources which have been introduced across NHS Wales.	30 June 2021 31 December 2021 30 June 2021 30 June 2021 15 July 2021
Planning cycle established with outline BCUHB Planning schedule/overall approach for 2021/2022 plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Strategy, Partnership and Population Health Committee.	2	1) Developed Cluster Plans to influence the Primary Care Recovery Plans. 2) Planning arrangements established to support development of a high level plan with identified support from Corporate Teams. 3) Programme Groups led by designated programme lead with input from Divisional Teams with direct reporting to the Planning Workstream. 3) Planning and Performance, workforce, financial and informatics functions supporting oversight of plan development 4) Plan supported by F&P on 25.3.21 for submission to Board on 30.3.21	2		
BCUHB Annual Planning cycle in place that responds to national NHS Wales annual planning timetable and requirements.	2	Welsh Government annual planning framework issued. Communications Team support to the plan to improve the engagement.	2		

Review comments since last report: Actions, timelines and scoring previous updated to reflect that the Plan was supported by Finance and Performance Committee and was approved by the Health Board for submission to Welsh Government (WG) on 30 March 2021. Correspondence from WG on 11 March 2021 acknowledges the considerable uncertainty hindering firm planning commitments across NHS Wales and the draft Plan is being refreshed to take into account the recovery fund resources which has now been made available and to tackle the residual financial gap, with a view to being presented to the Board in July, following Finance and Performance consideration in June. Taking into account the discussion at the last SPPH Committee meeting, together with the above factors, the scoring of this risk has been revised, and increased from 3 to 6. Agreement of the refreshed plan by the Board will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date: 14 May 2021**
Mark Wilkinson, Executive Director of Planning and Performance	Strategy Partnerships and Population Health Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF 21-21		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Delivery of a Planned Annual Budget									
There is a risk the Health Board spends in excess of its planned annual budget. Any financial deterioration against the financial plan may result in the Health Board breaching its statutory duties. This could affect the provision of healthcare across North Wales, potentially leading to Welsh Government intervention and reputational damage, impacting on the Health Board's ability to remain sustainable.		Inherent Risk	5		4		20		Moderate 8-10
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Board led annual operational plan, developed and approved in conjunction with Welsh Government, setting out the Health Board's key priorities	2	1. Focused financial modelling and forecasting to deliver efficiency and achieve set Welsh Government targets. 2. A structured programme to demonstrate engagement with all stakeholders to agree a realistic and achievable savings plan 3. Financial and business partnering strategy, offering clear and reliable leadership from senior management team 4. Savings Opportunities and Benchmarking shared with Budget Holders 5. Strategic Support agreed with WG to support transformational change programme to be agreed with Board in March 2021 6. Finance led analytical review of the underlying deficit and cost pressures by Division to establish how much real new money is available to cover pay and inflation 7. Finance led evaluation of the recurrent Forecast Outturn; compare with recurrent budget including the impact of COVID-19 on our spend 8. The Health Board has submitted a draft plan with a £28m financial risk as agreed by the Board.		1. Consistent approach to be adopted across Divisions, in line with best practice, from April '21 2. Finance Team stategy includes as a key outcome to develop our approach to business partnering, to maximise the finance functions contribution to divisional management teams 3. Co-produce 2021/24 Planning principles, timetable and key deliverables with ET, EMG and SPPH Committees. 4. An action plan to address the deficit is being formulated as part of the refresh Plan as at Q1 5. Plans to deliver savings against the agreed Plan need to be finalised.	Complete 31 May 2021 31 May 2021 30 June 2021 30 June 2021
Oversight of financial position and controls through Health Board Committees. Scrutiny through reporting to Welsh Government and the annual statutory Audit	2	1. Formal finance meetings and communication between senior colleagues in the Health Board and Welsh Government 2. Oversight arrangements in place through the Finance & Performance Committee and the Board. 3. Annual assurance of financial position by Audit Wales. 4. Annual financial programmes monitored through the Finance and Performance Committee. 5. Finance report format revised to provide clearer position on financial position and risks. Consistent reporting across all Divisions from April '21. 6. Evaluation in relation to finance capacity and capability to support Divisions in delivering timely financial plans that link to activity and workforce impacts has been undertaken. Gap analysis has been undertaken in conjunction with Divisions to assess what skills they need from finance, to ensure the structure of the team meets the needs of the senior managers		1. Embed ownership of savings by Divisional managers supported by finance. 2. Review consistency of content and format of individual Divisional finance reports.	30 June 2021 30 June 2021

Review comments since last report: Actions to achieve target risk score together with timelines reviewed and updated with a number of actions having been completed and now shown as key mitigations. It is considered that the action plan to address the deficit will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Executive Director of Finance, Sue Hill	Finance and Performance Committee	**13 May 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-22		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets									
There is a risk that the Health Board fails to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding. This could impact on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patient, staff, public, reputational damage and litigation.		Inherent Risk	5		4		20		Moderate 8 - 10
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy in place and approved by the Board in January 2019 with updates provided to the Strategy, Partnership and Population Health Committee.	2	Development for business case for key projects identified in key strategies.	1	Secure WG funding to support Business Cases (short and long term).	31 March 2022
Annual Capital Programme in place and approved by the Finance and Performance Committee with regular reports provided to the committee.	2	Capital Investment Group with representation from all divisions with monthly updates to the Executive Team in place.	2	Rationalisation of the Health Board Estate.	31 March 2022
		Capital Programme based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee.	2	Review undertaken and work is ongoing to secure capacity to deliver all the projects.	30 September 2021
		Selection criteria signed off by the Executive Team which links back to risk, service continuity, service transformation and sustainability.	2	Development of Digital Strategy (due to be presented to the Board on 20 May 2021)	30 June 2021
		1) Project Teams in place to deliver the business case and projects. 2) 3 year Capital Programme agreed with Executive Team and approved by F&P Committee on 25 March 2021.	1		

Review comments since last report: Actions reviewed and updated to reference approved capital programme which is now shown as a mitigation. It is considered that the action in relation to securing WG funding to support Business Cases (short and long term) will have the most material impact on the risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**17 May 2021**

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCU
CRR20-07 - Informatics infrastructure capacity, resource and demand

Appendix 2 – Remapping BAF Risks to Annual Plan

- Remapping of BAF risks to the revised strategic priorities and enablers as set out within the Draft Annual Plan for 2021-22: -
  - **Priorities**
    - 1 Covid19 response
    - 2 Strengthen our wellbeing focus
    - 3 Primary and community care
    - 4 Recovering access to timely planned care pathways
    - 5 Improved USC pathways
    - 6 Integration and improvement of MH Services
  - **Key enablers:-**
    - Making effective and sustainable use of resources
    - Transformation for improvement
    - Effective alignment of our people

Remapped BAF Risks

New BAF Ref.	New priority alignment	20-21 Plan Priority	Previous BAF Ref.	Title
N/A Archived	5 Improved USC Pathways	1 Safe USC	20-01	Surge/ Winter Plan
21-01	**5 Improved USC Pathways**	**1 Safe USC**	**20-02**	**Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)**
21-02	2 Strengthen our wellbeing focus	2 Essential Services and Planned Care	20-03	Sustainable Key Health Services
21-03	3 Primary and Community Care	2 Essential Services and Planned Care	20-04	Primary Care Sustainable Health Services
21-04	**4 Recovering access to timely planned care pathways**	**2 Essential Services and Planned Care**	**20-05**	**Timely Access to Planned Care**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-05	**6 Integration and Improvement of MH Services**	**3 Mental Health Services**	**20-07**	**Effective Stakeholder Relationships**
21-06	6 Integration and Improvement of MH Services	3 Mental Health Services	20-08	Safe and Effective Mental Health Delivery
21-07	6 Integration and Improvement of MH Services	3 Mental Health Services	20-09	Mental Health Leadership Model
21-08	6 Integration and Improvement of MH Services	3 Mental Health Services	20-10	Mental Health Service Delivery During Pandemic Management
21-09	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-11**	**Infection Prevention and Control**
21-10	**2 Strengthen our Wellbeing focus**	**4 Safe and Secure Environment**	**20-12**	**Listening and Learning**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	Prev. BAF Ref.	Title
21-11	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-13**	**Culture – Staff Engagement**
21-12	**2 Strengthen our wellbeing focus**	**4 Safe and Secure Environment**	**20-14**	**Security Services**
21-13	2 Strengthen our wellbeing focus	4 Safe and Secure Environment	20-15	Health and Safety
21-14	**1 Covid 19 response**	**4 Safe and Secure Environment**	**20-16**	**Pandemic Exposure**
21-15	**NB aligned to key enabler – Making effective and sustainable use of resources**	**5 Effective Use of Resources**	**20-17**	**Value Based Improvement Programme**
21-16	**NB aligned to key enabler – Transformation for Improvement**	**5 Effective Use of Resources**	**20-18**	**Digital Estate and Assets**

Remapped BAF Risks continued

New BAF Ref.	New priority alignment	20-21 Plan Priority	BAF Ref.	Title
21-17	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-20	Estates and Assets Development
21-18	NB aligned to key enabler – Effective alignment of our people	5 Effective Use of Resources	20-21	Workforce Optimisation
21-19	1 Covid 19 response	2 Essential Services and Planned Care	20-25	Impact of COVID-19
21-20	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-26	Development of Annual Operational Plan 2021-22
21-21	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-27	Delivery of a Planned Annual Budget
21-22	NB aligned to key enabler – Making effective and sustainable use of resources	5 Effective Use of Resources	20-28	Estates and Assets

Board Assurance Framework Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability that the risk will be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Board Assurance Framework Key field guidance/ definitions of assurance levels

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Trained staff - Insurance procured
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE, and Internal/External Audit etc.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Updated Health Board Risk Management Strategy & Policy
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director: Information Governance and Risk David Tita, Head of Risk Management
Craffu blaenorol: **Prior Scrutiny:**	Audit Committee on the 10th June 2021 Executive Team (ET) on the 26th May 2021
Atodiadau **Appendices:**	Appendix 1: Updated Risk Management Strategy and Policy (including the revised Risk Management Appetite Framework) Appendix 2: Equality Impact Assessment (EQIA)

Argymhelliad / Recommendation:

The Board is requested to ratify the approval of the revised Risk Management Strategy and Policy by the Audit Committee.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This report provides a summary of key changes that have been made to the attached updated Risk Management Strategy and Policy for the Health Board. The Health Board`s vision and strategic approach to risk management ensures that all staff including partners, contractors etc. who provide services with and/or on its behalf, place effective risk management at the heart of what they do.

Cefndir / Background:

The Health Board is committed to embedding a risk-based, agile, dynamic, enterprise-wide, integrated risk stratification and collaborative approach in effectively reducing and managing risks as it delivers its Annual Operational Plan for 2021/22 in a post-Covid-19 era. This will encourage staff to explore integrated, risk-based prioritisation and stratification tools in delivering more joined-up, patient focused personalised outcomes and effective allocation of resources.

The Health Board`s vision statement for risk management has been refreshed to reflect the new the direction of travel as it navigates through recovery in a post-Covid-19 era. The Equality Impact Assessment has also been updated as part of the process of updating the attached Risk Management Strategy and Policy.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The following are the main changes included in the attached updated Risk Management Strategy and Policy.

Risk Appetite Framework:

- This updated strategy proposes a Risk Appetite Framework for the Health Board, which is split into three sections i.e. the one we are currently using, one that we are proposing for 2021/22 and one for use in exceptional circumstances.
- The proposed section in the Risk Appetite Framework for 2021/22 takes into consideration the current circumstances and the Health Board's requirement to recover from the COVID pandemic thus recognising the harm that could be caused to patients by long waiting lists for treatment.
- The proposed Risk Appetite Framework also includes a revised risk appetite for quick implementation with Gold Command approval should the Health Board find itself in exceptional circumstances in the future. This will support improved governance during exceptional situations.

This Risk Appetite Framework stresses the importance for staff to embrace appropriate and informed risk exposure that aligns with the Health Board`s risk tolerance, risk capacity and risk capability.

Risk Management training and learning from risks events:

- The focus in 2021/22 will be on developing staff capacity and capability in risk management as potential benefits will include improved outcomes for our patients, and greater efficiency of our core processes. The Health Board has embarked on a drive known as `Operation 1000 staff` which will see over 1000 staff across its services receive risk management training that is appropriate to their roles and responsibilities.
- This refreshed strategy recognises that learning from the experience from the past 12 months (including the pandemic and a bomb threat) and also the benefits of learning from risks is important in continuously improving outcomes for our patients and the wider population of North Wales.

Focus on horizontal collaboration in managing Pan-BCU Risks, risk aggregation and joined-escalation:

- This updated strategy stresses the importance of horizontal collaboration in jointly identifying, assessing, reducing and managing shared risks or Pan-BCU risks. There is greater emphasis for Services, Departments, Divisions and Area Teams which share similar risks to frequently talk to each other through joined-up risk assessment meetings and work together in collaboratively reducing and managing risks and in considering risk aggregation and joined-escalation.
- As part of the focus on collaborative risk management, this updated strategy discourages silo risk management and strongly challenges the same services located across the three Sites (East, Central and West) to start considering and holding joined cross-site risk meetings to facilitate peer learning and better triangulation of risk-based intelligence in delivering greater outcomes to our patients. There are plans in the weeks ahead to run a pilot cross-site, by organising joined risk meetings for Ophthalmology, Emergency Departments (EDs) and Endoscopy so they can discuss their risks, generate shared learning and consider risk aggregation and joined risk escalation where there is added value for doing so.

Clarification of the risk escalation and de-escalation process:

- The updated strategy has streamlined, simplified and clarified the Health Board`s risk escalation and de-escalation process. It also emphasises the Health Board`s commitment to ensuring appropriate risk scrutiny and oversight within an open and transparent culture which is underpinned by Good Governance. The updated strategy states that risks are to be escalated in a dynamic and timely way and in real time via any of the followings standard approaches:-
  - ✓ The Governance route: through appropriate governance or Quality and Safety meetings.
  - ✓ Expedited escalation route through management.

Opsiynau a ystyriwyd / Options considered

No other options have been considered in terms of the requirement to update the Health Board`s Risk Management Strategy and Policy.

Goblygiadau Ariannol / 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.

Dadansoddiad Risk / Risk Analysis

An associated risk **(Potential inability to fully and timely implement the updated Risk Management Strategy - ID 3932)** has been identified, assessed and added onto the system and is being progressed to go `live`.
Risk currently scores `12` and has identified the following controls which are in place:

1. Regular monitoring of progress with implementation of the updated Strategy and Annual Risk Management Improvement Plan.
2. Risk Management Training Programme in place and being delivered using various platforms and technologies.
3. Prioritisation of core aspects of the updated Strategy and Annual Risk Management Improvement Plan.

The following actions will be implemented to enable us to achieve the target risk score for this risk:-

1. Re-evaluation of the timescales for delivering the updated Strategy and Annual Risk Management Improvement Plan.
2. Consider the roll out of more forms of risk management training formats (e.g. eLearning, Video etc.).
3. Secure and deliver more training days and publicise these across the Health Board on the intranet.
4. Continue to populate the training and encourage staff to attend at a time suitable to them.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Updating the strategy complies with one of its stated expectation of an annual update and review.

Asesiad Effaith / Impact Assessment

Due regard of any potential equality/quality and data governance issues have been factored into the updated Risk Management Strategy and Policy as part of the Equality Impact Assessment. This includes making the strategy available in other languages and formats.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version 7 & 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:	10th June 2021								
Date activated (live):	1st August 2021								
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)								
Date of next review:	July 2022								
Date EqIA completed:	Refreshed May 2021 (Original 2016)								
First operational:	1st October 2020								
Previously reviewed:	Dec 2015	Mar 2016	July 2016	July 2017	July 2018	Dec 2018	July 2018	Dec 2019	Apr 2021
Changes made yes/no:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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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 a dynamic, agile, proactive, integrated, Enterprise-wide strategic approach that is wrapped around the Principles of Good Governance. This emphasises the appropriate and timely management of risks in fostering the achievement of BCU`s objectives as defined in its Annual Operational Plan 2021-22. This Vision Statement sets out the Health Board`s strategic vision and ambition for risk management for 2021-22 and 2022-23 and underscores appropriate risk governance including the timely and dynamic escalation/de-escalation of risks. BCU will explore value-based, bottom-up, top-down and outcome-focused approaches in integrating risk management in better decision-making, priority/objective setting and in driving continuous improvements in patient care and safety.** **First Year – 2021/22: Training and capacity building in risk management (Operation 1000 staff); transition onto the new Datix platform i.e. Enterprise Risk Manager (dependent on WG) and system optimisation (i.e. migrate all actions from the Risk Management onto the Action Module by 31/03/2022). To pilot cross-site risk meetings in order to foster peer learning, joined/collaborative risk management and escalation and to continue to strengthen learning from risks.** **Second Year – 2022/23: The focus in 2022/23 will be on encouraging Services, Areas, Sites etc. to improve their governance footprint, learning from risks, rollout results of pilot and continue to refine cross-site risk meetings for similar services and delivery of further risk management training. The above objectives will be measured through the implementation of the Health Board`s Annual Health check and/or snapshot Audits.**

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. • It will focus on continuous staff training and capacity building in risk management.	• Enhance organisational and system 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 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 business activities as the effective management of risks is an inherent part of its approach to continuous learning, improvement and Good Governance. The Health Board is committed to implementing and embedding a robust risk management framework that supports the timely and dynamic identification, assessment, mitigation and management of both clinical and non-clinical risks to the achievements of its operational and strategic objectives. Staff are encouraged to integrate risk management into key business/service planning, objective/priority setting, and better decision-making as well as in effectively managing risks in real time and in a dynamic way. BCU`s approach to risk management seeks to enhance strategic planning and prioritisation and strengthens its agility, capacity and capability to respond to emerging challenges and threats.

BCU`s Risk Management Strategy and Policy will draw inspiration 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 underscores the fact that risk management is everyone`s responsibility, a tool for improving productivity, ensuring business continuity and sustainability and achieving robust organisational planning and performance reporting. It identifies staff training and senior leadership engagement, clarity of roles and responsibilities, consistency, regular monitoring and review of risks including Good Governance, scrutiny, oversight and assurance as key drivers for embedding a positive risk-aware culture 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 as articulated in its Annual Operational Plan 2021-22.

BCU`s approach to risk management will focus on developing local capacity and capability in risk management by delivering staff-focused risk management training within the context of `Operation 1000 staff` which will see at least 1000 staff trained in risk management in 2021/22. The Health Board will adopt an enterprise-wide approach to risk management by discouraging silo thinking and seeking to encourage a more joined-up, collaborative, system thinking and shared approach to risk management as a risk in one part of the organisation, if realised, could affect another part of the business. Training in risk management will enable staff to better integrate risk management into how they lead, organise, plan and deliver the Health Board`s core 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.

3. Definition of key concepts

This Risk Management Strategy and Policy is underpinned and informed by the following definitions: -

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. It is also an integrated and co-ordinated approach to mitigating and managing all risks faced by BCU.

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”. The principles of risk management are; - proportionate, aligned, comprehensive, embedded and dynamic.

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 (probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).

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. Risk assessment techniques include questionnaires and checklists, Workshops and brain storming sessions, and inspections and audits.

Assurance: This is a process to provide evidence that the controls in place are effective and working and that the Health Board is doing its best to appropriately reduce and manage risks to the achievement of its operational and strategic objectives. Levels of Assurance:

1. The first level of assurance comes from the department that performs the day to day activity, for example the data is available
2. The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
3. The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, and HSE etc.

Controls: These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. Impact could range from negative to positive. Some types of controls used in **reducing** risks include preventive, corrective, detective and directive controls.

Risk Mitigation: This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).

Actions: Actions are steps which the Health Board is 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 target risk score and thus reduce the risk to a tolerable and/or minimal level or even eliminate it altogether.

Distinguishing between a risk and an issue
A **risk** is an event that might occur and that could have an effect (usually negative) upon the organisation and/or its stakeholders. A risk is characterised by uncertainty.
An **issue** is something that has already happened or will definitely happen. An issue is a certainty.
e.g. If we are short staffed now or lack money to deliver a service, the shortage of staff or lack of money are issues (as these are already happening) and the risk will be the implications of staff shortage or the lack of money to the successful delivery of our operational and strategic objectives. The uncertainties these may cause is what will constitute the risks in both cases.

4. Objectives

The main objectives of this strategy and policy are:

- To provide an overarching framework including a clearly defined structure, consistency and standardisation and governance arrangements, roles and responsibilities for the effective risk management of both operational and strategic risks.
- To enable staff to understand our risk environment and to use the Health Board`s risk appetite framework 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 including learning and fostering a blame-free and open culture.
- 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. 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 such risks are appropriately identified, assessed, captured, reduced 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, processes and governance arrangements for risk management. It underscores the principles, 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 including contractors and staff etc.

6. The Board's Appetite for Risk

Risk appetite is defined as the amount and level of risk an organisation is willing to tolerate or accept 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 and its level of risk maturity.

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 Health Board`s Risk Appetite Framework aligns with its proactive, inclusive and enterprise-wide approach to risk management as well as its commitment to actively reduce, control and manage risks which could compromise the achievement of its objectives and priority areas. It is a live document, which will be regularly reviewed and monitored to ensure that any changes to the Health Board's strategy, objectives or capacity to manage risk is properly reflected. 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 the decision to hold a risk outside the Health Board`s Risk Appetite Framework will need to be ratified by the Board. The Health Board`s Risk Appetite Framework stresses the importance for staff to embrace appropriate and informed risk exposure that is aligned with the Health Board`s risk tolerance, risk capacity and capability.

As outlined in appendix `A`, the Health Board`s updated Risk Appetite Framework for 2021/22 is split into three sections i.e. the one currently in use; the one being proposed for 2021/22 and then one for use in exceptional circumstances. The proposed section in the Risk Appetite Framework for 2021/22 takes into consideration the current circumstances and the Health Board's requirement to recover from the Covid-19 pandemic, thus recognising the harm that could be caused to patients by long waiting lists for treatment. It recognises that the use of risk-based approaches such as risk stratification in prioritising and allocating resources could be key determinants in enabling the Health Board to better tackle post-Covid-19 challenges and threats more efficiently and effectively. The section in the updated Risk Appetite Framework for use in exceptional circumstances also supports quick implementation with Gold Command approval should the Health Board find itself in exceptional circumstances in the future. This will also support improved governance during emergency situations. The Health Board`s Risk Appetite Framework will be widely communicated through mechanisms like trainings, drop-in sessions, Q&S/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. BCU`S risk management process also

aligns with the process outlined in The Orange Book: Risk Management – Principles and Concepts (2020) which includes risk identification and assessment, risk treatment, risk monitoring and reporting. These emphasise the need to identify, assess, review, monitor and effectively reduce and manage risks to enable the achievement of organisational objectives. 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.** BCU`s risk management process comprises five interrelated and complementary steps as outlined in the diagram below.

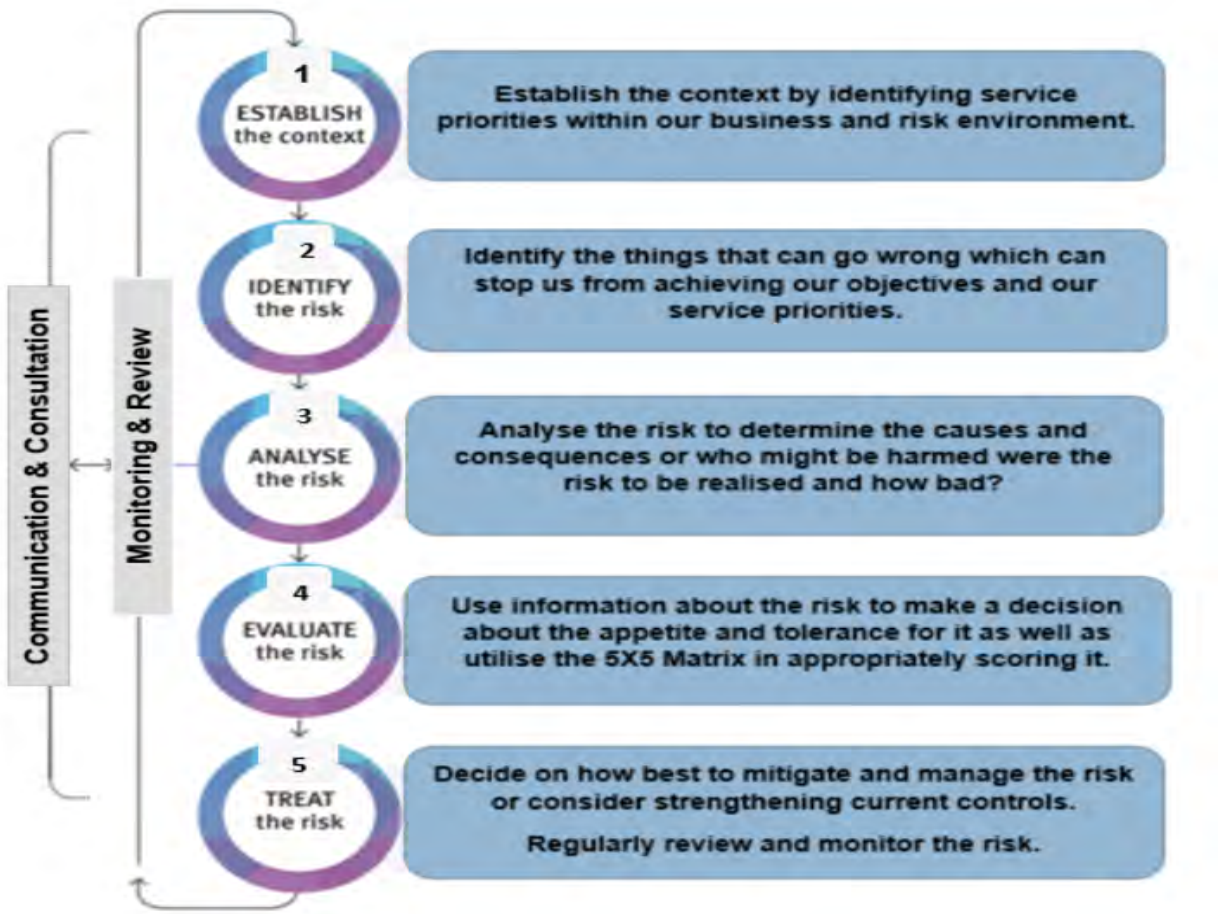

Figure 1 - BCU`s Risk Management Process.

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 in order to clearly identify risks which may negatively impact on their achievement.

Step 2: Risk Identification

The focus here is to identify the risk or what could 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 transformation etc. Staff should adhere to the Health Board`s structured approach for describing risks also

referred to `Cause and Effect Analysis` or the `Bow-Tie` model. This model clearly identifies the cause, the event and the effect.
It is helpful to frame the description of a risk in three parts by starting with these phrases:

- 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 …

Risk description must be clear and concise with appropriate use of language e.g.

> "There is a risk that patients may not be discharged promptly from the Community Hospital.
> This may be caused by medications not being dispensed in a timely manner due to delays from pharmacy. This could lead to stress and anxiety, poor patient experience, delayed flow and reduced bed capacity."

Step 3: Risk Analysis
Determine the cause and effect and analyse what could 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 if the risk were to be realised (likelihood). The NPSA consequence and likelihood descriptors are a useful guide and the 5 x 5 grading matrix in assessing and scoring the risk. You can access the 5 X 5 Matrix by clicking on the link to the Guidance for Adding a new risk below and checking on pages 14 – 16. http://howis.wales.nhs.uk/sitesplus/861/page/71616

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 reduce 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 decide on how best to manage it.

Risk Review and Monitoring
Risk management is a dynamic and iterative process; hence, risk owners/leads will need to periodically review, re-assess and monitor their risks in line with the following timescales:-

- Risks scored 15 and above should be reviewed at least monthly
- Risks scored 9-12 should be reviewed at least bi-monthly
- Risks scored 1-8 should be reviewed at least quarterly.

NB: Please note that the above is just a guide and does not replace the timely, agile, dynamic and effective review and management of risks in real time.

8. Three Tier Risk Management Model

The Health Board utilises a three Tier risk management model, which specifies that risks on risk registers across the Health Board as held on Datix will be categorised and managed in line with the 3 tier model as depicted in **Figure 2** below.

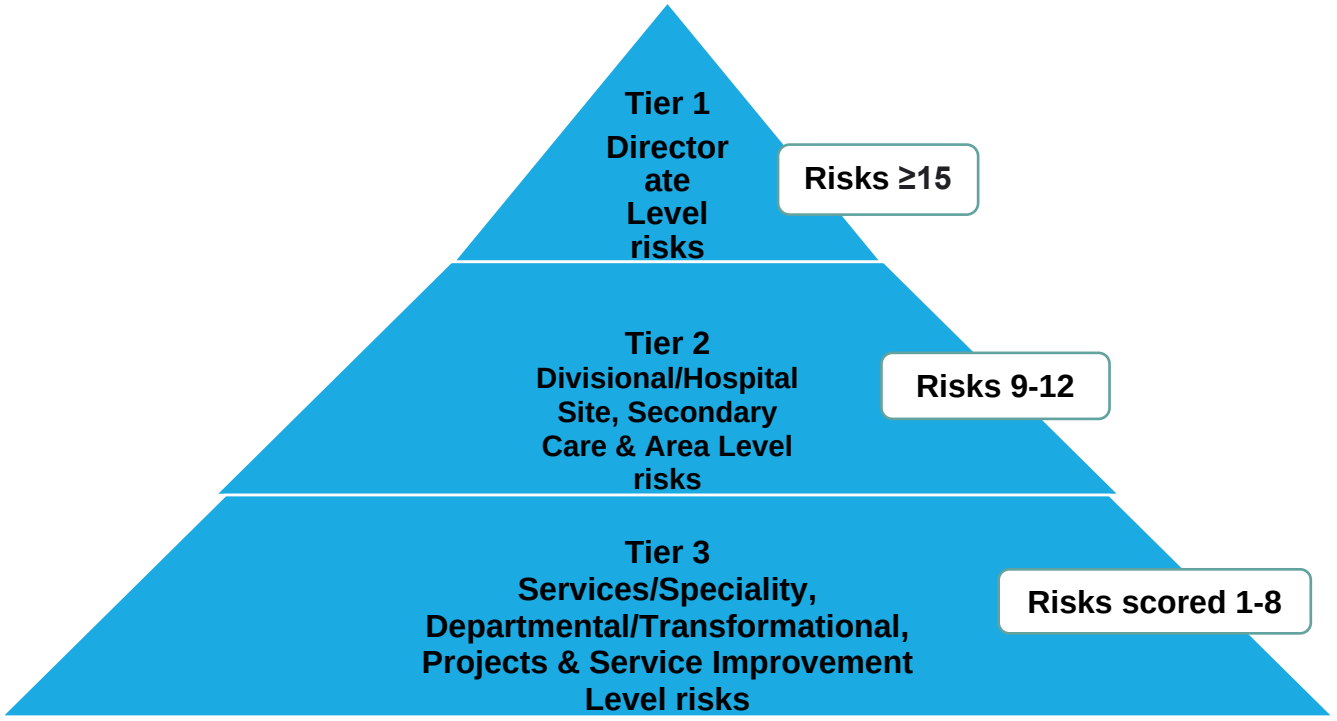

Figure 2 – Risk Management Tiers and oversight.

*__All risks must be managed in line with the three-tier risk management model. Hence,__

- Risks scored 1-8 must be managed at tier 3, will have the lowest potential to disrupt business operations or commissioning arrangements.
- Those scored at 9-12 after escalation and approval will be managed at tier 2, Divisional, Hospital Site, Secondary and Area Levels.
- Those scored 15 and above will need to be managed at tier 1 after the escalation process has been completed and the risk has been approved by a relevant committee. Tier 1 risks will have the greatest potential to negatively impact on or disrupt business operations/activities;

It is important to note that placing risks into tiers is for the purpose of governance and oversight. The responsibility for mitigating and managing risks on a daily basis resides with services or departments that escalated the risk. Effective risk management is built on empowering staff to own, manage and lead on their risks while translating any benefits into tangible patient-centred outcomes and positive patient experience.

All new risks added onto Datix must be held on Tier 3 under the status `Being Developed`. The status will only be changed to `Under Review` which alongside the status `Awaiting decision to close` denote our `live` risk register once the risk has been:-

- Appropriately completed and reviewed by the relevant manager and deemed satisfactory.
- Presented at the relevant Quality and Safety meeting and scrutinised in terms of its title, description, controls, further action and scores. However, in the case where there is an intention to escalate the risk, then it must be held under the status `Being Developed` until the outcome of the escalation is known and its status then changed accordingly.

- It is best practice to hold a governance footprint of a risk as it goes through its escalation process, ensuring that key decisions made in the process are adequately captured within the Datix system.

8.1 Corporate Risk Register (CRR)

The score of a risk is the main determinant for its escalation, hence,

- Risks scored ≥15 when approved as outlined above, recommended by the Executive Director, RMG, Executive Team (ET), and approved by the relevant Board Committee will be placed on Tier 1 and the CRR.

However, in exceptional circumstances, a risk which is linked to the development and delivery of the Health Board`s Annual Operational Plans and/or the achievement of one of its key deliverables/operational objectives may be escalated for consideration, approval and inclusion onto the CRR irrespective of its score. In some instances, risks may be de-escalated from the BAF for continuous management through the CRR. The CRR are Directorate level risks that encompass all significant/high level operational risks and in rare cases, those linked to the Annual Operational Plan or de-escalated from the BAF.

It is the responsibility of every risk owner; senior manager and Executive Director who owns risks on the CRR to ensure that updates/feedback from committees and the Board are captured on their related CRR risk on Datix.

8.2 Divisional, Secondary Care, Hospital Site Risk and Area Level Risks (Tier 2)

Divisional, Secondary Care, Area Teams and Hospital Directors are expected to ensure that there are appropriate processes, systems and governance arrangements in place to regularly review, scrutinise and effectively manage all tier 2 risks within their Areas, Divisions, Hospital Sites and Secondary Care. They will be required to periodically present their Divisional risk register reports and any assurance thereof at the Risk Management Group (RMG). The Cycle of Business for the Division, Hospital Site, Area and Secondary Care Q&S and Governance meetings should reflect how the Services and Departments under their remit periodically report their risks to them.

8.3 Service/Departmental, Transformational and Service Improvement Risk Management (Tier 3)

These are risks, which score 1-8 and should be regularly reviewed, scrutinised, approved, reduced and managed at the Service or Departmental levels while those which score above 8 should be escalated in accordance with guidance and the approval of either the relevant Q&S meeting and/or the triumvirate. No risks which score above 8 should be held on the `live` risk register at Tier 3. However, risks which score more than 8 which are being escalated will need to be held at Tier 3 under the status of `Being Developed` and can only be moved onto the `live` risk register after they have successfully gone through the entire escalation process. Tier 3 is therefore the entry point of all risks onto risk registers and Datix.

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:

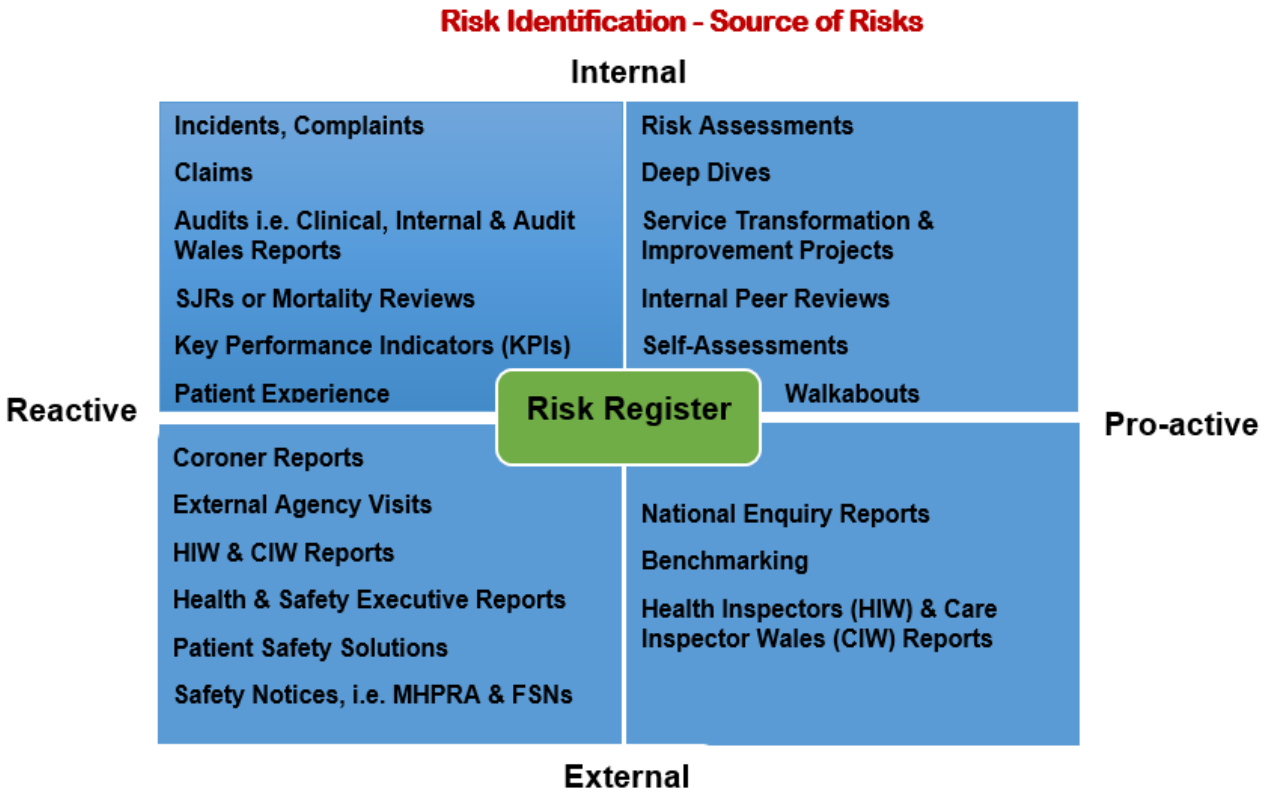

Figure 3 - Shows some examples of different source of risks.

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.

ERM will provide a comprehensive approach to identifying, assessing, mitigating and managing risks to the delivery of high quality patient-centred outcomes or the achievements of the Health Board`s objectives in line with its Risk Appetite Framework. ERM enables more joined-up, system thinking, enterprise-wide, collaborative and organisational-wide approach to effective risk reduction and management as opposed to silo risk management. It will provide a platform for the Health Board to establish a clear view and understanding of its overall risk capacity while nurturing and embedding a positive risk-aware culture.

The following figure depicts BCU`s Enterprise risk management framework.

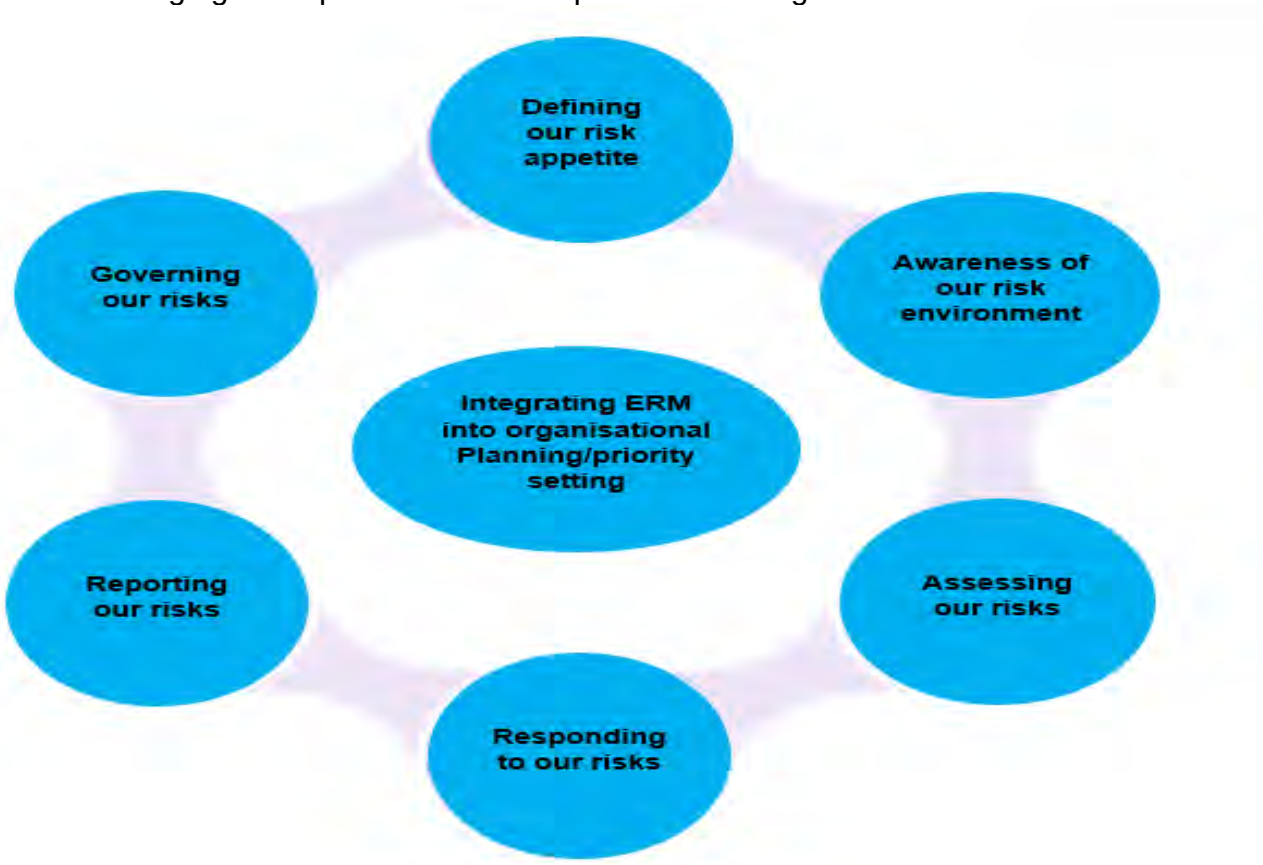

Figure 4 - BCU`s Enterprise Risk Management Framework

11. Optimising 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 which staff are expected to adhere to. There are two ways through which risks can be identified, assessed and escalated i.e.-

i. A standard approach via regular governance and Q&S meetings and/or Triumvirate.
ii. An organisational discovery approach from the Board, Committees, Executive Team delivery and operational groups as they may identify risks from performance, quality and safety-related reports and request they be timely assessed and referred to the Risk Management Group to incorporate within the standard risk management process.

Risks can crystallise quickly hence, there is need to ensure risk escalation/de-escalation including risk aggregation take place in a dynamic, agile and timely way through either route.

11.1 The standard approach to risk escalation

Each Service, Department, Area, Site, Division or Directorate etc. within the Health Board is

expected to maintain a risk register on Datix and a local risk management procedural document which defines how risks are identified, assessed and managed within their unit. Services, frontline staff, their local governance meetings and triumvirate constitute the bedrock of BCU`s risk management arrangements. Datix is the sole repository for capturing risks which have been identified, assessed and added onto local risk registers that are being managed by the local Service, Department, Division, Area Team etc. Staff should not hold risks on paper-based systems or spreadsheets.

High level operational risks identified, assessed and added onto Datix by services and directorates should be escalated speedily via appropriate governance routes for consideration and approval so that such risks could be held at the right Tier and assigned the right profile, handler, manager and resources. There are two pathways for escalating or de-escalating risks:

- **Governance route**: through appropriate governance or Quality and Safety meetings.
- **Expedited escalation route**: Through the Service, Area and Directorate Triumvirate to the Divisional and/or Secondary Care SMT, the relevant Executive Director, RMG or its Chair`s action to the ET and then, to the appropriate Committee for approval.

However, there may be instances when escalation of risks can`t be implemented via the normal governance route because there is no meeting imminent. In such a situation, and in order to ensure that risk escalation is timely, agile and dynamic, escalation should be pursued via the expedited escalation route as described above. Escalation provides an opportunity for appropriate risk oversight and scrutiny and for raising the profile and visibility of the risk as well as requesting for support and resources. There must be sufficient clarity around the expectation from and rationale for escalating a risk. The next table shows BCU`s escalation and risk governance arrangements.

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 (CRR) **Directorate Level risks**	15-25	High to Very High	Executive Directors will lead on risks scored 15 and above, escalated and approved for inclusion onto the CRR although responsibility for managing and mitigating such risks on a daily basis will reside with original risk owners. **Reviewed monthly**	Board/ Committee	Appropriate Committee with the assigned risks on the CRR. Once reviewed, the Risk Management Group will have oversight of the entire CRR prior to authorisation by the Executive Team for Board or Committee approval

Figure 5a -The Health Board`s escalation and 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 2 **Divisional, Hospital Site, Secondary Care & Area Level risks**	9-12	Moderate	Managed at Divisional/Hospital Site, Secondary Care & Area level and led on by Directors with local ownership and input. **Reviewed bi-monthly**	Appropriate Divisional Governance meeting or Divisional Risk Meeting	Risks with a current score 9-12 will be managed under the leadership of a Director. Risks scoring above 12 are escalated to the Executive Team for consideration and approval as Tier 1 risks *CRR.
Tier 3 **Services, Specialities, Departmental, Transformational, Projects & Service Improvement Level risks**	4-8	Low to Very Low	Managed at local level Service, Speciality, Area/Directorate or Department including risks related to transformational, projects and Service Improvement. **Reviewed quarterly**	Service, Speciality, Area / Directorate or Department or relevant Group meeting or local governance meeting.	Risks with current score 1-8 are managed at local level with oversight from relevant local governance meetings. Those which score >8 will be escalated to the Divisional or Site governance meeting for consideration and escalation.
	1-3	Very Low			Risks escalated are still locally owned and managed.

Please note: This is a Continuation of Figure 5a above.

*The above timescales for reviewing risks are a minimum requirement and do not replace the dynamic, agile and timely review, mitigation, management and escalation of risks in real time.

11.2. From Silo to shared risk management and governance

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 not necessarily be part of the service in which the risk has been identified. For example, a service may identify a risk, which requires inputs from Informatics, Estates and Facilities, Safeguarding, Health & Safety etc. to effectively manage it. In such a situation, Services etc. should ensure that all key stakeholders who can contribute to the effective management of risks are involved in the discussions on how best to reduce and manage the risks. In other instances, such stakeholders like the Local Authority may be external; hence, there is need for shared agreement and clarity on roles and responsibilities in appropriately reducing and managing such risks.

11.3 Management of Pan-BCU Risks:

There are two types of Pan-BCU risks i.e. those that are owned by Pan-BCU Services like North Wales Managed Clinical Services (NWMCS) and those, which span-across more than one site i.e. East, Central and West. Whilst Pan-BCU risks like those owned by NWMCS will be reviewed and scrutinised by their governance arrangements, those, which span-across more than one Site should be managed collaboratively through joined risk meetings. It is thus important to establish cross-site meetings to bring together the same services that operate on the three regions around the table to discuss their risks, generate shared learning, agree on roles/responsibilities and how best to reduce and manage such risks or to consider risk aggregation and joined escalation. The aim here is to avoid the risk of silo management and escalation of risks and to create a platform for colleagues to start having meaningful risk-based conversations as the crystallisation of a risk in one service e.g. ED in the Central could impact on ED in the West or East and vice versa.

11.4. Appropriate Risk Reporting

Services, Departments and Divisions etc. should ensure that they regularly receive, review and scrutinise their risk registers at their governance or Q&S meetings. Risk registers should comprise of clear, high quality information on the controls and further actions in place, sources of assurance and reference where possible etc. High quality risk register reports that are reviewed and discussed at governance meetings constitute a good source of assurance. The Cycles of Business for governance meetings at Divisional, Hospital Site, Secondary Care and Area Levels should include assurance and oversight of risk management arrangements for Services and Departments within their remit. This should include presentation of risk registers for review and scrutiny of risks. Agendas and minutes from governance meetings should demonstrate governance footprint of risks that were reviewed and discussed as well as decisions, which were made.

12. 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 have been identified, assessed and are properly managed in line with best practice. It is thus a robust tool, which the Board uses to reinforce strategic focus and better management of risks and in gaining assurance. The BAF also provides a structured framework for identifying and mapping the main sources of assurance across the Health Board and co-ordinating them to best effect. It thus provides a structure and process through which the Health Board can focus on those principal risks which could compromise the achievement of its strategic objectives as defined in its Clinical Strategy and Annual Operational Plan.

The Health Board`s BAF and CRR are symbiotically linked; inform, shape and feed-off each other as both toolkits are regularly updated, received and scrutinised by relevant committees and the Board as per their cycles of business. The BAF is thus the main tool that the Board uses in discharging its key responsibility of internal controls and gaining assurance that principal risks are managed in accordance with this Risk Management Strategy and Policy.

The next flowchart shows BCU`s escalation and de-escalation process:

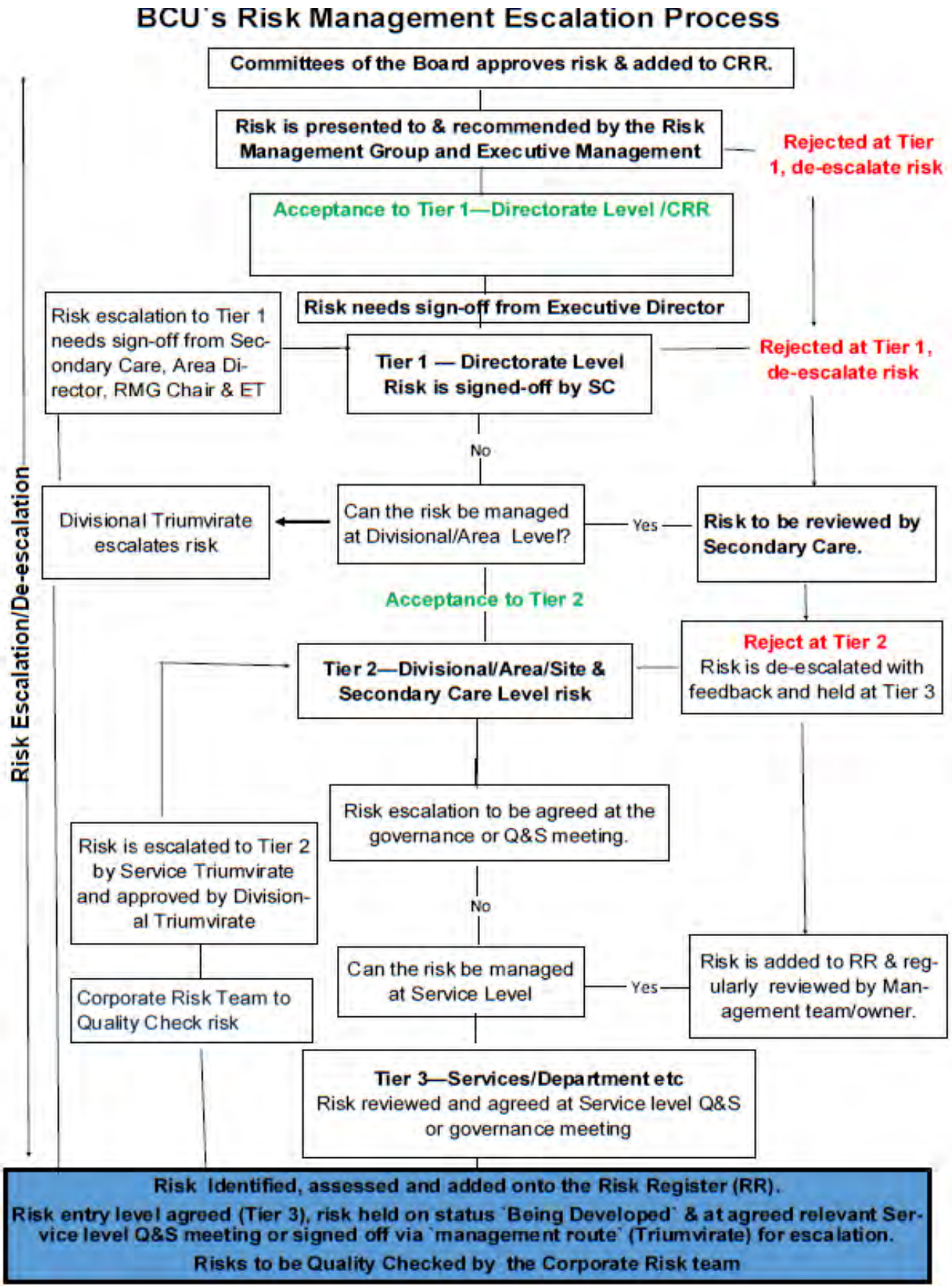

Figure 6 **- Escalation/De-escalation route**

13. Individual 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: -

13.1 Chief Executive or Accountable officer

The Chief Executive has delegated responsibility from the Board to ensure that the Health Board has a robust risk management architecture; systems and processes in place to foster the effective mitigation and management of risks. 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. The Chief Executive 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.

13.2 Deputy Chief Executive

The Deputy Chief Executive has been delegated responsibility from the Chief Executive to operationally deliver the Risk Management Strategy, 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 Interim Director Of Governance and/or Assistant Director of Information Governance and Risk and the Head of Risk Management.

13.3 Board Secretary

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).

13.4 Executive Directors

Executive Directors have overall responsibility for the operational management of risks within their directorates and are the named senior responsible officer for individual risks on the Corporate Risk Register. They are also responsible for the effective allocation of resources to timely reduce risks within their remit, while ensuring prompt escalation and de-escalation of

risks where appropriate. They shall also be responsible for ensuring that Senior Managers under their portfolio have effective risk management systems and processes in place in their Directorates, Areas, Hospital Sites, and Divisions to demonstrate robust identification, assessment, mitigation and management of all risks. They are responsible for ensuring that best practice in risk management and a positive risk-aware culture are fully embedded in their portfolio.

13.5 Independent Members (IMs)
Independent Members have an important role in risk management in seeking assurance on the robustness of processes and the effectiveness of controls through constructive, robust, positive and effective challenge to the Executive Directors and senior management. The role of Independent Members is not to manage individual risks but to understand and question risk on an informed and ongoing basis. IMs are expected to satisfy themselves that the Health Board`s risk management arrangements are effective, efficient and fit-for-purpose.

In addition, IMs chair Board Committees and in line with the relevant committee's terms of reference, should gain and provide assurance to the Board that risks within its remit are being managed effectively by the risk owners and report any areas of concern to the Board.

13.6 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. They are responsible in ensuring that significant clinical risks identified and assessed in their portfolios are brought to their attention in a timely manner and, if approved, escalated promptly and properly managed.

13.7 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.

13.8 Senior Managers (including Directors)
Senior managers will take the lead on risk management within their divisions, sites and areas and set the example through visible and exemplary leadership. They are also responsible for the effective allocation of resources in managing, escalating and de-escalating operational and strategic risks within their remit.

13.9 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 reduce 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.

14. Committee and Group Roles & Responsibilities

14.1 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 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 UK Corporate Governance Code recommends that:

> 'the board should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the company is willing to take in order to achieve its long-term strategic objectives'.

The Code recognises that as risks can emerge and crystallise rapidly, the risk management architecture in place should facilitate the timely, dynamic and agile escalation of principal risks to the attention of the Board in real time.

The Financial Reporting Council (2014) Guidance on Risk Management and Internal Controls states that, the board has ultimate responsibility for ensuring that appropriate risk management processes, systems, internal control, and risk-aware culture are embedded throughout the organisation. Hence, 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 and 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 work plans of those committees.

14.2. Committees

The key responsibility of committees here are to-

- Provide scrutiny, oversight, approve and recommend risks for inclusion on the CRR.
- Approve new risks for escalation and inclusion onto the CRR and/or approve existing ones for de-escalation from the CRR once they have been appropriately reduced and managed to lower scores.

- 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.
- Committees may through `horizon scanning` and a `top down approach` recommend that potential risks/threats from related reports e.g. Quality or Performance Reports be identified, assessed and captured on the risk register by the relevant Services or Divisions and escalated if applicable.
- Committees to note completion of actions as evidence for proposed changes in scoring.
- Committees should not be involved in the operational management of risks but should satisfy themselves that the Services and Divisions under their remit have robust risk management arrangements in place. They should also provide scrutiny and oversight, constructive challenge, gain assurance and hold Executive Directors to account for the effective management of risks under their portfolios.

Risks on the CRR are aligned to Committees for regularly review and scrutiny prior to the Board receiving 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)

14.3 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 mitigating and 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 Health Board`s objectives as defined in its Annual Operational Plan could be appropriately reduced and managed. 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.

14.4 The Executive Team (ET):

The ET fulfil the following responsibilities:

- Receive, review and scrutinise the CRR and recommend any new risks that are being escalated to the attention of the relevant committee.
- Identify risks from other reports and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.
- Gain assurance from the RMG that the CRR and BAF are robust, effective and fit for purpose.

14.5 The Risk Management Group

The Risk Management Group will maintain oversight of the risk management system and overall governance and reporting arrangements ensuring that they are 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 1) and providing scrutiny and oversight of the full Corporate Risk Register prior to review by the ET. As part of the Health Board governance arrangements, the Risk Management Group will report to the ET. The RMG will also perform the following functions:

- Review and scrutinise Divisional risk register reports including new risks for escalation and either recommend them to the ET or decline and provide feedback on changes that need to be made to strengthen the risk assessment prior to re-escalation if applicable.
- Challenge risks that are being presented for consideration and escalation.
- On behalf of the ET, the RMG will receive, review and scrutinise the CRR with focus on the risk entries, controls in place, new actions that have been added and old ones that have been completed, risk score etc. and make recommendations to the RMG.
- On behalf of the ET, the RMG will sign-off completed actions that were implemented to support in mitigating and managing risks to attain their target risk score (recognising that these will still need to be reported to Committees for evidence to support any proposed changes in score), before they can be archived from future reports.
- Identify risks from other reports and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.
- Review and scrutinise risk management performance reports, audits, the updated Risk Management Strategy and its associated procedural documents as well as any other risk management related reports and advise accordingly.
- On behalf of the ET regularly review, challenge and scrutinise the Health Board`s risk management architecture, monitor its Risk Management Annual Improvement Plan and provide assurance to the ET.

14.6 Divisional/Hospital Site/Area/Secondary Care etc. Risk Management Arrangements or Q&S Meeting

All Divisions/Hospital Sites/Area/Secondary Care etc. must have the necessary arrangements in place for good governance, quality, safety and effective risk management. Divisional Q&S or governance meetings are responsible for ensuring that there are effective systems and process in place across Services and Departments under their remit to ensure robust risk management and provide assurance that these are operating effectively. Q&S or governance must create the enabling environment for bottom-up risk reporting with Services and Departments under their remits routinely providing their risk register reports for review, scrutiny, assurance and oversight.

15. Risk Management Training

The Corporate Risk Team is committed to developing organisational capacity and capability in risk management as a driver for improving risk awareness, developing risk management skills in the local workforce and embedding best practice in risk management. Bespoke risk management training resources have been developed and tailored to suit staff in various roles and responsibilities. The Corporate Risk Team has launched an initiative to train 1000 staff across the Health Board in risk management for 2021/22, with various training slots advertised on the intranet and staff informed and encouraged to book. The plan is for all staff (including Board Members) in the next few years to receive training and/or refresher in risk management that is appropriate to their roles and responsibilities.

16. 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.

17. Performance Measurement and Monitoring of Risk Management Culture

The Health Board will undertake regular Risk Management Self-assessments, annual internal audits, Snapshot Audits and/or an annual health check of its risk management culture using key performance indicators (KPIs) in measuring the effectiveness of risk management arrangements across its services. These will explore a sample of 20 risks randomly selected from each Directorate risk registers and 10 from the Corporate Risk Register in measuring the following KPIs.

17.1 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 which are in date and/or out of date;
- % of actions linked to Directorate risks which are out of date.

17.2 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: - e.g.

- % of risks with all key dates completed;

17.3 Data Quality: This measure will focus on evaluating the accuracy of risk entries e.g. risk description, controls, actions and titles. It will consider: -

- % of risks with titles focusing on the risks and not issues.
- % of risks with appropriate descriptions

17.4 Risk Management Training: This metric will measure the number of staff who have attended the Health Board`s ongoing risk management trainings i.e. `Operation 1000 Staff`.

- % of staff who have attended the Health Board`s risk management trainings.

17.5 Appropriate risk escalation: This measure will seek to randomly identify some risks, which were escalated onto tiers 2 and 1 to ascertain if they were escalated in line with this Risk Management Strategy and Policy.

- % of risks escalated to tiers 2 and 1 that have governance footprint captured on agendas and minutes as defined by this Strategy.

18. Conclusion:

The use of ERM will thus provide a framework through staff across the Health Board to timely and proactively identify, assess, manage and reduce 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`.

19. 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.
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- 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
- HM Treasury (2020) The Orange Book: Risk Management – Principles and Concepts
- 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

20. Acronyms:

No	Acronyms	Meaning
1	WG	Welsh Government
2	HIW	Health Inspectorate Wales
3	HSE	Health & Safety Executive
4	SC	Secondary Care
5	ET	Executive Team
6	ED	Emergency Department
7	RMG	Risk Management Group
8	Q&S	Quality & Safety
9	IMs	Independent Members
10	CRR	Corporate Risk Register
11	BAF	Board Assurance Framework

12	RR	Risk Register
13	KPIs	Key Performance Indicators

Appendix A – BCU`s Risk Appetite Framework – May 2021

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*", Annual Operational Plan 2021/22.

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.

BCU`s Risk Appetite Framework

Risk Domains	Current Risk Appetite Framework 2020/21 Description of risk categories	Proposed Risk Appetite Framework 2021/22 Description of risk categories	Risk Appetite Framework during exceptional Circumstances e.g. Pandemic or loss of Acute Hospital Description of risk categories
Risk Appetite	**Category: Cautious (Low Score 1 - 6)**	**Risk Appetite Category: Cautious (Low Score 1 - 8)**	**Risk Appetite Category: Cautious (Low Score 1 - 8)**
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	BCUHB places the safety of its patients and staff at the heart of everything it does. It has a cautious risk appetite for patient and staff safety risks that could result in harm or discomfort to patients and staff which may arise from the delivery of its core business activities. BCUHB recognises that during exceptional circumstances and in line with full clinical risk stratification, it will be prepared to accept a slightly higher threshold for patient and staff safety risks such as falls, delay referral to treatment, limited access to some operations, cancellation of appointments, etc. BCUHB will however not accept risks associated with underperformance, unprofessional conduct, Never Events	BCUHB places the safety of its patients and staff at the heart of everything it does. It has a cautious risk appetite for patient and staff safety risks that could result in harm or discomfort to patients and staff which may arise from the delivery of its core business activities. BCUHB recognises that during exceptional circumstances and in line with full clinical risk stratification, it will be prepared to accept a slightly higher threshold for patient and staff safety risks such as falls, delay referral to treatment, limited access to some operations, cancellation of appointments, etc. BCUHB will however not accept risks associated with underperformance, unprofessional conduct, Never Events (as

	circumstances which may compromise the safety of any staff member or group.	(as these shouldn`t occur in the first place), taking shortcuts, bullying, or an individual's competence to perform tasks safely and/or any incidents or undue circumstances which may compromise the safety patients and/or any staff member or group.	these shouldn`t occur in the first place), taking shortcuts, bullying, or an individual's competence to perform tasks safely and/or any incidents or undue circumstances which may compromise the safety patients and/or 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.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB is committed to providing high quality healthcare services to patients and the entire population it serves with the view to delivering better outcomes and greater value for money that are informed by cutting-edge knowledge, best practice and professionalism. BCUHB has a moderate appetite for risks that could impact adversely on the quality of its healthcare services and patient-centred outcomes. It acknowledges that in exceptional circumstances, it will explore appropriate risk stratification and due diligence in deciding on the amount of risk associated with quality and patient outcomes it would be able to accept in pursuant of its operational and strategic objectives.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB is committed to providing high quality healthcare services to patients and the entire population it serves with the view to delivering better outcomes and greater value for money that are informed by cutting-edge knowledge, best practice and professionalism. BCUHB has a moderate appetite for risks that could impact adversely on the quality of its healthcare services and patient-centred outcomes. It acknowledges that in exceptional circumstances, it will explore appropriate risk stratification and due diligence in deciding on the amount of risk associated with quality and patient outcomes it would be able to accept in pursuant of its operational and strategic objectives.

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.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB places emphasis on promoting staff safety and well-being as it recognises that a healthy staff is key to driving high productivity and ensuring the achievement of its core business objectives. BCUHB realises that during exceptional circumstances, its staff could however be stretched and put under enormous pressure as they support the delivery of its core operational and strategic objectives. It recognises that in pursue of its core objectives, it will have a moderate risk appetite for risks associated with Workforce and OD. This acceptance will be based on the understanding that such risks will be timely identified, assessed and appropriately reduced and managed.	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB places emphasis on promoting staff safety and well-being as it recognises that a healthy staff is key to driving high productivity and ensuring the achievement of its core business objectives. BCUHB realises that during exceptional circumstances, its staff could however be stretched and put under enormous pressure as they support the delivery of its core operational and strategic objectives. It recognises that in pursue of its core objectives, it will have a moderate risk appetite for risks associated with Workforce and OD. This acceptance will be based on the understanding that such risks will be timely identified, assessed and appropriately reduced and managed.

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 (Score 9 – 12)** BCUHB will have a moderate risk appetite for risks associated with regulation and compliance as it recognises that the regulatory and compliance landscape will be challenging and daunting during exceptional circumstances.	**Risk Appetite Category: Moderate (Score 9 – 12)** In order to foster a culture of high quality safe care across all its services, BCUHB is committed to ensuring compliance with regulatory, policy and legislative instruments and will greatly discourage and frown at non-compliance and/or staff taking shortcuts. BCUHB will have a moderate risk appetite for risks associated with regulation and compliance as it recognises that the regulatory and compliance landscape will be challenging and daunting during exceptional circumstances.
Risk Appetite	**Category: Moderate (Score 8 – 10)**	**Risk Appetite Category: Moderate (Score 8 – 10)**	**Risk Appetite Category: Moderate (Score 9 – 12)**
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	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	BCUHB is committed to maintaining high standards of conduct, ethics and professionalism at all times as underpinned by its Values and Behaviours. It recognises that the mitigation and management of risks associated with reputation and public confidence could be exacerbated during exceptional circumstances. It will have a moderate risk appetite for reputation and public confidence risks that

	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.	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.	can inhibit the achievement of its core business objectives. However, BCUHB won`t accept high risks associated with reputation and public confidence as these could lead to poor perception of its services and image, trigger adverse press and media coverage, reputational damage, financial penalties and loss of core business activities.
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	**Risk Appetite Category: Moderate (Score 9 – 12)** 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	**Risk Appetite Category: Moderate (Score 9 – 12)** BCUHB recognises that in order to deliver high quality personalised transformational health services to its patients and the wider population, it is helpful to tap into the immense benefits which can accrue from working in collaboration both vertically and/or horizontally within and outside its boundaries with key stakeholders, agencies and partners as well as across organisational and professional divide. However, it will have a moderate risk appetite for all risks associated with partnership working which could inhibit the achievement of its operational and strategic objectives. 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

	population health and the general wellbeing of local people through the implementation of "Living Healthier Staying Well".	Future Generations Act, which will support the Health Boards commitment to improving population health and the general wellbeing of local people through the implementation of "Living Healthier Staying Well".	the Well Being of Future Generations Act, as these will support BCUHB`s commitment to improving population health and the general wellbeing of its local population 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: Moderate (Score 9 – 12)** 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 15)** BCUHB acknowledges the exacerbating constraints and pressure during exceptional circumstances which could be exerted on its capacity and resources to effectively and efficiently reduce and manage finance risks to the delivery of its core business operations and objectives. It will therefore have an open risk appetite for risks associated with finance and will accept finance risks to the achievement of its core business objectives that are scored at 15. It won`t accept very high finance risks which could compromise the judicious, effective and efficient use of public funds placed at its disposal for the smooth delivery of its core business objectives.
Risk Appetite	**Category: Open (High Score 12 - 15)**	**Category: Open (High Score 12 - 15)**	**Risk Appetite Category: Open (High Score 15)**
Innovation &	The Health Board wishes to maximise opportunities for developing and growing our services by encouraging	The Health Board wishes to maximise opportunities for developing and growing our services by encouraging	BCUHB recognises that innovation and strategic change are critical drivers for the delivery of high quality patient-centred care

Strategic Change	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.	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.	and encourages staff to explore innovation, new technologies and cutting-edge approaches and models in delivering patient care. It will however, have an open risk appetite for innovation and strategic change risks and will accept related risks scored15 that are associated with innovation, research and development to enable better integration of care, development of new models of care and the use of technology to address changing demands.

This Statement will be regularly reviewed and modified so that any changes to BCUHB`s strategy, objectives, priority areas or our capacity to manage risk are properly reflected. It will be communicated throughout BCUHB in order to embed sound risk management and to ensure risks are properly identified and managed.

Appendix B: Guidance for completing the BAF Template

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary.
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk was to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high).
Risk Likelihood		The probability were this to happen if the risk was to be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently.
Score		Impact x Likelihood of the risk happening.
Appetite	Definition	Is defined as the amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options.
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities.

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored.
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Trained staff - Risk Assessment - Evidential data sets - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available.
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance.
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE and Internal/External Audits, etc.

Form 1: Preparation

Part A must be completed at the beginning of a Policy/function/strategy development or review, and for every such occurrence (to be completed with the aid of the Step-by-Step Guide.)

Step 1 - Preparation		
1.	**Title of Policy** - what are you equality impact assessing?	Updated Risk Management Strategy and Policy.
2.	**Policy Aims and Brief Description** - what are its aims - give a brief description of the Policy (The What, Why and How?)	The aims of the Risk Management Strategy and Policy within the BCUHB will be to: a) Create a culture that puts patient safety and that of everyone at the centre of everything we do; b) Create a fully 'risk aware' approach – where risk management is embraced and embedded within the organisation's culture including strategy design, priority and objective setting as well as integrated into the working practices at all levels across the organisation. c) Provide a framework including a clearly defined structure, consistency and standardisation in the effective management of strategic, operational and commissioning risks. d) Set out the organisational governance arrangements and responsibilities for risk management. e) 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. f) 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. g) 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. h) To underscore its importance in driving business sustainability and financial viability while underlining the fact that Risk Management is everyone's responsibility. Explicit reference to Equality and compliance Legislation within the Risk Management Objectives: c) To ensure that the BCUHB satisfies all statutory duties and undertakings and complies with all appropriate legislation (eg Health and Safety at Work Act 1999, Equality Act 2010);

Step 1 - Preparation		
3.	**Who Owns/Defines the Policy?** - who is responsible for the Policy/work?	Deputy Chief Executive and Executive Director of Nursing
4.	**Who is Involved in Undertaking this EqIA? -** who are the key contributors to the EqIA and what are their roles in the process?	Justine Parry - Assistant Director Information Governance and Risk David Tita – Head of Risk Management & Assurance
5.	**Other Policies** - Describe where this Policy/work fits in a wider context. Is it related to any other policies/activities that could be included in this EqIA?	The Health Board`s Annual Operational Plan for 2021/22 Single Equality and Human Rights Scheme Equality Impact Assessment Policy Health & Safety Policy
6.	**Stakeholders** – Who is involved with or affected by this Policy?	All staff, contractors, Trade Unions and stakeholders
7.	**What factors may contribute to the outcomes of the Policy? What factors may detract from the outcomes?** These could be internal or external factors.	Effective implementation of the Risk Management Strategy and Policy by all staff, contractors, Trade Unions and stakeholders (Clinical, business and Corporate Functions). Availability of training for staff across the Health Board. Another surge in Covid-19 may detract staff from timely implementing this Risk Management Strategy and Policy.

Form 2: Evidence Gathering

Equality Strand	Key Considerations	Responses
Race	Do you think that the policy impacts on people because of their race?	No
Disability	Do you think that the policy impacts on people because of their disability? (This includes visual impairment, hearing impairment, physical disability, learning disability, some mental health issues, HIV positive status, multiple sclerosis, cancer, diabetes and epilepsy.)	Yes, for example the Risk Management Strategy & Policy is not published in braille. However, support will be provided to those with disability in appropriately accessing the Risk Management Strategy and Policy as it is reasonably practicable.
Gender	Do you think that the policy impacts on people because of their gender?	No
Sexual Orientation	Do you think that the policy impacts on people because of their sexual orientation?	No
Age	Do you think that the policy impacts on people because of their age? (This includes children and young people up to 18 and older people.) Do you think that the policy impacts on people because of their caring responsibilities?	No No
Religion / Belief	Do you think that the policy impacts on people because of their religion or belief?	No

Welsh Language	Do you think that the policy impacts on people who can only read documents in Welsh?	Yes However, as this document is only published in English, appropriate measures will be put in place to support those who may want to access it in Welsh including signposting them to the Welsh language service of the Health Board.

People have a human right to: life; not to be tortured or treated in a degrading way; to be free from slavery or forced labour; to liberty; to a fair trial; not to be punished without legal authority; to respect for private and family life, home and correspondence; to freedom of thought, conscience and religion; to freedom of expression and of assembly; to marry and found a family and to not be discriminated against in relation to any of the rights contained in the European Convention.	
Human Rights	**Yes**

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15 July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Annual Plan 2021 to 2022: Shaped by a Three Year Transformation Plan 2021 to 2024
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mr Mark Wilkinson, Executive Director of Planning and Performance Mrs Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Mr John Darlington, Assistant Director - Corporate Planning Mr Rob Nolan, Finance Director – Commissioning and Strategic Financial Planning
Craffu blaenorol: **Prior Scrutiny:**	The plan has been discussed by the Planning workstream, Executive Team, Stakeholder Reference Group, Executive Management Group, Local Partnership Forum, Strategy Partnerships & Population Health and Finance & Performance Committees. This builds upon the draft plan which was approved by Board in March 2021
Atodiadau **Appendices:**	Appendix 1: Draft 2021/22 plan Appendix 2: Programme Action Plans Appendix 3: Executive Summary (*for use with partners / to inform communication etc*) Appendix 4 : Equality Impact Assessment Appendix 5 : Socio-economic Impact Assessment

Argymhelliad / Recommendation:

The Board is asked to approve the plan.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**Y**

Equality Impact (EqIA) and a socio-economic (SED) impact assessment have been completed and are attached at Appendices 4 and 5

Sefyllfa / Situation:

The purpose of this report is to present the Annual Plan for 2021/22.

Cefndir / Background:

Integrated Medium Term Plan (IMTP) planning arrangements were paused in 2020 due to the pandemic. Subsequently the NHS Wales Planning Framework was received on 14 December and reinforced the requirement for every NHS organisation to have an annual plan for 2021/22.

Correspondence from Welsh Government (WG) on 29th January emphasised a greater level of detail on a small number of immediate priorities including vaccination, workforce, and stabilisation through to early recovery actions.

'A Healthier Wales', Welsh Government's long-term plan for health and social care services in Wales sets the context of all our work for the forthcoming years. It sets out the vision of a 'whole system approach to health and social care'.

The Primary Care Model for Wales is an important element of our plan and predicated on locality level population needs assessment and planning the use of available resources, not just those of the NHS, to meet that need. In view of this, the Minister for Health and Social Services expects significant progress by Health Boards to support and empower the planning function at cluster level and to draw in Local Authorities and third and independent sector service providers. Optimal cluster working supports optimal regional partnerships and progress with 'A Healthier Wales'. Accordingly, Clusters are responding to BCU core priorities in developing their plans and developing a summary annual 'plan on a page'.

'Health and Social Care in Wales –COVID-19: Looking forward' sets out at a high level the approach WG will take, building on new ways of working and opportunities to do things differently. The task will be to rebuild all services, not just hospital services but primary care, community, social care, right through to very specialist services.

Correspondence from WG on 11th March acknowledged the considerable uncertainty hindering firm planning commitments across NHS Wales given, for example, the need to better understand the pattern of the Covid-19 virus and impact of vaccination. A draft annual plan was shared with WG in March with work undertaken since to refresh modelling work and the plan and in light of the allocation of additional funding which has influenced our plans alongside feedback from WG.

Asesu a Dadansoddi / Assessment & Analysis

This plan has been developed in the context of the unique challenges arising from the pandemic, which face all public services and society at large. It reflects the challenges the Health Board has to address in delivering health services, whilst supporting and protecting staff.

Alongside the delivery of our immediate priorities, we are building on relationships and existing partnership structures and we will be fully engaging and involving the public, staff, trade unions and partners in the transformation and reshaping of services.

Our approach to planning for 2021/22 is summarised below:

- Future recovery and transition from operational response to integrated strategic planning – opportunity to step back
- Outlook for Covid19 uncertain - the four harms remain the context
- Build on the core priorities identified in Q3/Q4
- Rolling plan building on actions in 2020/21
- Strengthened accountability throughout the organisation

Our work to deliver transformation and innovation, aims to deliver improved trajectory of outcomes, patient experience and financial performance year on year. Further improvements will be made leading to de-escalation, using a maturity matrix approach to assess progress.

Opsiynau a ystyriwyd / Options considered

Our plan will be underpinned by robust business cases. Priority schemes are identified which in turn consider potential options for delivery.

Goblygiadau Ariannol / Financial Implications

The plan integrates service, activity, financial and workforce implications within resources available.

Dadansoddiad Risk / Risk Analysis

All schemes will be required to identify key risks and a risk analysis undertaken to demonstrate how these will be managed.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

IMTP planning arrangements are currently paused with the requirement for every NHS organisation to have an annual plan for 2021/22. However, the development of an approvable Integrated Medium Term Plan is a critical organisational aim going forwards as this forms a statutory requirement under the NHS Finance Act.

Asesiad Effaith / Impact Assessment

Underpinning schemes and business cases will take into account any potential equality/Welsh Language/quality/data governance/digital/children's rights implications which may require an impact assessment to be carried out.

APPENDIX 1

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Annual Plan 2021 to 2022

Shaped by a Three Year Transformation Plan

2021 to 2024

2nd July 2021

Chairman and Chief Executive Foreword

The last year has undoubtedly been the most challenging in the history of the many NHS organisations that have served the people of North Wales. Responding to the pandemic has required us to develop and implement new services such as Test Trace and Protect (TTP), mass COVID-19 vaccination, and establish three Enfys hospitals at high speed. We have also redeployed staff into other pressurised services, for example critical care, to increase their capacity to an unprecedented scale. Some important activities, such as much of planned care have been severely interrupted or stopped due to the constraints deriving from COVID-19, causing worry to patients and in some cases, harm. This has also been the cause of significant concern for the organisation and the clinical teams responsible for carrying out said activities. All told, it would be hard to find a member of staff who has not had the most disruptive and difficult year of their working lives. We are incredibly grateful for their professionalism and sheer hard work, and do not underestimate the toll this has taken on individuals and teams.

One of our new services has been our programme for mass vaccination, and the success of this programme, mirrored across the rest of the UK, gives us a glimmer of confidence about the future. Of note have been a range of genuine service improvements driven by the need to work differently due to the pandemic and there are many examples of different specialisms and localities working cooperatively to maintain, and in some cases extend, services. There has been a real receptiveness to working in new ways: we have embraced new digital technologies and rediscovered the value of our partnerships with local authorities, and many others. All we have achieved, we have achieved through working together and we would like to acknowledge all our partners during this year. One example of many, has been the determination and community spirit displayed in rapidly and successfully trialing the use of the COVID-19 Pfizer vaccination in primary care on the Llyn peninsula.

Away from the pandemic, we have demonstrated sufficient progress to be taken out of 'special measures' and into 'targeted intervention', although we are clear there is much work that remains to be done to build a genuinely fit for purpose and integrated organisation and so, as always at this time of the year, we are turning our attention to plans for the coming year.

COVID-19 will remain as our most significant focus at least for the first half of 2021/22-as will moving into a service recovery phase. We are concerned about the tens of thousands of people who have now been waiting even longer to receive care. This is one of our core priorities, alongside looking at enhanced pathways for urgent and emergency care, and re-engaging with our vital longer term work to improve population health.

To achieve our priorities we will engage with our workforce, partners, and the wider communities of North Wales in new and innovative ways over the next 12 months and beyond.

Thank you for taking the time to read our plan and we look forward to working with our people, patients, and partners as we continue to grow and improve our services for the benefit of the people of North Wales.

Mark Polin
Chairman

Jo Whitehead
Chief Executive

Betsi Cadwaladr University Health Board

Plan for 2021/2022 in the context of a three year transformation programme

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1. Introduction

	BCUHB Plan on a page for 2021/22				
NHS Vision	A Healthier Wales				
Key Priorities	Covid-19 response	Improvement and involvement Mental Health Services	Unscheduled care pathways	Recovery of access to planned care pathways	Strengthen our wellbeing focus

What the people of north Wales can expect				
Improve population health and well-being	Health professionals working in primary care enabled to undertake remote consultations, share information with patients and to update the patients' clinical records. Improved patient access to services, whilst maintaining social distancing protocols and improving delivery of GMS standards.	Additional urgent primary care capacity in place to support practices and emergency department service delivery, through the implementation of Urgent Primary Care Centres.	Transformation of Community Services through development of the Home First Bureau to reduce unnecessary admissions into hospital, with pathway improvements to keep to delays to a minimum. More patients receiving care at home rather than in hospital.	Increased capacity to improve access to care for children who require neuro-developmental assessments.
Better health and social care services	Delivery of planned care recovery schemes to reduce cohort 1 Covid-19 backlog for all over 52 week waiters by March 2022.	Dedicated urological specialist teams supported by robotic assisted surgery facilities to improve patient outcomes, reduced complication rates, less pain and quicker return to normal activities.	Roll out of mental health practitioners into primary care settings, and introduction of community connector roles in localities to support patients struggling with their mental health.	Improve care closer to home opportunities in the eye care programme, improving the care of patients at risk of irreversible sight loss, and maximising eye health and sight retention for the north Wales population. Improved access and elimination of the current waiting list backlog.
Health and social care workforce	Consistently higher clinical outcomes in stroke care through early supported discharge and provision of specialist, integrated, inpatient and community rehabilitation services.	Strengthened emergency departments, delivering improved access to services in line with the Welsh access model, including a 'contact first' system, a 'streaming hub' and 'waiting & care', leading to more efficient navigation of patients.	Recovery programme for planned care, supporting improved access to diagnostic and treatment services for patients.	Development of cancer services and implementation of the new single cancer pathway, ensuring more timely care, in line with national standards.
Higher value health and social care				

Enablers	Finance	Workforce	New ways of working	Estates	Governance	Organisational development

Consult and engage with patients, public, staff and stakeholders

The principal role of the Health Board is to ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework. This will allow us to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, in a manner that promotes human rights.

This plan has been developed in the context of the unique challenges arising from the pandemic, which face all public services and society at large. It reflects the challenges the Health Board has to address in delivering health services, whilst supporting and protecting staff.

Alongside the delivery of our immediate priorities, we are building on relationships and existing partnership structures and we will be fully engaging and involving the public, staff, trade unions and partners in the transformation and reshaping of services.

The essential first step will be to work in partnership to build a sustainable vision for the future. This will lead to an integrated medium term plan being developed in readiness for 2022/23, with a focus on prevention, physical and mental well-being, population health, primary care and hospital services. Effective partnership working will be essential to improving the delivery of services we provide to the population of North Wales.

Work to tackle the COVID-19 pandemic has served to further galvanise partnership working at a local, regional and national level where we are actively engaged in a number of all Wales programmes. Our Plan recognises the work that is required in partnership to support vulnerable communities and protect the health and wellbeing of the population to support the principles of 'A Healthier Wales'.

We will continue to build upon existing local, regional and national partnerships, for example, working as part of the North Wales Regional Partnership Board on the transformation and reshaping of services.

The Health Board will work to deliver transformation and innovation, aiming to deliver improved outcomes, performance, patient experience and financial performance year on year. These improvements will contribute to the actions required to demonstrate progress against the Targeted Intervention Framework published by Welsh Government.

1.1. Achievements 2020/21

The Health Board faced unprecedented challenges during 2020/21 as a result of the pandemic. The response of our staff, partners and the many volunteers who came forward to support us enabled significant achievements, as set out below:

- Maintaining essential services for our patients;
- Rapid establishment of the Test, Trace, Protect service;
- Delivering 'home first' services, discharge to assess pathways and support to care homes in partnership with local authorities and third sector organisations;
- Supporting and protecting our staff, including the establishment of staff support and wellbeing hubs;
- Development of 'red hubs' to ensure patients had access to primary care services, including urgent dental care, eye care and general medical services;
- Ensuring an effective response to COVID-19 demand on hospitals including the second peak of activity and managing local outbreaks with our partners;
- Commissioning of 3 temporary Enfys Hospitals in Llandudno, Deeside and Bangor, delivered high quality clinical facilities at speed and in conjunction with local authority and education partners;
- Establishment of a clinical advisory group facilitating rapid roll out of new digital technology and pathways of care;
- Rapid establishment of the mass COVID-19 vaccination programme across North Wales; and
- Removal from Special Measures and progression to Targeted Intervention escalation status, and achieving financial balance within the resources allocated by Welsh Government.

1.2. What the people of North Wales can expect

A number of significant developments within our plan are set out below to illustrate what our plan is seeking to deliver for our population in North Wales:

- Further roll out of digital technology with more virtual appointments provided in primary care and within our hospitals. Access to appointments improved due to having more options for timely consultations. This will also reduce patients having to travel for services and reduce the risk of COVID-19 spread and will be safer for staff and patients;
- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible;
- Increased capacity will support improved access to care for children who require neuro-developmental assessments;
- Roll out of the mental health practitioner model and community connector role to localities to improve support to patients within primary care;
- The development of pathfinder urgent primary care centres to ensure timely, efficient care for patients with urgent primary care needs and reduce demand for minor illness / injuries on our Emergency Departments. The service will create more capacity for GP practices to better manage patients with more complex conditions;
- By strengthening our emergency departments, we will deliver improved access to services in line with the Welsh access model including a 'contact first' system, 'streaming hub', and 'wait & care system', leading to more efficient navigation of patients;
- Developments in cancer services and implementation of the new single cancer pathway will ensure more timely care for our patients in line with expected national standards;
- Patients will receive consistently higher clinical outcomes in stroke care through early supported discharge and provision of specialist integrated community in-patient rehabilitation services;
- The planned care recovery programme will support improved access to diagnostic and treatment services for patients;
- The eye care programme will optimise care closer to home and improve the care for patients at risk of irreversible sight loss, maximise eye health and sight retention for the North Wales population including improved access and elimination of existing waiting list backlog;
- The prehabilitation programme, including for example, conservative management for early onset osteoarthritis, will maximise patient fitness prior to treatment and avoid or shorten hospital stays wherever possible;
- Building capacity within to retain and sustain improvement through a network of 1800 champions, connectors and influencers in order to grow a BCUHB social movement of change;
- Dedicated urological specialist teams supported by robotic assisted surgery will improve patient outcomes, reduce complication rates and deliver improved access for patients with less pain and quicker return to normal activities;
- The Home First bureau (operating 08.00 – 20.00 daily) will support patients to return to the best life possible following their period of illness, through maximising the opportunity for active therapeutic input and support to patient discharge from hospital. This will reduce delay in transfers of care leading to shorter length of stays within hospitals and increase in patients returning home rather than having to be cared for in a community bed;

- Care home quality nurses will work with the care home sector to deliver safe effective care to the residents of North Wales. Quality of life will be enhanced by ensuring patients receive the care and support they need, have a positive experience of care and are safeguarded and protected from avoidable harm; and
- Implementation of an audiology led earwax management pathway will provide care closer to home, improve patient experience and reduce unnecessary onward referrals to secondary care ENT and audiology services.

2. Our vision for the future

The Health Board's vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, reducing health inequalities. This means that, over time, the people of North Wales should experience a better quality and length of life.

We aim to provide excellent care, which means that our focus for the next three years will be on developing a network of high quality services, which deliver safe, compassionate and effective care based on what matters to our patients. We will ensure our work is closely aligned with Welsh Government's long-term vision for achieving a 'whole system approach to health and social care'.

To do this we will:

- Improve population health and well-being through a focus on prevention;
- Improve the experience and quality of care for individuals and families;
- Enrich the well-being, capability and engagement of the health and social care workforce; and
- Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste.

2.1. Our strategy: Living Healthier, Staying Well

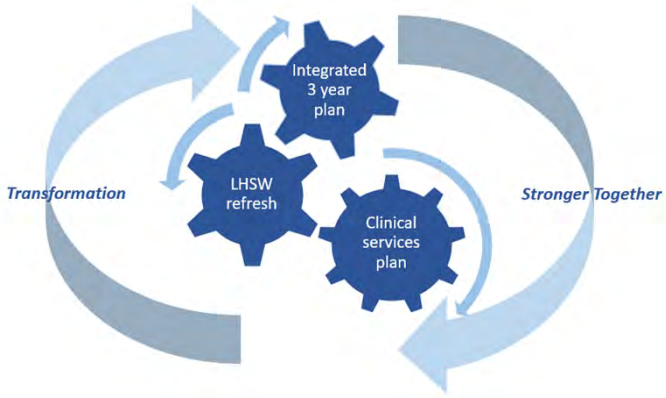
As we move forward into the COVID-19 recovery phase, it is timely to take stock and check with our staff, patients, partner organisations and the public how COVID-19 has affected health and well-being and what we can learn from this experience.

We also want to check on the progress of our long-term strategy for health, well-being and healthcare, Living Healthier, Staying Well (LHSW). It has been three years since we developed this. Change takes time, and we need to check whether we are achieving what we set out to do, and whether the principles and priorities are still relevant. To facilitate this we are beginning a review and refresh of LHSW, and will:

- Check in with our staff, patients, partners and public whether the principles are still valid;

- Review our strategic priorities to ensure they are consistent with 'A Healthier Wales';

- Address those elements of LHSW that proved challenging to implement e.g. an integrated system wide approach to healthcare and integrated care pathways;
- Test the strategy is still relevant in the changed environment;
- Provide the framework for development of a Clinical Services Plan.



We are developing a discussion paper and will be asking people – patients, carers, community groups, partner organisations and others – for their views. The refresh work will be completed by the autumn to feed into the development of the integrated three year plan 2022/25 and to provide the basis for the clinical services plan.

2.2. Carers Strategy

The Health Board continues to work closely with carers and we remain committed to working and engaging with service users, patients, families, carers and the wider public. Within the forthcoming 12 months utilising co-production we will be undertaking a carers mapping exercise across all carers age groups and self-assessment. This gap analysis will support the development of our 2021 – 2024 Three Year Carers Strategy and implementation plan adopting a therapeutic alliance approach with our service users, professionals and carers.

2.3. A Healthier Wales

Our vision and strategy is aligned to 'A Healthier Wales', which sets out a long-term future of a 'whole system approach to health and social care'. This is focussed upon:

- Health and well-being, preventing illness and enabling people to live independently for as long as they can, supported by new technologies;
- Integrated health and social care services which are delivered closer to home; and
- Close collaborative working to impact on health and well-being throughout life.

These are consistent with the aims of our living healthier, staying well strategy which is aligned to the expectations of Welsh Government as illustrated below:

'A Healthier Wales'	…How we deliver locally:
Health and social care system to work together	▪ Regional Partnership Board and other partnerships supporting integrated planning and delivery; ▪ Expansion of community resource teams; ▪ Delivering our unscheduled care model with our partners.
Shift services from hospital to community	▪ Health and well-being centres; ▪ Eye care plan, delivering more care through primary care optometry services; ▪ Unscheduled care pathways; ▪ Mental health services delivery plan;
Get better at measuring what really matters	▪ Revised performance and accountability framework; ▪ Stronger governance arrangements;
Make Wales a great place to work in health and social care	▪ Workforce strategy: staff engagement, leadership, culture and climate, motivation, innovation and learning;
Work together in a single system	▪ Medical and Health Sciences School; ▪ Unscheduled care / emergency ambulance services commissioning; ▪ Mid Wales healthcare collaborative; ▪ Commissioning secondary and specialist services.

2.4. Programme for Government

Our plan supports key elements of the delivery of Welsh Government Programme for Government (published on 15th June).

Our recovery plans are aligned to the Programme for Government and detail how we will move forward following the extraordinary challenges the Health Board have faced this year. We are investing in our staff, and our services to overcome the backlog caused by the pandemic and to build on existing services, utilising new ways or working, integrating with social care partners, taking a cohesive approach to delivering care in North Wales. Specifically we will:

Protect, re-build and develop services for vulnerable people;
Build a stronger, greener economy as we progress towards decarbonisation;
Celebrate diversity and move to eliminate inequality in all of its forms; and
Provide effective, high quality and sustainable healthcare. Key examples of which include:

Programme for Government plans	Example of what we have planned
Establish a new medical school in North Wales	Promoting 'train, live and work in North Wales', retaining local skills and attracting employees to North Wales
Provide treatments which have been delayed by the pandemic	Using our 6 point plan to tackle and recover from COVID-19 impact on planned care service
Deliver better access to doctors, nurses, dentists and health professionals	Utilising new ways of working, including the piloted AccuRx scheme used throughout the pandemic
Reform primary care, bringing together GP services with pharmacy, therapy, housing, social care, mental health, community and third sector	Developing urgent primary care centres so as to increase primary care capacity, and supporting emergency services by reducing pressures on service delivery. Developing integrated health and social care localities, with strong links to Primary Care Clusters and Community Resource Teams (CRTs), in order to meet the needs of individual communities across North Wales. Embed mental health within core CRT delivery. Identify opportunities to work with the National Primary Care Programme
Prioritise investment in mental health	Developing and implementing new services including increased access to services and early intervention programmes supported by the transformation fund. See Section 11
Prioritise service redesign to improve prevention, tackle stigma and promote a no wrong door approach to mental health support	Developing our services further in terms of CAMHS, ICAN, older people crises and more. Ensuring multi-disciplinary staff are trained to provide best quality services for patients Actively support staff in their workplaces to maintain optimum wellbeing
Roll out CAMHS 'in-reach' in schools across Wales	Joint working with social and educational services within schools Establishing and implementing effective and timely transition arrangements that support young people into adult services
Introduce all-Wales framework to roll out social prescribing to tackle isolation	Piloting elemental software which enables social prescribing projects to monitor progress at an individual and programme level. Understanding the demand, delivery and impact of social prescribing in North Wales so we can better develop our plans for meeting the population needs
Review patient pathway planning and hospice funding	Within the forthcoming 12 months utilising co-production we will be undertaking a carers mapping exercise across all carers age groups and also a self-assessment. This gap analysis will support the development of our 2021 – 2024 Three Year Carers Strategy and implementation plan adopting a

	therapeutic alliance approach with our service users, professionals and carers
Focus on end-of-life care	Exploring models of end of life care in partnership with hospices to ensure improved access across North Wales and so that more patients can be cared for closer to their homes.
Invest in and roll-out new technology that supports fast and effective advice and treatments	Identifying new ways of working for future effective service delivery, including the eConsult and Attend Anywhere programmes. Working with partners to develop a digital strategy for personalised care and support, aligned to the role of equipment stores and telecare/ telehealth services
Introduce e-prescribing and support developments that enable accurate detection of disease through artificial intelligence	Build upon remote prescribing opportunities during and post the COVID-19 pandemic through the EMIS GP prescribing system, allowing our clinicians to prescribe from remote sites and when working from home, supported by a 'remote prescribing policy' Respond to the outcome of the WG independent e-prescribing review when published
Invest in a new generation of integrated health and social care centres across Wales	Respond to the review of primary care estates commissioned by WG Completion of the new WG funded developments in Waunfawr and Ruthin Further the development of CRTs and co-location of integrated teams
Establish new Intensive Learning Academies to improve patient experiences and outcomes	Supporting the further implementation of the primary care model in Wales, leading new ways of working and innovation in primary care. Promoting a sustainable Dental Therapist / Nurse workforce in North Wales by providing expanded local opportunities and training for dental staff, which will improve skill mix, recruitment and retention
Develop local community hubs to co-locate front-line health and social care and other services	Our Well North Wales work has benefited from Early Years and Prevention funding which has helped to develop a more integrated service concerning homelessness and food poverty. Providing access to the right information, when needed to improve mental health and wellbeing e.g. number of individuals supported through our ICAN community hubs

2.5. Equality, diversity & inclusion

The Health Board has a Strategic Equality Plan (SEP) which provides a framework to help ensure that equality is properly considered within our organisation and influences decision-making at all levels. The SEP sets out the steps we are taking to fulfil our specific duties under the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 and describes the Health Board's arrangements for equality impact assessment. We have gathered and analysed relevant information and are maintaining engagement with communities, individuals and experts to help inform our direction.

It is well recognised that COVID-19 has further magnified inequalities for many people with protected characteristics and those who are socio-economically disadvantaged. For some individuals, these inequalities may also be increased further by barriers to accessing healthcare, marginalisation from society or discrimination. As part of our recovery and as planned care restarts and the focus is on those people who are most in need of urgent treatment it is necessary to ensure equality considerations are built into plans. Our equality impact assessment procedures and tools have been further developed as a framework to help identify and mitigate impact and provide an overview of some of the barriers to accessing healthcare for further consideration.

Key themes include: ensuring accessible communication and information, making reasonable adjustments, addressing the barriers experienced by disabled or neuro divergent people, meeting the needs of those with sensory loss, considering socio-economic disadvantage, mitigating for digital exclusion and optimising opportunities for engagement and co-production.

In addition to the immediate enhancement of impact assessment guidance, our plans to deliver the SEP have been reviewed to reflect this emerging evidence. Further information about the SEP and equality objectives is published and available here.

2.6. Welsh language

The Health Board has sought to demonstrate its commitment to promoting the use of the Welsh language over a number of years. Our Welsh language strategic forum continues to provide leadership, commitment and operational support to ensure the Welsh language is embedded within all our services. Ongoing development and compliance with the Welsh Language Standards under the Welsh language (Wales) Measure 2011 and 'More than just words' will be continuously monitored to ensure needs and demands are assessed and managed, whilst maintaining an ethos of quality improvement.

This focus provides clarity on the importance of the Welsh language in developing new services, influencing organisational behaviour and actively offering patient-centred Welsh medium care. Our Welsh language key priorities plan will continue to ensure organisation-wide consistency in delivering the Welsh Language Standards, provide timely translation services to staff, patients and the public, and build on the 'active offer' approach to services so that patients are offered timely access to language appropriate care.

2.7. Sustainability

The Health Board recognises the need to change the way we work, ensuring that we increasingly adopt the sustainable development principles defined within the Well-being of Future Generations Act: this means taking action to improve economic, social, environmental and cultural well-being. There are five ways of working set out in the Act, which we need to think about when working towards this:

Throughout the development of our plan we have sought to use the five ways of working to inform our decisions and help us prioritise the actions we will take to work towards our own well-being objectives and in turn, contribute to the seven national well-being goals. Examples of this approach are set out in the table below:

	Selection of work programmes supporting the ways of working within the Health Board:
Long-term	• New **single cancer pathway** across North Wales delivering the national target of 75% of all patients achieving the single cancer pathway; • Development and commencement of implementation of long term plans for **sustainable diagnostic services** (radiology and neurophysiology);
Integrated	• **Urgent primary care centres** to be piloted, supporting an integrated model of unscheduled care; • Develop the stroke service model focusing initially on early supported discharge and rehabilitation to deliver improved outcomes, supporting improved compliance with stroke guidelines; • Develop sustainable endoscopy service across North Wales;
Collaboration	• **Home First bureau** consolidation and mapping all of our resources to support discharges including continuing healthcare, home first bureau, frailty, discharge to recover then assess (D2RA) therapies, and community resource teams; • **Outpatient transformation programme**, end to end pathway redesign, 'Once for North Wales', workforce modernisation and digital enablement of staff and service users;
Involvement	• Deliver community **food poverty education** programmes within North Wales communities, to reduce food poverty - aligned to the Welsh Government initiative for 'A Healthier Wales'; • Develop an appropriate **interface** with CAMHS to ensure effective transition for young people with mental health conditions into adult services;
Prevention	• **COVID-19 vaccination programme** and development of a sustainable delivery model / annual vaccination programme; • Support the '**Sport North Wales'** development/ approach.

Whilst demand for healthcare continues to grow, the Health Board is committed to meeting the challenges of achieving carbon reduction, waste reduction and securing products and resources from sustainable sources where possible to ensure that our environmental impact is reduced as far as is reasonably practicable.

As part of our corporate commitment towards reducing our impact, we maintain a formal environmental management system (EMS) designed to achieve sustainable development, compliance and mitigation against the impact of climate change, in a culture of continuous improvement.

Effective environmental management is achieved through:

- Promotion of the environmental policy to all relevant stakeholders;
- Identification of all significant environmental aspects and associated legal requirements;
- Establishing objectives and monitoring targets aimed at reducing environmental and financial impacts;
- Provision of appropriate training to all relevant personnel;
- Regular internal and external audits of practice;
- Regular review of the effectiveness of the EMS by the Environmental Steering Group; and
- Working with local, regional, and national partners to ensure best practice procedures are identified and implemented.

2.8. Research and innovation

We will continue to deliver our research and innovation strategy working closely with the Research, Innovation and Improvement co-ordination hub in North Wales as part of the all Wales initiative set out in 'A Healthier Wales'. A key aim in 2021/22 is to work with our partners to develop a North Wales cross sector vision for research and innovation.

In 2021/22, we will continue to recruit to urgent public health COVID-19 studies, reflecting the critical importance of this research contribution at the current time.

We are working closely with Health and Care Research Wales (HCRW), to set out plans for the recovery and resilience of non-COVID-19 research. We are contributing, through HCRW, to the Clinical Research, Resilience and Growth (RRG) UK Programme. Locally, we will re-open paused non COVID-19 studies, aligned to the resumption of clinical services, as well as continuing to seek out new opportunities to open research studies, and embed research and innovation into clinical services.

We will be seeking to build our research capacity by submitting a business plan to Welsh Government for a clinical research centre, which will recruit to both COVID-19 and non-COVID-19 early phase clinical trials. We expect to commence this work in quarter two of 2021/22.

We will develop an infrastructure for innovation, working with the all Wales leads, in order to enable the adoption and spread of innovation, to support the transformation of services and care (see section 3).

Together with Bangor University we have an ambition to develop a transformational inter-professional Medical and Health Sciences School by 2025. This represents a significant opportunity for North Wales that will allow us to align education and training to our clinical strategy, support the delivery of our research strategy and address key challenges in our medical and clinical workforce. In addition, strengthening university links to support the health Board progress for example real time evaluation and outcomes data which will serve to support our value based healthcare work.

We have developed a joint programme structure to support planning for this substantial new development. Our approach for North Wales is being shaped and developed during 2021/22 in line with Welsh Government requirements, subject to ministerial consideration and approval.

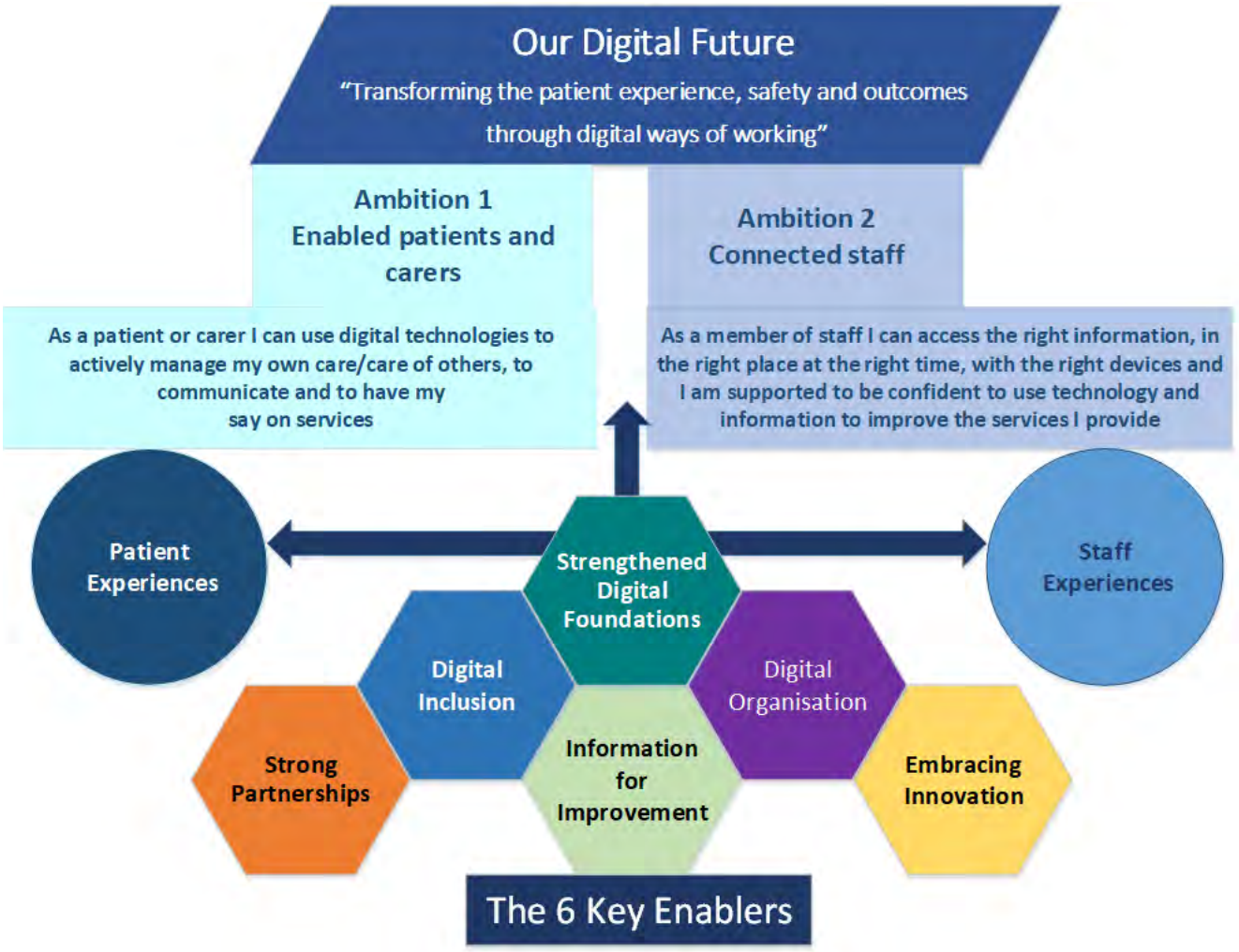
Looking forward, we will ensure that we can continuously evidence how our activities meet the University Health Board status criteria through our plans.

2.9. Our digital future

The Health Board is committed to harnessing the opportunities presented by digital transformation. Our digital vision is concerned with "transforming the patient experience, safety and outcomes through digital ways of working". This means putting the experiences of patient, carers and staff at the very heart of what we do. Achieving this involves ensuring that we get the basics right.

This strategic approach is informed by feedback from extensive engagement and supports the delivery of our strategic priorities in Living Healthier, Staying Well and our population and organisational outcomes.

We have identified two critical ambitions, which will drive our adoption of digital technology, as set out in the diagram below:



3. Our approach to longer term transformation

The Health Board has recognised for some time the need to build greater capacity and capability for transformation and improvement. The pandemic has further crystallised the need and wish to do so, whilst also providing a number of opportunities where a post-pandemic 'new normal' could be established if we build upon how we have needed to work differently during the pandemic.

In addition, the pandemic has brought further significant challenges in maintaining a safe and secure environment both physically and psychologically for our patients, staff and visitors. These challenges continue to grow and require a renewed focus upon transformation to meet current and future population demand.

Our approach to clinical service transformation is multi-faceted and will be supported by key enabling strategies, covering:

- Quality improvement and patient experience;
- Clinical strategy driving improvement;
- Digitally enabled / digital strategy;
- Workforce strategy and strategic organisational and system development;
- Effective use of all our resources, adopting a Value Based Healthcare approach;
- Innovation, research and development; and
- Ensuring all our physical assets are safe and fit for purpose; maximising capital investment.

As part of the £12m capability strategic funding allocated by Welsh Government, the Health Board has allocated £5.3m in 2021/22 to provide additional capacity to drive forward engagement with our population, staff and stakeholders, to continue to improve governance and to transform clinical and operational services.

The current proposal for the allocation of strategic support to transformation is broken down as follows:

Area for investment to deliver transformation	Description	Investment £m
Transformation	Resource and systems	1.9
Engagement	External and internal including clinical service strategy	1.8
Capacity	Pan BCUHB capacity and capability	1.1
Public Affairs	Stakeholder and reputation management	0.5

Successful transformation and improvement activities are not the concern of a single team, but rather something that needs to be embedded across the Health Board, through all of our systems and processes. To do this we will draw upon the experiences of other organisations and invest in a transformation and quality improvement (QI) approach, which is capable of maturing and informing our decision-making.

A proposal of how to deploy an augmented transformational capacity, alongside quality improvement, has been tested with Board members and senior clinicians and managers, and has been positively

received. Work on this is now underway and covers transformation at Board level, delivering large or complex programmes or transformation, as well as encouraging our whole workforce to get involved in smaller pieces of transformation that are important to them.

We will supplement our existing QI approaches by building upon the well tested Kaizen methodologies to support continual improvement at every level of our workforce. This approach, along with the broader “toolbox” of methodologies we will use, is summarised below:

Quality Improvement Methodology

We will build our QI and transformation toolbox upon tried and tested approaches.

- ## Kaizen Principles

Kaizen is generally taken to refer to a collection of concepts that support business improvement. It underpins the successful Lean, Six Sigma, the IHI Model for Improvement and PDSA methodologies, as well as many others.

A key principle is that improvement is everyone's business, and that no improvement intervention is too small or insignificant if those involved feel motivated to address it. This approach is tested and presents excellent opportunities for us to engage our whole workforce in making improvements that are important to them. In so doing pride, mutual learning opportunities, and a feeling of value arise from being given appropriate autonomy to make changes, naturally leading to further improvement.

- ## Value Based Care Principles

These internationally recognised principles support improvements in care experience, and outcomes, by focusing upon the value to the individual and our wider society. Value is not the same as cost.

- ## Closer to Home Principles

Whilst travel for highly specialised health interventions might sometimes be necessary in order to access the greatest expertise where that will improve outcomes, we want as much care as possible to be delivered as close as possible to where people live. This includes the appropriate use of technology when physical travel to an appointment might not add additional value.

- ## De-medicalisation Principles

Too many interventions are unnecessarily complex, add nothing more than simpler interventions could have done, and put the individual at risk of medical harm. Principles to recognise and minimise this are important.

- ## Information Rich

We will extract meaningful information from the many data sources to prioritise and then assess the impact of our QI and transformational activity.

- ## Pathways of Care

We will bring the above principles together to guide the creation of pathways of care that ensure the highest value interventions are recognised, that delivery of care is delivered as close to home as possible, and with the lowest risk of harm from unnecessarily complex intervention.

A successfully embedded approach to transformation and quality improvement will need to be multi-faceted. Our proposed approach can be described on three planes, namely **local** (*micro*), **system improvement** (*meso*), and **Board** (*macro*), although in practice activity will spans across these levels. Our approach is described in more detail below.

Local team based quality improvement and transformation *(micro level) - encouraging multiple, small pieces of local QI activity that make a practical difference to those involved, recognising that QI is everyone's business and that everyone has expertise to contribute.*

Successful improvement, and enhanced work satisfaction, requires a workforce that is empowered to make and own improvements at a local level. There are many local changes that are best made by our experienced, informed, workforce. Although these may be relatively small changes individually, they collectively add up to a significant impact, improved further when learning is shared and applied across the integrated organisation.

To do this we will supplement our existing QI approaches with an approach that is built upon the well tested Kaizen methodologies to support continual, small change improvement at every level of our workforce.

In 2021/22 we will:

- Agree our BCUHB methodology, built upon Kaizen principles, to encourage, empower and support individual teams to initiate local improvement activities. This methodology will include mechanisms for sharing learning and access to support and resources for any members of our workforce, at whatever level, wanting to undertake a local improvement activity;
- Align our organisational and system development route map to support this ethos, providing generic skills and underpinning a culture, that improvement is something that we can all contribute to; and
- Launch an internal portal, to support the agreed BCUHB methodology for local improvement, in addition to the support from our OD and QI teams.

System, coordinated quality improvement and transformation *(meso level) - ensuring the tools and systems for transformation and QI are hard-wired into the organisation, that they support the strategic direction of the organisation, and that they are built upon tried and tested methods for successfully delivering transformation and quality improvement. These systems will provide coordination for the bigger pieces of work required in transformation.*

At this level, we will structure our system-wide approaches to transformation and improvement so that they support a consistent contribution to, understanding of, and deployment of, Health Board strategies. These approaches will be focussed on where we wish to travel to, rather than where we are coming from, and supported by a PMO that is built upon Value Based Care principles.

In 2021/22 we will:

- Build on our existing approach to implementing clinical pathways to underpin service development. Our pathway approach will be reflective of our span across an integrated healthcare community, and will minimise over-medicalisation. We will incorporate into this the learning on pathways from other organisations and jurisdictions such as Canterbury, New Zealand;

- Support the development of clusters by helping them transition from the traditional functional approach to service redesign, to a flow-based system-wide management approach, by incorporating

data from different parts of the Health Board, enabling us to measure patient outcomes across the whole pathway, linking all of the services in each patient's journey;

- Apply GIRFT methodology to a number of areas, including (but not limited to) hip and knee replacement;

- Explore the opportunities of a strengthened approach to prioritisation so that we can be assured that the service redesign opportunities we focus attention on are those likely to make the biggest improvements for our population;

- Further develop the business intelligence approach that we deployed in 2020/21 to better understand system wide data, to capture data that is meaningful and provides a valid representation of 'value', and that is forward looking in order to allow mitigating intervention.

Board level quality improvement and transformation *(macro level) - ensuring QI and transformation are strategically prioritised, and that the Health Board strategic direction both guides our priority areas of transformation whilst being informed by the QI and transformation activity occurring across the organisation.*

At a 'macro' level we will develop the strategic architecture for transformation which is necessary to provide a clarity of direction for the organisation and within a wider system. This transformation direction will be firmly rooted in the principles and values of 'A Healthier Wales'. This will include actions to maximise the impact of our position as an integrated health organisation, fully contributing to a wider system of health and well-being, placing citizen self-empowerment at the centre and complex specialist services more peripherally.

In 2021/22 we will:

- Provide greater senior coordination of quality improvement and transformation strategy by investing in a coordinating team containing the expertise to inform our Health Board strategy and to support transformation and quality improvement activity at meso and micro levels;

- Further develop the maturity and opportunities for earned autonomy for health and social care localities, to enable them to keep care as close to home as possible, medicalised only when appropriate and able to contribute to supporting more resilient communities at locality level; and

- Further develop the support provided to health and social care localities, so that they can better identify and contribute planning priorities from local communities upon which our annual planning cycles will be built.

Summary of actions to progress Transformation in 2021/22:

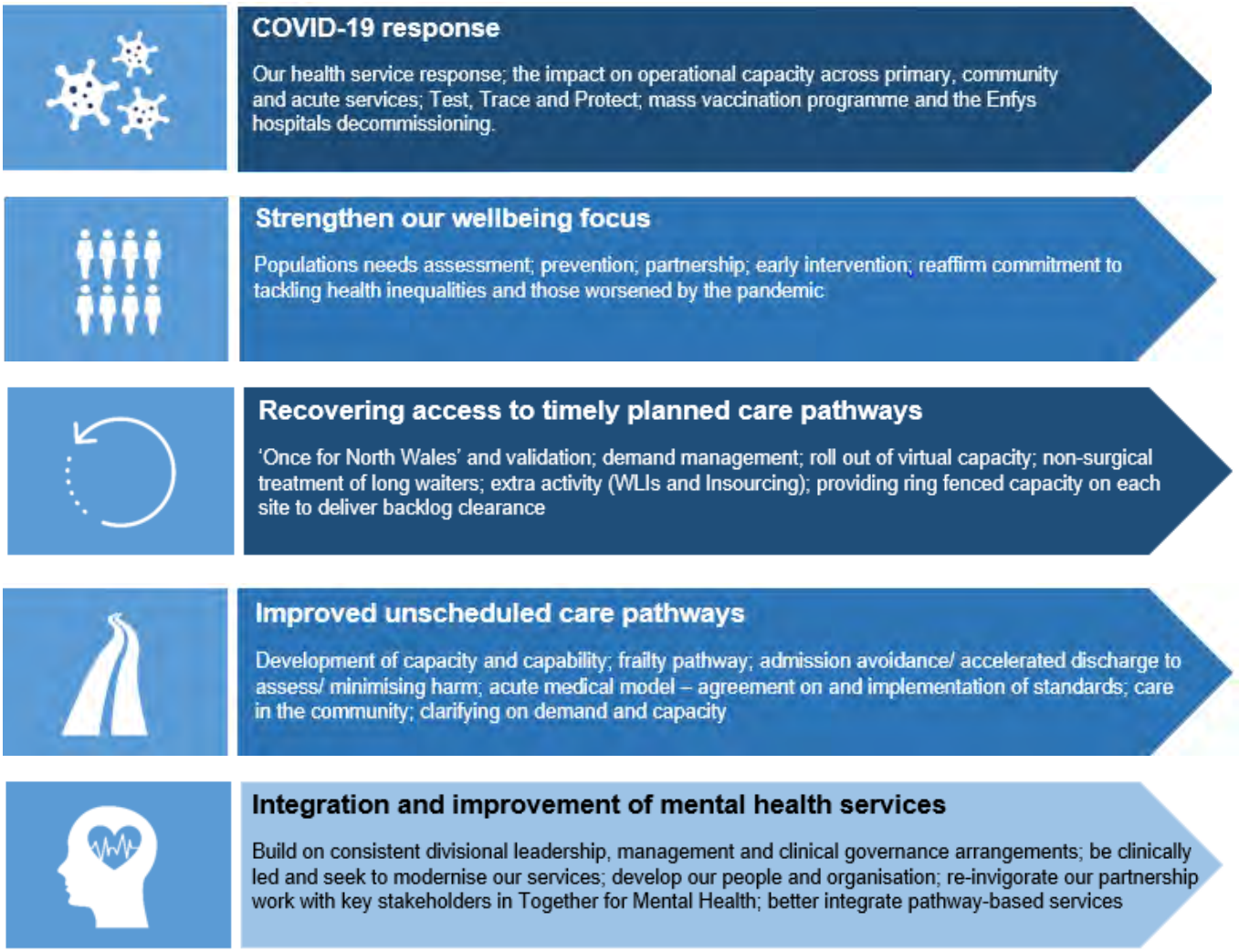
A summary of the key actions we will progress to support the implementation of our transformation and quality improvement approach is set out in the table below:

	Key Deliverables 2021/22
	• Recruit remaining leadership posts for transformation and QI and faculty;
	• Agree a BCUHB Kaizen methodology to facilitate and empower local, small change service improvement;
	• Agree roll out programme for BCUHB Kaizen methodology, supported by an organisational development programme, and creation of internal QI web portal and support team;
	• Create a BCUHB clinical pathway toolkit that incorporates the principles of value based care, 'Too Much Medicine' / de-medicalisation, and care closer to home. It will also include establishing a clinical pathway work plan to commence creating our library of clinical pathways;
	• Specifically apply GIRFT methodology to hip and knee replacement clinical pathways, resulting in end to end Value-Based clinical pathways for both conditions
	• Agree a BCUHB prioritisation process through which potential service investments will be required to progress, incorporating steps to ensure that the clinical pathway methodology and service redesign toolkit have been appropriately deployed;
	• Increase the scope of our business intelligence unit to ensure metrics built upon 'value' are rigorously captured and presented, such that they can track the progress of completed clinical pathways, and inform any necessary intervention;
	• Agree maturity progress targets with each locality against accepted maturity matrices, to ensure localities are well placed within our transformation programme;
	• Refresh our planning processes across the organisation leading to an approvable integrated medium term plan.

4. Tackling immediate priorities in 2021/22

This plan sets out the key priorities and deliverables for the Health Board over the next year. It builds upon priorities identified in 2020/21 and reflects the guidance issued by Welsh Government.

We have identified the following five key priorities as critical for 2021/22 and each of these is supported by actions which will enhance delivery in 2021/22 and shape future services:



4.1. Early Recovery Schemes (supported by All Wales Recovery Fund)

A number of schemes have been supported by Welsh Government to support early planned care recovery.

Endoscopy is the biggest single scheme. Our proposal delivers an additional 2,227 sessions over the four quarters of 21/22. This will fully clear the current backlog of over eight week waits taking into account year-on-year growth, and our underlying sustainability gap. This additional capacity will be delivered by a mix of recurrent investment in our endoscopy services and non-recurrent measures. The

recurrent consequences of 2021/22 spending in future years will be addressed out of our £30m performance fund monies set out in section 4.2.

The next most significant element is our proposed use of the independent sector. We have a confirmed spend of 600 cases by March 2022, with the potential to add an additional 450 procedures.

Additional funding of £2.9m for diagnostics will clear 4,000 patients waiting over eight weeks for CT, MRI, or ultrasound. Allowing for expected demand growth, this would deliver waiting times for the major modalities of a maximum eight weeks, with reduced waiting times of up to 6 weeks for vital diagnostics.

The balance of our proposal relates to a number of smaller schemes including oncology consultant staffing capacity to manage late presentation due to paused screening programme and drop in unscheduled care referrals. Validation of waiting lists typically delivers reductions in number of patients listed by around 10%. For example, by checking on a patient's condition and establishing any additional risk factors, establishing the patient's wishes regarding treatment and through providing good communication with patients, their carer and GP, including patients who may no longer require treatment. At the end of March 180,000 patients were waiting for a follow-up appointment, of those 55,000 people were 100% delayed.

Pathway trackers will provide validation and pathway management support across all planned care aspects, for example within gynaecology services to support patients through their care pathway and to ensure that pathways are being managed in the most appropriate way in line with COVID guidelines. Pre-COVID the default for pathway management was face to face consultation, whereas this resource will allow consultants to review the referrals already in the system and potentially change the mode of management considering the options available.

Validation support is also being provided within therapy services for example podiatry caseload, including patients who require ongoing review. Many of these reviews had been paused resulting in 5000 patients requiring follow up. Validation will ensure that the right capacity is in place to meet patients identified needs. In addition, a Speech and Language (SALT) validation process on the COVID -19 backlog has been introduced to assist to create a sustainable service for the future that includes a graduated pathway of access including virtual and face-to-face appointments, virtual training tools, self-help tools and up to date signposting information. This activity will support a range of patient groups (including head and neck cancer, progressive neurological conditions (e.g. MND, Parkinson's Disease, MS) and patients presenting with symptoms related to COVID-19 (respiratory dysphagia; post extubation dysphagia, communication difficulties post COVID-19). The full list of Welsh Government approved schemes is as follows:

Scheme	£000's	£000's
Women's directorate pathway trackers	55	
Women's services to review referrals already and potentially change to virtual activity, See on Symptoms (SOS), advice and guidance	61	
Dermatology validation	127	
Speech and Language Therapy - clinical validation and backlog clearance	630	

Site based pathway trackers with clinical support	254	
Sub total - validation / triage / signposting		**1,127**
Diagnostics capacity to support waiting list backlog	2,885	
Endoscopy capacity to support waiting list backlog	8,200	
Sub total – diagnostics		**11,085**
Oncology capacity to support suspected cancer pathway	1,250	
Outsourcing activity within independent sector	6,480	
Subtotal – additional capacity		**7,730**
Grand total		**19,942**

4.2. Key deliverables for 2021/22 (supported by performance fund)

In order to progress the priorities above we will utilise the additional strategic financial support provided by Welsh Government through the £30m performance fund for the next 3 years. The table below shows the areas in which we will invest, along with the expected impact and return from these investments:

Performance fund schemes (subject to approval via robust business cases)

Key to priorities:

❶ COVID-19 response
❷ Strengthen our wellbeing focus
❸ Recovering access to timely planned care
❹ Making effective and sustainable use of resources
❺ Improved unscheduled care pathways
❻ Integration and improvement of mental health services
❼ Transformation for improvement
❽ Effective alignment of our people

Scheme Title	Overview	Addresses Key Priorities above ❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽	Net Cost £000s Full Year (FY) / Part Year Effect (PYE) FY	PYE	Key Deliverables / Return on Investment
Attend Anywhere	Supporting virtual hospital outpatient consultations.	❶ ❸ ❹ ❼	379	379	• Reduction in the number of patients travelling for services / visiting our premises • Approach is more efficient in its structure, reduces risk and supports a better patient experience

				• Face to face consultations reduced thus achieving the need for social distancing and reducing the risk of COVID-19 spread • Safer for our staff and patients • Reduces waiting times • Based on 4,226 new outpatient appointments / 16,413 follow up appointments for April / May 2021, equating to 25,356 new outpatients / 98,478 follow up appointments for 2021/2022
Continuation of AccuRx digital communication tool in GP practices	Supporting virtual primary care consultations, improved access and communication, and efficient administration.	❶ ❸ ❹ ❺ ❼	415 300	• Provision of a communication tool between GP and patient to facilitate self-monitoring of chronic conditions • Screening such as obesity, smoking and asthma, provision of advice remotely, COVID management pre and post appointment direct interface with the GP clinical record • The improvements above will be measured by: o Patient satisfaction surveys o Achievement of access standards o Reduced DNA rates o COVID-19 response and recovery o Enabling care closer to home o Improving access to safe planned care (freeing up capacity in GP practices for support proactive care)
Planned care recovery schemes	Delivery of agreed 'early DTC' planned care recovery schemes (including additional programme management capacity), to include diagnostics, e.g. endoscopy, laminar flow theatres and inpatient T&O bed provision	❶ ❷ ❸ ❹ ❼	15,000 14,732	• Capacity planning validation and 'Once for North Wales' outpatients • Improved patient communication and better understanding of demand • 'Once for North Wales' services, value based pathways • Use of virtual capacity (such as video consultations) and care closer to home

	(including relocation of outpatient therapy provision in Wrexham.				• Non-surgical approaches to long waits • In sourcing additional capacity to include no over 8 week waits for endoscopy by 31 Mar 22
Development of a cancer-specific and non-cancer elective prehabilitation programme and conservative management pathways / avoidance of secondary care	Prehabilitation delivery within care pathway between listing for surgery and the surgical date maximising fitness prior to treatment. Pathway redesign with a focus upon conservative management for early onset osteoarthritis and pain, as per Getting It Right First Time best practice pathways.	❷ ❸ ❹	❼	900	450	• Reduced postoperative complications • Reduced use of critical care • Reduced length of hospital stay by 2 days • Reduced readmission rates • Overall reduction in costs • Better long term patient health reducing diabetes, hypertension, dementia and recurrence of cancer • Reduce unnecessary secondary care intervention • Ensure patients are physically and psychologically prepared for surgery • Ensure timely access to a service. • Release c3,000 bed days across BCUHB per year
Eye Care Services: transform eye care pathway	Invest in the pathway redesign to transform the provision of eye care and deliver a sustainable service for the population of North Wales.	❷ ❸	❼	2,590	1,563	• Maximising eye health and sight retention for the North Wales population • Achievement of national standards, the eye care measure and access targets • Elimination of existing backlog • Significantly improved patient experience and outcomes • Increased capacity of hospital services optimising the management of patients at risk of irreversible sight loss • Significant reduction in unnecessary / inappropriate referrals • Significantly improved operational efficiency and productivity

				• Adherence to and consistent application of best practice and guidelines
Urgent Primary Care Centres (UPCC) pathfinder programme	The UPCCs provide additional capacity to support GP practices and Emergency Departments, with patients triaged to the centres both in and out of hours. These pathfinders will be further developed, with the continuation of the Wrexham/Mold Centres (supporting 6 clusters) and the North Denbighshire Centre commencing in Q1, in Rhyl. Development of a pathfinder in the West Area, with the aim that this will be in place in readiness for winter.	❷ ❺	2,200 1,600	• More timely, efficient care for patients with urgent primary care needs that meet the UPCC inclusion criteria • More capacity within ED and GP to provide more timely care for other patients with urgent needs that they may not have been able to deal with on the day/within-waiting times • Ensuring UPCC offers a cost effective service to the Health • Board and the wider population • Ensuring that the UPCC clinical capacity is used (appropriately) to full capacity • Reduced demand for minor illness/injuries treatment in ED • Improved access in GP practices for those patients with more complex conditions • Reduced demand for minor illness/injuries treatments in ED • Improved access in GP practices for those patients with more complex conditions
Single Cancer Pathway	Implement the new Single Cancer Pathway across North Wales To improve Health Board performance against the Single Cancer Pathway measures.	❹ ❺	2,000 1,500	• Improved performance against the Single Cancer Pathway measures / targets
Stroke Services	Confirm and agree the stroke service model and business case to improve stroke services across North Wales.	❷	3,852 1,059	• Provide specialist stroke recovery support at home. This follows the care closer to home strategy of the Health Board

	Provide a 'Once for North Wales' network approach to ensure consistency of clinical outcomes for Early Supported Discharge (ESD) and Specialist Integrated Community In-patient Rehabilitation Services.				• Reduce time spent in hospital for 37% of current stroke patients (and all the risks to deconditioning involved in prolonged hospital stay) with an intended 12% reduction in bed days • Improved recovery and increased independence following stroke recovery • Consequential improvements in performance measures achieved within the first twelve months of full ESD implementation, increased therapy interventions and additional specialist nurses in post - 515 patient discharges home sooner with ESD / reduction of 2,575 bed days
Urology Services	Implement preferred service model for acute urology services. Finalise urology review. Linked to robotic assisted surgery Implementation of robotic surgery for cancer patients across North Wales.	❸	929	929	• Continued delivery of urology services across BCUHB • Improved recruitment and retention rates • Dedicated urological specialist teams • Reduced complication rates • Improved access for patients • Retain services and reduce outsourcing • Provide an equitable service • Provide increased choice • Potential to attract activity and income from other health boards • Reduced recovery time with less pain and quicker return to normal activities • Provides best practice techniques for patients requiring diagnostics and treatment • Improved cancer staging • Decreased cancer waiting times • Continued delivery of specialist cancer services • Reduced length of stay in an acute setting: patients are home quicker following safer surgery • Increased throughput

					• Improved utilization of operating department facilities and theatre efficiencies
Home First Bureau (HFB)	Implement Welsh Government guidance by developing a HFB model that is available 08.00 – 20.00 daily that mitigates the risks to vulnerable people, protects resource, maximises the opportunity for active therapeutic input and provides challenge into the discharge pathway for support outside of hospital.	❶ ❹ ❺	1,770	1,770	• Increase in the number of patients on pathway 2 (own home) rather than requiring pathway 3 ((step down facilities) • Reduction in number of delayed transfers of care • Increase in assessments of patients post discharge leading to shorter length of stays and releasing beds allowing for an improved patient flow within hospitals • Positive advantage for the patients who have a delayed transfer of care due to lack of resources to assess • Increase in patients returning home rather than having to be cared for in a community bed • Reduce the overall long-term placements in hospital/care home • Allowing patients to return to the best life possible following their period of illness, think home first
ED workforce	Workforce capacity to meet population demand and deliver Welsh access model.	❹ ❺ ❽	1,200	1,200	• Supports delivery of Welsh access model and access principles and priorities adopted across all sites • Emergency department access pathway delivery to include a 'contact first' system, 'streaming hub', and 'wait & care system', leading to more efficient navigation of patients
WOD Resource: Strategic Recruitment and Resourcing	Delivery of workforce optimisation programme encouraging reduction in agency spend and efficiency's.	❹ ❽	270	270	• Reduce vacancy levels • Improve retention • Reduce agency spend • Increase levels of bank provision
Neurodevelopmental (waiting times -	Increase access capacity supporting the recovery in	❸ ❻	1,400	1,400	• Provision of additional ND assessments for lost activity

backlog) Recovery of lost activity	waiting times for Neuro-developmental assessments due to the suspension of non-urgent activity between March 2020 and phased restart which commenced in October 2020.			• Achieve RTT compliant waiting list for ND assessments within the time period of the next 12-24 months
CAMHS training and recruitment	Recruitment of child psychiatry trainees across BCUHB supporting progression to future consultant posts with additional specialist nursing support posts for non-medical prescribing.	❹ ❻		• Support service continuity • Ongoing provision of child psychiatry within CAMHS services across BCUHB • Reduced clinical risk • Reduced reliance on locums
Primary & Community Care Academy	Further development of the academy to support recruitment, innovation and research in primary & community services. This will continue to support the delivery of the national model for primary care and contribute to a sustainable service.	❸ ❹ ❺ ❼ ❽	3,229 940	• Number of professionals choosing to follow a career in primary care • Retention of staff post training • Retention of staff post retirement age • Increase in the number of MDT professionals in primary care • Recruitment of suitably qualified/experience of staff to vacancies in primary care • Increase number of extended and advance practice clinicians working within primary and community services • Practitioners working to the ceiling of their competencies within primary care • Increased number of professionals both clinical and non-clinical who have received education and training in their relevant fields based on a skills gap analysis

					• Increased capacity within primary and community care health settings to meet demand • Improved communication between primary, community and secondary care and partner agencies
Care Home Quality Nurses	To ensure the care home sector continues to deliver safe effective care to the residents of North Wales.	❶ ❷ ❹ ❺	102	102	• Enhancing the quality of life for people with care and support needs • Delaying and reducing the need for care and support • Ensuring that people have a positive experience of care • Safeguarding and protecting from avoidable harm
Continuing Health Care infrastructure	Restructure of the 3 area continuing health care teams – strengthening the new assessment and review functions within CHC.	❹ ❺	1,138	1,138	• Compliance with CHC legal framework requirements, with assessments and reviews being conducted within required timescales • Timely decisions on eligibility • Reduction in dispute cases • Reduction in retrospective cases • Reduction of care homes in escalating concerns due to quality assurance concerns • Reduction in number of complaints with regards to discharge from hospital arrangements and application of correct CHC processes • Improved patient and family experience • Improved recruitment into CHC teams • Clinical outcomes measurable following PDN involvement in care homes e.g. reduction in avoidable HAPU's, reduction in falls with harm, reduction in WAST attendances and transfers to hospital sites • Reduction in CHC overdue reviews, reduction in the number of patients receiving additional staffing hours. Patients will be assessed in the right place,

				right time by expert staff so as to ensure correct eligibility decision first time
Advanced Audiologist / Ear Wax (Primary Care Audiology / pathway redesign)	Extension of the advanced practice scheme and implementation of an audiology led earwax management pathway across BCUHB.	❸ ❹ ❼	800 461	• Evaluation of existing services will continue to ensure a safe, effective and high quality service is delivered. • Key performance data will be collected, analysed and shared routinely at a whole service level and locally within each practice or and/or locality. This will include: o Demand and activity o First point of contact (enabling more than 22,000 people each year to access Audiology) o Referral rates to ENT and audiology o Appropriateness of onward referral o Patients experience o Primary Care clinician experience

In 2021/22, the part year effect of all the above schemes fully commits the £30m performance funding, whereas in 2022/23 there is a full year effect of £38.44m leading to a potential over commitment of £8.44m. This will be managed down via business cases and 2022/23 planning.

It is critical that the investments set out above, along with the other actions to be identified, are delivered in a timely fashion and have tangible impacts upon the performance of our services.

The table below sets out a high level summary of key performance metrics for 2021/22:

	Lead Executive Director	30 Jun 2021	30 Sept 2021	31 Dec 2021	31 Mar 2022
Number of people waiting over 52 weeks for planned care treatment (inpatient, outpatient or day case)	Deputy CEO	43,500	43,500	48,000	43,000
Number of people waiting between 36 and 52 weeks for planned care treatment (inpatient, outpatient or day case)	Deputy CEO	55,600	55,600	51,600	44,500
Compliance with the eye care measure	Deputy CEO	45%	55%	70%	80%
Compliance with the single cancer pathway	Dir. of Therapies & Health Sciences	65%	67.5%	70%	72.5%
Number of people waiting over 8 weeks for a diagnostic procedure (excluding endoscopy)	Dir. of Therapies & Health Sciences	3,600	2,000	500	0
Performance against the mental health measure Part 1a	Dir. of Public Health	81%	76.8%	88.8%	83.1%
Performance against the mental health measure Part 1b	Dir. of Public Health	90%	83.2%	92.9%	83.1%
CAMHS – time to assessment	Dir. Of Primary & Comm. Care	30%	40%	50%	60%
CAMHS – time to treatment	Dir. of Primary & Comm. Care	25%	40%	60%	60%
Emergency department & MIU compliance against the 4 hour performance target	Deputy CEO	70%	73%	75%	80%
Ambulance handover delays over 1 hour	Deputy CEO	1,300	1,200	1,200	1,200
Number of people waiting over 12 hours in our emergency departments	Deputy CEO	2,200	1,700	1,000	1,000

The above trajectories have been refreshed from our March draft plan to reflect actual performance up to mid-June. Quarterly profiles have been derived from this revised starting position. The quarterly differentials within our March plan continue to apply and are being continually monitored and reviewed with service leads.

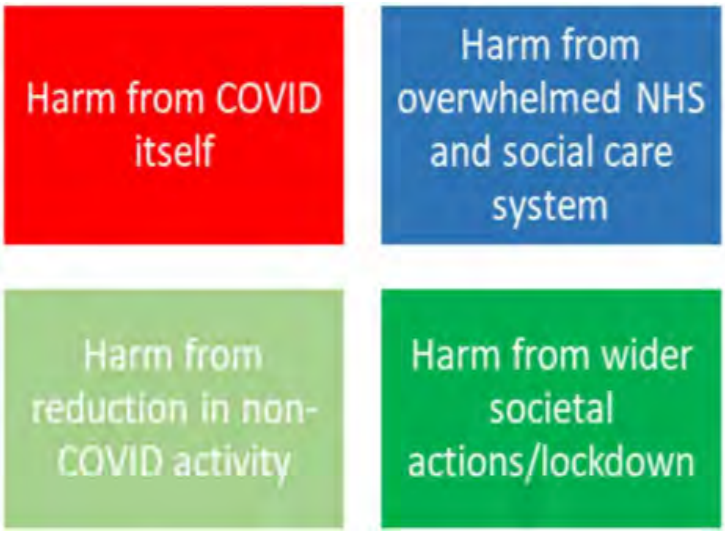
The performance metrics above highlight the total number of patients waiting over 52 weeks are expected to remain broadly the same over the year. Section 9 describes the work we are doing in terms of planned care recovery and explains that the shape of the waiting list cohort is changing as we plan to clear pre-pandemic over 52 week waits by the end March 2022 alongside seeing the continued deterioration in our waiting lists due to COVID-19.

Adult mental health operational teams have put strengthened arrangements in place to monitor and review performance, holding services to account.

CAMHS services fall under the Targeted Intervention Framework within which Access (including the Mental Health Measure (MHM) targets) and Workforce are two of the identified workstreams. Based on a demand increase in CAMHS services, both in relation to the number and acuity and complexity of referrals we have updated the CAMHS trajectories. Priority is being given to the development of a robust workforce plan which will support the sustained delivery of the MHM 1a (assessment) and 1b (therapy) targets, in the meantime a tender process is underway for private provision of assessments and therapy to enhance the capacity of the local teams. The figures included in the trajectory assume that teams can continue to access private providers via single tender waivers until a full tender has commenced and that demand does not escalate beyond currently anticipated levels, however the latter is extremely difficult to predict given uncertainties around expected demand.

5. COVID-19 and recovery

This plan has been developed paying particular attention to the effective management of risk and the avoidance of harm. The potential for harm during the pandemic is particularly heightened and the Health Board has considered the four dimensions of harm arising from COVID-19 as set out here:



Using this framework to view potential harm whilst developing the plan has enabled key priority areas to be identified for immediate action, reflecting the urgency of the current situation. The plan also identifies critical strategic steps, which need to be progressed at the same time in order to drive further improvement in services.

As we continue to see a high prevalence of COVID-19 and the emergence of new variants, we will maintain our health response working with partners to manage the impact on operational capacity across primary, community and acute services. Our planning assumptions for the next 6 months continue to prioritise COVID-19 programmes alongside re-establishing services, capturing and utilising new ways of working and maintaining good practise from lessons learnt throughout the first and second waves of the pandemic.

Test, Trace and Protect continues to play a pivotal role in our overall approach to preventing the transmission of COVID-19 across North Wales, and protecting our population. Our plan focuses upon the delivery of a resilient, sustainable service.

5.1. Primary and community care recovery

Primary care and community based services face particular challenges in continuing to respond to the requirements of the pandemic whilst also making progress towards recovering full service delivery, including addressing the backlog in supporting patients with chronic conditions.

As part of our COVID-19 response in primary care, we will:

- Continue to work in partnership with GP practices to deliver the COVID-19 vaccination programme, along with community pharmacies and other primary care professionals. Joint plans will be developed to deliver the booster programme which will need to consider the impact on primary care capacity and potentially wider recovery;

- Continue to implement any Welsh Government contract changes to support independent contractors across primary care to protect some elements of our primary and community services. As we develop our plan for recovery during 2021/22, we need to consider how to rebalance funding,

workforce and other resources to support the development of primary and community care services to stabilise and then move care closer to home;

- Continue to work in partnership with the national Strategic Programme for Primary Care and ensure resources developed are utilised to support the sector;
- Work with cluster leads and contractors to support the recovery of planned care for patients with chronic conditions;
- Continue to provide support to primary care contractors in the development, roll out and evaluation of new technologies, including telephone triage/consultation and video consultation, and the eConsult and AccuRx digital tools. The evaluation will include a reflection of feedback from patients and clinicians, as well as a review as to how they can support efficient working and improve access, in the context of recent significant increases in demand in GP practices;
- Introduce pathways and resources to provide support for patients presenting with long COVID syndrome in line with national guidance; and
- Work in partnership with secondary care clinicians to support patients waiting for planned care treatment in primary and secondary care services.

5.2. Vaccination implementation plan

Further to the All Wales National Strategy published on the 11th January, a North Wales Mass Vaccination Implementation Plan (MVIP) was developed to set out the route for delivery of the COVID-19 vaccine programme. The plan was developed as a matter of urgency alongside the implementation of the mass vaccination programme itself.

A North Wales Strategic Vaccine Group was established with multi-agency partners reporting initially to the North Wales Strategic Co-ordination Group (SCG). A tactical delivery group was also established to ensure implementation of the programme. The initial delivery model adopted was as set out below.

Setting	Cohort
Hospital Vaccination Centre (HVC)	Frontline healthcare workers Care home staff
Mass Vaccination Centre (MVC)	Care home staff Frontline healthcare workers Frontline social care workers Age cohorts
Primary care (GP Surgeries)	Frontline healthcare workers Frontline social care workers Care home staff (complete) Age cohorts (initial focus on over 80s)
Local Vaccination Centre (LVC) Contingency service	Frontline social care workers Age cohorts Support for primary care
Care homes	Care home residents
Domiciliary care	All housebound
Community pharmacy	Frontline healthcare workers Frontline social care workers Care home staff (mop up) Age cohorts (initial focus on over 80s)

Implementation of the programme is progressing at pace and the programme has been required to be fluid in order to respond to changing scenarios in relation to priority cohorts, vaccine supply, and changing guidance from the UK Joint Committee on Vaccination and Immunisation (JCVI) in relation to the vaccines. In particular, changes to the recommended eligible groups for the Astra Zeneca (AZ) vaccine have necessitated rapid changes in delivery.

To date, all targets for the vaccine programme in terms of delivery for priority cohorts have been achieved. It is expected that the target for offer of the vaccine to all adults by July will also be achieved, subject to availability of supplies. The table below sets out the progress (as at 29/06/21) in delivery of vaccines by priority cohort.

Priority Group	% Vaccinated 1st dose	% Vaccinated 2nd dose
P1.1	106%	95%
P1.2	91%	82%
P2.1	98%	94%
P2.2	98%	91%
P2.3	100%	97%
P3	98%	95%
P4.1	97%	94%
P4.2	96%	90%
P5	95%	92%
P6	89%	76%
P7	90%	81%
P8	88%	69%
P9	89%	53%
P10.1	81%	14%
P10.2	62%	5%
P10.3	71%	4%

An equality impact assessment was undertaken on commencement of the development work for the vaccination programme. This has been reviewed and an updated action plan put in place to address barriers to participation. Excellent work has been undertaken in conjunction with Local Authority partners including vaccination of homeless people, gypsy and traveller communities, the D/deaf community, and to engage with many community groups to address language and cultural barriers.

As at 30th June 2021, 877,383 vaccine doses had been delivered across all cohorts in North Wales; and a total of 376,206 people have now received both 1st and 2nd dose vaccinations. Immediate next steps for the vaccination programme include:

- Retention of facilities at Deeside leisure centre to ensure successful completion of the initial vaccination cycle;
- Secure new sites to ensure adequate local capacity including the OpTic Centre in St Asaph and Bangor Cathedral;
- Expansion of the network of Local Vaccination Centres in the East;
- Diversifying delivery methods to ensure all groups have access to the vaccine – leaving no-one behind; and
- Developing surge vaccination proposals to support areas of outbreaks and high risk areas and settings, including response to the growing impact of Variants of Concern.

Ongoing issues of concern include:

- The change of recommended age groups for AZ, as referred to above, creating reluctance to take up the vaccine in the younger adult cohorts;
- Vaccine supply concerns due to an increase of 60,000 in the 30-39 age group requiring Pfizer, as well as disruption caused by pressures on the global supply chain; and

- The increasing need to return to 'business as usual' within the Health Board, with consequent impact on staff capacity and availability.

Further work will be undertaken pending confirmation of the booster programme by the JVCI which will also link into the Health Board flu vaccine programme for the purposes of planning and delivery.

The programme is currently working up future models for the booster programme, based on the most likely option identified by Welsh Government:

- Cohorts 1-9 and children 12 to 17 (2 doses)
- Cohort 10 in priority order from circa 6 months from 2nd dose.

This equates to circa 700,000 doses needing to be delivered. Outline plans were shared with Welsh Government on 18th June. Key assumptions still outstanding include vaccine type; length of programme; concurrent delivery with flu; start date; vaccine supply chain and potential primary care support.

5.3. Safe Clean Care Harm Free (SCC-HF)

As part of the Health Board's response to all health care associated (nosocomial) infections transmission, including concerns around the COVID-19 pandemic, a large-scale change mobilisation programme has been launched supporting the Health Board's approach of 'Stronger Together'. SCC-HF utilises the behavioural science methodology defined as COM-B (Capability, Opportunity, and Motivation - Behaviour) with specialist advice and support in applying this technique provided by Public Health Wales (PHW) and their behavioural science unit.

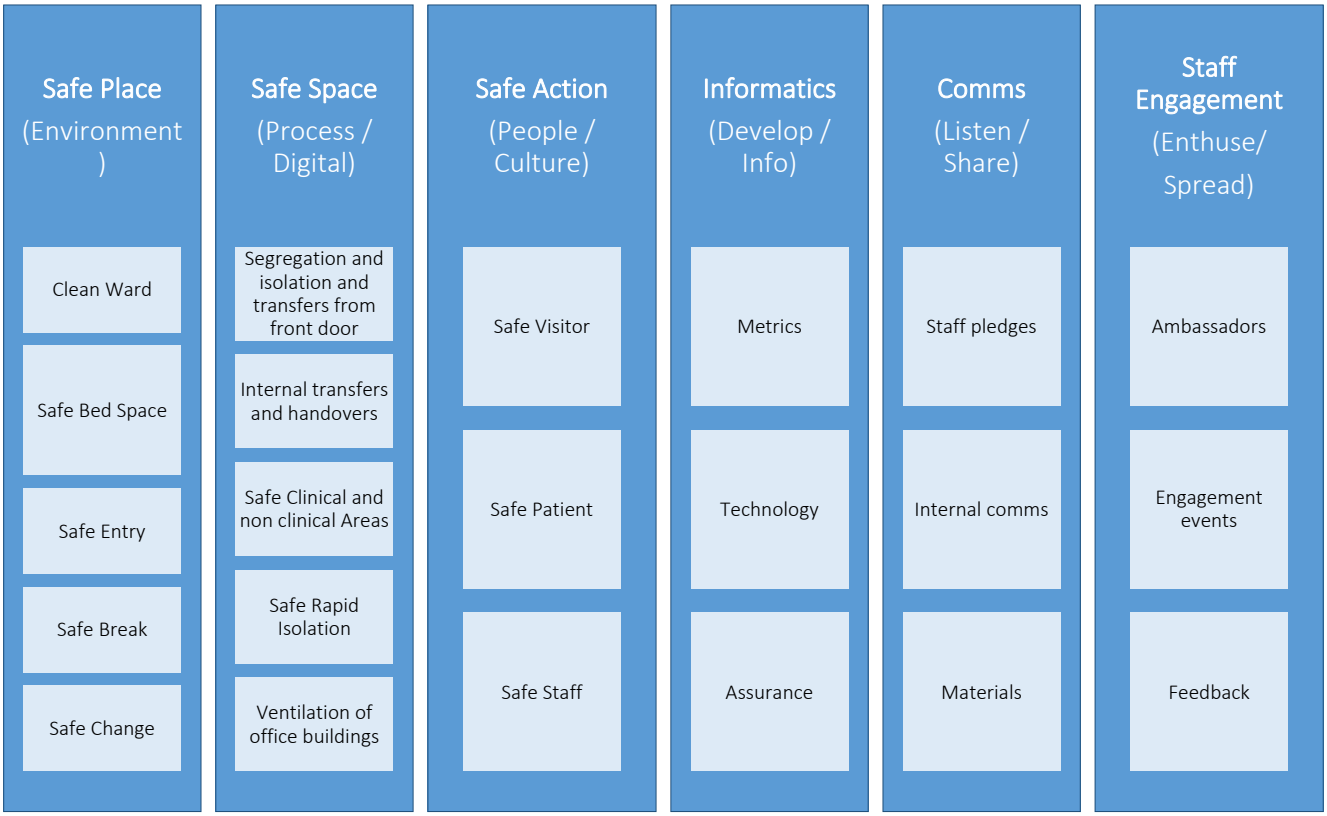
The key aim is to achieve sustainable changes in staff behaviour in order to create a harm free zero tolerance attitude to nosocomial transmission within our health care settings by December 2021 at the latest. This approach equally fully reflects the 'Safe Clean Care' principles previously adopted within the Health Board.

In 2018, the Health Board implemented a Safe Clean Care strategy to strengthen infection prevention leadership and assurance. Due to COVID-19 and related factors the original philosophy has been amended and strengthened to now include new priorities and re-branded as Safe Clean Care – Harm Free (SCC-HF).

This sits alongside the learning from all our nosocomial post infection reviews shaping the behavioural change which is needed across the health board to deliver safe clean care harm free. The focus is upon reducing the 'intention to action gap', as no one comes to work to do harm.

Safe Clean Care Harm Free (SCC-HF) Programme on a Page

The overall programme has been structured to fully reflect standard project management principles as follows.

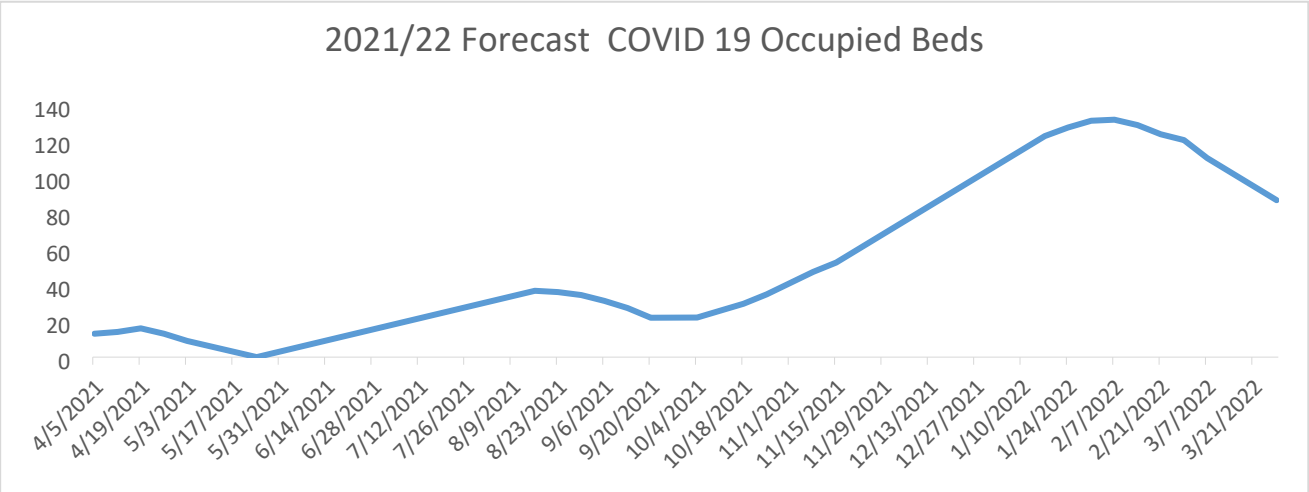


5.4. Coronavirus Co-ordination Unit

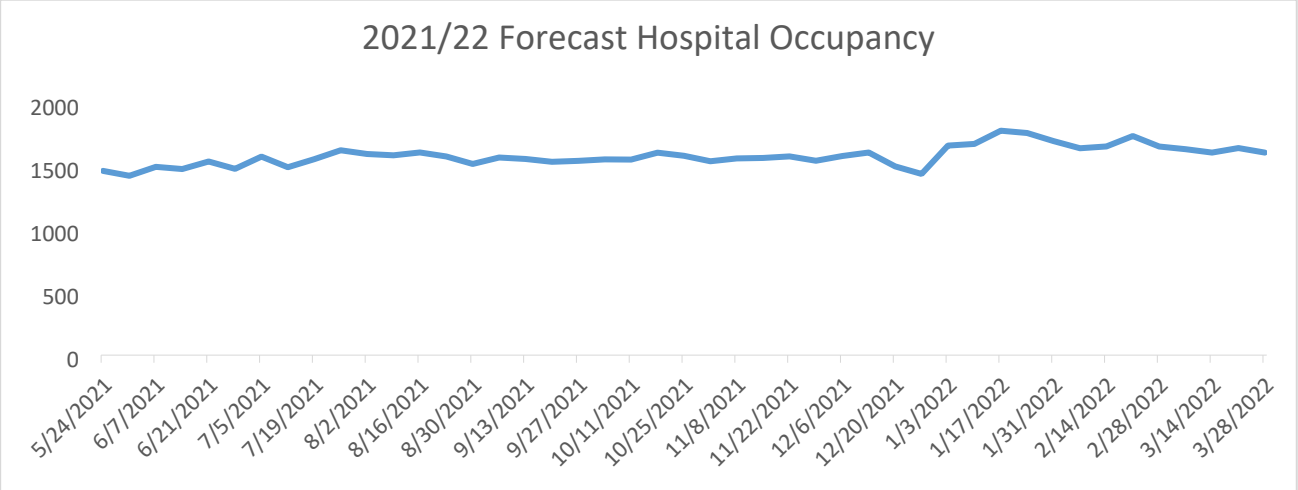
The Health Board Coronavirus Co-ordination Unit supports the response to the current phase of the COVID-19 pandemic. Our plan envisages that the Executive Incident Management Team (EIMT) will phase down its activities as community transmission continues to stabilise, alongside the reduction in COVID-19 related hospital admissions and intensive care demand. This will allow a greater focus on 'business as usual' as activity begins to re-generate and recovery and reset accelerate. It is well recognised, however that the impact of the pandemic is not entirely predictable and will remain significant throughout the course of the year, and likely for many years to come.

Our current assumption for new cases of COVID-19 during the year 2021/22 is a third wave in the summer months with peak hospital occupancy forecast mid to late August before a further increase in the winter months. Forecast hospital occupancy volumes are based on the most likely scenario (MLS) (issued in March 2021) with timing adjusted locally to move the peak occupancy to later in the year and factor in differing peak times for each of our sites as observed in previous waves.

Revised national modelling work will continue to be reviewed and inform our local planning assumptions. The following chart sets out our current forecast demand for COVID-19 beds, using 30% of MLS in the summer months moving to 100% in the winter period.



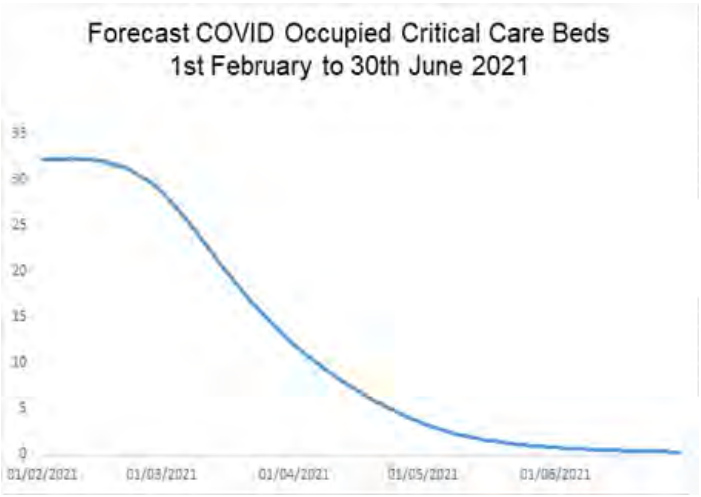
We have reviewed our plans for hospital occupancy for quarter 1 and beyond, taking into account the changing situation regarding COVID-19, an expected demand increase on non-COVID unscheduled care and planned care recovery. Expected bed occupancy for acute and community sites (medical and surgical beds) combined is shown in the following chart.



Our plans will continue to be refined as we gain further intelligence in relation to COVID-19 and the anticipated increased prevalence of other infections over the winter months.

Whilst we are seeing the number of admissions to critical care stabilising we are not expecting to see a significant reduction and it will be some time before the vaccine has an impact on critical care.

We have been consistently tracking between the MLS and reasonable worst case scenario (RWC) and based on this, our forecast will continue at 45% of the reasonable worst case for critical care occupancy as shown in the graph below.



We have considered the information emerging from the above in setting our bed planning for 2021/22. Our current plans involve the following:

- Designated COVID-19 hospital beds in our hospitals, including potential surge beds, are being reviewed in light of revised modelling in 2020/21;
- Our non-designated COVID-19 hospital beds will increase to 1,869, reflecting the change in use for some of the surge capacity previously in place to meet Covid needs;
- The national recommendation for minimum capacity invasive ventilation beds is to maintain 25% above baseline. Revised national capacity analysis suggests a range of 25 to 47 occupancy (31 to 59 beds at 80% occupancy) taking into account higher and lower projections. The funded complement of 36 beds will meet the lower end of this range. Planning is continuing concerning surge capacity staffing to address the higher end should this be required;
- Non-invasive ventilation outside of critical care is being reviewed but in the region of 27 beds may be maintained; and
- Post anaesthetic care units to be in place and by end of quarter 1 there will be 9 PACU beds across North Wales.

In addition to the direct impacts upon hospitals outlined above, it is expected there will be a COVID-19 related additional increase in demand for longer-term care packages and care home placement, despite the greater focus on discharge to recover then assess pathways.

Given the uncertainties regarding the continued impact of COVID-19, contingency plans for our escalation of COVID-19 response and bed capacity will continue into 2021/22. Monitoring and surveillance will continue to ensure that early warning signs of potential need for escalation are acted upon. The EIMT arrangements will be escalated to respond as required in the event of a significant or generalised increase in COVID-19.

The digital legacy of COVID-19 will inform future change and being reflected in the demand and capacity modelling assumptions and local solutions. We will work to optimise this benefit whilst also ensuring that the adoption of digital technology does not unfairly exclude some members of the population, leading to an unintended adverse impact by widening health inequalities.

Whilst the immediate hospital pressures of COVID-19 are expected to reduce, other aspects of demand for services are indicated to rise. This includes attendances at emergency departments, emergency admissions and GP referrals. Our plan sets out how we propose to respond to these changes in demand.

We are also acutely aware of the impact on our workforce of COVID-19 and with that in mind have taken into account a number of factors to ensure the continuity and resilience of our workforce for the coming period.

Initial indications are we need to recruit and deploy additional workforce capacity to build into existing measures such as transitioning the vaccination programme to business as usual and supporting the planned care backlog. With this in mind we are increasing bank hours plus other internal temporary staffing mechanisms in the first part of next year, given the timescales for substantive recruitment and the necessity to keep the workforce flexible until stability is restored in the second half of the year.

We have stable recruitment profiles in terms of students qualifying and taking up established roles across the Health Board and have an international nurse recruitment programme in place which will provide us with 111 nurses. We also expect to see the number of returners fall across the year 2021/22 in line with the COVID-19 related programmes' activity decreasing, given that the majority of returners have come back to support these programmes. There are initiatives being worked on to try to retain some of this workforce to support the organisation given the different, but ongoing workforce pressures the Health Board will face over the coming year.

6. Key performance lessons learnt and challenges for 2021/22

2020/21 proved to be a challenging year across the whole health and care sector. Section 1.1 set out some of the Health Board's key achievements during the year but there are challenges that clearly remain to be addressed, requiring focussed attention in our 2021/22 Plan.

For our primary care contractors, these include:

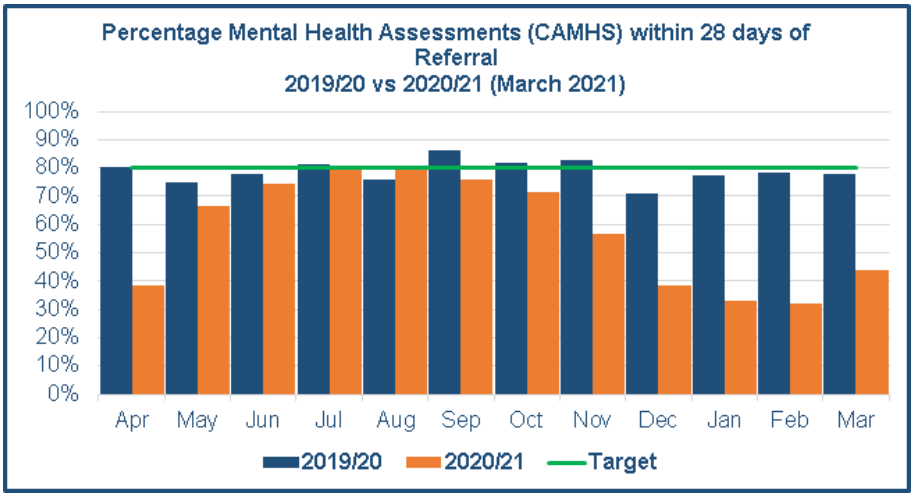
- Growing demand for primary care services, with a wide range of face to face and digital access routes now in place;
- Significant pressures on workforce, including those arising from COVID-19;
- A decrease in capacity of some key services due to infection prevention and control (IPC) requirements, such as phlebotomy;
- Support for patients those with one or more chronic diseases, and addressing the backlog of care; and
- Support for patients whilst they wait for their planned care treatments from secondary care services.

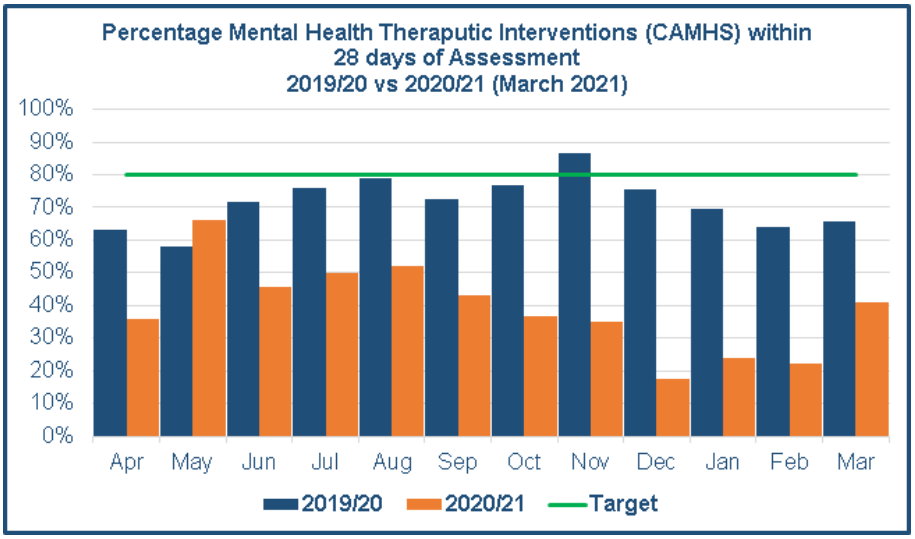
Whilst significant improvements have been achieved in adult mental health provision in relation to access to mental health assessment and treatment within 28 days of referral, there remain challenges

in achieving the commencement of psychological therapy within 26 weeks of referral. Current delivery is improving, however we only achieve a performance of 45% against a target of 80%, resulting in longer waiting times for our patients.

Child and adolescent mental health services (CAMHS) continue to see challenges relating to reduced capacity within the teams and reduced physical capacity within CAMHS accommodation due to social distancing requirements. As a result, performance against access standards has been impacted. Current delivery is 17% against a target of 80% for children and young people commencing therapeutic interventions within 28 days of assessment and only 38% receive an assessment within 28 days of referral. Improvement in access to services is required to meet Welsh Government assessment targets and there is a need to further develop early intervention post diagnostic services.

The graphs below summarise the performance challenges facing our CAMHS service in meeting the requirements of the Mental Health Measure:





Following the first lockdown in March 2020 there was a significant reduction in both the number of attendances and ambulance conveyances to the three Emergency Departments across North Wales. Activity has fluctuated over the past 12 months with increases and decreases broadly corresponding to changes in COVID-19 lockdown restrictions, however, the total number of attendances across the

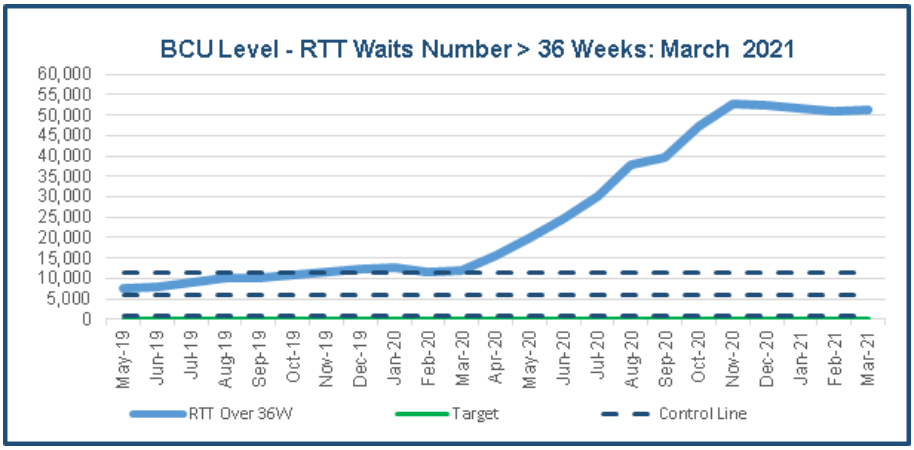
Health Board for 2020/21 has remained below pre-COVID-19 levels. We expect that the further lifting of restrictions will result in an increase in attendances to pre COVID-19 levels.

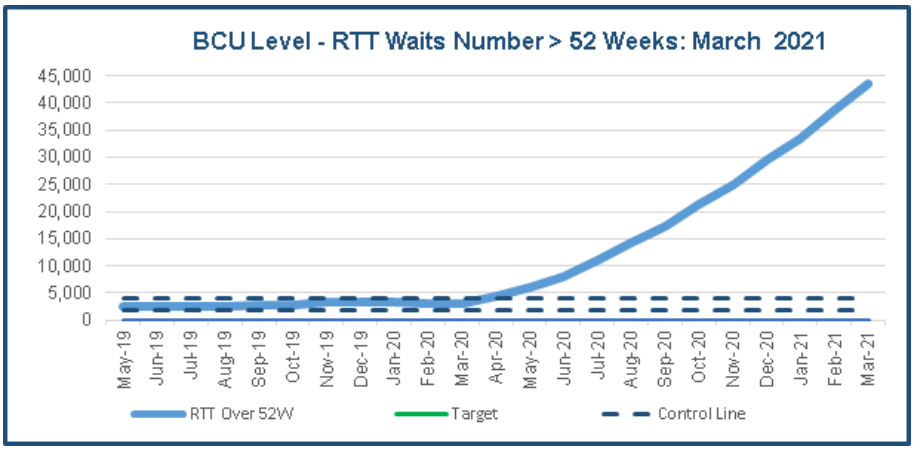
Our unscheduled plan in section 11 reflects the work being undertaken to address this anticipated increase and includes actions to improve flow in our secondary care Emergency Departments and the transformation of emergency and urgent care services, with initiatives such as Phone First, 111, the use of alternative pathways and the development of Urgent Primary Care Centres.

Initially, the COVID-19 pandemic had a significant impact upon the number of urgent suspected cancer referrals from our General Practices, falling to 37% of the 2019 monthly average in April 2020. However, after a joint communications campaign by the Health Board and Welsh Government, referral rates quickly increased and were at pre-pandemic levels again by July 2020. From 1st January 2021 cancer performance measures moved to the Suspected Cancer Pathway and our plans for 2021/22 include a number of initiatives to support delivery of the new measure.

During the first few months of the pandemic the number of patients waiting over 8 weeks for a diagnostic test rose to a peak of just over 15,700 by September 2020. Capacity was significantly reduced due to the need to work safely with COVID-19 and non-COVID-19 patients and as such the focus was on seeing patients on an urgent or urgent suspected cancer pathway. At the end of March 2021 the number of patients waiting over 8 weeks had been reduced to just over 8,000. The highest number of delays are in Endoscopy, Cardiology and Radiology and reducing the delays in these areas is a focus of the Annual Plan for 2021/22.

At the end of March 2020, there were 11,798 patients waiting over 36 weeks, and 3,113 patients waiting over 52 weeks on a Referral to Treatment pathway. At the end of March 2021, the number of patients waiting 36 weeks was 51,433 and the number waiting over 52 weeks was 43,423. Comparing these figures highlights the impact of the pandemic on planned care services and the scale of the task to address the backlog of long waiting patients.





A new model of waiting list management, alongside that of the Referral to Treatment model was introduced to ensure the safe management of the growing numbers and length of wait for patients on our waiting lists. In line with other Health Boards in Wales, the Health Board implemented the Royal College of Surgeons risk stratification methodology to manage the waiting list on the basis of level of risk of harm to patients.

In addition, the Health Board adopted new ways of working such as virtual clinics and consultations for our patients. This was complemented by the introduction of Consultant Connect to enable GP's to access consultant advice and thus reduce the need to refer patients into secondary care.

The pandemic has been a catalyst for modernising the outpatient follow up model which will release capacity to help reduce the waiting times for patients. Where appropriate and clinically safe to do so, patients are now discharged from follow up with either a 'See on Symptom' (SoS) or a 'Patient Initiated Follow Up' (PIFU). This allows patients to come back into the system without having to see their GP for a re-referral.

7. Key integrated planning assumptions – COVID-19 workforce and finances

Developing this plan in the context of the pandemic has been complex given the uncertainty with regard to resource availability, particularly workforce and the overall impact and implications of COVID-19. This has required a number of assumptions to be made in support of our planning activity. Given the importance of these assumptions, it is critical that they are documented so that they can be understood when assessing the delivery aspects of this Plan. We have identified five workforce assumptions:

- The sickness absence rate forecast for the year ahead has factored in the potential effects of Long COVID by identifying staff with open COVID-19 related sickness record in excess of 28 days, which currently stands at around 41 staff. Whilst we expect to see staff sickness reduce across the year, we expect this to be a gradual reduction primarily driven by a major reduction in COVID-19 sickness as the vaccination programme works through the cohorts and staff are vaccinated. This assumption is reflected across the other sickness lines reported in the minimum data sets (MDS) which support this Plan;

- With regard to vaccination, our workforce delivery model is underpinned by robust plans which provide assurance that through working in partnership we can achieve, if not exceed, our expectations in this most critical and challenging of COVID-19 programmes. Our plans detail the additional workforce to extend and expand the vaccination programme to support the delivery of cohorts P5-P10. The current plans are based upon primary care teams delivering approximately 60% of doses with the remaining 40% delivered through Mass Vaccination Centres (MVCs) and Local Vaccination Centres (LVCs). Staffing numbers are flat lined until July and then decrease in line with the plan, with contingency for provision of a business as usual service being required across Q3 and Q4 of 2021/22;

- The Test Trace Protect staffing has been flat lined across the year as it is estimated that this service will stay in place across 2021/22;

- For other COVID-19 related Whole Time Equivalents (WTEs) we have factored in a reduction at the rate of 10% each month from April 2021 onwards. This is based on looking at the areas currently supporting the COVID-19 programmes and estimating when they might start to stand down or reduce their services. This will of course be subject to review based on experience against the forecasting;

- We expect the cleaning standards put in place as part of the COVID-19 programme to stay in effect for the whole 2021/22 and as such have flat lined the WTEs associated with this work;

The financial assumptions associated with the COVID-19 operational response are:

- The Test, Trace and Protect and vaccination programmes remain active throughout the year;

- Specific financial arrangements for continuing healthcare and funded nursing care will continue for quarter 1 and be funded by Welsh Government;

- Other COVID-19 costs will continue until mid-August and be funded by Welsh Government.

Clearly, there remains a degree of uncertainty about these assumptions and they will be subject to review within the quarter 1 period with appropriate amendments being made to the plan in year.

Welsh Government planning guidance confirms that known COVID-19 costs will be funded through an additional resource allocation. Therefore, the financial assumption in the plan is that COVID-19 costs as shown in the table below and estimated at £115.7m, will be funded in the same way.

Funding of COVID	Pay £'000	Non Pay £'000	Total £'000
Covid funding - Stability funding	10,894	31,299	42,193
Covid Funding – PPE		6,544	6,544
National Programme - Cleaning Standards	2,297	192	2,489
National Programme – Care Homes		1,250	1,250
National Programme – Vaccination Programme	7,722	4,961	12,683
National Programme – Testing	2,374	429	2,803
National Programme - Tracing	2,806	10,721	13,527
National Programme - Protect	77		77
Surge Funding	122	1,340	1,462
Impact on Non Delivery of Savings		32,663	32,663
Total COVID-19	**26,292**	**89,399**	**115,691**

The Welsh Government has indicated that there will be an allocation of £170m to NHS Wales to cover some of the costs associated with COVID-19 during the first half of the financial year. The Health Board expected share of this allocation is £38.4m.

It is anticipated that the plan will be subject to quarterly review and amendment, as national and local assumptions around the impact of COVID-19 and recovery of planned care activity are updated.

8. Strengthen our wellbeing focus

The following table sets out the key deliverables for this element of our plan, with further supporting information below:

Key Deliverables 2021/22
• Continue to work to reduce the prevalence of smoking and associated harms;
• Progress our smoke free site activity by ensuring increased access to support services and the progression of the mental health smoke free action plan;
• Establish initiatives to be implemented as part of the homelessness/poverty programme, (in partnership with housing associations, third sector and local authorities);
• Implement the infant feeding project, by increasing training rates and improve activity rates;
• Develop and commence a children's tier 3 obesity service, and establish and implement referral mechanisms;
• Establish a Physical Literacy North Wales programme;
• Continue to focus on our vaccination planning, ensuring our general vaccination programmes are on track, alongside the additional COVID-19 vaccination planning for winter 2021/22;
• Continue to deliver the regional Test, Trace and Protect programme with a range of partners;
• Progress in partnership the inverse care law programme which seeks to identify opportunities for early intervention actions and targeted services.
• Implement the neurodevelopment model of working, improving access to services for children to meet Welsh Government assessment targets and further develop early intervention post diagnostic services;

The Health Board remains committed to a population health focus including strengthening wellbeing actions and tackling inequalities. The harm caused to the population of North Wales by COVID-19 is and will potentially be significant for some time to come and we recognise that the pandemic has hit our poorest communities the hardest.

Whilst overall health in North Wales is good, we still have long-standing health challenges across the region. These include our high smoking rates, issues relating to obesity (all ages), and limited physical activity levels. In recent years we have successfully progressed our work on the 'lifestyle bundle', to support healthy choices, promote self-care, ensure a focus on prevention and resilience work, and to support clinical pathway work (e.g. diabetes). We have placed a particular focus on setting up the required services, and therefore in 2021/22 we will start turning our attention to the wider challenges for individuals and communities.

From a population health perspective, we will continue to build on our activities and our plans for improving the health and well-being of the population in North Wales. We will do so in partnership

through whole system working – building on our work with localities, local authorities, universities and the Third Sector.

During the year ahead we will focus on health protection activities, prevention and early intervention, and improving health and well-being. We will specifically continue to place a significant focus on ensuring a good start in life though a focus on the health of the child.

This work will be underpinned by the refresh of our population needs assessment and well-being assessments. This work will be undertaken in partnership across the region, and will ensure a renewed focus on understanding needs at the local and regional level to support our planning work.

Our priorities are set out below.

8.1. Health Protection - we will:

- Continue to focus on our vaccination planning, building on the significant progress made to date to continue to improve the reach of this programme throughout our population, communities and priority groups. This will include ensuring our general vaccination programmes are on track, alongside the additional COVID-19 vaccination planning for winter 2021;

- Deliver the regional Test, Trace and Protect programme with a range of partners.

8.2. Prevention and early intervention - we will:

Further progress the key programmes which support life style choices, health improvement and the management of long term conditions through the continuation of the 'Prevention and Early Years' and 'Healthy Weight: Healthy Wales' funding. These include:

- Increasing take up of smoking cessation services through creating greater accessibility;

- Improving infant feeding rates through targeted support for families;

- Reducing childhood and adult obesity through further developing pathways and capacity;

- The creation of a network of physical literacy experts to support individuals, children and families,

- Progress the inverse care law programme through mapping current services and needs, and identifying areas of opportunity – through a partnership approach'; and

- Develop a framework on mental well-being (all ages), to support the wide range of public health mental health activities underway across the Health Board. This will support the targeted intervention activity, but more importantly support the emerging additional needs emerging post COVID-19.

8.3. Improving health and wellbeing - we will:

- Progress our work on the inverse care law, with a focus on our locality working, building upon our social prescribing activity across the region;

- Work to meet the needs of those most at risk through our strategic partnerships - the Alcohol Harm Reduction Strategy, the North Wales Suicide and Self Harm Reduction Strategy, and our Immunisation Strategy;

- Further grow the Well North Wales programme of work by expanding our food poverty and homelessness initiatives;

- Link with our community experts and third sector colleagues to help extend our reach to all vulnerable and hard to reach groups, alongside the work of our newly appointed BAME outreach officer;

- Explore and agree the next steps for our arts and health programme; and

- Support the Sports North Wales programme – to ensure the focus on meeting needs and promoting physical activity.

9. Recovering access to timely planned care pathways

Recovering access to timely planned care requires a whole system response with primary and secondary care clinicians working together to support patients both waiting for and having access to care in primary and secondary care settings.

Our ambition is to provide state of the art facilities, ultimately staffed by local NHS teams using modern equipment within timescales that will reduce harm to patients and enable robust and sustainable NHS services for our population of North Wales.

A strategic outline case for the development of Diagnostic & Treatment Centres was approved by the Board in May which envisioned highly technologically advanced equipment and a blended workforce that will provide much needed services, giving patients with cancer and vague symptoms the ability to have earlier assessment, diagnostics and treatment which would be regarded as world class. The exploration of options to expedite delivery of this much needed capacity to reduce harm associated with increases in demand associated with Covid delays has now commenced. This will enable the Health Board to achieve our goal of addressing the risk of harm associated with long waits and deliver a new and sustainable planned care service for our North Wales population. This could be achieved within around two years, compared to a more traditional process that could take us five to six years to achieve the same goal.

The approach would enable us to reduce harm and provide health and socio-economic benefits to our population. The proposal is to utilise funding that leaves a positive legacy and wholly owned and run facilities by the Health Board.

The key benefit of a revenue and partnership route for example is that it improves the efficiency of the unit - providing state of the art facilities procured cost effectively and equipment that has a guaranteed efficiency as part of the contract, with fast turnaround of equipment and minimal “downtime”, delivering high levels of efficiency.

In terms of workforce availability, a partnership approach may afford additional employment flexibilities. The proposed service model is also likely to be inherently more attractive offering rotational opportunities, clinical skills development, and multi professional education and training.

The model will enable decoupling of unscheduled and scheduled care, reducing cancellations on the day of surgery, providing capacity to better manage unplanned access via Emergency Departments. It will provide an improved environment for patients and our workforce who would be able to focus and deliver a new model of surgical delivery free from the disruption of the district general hospital pressures and in turn attract further research and development opportunities.

This proposal will ensure that all appropriate patients currently being treated outside of North Wales can be repatriated to receive healthcare closer to home.

The following table sets out the key deliverables for more immediate planned care recovery, with further supporting information below:

Key Deliverables 2021/22

- Deliver the 'Six Point Recovery Plan' that builds on improving business process and improving care through reducing waiting times across North Wales;
- Support the continuation of AccuRx on line platform for GP Practices, to promote efficient access to general medical services;
- Increase dental treatment provision, moving towards delivering the pre-COVID-19 activity levels throughout 2021/22;
- Work with cluster leads to develop and implement proposals to address primary care backlog, particularly in relation to supporting patients with one or more chronic conditions;
- Continue to develop the Primary & Community Care Academy to support the delivery of the Primary Care Model for Wales, with a focus on innovation, research, new ways of working and recruitment;
- Deliver an earwax management programme to improve access for patients;
- Build upon the 'Once for North Wales' approach, using our hospital capacity flexibly to meet the needs of the whole population. Implement consistent approaches to demand management and patient validation through our outpatient transformation programme and end to end pathway redesign;
- Implement 'Attend Anywhere' and online consultations (eConsult) to improve access. Improve the triage process to ensure the most appropriate clinician to meet a patient's need;
- Develop a diagnostic and treatment centre model to transform planned care service delivery;
- Ensure patients are physically and psychologically prepared for surgery, improving patient outcomes and reducing length of stay, for example through prehabilitation;
- Deliver a sustainable eye care service for the population of North Wales based on the work to support the introduction of the national eye care measures;
- Deliver improvement against the single cancer pathway, enabling delivery of the national target of 75% of all patients achieving the single cancer pathway;
- Implement urology services redesign enabling work to progress on service developments including the introduction of robotic surgery in North Wales;
- The implementation of the national Maternity Strategy for Wales (2019-2024) to include the transformation of maternity services and working in partnership with early years services;
- Transformation of gynaecology and specialist services. Review of free standing midwifery led units across the North Wales community, review of access to water birth services and the refurbishment of acute maternity units across all sites in addition to birth choices

The Health Board and primary care contractors continued to deliver essential services throughout 2020/21 in line with Welsh Government requirements. The impact of COVID-19 however meant that there were detrimental impacts upon other services, which were curtailed, including significant aspects

of planned care with associated risk and harm. Ensuring that planned care services can expand to address the risks identified and begin to reduce the backlog of patients waiting is a key priority for our plan.

9.1. COVID-19 impact on planned care

The backlog of treatment for patients which arose before and also due to COVID-19 continues to increase. The following table sets out the number of patients waiting over 36 and 52 weeks by treatment stage as at 10th June 2021:

	Waiting list backlog	
	Waiting between 36 – 51 weeks	Waiting over 52 weeks
Stage 1 – outpatients	7,978	25,326
Stage 2 / 3 – diagnostics	2,043	5,102
Stage 4 –inpatients and day-cases*	1,674	12,577
Total	11,695	43,005

Note: stage 1 outpatients / stage 2 and 3 diagnostics / stage 4 inpatients & day cases.

The table illustrates the significant number of patients whose treatment is currently paused. This number continues to rise, with a forecast, based on current activity levels of 50,000 over 52 week waiters by the end of 2021/22. The distribution of waiters across sites is generally comparable, with the "Once for North Wales" approach starting to level the inequalities of wait for high-risk patients, however the variable patterns of long waiting patients across our hospital sites continue.

In addition to the reduction of activity levels as a result of the pandemic, there was a marked reduction in referrals. This has begun to recover, and there remains an expectation of increasing demand during 2021/22, as set out below:

- Demand for urgent suspected cancer referrals has returned to pre-COVID-19 levels but cumulatively the total demand is around 4000 cases lower in December 2020 than it was at the same point the previous year;

- The number of cancer patients starting treatment in 2020/21 was 3648, which is set to increase to 4233 during 2021/22; and

- Screening services reopened during December and the demand via these services will be carefully monitored to assess volume, type and stage of demand filtering. The temporary cessation of screening services has contributed to the reduction in newly diagnosed cancers generally and in early stage diagnoses in particular.

It expected that referrals will increase, compared with 2020/21 levels, particularly in quarters 3 and 4, as more patients present. In relation to cancer services this has been estimated as follows:

- Urgent cancer outpatient referrals are expected to rise from 23,091 in 2020/21 to above pre-COVID levels at an estimated 27,500; and

- Urgent non-cancer outpatient referrals are expected to rise from 27,308 in 2020/21 to closer to pre-COVID levels at an estimated 31,926.

As the year progresses the number of referrals will be monitored against these assumed levels, to understand the ongoing impact of the pandemic, alongside the transformation work.

Single Cancer Pathway performance (62 day) which currently stands at 68% compliance, has a planned action to increase to 75% to meet the national standard. This will be supported by the delivery of the suspected cancer pathway programme including the implementation of diagnostic pathways for each area; lung and endoscopy.

9.2. 2021/22 planning assumptions

In order to support our planning assumptions we have considered the predicted demand for COVID-19 total occupied beds and COVID-19 occupied critical care beds to the end of June 2021.

In March, our planning assumptions were that Q1 (2021/22) is likely to be similar to Q4 (2020/21) in terms of admission and occupancy, noting that there are many unknowns around vaccine and the new variant. Actual activity has been incorporated into Welsh Government minimum dataset for quarter 1 (MDS) and assumptions will be regularly updated and tested.

This aligns with our financial assumption that COVID-19 response will continue to be the main clinical and operational priority in the first six months of the year, with planned care activity stepping up in the second half of the year. Welsh Government has provided strategic support of up to £90m over the next three years to be used to improve performance across North Wales in both planned and unscheduled care. This will be critical to addressing the backlogs and the Health Board's ambition is to design and implement a clinical model which will provide improvements to performance, patient outcomes and efficiency.

9.3. Our recovery programme

The Health Board has set out a six-point recovery plan to re-start, treat and transform planned care, for increasing activity and reducing waiting times.

The plan provides an integrated solution to addressing the immediate challenges whilst identifying the critical need for longer term transformation solutions through the Diagnostic & Treatment Centre approach and changing to a value based pathway approach.

The re-start programme deals with cohorts 1 &2 which have been defined as patients waiting over 52 weeks as of March 2020 and cohort 2, patients waiting from 1st April 2020 to 4th April 2021.

The organisation has compiled an action plan and trajectory to recover cohort 1 by March 2022 and commencing cohort 2 clearance over the next two-three years. This activity is regarded as additional to the core plan and will be undertaken via additional clinical sessions, outsourcing and insourcing. There

is also a commitment to pursue an option of modular theatres and wards to support orthopaedic elective activity and preventing disruption from further unscheduled care pressures.

The plan is summarised below:

2020/21	2021/22 to 2024/25	2025
Six point plan established **Enablers:** • Diagnostics • Workforce • Digital • Performance fund • Effectiveness	Strategic outline case March 2021, outline and full business cases June 2022. • **Point 1** – capacity planning validation and Once for North Wales outpatients. • **Point 2** – patient communication and understanding demand. • **Point 3** – Once for North Wales services, value based pathways. • **Point 4** – use virtual capacity and care closer to home. • **Point 5** – non surgical approaches to long waits. • **Point 6** – In sourcing and extra capacity.	Handover to Diagnostic and Treatment Centre or Centres Ambulatory care model In patient capacity

The need to implement an early recovery programme is part of the 'Six Point Recovery Plan' and comprises the following activities:

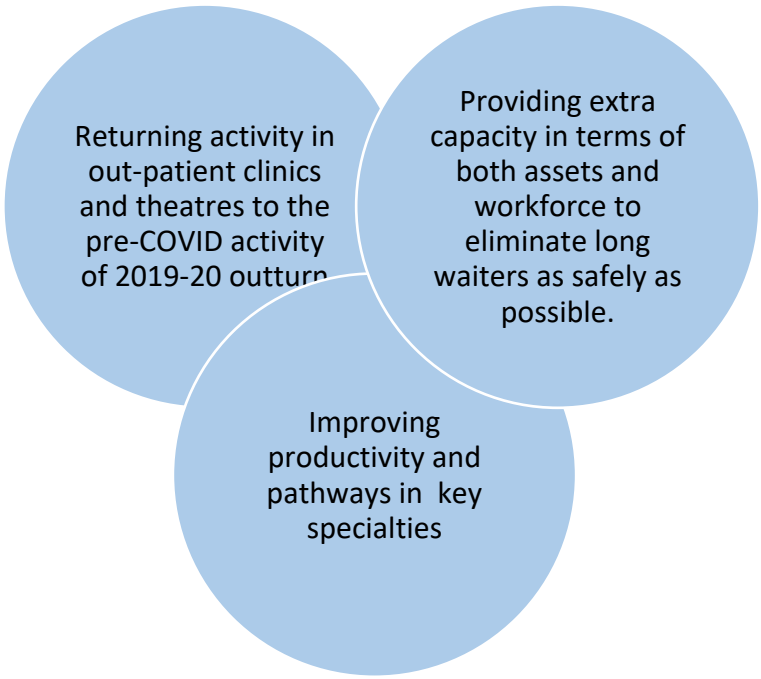
- Capacity planning, validation and "Once for North Wales" outpatients. An example of the "Once for North Wales" approach is eye care pathway patients (especially cataract patients) where one waiting list will identify priority patients who will be transferred to alternative sites for treatment. Resources will be utilised in a prioritised way no matter where in North Wales the patient lives;
- Patient communication and understanding demand;
- Value based pathways;
- Use of virtual capacity and care closer to home; and
- Insourcing and extra capacity.

A summary of the short-term actions which will form the 2021/2022 plan is set out below:

Substantive staff continue to deliver P1-P2 activity both stage 1 and stage 4	Using 'Once for North Wales' Approach	Insourcing model to be used for long waiters stage 1 and stage 4	Theatres to be used each weekend across North Wales to facilitate the insourcing activity, day-case only (8 theatres)	Modular theatre and wards x3 either centrally located or on each site for insourcing activity treating P4 long waiters	Capacity plan/activity schedule to understand timelines for backlog and clearance (starting in quarter 1)

Note: P1 highest clinical priority / P4 lower priority.

Within the recovery plan, there are three fundamental elements:



The first element is to improve productivity back to the pre-COVID activity of 2019/20. This will provide extra activity that is currently unavailable and provide planned care to the previous baseline level, from which further productivity improvements can be made.

The second element builds on this productivity by reviewing pathways and moving to the value based system. It will also address some of the underlying demand and capacity shortfalls that have been historically identified such as the requirement for further orthopaedic capacity. The six-point plan describes improving patient outcomes and provides alternatives to current treatments, such as the move towards more "office based decisions", earlier interventions and diagnostics by primary care.

As we address the capacity gaps through new ways of working, we also need to address the substantial numbers of long waiters. The backlog has two components:

- The backlog from 2019-20 of 14,911 over 36 week waits, of which 3,113 were over 52 weeks. (This highlights the shortfalls in capacity at that time.);
- The COVID-19 pandemic then paused all routine elective activity, which led to an increased backlog of 43,255 over 52 week waiters;

Giving a total backlog position of 46,338 (3,113+43,255), across all stages.

To be able to understand the scale and implications of the backlog, the table below lists the key specialties and the amount of extra sessions required (based on the 2019/20 activity outturn) to clear the backlogs.

Speciality	Stage 4 sessions required to reduce back log below 36 weeks (across BCU)	Stage 4 sessions required to reduce back log below 52 weeks (across BCU)
General surgery	1448	1239
Urology	418	371
Trauma and orthopaedics	2576	2340
ENT	642	611
Ophthalmology	328	348
Max/Fax	215	191
Total	**5627**	**5100**

Understanding the amount of sessions required, allows some indicative timelines to be forecast. Whilst some of the specialties listed above could recover in 6-9 months, general surgery and orthopaedics would need to be measured in years. This timeline is indicative and assumes that the service is not subject to further disruption due to further COVID-19 outbreaks or winter pressures.

The table below summarises the anticipated phasing of key elements of the short-term recovery plan:

Scheme	Commencing from:	Speciality	In-patient	Day Case	OPD
Insourcing for risk stratified P4	Q1	Orthopaedic Urology Ophthalmology General surgery Women's services Maxillofacial services	Yes Yes Yes Yes Yes N/A	Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes Yes
Additional Clinical Activity sessions (ACSs) For P2-3 risk stratified patients	Q1	All specialties	Yes	Yes	Yes
Modular theatres and ward	Q2	Orthopaedics'	Yes	Yes	N/A
Prehabilitation	Q1	All cancer Specialties	Yes (Critical care)		
DGM to run insourcing work	Q1	Orthopaedic Urology Ophthalmology General surgery Women's services Maxillofacial services			
Working towards delivering Endoscopy standards	Q2	Endoscopy		Yes	Yes
Working towards delivering Single Cancer Pathway	Q2	All cancer vague symptom specialties	Yes	Yes	Yes

Key Performance Indicators
Our summary of activity plans for 21/22 for the following: • First outpatient appointments (OPA) (face to face) - 110, 523; • First OPA - virtual (not face to face) – 37,408; • Follow up OPA – (face to face) - 266, 710; • Follow up OPA - virtual (not face to face) – 214, 207; • Number of inpatient procedures - 23, 186; • Number of day case procedures - 27,810.

9.4. Primary Care Recovery

In response to the ongoing challenges in primary care, the following priorities have been identified:

- Ensure primary care involvement and engagement in the transformation of clinical pathways, to support recovery and address the planned care backlog across the whole system, reviewing the impact of any operational changes and provider capacity. This will be supported by the Transformation Office of the Health Board.

- Provide additional funding to ensure continued use of the AccuRx and eConsult online platforms in GP practices, supporting improved access and demand management for general medical services. This was a specific request from primary care providers who are experiencing a number of workload efficiencies as a result;

- Encourage GP practices and community pharmacies to report their escalation levels, with Area teams taking proactive action to provide support where necessary;

- Establish a Dental Training Academy, hosting a training unit, General Dental Services (GDS) contractor and Community Dental Services (CDS), with a focus on increasing access to dental services in the west area of the health board. The tendering process for providers is currently underway, and it is envisaged that this will provide valuable additional activity within the West of BCUHB, as well as generating an advanced practice dental workforce within BCUHB;

- Increase the number of core urgent access sessions commissioned from general dental practices, providing an additional 250 to 700 patient appointments dependent on complexity of treatment needed. Proposals have been developed to commission further urgent and non-urgent sessions, as well as additional orthodontic activity;

- Complete the Pharmacy Needs Assessment by October 2021, providing a reference for the planning and commissioning of future community pharmacy outlets and services;

- Support the training of additional independent prescribers in community pharmacies; and

- Continue to develop the integrated eye care programme and Ophthalmology Diagnostic and Treatment Centre (ODTC) model of care, optimising care closer to home and improving access to services.

In relation specifically to chronic conditions, diagnostics and screening, proposals are now being advanced with our clusters, recognising that schemes need to be put in place over the summer months. In order to progress this work dedicated project management support will be identified and in the interim, independent contractors are being encouraged to adopt a triaged approach where chronic disease management backlogs exist, to ensure that those with highest need are prioritised.

Furthermore, the priorities listed below will be delivered to support the whole recovery and ongoing development.

9.5. Primary care sustainability - we will:

- Develop our Primary and Community Care Academy, including the establishment of the Dental Academy with a dental training unit and provision of dental services, an additional training hub to further support advanced practice training in primary care, the further development of the Physician Associates programme and piloting of 'Project Flex', a flexible approach to GP recruitment.

9.6. Primary care premises – we will:

- Continue to engage at a national level with Welsh Government to review all primary care facilities, in order to develop a robust primary care estates strategy to support the delivery of new ways of working, growing demand and care closer to home.

9.7. Health and social care locality working – we will:

- Ensure that integrated localities continue to develop and deliver their priorities for 2021/22, which include:
    - effective delivery of the COVID-19 vaccination programme;
    - integrated mental health and well-being; and
    - chronic disease management, in particular diabetes and lifestyle choices.
- Further develop MDT working and advanced health practitioners working in primary care settings;
    - developing the community resource teams;
    - support for care homes; and
    - frailty pathway development.

9.8. HMP Berwyn

There has been a very different year at HMP Berwyn during 2020 / 2021 as a result of the impact of COVID-19 on the prison population. As a result of this our priorities for 2021/ 2022 are:

- To offer an enhanced mental health and learning disability provision specifically addressing difficulties around recruitment and retention of specialist staff; and
- Enhancing capacity to address the unacceptable long wait for routine dental care for residents at HMP Berwyn.

We will review our primary care and substance misuse services structure to ensure we continue to deliver a responsive and fully integrated health and wellbeing service at HMP Berwyn. This will include a retendering process for our in hours and out of hours GP service subject to Board and Welsh Government approval.

9.9. Specialist Services

Specialist services for the population of North Wales are predominately provided from Health Board and NHS England providers with a small number of services provided from NHS Wales's providers.

The Health Board is a provider for a number of regional and national specialist services including Artificial Limb and Appliance Services, cardiac services, CAMHS, cochlear and bone anchored hearing aids, Inherited bleeding disorders, neonatal intensive care, mental health services - forensic psychiatry, positron emission tomography (PET) services and renal services.

As a provider the Health Board has a number of models in place for delivering specialist services across the region, these include care provision locally in a single site or a combination of 2 or 3 hospital sites.

Similarly, there are a number of models in place for specialist services provision from NHS England providers, with care being provided both at the specialist provider facility and as outreach into Health Board facilities. The outreach services and models vary across specialist services and the hospital sites. They include models where the specialist services are described as provider at or provider with the Health Board. The model of care is of particular importance in relation to the governance arrangements in place.

We are working with Welsh Health Specialist Services Team (WHSST) to develop a joint work plan and services strategies to ensure progress is being made in terms of equity, quality, sustainability and repatriation.

This work will inform planned and unscheduled care pathways, the wider Health Board recovery and also shape our clinical services plan. Areas of focus in 2021/22 include CAMHS, cardiology, plastic surgery, paediatrics, neurology and acquired brain injury.

10. Improved unscheduled care pathways

The following table sets out the key deliverables for this element of our plan, with further supporting information below:

Key Deliverables 2021/22
• Further develop the pathfinder Urgent Primary Care Centres, supporting an integrated model of unscheduled care and integrating these with the 'contact first' development and roll out of 111;
• Develop the Home First Bureau approach to support timely discharges , by consolidating our resources including continuing healthcare, frailty pathway, discharge to recover and assess, and community resource teams;
• Deliver support to care homes with a focus on quality assurance;
• Implement the recommendations in the Welsh Government document 'Rehabilitation: A Framework for Continuity and Recovery 2020-21' to support the ongoing needs of COVID-19 patients;
• Complete a systematic review of Emergency Departments, working with local emergency admitting teams to map the current availability of services and identifying gaps to be addressed to develop and deliver improvement to the service;
• Implement Emergency Department access and patient flow (using the Welsh Access Model/ Emergency Department Quality and Delivery Framework / Frailty and Acute Medical Model);
• Implement the stroke service model strategic case enabling work to progress on strategic service development, strengthening acute stroke services across each of the three district general hospital sites;
• Develop a clear set of pathways for certain conditions to support the direct referral of patients to the most appropriate setting and provide a more seamless and efficient service to improve patient flow;
• Implement Same Day Emergency Care (SDEC) improving service delivery through standardisation and resulting in improved patient outcomes;
• Developing the unscheduled care hub, 111 service / contact first, reducing Emergency Department unnecessary attendances

Responding to urgent and emergency care needs across the whole range of Health Board services has been a considerable challenge throughout the pandemic, however significant innovation and change has been delivered during this period through the re-design of patient pathways. We will build on these COVID-19 pathway improvements, including the speed at which change has occurred and use this learning to help shape and review our unscheduled care patient pathways going forwards.

We will need to ensure a robust approach to addressing the ongoing demands of the pandemic and the winter pressure challenges ahead, with appropriate surge plans in place as required, dependant on the ever-changing environment of the pandemic.

As set out in Section 4, it is expected that the demands placed upon hospital inpatient services as a result of COVID-19 will reduce as we move into 2021/22. Whilst this is positive in terms of reducing this specific demand within our hospitals, there are indications that demand arising from other causes will increase during the year. This has been assessed against the 2018/19 baseline data and we expect a significant increase in emergency admissions from 58,085 in 2020/21 to 95,337 in 2021/22 based on the following assumptions:

- April - June 2021 5% increase (taking account of any reduction in restrictions and acuity of patients), Royal College of Emergency Medicine also suggests 5% uplift;
- July – August 2021 15% increase – this predicts circa 17-18,000 attendances over these months (taking account of social economic elements and expected increase in surgical emergencies);
- September – October 2021 - 5% increase (expecting admission rates to increase due to the above);
- November 2021 onwards – 100% comparison to 2018/19 (expecting usual seasonal conditions (for example respiratory, frailty etc.).

Given the significant performance challenges which the Health Board currently faces and the demand projections above, the need to undertake a fundamental re-assessment of key aspects of our unscheduled care delivery is clear.

The following elements have been identified as key to tackling the problems associated with unscheduled care:

- Leadership and trust across systems;
- Ability to align goals across health and social care; and
- A whole system approach.

In 2020/21, short term funding was directed to hospital front door (SDEC) and early supported discharge (D2RA = Discharge to Recover and Assess). Short term funding has not enabled sustained change or enabled a thorough assessment of the impact of the interventions. Longer term or invest to save funding will depend on being able to demonstrate good patient and system outcomes.

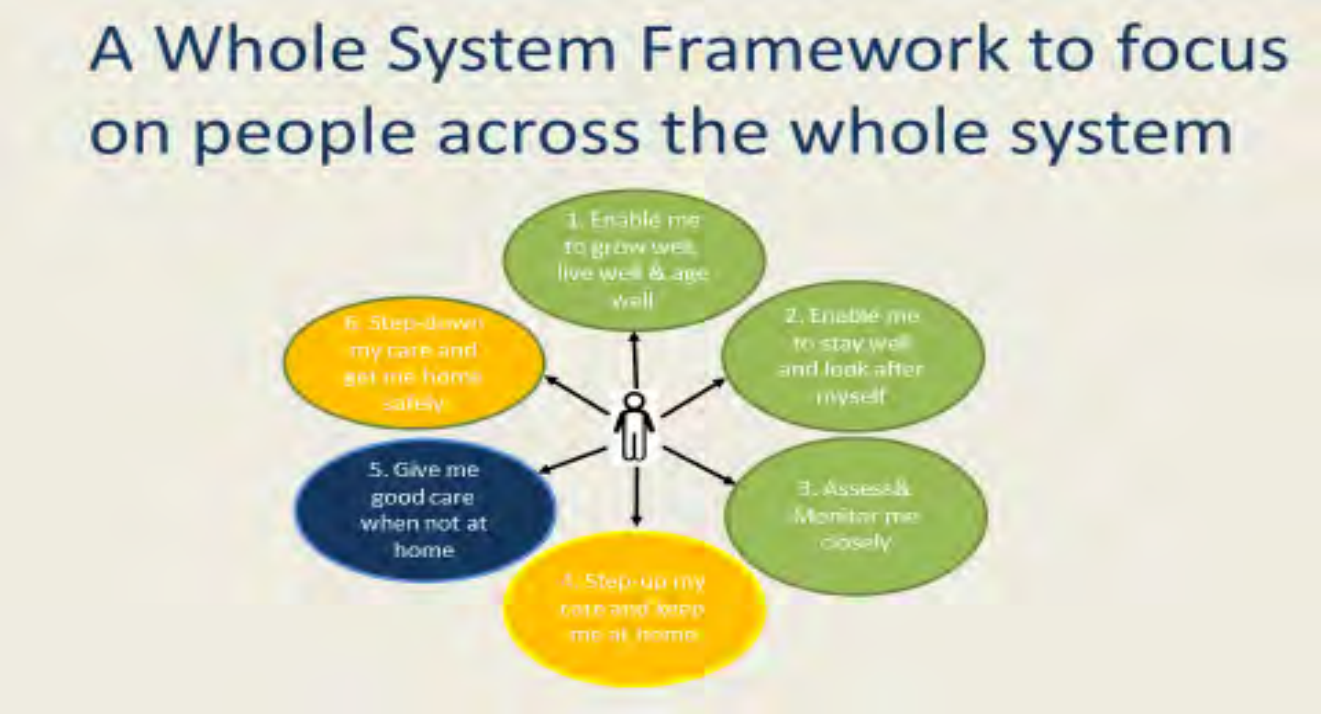
There are some areas of excellent practice in the Health Board, however the Board have recognised the need to sustain, embed and disseminate this practice. Clinical teams must be supported to describe a vision for their services and to define what good looks like for staff and patients.

It is recognised that the Health Board requires support to address these challenges. We are able to map the unscheduled care system in a number of ways in order to break it down into manageable parts whilst not losing sight of the connectivity that is required to make services work effectively together. To this end the Health Board has joined forces with the National Collaborative Commissioning Unit (NCCU) who are supporting the Board and its social care partners to deliver a comprehensive improvement programme designed to improve timely and appropriate access to urgent and emergency care services. Translated into practical terms the Health Board has committed to ensuring that our

citizens are helped and supported to access the right care, delivered by the right professional in the right place, first time and every time.

The Health Board will maximise the opportunity to secure recurring central funding through the NCCU commissioner which will allow us to continue our support to programmes such as Same Day Emergency Care (SDEC), Welsh Access Model (WAM), Contact First linked to 111 rollout and Discharge to Recover and Assess (D2RA). Recurring funding will provide an opportunity to break the cycle of 'stop/start' of initiatives and allow teams to apply a truly transformational approach to modernising and improving the services and care we provide.

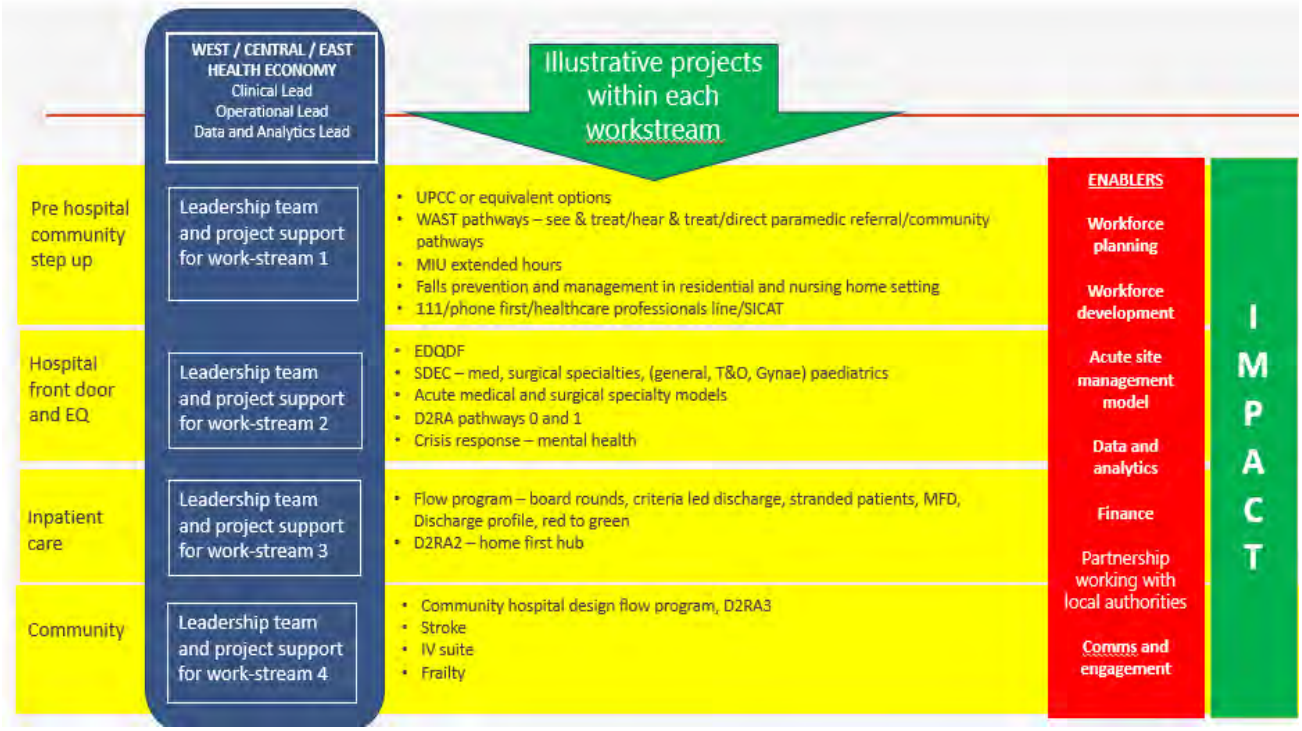
We describe an effective service as a service that should lead to good patient outcomes and good patient and staff experience in each of the domains depicted below.



In order to address this deficit in our service delivery, the NCCU has agreed to work with us to frame a programme and provide ongoing support and challenge over the next 18-24 months to help the clinical and managerial teams own the developments and embed the change.

The NCCU team have met with a range of staff and teams as well as stakeholders across the health and social care system to review local urgent and emergency care plans and have developed an outline plan. The NCCU team's expertise will support clinical and managerial leadership teams to develop, implement and embed change and deliver improvements that focus on reducing harm, improving quality of care to ensure better outcomes for patient and better staff experience.

The following diagram illustrates the emerging plan setting out 4 key workstreams and supporting illustrative projects for the urgent and emergency care transformation programme of work



Welsh Government has provided strategic support of up to £90m over the next three years to be used to improve performance across North Wales and this will be allocated across planned and unscheduled care. We will use this funding to drive forward the most critical aspects of service change that will support service transformation and enhanced performance in unscheduled and planned care.

In addition to the work described above, we are taking a system and pathway approach to ensure we can deliver seamless care across all services. This will include developments such as 'Contact First' and the implementation of 111, working alongside our GP Out of Hours service. We saw a significant drop in attendances and admissions across our Emergency Departments during the first phase of the pandemic in spring 2020 and we will endeavour to implement lessons learned, alongside these new services to maintain this position by continuing to educate and support the North Wales population and offering seamless services with primary care and other unscheduled initiatives.

In primary care, we will:

- Further develop the Urgent Primary Care Centre (UPCC) pathfinders as part of a national programme of innovation to develop alternative urgent care services. The UPCCs provide additional capacity to support GP practices and Emergency Departments, with patients triaged to the centres both in and out of hours. These pathfinders will include the continuation of the Wrexham/Mold Centres (supporting 6 clusters) and the North Denbighshire Centre commencing in Quarter 1, in Rhyl; and

- Continue to be a key partner to the national strategic programme, sharing the ongoing learning and evaluation; contributing to the Welsh Government priority to transform unscheduled care. Furthermore, a business case will explore the development of a UPCC pathfinder in the West Area, with the aim that this will be in place in readiness for winter, integrating these with the 'phone first' development and roll out of 111.

11. Integration and improvement of mental health services

The following table sets out the key deliverables for this element of our plan, with further supporting information below:

Key Deliverables 2021/22
• Development of clear patient centred pathways of care and crisis services;
• Recruit and train psychiatrists in CAMHS supporting progression to future consultant posts, along with additional specialist nurses;
• Implement a number of support mechanisms including investing in the roll out of the mental health practitioner model and community connector role to localities in order to improve primary care resilience;
• Design clear and well-defined model of inpatient care that meets the population demand and draws upon the highest quality evidence base, improving our holistic approach to care;
• Introduce a programme of work across the mental health division to review long length of stay and delayed transfers of care, promoting safe and timely discharge of patients to the appropriate setting;
• Implement ward accreditation to improve the fundamentals of care and leadership, improving service delivery and outcomes for patients and their families, with all wards achieving a bronze award or above;
• Implement a programme to integrate health systems and develop digital health initiatives;
• Enhance leadership within mental health, developing a sustainable workforce plan including training to support service redesign;
• Further develop the delivery of clinically led safe and effective services, aligned with the Dementia Strategy;
• Work with area teams and local authorities to provide support to care homes through a team based approach;
• Implement an agreed model for early intervention in psychosis;
• Deliver clinically led, safe and effective services for mothers and babies and commission two specialist services placements.

The need to deliver continued improvement in our mental health services for people of all ages is a key priority for the Health Board and is reflected clearly in the targeted intervention framework published by Welsh Government. Recent events have seen the emergence of increasing mental health and wellbeing needs arising from the pandemic, which require an effective and timely response.

During the pandemic, there was a reduction in referrals to some services and it is envisaged that this will be reversed in 2021/22. Our planning assumption is for demand to return to pre COVID-19 levels, which will see an increase from 11,400 to 14,645 referrals under section 1a of the Mental Health

Measure. Similarly, crises referrals are expected to reflect activity prior to COVID-19, with the usual fluctuations in seasonal demand.

We have commenced work to transform our mental health services and to ensure long-term sustainable delivery. This work is taking into consideration the various services in place, which are experiencing pressure including that felt by helplines and crisis response during the pandemic.

Within the Welsh Government budget for 2021/22, recurrent funding for mental health services was secured which is to be targeted towards delivering improvements in specific priority areas in the Together for Mental Health Delivery Plan 2019-2022 which was refreshed in October 2020 in light of COVID-19. The Mental Health & Learning Disability (MH&LD) Division, in collaboration with CAMHS services, submitted proposals against this recurrent funding which will embed quality improvement approaches in service re-design and also address the impact of COVID-19 on the current demand and models of service.

The specific proposals related to:

Eating Disorders – CAMHS and Adults services	£971,505
Perinatal services	£156,000
Increased assess to psychological services – CAMHS and Adult services	£652,450
Specialist CAMHS	£813,000
Crisis Care/Out of Hours Provision (all ages)	£903,000

During 2021/22, there will be a particular focus to ensure that the MHLD Division is working more closely across the organisation and with partners. We will re-invigorate our partnership work through engaging with key stakeholders in keeping with the Together for Mental Health Strategy and ensure our clinicians lead and support the work we need to do to modernise our services.

In terms of the £12m capability strategic support allocated by Welsh Government, the Health Board has allocated £6.7m in 2021/22 to improve mental health and learning disability services (including CAMHS) and progress the mental health strategy in partnership.

The strategic support resource which has been made available to mental health services will support delivery of engagement and transformation programmes across the Health Board, which are clearly aligned to the following 5 main strategic drivers:

1. Supports the requirements outlined within the Welsh Government Targeted Intervention Framework.

2. Aligns plans against the 4 strategic objectives of the Division, namely:
    a. Delivery of safe and effective services in partnership;
    b. Stronger and aligned management and governance;
    c. Engagement with staff, users and stakeholders;

   d. Review of capacity and capability.

3. Addresses the 4 ministerial priorities for mental health namely:
   a. Tier 0/1 prevention;
   b. Crisis prevention/response;
   c. Suicide prevention/response;
   d. CAMHS.

4. Learning from COVID-19 – applying lessons learned from the impact of the COVID-19 outbreak, and its management, on health and social care in Wales

5. Together for Mental Health Delivery Plan 2019/22 key priority areas:
   a. Eating disorders;
   b. CAMHS;
   c. Further development of perinatal mental health services;
   d. Increased access to psychological services (all ages);
   e. Crisis care/out of hours provision (all ages);
   f. Early intervention in psychosis.

Other priorities identified for improvement include:

- Divisional management and clinical governance arrangements are being strengthened to ensure delivery of safe services;

- We will continue to strive to achieve the national target of 90% provision of valid care and treatment plans;

- We are committed to appointing a substantive service leader to support the improvement of psychological therapies;

- CAMHS transformation and Improvement; to develop a workforce plan and sustainable workforce, service model and enhanced care pathways, including:
  - Crisis; improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible;
  - A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it; and
  - Multi-agency children's transformation work developing integrated pathways of care.

- Within CAMHS there are also specific requirements to address long waiting lists for access to services. In response to this resource has been identified from the planned care performance fund which will enable the following actions:
  - By 30 June 21, gain external support to increase therapy capacity and assessments for therapy;
  - Development and implementation of a Children and Young People (CYP) workforce plan during Q1 to Q2 including considering new roles and the recruitment of psychiatry trainees in each Area and appoint twelve family wellbeing practitioners to posts across the teams;

- Embrace and fully utilise 'Attend Anywhere' and ensure that this is utilised by all teams (supported by effective performance information processes) during Q1;
- Modernise our working practices, utilising new IT hardware for staff during Q1 and Q2; and
- Improve our offer with the development of a CYP website to promote the service and support recruitment (Q2).

The current proposals for the allocation of £6.7m strategic support funding is as follows:

Mental Health for Adults and Children		
Description	**Cost £m**	**Key deliverables**
Older Persons Crisis Care	0.5	Improved and earlier response for older adults with severe and enduring mental health and those with dementia crisis; Improved patient experience; Reduction in unplanned/avoidable admissions/attendances at Emergency Departments; Reduction in DTOCs in acute hospital setting.
Eating Disorders	0.5	Local specialist assessment and treatment of individuals (in line with NICE 2017 guidance); Individuals will be offered a range of psychological interventions; Specialist treatment which will ensure safe and effective management of psychological, physical and social aspects of their eating disorder; Collaboration with CAMHS to ensure seamless transition and integration of care across services for young people requiring adult services.
ICAN Primary Care	1.7	Direct and rapid access to wider ranging support in primary care; Tier 0 support by introducing ICAN connectors and ICAN community hubs.
Medicines Management	0.6	Improved patient compliance and education with current medication
Occupational Therapy	0.4	Increased therapy leadership across the Division to assist in reviewing and improving patient flow between primary and secondary care; Improved MDT working with a focus on recovery and overcoming barriers that prevent patients doing activities that matter to them and also discharge support.
Perinatal	0.2	Reduce mental illness in the mother and improve the mother-infant relationship;

		Regular and on-going training to allied mental health and primary care colleagues to improve understanding and knowledge of perinatal mental health.
Early Intervention in Psychosis	0.3	Reduce treatment delays at the onset of psychosis; Promotion of recovery; Reduction in episodes of relapse.
Psychiatric liaison	0.3	Timely response; Reduction in delays in Emergency Departments for mental health assessment; Signposting to alternative support services.
PMO Support Function	0.2	Project support for managing and reporting against all initiatives across the Division; Dedicated support to clinicians for tracking outcomes.
Consultant Therapist	0.1	Support key strategic priorities of the Division, strengthening leadership and cross divisional working and assisting in reviewing and improving patient flow between primary and secondary care. Lead pathway development to further meet the ambition for integrated service improvement and transformation through a holistic approach to care and improved multi-disciplinary ways of working.
CAMHs transition and joint working	0.8	Effective and timely transition arrangements that support young people into adult services; The needs of young people and their families met; Effective joint working arrangements between adult mental health, CAMHS and local authority professionals.
Integrated autism service	0.7	Timely assessment for individuals; Dedicated support to individuals and their families.
Joint commissioning pot with AISBs	0.3	Joint approach to commissioning health and wellbeing services for local population via community localities.
Wellness, Work and Us	0.2	Staff will feel valued empowered individuals; Reduced stigma around mental health; Dedicated staff wellness areas to support wellbeing of our staff.
Total	6.7	

Resources for mental health services will continue to be ring-fenced in 2021/22. Compliance of individual organisations with the ring fencing requirement is monitored on an annual basis by Welsh Government. Additional funding has been allocated to the ring fenced mental health allocation for the Health Board as a cost growth uplift. This will contribute to funding unavoidable cost growth in mental health services and includes funding to cover the first 1% of 2021/22 pay awards.

12. Enablers

We have identified a number of priorities and enablers, which are critical to the success of our plan, which are described in brief below. They also support the programme of development, which is key to demonstrating progress against the Targeted Intervention Framework, which will be a key measure of success in 2021/22. The table below identifies the targeted intervention domains and the relevant enablers:

Targeted intervention domains	Our core key priorities and enablers supporting targeted intervention delivery;
Mental Health (adults and children)	• Transformation for improvement • Integration and improvement of mental Health Services
Strategy, planning and performance	• Transformation for improvement • Stronger governance • Making effective and sustainable use of our resources. • Aligning our people
Leadership (including governance, transformation and culture)	• Transformation for improvement • Enabled by effective alignment of our people • Stronger governance
Engagement (patients, public, staff and partners)	• Transformation for improvement • Strengthening our population health focus

12.1. Organisational development

We have committed to embark on a programme of work which aims to align each and every member of the organisation behind the goal of "One NHS organisation", working with our partners and citizens to deliver co-ordinated seamless care or service for individuals. Our approach to this ambitious work programme, titled 'Mewn Undod Mae Nerth' (Stronger Together), is framed by evidence-based research, which will allow us to join the threads across the organisation and the system that facilitate the conditions for and are associated with high performance through an engaged and motivated workforce, committed to delivering the healthcare goals for North Wales.

Our plan is informed by previous commissioned reviews and by 'A Healthier Wales' and is driven by the quadruple aims described therein:

- Improved population health and wellbeing;
- Better quality and more accessible health and social care services;
- Higher value health and social care; and

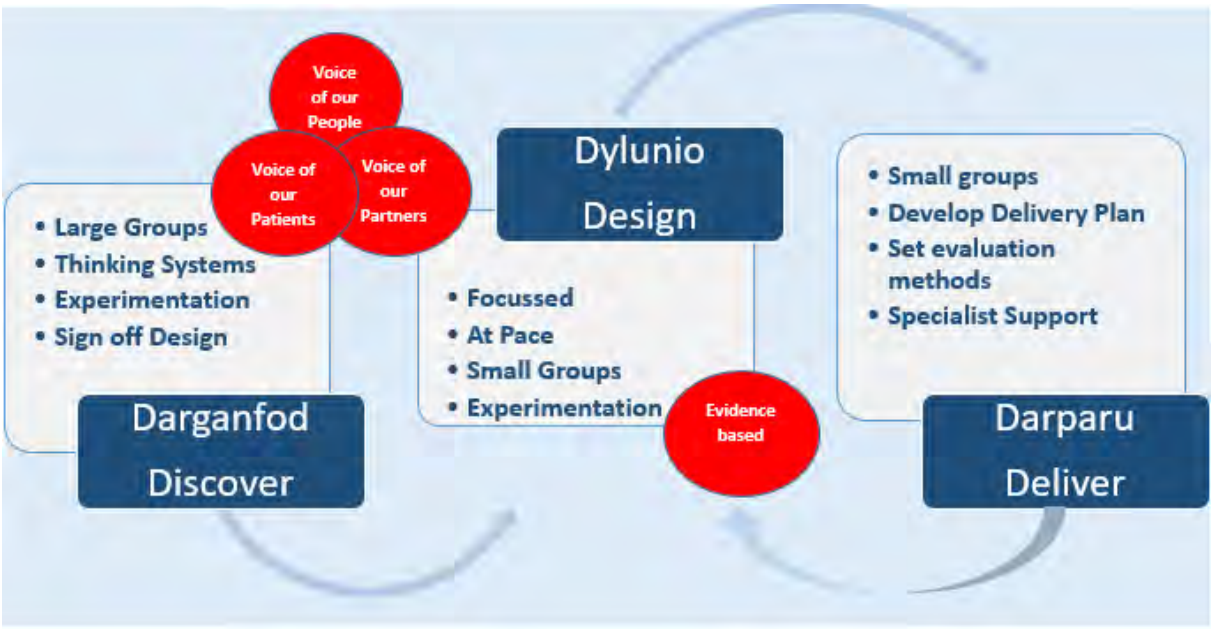
- A motivated and sustainable health and social care workforce.

The overarching approach we are adopting will enable the organisation to discover its current capability and answer the question: "What do we need to do as an organisation and system of care to succeed in the achievement of our purpose and goals?" Its design aims to integrate all existing quality, performance and productive service change and development activities currently taking place within the organisation.

We are working in partnership with our people so that the solutions to the problems we face are co-produced with people who work across the organisation and understand the challenges. Our approach will continue to be inclusive to ensure that those who contribute are truly representative of our people and that wider cultural aspects are taken into account.

Applying the framework for large-scale change, we are using the model of discover, design, delivery to inform our strategic organisational development route map. The model is shown in the diagram below:

12.1. Mewn Undod Mae Nerth (Stronger Together)

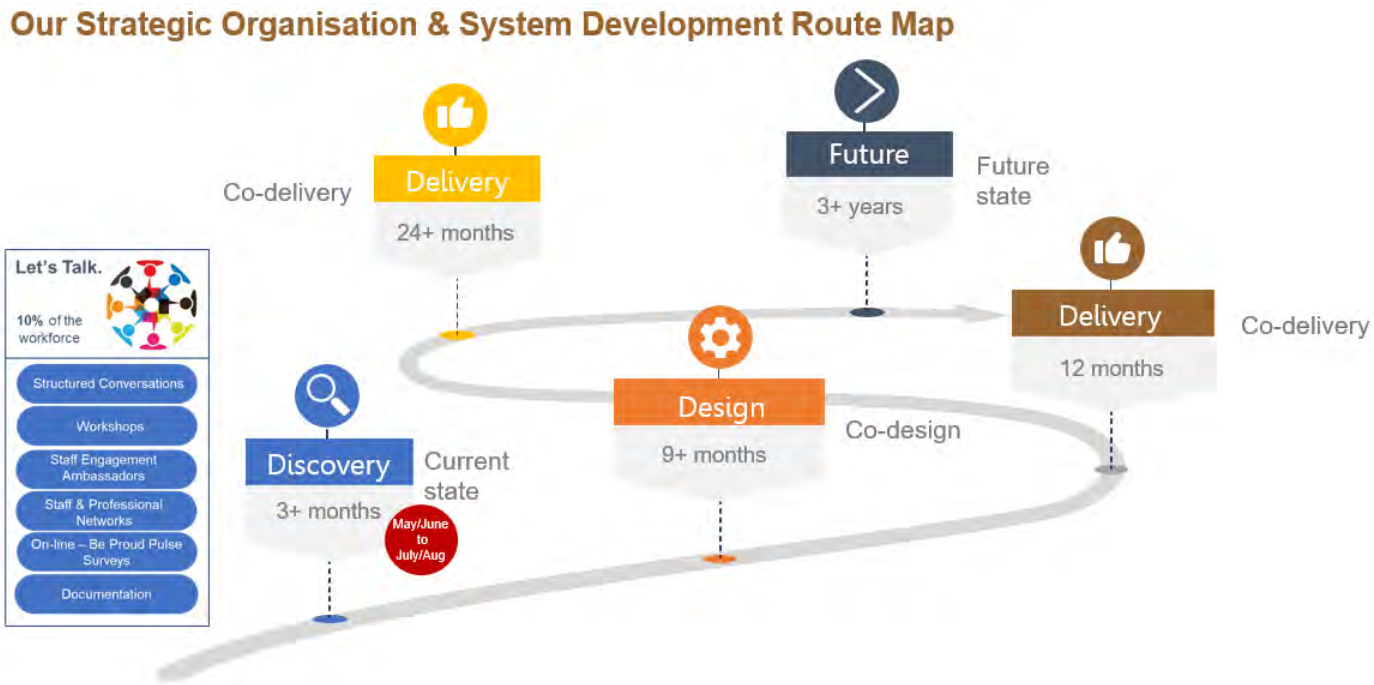


This work is consistent with and aligned to the seven themes within 'A Healthier Wales: Our Workforce Strategy for Health and Social Care'. As we move through the phases this will inform our contribution to the refresh of the Regional Workforce Board - workforce strategy, together with the updating of the Health Board's own workforce strategy.

The approach is positioned as organisation-wide and systematic, engaging our workforce, our partners and fundamentally our patients in the pursuit of a strategic organisation and system development route map for the Health Board. It is aligned to our vision for transformation as detailed earlier in this plan.

The goals and outcome measures have been established for the first phase, and work commissioned began in earnest at the beginning of April 2021.

We are clear on the route map and are well into our Discovery Phase "Let's Talk". The graphic below illustrates the timeline and key milestones. As described above we are working with our people and partners to deliver this work and in doing so are not only bringing together change agents from across the organisation to support delivery, but also building the capacity, capability and confidence to be self-sustaining in our focus on organisational health and the significant alignment with improved care, outcomes and experience. Our aim is to create a "social movement" across all groups and levels supporting our organisational and individual recovery and at the same time setting the tone for the culture we want to see, hear, feel and experience.



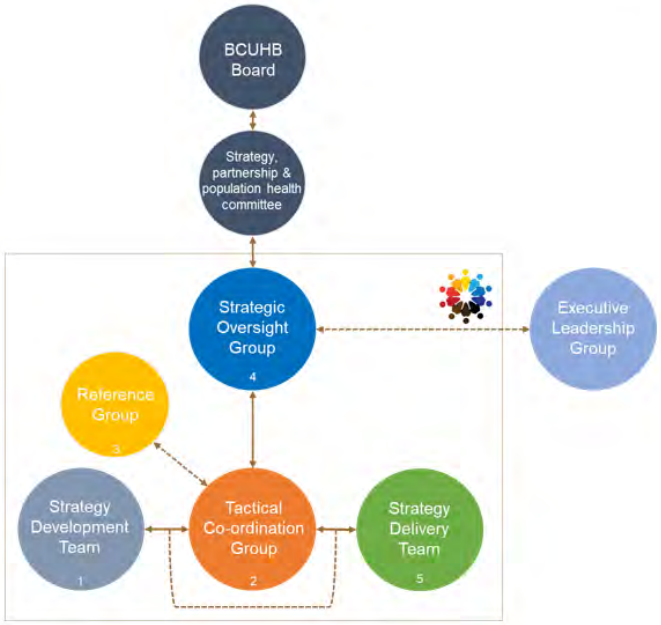
We have been clear from the start that this is championed and led from the Board through our organisation to our citizens and as such, the delivery structure is led by the Chief Executive. The structure below outlines the primary delivery structure.

Our Delivery Structure

Design Principles

The following design principles have been used to inform and develop the oversight & delivery architecture:

- Chief Executive Sponsorship.
- Collective Executive ownership.
- Connecting & coordinating interdependant teams & individuals.
- Connecting, coordinating & collective ownership of interdependant activities.
- Supports the model of a single corporate plan (master schedule)



In addition, and critically, we have built the development of our Board Development Programme on these design principles and are clear that the learning and feedback from our Discovery work will inform the further design of the programme in quarter 3.

In addition, the measures of success and maturity set out across the maturity matrices developed across the 4 domains will be supplemented with the learning and feedback from the Discovery work, with the evidence, outcomes and reference groups being formed by people from across our organisation, partners and population. The longer-term aim is that Mewn Undod Mae Nerth evolves from a title for this piece of work to a way of working. This will clearly take longer to achieve but the work over the course of this year, building on the experiences of the last, will be fundamental to the strength of the foundations underpinning sustainable change and improvement.

Key Deliverables 2021/22

- Establish and mobilise the 3 year strategic organisational and system development route map – Stronger Together;
- Develop an Organisational and Leadership Development Strategy 2022 – 2025
- Align the Board and Senior Leadership development as part of this Strategy

12.2. Stronger governance

The Health Board continued to strengthen its system of integrated governance in the latter part of 2020/21 and will build on this progress to embed change in 2021/22. This will ensure that systems are in place to keep our public and staff safe and informed. Performance and accountability remain key priorities alongside co-worker involvement and engagement in decision making through social partnerships. This will support the transfer of innovations into practice, working with partners.

The Health Board will oversee the delivery of the Targeted Intervention Improvement Plan through the use of maturity matrices for the four improvement domains which are:

- Mental Health Management;
- Strategy Planning & Performance;
- Leadership; and
- Engagement.

The Board has appointed Executive Directors to lead each of the domains, supported by a link Independent Member in order to effectively draw upon the breadth of skills and knowledge within the Board.

Executive Directors have developed maturity matrices within their domains that have been co-ordinated through the Targeted Intervention Steering Group and agreed by the Board. In May 2021 the Board agreed baseline reference points to reflect the current position in each domain, against which progress will be measured.

Progress will be tracked bi-monthly by the Health Board with a formal review of progress every 6 months as part of the standard reporting arrangements to the Board. Improvement expectations for the second six-month period will be set in November 2021. Actions to deliver the improvements required are contained throughout this plan and supporting programme level action plans.

The delivery of actions contained in this plan will be evidenced via the Board's performance report, with scrutiny and challenge provided by both the Finance and Performance Committee and the Quality, Safety and Experience Committee. Accountability for the delivery of actions will be clearly articulated across the organisation with service areas held to account for their performance through the monthly accountability review process.

Progress in the reducing risks set out in the Board assurance framework will be subject to review by the Health Board and its committees throughout the year as the actions set out in the plan are delivered.

Finally, following feedback from the Board, work has commenced to develop a new Integrated Quality and Performance Report (IQPR). This new report and underpinning processes will align with the Health Board's Performance and Accountability Framework and will seek to ensure that overall there is a more robust process of assessment and reporting in place.

Assessment against the key outcomes will be a standing agenda item at the quarterly divisional executive accountability reviews and local accountability reviews. The information collated will also be used to contribute to our assessment against the Targeted Intervention Framework.

12.3. Making effective and sustainable use of resources

The Health Board's current availability and use of resources presents a number of challenges, including but not limited to, high premium rate pay expenditure, the quality and volume of estate and delivery of effective demand and capacity planning.

Against this baseline position, the pandemic has placed significant additional strain upon all of the Health Board's resources, most notably our people and estate. These demands are expected to continue during the period of this plan and therefore focused action is required to ensure that we make the best use of resources in the short, medium and long term. Our approach to this challenge is set out below:

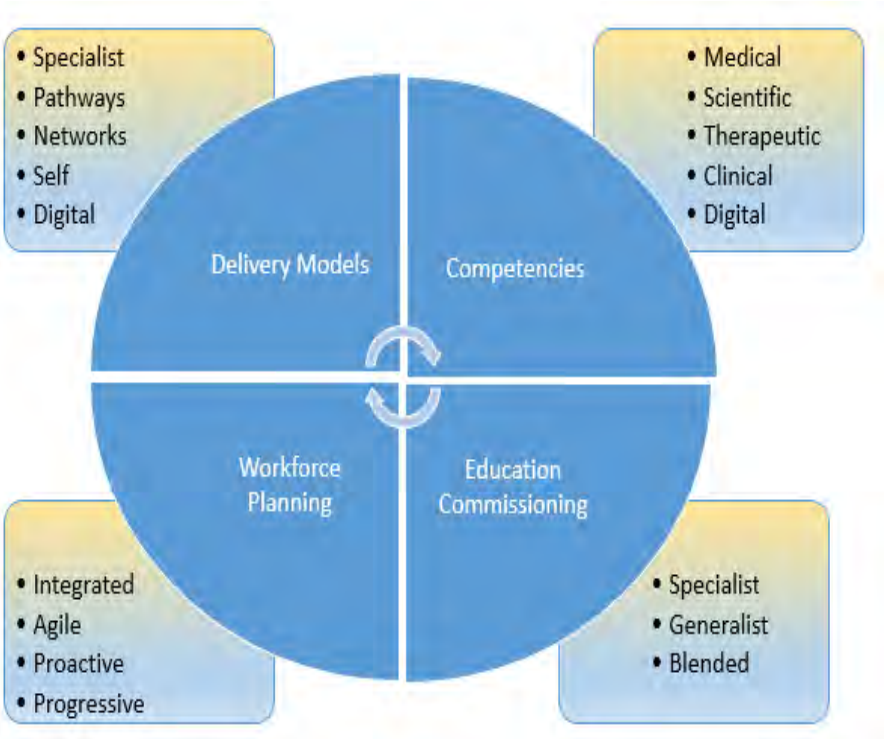
- We will adopt a new approach to building our financial plan, including the development of a three year financial and service strategy;
- We will implement a workforce optimisation plan;
- Applying principles of value based healthcare, we will identify unwarranted variation ensuring transparency about why realistic decisions based on available resources are required. We will develop strategies to overcome barriers to implementation of change and build capacity and capability to implement the best available research evidence into effective action; and
- Decarbonisation – we have a number of capital investments which support our commitment to improve energy efficiency and reduce reliance on fossil fuels. We will continue to increase our sustainable energy generation and reduce our carbon footprint. This will include the provision of the new electrical service vehicles and the associated charging points.

12.4. Workforce

The following table sets out the key deliverables for this element of our plan, with further supporting information below:

Key Deliverables 2021/22
• Deploy a clinically led service and workforce review programme to support effective planning, commissioning and deployment of our workforce across the Health Board, in order to ensure focussed and efficient recruitment, integration of new roles and optimisation of resources;
• Continue to execute improvements in staff safety, support, wellbeing and resilience, in order to improve attendance, retention and contribution;
• Develop and deploy an integrated multi professional education structure, together with the further enhancements in strategic educational collaboration, to support establishing the Health Board as a learning organisation and an employer of choice;
• Develop and deploy a programme of work, as part of the strategic equality plan, to support the organisation in meeting its Socio-Economic duty;
• Refresh the workforce strategy 2019 – 2022 for the period 2022 – 2025.

Building on the work undertaken through the pandemic we will focus on improving the connectivity between service design and delivery and workforce shape and supply. This will include clinically led reviews of existing delivery models, which will then inform the workforce plan and ensure the skill mix is correct for service delivery and sustainability leading to proactive workforce commissioning and placement opportunities across primary, community and secondary care settings, whilst continuing to develop a longer-term approach to agile and flexible working.



Recruitment and, importantly, retention of staff will continue to be managed through collaboration between operational and clinical teams, clinical corporate teams and workforce teams. Informed and supported by both workforce and service reviews and education improvement plans, we will ensure that we have systems in place to make it easier for managers to plan, recruit and on board staff in an efficient way. Where this means agreement to proleptic appointment i.e. proactive in anticipation of turnover to facilitate handover and reduce gaps requiring interim support and/or increasing establishment to reduce high cost temporary workers, we will work in partnership to facilitate this - reducing barriers and realising benefits.

Clearly the scale of the challenge in terms of delivery of additional activity as part of our unscheduled and planned care improvement is significant. Set against a context of post pandemic fatigue and the assumptions built into our planning to date, we are clear that resourcing delivery of our plan will be multi-faceted.

Supported by the work undertaken nationally with regard to flexibility of rates etc. and the clarity of clinical direction our plans for 2021-22 are based upon pump priming additional capacity and capability through:

- In house additional clinical activity – a blended approach of flexibility of sessions, additional sessions and utilising extended/blended roles. Opportunities for further enhancement of additional roles ,e.g. physician associates, to support sustainability of ongoing services is one, but important, key to our planning and delivery;
- Insourcing additional capacity and capability – flexible service delivery supplemented by dedicated and protected capacity and capability focussed on elective care. Particular examples include diagnostic services/endoscopy;
- Outsourced additional capacity and capability – whilst recognising the balance required, these services will be deployed to support those clinical specialities where the volumes are high and risk of harm is significant; and
- Further development of enhanced services around the patient out of hospital – increasing our bed base is not the solution either to provision of improved care and outcomes or in terms of attracting and retaining high quality staff. Using the challenges as a catalyst for changing our models from traditional to contemporary/evidence based and patient centred is essential and is factored into the assumptions in our workforce planning.

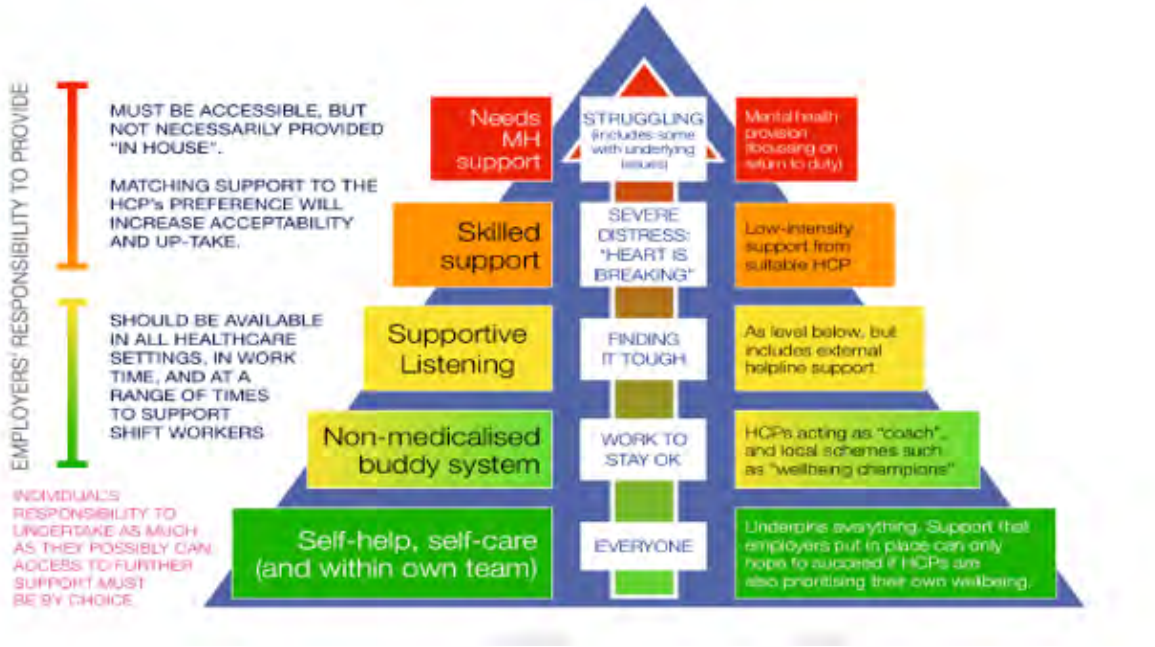
These measures will provide the necessary capacity and capability to deliver the care critical for our communities now, whilst supporting the development of improved pathways of care across our footprint, optimising our architecture and driven by improved outcomes.

Consistent with our responsibilities under the quadruple aims as well as our Socio Economic Duty we will continue to work with partners as part of the foundational economy challenge fund project - “Solving challenges with recruitment, retention and training of North Wales’ social care and health workers.”

In addition, the development of an integrated multi professional education structure, together with the further enhancement of strategic educational collaboration will be an essential element in achieving our vision for transformation. Building on the work done to date to work towards establishing the Health Board's reputation as a learning organisation, committed to education and continuous learning and innovation and as a result an employer of choice.

Developing a career escalator will support us in illuminating the opportunities across the organisation as well as enabling us to better spot and nurture talent within the organisation. Creating the right environment and establishing the required infrastructure for our leaders to excel will be central to our talent and succession planning programmes.

We will continue to ensure that our staff continue to be supported with safe working conditions and that we are providing additional support for wellbeing both physical and psychological. Below is a diagram that outlines the levels of support that are in place to support staff and some of the broad types of provision that enable that support offer.



Building on the services delivered through our occupational health and wellbeing service and the staff support and wellbeing services deployed during the pandemic, we will continue to build capacity through the organisation to better support our staff within their teams. Using a model that enables staff to support themselves with signposting through to access specialist support and advice we will work with partners to build upon the resilience demonstrated through the last 12 months.

12.5. Capital

The Health Board has access to a number of sources of capital including its discretionary allocation, the all Wales major capital programme, specific all Wales programmes, charitable funds and the Intermediate Care Fund (ICF). Taken together these form the capital programme.

The Welsh Government has confirmed that the Health Board's discretionary allocation for 2021/22 is £14.421m. After making provision for slippage and brought forward commitments from 2020/21, together with a 15% over-commitment to allow for potential in-year slippage, we will develop a discretionary capital programme of circa £15.7m total value.

Welsh Government have confirmed the establishment of a *"Funding Programme for Targeted Improvements in the NHS Estate in Wales"*. The programme is focused upon improvements with respect to estate infrastructure, mental health, decarbonisation and fire safety. Following a review of the bids received the national Estates Advisory Board have supported additional funding for the Health Board of £4.597m.

National programmes are established for radiotherapy and imaging. The Health Board's bids total £5.075m. 2021/22 is expected to be the final year of the ICF funding programme and investment is focused upon those schemes that have commenced.

Finally, the Health Board regularly submits business cases to Welsh Government in order to access the all Wales major capital programme resource and the draft capital resource limit for 2021/22 indicates the following:

Capital projects with approved funding	£million
Primary Care - Central Denbighshire Ruthin	1.586
North Denbighshire - Royal Alex – Fees	0.181
Holyhead - Substance Misuse	0.376
Shotton - Substance Misuse	0.454
PAS System	0.169
Emergency Dept. Systems	0.335
ICF Funding	0.793
Wrexham - Fees to OBC	1.397
Approved funding	**5.291**

For 2021/22, the following priorities have been identified for the programme to focus on:

- Mitigating risk (and addressing compliance)
- Supporting patient safety
- Recovering (and learning) from COVID-19

- Service recovery (planned care)

The following draft programme has been developed for the total anticipated resource:

Discretionary and national programmes	£million
Estates - Risk and compliance - Patient safety - Recovering (and learning) from COVID-19 - Service recovery - Accommodation - Decarbonisation	 3.261 2.946 3.131 3.810 0.500 1.430
Medical devices replacement programme	2.188
Imaging and radiotherapy national Programmes	5.075
Informatics	3.123
All Wales capital projects approved funding	5.291
	30.755

12.5. Financial plan

▪ Financial context

The Health Board has historically been unable to meet the challenge of living within the resources allocated by Welsh Government, despite significant savings being delivered. Utilising the deficit cover funding provided by Welsh Government in 2020/21 allowed the delivery of a small surplus and the revised plan for 2021/22 will deliver a break-even position after confirmation of additional funding to offset the impact of non-delivered savings during the COVID-19 pandemic.

This performance is illustrated in the following table:

Looking forward to 2021/22, the Health Board continues to face a significant underlying deficit position, which is a consequence of our residual infrastructure and delivery inefficiencies from 2019/20 combined with the impact of the non-delivery of recurrent savings in 2020/21, as shown below:

	£000
Residual Infrastructure and Delivery Inefficiencies	(42,500)
Impact of COVID on our Savings Delivery Plan for 2020-21	(32,663)
Underlying deficit carried forward	(75,163)

▪ Annual Plan – Financial Planning Principles

The revised financial plan is aligned with the following Welsh Government Planning Principles:

1. Annual 12 month plans

The plan includes 12 months' cost assessment on a robust basis aligned with national and Heath Board priorities (unless explicitly described as less than 12 months)

2. National Priorities

The plan assumes 12 months' non recurrent funding for national priorities and programme areas in relation to:

a. COVID Mass Vaccination Programme
b. Testing costs including Welsh laboratory costs and community testing schemes
c. Use of PPE for infection control
d. Implementation of enhanced cleaning standards
e. Contact tracing
f. NHS commissioned social care packages
g. Continuation of the transforming access to unscheduled and emergency care programme

3. Aligning assumptions across organisations

The plan aligns with assumptions in other NHS Wales organisations' plans

4. Non-recurrent Stability Funding

Confirmation of non-recurrent stability funding for the first six months has already been provided to the Health Board and has been applied against all other remaining in- year COVID 19 additional costs. The plan anticipates non recurrent funding for these costs where applicable for the second half of the year

5. Recovery Plan Allocations

The plan includes both allocation and expenditure in relation to confirmed Recovery Plan allocations

6. Recurrent brought forward position

The plan assumes non recurrent allocations for the impact of COVID-19 on the recurrent (brought forward) 2021/22 operational position, materially relating to 2020/21 non delivery of savings

7. COVID 19 Additionality

Anticipated in year COVID 19 stability funding relates to additional costs of the COVID-19 response

Strategic support

The Health Board received confirmation of a package of strategic support in November 2020. This package contained support to cover the historic deficit position, to improve performance and to drive a programme of transformation linked to a sustainable clinical model for North Wales. Resources were allocated to meet the following objectives:

- Improvement in service performance, patient experience, and financial performance year on year;
- Engagement with the public, staff and partners as an essential first step to building a sustainable vision for the future leading to a medium term plan, focusing on well-being, population health and primary care as well as secondary care services;
- Strengthening the ability of the organisation to deliver on a wide-ranging change programme;
- Further improvements leading to de-escalation from targeted Intervention, using a maturity matrix approach to assess progress; and
- Transformation and innovation to support improved outcomes and patient and staff experience.

The funding allocated is summarised in the table below:

Strategic support	Welsh Government response				
£m	20/21	21/22	22/23	23/34	Total
Deficit cover to the value of:	40	40	40	40	160
Performance **Planned care** Planned care & USC (section 4) **Enhance leadership in:** MHLD Governance, delivery and OD	10.3 0.7	30	30	30	101
Transformation Agenda Implementation of Mental Health Strategy in partnership (section 12) Build capacity & capability to deliver transformation (section 3)		6.7 5.3	6 6	6 6	18.7 17.3
Total strategic support	51	82	82	82	297

▪ 2021/22 funding

The potential of a COVID-19 3rd wave and the related workforce constraints are the main risk to the delivery of the schemes this year and so the Health Board is actively identifying alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve performance.

A significant proportion of the schemes, mainly those which include recruitment of staff, have a recurrent impact which will need to be reflected in future years' planning.

▪ Local planning assumptions

The Health Board is focused on six key priorities across the integrated system, which will be facilitated by the additional strategic support allocation:

1. Improving patient experience
2. Responding to COVID-19
3. Recovering planned care performance
4. Improving unscheduled care performance
5. Improvements to MHLD
6. Developing the sustainability of the Health Board across all domains

▪ Resource allocation

The Health Board's resource allocation is £1,670.5m, with a 2% uplift for inflation of £26.5m (hospital and community health services and prescribing of £23.7m and mental health ring fenced uplift of £2.8m). This results in an initial allocation of £1,697m, which includes the strategic support of £82m referred to above.

In addition, there are a number of allocations which are not contained in the Health Board resource allocation of £1,697m and are detailed in the following table:

	£000
COVID-19	77,297
Removal of Donated Assets / Government Grant Receipts	(800)
Single Cancer Pathway	278
Substance Misuse	5,520
Substance Misuse inflation	267
IM&T Refresh Programme (in line with 11-12)	1,931
Consultant Clinical Excellence Awards	422
Prevention and Early Years Funding	1,301
Specialist Registrar	360

WAST Emergency Services	287
MSK Orthopaedic Services	1,150
National Dementia Bid - North Wales/Powys	121
Obesity Pathways	334
'A Healthier Wales' Prevention - SLC Resources	20
DDRB Pay Award 2020-21 For GP Trainees	42
'A Healthier Wales' Improving lives programme	57
Mental Health Service Improvement Fund	3,297
NHS Wales Collaborative Secondment Apr-May 2021	18
OPD transformation	31
Dementia Fund	2,153
Dental Contract: Innovation Funding Round 1	100
Outpatient Transformation Fund 2021/22	40
Suicide Prevention Funding	70
VIR1828 - SBRI Centre of Excellence 2021/22	382
Welsh Risk Pool	(3,132)
Total	**91,546**

These additional items total £91.5m, which gives a total baseline resource allocation of £1,788.6m reflected in the financial plan, which includes funding for COVID-19 expenditure of £116m and the additional COVID-19 recovery funding of £20m.

▪ Expenditure

Expenditure budgets have been reviewed and the key unavoidable financial impacts for 2021/22 are shown in the following table:

Changes to operational cost base	Net Cost Base
Pay	**£'000**
Pay/Award/Pension/Inflationary pressures	7,876
Changes to the workforce (Non COVID-19)	618
Non pay	
Inflationary pressures	0
Service change	352
Strategic priorities e.g. digital, ICF	1,429

Primary care prescribing	
Volume growth	0
Price growth/inflationary pressures	6,197
Secondary care drugs	
Volume / Price pressures	0
CHC/FNC	
Volume of CHC packages	0
Cost of CHC packages	4,691
Out of Hours and Macmillan Support	255
Commissioned services	
Welsh Risk Pool	0
Specialist services – via WHSSC	4,851
EASC	3,493
English contracts	1,460
Other local pressures/service change	
Corporate (incl H&S and IPC schemes)	1,922
	33,143

This illustrates that the operational cost base will increase by £33.1m, which includes pay and price inflationary pressures, and unavoidable cost pressures. This increase is £6m greater than the inflation uplift received through the allocation, which will need to be offset through savings and efficiencies.

▪ Cost of COVID-19

The Health Board continues to prioritise the response to COVID-19. In addition to our hospital response, both the vaccination programme and the Test, Trace and Protect programme will be key operations during 2021/22 as set out earlier in this plan.

The current estimate of direct COVID-19 costs equates to circa £116m of expenditure, with an additional £20m on COVID Recovery, the detail of which is illustrated in the following table:

	Allocated	Anticipated	Total
Funding of COVID	£000	£000	£000
Covid funding - Stability funding	38,394	5,261	43,655
Covid funding - PPE		6,544	6,544

National Programme - Cleaning Standards		2,489	2,489
National Programme - Care Homes		1,250	1,250
National Programme - Vaccination programme		12,683	12,683
National Programme – Testing		2,803	2,803
National Programme – Tracing		13,527	13,527
National Programme – Protect		77	77
Surge Funding		32,663	32,663
Total COVID	**38,394**	**77,297**	**115,691**

COVID Recovery Funding	£000	£000	£000
Planned Care Recovery Fund (£100m)	19,942		19,942
MH Helpline funding	343		343
Total COVID Recovery	**20,285**	**0**	**20,285**

The Health Board has confirmed plans to continue to use the field hospitals as mass vaccination centres until the following dates:

- Bangor – 31 May 21
- Llandudno – 31 July 21
- Deeside – 31 October 21

Savings

The Health Board has historically applied a consistent savings target across the organisation. Whilst this approach has yielded savings, it has not focussed particular attention upon areas where there are recognised savings and efficiency opportunities, which vary across service areas. For 2021/22 a more focussed approach will be adopted, using updated benchmarking data to identify opportunities for each service area.

Detailed opportunity analysis has been undertaken using external benchmarking and cost comparison. This has been provided to assist divisions and pan BCU functions to identify areas which can deliver recurrent savings by transforming service delivery. The benchmarking reviews have been undertaken to prioritise cash releasing benefits at this stage and have not been linked to patient outcomes. They require further work to verify the cash releasing value. Areas for potential pathway and value work have been identified in discussion with both the Finance Delivery Unit and the Delivery Unit of Welsh Government and these will be reflected in the emerging programme of work.

The following table illustrates the opportunities which have a high to medium confidence level in the quality of benchmarking, which gives a range between £70.7m and £114.1m to be delivered over a three year period:

Savings work streams	BCUHB Benchmarking 3 Year Opportunity 2020 £m Low	£m High
	70.7	114.1
Improving value and releasing capacity: requiring prior investment in patient pathway management	8.5	13.8
Referral management (Health and Social Care localities and secondary care consultants)	2.1	4.2
Management of Ambulatory Care sensitive conditions (community & primary care)	5.1	7.6
Alternative clinical pathways for regular attenders	0.5	0.7
Community Hospital DTOCS (Community, Primary Care, Private Sector, Councils)	0.5	0.7
Mental Health DTOCS (Community, Primary Care, Private Sector, Councils)	0.1	0.2
Pressure Ulcers & Healthcare Acquired Infections (Hospital Nursing)	0.2	0.3
Improving Efficiency within own Budgets	19.7	36.4
Theatres: Theatre utilisation/ unused sessions	0.0	0.1
Theatres: Theatre list productivity - surgical time	3.5	8.9
Theatres: Lost time, both late start & early finish	1.4	2.0
Theatres: Cancelled theatre sessions over 9%	1.0	1.5
Planned Care: Average Length of Stay	2.0	2.9
Urgent Care: Average Length of Stay	6.2	10.3
Outpatients: New to Review Ratios	5.3	10.6
Outpatients: DNAs	0.2	0.2
Cash Releasing	42.6	63.9
Community Hospitals: Elderly Wards NHS Benchmarking	1.2	1.7
Mental Health Hospitals: Mental Health NHS Benchmarking	3.7	5.2
Pathology	1.5	2.0
Facilities Management	1.6	2.4

Workforce: Temporary Staffing & vacancies	8.7	13.1
Workforce: Sickness (including within temporary staffing)	0.6	0.9
Workforce: Suspensions	0.1	0.1
Workforce: Pay Protection	0.1	0.1
Ward Nursing levels: Welsh Government Finance Delivery Unit (FDU) Ward Benchmarking	1.7	4.4
Corporate Staffing: FDU Corporate Benchmarking	0.7	2.6
Medicines Management: Primary Care Prescribing	13.6	17.2
Continuing HealthCare	8.3	12.4
Contracting	0.9	1.6
HSDU	0.1	0.1

Based on benchmark data, we have allocated the high value opportunities of £114m across service areas and this clearly shows that the opportunities vary widely. The table below illustrates the impact of delivery of the opportunities of £114m over a 3 year period and how this compares to the discretionary budgets held in the divisions:

Divisions	Year 1 £m	Year 2 £m	Year 3 £m	3 Year Savings Target £m	Divisional Budget	% Saving Target of Overall Budget
Ysbyty Gwynedd	2.6	5.1	7.7	15.3	92.3	16.6%
Glan Clwyd	2.6	5.2	7.8	15.5	112.5	13.8%
Wrexham Maelor	2.6	5.2	7.7	15.5	97.8	15.8%
North Wales Services	0.8	1.6	2.3	4.7	95.3	4.9%
Women's	0.4	0.9	1.3	2.6	38.4	6.7%
West Area	1.7	3.3	5.0	10.0	95.8	10.4%
Centre Area	2.6	5.2	7.8	15.6	139.7	11.2%
East Area	2.4	4.8	7.2	14.3	141.1	10.1%
Other Area	0.2	0.3	0.5	0.9	13.4	6.7%
MHLD	2.0	3.9	5.9	11.8	118.6	9.9%
Corporate	0.9	1.8	2.7	5.3	120.2	4.4%
Contracts	0.4	0.8	1.2	2.4	186.8	1.3%
	19.0	38.0	57.0	114.0	1,260.7	9.0%

The methodology for addressing opportunities will be aligned with both the service transformation programme and the adoption of value based healthcare principles. The next steps are to progress these opportunities to validated projects and agree the final distribution of the savings target for 2021/22 and beyond.

The savings plan will be pathway and service focused to support the Health Board's transformation programme and the Service Improvement and Programme Management Office (PMO) teams will be appropriately resourced to support the service areas to identify, validate and deliver savings opportunities.

As part of the transformation programme, we will develop a rolling three year plan, which will deliver a reduction in the cost base commensurate with the strategic support package of £82m, as described in section 3 of the plan.

Based on our current understanding of the opportunities analysis, we would expect delivery of savings of between £20m - £30m in a full year. We have therefore set an ambitious internal stretch target of £25m of identified opportunities to allow for a realistic contingency against schemes not delivering in year. This pipeline target includes a significant component drawn from the transactional and non-recurrent savings historically delivered, as part of the financial control measures we will put in place.

Notwithstanding the internal stretch target of £25m, the financial plan is predicated on circa £17m of savings delivery, recognising that there will be less opportunity to deliver savings in the early part of the year due to COVID-19. . The service areas have so far identified £11.7m of savings against the plan for £17m (69%); delivery is dependent upon the Health Board's ability to realise the savings not being compromised by COVID-19 pressures.

The financial plan

The proposed methodology for the financial plan and apportionment of budget by service area was presented for approval to the Finance and Performance Committee in February 2021, and is summarised below:

1. Allocate the core uplift to divisions' recurrent budget
2. Agree the forecast spend for 2021/22 based on agreed planning assumptions, including £17m savings delivery
3. Identify the residual financial risk

Having adopted this approach, the summary financial position is set out in the table below:

	£000	£000
2021-22 Allocation	1,670,545	
2% Uplift	26,509	
Allocation for 2021-22		1,697,054

Additional Anticipated Resources		91,546
		1,788,600
2021-22 Forecast Spend	1,755,457	
Pay Award	7,876	
Inflation	20,691	
Cost pressures	4,576	
2021-22 Revised Forecast Spend		1,788,600
Break even position		0

Financial Strategy

The Health Board is developing a financial strategy which will articulate our ambition to deliver sustainable health care for North Wales and is aligned to the significant transformation programme being progressed this year. It will be predicated upon the Health Board's adoption of value based health care principles to drive better outcomes for our population and focusing on clinical pathways for conditions.

The financial strategy will consider the significant and long-standing issues discussed and reviewed by the Finance and Performance Committee and the Finance Delivery Unit of Welsh Government and will align with the other enabling strategies developed across the Health Board which will all be reviewed and refreshed in line with the vision of the Stronger Together programme.

Financial governance

The Health Board has reviewed its governance arrangements during 2020/21. In response to the recommendations of this review a finance and transformation delivery group will be established. This group will be set up to support the execution of the Health Board's key financial priorities with oversight provided through the Finance and Performance Committee. The priorities are set out below:

- Improving financial performance and accountability;
- Delivery of the savings programme;
- Wider adoption of value based healthcare principles;
- Management of specific financial provisions; and
- Utilisation of strategic support funding.

▪ Risks to the financial plan

The following risks to the financial plan have been identified:

- Significant risks on Planned Care Recovery due to the potential impact on capacity from a COVID-19 3rd wave, alternative options are being explored;
- Impact of a COVID-19 3rd wave on our core planning assumptions and the cost of COVID;
- Failure to deliver savings plans required to improve the underlying financial position of the organisation and improve productivity. This risk is currently estimated as £5.732m;
- Limited ability to deliver the clinical strategy and revised patient pathways within available resources; and
- Inability to effectively manage cost and volume growth

These financial assumptions are subject to further refinement in line with additional NHS Wales guidance and the confirmation of our final specific allocations.

▪ Conclusion

We will deliver the commitments in this plan and deliver a break even position in year, to support the Health Board's ambition to achieve the statutory duty to breakeven over a three year period, by the end of 2022/23.

13. Risks and issues

This Plan has a particular focus upon the effective management of risk and the avoidance of harm. The potential for harm during the pandemic is particularly heightened and the Health Board has determined its priorities with a view to minimising the four dimensions of harm arising from COVID-19. Underpinning our priorities is a commitment to driving improvement using a consistent quality improvement methodology, supported by a modern digital infrastructure.

As part of our Board Assurance Framework, we routinely manage and review our risk registers noting and responding to the risks and opportunities that could impact the planned delivery of our plan. Our Executive Team regularly reviews this, with corporate functions and divisions working closely with Directors and the Board to ensure that risks are appropriately mitigated and managed.

Programme level delivery plans have been developed and provide further detailed actions and timescales.

APPENDIX 2

Board Level Monitoring	Ref	Key Priority COVID-19 response Strengthen our population health focus Recovering access to timely planned care pathways Improved unscheduled care pathways Integration and improvement of mental health services	Lead (Job Title and contact person)	Programme (What)	Action (How)	Programme/Patient Outcome (Why)	Lead Director	Target Date (When)	Risks	Finance	Target improvement linked	Board Level Monitoring	Board or Board Scrutinising Committee
Y	E1.1	Enabler	**Executive Director of Governance programme sponsor (specific actions allocated to Exec lead portfolios)**	Pan BCU Support Programmes - Targeted Intervention: The de-escalation for Betsi Cadwaladr University Health Board from Special Measures to Targeted Intervention (TI) outlining areas for further improvement Current priorities identified for improvement: mental health, engagement, leadership, strategy and planning, planned care and performance.	• Engage and communicate internally within the divisions, and with partners and stakeholders on the Maturity Matrix approach (CAMHs and Adult MH). • Progress the joint working between CAMHs and Adult MH, with a focus on financial allocations and the transition pathway. (CAMHS and Adult MH). • Establish the improvement and development group to support the CAMHs programme delivery (CAMHS). • Review the MHLD leadership structure, with leads identified to support the key delivery areas (Adult MH). • Progress the crisis concordat activity to support our clinical pathway focus (Adult MH). • Undertaking a stakeholder mapping exercise and develop a relationship management approach to relevant stakeholders in the domains of patient, partners, staff and public. • Consolidate a team for engagement across the four engagement domains, drawing from best practice. • Use the development of key strategies (i.e. Living Healthier, Staying Well and Clinical Service Strategy) as a PDSA exercise to improve engagement process and outcomes. • Develop an engagement process to encourage openness, transparency and trust with our citizens. Leadership priorities for the next quarter: • Ensuring executive, senior leadership and partner ownership and engagement in the delivery of discovery phase of Mewn Undod mae Nerth/Stronger Together. • Aligning the Board development programme with Mewn Undod mae Nerth delivered by the King's Fund with additional support from the Good Governance institute. • Reviewing clinical leadership support structures and resources to improve multi professional clinical engagement. • Mobilising additional capacity and capability to support transformation, organisational and system development, engagement and governance • Starting the refresh of Living Healthier Staying Well. • Using the refresh as the basis for our Clinical Services Strategy implementation plan. • Develop a revised planning process to allow for a draft approvable IMTP to be agreed for 2022-25. • Implement and embed the Performance and Accountability Framework including regular reviews, appropriate escalation, and revised performance reporting.	Programmes of work have been informed by the established maturity matrices which will be used to assess progress against the targeted intervention framework in 2021/22.	Director of Governance	Milestone actions for delivery by 30th September are identified. These will be reviewed and refreshed on a quarterly basis.		Core Funding	Y	Y	
Y	E1.2	Enabler	**Associate Director of OD**	Pan BCU Support Programmes - Stronger Together	Establish and mobilise the 3 year strategic organisational and system development route map, Mewn Undod Mae Nerth/Stronger Together, comprising 3 phases - Discovery, Design and Deliver. The Discovery phase is an ambitious 3+month engagement process to talk with 10% of the BCU workforce through a combination of 1 2 1 conversations, focus groups and workshops. This extensive engagement across all areas of the Health Board will provide key thematic feedback from staff and provide the foundation for a 9 month design phase of Mewn Undod Mae Nerth/Stronger Together to renew the Health Board's culture and organisational systems, aligned to the Health Board's strategic goals and purpose .	Listening to the experiences of staff working across the Health Board to learn from examples of best practice and understand what may be preventing staff from making further improving delivery of exemplar patient care pathways. The Discovery phase makes no assumptions about what the solutions may be and thus enables the co-production with staff of improvements to the health board's culture and organisational systems.	Executive Director of Workforce & Organisational Development	30th June-30th September discovery; 31st December-31st March design		Core Funding	Y	Y	
Y	E.3	Enabler	**Associate Director of OD**	Organisational and Leadership Development Strategy 2022-2025	The development of an Organisational and Leadership Development Strategy 2022-2025 which is aligned to Mewn Undod Mae Nerth/Stronger Together. The development of the strategy will be informed by the discovery phase of Mewn Undod Mae Nerth/Stronger Together and will be developed as a key part of the subsequent design phase of Mewn Undod Mae Nerth/Stronger Together to ensure the Health Board's organisational design and its leadership are enabled to deliver the Health Board's strategic goals and purpose during the final delivery phase of Mewn Undod Mae Nerth/Stronger Together	An organisational and leadership development strategy aligned to and informed by the strategic organisational and system development route map of Mewn Undod Mae Nerth/Stronger Together to enable delivery of organisational and leadership development interventions that support the Health Board's strategic goals and purpose over the next 3-10 years	Executive Director of Workforce & Organisational Development	31st December-31st March		Investment case for Design phase of Mewn Undod Mae Nerth to include funding to support delivery of the organisational and	Y	Y	
Y	E4.1	Enabler	**Associate Director of OD**	Aligment of Board and senior leadership development as part of the development of an Organisational and Leadership Development Strategy 2022-2025	The development of an Organisational and Leadership Development Strategy 2022-2025 during the design phase of Mewn Undod Mae Nerth - informed by the discovery phase - will include evidence based targetted development programmes for Board members and all senior leaders, as well as for all levels of leaders across the Health Board, inclusive of clinical and non-clinical leaders	To better enable the Health Board to delivery its strategic goals and purpose over the next 3-5 years through providing Board members and senior leaders with evidence based leadership development support and training	Executive Director of Workforce & Organisational Development	Q3-Q4		Investment case to support design phase of Mewn Undod Mae Nerth/Stronger Together to include funding to support	Y	Y	
Y	E4.2	Enabler	**Associate Director of OD**	Continue to execute improvements in staff safety, support, wellbeing and resilience in order to improve attendance, retention and contribution.	Two key programmes will be undertaken to improve Health and wellbeing and creation of a culture of psychological safety. The first will enhance the services available to support staff's mental health through the implementation of a more integrated model of staff wellbeing support services from supporting self-care through to crisis support. The second programme will implement a new Speak Out Safely process, replacing the Safe haven system, to better enable staff to raise concerns confidentially. This will include the creation of a Speak Out Safely Guardian and an MDT to receive, manage and monitor concerns raised, supported by a new on line system for raising concerns in an confidential and anonymous manner	Through the staff wellbeing support service, support and promote enhanced emotional resilience and wellbeing amongst staff, reducing staff absence, improving recruitment and retention, and supporting the Health Board becoming an employer of choice. through the new Speak Out Safely process, support the creation of a culture of psychological safety at work, and through this support the delivery of safe patient care	Executive Director of Workforce & Organisational Development	Q3-Q4 for staff wellbeing service; Q1-Q2 for Speak out safely		12 month investment to support enhanced wellbeing support service agreed. Funding to support new Speak out	Y	Y	
Y	E3.1	Enabler	**Associate Director of OD**	Develop and deploy a programme of work, as per the Strategic Equality Plan, to support the organisation in meeting its Socio-Economic Duty	Implement Year 2 of the Health Board's approved Strategic Equality Plan, delivery being monitored through the Strategic Equality and Human Rights Forum. As well as meeting its Socio-Economic duty and other equality priorities, there will be a focus on race equality with the establishment of a Race Equality Action Plan, taking account of the outcome of the Welsh Government's consultation on Race Equality in 30th June.	Delivery of inclusive patient services and management of staff, ensuring patients with protected characteristics are not disadvantaged in such a way as to adversely impact on health care outcomes and that staff are not disadvantages in terms of recruitment, development, training and promotion opportunities.	Executive Director of Workforce & Organisational Development	30th June-31st March	Public Sector Duty and Socio-Economic duty on risk register	Investment case to expand corporate equality team completed	Y	Y	
Y	E3.3	Enabler	**Associate Director Of Health, Safety & Equality -**	Implement Year 2 of the Health & Safety Improvement Plan to ensure staff are proactively protected, supported and safe. This includes providing specific guidance, training and support on legislative compliance. Identifying and supporting staff at greater risk of contracting Coved and providing specific risk assessment advice. Provide adequate manual handling training and support to staff. Investigate incidents and provide, fit test training, risk assessment advice and support staff ensuring environmental and social impacts are monitored and complied with.	Ensure effective Health and Safety through Make it Safe reviews, incident investigations achieved via incidents reported on Datix, 72 hour reviews undertaken tracking on line lists with liaison with infection control and Track and Trace. This will then determine if it will be required to be reported as a RIDDOR incident inline with legislative compliance which is required within 10 days. Site visits are reported through Quarterly and annual reports to the Strategic Occupational Health Group and QSE. Union partners are kept up to date on compliance issues on a weekly basis. The frequently asked questions and guidance provided to staff is updated when legislation or guidance is changed. The fit testing programme in place to support suitable compliance with COSHH and HSE guidance. A continual programme of fit testing is in place and recorded on ESR system with reports provided to PPE steering group for escalation. A package to ensure that manual handling training is effectively implemented has been presented with a recommended program to move from 58% compliance to 85% within 2 years, risk assessment awareness and management of safety critical systems have established training dates. A full action plan to comply with legislation has been developed for Y2 and evidenced through the appropriate governance structure and reporting on KPI's.	Reduce the risk of transmission patient to patient staff to patients, patients to staff. Ensure safe systems of work are implemented in all service areas.	Executive Director of Workforce & Organisational Development	30th September	BAF risk register programme	Core funding required	Y	Y	
Y	E3.4	Enabler	**Associate Director Of Health, Safety & Equality**	Security, V&A Improvement Plan	Ensure adequate security provision is in place including restraint training, clinical audit system, lone working, lockdown procedure, V&A case management compliance with Welsh Security Framework and further development of the obligatory response to violence collaborative. A 12 month action plan has been developed subject to additional support to review all aspects of the security gap analysis.	Effective management of violence reduces the risks of absenteeism, stress in the workplace leading to better patient safety outcomes and staff retention.	Executive Director of Workforce & Organisational Development	31st March	BAF risk register programme	Core funding required	Y	Y	
Y	E3.5	Enabler	**Associate Director Of Health, Safety & Equality**	Occupational Health action plan and Safe, Effective Quality Occupational Health services (SEQOSH) accreditation	A workplan to establish effective Health Surveillance has been developed to be completed within 12 months. This includes review of respiratory sensitizers, latex, noise, vibration, night workers, nitrous oxide, welding fumes and dusts. A review of wellbeing is in place developing more effective KPI's to report on numbers of people accessing support in conjunction with the Wellbeing Cell. The group plans to report in August 2021 defining progress on action plans. The Occupational Health Team report to the strategic Occupational Health Group. A plan to implement a immunisation programme is defined with the 3 year business case. The SEQOSH accredited system ensures continual reporting on the action plan is being implemented. The Corporate Health Standards form part of the Wellbeing Programme a comprehensive action plan has been developed to maintain accreditation in July 2021.	Continue to maintain all aspects of Safe Effective Quality Occupational Health Service accreditation. Implement a comprehensive immunisation and health surveillance system. Effectively support the staff Wellbeing Strategy and improve mental health support for staff.	Executive Director of Workforce & Organisational Development	31st December	BAF risk register programme	Core funding required	Y	Y	
Y	E3.6	Enabler	**Associate Director of Workforce Planning & Performance**	Delivery of workforce optimisation programme encouraging reduction in temporary premium cost spend and workforce efficiency addressing the following issues: High levels of vacancies, High number of leavers, Aging workforce, High agency spend, Low levels of bank provision	Workforce Optimisation programme structure put in place. Ensure effective recruitment team structures and resources are in place. Workforce KPIs and targets in place and tolerances set to monitor and identify.	Reduction in vacancies and leavers across targeted areas. Reduction in agency spend as a result of filling long term vacancies. Clear workforce KPIs in place to monitor and provide early warning indicators	Executive Director of Workforce & Organisational Development	30th September - 31st December	BAF risk register programme	Business case in place with money identified in the financial plan	Y	Y	

Y	E1.3	Enabler	**Associate Director of Nursing - Infection Prevention, Nursing Midwifery & Patient Services**	Pan BCU Support Programmes - Safe Clean Care Harm Free	Develop a programme of work to ensure we are' Making our place safe through, clean wards, safe bed space, safe entry, safe break and safe change'. Through Safe clinical and non-clinical areas (transfers), safe wards and safe rapid isolation. Ensuring our actions are safe, for patients, visitors and staff. Support the workstreams release more time to care through; Infection prevention and control cockpit development. Building designing and purchasing IT enables solutions Develop tools/ material to support the behavioural change Safe Clean Care workstreams	Providing a safer place providing health for North Wales population, reducing infection spread. Identifying areas of improvement across the wards and hospital to support safe care. Improving the place of work for staff, reducing injury at work. Developing and using digital technology solutions to improve delivering and monitoring safe ways of working.	Shared responsibility for sections of SCC Strategy: Chief Operating Officer - Safe Clean Care Harm Free – Safe Place - Safe Clean Care Harm Free – Informatics Executive Medical Director - Safe Clean Care Harm Free – Safe Space Executive Director Nursing & Midwifery - Safe Clean Care Harm Free – Safe Action Executive Director Workforce & Organisational Development - Safe Clean Care Harm Free – Communications &	30th June - Divisions to identify Business case to address SCC Strategy. 30th September - Approve/engage/research business case and strategy 31st December - 31st March - Implement new ways of working		COVID Funded / Capacity & capability		Y	
y	E.1.6 E.1.6	Enabler	**Head of Programmes, Assurance and Improvement**	Creation of a Digital Strategy	Development and Implementation of the digital strategy which has been approved by the Board.	To deliver key enablers across North Wales which will drive digital transformation of care and deliver commitments outlined within the Strategy over the next three years.	Executive Director of Primary & Community Care	31st May 30th September	• Approval at Trust Board is not received. • Competing priorities with lack of sustainable investment in digital • National infrastructure and projects may not deliver what is needed and/or at the required pace • Unable to keep up with the pace of digital change to meet the expectations of our patients, carers and staff • Information is not safe • Insufficient staff capability and capacity to deliver the Strategy • Organisational culture and service planning does not change • Lack of engagement from staff	Business Case approval for difference projects will be required.		y	Board & FPIG
y	E1.7 E1.7 E1.7 E1.7	Enabler	**Project Manager**	Deliver Phase 3 of Welsh Patient Administration System implementation	Phasing and approach agreed Support from Welsh Government for continuation of project team in place System in place (pending business case)	Delivery of a single patient administration system Welsh Patient Administration System (WPAS) -across BCUHB. This will streamline the care process and enable up to date accurate information to be available for service delivery across the Health Board. Improve the ability to manage patient pathways seamlessly throughout the hospitals within the Health Board. Provide timely and accurate information for clinicians and managers. Enable services to modernise in response to changing working models. Reduce variation in scheduling, tracking and reporting throughout the Health Board.	Executive Director of Primary & Community Care	30th June – Re-start the project. 30th September – System build and data migration. 31st December – UAT user acceptance testing and training. 31st March – Lead to up to implementation in May 2022	Corporate Risk - CRR10A/NF01 National Infrastructure and Products. Project level risks: There is a risk that key resources (project and services) will not be available to support key activities on the project. There is a risk that project will continue to defer the scope of the data migration iterations. There is a risk that operational users are unable to attend WPAS training There is a risk that slippage in either the BCU or the Velindre data migration plan may impact overall WPAS timescales. There is a risk that BCU do not have sufficient resources to keep up with the demands of a complex data migration activity.	Funding through WG until September 2021. Business case has secured funding for post 2021 required from WG.		y	Board and FPIG
y	E1.8	Enabler	**Programme Manager**	Deliver Symphony - Phase 1 2020/2021	Implement V2.39 in the West ED and 6 Minor Injury Units associated with the West (including LLGH)	Phase 1 required before WPAS West implementation – West ED and MIUs were previously using PIMS to record attendances. Phase 1 complete (with the exception of 2 MIUs which are currently closed with no imminent plans to re-open). The system will bring: • Improved Continuity and Timeliness of Care • Improved Quality of Patient Care, Experience and Safety • Improved Discharge • Improved Data Quality and Standards • Improved Data Sharing across BCUHB and Intelligent • Improved Administration Efficiency The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th June – Complete implementations in MIUs	Health Board risk - BAF20/28 - Effective Use of Resources Project level risks: • There is a risk that resource may become an issue for the project if Establishment Control/Recruitment cannot be achieved in a timely manner. • There is a risk that Tywyn and Dolgellau MIUs will not be able to implement BCU Symphony at a time which is suitable for both the MIUs and the project team. • There is a risk that generic log on to the system may not be an acceptable method to be used for Information Governance purposes.	Funded		y	Board & FPIG
y	E1.9 E2	Enabler Enabler	**Programme Manager**	Deliver Symphony - phase 2 2021/2022	Upgrade from V2.29 to V2.39 Move East area onto the Health Board Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including 1 minor injury unit associated with the East	Phase 2 will bring improved functionality and the latest version of Manchester Triage. Manchester Triage 1 is currently used within Symphony 2.29 in the East. This version of Manchester Triage is out dated and has been flagged as a significant clinical risk as both presentation flow charts and discriminators have been updated in newer versions. The benefits listed in Phase 1 will also apply to Phase 2. The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th June – Data migration testing 30th September – End user training, Go Live period (July), Phase closure	Health Board risk - BAF20/28 - Effective Use of Resources. Project level risks: •There is a risk that resource may become an issue for the project if Establishment Control/Recruitment cannot be achieved in a timely manner. •There is a risk that Tywyn and Dolgellau MIUs will not be able to implement BCU Symphony at a time which is suitable for both the MIUs and the project team. •There is a risk that generic log on to the system may not be an acceptable method to be used for Information Governance purposes. •Availability of adequate funding (Capital and Revenue) •Availability of key personnel to undertake the enabling activities required for readiness (EMIS, NWIS, BCU Programmes, Information and ED resource)	Funded		y	Board & FPIG
y	E2.1 E2.1 E2.1	Enabler	**Programme Manager**	Deliver Symphony - Phase 3 2021/2022	V2.39 implemented in Central and 2 minor injury unit's Implement Symphony v2.38 into 2 minor injury units in Central area	The completion of the Phase 3 implementation will see all ED/MIU areas using a single system for the time, providing standardisation across BCU in readiness for a move to the National Welsh Emergency Department system. The benefits listed in Phase 1 will also apply to Phase 3. The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th September – Phase 3 planning 31st December - to be determined from 30th September planning 31st March- to be determined from 30th September planning	To be determined from planning in 30th September	Funded		y	Board & FPIG
y	E2.3 E2.3	Enabler	**Head of Patient Records & Digital Integration**	Development of the acute digital health record (Clto DHR) pan-BCU	Deliver the project for the Digital Health Record (4 year project to Nov 2024)	The development of the Digital Health Record will allow a single view of the patient record, having this in place will support the integration with local and national systems and will provide greater access to systems and information that are safe and reducing the use of paper from the how we work. We will have one system that is capable of gathering patient information from scanned records, new content from e-forms and current and future systems. Part of this project is also to develop digital ways of sharing information across our borders.	Executive Director of Primary & Community Care	31st December – * Minimum Viable Product (MPV) & two Early Adopters * New scanning contract in place 31st March – Phase Roll out programme established and underway	The common risks across the digital projects are escalated to our Patient Records Transition Programme. There can be described as * Spectrum of digital readiness and literacy amongst users * BCU is non-compliant with key legislation * Digital readiness of the organisation - infrastructure, hardware and network * Quality of the data within the source system causing data within other linked systems to be inaccurate * A delay to the project achieving its objectives, due to emerging events/issues e.g. Covid, new corporate initiatives	Funded		y	Board & FPIG
Y	E2.9	Enabler	**Head of ICT**	Strengthen cyber security	Review and identify areas of improvement as part of Cyber Security Providing Assurance that all necessary measures are taking place to reduce and manage the risk of a Cyber security.	Providing Assurance that all necessary measures are taking place to reduce and manage the risk of a Cyber Incident through the deployment of key processes, accreditation and risk management as well as new and emerging technologies.	Executive Director of Primary & Community Care	30th June-31st March – (Funding to be confirmed)	Corporate Risk - ICT01 – Cyber Security There is a risk of cyber security attacks due to a lack of assurance around cyber security threats and lack of a dedicated Cyber Security Team which could lead to a total loss of all Health Board data stored on BCU servers. This could impact patient care, Health Board reputation, confidentiality, and breaches of legislation, financial impact (fines and cost of recovering data). If this risk is not addressed it could lead to the organisation not meeting legislative requirements such as GDPR and NIS-D. We could also be open to Civil suits should patient safety incidents occur as a result of a cyber-attack.	Not funded.		Y	Board & FPIG

Y	E1.4	Enabler	**Assistant Director of Strategy and Planning**	Pan BCU Support Programmes - LHSW & Clinical strategy review	Take stock and check with staff, patients, partner organisations and the public how Covid-19 has affected health and well-being and what we can learn from this experience. Review lessons learnt and strategy successes, challenges, opportunities. Develop plan to implement lessons learnt initiatives into a new strategy with new objectives. Create dissemination of new strategy to ensure engagement with stakeholders	• Check in with our staff, patients, partners and public whether the principles are still valid • Review our strategic priorities to ensure they are consistent with "A Healthier Wales" • Address those elements of LHSW that proved challenging to implement e.g. an integrated system wide approach to healthcare and integrated care pathways • Test the strategy is still relevant in the changed environment • Provide the framework for development of a Clinical Services Plan	Executive Director of Planning and Performance	30th June Review of current strategy plan developed 30th September Approval of refresh plan approve - Engagement plan developed 31st December/31st March - Engagement process initiated		Core Funding	Y	Y	
Y	E1.5	COVID-19 response	**Consultant - Anaesthetics & Intensive Care / Clinical Lead for Critical Care**	Enhanced recovery from critical illness The provision of robust and consistent staffing within traditional 'medical' critical care rotas to ensure patient safety	Enhanced recovery from critical illness by meeting national standards with regards Clinical Psychology (providing integrated Clinical Psychology support within critical care teams), Therapies (providing a structured, individualised rehabilitation programme through dedicated Occupational Therapy, Physiotherapy, Speech and Language Therapy, and Dietetics input) and designated critical care Pharmacist at the three acute hospital sites.	1. Improved quality of patient care during critical illness and during the recovery from critical illness 2. Improved patient safety and quality of care 3. Reduced costs through reduced length of critical care and ward stay, reduced readmission, and decreased longer term healthcare utilisation 4. Equity of access to support across North Wales 5. Raised staff well-being and retention 6. Clinical staff (in particular critical care nursing staff) able to concentrate on core clinical activity The provision of robust and consistent staffing within 'medical' critical care rotas by recruiting experienced critical care nurse or allied health professional staff to advanced clinical practice roles at the three Acute Hospital sites	Executive Medical Director	30th June - 30th September Development of Business Case 31st December Business Case submitted for internal sign-off and approval 31st December / 31st March Development of a programme plan, recruitment ready for implementation 2022	Financial resources Ability to recruitment skilled staff Failure to meet national standards and recommendations Protracted length of patient stay Increased length of time for patients to regain independence Increased dependence at critical care and hospital discharge Inequitable access to clinical psychology and therapy services across North Wales Clinic cancellation due to lack of dedicated nursing staff resource	Business Case to be approved. Circa £1M revenue funding tbc		Y	**QSE & Board**
Y	C1	COVID-19 response	**TTP Programme Director**	Ensure adequate testing capacity is available across North Wales in line with the revised Welsh Government Testing Strategy. * Lab Turnaround Times for swabs is a PHW responsibility * Contracts for Regional, Local and Mobile testing units and WAST are Welsh Government managed contracts) Testing capability located across the region to ensure the volume of testing slots are adequate and able to provide a test within 24 hours and easily accessible preferably no more than 30 minute drive. Lateral Flow Devices (LFD) issued in accordance with Welsh Government policy; currently manage the distribution across the Health Board and LFD collect points via the existing testing infrastructure for the population who are not able to work from home (all other distribution managed by Welsh Government)	Government contracts with an external provider to provider Regional and Local Testing sites – two and four respectively across the region. Note: Government contract with another external provider to provide mobile testing units (MTUs). MTUs move across the region including to more remote areas. They also respond in the event of outbreaks. Activity is monitored for every unit in conjunction with epidemiology reports. To work strategically with partners to agree the most appropriate deployment of the mobile testing units.	PCR testing needs to be undertaken as rapidly as possible for anyone demonstrating Covid symptoms and for cases where the TTP service has recommended a test. The earliest identification of positive cases will help to ensure transmission of the virus is reduced, or prevented. The desired outcome is to minimise and eliminate transmission of Covid.	Executive Director of Public Health	Measure through capacity and Turnaround Times. Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team and not expected to be reduced before 31/3/22.	Inadequate testing capacity – risk that positive cases are either not identified or not identified in a timely manner. Risk is increased transmission. Access to testing – if tests are not accessible, population may be deterred from testing. Public perception, and the need to reiterate core messages (e.g. only essential travelling outside the UK).	COVID Funded		Y	PPPH & Board
	C1					MTUs are used to move around the region 1. reaching more remote communities to improve access to testing, 2. in response to outbreaks and the requirement to rapidly test. The speed of testing, The desired outcome is to minimise and eliminate transmission of Covid.	Executive Director of Public Health	Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team. No plans to reduce capacity.					
	C1				To maintain the Health Board-operated Community Testing Units to ensure that appropriate PCR testing is provided for patients requiring pre-operative testing, as well as meeting the needs pre-treatment needs of cancer and renal patients. Work with secondary care services to dynamically manage the recruitment and retention of staff to meet service requirements and ensure that capacity/ demand is continuously monitored in line with national and regional data, allowing for surge capacity to be deployed as required	To ensure patients do not have Covid prior to treatment in order to: * Protect the patient – if they are covid positive, they are at greater risk during and following a procedure * Protect other patients from potentially contracting the virus whilst in the care of BCU HB * Protect our workforce by minimising exposure to the virus	Executive Director of Public Health	30th September – capacity plans are in the progress of being built now with the planned care services. The target is to ensure there is adequate capacity to provide the required PCR testing within a 72 hour pre treatment period.	Retaining staff to deliver service. Services providing CTUs with timely information regarding pre op testing plans. Maintaining current CTU locations as other services return to "business as usual" and request the return of facilities.				
	C1				Point of Care testing devices to be evaluated and implemented to support the rapid turnaround of tests for patients arriving in departments such as A&E. Roche Liat and Lumeira devices being evaluated for different departments.	To provide rapid test results to enable departments to treat patients safely on the appropriate pathway in accordance with their Covid-status Improves the decision-making time to protect patients and the workforce	Executive Director of Public Health	30th September evaluate 31st December devices implemented subject to effectiveness of evaluation	IT connectivity to manage test results	COVID Funded (Finance to check if Roche Liat devices are covered by covid funding)			
	C1				Lateral flow testing devices deployed to BCU frontline staff c.17,000; managed through Shared Services for distribution and line managers for registration and replenishment.	One in three people who are covid positive do not demonstrate symptoms. Regular LFD testing aims to identify staff who are asymptomatic to prevent transmission in the workplace, amongst patients, and the wider workforce.	Executive Director of Public Health	31st May	Managing storage and replenishments of kits Staff registering kit and reporting results; if staff are not regularly testing in line with guidance, asymptomatic staff will be missed creating risk of transmission	COVID Funded			
	C1				Create LFD collect points across the region utilising the existing infrastructure such as RTS, LTS and MTUs for the population who are not able to work from home. Also link up with Covid Support Hubs being developed under the Protect agenda.	To provide easy access to LFD kits to the members of the population who cannot work from home. Regular testing to identify asymptomatic cases and reduce the risk of transmitting the virus unknowingly.	Executive Director of Public Health	30th June – in place by the end of 30th June and on-going until WG policy determines otherwise	Public confusion re type of test to use i.e. PCR v LFD	COVID Funded			
Y	C1.1	COVID-19 response	**TTP Programme Director**	Deploy effective tracing service with partners across North Wales to minimise transmission of virus and adapt the service provision as Welsh Government policy evolves.	Ensure there is an adequate resource at a regional and local level to deliver effective tracing in response to the identification of positive cases, including variants of concern and returning travellers	Adequate resources will ensure that tracing responses are rapid as soon as positive cases are confirmed; isolating the positive case and their identified contacts, in turn reducing transmission	Executive Director of Public Health	By 30th June and on-going through 2021-22	Public do not adhere to guidance A third wave exceeds capacity Staff attrition falls below the required threshold Difficult to recruit as the economy opens up as these are temporary roles	COVID Funded		Y	QSE & Board
	C1.1					Resource in place to manage a third wave and skills developed to address international travellers, backward contact tracing, EHO capacity, to ensure the tracing response is as effective as possible in limiting the transmission of the virus	Executive Director of Public Health						
Y	C1.2	COVID-19 response	**TTP Programme Director**	Continue North Wales liaison on protect agenda coordinating multi-agency response	Individuals and communities impacted by Covid can access the support available.	5 'protect' schemes in progress in partnership with WG, with ambition to increase further. The schemes will support individuals impacted by Covid to access LFDs, financial advice, food poverty support, MH support and other locally-identified support services.	Executive Director of Public Health	30th September and ongoing	Funding pulled after initial pilot phase	COVID Funded		Y	
Y	C1.3	COVID-19 response	**Vaccination Programme Lead.**	Implement and deliver the BCUHB mass vaccination programme.	Development of a sustainable delivery model as we move into an annual vaccination and booster programme, in line with evolving national clinical guidance and Welsh Government Strategy. This will ensure we have a strategy for future proofing the programme, transforming it into a 'business as usual' model.	To ensure our citizens have a robust process of planning short, medium and long term within the BCUHB vaccination programme. This will involve being able to respond to changing guidance, changes in vaccine supply and any other interdependency which may require action and a change in approach.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme	The Vaccination Strategy for Wales currently sets out 3 milestones based on the JCVI's prioritisation advice. Milestone 1: To have offered the vaccine to all individuals in cohorts 1-4 by mid February. BCUHB achieved this along with other Health Boards in Wales on 12 February 2021. Milestone 2: To have offered the vaccine to all individuals in cohorts 1-9 by mid April. That includes all those aged 50 and over. BCUHB achieved this and along with other Health Boards in Wales on 4 April 2021. Milestone 3: It is our aim to offer everyone in the current 10 priority groups their first dose of the vaccine by the end of July 2021. We remain on target to achieve this next milestone. Future milestones based on the next phase including the booster programme are expected in Quarter 2 via the WG. This will also include guidance and criteria. By 31st December	Changing guidance, lack of National clarity on the next phase. Meeting legal obligations, having data and other intelligence robust enough to support. Compliance with evolving National Guidance and development of multiple vaccines. Return of redeployed staff, turnover of agency staff. Lack of clarity of the medium and longer term plan. Data quality. IT framework & capabilities	COVID Funded		Y	
	C1.3				Demonstrable equal access to the vaccination programme for all groups with special characteristics or other underserved groups as defined within the North Wales Vaccination Implementation Plan.	To ensure that our citizens within these groups are identified and engaged with to ensure that any inequalities are addressed and mitigated within the programme implementation.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Ensure the mechanisms in place continue with the interpretation of clinical guidance, development of clinical pathways and maintain and review them as required.	To ensure our citizens vaccines are delivered safely, protecting public trust and confidence in the immunisation programme.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Development of a workforce model which will deliver the programme, flexible enough to adapt to the evolving plans from one phase to the next.	To ensure our citizens can reply on a skilled, sufficient and sustainable workforce to deliver their vaccines in the most effective and safe way.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Development of an estates plan which will provide the capacity to deliver the programme, flexible enough to adapt to the evolving plans from one phase to the next.	To ensure our citizens can reply on a skilled, sufficient and sustainable workforce to deliver their vaccines in the most effective and safe way.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Develop an efficient contact process and self-service booking system under Welsh Government Guidance.	Provides our citizens with appropriate contact methods and the ability to book vaccination appointments that fit in with their schedule providing the ability to update or amend. This will avoid frustrations caused by having to phone the booking centre.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
Y	C1.5	COVID-19 response	**Assistant Area Directors for Children's Services**	COVID recovery - all Children's Services	Establish gap and conduct recovery analysis, establishing new activity and waiting times trajectories of new capacity within current guidelines, develop new plans required to achieve at Service Level across Community and Acute Services	Improved access for Children and young people with reduced waiting times. Developed new ways of working.	Executive Director Primary & Community Care	30th June – Baseline assessment.	Allocation of funding to reduce backlog	Performance Improvement Funding		Y	Board & QSE
	C1.5						Executive Director Primary & Community Care	30th September - Service Level plans to deliver agreed.					
	C1.5						Executive Director Primary & Community Care	31st December-31st March - Ongoing performance monitoring via Regional Childrens Services Group.					

Y	R1	Recovering access to timely planned care pathways	**Assistant Area Directors Primary Care**	Continuation of accuRx communication platform, to provide IT infrastructure to enable GPs and other health professionals working in primary care to undertake remote consultations, share information with patients and to update the patients' clinical records with the consultation event.	Commission a fixed term contract on behalf of GP practices whilst awaiting an all Wales decision to support long term provision.	Supports GPs and other health professionals to communicate more effectively with their patients in the delivery of care; includes medical surveys, text and photo responses, patient triage, text messaging, vaccination booking, and with the plus version video consultations and digital documents.	Executive Director Primary & Community Care - Acting Executive Medical Director	30th June	Risk to implementation: Procurement processes may prevent timely implementation. Need for consistent Data Protection standards and documentation across the health board and multiple independent contractors.	Performance Fund		Y	FPIG
	R1				Interim contract in place for accuRx use by North Wales practices.	Maintain new ways of working, support recovery and the delivery of access standards. Supports social distancing to be achieved within Primary Care premises and more choice of consultation method to be available to patients. Improved access for patients	Executive Director Primary & Community Care - Acting Executive Medical Director	30th June	Risk if not implemented: Poor patient access to primary care Unsustainable primary care services unable to meet demand				
	R1				Work with NWIS to agree long term contract requirements	Improved delivery of GMS access standards (see related action below) Efficient use of clinical capacity. MDS ref:	Executive Director Primary & Community Care - Acting Executive Medical Director	30th September					
	R1				All Wales contract in place for accuRx	• In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • Ambulatory sensitive conditions referral numbers	Executive Director Primary & Community Care - Acting Executive Medical Director	31st December					
Y	R1.1	Recovering access to timely planned care pathways	**Assistant Area Directors Primary Care supported by PC Academy lead**	Review the uptake, requirements and patient satisfaction in relation to alternative/new technologies supporting patient access to GMS	Extend eConsult provision to participating practices.	Improved or maintained access to General Medical Services Monthly eConsult activity and patient satisfaction reports to demonstraite increased access. Efficient service provision MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4	Executive Director Primary & Community Care	30th June	Risk to implementation: Not a contracted requirement to participate. Growing demand as evidence of unmet demand and more patients contacting practices through virtual routes Risk if not implemented: Poor patient access to primary care Unsustainable primary care services unable to meet demand	Primary Care (WG Investment Fund grant – linked to the Academy)		Y	FPIG & Board
	R1.1				Monitor eConsult activity including patient satisfaction		Executive Director Primary & Community Care	30th June					
	R1.1				Monitor patient/clinical satisfaction in relation to video and telephone consultations		Executive Director Primary & Community Care	31st December					
	R1.1				Review access to virtual consultation training		Executive Director Primary & Community Care	30th September					
	R1.1				Review ongoing use and satisfaction with accuRx (and feed information into future contract requirements – see specific action above)		Executive Director Primary & Community Care	31st December					
	R1.1				Feed local learning into the national Strategic Programme to inform future strategies		Executive Director Primary & Community Care	31st March					
Y	R1.2	Recovering access to timely planned care pathways	**Asst Director Primary Care Contracts supported by Asst Area Directors Primary Care**	Delivery of all Wales access standards through GMS Contract (detailed in non-mandated QAIF)	Review 2020/21 performance against standards (validated data released June 21)	Improved achievement of GMS Access Standards Maintained or improved access to primary care GP practice services for patients MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • A&E attendances	Executive Director Primary & Community Care	30th June	Some GP practices may not participate the QAIF is not mandated Investment is required in phone systems to improve access and monitoring. This is a barrier particularly in some of our managed practices. High demand in primary care including c-19 vaccination programme and impact of planned care backlog	Primary Care		Y	FPIG & Board
	R1.2				Support provided to practice managers in interpreting and implementing the requirements of the standards by Primary Care Contract team		Executive Director Primary & Community Care	31st March Rolling contractual programme					
	R1.2				Work undertaken with clusters/practices to identify and disseminate good practice via Access Standards forum		Executive Director Primary & Community Care	30th June-30th September					
	R1.2				Performance reports provided to Board in line with regulatory requirements.		Executive Director Primary & Community Care	30th June-31st March					
Y	R1.4	Recovering access to timely planned care pathways	**Asst Director Primary Care & Community Services, supported by Area Medical Directors and Planned Care Lead**	Working with planned care programme leaders to ensure a whole system response to patient demand pressure areas (also refer to planned care section)	Development of timely and accurate information for current and new patients, and primary care clinicians, regarding care pathways and waiting times	Improved patient communication and provision of alternative services if appropriate, to support patients waiting for planned secondary care, including regular updates. (Activity data will be detailed in the planned care action log) Alleviate patient concerns Seek feedback from primary care in relation to the impact of waiting list validation and patient queries. Robust management of clinical risk MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • All elective activity • Urgent cancer OPD referrals • Urgent non-cancer OPD referrals	Executive Director Nursing & Midwifery	30th June	Risk to implementation: Planned Care leads capacity to fully engage Complexity across specialties and sites Insufficient resourced capacity in primary care to participate Risk if not implemented: Poor patient outcomes and increased clinical risk Primary care unable to cope with additional demand relating to queries and supporting patients whilst they wait	Performance Fund –assuming further allocation from WG		Y	FPIG & Board
	R1.4				Ensure robust communication with primary care clinicians regarding waiting times and clinical review processes		Executive Director Nursing & Midwifery	30th June					
	R1.4				Development of proposals to manage the backlog of planned care in the primary care sector		Executive Director Nursing & Midwifery	30th June					
	R1.4				Link to the transformation of prioritised system wide care pathways, ensuring primary care involvement.		Executive Director Nursing & Midwifery	31st March					
Y	R1.6	Recovering access to timely planned care pathways	**Asst Director Primary Care & Community Services, supported by Academy Manager**	Further development of the Primary and Community Care Academy	PACCA Business Case finalised	Supporting the further implementation of the primary care model in Wales, leading new ways of working and innovation in primary care. Further integrated working with the Strategic Programme for primary care and HEIW Promotion of North Wales as a place to train learn and work; particularly in relation to primary care professions, with targeted recruitment initiatives. (Subject to business case approval), increased numbers of advanced practitioners working in primary care settings Support the sustainability of GMS Primary Care through the development of training posts supernumerary to the costed established to develop a cohort of practitioners who are Primary Care ready. Supported primary care internships, including Physicians Associates Deliver a range of development, training and education programmes to support the development of clinical and non-clinical practitioners. Increase skills and knowledge in Community Pharmacy to meet population need and develop services that can be provided closer to home via an alternative primary care contractor. MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • In-hours GP demand v capacity: number of community pharmacies at escalation level 3 and 4	Executive Director Primary & Community Care	30th June	Risk to implementation: Approval of Business Case and allocation of additional funding Risk if not implemented: Academy not further developed and unable to meet the needs of primary care, both to support innovation but also improve recruitment and sustainability (as a response to the BAF)	Performance Fund		Y	Board & ?QSE
	R1.6				Planning for all programmes, with the completion of the delivery plan 2021/22 (subject to funding), to include:		Executive Director Primary & Community Care	30th June					
	R1.6				Training Hub established and posts advertised		Executive Director Primary & Community Care	30th September					
	R1.6				Level 7 Vocational Education Programme in place		Executive Director Primary & Community Care	30th September					
	R1.6				Community Pharmacy training Programme - 30th September and 31st December due to timing of taught modules at University		Executive Director Primary & Community Care	31st December					
	R1.6				Evaluation Lead and Research Development appointed		Executive Director Primary & Community Care	30th September					
	R1.6				Trainees in post and commencing education programmes / ongoing evaluation of training hub		Executive Director Primary & Community Care	31st December					
	R1.6				New Cohort of Practitioners to join Vocational training Programme		Executive Director Primary & Community Care	31st December					
	R1.6				Further development and testing of competency framework		Executive Director Primary & Community Care	31st December					
	R1.6				End of year report		Executive Director Primary & Community Care	31st March (published 22/23)					
Y	R1.7	Recovering access to timely planned care pathways	**Programme Lead for Dental Academy**	Development of a North Wales Dental Academy, to include a training unit, GDS and CDS provision	Robust programme governance arrangements were established in 2020/21	Increase in number of dentists trained and working in north Wales Additional access to dental services and improved performance against dental access targets. NB This is difficult to provide a definitive level of activity as we are delivering a totally new model (to Wales/UK) for the delivery of services and pushing the boundaries of Contract Reform. Any further covid surge will also impact on this given the strict IP&C required for dental services. Once a preferred provider is appointed additional clarity will be provided; specified activity/targets are not set in the contract, but asked the provider to define innovative delivery methods and with activity targets to be agreed. Further detail will be available in Sept/Oct 21. MDS ref: • Number of AGPs	Executive Director Primary & Community Care	30th June	Risk to implementation: Procurement of appropriate provider Ongoing capacity restrictions due to IP&C/covid Risk if not implemented: Poor dental access Ongoing challenges in attracting dental practitioners to north Wales	Primary Care		Y	Board & QSE?
	R1.7				Advertise the contract			30th June					
	R1.7				Award to preferred provider			30th September					
	R1.7				Seek Board & WG approval to award preferred bidder			30th September					

	R1.7				Commission facility	• Number of courses of treatment Also improvement to dental access targets over time (see notes above)		31st March					
Y	R1.8	Recovering access to timely planned care pathways	**Asst Director Dental Services**	Implementation of the dental contract reform (as directed by Chief Dental Officer/Welsh Government)	Implemented by the dental contracts team as a core priority	Delivery of all Wales model of dental care Utilise all aspects of the contract in a flexible manner and deliver increased access, improved responsibility in oral health wellness, better patient outcomes from a dental led, whole system delivered ethos. MDS ref: • Number of AGPs • Number of courses of treatment	Executive Director Primary & Community Care	31st March	Risk to implementation: Ongoing IP&C restrictions due to C-19 Risk if not implemented: Not able to demonstrate delivery of national contract requirements	Primary Care		Y	Board & FPIG?
Y	R1.9	Recovering access to timely planned care pathways	**Asst Director Dental Services**	Commission additional general dental provision	Undertake non-recurring procurement exercise with GDS contractors, commissioning services that will replace lost activity.	Increased access to urgent dental services, general dental services, in a timely manner. Access provision for new patients is expected to continue to increase as GDS services continue to remobilise, although the capacity to accommodate new patients is likely to become more limited during the second half of the year as services become saturated and the patient demand for resumption of routine normal services grows. Deliver CDO expectations for provision of access for new patients across the HB of 1,500 new patients/week for at least 30th June and 30th September (noting that anyone not treated in the preceding 12months is classified as a new patient) MDS ref: • Number of AGPs • Number of courses of treatment	Executive Director Primary & Community Care	31st December	Risk to implementation: Ongoing IP&C restrictions due to C-19 GDS capacity Risk if not implemented: Unable to improve access to dental services	Primary Care and Performance Fund		Y	Board & FPIG?
	R1.9				Increase provision of Urgent and Emergency sessions along with sessions specifically targeted at high needs patients who have traditionally had difficulties accessing GDS services		Executive Director Primary & Community Care						
Y	R2	Recovering access to timely planned care pathways	**Assistant Director for Pharmacy and Medicines Management (West)**	Relaunch of a community pharmacy care home enhanced service to form part of our recovery plan.	Update of the enhanced service for community pharmacy, including relaunch of Tier one that supports medicines management in care homes.	Effective medicine management via pharmacist to support reduction in admissions to hospital, including improved medicines reconciliation on discharge and reduced readmission of patients due to medicines related harm Supports improved patient outcomes and quality of care. Reduction in medication errors/incidents within the care homes. Increase number of care homes having received level 1 support and completed an action plan. By proxy this will reduce medication errors in care homes. (NB this data is not held by the health board; CSSIW will be approached to advise) MDS ref: • Care Homes DES • Emergency admissions	Executive Director Primary & Community Care	31st March	Risk to implementation: Restrictions relating to IP&C Community Pharmacy capacity Risk if not implemented: Poor patient outcomes and increase in medication incidents Increase in hospital demand	Primary Care		Y	Board & PPPH or QSE?
	R2				A national review of the specification of the service has commenced led by the All Wales Consultant Pharmacist for community health care.		Executive Director Primary & Community Care						
	R2				Increase provision of Discharge Medication Reviews for patients resident in care homes.		Executive Director Primary & Community Care						
	R2				Commission level 1 service that will support medicines management governance and safe use of medicines within care homes. This covers: • Patient entered care • Transfer of care • Monitoring are review		Executive Director Primary & Community Care						
Y	R2.3	Recovering access to timely planned care pathways	**Clinical Director Audiology and Head of Adult Audiology**	Delivery of advanced practice audiology in primary care and provision of Ear Wax Management Services (subject to business case approval / additional funding)	Extension of the advanced practice audiology scheme and implementation of earwax management service across north Wales (subject to business case approval / additional funding)	Compliance with Welsh Health Circular for Ear Wax Management Improved capacity for ear wax management and subsequent reduction in patient concerns Improved patient outcomes and access to specialist services 'closer to home' Support for GP practices to manage audiology demand MDS ref: In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4	Executive Director of Primary & Community Care	31st March	Risk to implementation: Timely approval of business case and confirmation of funding Risk if not implemented: Non-compliance with WHC Unable to support primary care demand & capacity, and delivery of improved access	Performance Fund		Y	Board & PPPH
Y	R1.3	Improved unscheduled care pathways	**Asst Director Primary Care & Community Services, supported by Asst Area Directors Primary Care**	Development of urgent primary care centres as pathfinders, feeding into the national programme of work for primary care.	Presentation to WG of pathfinder proposals for 2021/22 to secure additional funding for current pathfinders (East & Central Areas).	Additional urgent primary care capacity in place to support practices and emergency department service delivery. Monthly activity levels are included in the KPIs; estimated in East Area 1200-1800pm; Central Area 1000pm. Improved patient satisfaction. Timely access to services in response to on the day demand Integrated working with the unscheduled care programme, including 'phone first' and the implementation of 111. MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • A&E attendances	Executive Director Primary & Community Care	30th June	Risk to implementation: Capacity to deliver pathfinders Recruitment of multi-disciplinary workforce Confirmation of funding Recruitment to short term posts Links with 111 and GPOOH as they also change during this period Risk if not implemented: Unable to meet patient demand for unscheduled care in primary and secondary care.	Performance Fund (for West Area) and WG UPCC grant (subject to approval)		Y	PPPH & Board
	R1.3				Further development of UPCC pathfinder in East Area covering 6 clusters		Executive Director Primary & Community Care	30th June					
	R1.3				Commence UPCC pathfinder in North Denbighshire in partnership with mental health third sector		Executive Director Primary & Community Care	30th June					
	R1.3				Development of proposals/business case for a UPCC pathfinder(s) in West Area		Executive Director Primary & Community Care	30th June					
	R1.3				Implementation of UPCC(s) in West Area (subject to approval/funding)		Executive Director Primary & Community Care	31st December					
	R1.3				Participation in national evaluation of all pathfinder UPCCs, with recommendations for a future model of care.		Executive Director Primary & Community Care	31st March					
	R1.3				Local review of UPCC pathfinders, including cost benefit analysis to determine future requirement for north Wales		Executive Director Primary & Community Care	31st March					
y	I1.1	Improved unscheduled care pathways	**Community Services lead**	Implementation of Single Care Home Action Plan	Development and Implementation of the Quality Assurance Framework	• All residents in a North Wales Care Homes receive safe, high quality and equitable care at all times. • That the Health Board is able to commission services that are fit for purpose, with a focus on improving health, reducing health inequalities, prevention, early and timely intervention and excellent end of life care. • Ensure that residents / patients are cared for in the most appropriate setting, promoting improved patient / resident flow between care settings. • Enhancing the quality of life for people with care and support needs. • Safeguarding and protecting from avoidable harm. • Ensuring that people have a positive experience of care. • Strong commissioning process that gives high quality of care as well as value for money Ensure evidenced based practise and improved quality outcomes. • Delaying and reducing the need for care and support, Reduction of unplanned admissions and attendances to ED, Reduction in falls, Pressure Ulcers, safeguarding referrals, medication errors, infection outbreaks. • Targeted interventions in area of inequality and deprivation. • Improved recruitment and retention in care homes, Improved access to joint training and education, Reduction in care Homes being managed through Escalating Concerns.	Executive Director Primary & Community Care	30th June. Secure Funding for additional Quality Posts. Questionnaire to partners. Hold two workshops to agree components of the QAF. Draft QAF by end of 30th June. Recruit to Quality Posts. 30th September Conclude recruitment and undertake engagement with providers and key stakeholders. 31st December Refine QAF and commence Implementation. 31st March Full implementation	Capacity of team, potential of further Covid outbreaks Market stability and viability of the care home sector			y	Board & QSE
	I1.1												
	I1.1												
	I1.1												
y	I1.2	Improved unscheduled care pathways	**Assistant Area Director (AAD) - Intermediate Care & Specialist Medicines and AADs of Community Services** **AAD Pharmacy and Medicines Management**	Transformation of Community Services - Home First Bureau	Development and implementation of a Home First Team in line with Home First Bureau Business Case.	Discharge to recover and assess is a National programme of work. National measures agreed and reported since March 21 in order to start collecting the baseline information. National measures reported since March 21 • Measure 1 – No. of people transferred on to each D2RA pathway. • Measure 2 - % of those transfers that took place within 48 hours of decision being made. • Measure 3 - % people transferred to a D2RA pathway a co-produced recovery plan in place. • Measure 4 - % of people transferred out of D2RA pathway to usual place of residence. • Measure 5 - % of people readmitted to Hospital within 28 days (post D2RA pathway). Benefits	Executive Director Primary & Community Care	30th June – Baseline data being collected. 30th June – Review of Home First Bureaus 30th September – Review of baseline data 30th September – Home First Business Case approved and all posts recruited to. 30th June – Training and education across system. 30th September – Gap analysis and recruitment	TThe D2AR investment in the Central Area has focussed on the provision of addition HCA staff, working over 7 days. Early evidence is demonstrating how these staff are enabling more care to be deliver in patients' homes. There is insufficient funding to maintain the posts for the full year. ICF funding not guaranteed post March 2022. Risk of staff leaving if contracts can't be renewed and notice having to be given to some staff Longer stays in acute and community hospitals	Performance Fund		y	Board & FPIG?
	I1.2				Recruit to the staffing model outlined in the business case (confirmation that this has been approved is required).		Executive Director Primary & Community Care						

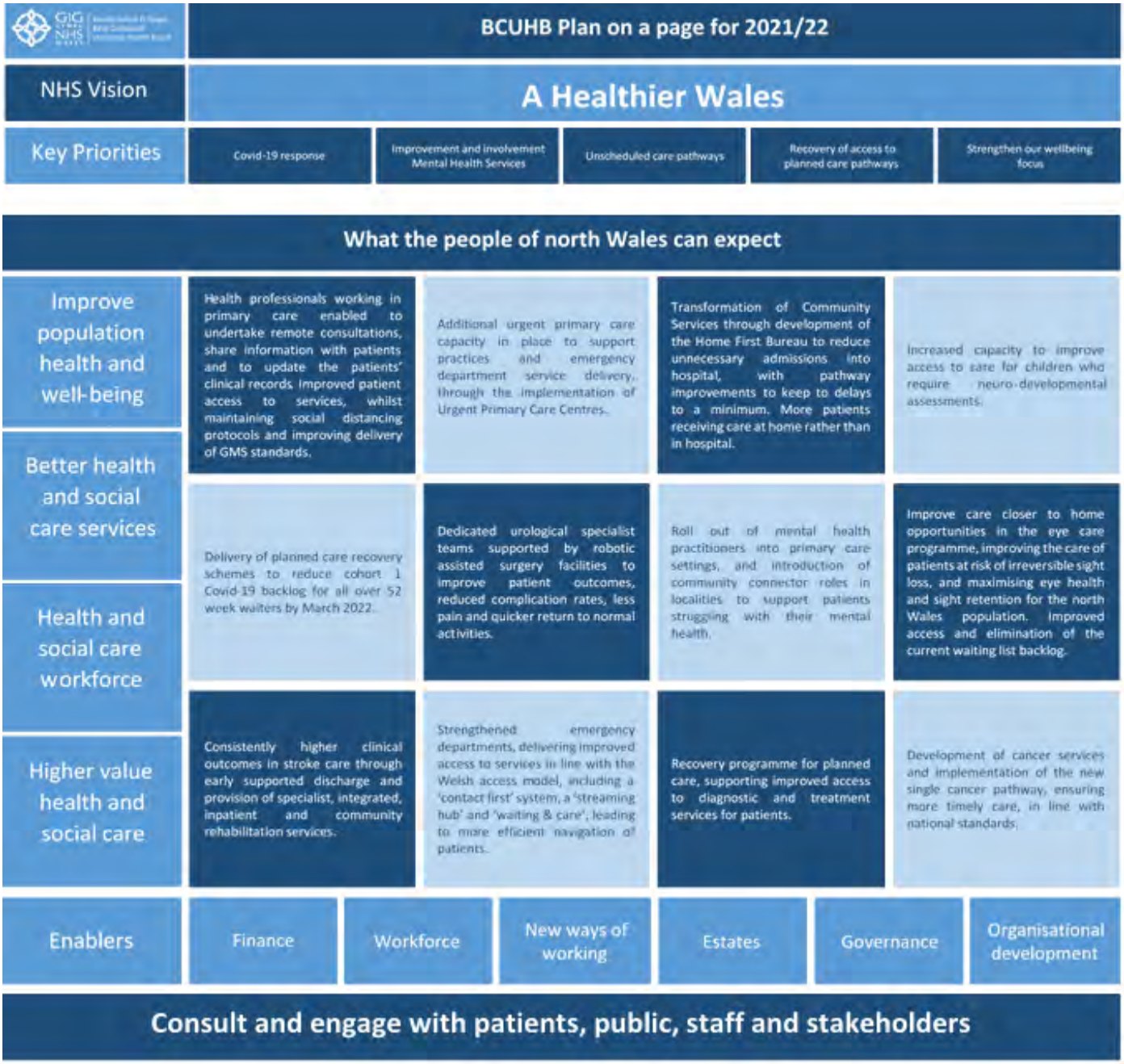
	I1.2				Consolidation and mapping all of our resources to support discharges including CHC, HFB, Frailty, D2RA, therapies and CRT. Fully implement Discharge to Assess capacity within the community.	• Reduction in unnecessary admissions into hospital. • Improvement patient pathway with minimal delays. • Patients receiving care at home rather in hospital. • Improved patient flow to maximise acute bed capacity. • Improved patient experience and more joined up care.	Executive Director Primary & Community Care	30th September – Gap analysis and recruitment 31st March – Ongoing monitoring					
	I1.2				East - Development of pathways out of hospital to support D2RA – e.g. EMI pathways. Pharmacy support needs to be included as part of the CRT. To support domiciliary and care homes to administer medication safely to people in their own homes. Supports care closer to home	Discharge Medicines review to be completed by community pharmacy to enable medicines reconciliation at change of care setting in line with NICE guidance.	Executive Director Primary & Community Care						
Y	I1.3	Improved unscheduled care pathways	**AAD Community Services West** **AADs Community Services**	Transformation of Community Services - Development of Frailty Pathways to deliver on the vison of Welsh Government for sustainable and integrated Community Health & Social Care.	COTE linked to CRTs and MDTs at pre crisis point (West only).	• Pilot impact of COTE support within CRTs (West) • Supports the expansion of Community Transformation work beyond South Wrexham.	Executive Director Primary & Community Care	Ongoing 30th June – workforce review. 30th September/31st December – extend MDT model from South Wrexham to Central Wrexham and NWW. Centre –30th June – design 30th September – Recruit 31st December – Implement 31st March – monitor East 30th June Marleyfield West - YG Frailty unit – on hold, funding not confirmed. Led by acute. West Frailty model in place West - MDTs established in Ynys Mon and Arfon – roll out to remaining areas by 31st December	Short term cost pressure whilst services cross over. Risk we won't have the funding. Can't recruit the right type of resources	Core Funding		Y	Board & QSE
	I1.3				Develop innovative workforce models to reduce risk of COTE consultant vacancies – eg nurse consultants; therapy consultants (East)	• Sustainable COTE workforce. • Improved patient care and avoiding unnecessary hospital admissions or increased lengths of stay.	Executive Director Primary & Community Care						
	I1.3				YG & YGC Frailty units established and staff recruited	• Improved patient experience and avoiding hospital admission and reducing length of stay. • Discharge Medicines review to be completed by community pharmacy to enable medicines reconciliation at change of care setting in line with NICE guidance.	Executive Director Primary & Community Care						
	I1.3				Frailty model embedded into community services and intermediate care approach to utilise step-up beds from primary care more consistently. Partnership working with LAs for Marleyfield step down beds (East).		Executive Director Primary & Community Care						
	I1.3				Inclusion of pharmacy requirements for frailty units /services, ED and SDEC (and all other clinical developments) in all three acute sites as part of the MDT team.		Executive Director Primary & Community Care						
Y	I1.5	Improved unscheduled care pathways	**Community Transformation Regional Programme Manager**	Community Services Transformation Programme: Continued implementation of regional and area-level transformation plans, aimed at developing place-based, integrated models of care and support increasing skills and capacity within primary care, community health and social care, to deliver care and support in people own homes and communities.	Joint programme with Local Authorities in order to: Expand and strengthen Community Resource Teams so as to meet the needs of the local population.	• Better and more seamless, integrated care and support within the community, that delivers what matters to the people of North Wales. By strengthening community services (including primary care, community health, social care and the third and community sector) the programme supports a shift towards prevention, early intervention, and well-being. This in turn will support demand management for secondary care services and statutory social care. • Integrated working will ensure the better co-ordination of services, reduce duplication and waste and ensure that care and support is delivered at the right time, in the right place and by the right person. Strengthen the role of digital technology in delivering future. focused and person-centred care	Executive Director Primary & Community Care	30th June-31st March– ongoing implementation of regional and area-level programmes of work 31st March – Sustainability planning for post programme continuation	Short-term Transformation and ICF funding not aligned to longer-term delivery timescales for change. Risk that programme momentum may slow once grant funding ceases.	WG Transformation Fund		Y	Board & PPPH
	I1.5				Strengthen place-based working through the development of integrated health and social care localities, leadership and governance.		Executive Director Primary & Community Care						
	I1.5				Develop an integrated workforce model able to deliver increasingly complex care within the community.		Executive Director Primary & Community Care						
	I1.5						Executive Director Primary & Community Care						
	I1.5				Expand the role of the community and third sector in delivering 'what matters' programme		Executive Director Primary & Community Care						
Y	I1.7	Improved unscheduled care pathways	**Assistant Area Director – Primary & Community Care**	Increased capacity within CRTs to support patients to be cared for in their own homes.	Employ additional HCSWs within CRTs in the Central Area, working from 7.30am to 9pm, 7 days per week.	Patients needing additional short term care in their own homes can be supported, avoiding unnecessary hospital admission. Patients no longer requiring acute care can be discharged to recover in their own homes. Patients with increased care needs, for example double handed care visits, can be discharged earlier / avoid admission to hospital while recovering or awaiting an increase in their package of care. Increased number of patients wishing to die at home can be supported to do so. Reduced demand on acute and community hospital beds.	Executive Director Primary & Community Care	30th June: Staff recruited with Winter Planning monies to continue in post, linked to CRTs. Data collection 30th September: Evaluation of service and business case to secure ongoing funding and contingency planning for exit strategy 31st December: subject to funding, recruit and deploy additional HCAs to support care delivery outside hospital 31st March Secure permanent funding, subject to further evaluation	Risk that there is insufficient capacity of other CRT staff and GPs to provide care (capacity put in place as GPs and DNs have said that they can manage more people at home with sufficient support staff, so currently, not an issue). Risk that NHS HCSWs are increasingly relied upon to provide domiciliary care where Dom Care Agency services are not available	FYE £1.045m D2AR funding secured to fund additional HCAs already employed until end of September. Need to secure remaining monies for full staffing and for 31st December and 31st March.		Y	Board & FPIG (in support of reducing DToC?)
	I1.7				Use additional capacity to facilitate provision of care and support in patients' homes	Contribution to reduced LOS. Contribution to reduced DTOC. Contribution to BCU implementation of D2AR pathways. Improved patient experience (being cared for at home, rather than in hospital). (Continuation of scheme implemented in Winter 2021, which has increased capacity in Enhanced Care services and, with the Home First Bureau, contributed to a 430% increase in patients listed for community hospital being discharged home instead).	Executive Director Primary & Community Care						
Y	I1.7		**Children & Young People Area Director**	Transformation of Child and Adolescent Mental Health Services (CAMHS) - Targeted Intervention Performance and Improvement Programme.	Two year improvement plan. A maturity matrix approach has been developed and agreed to support transformational change required, enabling an organisational focus on improvement priorities: Strategy & Sustainability Workforce Enhanced Care Pathways Access Involvement & Participation Psychological Therapies Provision Transition	Strengthened Regional leadership capacity and enhanced Regional governance embedded across services. Development of long term CAMHS Strategy with clinical, stakeholder and public involvement. Crisis care teams further developed to support children and young people presenting in crisis regarding self-harm, suicidal ideation and acute mental health difficulties. Improved Access to service for assessment and intervention to meet Mental Health measure targets	Executive Director Primary & Community Care	30th June – Baseline assessment	Timely allocation of Funding to implement Regional Transformation Structure. Workforce recruitment to deliver	Performance Improvement Fund & WG MH Funding Allocation		Y	Board & QSE
	I1.7						Executive Director Primary & Community Care	30th September - Developed Improvement Framework and structure		Performance Improvement Fund & WG MH Funding Allocation			
	I1.7						Executive Director Primary & Community Care	31st December -31st March & Ongoing Performance improvement monitored monthly at Strategic CAMHS Improvement Group. Ongoing Self-Assessment in line with reporting to Board Meetings.					
y	I2.1	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Emergency Department access and patient flow (Welsh Access Model / Emergency Department Quality and Delivery Framework / Frailty and Acute Medical Model)	Welsh Access Model implemented and access principles and priorities adopted across all sites – emergency department access pathway to include a 'Contact First' system, 'Streaming Hub', and 'Wait & Care System', leading to more efficient navigation of patients Pioneering key performance indicators verified and published for each site – 'Time to Triage', 'Time to Clinician', 'Outcome'	• Improved clinical outcomes by EDs through focus on efficiency and effectiveness to reduce time to triage and time to clinician. • Improved patient experience and quality of care within ED through a standardised pathway and direction to the most appropriate department in a timely manner – in line with the Welsh Access Model. • Enhanced engagement of ED workforce. • Increased value for money achieved from ED funding through innovation, improvement, adoption of good practice and eliminating waste. • Reduced patient harm from seamless journey to the right healthcare professional first time and improved health outcomes through effective triaging methods.	Executive Director Nursing & Midwifery	31st March implementation WAM – 31st March KPIs – Complete, although will be periodically published throughout 2021/22 – 30th June, 30th September, 31st December, 31st March	Funding of improvement support workforce – funding has now been confirmed through the National ED|QDF Team until March 2022.	Performance Fund		y	Board & FPIG
	I2.1				National Enablers for Service Improvement (NESIs) – Collection, analysis and evaluation of patient and staff feedback, with findings being fed into internal Health Board improvement groups to support service development initiatives	• Improved patient experience through collection of live qualitative patient data and experience. • Improved staff experience through analysis of qualitative feedback to inform changes in the department. • Improved patient safety and experience through implementation of a number of pathway improvement projects that focus on reducing delays and directing the patient to the right clinical outcome first time. • Reduced harm, improved patient experience and improved flow from utilisation of pre hospital pathways where appropriate. • Improved quality, reduced variation as a result of a standardised suite of Guidelines to ensure the same high standard of care regardless of where patients access services		NESIs PE – Ongoing through to 31st March SE – Ongoing through to 31st March					
	I2.1				Implementation of Pathway Improvement Projects (PIPs) for: ambulance handover & triage; clinical guidelines; navigation, and engagement to achieve CAREMORE standards. This will involve completion of scoping documentation and establishment of local working groups by 30th June. The programme of work and actions agreed nationally in place by 30th September. Pilot of PIPs across three BCU sites within 31st December and data Analysis & Evaluation (Local & National) within 31st March	• Improved quality and value as a result of a reduced number of unnecessary or duplicated investigations leading to efficiency savings • Improved patient experience and reduce harm from navigating patients to alternative services before they enter the system for triage. This proactive approach to patient management will ensure patients receive the correct care option in the most appropriate setting in a timely manner, while reducing the demand on ED.		PIPs: All to be in place by 31st March					
y	I2.2	Improved unscheduled care pathways	**Unscheduled Care**	Full year effect of 2020/21 Winter Plan and development of Winter Plan 2021/22	Established acute and community surge plans	• Prevention of harm by ensuring patients only stay in hospital for the appropriate amount of time	Executive Director Nursing & Midwifery	30th September	Workforce recruitment	Core Funding / WG Funding		y	Board & FPIG

	I2.2				Specific winter schemes implemented to meet increased demand during Winter as well as Covid19 demand	• Improved patient safety and experience through facilitation of efficient and safe discharges to the most appropriate environment		30th September					
	I2.2				Review of 2021-22 winter schemes including impact and spend to effectively inform winter plan 2021-22			30th September					
y	I2.3	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Same Day Emergency Care (SDEC)	Further develop and establish SDEC models across the 3 acute sites to better manage urgent care demand into a more scheduled way	Aligned to USC improvement programme • Improve patient / staff experience and reduce harm through avoiding unnecessary ED attendances / delays • Improved patient experience through being seen by the right healthcare professional first time • Maximise use of ambulatory care / SDEC service to ensure patients are only admitted when absolutely necessary • Efficient flow across the whole system will improve patient & staff experience; improve quality / reduce harm	Executive Director Nursing & Midwifery	30th September	Workforce recruitment	WG Funding through additional USC allocation (recurring)		y	Board & FPIG
y	I2.4	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Developing the unscheduled care hub, 111 service	Implementation of 111 in north Wales to integrate call handling and nurse assessment functions of GPOOH and NHSD into a single service. 111 will provide public facing access to urgent health information, advice and signposting for onward care.	Aligned to USC improvement programme • Improve patient safety, experience and clinical outcomes through timely transfer of information to support clinical decision making and care • Minimised duplication in assessment processes • Support delivery of services closer to patients home and improve self care rates • Support for patients to choose the right service at the right time • Reduced pressure on emergency care services and improved patient flow through reduced unnecessary ED attendances • Efficient service delivery with improved direction to alternative services	Executive Director Nursing & Midwifery	30th June - Phase 1	Workforce	HB allocation of National 111 programme		y	Board & FPIG
y	I2.6	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Implement Discharge to Recover & Assess (D2RA) pathways through further development of Home First Bureaus in each area	Further develop and embed the Home First Bureaus to support development of D2RA pathways following Executive approval of business case and support the step up and step down model of care in the community, to both avoid admission and support early discharge for medically stable patients	Establishment of Home First Bureaus in each area to support discharge planning: i) reduce delayed discharges ii) reduce unnecessary waits for assessments in hospital iii) reduce DTOCs iv) increase in number of patients returning home v) increase in short term step-down placements vi) reduction in long term placements vii) increase in assessments of patients post discharge leading to viii) shorter lengths of stay and releasing beds ix) improved patient flow across USC system This work is aligned to the USC improvement programme • Improve flow across the whole USC system through implementation of relevant discharge pathways and reduced patient delays • Improved patient safety and experience through facilitation of efficient and safe discharges to the most appropriate environment • Reduce harm by reducing patient length of stay to minimum	Executive Director Nursing & Midwifery	31st December	Workforce/Recruitment			y	Board & FPIG
y	I2.7	Improved unscheduled care pathways	**Unscheduled Care programme lead/ Area Director East**	Stroke Services: Enable work to progress on strategic service development - confirm and agree the stroke service model	Development of business case to improve stroke services across a whole system approach that will provide a "Once for North Wales" network approach to ensure consistency of clinical outcomes for Early Supported Discharge and Specialist Integrated Community In-patient Rehabilitation services. Phase 1 service proposal focuses on: Prevention including improved AF detection	The outcomes have been adapted from the WG Stroke Delivery Plan and cover the six elements of the stroke pathway and are linked to : • better management of AF, faster, effective acute care and Rehabilitation • better management of AF and the Health Board Health and Well Being Strategy of weight loss and smoking cessation Improved patient outcomes through: • reducing the risk of stroke through the prevention pathway • improving quality of life through an improved 72 hour Acute pathway and Specialist Rehabilitation with ESD and in-patient beds • improving quality of care and patient experience through an improvement in the total pathway • reducing disability through an improved 72 hour Acute pathway and Specialist Rehabilitation with ESD and in-patient beds • improving survival rates through an improved 72 hour pathway • reduced variation across NW • Improve Sentinel Stroke National Audit Programme and related performance criteria • Improve compliance with Stroke Guidelines (Royal College of Physicians recommendations) • Reduced disability and reliance on social care • Improved prevention through reduced risk of another stroke • Improved patient safety and outcome through timely swallowing assessments: improved access to occupational therapy, physio therapy, speech and language therapy interventions • Improved patient experience through early supportive discharge processes • Improved staff experience with improved recruitment and retention of specialist staff	Executive Director Nursing & Midwifery	Stroke Prevention – 30th September	Affordability of the new model Workforce recruitment & retention Ability to maintain 65% & 85% occupancy rates Suitability of estates to provide an appropriate rehabilitation environment	Performance Fund		y	Board & FPIG
	I2.7				Strengthening of acute services across 3 DGH sites; including improved OOH pathway for diagnosis; treatment and recovery			Acute services – 30th September					
	I2.7				Development of Early supported discharge (ESD) across the 3 areas			ESD – 30th September 20% / 31st December 70% / 31st March 100%					
	I2.7				Specialist community inpatient rehabilitation beds across the 3 areas			Specialist Community inpatient beds – 30th September					
	I2.7				A consistent approach to Stroke Rehabilitation across all sites in proportion of confirmed stroke patients receiving specialist rehabilitation and length of stay	Measures of patient experience and outcomes will be aligned to the standards for stroke care throughout the pathway.		Consistent approach to rehabilitation – 31st March					
Y	R2.6	Strengthen our population health focus	**Assistant Area Directors for Children's Services**	Neurodevelopment (ND)- improve access to services to meet WG 26 weeks assessment targets and further develop early intervention post diagnostic services.	Implement ND Performance 2 year Improvement Plan.	Improved access for Children and young people with reduced waiting times. Service offer post-assessment & treatment / intervention. Work with National group to develop case for service post assessment.	Executive Director Primary & Community Care	30th June – Baseline assessment. 30th September - Improvement Plan and structure to deliver agreed. 31st December/4 - Ongoing performance monitoring via ND Regional Steering Group.	Allocation of Funding. Timely agreement of Full Tender for external provider to support backlog.	Performance Fund		Y	Board & QSE
	R2.6				Management and review existing waiting list and plan to reduce waiting times within core capacity and commissioning of private provider to reduce backlog.		Executive Director Primary & Community Care						
	R2.6				Develop Workforce Strategy and plan. Recruit and implement new model of working.		Executive Director Primary & Community Care						
Y	R2.7	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Delivery of agreed planned care recovery schemes (including additional programme management capacity), to include diagnostics, e.g. endoscopy, laminar flow theatres and inpatient T&O bed provision (including relocation of outpatient therapy provision in Wrexham)	Provide recovery plans for each site for for Cohort 1 & 2 by mid-May. This will include extra capacity, insourcing requirement and outsourcing and workforce requirements	The recovery plan will reduce by March 2022 all over 52-week waiters, except orthopaedics within cohort 1. Cohort 2 patients (covid backlog) will then be treated reducing/eliminating long waiters and moving the organisation back towards a risk stratified/36 week position	Executive Director Nursing & Midwifery	30th June-Develop and agree a plan	Inconsistent planning Inconsistent trajectories Inability to link finances to trajectory workforce may not be available to deliver this additionally. Not sufficient resources to clear backlog 1&2 Not treating patients in turn Unscheduled care disruption to planned care and/or further covid outbreaks further urgent demand into the system above core may also require additionally	Performance Fund	Y	Y	Board & FPIG
	R2.7				Develop a plan for physiotherapy regarding their relocation	Trajectories by mid may for the Cohort 2 reduction in over 52 week waiters		31st March- delivery of cohort 1 with exception of orthopaedics					
Y	R2.8	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Build additional capacity to deliver COVID19 safe services, improve patient experience and waiting times.	P1-and P2 risk stratified patients are treated in order, followed by re-introduction of P3-4 activity. Insourcing and weekend capacity plan.	Will ensure that high risk stratified patients will be treated in accordance with appropriate timelines	Executive Director Nursing & Midwifery	31st December		performance fund	Y	Y	Board & FPIG
	R2.8				Continually review capacity of external providers to deliver more activity, to support more efficient services	contracting reviewing external capacity on a monthly basis		30th September					
	R2.8				Introduce super green pathways to protect elective capacity	Provides ring fenced capacity to ensure minimum disruption to core and additional activity, ensuring reducing in long waits and value for money		30th September					
Y	R2.9	Recovering access to timely planned care pathways	**North Wales Musculoskeletal Network Delivery Manager**	Support orthopaedic patients facing extended waiting times as a result of COVID19 constraints, by delivering a non-surgical treatment programme such as escape from pain, digital apps	Programmes developed to support patients whilst they are awaiting an extended period of waiting	The six-point recovery plan includes schemes to support patients whilst awaiting their procedure, such as Escape from pain and habilitation programmes. These will support healthier living and improve mobility	Executive Director Nursing & Midwifery	31st December	Funding for programme. Workforce to deliver model Patient uptake Facilities to deliver the model	transformational Funding	Y	Y	Board & QSE
	R2.9				Implement 'Escape from Pain' programme for orthopaedics using digital app for orthopaedics, Develop a communication tool	Improve mobility and prevent extended length of stay once ready for their operation. Prevents further complications			requires business case and option appraisal				
	R2.9				introduction of Orthopaedic habilitation programmes to support patients mobility and general health whilst awaiting an intervention								
Y	R3.2	Recovering access to timely planned care pathways	**Hospital management teams/Head of Planned Care Improvement**	Insourcing to support provision of service for cohort 1&2	Tender specification for insourcing	This will provide additional capacity to the organisation in the form of insourcing and outsourcing	Executive Director Nursing & Midwifery	30th June	Tendering process not completed on time unable to allocate the insourcing work due to lack of providers Unable to provide facilities for insourcing company.	Performance funding transformational funding	Y	Y	Board & FPIG
	R3.2			Outsourcing specification for Orthopaedics	Tender specification for outsourcing	this modelling will allow the organisation to understand, capacity required, cost and trajectories to reduce long waiters in the organisation							
	R3.2				Demand and capacity modelling complete to treat all over 52 week waiters and to get the organisation to 36 weeks								
Y	R3.4	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Develop the Outpatient transformation programme Including 'Once for North Wales', workforce modernisation and digital enablement of staff and service users with attend anywhere and consultant	Approve and recruit outpatient transformation programme team to progress the work across all sites	Allowing improved access for patients and reduce waiting times. Development of further straight to test pathways. Reduce face to face consultations will provide further OPD capacity reduce follow up backlog	Executive Director Nursing & Midwifery	Phased delivery over 12 months from point of recruitment, anticipated delivery by 31st March if recruitment and implementation successful	supported by executives unable to recruit lack of clinical ownership/leadership	performance fund	Y	Y	Board & FPIG

	R3.4			connect.	Transforming outpatient department for 'Once for North wales' approach.	Will reduce Outpatient waiting times and give patients more choice will support deliver of Suspicious Cancer pathway will support delivery of 16 week out-patient target							
Y	R3.5	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	To explore external capacity to support access to treatment	External providers canvassed on fortnightly basis to assess available capacity	To establish availability of additional capacity to reduce waiting times – below 52 weeks by March 2022	Executive Director Nursing & Midwifery	30th June out to tender, insourcing early July- If these time frames work then outsourcing could be August insourcing September. Hope that helps	unable to resource further capacity unable to reduce backlogs costs	Performance funds transformational funds	Y	Y	Board & FPIG
	R3.5				Fortnightly review of capacity to assess any external capacity available								
Y	R3.6	Recovering access to timely planned care pathways	**Endoscopy Network Manager**	Development of sustainable endoscopy services across North Wales	Deliver on 2 year endoscopy plan, adopting an outsourcing, insourcing model, whilst recruiting substantively to enable the demand and capacity gap to be resolved. Develop and initiate a recruitment plan responding to future predicted growth in all aspects of the services (including BSW) spanning 2021/22 – 2023/4.	Reduce diagnostic and endoscopy waiting times, improve cancer outcomes	Executive Director Nursing & Midwifery	31st March	Recruitment of workforce	Core Funding	Y	Y	Board & FPIG
	R3.6				Standardising clinical and operational processes and procedures, supporting the formation of the 'North wales Endoscopy Service' supported by an improved endoscopy IT system.								
Y	R3.7	Recovering access to timely planned care pathways	**Divisional General Manager Cancer Services, Cancer Services**	Deliver suspected cancer pathway	1. Increased rapid access breast cancer clinic capacity across the Health Board – business case approved by Executive Team June 2021; these clinics have been provided on an ad hoc basis since November 2020 and can now be established as part of core activity once new posts are recruited to 2. Continuation of the early diagnosis lung cancer pathway which ensures patients with a suspicious chest X ray are directed straight to CT – funded in 2021/22 with a business case for ongoing funding being developed 3. Development of one stop neck lump clinics – project team established and pathway agreed; business case to be submitted this month 4. One stop rapid diagnosis clinic for patients with vague but concerning symptoms – project manager in post, project team established and pathway agreed; business case to be submitted this month 5. Increase in Clinical Nurse Specialist and support roles to support patients with their diagnosis and provide direct clinical care as appropriate – business case submitted and to be considered by Health Board business case review team in July 6. Patient navigators to track pathways and escalate delays – funded in 2021/22 with a business case for ongoing funding submitted and awaiting approval. 7. Pathway improvement posts to work with clinical teams to introduce the National Optimal Pathways for cancer ensuring pathways are as streamlined, efficient and effective as possible – business case submitted, awaiting approval (NB one post already funded by Wales Cancer Network and going through recruitment process)	Improve cancer outcomes reduce mortality ensuring rapid assessment of patients with suspected cancer	Executive Director Nursing & Midwifery	30th June 69% 30th September 69% 30th December 71% 31st March 75%	not enough out-patient capacity to achieve new standard pathways not sufficient to deliver new model Cancer services do not have a high profile in the organisation	Performance Fund transformational funds	Y	Y	Board & FPIG
	R3.7												
Y	R4	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Implementation of short term insourcing solutions for computerized tomography, magnetic resonance imaging and ultrasound to significantly reduce the backlog of routine referrals	Insourcing contract in place with external provider	Reduction in backlog of patients waiting over 8 weeks for scan. Stretch project to reduce waits to 6 weeks	Executive Director Nursing & Midwifery	30th September		Core Funding	Y	Y	Board & FPIG
	R4				Additional mobile scanners / staffing in place								
Y	R4.1	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Implementation of insourcing solutions for neurophysiology to significantly reduce the backlog of routine referrals	Insourcing contract in place with external provider	Reduction in backlog of patients waiting over 8 weeks for scan. High Street locations identified as ideal for this service.	Executive Director Nursing & Midwifery	30th September		Performance fund	Y	Y	Board & FPIG
	R4.1				Additional clinic space / staffing in place								
Y	R4.2	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Development and commencement of implementation of long term plans for sustainable diagnostic services (radiology and neurophysiology)	Recruitment to medical, scientific / allied health professional, supporting and administrative posts	Recruitment to agreed sustainable service models. Identification of suitable space to operate from.	Executive Director Nursing & Midwifery	31st March		Core Funding	Y	Y	Board & FPIG
	R4.2				Identification of estates and equipment priorities								
Y	R4.5	Recovering access to timely planned care pathways	**Clinical Director Therapy Services, Therapies & Health Science**	Increase specialist cancer therapy staff to meet All Wales benchmark: Produce a business case to appoint specialist allied health professional (dietitians/speech and language therapist)	Development of referral pathways particularly for upper gastrointestinal and hepatobiliary and pancreatic cancer which are Wales cancer network priorities and the Health Boards strategic priority for pelvic cancer services	Improved communication due to attendance at multi-disciplinary teams with improved multi-professional and interagency working. Increased equity of access to allied health professionals and rehabilitation programmes	Executive Director Nursing & Midwifery	30th September		Core Funding	Y	Y	Board & QSE
	R4.5												
	R4.5				Development of self-management information								
	R4.5				Implement timely interventions at all stages of the cancer journey for communication, eating and drinking, leading to faster progression to oral diet and fluids, reduction in the need to rely on radiologically inserted gastrostomy / percutaneous endoscopic gastrostomy enteral feeding, reduction in the costs of enteral feed and dietary supplements								
	R4.5				Use patient recorded outcome measures / holistic needs assessment and treatment summaries in line with person centred care philosophy across Wales								
	R4.5				Development of programmes of education to upskill generalist therapy staff, and multi professional teams supporting self- management; efficient use of resources and supporting increased numbers of patients and carers.								
	R4.5				Development of education programmes to upskill generalist therapy staff is required thus supporting increased numbers of patients and carers.								
Y	R4.6	Recovering access to timely planned care pathways	**Site Acute Care Director**	Eye Care Services: transform eye care pathway: Enable work to progress on strategic service developments eye care	Work with Eye Care Collaborative Group in place and robust with good engagement and appropriate structure in place to receive proposals and agree recommendations to HB. Linked in to all All Wales Groups Develop a Business Case to support strategic direction approved by PCTG and to Executive Management. Identify Priorities to include Increased capacity for IVT, implementation of Digital Eye Care system together with replacement of EoL equipment and lastly the re-tendering for Eye Care pathways to be delivered by Primary Care ODTCs	These actions allow the development of strategic direction for ophthalmology and developing a 2-3 year plan will support the delivery of a cataract service that will reduce the patents waiting times Implementation will enable increased capacity to treat wet AMD patients requiring specific treatment intervals to mitigate sight reduction (circa 570 extra treatments per week) Delivery of electronic referrals and image sharing reducing attendance at secondary care for stable glaucoma patients undertaken by Primary Care Optometrists	Executive Director Nursing & Midwifery	Already initiated with pump priming last year, continuation secured through previous funding whilst BC approval expected June 2021 enables re-tendering exercise by end 30th September	Required approval for BCUHB and WG Funding	Core Funding as part of Annual Business Plan 2021	Y	Y	Board & FPIG
Y	R4.7	Recovering access to timely planned care pathways	**Site Acute Care Director**	Enable work to progress on strategic service developments urology	Development of the urology plan (Robotic Assisted Surgery (RAS) Procurement) Completion of All Wales procurement process by end 30th June In parallel review of Business case to support RAS and Urology re-design for BCUHB approval	The plan will help address the demand and capacity imbalance and will support the reduction of waiting times and the development of a specialised centre of excellence for patients in north Wales	Executive Director Nursing & Midwifery	Procurement by 30th June Delivery RAS 30th September Urology redesign and implementation along with RAS training 31st December/31st March 0 tbc by Urology review group July 2021	Required approval for BCUHB and WG Funding	Performance Fund	Y	Y	Board & FPIG
Y	R4.8	Recovering access to timely planned care pathways	**Site Acute Care Director**	Implementation of the glaucoma pathway	Implemented and delivery on going. Performance against trajectory good with improvements on going as we work towards re-tendering process	As above with regards to the Eye Care Strategy, along with an additional 7,200 appointments (300 referral refinement)	Executive Director Nursing & Midwifery	31st March	Required approval for BCUHB Funding	Core Funding	Y	Y	Board & FPIG
Y	R4.9	Recovering access to timely planned care pathways	**Site Acute Care Director**	Implementation of the diabetic and age-related macular degeneration pathways	Review and identify areas of improvement for pathways Agree and implement pathway service improvements.	Updated pathways being reviewed	Executive Director Nursing & Midwifery	31st March	Required approval for BCUHB Funding	Core Funding	Y	Y	Board & FPIG
Y	R10.2	Recovering access to timely planned care pathways	**Clinical Leads and Matron**	Ensure Safe and Effective Care	1. Implement the recommendations of the HIW National Review of Maternity Services (November, 2020)	1. Safe and effective care, delivered in line with national standards, Welsh Government performance measures, MBBRACE, Each Baby Counts, RCOG and NICE guidelines.	Executive Director Of Public Health	Action 1: 31st December	MIS is a WG introduction as is out of our direct control and Saving Babies' Lives – securing the right USS capacity remains a risk	Core Funding		Y	Board & QSE
	R10.2				2. Implement the National MIS solution for Wales (HIW, November 2020).	2. A Midwifery Informatics System		Action 2: WG Initiative					
	R10.2				3. Implement the new outcomes measures and KPIs for the revised WG 5-Year Strategy.	3. Maternity Service User Engagement Strategy		Action 3: informed by WG timetable					
	R10.2				4. Benchmarking exercise against NICE Quality Standards	4. Reduction of birth intervention and induction of labour via latent phase community project.		Action 4: 30th September					
	R10.2				5. Demonstrate progress in using the Maternity Voice Group in co-producing the service model,	5. Reduced C-section rates		Action 5: 30th June					
	R10.2				6. Ongoing monitoring of safety equipment checks.			Action 6: 30th June					
	R10.2				7. Reflect workforce plans with national standards for maternity services.			Action 7: 30th September					
	R10.2				8. Implement 'Mothers and Babies Reducing Risk through Audits and Confidential Enquiries' (MBRRACE) recommended Local and National improvement initiatives to reduce stillbirth			Action 8: 31st March					
	R10.2				9. Implementation of the GAP/GROW I + II			Action 9: 31st March					
	R10.2				10. Mortality and Morbidity multi-professional reviewed carried out to conform to MBBRACE and perinatal mortality review tool (PMRT) requirements.			Action 10: 30th September					

	R10.2				11. Promoting normality in first pregnancy, latent phase project in community.			Action 11: 31st December					
	R10.2				12. Ensure compliance with the C-Section Tool Kit to maintain Elective C-Section rates under 10% by increasing external cephalic version (ECV) and maximising vaginal birth after caesarean (VBAC) Opportunities.			Action 12: 31st December					
	R10.2				13. Implement the MBRRACE and Each Baby Counts (EBC) Recommendations.			Action 13: 30th September					
Y	R10.4	Recovering access to timely planned care pathways	**Head of Women's Services**	Implement Sustainable Quality Care	1. Ensure staffing levels are birth rate plus and RCOG compliant	1. Birth Rate Plus compliant 2. Care closer to home 3. Sound and robust governance and risk management system 4. CSfM Workforce Sustainability	Executive Director Of Public Health	Action 1: 30th June	Welsh Government Birth Rate Plus plans / reviews.	Core Funding		Y	Board & QSE
	R10.4				2. Reduction of activity in contract agreement with CoCH services,			Action 2: 31st December					
	R10.4				3. Implement the 21/22 Revenue Business Development Plans.			Action 3: 31st March					
	R10.4				4. Develop stronger governance systems, for performance and accountability.			Action 4: 31st December					
	R10.4				5. National CfSM Peer Review by WG and Clinical Supervision Resource Mapping.			Action 5: 30th September					
Y	M1.1	Integration and improvement of mental health services	**Interim Director of Nursing**	Quality Improvement & Governance: Implementation of ward accreditation to improve fundamentals of care and leadership.	Proceed in completing ward accreditation by scoring as a minimum bronze across all of our inpatient wards.	• To improve service delivery and experience / outcomes for patients / families / carers by meeting fundamental standards for inpatient nursing • To increase the number of wards achieving a bronze award or above	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope programme of work	Links with corporate services and support to deliver	MHLD Revenue	Y	Y	Board & QSE
	M1.1							30th September, agree plan for roll-out					
	M1.1							31st December/31st March implement					
Y	M1.2	Integration and improvement of mental health services	**Interim Director of Operations**	Workforce Wellness & Organisational Development: We will enhance leadership within the Division and seek to actively support staff in their workplaces to maintain optimum wellbeing.	By further embedding the Wellness, Work & You Strategy.	To improve the skill mix to address shortfalls in service provision To ensure multi-disciplinary staff are trained to provide best quality services for patients	Interim Executive Director of Mental Health & Learning Disabilities	30th June agree scheme plan		Transformation Funding	Y	Y	Board & QSE
	M1.2				Develop a meaningful communication strategy.	To provide effective recruitment and retention To ensure our staff are well, supported and engaged		30th September/31st December/31st March implementation					
	M1.2				Develop a sustainable workforce plan including training to support the service redesign & improvement initiatives	Will have a safe, sustainable and stable leadership structure							
Y	M1.3	Integration and improvement of mental health services	**Programme Director**	Ablett / YGC MH Inpatient Redesign: We will continue to work with Corporate Planning colleagues to design on the YGC site for the provision of Adult and Older People's Mental Health inpatient services in the Central Area.	Progress the business case through gateway reviews and continuation of planning requirements.	To provide services which meet the strategic direction outlined within Together for Mental Health in North Wales and deliver the model of care developed through the Quality & Workforce groups; To provide an environment that supports staff to deliver safe, effective care to patients, carers and families; To deliver the flexibility to respond to future need – the solution should be designed to respond to future changes in service delivery	Interim Executive Director of Mental Health & Learning Disabilities	30th June	Delay in planning permissions	Capital Investment	Y	Y	Board & QSE
	M1.3							31st March, dependent on planning permissions outcome					
Y	M1.5	Integration and improvement of mental health services	**Medical Director, Head of Nursing CAMHS**	CAMHS: We will develop an appropriate interface with child and adolescent mental health services to ensure the most effective transition for young people with mental health conditions into adult services.	Develop effective and timely transition arrangements that support young people into adult services.	To provide a seamless services for patients / younger persons transitioning into Adult MH Services. To evidence based data sets, triangulated benchmarking with local data will underpin our work To have a clearly defined proposal for model of crisis care	Interim Executive Director of Mental Health & Learning Disabilities	30th June, develop improvement plan	Delay in recruitment processes. Availability of skilled and trained staff. Lack of project support.	Transformation Funding	Y	Y	Board & QSE
	M1.5				Develop effective joint working arrangements between adult mental health, child and adolescent mental health services and local authority professionals			30th September, agree plan					
	M1.5				In partnership we will develop and implement CYP workforce plan and recruit to specific roles.			31st December-31st March begin to implement improvements					
Y	M1.6	Integration and improvement of mental health services	**Medical Director**	Safe & Timely Discharge: We will introduce a programme of work across the division to review long length of stay and delayed transfer of care.	Develop a process to ensure timely escalation for issues relating to delayed transfer of care, long length of stay and out of area patients	To reduce long length of stay, delayed transfers of care and out of area placements To provide care closer to home	Interim Executive Director of Mental Health & Learning Disabilities	30th June, review work to date	Fragility of care home sector	MH&LD baseline budget	Y	Y	Board & QSE
	M1.6							30th September, agree plan and begin roll-out					
	M1.6							31st December-31st March, on-going work with adjustments as required					
Y	M1.7	Integration and improvement of mental health services	**OPMH Clinical Lead**	Dementia Care: Delivery of clinically led, safe and effective services will be further developed aligned with the dementia strategy.	Work with partners to promote and support initiatives to reduce the risk and delay onset of dementia, including links between hearing loss and dementia.	To have a defined model of care that meets the population demand and is of the highest quality evidence base To improve holistic approach to care	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme	Demographic change.	TBC	Y	Y	Board & QSE
	M1.7				Extend support services so that all with patients with dementia and mild cognitive impairment have access to support, tailored to them, to incorporate the six steps into their daily life.	To ensure that staff are trained and developed multi-disciplinary staff to provide best quality services for patients		31st December-31st March begin implementation					
y	M1.8	Integration and improvement of mental health services	**OPMH Clinical Lead**	Older Persons (OPMH): Development of Crisis care support for older adults (over 70) with an acute mental illness over the age of 70 and people of any age living with dementia.	Work with Area Teams and LA partners, develop a team approach to support care home in order to avoid crisis situations.	To reduce the use of clinically unjustified out of area placements and provide care closer to home To have a clear admission criteria and planned discharge	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme with supporting SOPs	Delay in recruitment processes. Availability of skilled and trained staff. Failure to recruit.	Transformation Funding	Y	y	Board & QSE & PPPH?
	M1.8				Further define a vision for service provision for older person's mental health.	To define model of inpatient care that meets the population demand and is of the highest quality evidence base Improved holistic approach to care							
	M1.8				Define and implement the proposed model of crisis care	To have trained and developed multi-disciplinary staff to provide best quality services for patients To have more people having quicker access to services providing appropriate and timely crisis support to maintain people receiving care in their own homes.		31st December-31st March begin implementation					
	M1.8				We will recruit a crisis care team	To reduce avoidable and emergency admissions To provide support to EMI and commissioned care home settings							
y	M1.9	Integration and improvement of mental health services	**Interim Director of Nursing**	Early Intervention Psychosis: Enhancing the current Multi-disciplinary Team with trained and developed multi-disciplinary staff to provide best quality services for patients and families.	Develop and implement agreed early intervention in psychosis model of care	To provide an equitable service across North Wales To provide swift access to dedicated service / practitioner	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Availability of skilled and trained staff.	Transformation Funding	Y	y	Board & QSE
	M1.9					To provide each patient / family with a crisis and management plan		30th September, begin recruitment	Availability of space for resource				
	M1.9				We will recruit to specific workforce dedicated to this service	To reduce in emergency admissions To reduce bed occupancy and out of area placements		31st December, integrate in to local teams					
	M1.9				We will develop integrated pathways	To provide a service for younger persons and adults		31st March, evaluate					
y	M10	Integration and improvement of mental health services	**Consultant Psychiatrist**	Forensic Services: Development of a model for forensic and low secure provision for both mental health and learning disabilities services in North Wales.	Develop whole system patient flow pathways.	To reduce placements outside of Wales by providing care closer to home To strengthen commissioning arrangements	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan		Likely to require a full business case	Y	y	Board & QSE
	M10				We will define required establishment and workforce plan.	More people having quicker access to services To have trained and developed multi-disciplinary staff to provide best quality services for patients		31st December Develop options appraisal					
	M10				We will develop options for secure service provision / service transformation to inform robust service business case.	To strengthen partnership approach to achieving best outcomes for patients / families / carers							
y	M10.1	Integration and improvement of mental health services	**Interim Director of Operations**	Learning Disabilities: We will implement the strategy for learning disabilities services in partnership with people with lived experience, their families, health and social care organisations across North Wales and the voluntary sector.	Define the required establishment and skilled workforce.	To provide care provided closer to home and reduce out of area placements To improve patient / carer experience through effective partnership working	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan	Availability of skilled and trained staff.	Healthier Wales & ICF Funding	Y	y	Board & QSE
	M10.1				We will review and develop commissioning arrangements								
	M10.1				We will further develop fully functioning multi-disciplinary teams to provide best quality services for patients including preventative models of care.			31st December Develop future options appraisal					
	M10.1				We will define the new model for assessment and treatment and domiciliary care.			31st March Evaluate work programme to date					
y	M10.2	Integration and improvement of mental health services	**Medical Director**	Maternal Care & Perinatal Services: To enhance delivery of clinically led, safe and effective services for mother and babies that require perinatal mental health services.	Work proactively to develop the existing service pathways and ensure alignment to Welsh Government guidance	• To ensure our services are aligned to Welsh Government guidance • To reduce mental illness in the mother and improve the mother-infant relationship • To provide regular and on-going training to allied mental health and primary care colleagues to improve the understanding and knowledge of perinatal mental health • To have a multi-skilled and specialist workforce to support our patients • To provide a modernised service by developing integrated pathways • To reduce the need for out of area placements and support care closer to home • To ensure our services are aligned to Welsh Government guidance • To reduce mental illness in the mother and improve the mother-infant relationship • To provide regular and on-going training to allied mental health and primary care	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Availability of skilled and trained staff. Availability of space for resource	Transformation Funding	Y	y	Board & QSE
	M10.2				We will provide dedicated professionals as above would allow a more seamless process, more flexibility			30th September, begin recruitment					

	M10.2				We will improved access to specialist clinical expertise specifically early intervention and treatment by recruiting additional specialised staff	colleagues to improve the understanding and knowledge of perinatal mental health • To have a multi-skilled and specialist workforce to support our patients • To provide a modernised service by developing integrated pathways • To reduce the need for out of area placements and support care closer to home		31st December, integrate in to local teams					
	M10.2							31st March, evaluate					
y	M10.3	Integration and improvement of mental health services	**Clinical Lead Occupational Therapist**	Primary Care & ICAN: To build on actions from within the Winter Plan and further develop the demand and capacity modelling to continue to review and improve patient flow between primary and secondary care. To work with Primary Care Services together with ICAN to offer direct and rapid access to wider ranging support supported by trauma informed approaches at cluster level.	Develop locally agreed protocols and project plan with Clusters.	To provide effective and efficient service delivery including released general practitioner time.	Interim Executive Director of Mental Health & Learning Disabilities	30th June Engagement with primary care clusters	Availability of skilled and trained staff.	Transformation Funding	Y	y	Board & QSE
	M10.3				We will recruit key staff members dedicated to support the work	To deliver care at or as close to home as possible To provide access to the right information, when needed to improve mental health and wellbeing e.g. number of individuals supported through ICAN community hubs		30th June Recruitment of OTs for model across North Wales					
	M10.3				We will roll out Primary care Mental Health Practitioners to current ICAN Test sites with a wider roll out across the Region								
	M10.3				We will develop a training plan	To provide the best possible outcome, diagnosed early and treated in accordance with clinical need		30th September Internal and external promotion of ICAN primary care model with GP Clusters and partner agencies					
	M10.3				We will develop an evaluation framework	To provide staff that are fully engaged in delivering excellent care and support to patients and families							
	M10.3				We will identify further GP surgeries for roll out	To provide standardised systems and processes To reduce the number of referrals into MH primary care services (< MHM part 1)		31st December-31st March evaluate impact					
	M10.3				We will share learning and evaluation at regular time points with division, clusters and wider partners								
y	M10.4	Integration and improvement of mental health services	**Head Of AMH Clinical Psychology & Psychological Services**	Psychological Therapies: To increase access to psychological therapies across both mental and physical health services.	Review of existing offer and service provision and develop an improved model of care.	• To improve interventions based on good quality and timely research and best practice • To train staff to deliver excellent care and support to patients and families • To standardised systems and processes • To improve access to services and reduce waiting times	Interim Executive Director of Mental Health & Learning Disabilities	31st March	TBC	TBC	Y	y	Board & QSE
	M10.4				We will develop workforce plan								
y	M10.5	Integration and improvement of mental health services	**Head of Operations**	Rehabilitation Services: To agree a long term model for rehab services and support whole system patient flow pathways.	Develop a plan in relation to Specialist Bed Based Care with the driving principle being – Right Care, Right Time Right Place.	• To reduce placements for low secure provision outside of Wales and provide care closer to home • To have an agreed establishment and workforce plan • To have strengthened commissioning arrangements • To have trained and developed multi-disciplinary staff to provide best quality services for patients • To reduce in patient transport	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September review and agree plan	Identified funding stream	Likely to require a full business case	Y	y	Board & QSE
	M10.5				We will define the bed based care and community model			31st December, seek Divisional approval and consider funding requirements					
	M10.5				We will review our estate requirements								
	M10.5				We will develop our workforce model			31st March finalise plan					
y	M10.7	Integration and improvement of mental health services	**Medical Director**	Unscheduled Care & Crisis Response: We will further develop an all age crisis response pathway.	Work with our 3rd sector partners to develop a pathway to include crisis, community and home treatment provision.	To reduce use of inappropriate s136 To reduce the use of clinically unjustified out of area placements	Interim Executive Director of Mental Health & Learning Disabilities	31st December	TBC	Additional resources for MH 2021 – 22	Y	y	Board & QSE
	M10.7				We will develop a business case to secure funding	To have clearly defined admission criteria and planned discharge that's linked to community alternatives To have a defined crisis pathway							
y	M10.8	Integration and improvement of mental health services	**Head Of Specialist Tier 3 Eating Disorders Service**	Eating Disorders: To address the significant deficits in service provision for early intervention and treatment and to improve the clinical needs and challenges of current Eating Disorder (ED) service provision in North Wales and North Powys.	Develop and implement the provision of a MARSIPAN `Team' to facilitate medical and psychiatric admissions for ED patients (MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, Royal College of Physicians, 2014).	To meet the targets for review within a week for urgent cases and 4 weeks for all cases by the specialised team	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Failure to recruit. Availability of skilled and trained staff. Lack of project support. Availability of space for resource	Transformation Funding	Y	y	Board & QSE
	M10.8					To have dedicated professionals to allow a more seamless process, more flexibility, and the ability to offer more 'slots' / availability to service access		30th September, begin recruitment					
	M10.8				We will work collaboratively alongside existing staff in CAEDS and therefore strengthen the ED workforce.	To improve access to specialist clinical expertise in ED at Tiers 1 and 2 and specifically early intervention and treatment.		31st December, integrate in to local teams					
	M10.8					To provide a service for younger persons and adults		31st March, evaluate					
y	M11	Integration and improvement of mental health services	**Head of Operations**	Liaison: To provide an appropriate and consistent psychiatric liaison response across North Wales.	Review the evidence based data sets, triangulated benchmarking with local data.	• To have a defined model of care that meets the population demand and is of the highest quality evidence base • To have trained and developed multi-disciplinary staff to provide best quality services for patients • To increase more people having quicker access to services providing appropriate and timely crisis support • To reduce avoidable admissions • To reduce unplanned/avoidable admissions/attendances at ED	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope requirements	Delay in recruitment processes. Failure to recruit. Availability of skilled and trained staff. IT to support NHS 111 implementation	Transformation Funding	Y	y	Board & QSE
	M11				We will undertake capacity modelling			30th September, develop and agree a plan					
	M11				We will define the proposed model of service we will further develop pathways & workforce, and improve patient experience.			31st December, agree proposals					
	M11							31st March, implement					
y	M11.1	Integration and improvement of mental health services	**Interim Deputy Director**	Partnership & Engagement: To deliver clinically led, safe and effective services in partnership with patients, their families, social care and third sector colleagues.	Review of Caniad (third sector working) arrangements.	To ensure all key stakeholders are involved in and at the heart of everything we do	Interim Executive Director of Mental Health & Learning Disabilities	31st December	N/A	N/A	Y	y	Board & QSE & PPPH?
	M11.1				We will establish joint working approach with area teams to ensure joint planning, engagement and delivery of joint pathways	To have strengthened commissioning arrangements							
	M11.1				We will re-instate our Patient Experience Group & Together for Mental Health Partnership Board								



Introduction

Our Plan sets out the improvements we intend to deliver over the coming year, working with our staff, public, and partners. It recognises the need to refresh our thinking about the future of health and services, whilst also delivering here and now for the people of North Wales.

Vision & Strategy

The Health Board's vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, reducing health inequalities. This means that, over time, the people of North Wales should experience a better quality and length of life.

To do this we will:

- Improve population health and well-being through a focus on prevention;
- Improve the experience and quality of care for individuals and families;
- Enrich the well-being, capability and engagement of the health and social care workforce; and
- Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste.

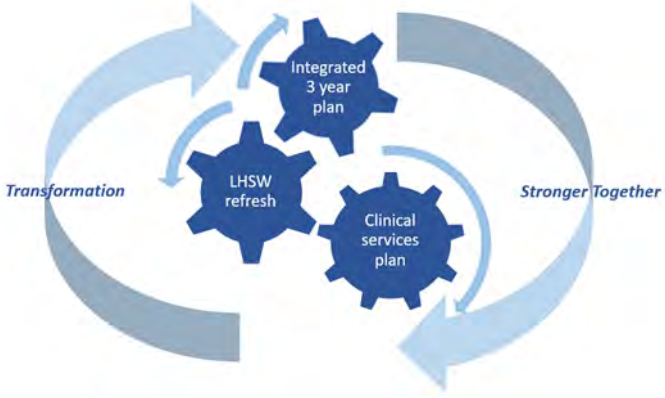
The Health Board's longer term strategy for health, well-being and healthcare, Living Healthier, Staying Well (LHSW) set out how we intended to make progress. It has been three years since we developed this and the time is now right to pause and review to ensure that our strategy remains valid. To facilitate this we are beginning a review and refresh of LHSW, and will:

- Check in with our staff, patients, partners and public whether the principles are still valid
- Review our strategic priorities to ensure they are consistent with "A Healthier Wales"
- Address those elements of LHSW that proved challenging to implement e.g. an integrated system wide approach to healthcare and integrated care pathways
- Test the strategy is still relevant in the changed environment
- Provide the framework for development of a Clinical Services Plan

This refresh work will be completed by the autumn, in time to feed into the development of the integrated three year plan 2022/25. It will also provide the basis for the development of a new clinical services plan which will describe how we will deliver care in the future.

Changing the way we work – Engagement and Transformation

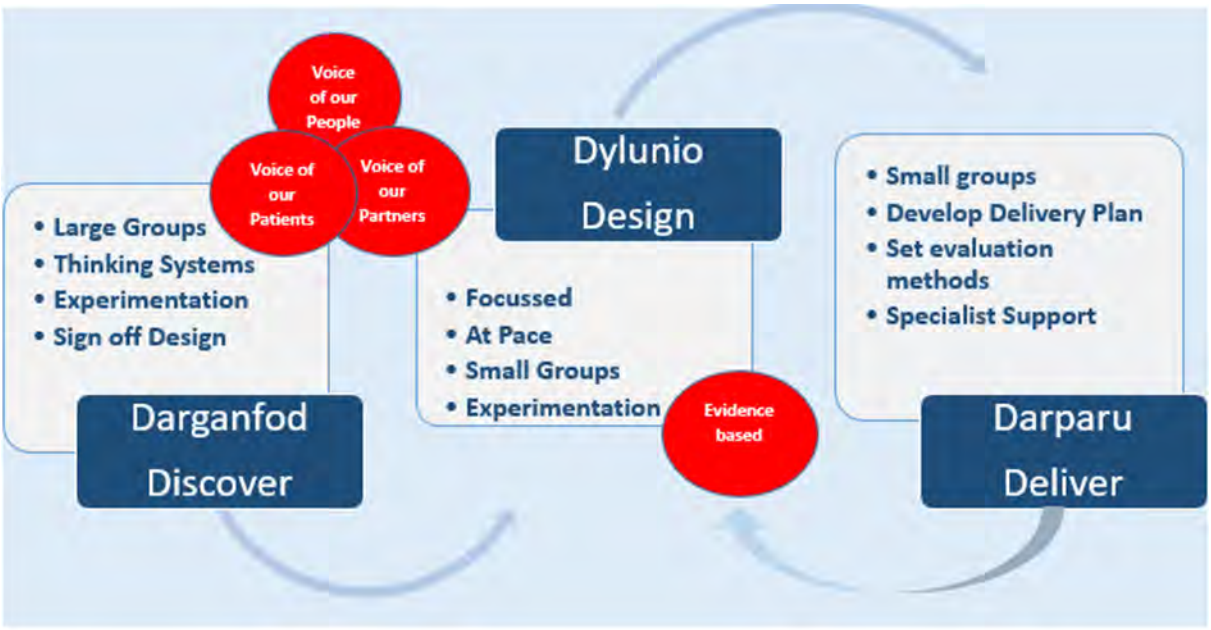
We recognise the need to build greater capacity and capability for transformation and improvement. This is critical to our ability to design and deliver our refreshed clinical strategy.



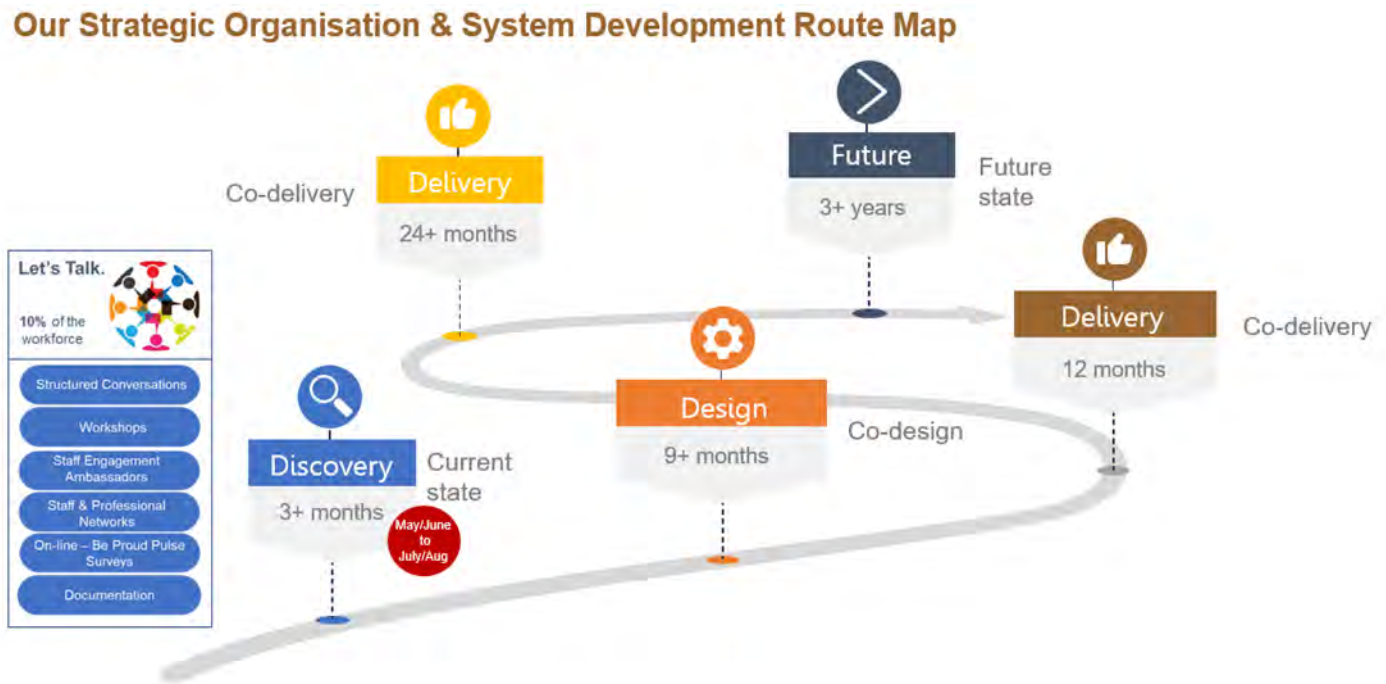
Successful transformation and improvement activities are not the concern of a single team, but rather something that needs to be embedded across the Health Board, through all of our systems and processes. To do this we will draw upon the experiences of other organisations and invest in a transformation and quality improvement (QI) approach, which is capable of maturing and informing our decision-making.

To inform and enable this transformation, we have committed to embark on a programme of work which aims to align each and every member of the organisation behind the goal of "One NHS organisation", working with our partners and citizens to deliver co-ordinated seamless care or service for individuals. Our approach will enable the organisation to discover its current capability and answer the question: "What do we need to do as an organisation and system of care to succeed in the achievement of our purpose and goals?"

We are working in partnership with our people so that the solutions to the problems we face are co-produced with people who work across the organisation and understand the challenges. Our approach to this ambitious work programme, titled Mewn Undod Mae Nerth (Stronger Together) is set out in the diagram below -



The goals and outcome measures have been established for the first phase (Discover), and work began in earnest at the beginning of April 2021. This programme will support transformation over a number of years, with the milestones set out below.



Immediate Priorities for 21/22

There are many immediate priorities which need to be addressed whilst we are building out longer term strategy and transformation capability. The following priorities have been identified for the year ahead.-

COVID-19 response

Our health service response; the impact on operational capacity across primary, community and acute services; Test, Trace and Protect; mass vaccination programme and the Enfys hospitals decommissioning.

Strengthen our wellbeing focus

Populations needs assessment; prevention; partnership; early intervention; reaffirm commitment to tackling health inequalities and those worsened by the pandemic

Recovering access to timely planned care pathways

'Once for North Wales' and validation; demand management; roll out of virtual capacity; non-surgical treatment of long waiters; extra activity (WLIs and Insourcing); providing ring fenced capacity on each site to deliver backlog clearance

Improved unscheduled care pathways

Development of capacity and capability; frailty pathway; admission avoidance/ accelerated discharge to assess/ minimising harm; acute medical model – agreement on and implementation of standards; care in the community; clarifying on demand and capacity

Integration and improvement of mental health services

Build on consistent divisional leadership, management and clinical governance arrangements; be clinically led and seek to modernise our services; develop our people and organisation; re-invigorate our partnership work with key stakeholders in Together for Mental Health; better integrate pathway-based services

What the people of North Wales can expect

The priorities above will be addressed using our own staff and resources as well as drawing in extra capacity from external sources. To deliver sustainable improvement requires critical investments in capacity and resilience both in terms of physical capacity and workforce supply.

A number of significant developments within our plan are set out below to illustrate what our plan is seeking to deliver for our population in North Wales:

- Develop proposals for a Diagnostic and Treatment Centre approach in North Wales. This will provide dedicated capacity to address long waiting lists for diagnostic tests and surgery, as well as improving waiting times for cancer diagnosis and surgery.
- Working with Bangor University we will develop proposals for a transformational inter-professional Medical and Health Sciences School, to be established by 2025. This will allow us to align education and training to our clinical strategy, support the delivery of our research strategy and address key challenges in our medical and clinical workforce.
- Develop our Primary and Community Care Academy, including the establishment of a Dental Academy with a dental training unit and provision of dental services. We will develop an additional training hub to further support advanced practice training in primary care, the further development of the Physician Associates programme and piloting of 'Project Flex', a flexible approach to GP recruitment.

Key areas of improvement include:

- Further roll out of digital technology with more virtual appointments provided in primary care and within our hospitals. Access to appointments improved due to having more options for timely consultations. This will also reduce patients having to travel for services and reduce the risk of COVID-19 spread and will be safer for staff and patients;
- Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible;
- Increased capacity will support improved access to care for children who require neuro-developmental assessments;
- Roll out of the mental health practitioner model and community connector role to localities to improve support to patients within primary care;
- The development of pathfinder urgent primary care centres to ensure timely, efficient care for patients with urgent primary care needs and reduce demand for minor illness / injuries on our Emergency Departments. The service will create more capacity for GP practices to better manage patients with more complex conditions;
- By strengthening our emergency departments, we will deliver improved access to services in line with the Welsh access model including a 'contact first' system, 'streaming hub', and 'wait & care system', leading to more efficient navigation of patients;
- Developments in cancer services and implementation of the new single cancer pathway will ensure more timely care for our patients in line with expected national standards;
- Patients will receive consistently higher clinical outcomes in stroke care through early supported discharge and provision of specialist integrated community in-patient rehabilitation services;
- The planned care recovery programme will support improved access to diagnostic and treatment services for patients;
- The eye care programme will optimise care closer to home and improve the care for patients at risk of irreversible sight loss, maximise eye health and sight retention for the North Wales population including improved access and elimination of existing waiting list backlog;
- The prehabilitation programme, including for example, conservative management for early onset osteoarthritis, will maximise patient fitness prior to treatment and avoid or shorten hospital stays wherever possible;
- Building capacity within to retain and sustain improvement through a network of 1800 champions, connectors and influencers in order to grow a BCUHB social movement of change;
- Dedicated urological specialist teams supported by robotic assisted surgery will improve patient outcomes, reduce complication rates and deliver improved access for patients with less pain and quicker return to normal activities;
- The Home First bureau (operating 08.00 – 20.00 daily) will support patients to return to the best life possible following their period of illness, through maximising the opportunity for active therapeutic input and support to patient discharge from hospital. This will reduce delay in transfers of care leading to shorter length of stays within hospitals and increase in patients returning home rather than having to be cared for in a community bed;

- Care home quality nurses will work with the care home sector to deliver safe effective care to the residents of North Wales. Quality of life will be enhanced by ensuring patients receive the care and support they need, have a positive experience of care and are safeguarded and protected from avoidable harm; and
- Implementation of an audiology led earwax management pathway will provide care closer to home, improve patient experience and reduce unnecessary onward referrals to secondary care ENT and audiology services.

Governance and Targeted Intervention

The actions set out above are intended to improve service delivery and address the specific areas identified in the Targeted Intervention Framework. The Board will oversee the delivery of the targeted intervention improvement plan through the use of maturity matrices for the four improvement domains which are:

- Mental Health Management;
- Strategy Planning & Performance;
- Leadership; and
- Engagement.

In May 2021 the Board agreed baseline reference points to reflect the current position in each domain, against which progress will be measured. Progress will be tracked bi-monthly by the Board with a formal review of progress every 6 months as part of the standard reporting arrangements to the Board. Improvement expectations for the second six-month period will be set in November 2021. Accountability for the delivery of actions required will be clearly articulated across the organisation with service areas held to account for their performance through the monthly accountability review process.

Resources

The Health Board has significant financial resources at its disposal to deliver the commitments in this plan. Allocations received and anticipated from Welsh Government total £1,789m. This includes specific additional allocations of :

- Strategic Support £82m
- COVID Costs £116m
- COVID Recovery £20m

We will deliver the commitments in this plan and deliver a break even position in year, to support the Health Board meeting the statutory duty to breakeven over a three year period, by the end of 2022/23.

Appendix 1: Summary of key performance metrics for 2021/22

	Lead Executive Director	30 Jun 2021	30 Sept 2021	31 Dec 2021	31 Mar 2022
Number of people waiting over 52 weeks for planned care treatment (inpatient, outpatient or day case)	Deputy CEO	43,500	43,500	48,000	43,000
Number of people waiting between 36 and 52 weeks for planned care treatment (inpatient, outpatient or day case)	Deputy CEO	55,600	55,600	51,600	44,500
Compliance with the eye care measure	Deputy CEO	45%	55%	70%	80%
Compliance with the single cancer pathway	Dir. of Therapies & Health Sciences	65%	67.5%	70%	72.5%
Number of people waiting over 8 weeks for a diagnostic procedure (excluding endoscopy)	Dir. of Therapies & Health Sciences	3,600	2,000	500	0
Performance against the mental health measure Part 1a	Dir. of Public Health	81%	76.8%	88.8%	83.1%
Performance against the mental health measure Part 1b	Dir. of Public Health	90%	83.2%	92.9%	83.1%
CAMHS – time to assessment	Dir. Of Primary & Comm. Care	30%	40%	50%	60%
CAMHS – time to treatment	Dir. of Primary & Comm. Care	25%	40%	60%	60%
Emergency department & MIU compliance against the 4 hour performance target	Deputy CEO	70%	73%	75%	80%
Ambulance handover delays over 1 hour	Deputy CEO	1,300	1,200	1,200	1,200
Number of people waiting over 12 hours in our emergency departments	Deputy CEO	2,200	1,700	1,000	1,000

APPENDIX 4

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

For:	Betsi Cadwaladr University Health Board 2021/22 Annual plan shaped by a three year transformation plan
Date form completed:	8th July 2021

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?**	Betsi Cadwaladr University Health Board 2021/22 Annual plan shaped by a three year transformation plan
2.	**Provide a brief description, including the aims and objectives of what you are assessing.**	The purpose of this screening is to consider the Equality Impact of the BCU Annual Plan. This is the overarching plan describing the key strategic themes for the organisation during 2021/22 and describes the key initiatives for action. The BCU Board is responsible for ensuring that services are planned and delivered to reflect the Welsh Government's vision for the NHS and the population needs of North Wales, working with partners and stakeholders to make the best use of our resources. The Health Board has a duty to plan for the future in a more structured way and provide a clear direction going forward, and for the people of North Wales to have a clear understanding of what the Health Board, working with partners, will deliver in the future. Guided by the principles within the Well-being of Future Generations Act, and together with our partners across the public and voluntary sectors, we are already shifting our focus to promote ways of working that prioritise preventing illness, promoting good health and well-being and supporting and enabling people and communities to look after their own health. We aim to provide excellent care, which means that our focus for the next year will be on the recovery from COVID-19 and developing a network of high quality services, which deliver safe, compassionate and effective care based on what matters to our patients. We will ensure our work is closely aligned with Welsh Government's long-term vision for achieving a 'whole system approach to health and social care', which echoes the 'Quadruple Aim' in 'A Healthier Wales'. We will: ▪ Improve population health and well-being through a focus on prevention

		▪ Improve the experience and quality of care for individuals and families ▪ Enrich the well-being, capability and engagement of the health and social care workforce ▪ Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste Our 2021/22 Annual Plan is the end product of a fully integrated process, which has taken account of service, quality and safety, financial and workforce considerations to ensure we have a coherent, consistent, and ambitious set of actions and deliverables. We need to develop in order to meet new challenges. We know that the overall health status of our population compares favourably to other parts of Wales, and this provides advantages and opportunities. However, the benefits of this are not equal across the population, and comparison against other areas of the UK and Europe demonstrates that people could achieve even better health and well-being. We welcome the commencement of the Socio-economic Duty, Part 1 of the Equality Act 2010 and are working to create an active focus on socio-economic disadvantage. We need to do more to help every one of all ages to have an active and healthy life and to stay well for as long as possible. This will involve helping people to be active physically and socially, and to adopt healthy lifestyle behaviours such as not smoking, eating well and minimising their intake of alcohol. We will only do this in partnership and with the help of other organisations such as local authorities and the voluntary sector. There are a number of specific challenges that our population face in the coming years which mean that we need to change the way we work now and how we involve people in order to meet them.

		▪ More people are living with one or more complex health issues such as diabetes or heart disease. We will support people to manage these conditions better so that they can live their life to the full. ▪ We know that more people are experiencing mental health issues with one in four of us affected at some point in their lives. ▪ There are more people living with dementia. We will work with our partners and people with experience of mental ill health to design and deliver modern services and do more to support people with long-term mental health problems. ▪ There are increasing demands on our primary care and community services with growing difficulties in attracting new GPs and other primary care practitioners to the area. ▪ There are increasing demands on our hospital services, for example, in our Emergency Departments. ▪ Waiting times for a number of operations such as replacement joints or eye surgery are too long and we need to see patients sooner and as such, we have undertaken significant work on improving timely access to both planned and unscheduled care. ▪ Bed occupancy in our acute and community hospitals is currently over 90 percent, on average much higher than 85 percent identified by the National Audit Office to operate effectively. ▪ Our workforce is changing and we face challenges in recruiting and retaining staff in a number of specialties and staff groups. ▪ The current size and condition of our estate is not sustainable in the long term and will not support our strategic direction. ▪ Challenges are posed with infrastructure and the delivery of core national information systems ▪ We are also facing significant financial constraints and we need to work together with our partners to ensure we make best use of our collective resources. As part of our recovery and as planned care restarts, the focus is on those people who are most in need of urgent treatment and it is necessary to ensure equality considerations are built into these plans.

		Our equality impact assessment procedures and tools have helped identify and mitigate impact and provide an overview of some of the barriers to accessing healthcare for further consideration. Key themes include: ensuring accessible communication and information, making reasonable adjustments, addressing the barriers experienced by disabled or neuro divergent people, meeting the needs of those with sensory loss, considering socio-economic disadvantage, mitigating for digital exclusion and optimising opportunities for engagement and co-production. This overall assessment takes into account underpinning programme level plans and evidence of alignment with the Equality Act. This provides assurance that new services and evolving work programmes are taking into account the needs of the Act and in turn support the decision making of the programmes and projects.
3.	**Who is responsible for whatever you are assessing i.e. who has the authority to agree or approve any changes you identify are necessary?**	The BCUHB Planning work stream chaired by the Executive Director of Planning and Performance, reporting to Executive Team. Supporting overall co-ordination, we have planning oversight group, ensuring triangulation of service, workforce and financial considerations within our planning work. Alongside the planning groups a task and finish EQIA engagement group was established as part of 21/22 planning work, with representation from across the health board to review Equality considerations and to ensure these are reflected and aligned with the plan.
4.	**Is the Policy related to, or influenced by, other Policies or areas of work?**	The Plan has been developed in the context of *A Healthier Wales: Our Plan for Health and Social Care*, published by Welsh Government in 2018. In addition, statutory duties under the *Social Services and Well-being (Wales) Act 2014* (SSWB) and the *Well-being of Future Generations (Wales) Act 2015*. Both Acts came into force in April 2016 and have major implications for the Health Board and the way that we carry out our functions.

		The *SSWB Population Assessment* (published March 2017) and the four *Public Services Boards' Well-being Assessments* (published in the period up to May 2017) have both provided helpful evidence to inform the development of LHSW. The plan has also been developed in the context of the wider legislative duties of the Health Board, national policy and guidance and local policy frameworks: ▪ Equality Act 2010 ▪ Equality Act 2010 (Statutory Duties) (Wales) regulations 2011 ▪ BCUHB Strategic Equality and Human Rights Plan 2016-2020 ▪ Special Measures Improvement Framework ▪ NHS Wales Delivery Framework March 2019 ▪ Maternity, Neonatal and Paediatric Strategic Framework (November 2016) ▪ Integrated Primary and Community Services Strategic Framework (November 2016) ▪ Together for Mental Health in North Wales (April 2017). We plan to check on the progress of our long-term strategy for health, well-being and healthcare, Living Healthier, Staying Well (LHSW). It has been three years since we developed this. Change takes time, and we need to check whether we are achieving what we set out to do, and whether the principles and priorities are still relevant.
5.	**Who are the key Stakeholders i.e.: who will be affected by your document or proposals?** **Has a plan for engagement been agreed?**	There are a wide range of stakeholders who are involved with, and affected by, this plan including: ▪ People, their families, carers and communities ▪ BCUHB Staff ▪ The Health Board's statutory advisory forums: - The Stakeholder Reference Group - The Healthcare Professional Forum - The Local Partnership Forum - Community Health Council ▪ Partnership organisations including Local Authorities, third sector and existing networks

		▪ Primary Care contractor professions: General Practice, Pharmacy, Dentistry, Optometry ▪ External NHS / health care providers such as North West England providers ▪ Welsh Health Specialist Services Committee (WHSSC) ▪ Welsh Ambulance Services Trust (WAST) ▪ Emergency Ambulance Services Collaborative (EASC) ▪ Neighbouring Local Health Boards in Wales ▪ Mid Wales Collaborative ▪ Public Health Wales ▪ Independent sector e.g. private care providers ▪ Specialist Services Commissioners and Cross-Border Providers ▪ Elected representatives including MP's, AM's, Town and Community Councillors.
6.	**What might help or hinder the success of whatever you are doing, for example communication, training etc.?**	The Annual plan sets out how the next year (2021/22) of the strategy will be implemented. This has been completed through the programme plans, namely: ▪ Health Improvement & Reducing Health Inequalities ▪ Mental Health ▪ Planned Care ▪ Unscheduled Care ▪ Women's Services ▪ Community and children's services ▪ Digitally Enabled Health and Care ▪ Transformed Workforce ▪ COVID19 Recovery Key enablers to effectively deliver the plan include: • Strong leadership, organisational, cultural and behavioural change will be required in order to deliver the organisations objectives. • The engagement of the staff of the Health Board in responding to and delivering the change required to fulfil this plan. • Ongoing communication, engagement and co-production with partners and stakeholders will be essential to the successful implementation of the priorities within the plan.

		• Ongoing research and development to monitor, evaluate, challenge and support innovation • Other key enablers include Informatics and Information and Estates aligned to delivering the Three Year Plan. • Service and divisional plans put into place aligned to deliver the change required will greatly help to ensure the success of the plan. • A clear accountability structure for transformational change will be essential to ensure performance management and remedial action where needed. • Resources will need to be re-aligned to deliver the changes required within our strategy and annual plan. There are potential barriers to change which may hinder the implementation of the plan and these may include: ▪ Uncertainty around COVID-19 ▪ Lack of capacity amongst staff to deliver the changes required ▪ Current services pressures leading to the inability to focus attention on the longer term changes required within the plan. ▪ Funding constraints, both revenue and capital, which may hinder the pace of change over time
7.	**Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.**	The Health Board has a Strategic Equality Plan (SEP) which provides a framework to help ensure that equality is properly considered within our organisation and influences decision-making at all levels. The SEP sets out the steps we are taking to fulfil our specific duties under the Equality Act 2010 (Statutory Duties) (Wales) regulations 2011 and describes the Health Board's arrangements for equality impact assessment. We have gathered and analysed relevant information and are maintaining engagement with communities, individuals and experts to help inform our direction.

		It is well recognised that Covid-19 has further magnified inequalities for many people with protected characteristics and those who are socio-economically disadvantaged. For some individuals, these inequalities may also be increased further by barriers to accessing healthcare, marginalisation from society or discrimination. As part of our recovery and as planned care restarts and the focus is on those people who are most in need of urgent treatment it is necessary to ensure equality considerations are built into plans. Our equality impact assessment procedures and tools have been further developed as a framework to help identify and mitigate impact and provide an overview of some of the barriers to accessing healthcare for further consideration. Key themes include: ensuring accessible communication and information, making reasonable adjustments, addressing the barriers experienced by disabled or neuro divergent people, meeting the needs of those with sensory loss, considering socio-economic disadvantage, mitigating for digital exclusion and optimising opportunities for engagement and co-production. In addition to the immediate enhancement of impact assessment guidance, our plans to deliver the SEP have been reviewed to reflect this emerging evidence. Further information about the SEP and equality objectives is published and available on our intranet An Equality Impact Assessment screening was undertaken on commencement of the development work for the vaccination programme. This has been reviewed and an updated action plan put in place to address barriers to participation. Excellent work has been undertaken in partnership with Local Authority partners including vaccination of homeless people, gypsy and traveller communities, the D/deaf community, and to engage with many community groups to address language and cultural barriers.

		The digital legacy of COVID19 will inform future change and reflected in the demand and capacity modelling assumptions and local solutions. We will work to optimise this benefit whilst also ensuring that the adoption of digital technology does not unfairly exclude some members of the population, leading to an unintended adverse impact by widening health inequalities. Under the Strategic Equality Plan a number of objectives are continuing to be delivered: BCUHB Equality Objective 1: • We will prioritise action to help identify and mitigate the impact of poverty for recipients of healthcare at risk of or actually living in low income households in North Wales. BCUHB Equality Objective 2: • We will prioritise action to reduce health inequalities and increase the accessibility of healthcare for people sharing different protected characteristics in North Wales. BCUHB Equality Objective 3: • We will prioritise action to respond to key policy and legal developments in healthcare for people sharing different protected characteristics in North Wales. BCUHB Equality Objective 4: • We will prioritise action to advance gender equality in North Wales. BCUHB Equality Objective 5:

		• We will prioritise action to address personal security for people sharing different protected characteristics accessing health services in North Wales. BCUHB Equality Objective 6: • We will increase engagement with individuals and groups sharing different protected characteristics in North Wales. BCUHB Equality Objective 7: • We will prioritise action to increase participation for people sharing different protected characteristics in health services across North Wales. BCUHB Equality Objective 8: • We will prioritise action to develop an inclusive culture where leaders routinely demonstrate their commitment to promoting equality within BCUHB and beyond and enable a fair and inclusive workforce. BCUHB Equality Objective 9: • We will prioritise action to advance race equality in North Wales BCUHB Equality Objective 10: • We will ensure compliance with the Public Sector Equality Duty

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

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	x		x		**Additional evidence considered:** • LHSW Children and Young People strategic framework – baseline assessment • Child Health Matters – A Vision for 2016 in Wales • Inequalities in Health: theory and evidence, presentation by Siobhan Adams, PHW, 2017 • LHSW Older People's strategic framework – baseline assessment • Dying Matters • Is Wales Fairer?, EHRC, 2015 • Together for Health Delivery Plans **Children and Young People** There has been very little change in the number of children in North Wales over recent years (with just over 124,000 aged 0-15 in 2016). This trend is likely to continue over the next 25 years with an overall increase of around 1% anticipated. Anglesey, Conwy and Flintshire are expected to see a decrease of around 6% in the number of children aged 0-15 by	

					2039; Denbighshire and Wrexham will remain about the same; and Gwynedd is expected to see an increase of around 9%. Support in the early years is crucial - experiences during childhood can have a significant impact on health and well-being in later life. Child poverty, Adverse Childhood Experiences, childhood obesity, disability, emotional and mental health and well-being, resilience, education attainment and many other factors can contribute. The First 1,000 Days of life are acknowledged as the most significant in a child's development. **Ageing Well** The estimated 2016 mid-year population of people aged 65 and over was nearly 157,000 and the population aged 85 and over was 20,289. By 2036 the older population will have experienced a greater percentage increase than Wales as a whole, with an increase of around 34% in those aged 65 and over and an increase of 23% in those aged 85 or over. About 1 in 4 people aged 85 or over are likely to have significant or complex needs. Reducing loneliness and isolation is one of the main challenges in improving well-being for people of all ages; however, for older people, the risk factors for loneliness and isolation tend to increase and converge. Participation and good community support networks are important.	

					Older people tend to be more likely to use care and support services including community based services as well as hospital services. Maintaining independence is important to people. Many older people are carers for relatives or friends. Actions being taken in response to meeting these needs are integrated into all our delivery plans in 2021/22 The plan therefore has the potential to deliver increased and improved services for people from pre-conception to end of life, particularly through its focus on ill-health prevention, early intervention and improvement for example, investment in primary and community services and mental health services, which aim to support and deliver care for people within their own homes and communities and reduce pressures on unscheduled care services. As we continue our COVID-19 recovery it is clear that people of different ages, particularly older people, have been disproportionately affected by the COVID-19 pandemic and our necessary organisational responses to it. This evidence has been extensively evidenced by a number of organisations and has been considered in impact assessing our immediate responses to the pandemic. At the core of this annual plan is the need to build our services back stronger and fairer for everybody in recognition of health inequality based on protected characteristics.	

					In an Office of National Statistics survery of those who said their well-being had been affected by the coronavirus, the most common ways older people said it had been affected were being worried about the future (70%), feeling stressed or anxious (54.1%) and being bored (43.3%).[1] The EHRC has reported that older people, particularly those in care homes, have been particularly affected by the pandemic.[2] Age UK have reported that Months of being 'cooped up at home' have led to muscle weakness – 'deconditioning' as clinicians term it - and sometimes a reduced sense of balance, increasing the risk of falls. [3] The research also found evidence of new and emerging cognitive decline. In some cases this might have happened anyway, but families told the Charity they feared it was exacerbated by the very difficult, often isolated conditions in which their loved ones were living, due to the pandemic. The research also uncovered many examples of depression, loss of hope, low mood, lack of support for meal preparation, deteriorating physical health and increased pain due to untreated health conditions. These have impacted on some	

[1] Coronavirus and the social impacts on older people in Great Britain - Office for National Statistics (ons.gov.uk)
[2] Equality and Human Rights Commission [EHRC] – How coronavirus has affected equality and human rights 2020 (equalityhumanrights.com)
[3] Age UK research on impact of the pandemic on our older population's health

					older people's appetites and diets, which in turn threatened to weaken their resilience still further. Other signs of the depressed state in which a sizeable minority of older people now found themselves, were their inability to gain pleasure from activities they usually enjoyed, and the fact they couldn't muster the energy and enthusiasm to look after themselves, or their homes, to their usual standards. Older people with pre-existing health conditions were some of the hardest hit by the pandemic so far and those who were shielding were about half as likely again to be feeling more anxious since lockdown than those who were not. An Age UK survey in September 2020 found that: • 1 in 3 respondents (4.2million) or 34% reported feeling more anxious since the start of the pandemic, • 1 in 3 (4.4million) or 36% agreed they felt less motivated to do the things they enjoy, • Over a quarter (3.2 million) or 26% can't walk as far as they used to, • 1 in 5 (2.4 million) or 20% are finding it harder to remember things, • 1 in 5 (2.3 million) or 18% say they feel less steady on their feet, • 2 in 3 (7.9million) or 64% felt less confident taking public transport, 2 in 5 (5.3 million) or 43% felt less confident going to the shops or 1 in 4 (3.3million) or 26% felt less confident spending time with family.	

					In recognition of this impact at the core of this annual plan is a package of programmes and projects that will have a positive impact of people of differing ages, including: • Test Trace Protect (TTP) – The TTP programme has been impact assessed in detail and specific measures put in place for care homes, arrangements for carers and communication needs. • Development of pathways out of hospitals to support discharge to recover and assess. • Relaunch of community pharmacy care home enhanced service. • Care of the elderly, linked to community resource teams • Establishment of frailty units • Improved access to children's neurodevelopment services Many of the above projects support the ethos of Care Closer to Home.	
Disability	x		x		**Additional Evidence Considered:** • Together for Mental Health in North Wales, 2017 • Strategic Dementia Plan (draft), 2017 • All Wales standards for communication and information for people with sensory loss. • Hearing Matters, Action on hearing Loss • Is Wales Fairer?, CEHR, 2015 • UN Convention for the Rights of Disabled Persons • Health and Social Care and Disability Equality Duty	

					• Equal Treatment: Closing the Gap (Disability Commission) • Cluster Profiles It is difficult to estimate accurately the number of disabled people in North Wales. The number of people on the Social Services disability registers is not seen as reliable due to under reporting. The number of adults of working age reporting themselves as disabled was around 409,000 in 2013. Around 4% of the population are estimated to be living with sight impairment. The number of people with vision impairment increases with age. Around 19% of the population in the UK have hearing loss or are deaf. Approximately 1 in every 1,000 children is born with a severe or profound haring loss. Many people within the deaf community will use BSL as their first or preferred language, and many others will know and use sign language. It is estimated that more than 70% of people aged over 70 have some form of hearing loss. It is estimated that the number of people who are deafblind – having vision and hearing impairments that significantly impact on day to day lives – will increase to around 1% of the population by 2030. There are around 2,700 people registered with Local Authority Social Services departments as having a learning difficulty or	

					learning disability. The actual number may be higher. Current projections estimate that the total number of people with a learning disability needing support has increased 2% each year until 2020. People with a learning disability are living longer, which is a positive outcome from improved health, social care and well-being support. However, it is important that the needs of older people with a learning disability, which may be more complex, are addressed. People may be at greater risk of dementia, experience poorer health, and experience barriers to care and support because of communication difficulties. Disabled people and people with mental health needs experience increased poverty and inequality. Amongst the key challenges identified in 'Is Wales Fairer?' are the need to improve living conditions, reduce homelessness, improve access to services and eliminate violence, abuse and harassment. There are barriers to care and support services arising from many factors – stigma and attitude; poor communication and information; accessibility; timeliness of response. The UN Convention on the Rights of Disabled Persons is designed to promote and protect the human rights of disabled person and ensure full and equal enjoyment. The 8 principles set the framework for the approach and the strategy programmes will seek to adopt the principles. Whilst article 25	

					relates specifically to health and healthcare, the Health Board has a broader responsibility in relation to the overall articles Around 1 in 4 people will experience mental health issues each year; and around 13% of respondents in the Welsh Health Survey reported receiving treatment for mental health needs. The number of adults with a common mental health need in North Wales is expected to increase from around 93,000 in 2015 to 99,000 in 2035. This may increase due to risk factors such as unemployment, lower income, debt and stressful life events. The Annual Plan has the potential to deliver reduced waiting times and increased and improved access to services for disabled people, particularly for example through a focus on community based services. By undertaking separate equality impact assessments for any changes, at a detailed project level, mitigating actions can be identified to ensure people at risk are supported It is recognised that there is a need for continued strengthening of strategic and operational/commissioning relationships with Local Authorities around meeting the needs of disabled people. The plan positively promotes disability equality and includes • Actions to meet the needs of people with sensory impairments – a commitment to raise awareness with all frontline staff of how to ensure communication support is in	

					place and review barriers to access via patient experience activity • A commitment to training all staff in the mandatory equality and human rights e-learning resource with refresher training every 3 years • A commitment to better meeting the needs of patients with Learning Disabilities outside of Mental Health and Learning Disabilities Division by undertaking self-assessment audit • Work to address the specific dental health and treatment needs of people with cognitive impairment. All Wales Standards for Accessible Communication and Information for People with Sensory Loss were introduced in May 2013 and became operational by Autumn 2013. There is a steering group within BCUHB that monitors implementation of the standards and a reference group consisting of third sector providers, BCUHB staff and service users. Programme action plans that positively impact this characteristic include: • Test Trace, Protect (TTP) – TTP has identified in its impact assessment particular challenges in engaging with the programme, particularly for neurodiverse people, people with cognitive impairment and sensory loss and specific measures put in place to support disabled people. • Stroke; Early supported discharge; specialist integrated community inpatient rehabilitation services. • Single Cancer Pathway development	There is an overarching EQIA for our digital strategy

					• Transformation of Child and Adolescent Mental Health Services (CAMHS) - Targeted Intervention Performance and Improvement Programme. • Timely access to treatment for CAMHs Programme action plans with potential negative impact this characteristic: A report by the World Bank Group in 2016[4] addressed the Digital Divide and how good use of ICT can support people and organisations to bridge this gap. Moving services online can create additional barriers for people with sensory loss, neurodiverse people, and people with carers. Our digital strategy and concurrent enabling schemes • Digital Strategy • Digitally enabled schemes e.g. Attend Anywhere; Virtual Visiting;	Detailed mitigating actions picked up in individual programme EQIAs. (Attend Anywhere; Virtual Visiting). These include additional support for those unfamiliar with or unable to use devices (virtual visiting) and alternative pathways and contacts for those unable to access online outpatient appointments (Attend Anywhere)
Gender Reassignment	x				**Additional Evidence Considered:** • Fair for all – Gender Equality Leaflet • It's Just Good Care; a guide for health staff caring for people who are trans*, CEHR, 2015 • LGBT in Britain – Trans Report, Stonewell 2018	

[4] WDR16BPBridgingtheDisabilityDividethroughDigitalTechnologyRAJA.pdf (worldbank.org)

					• Guidance for GPs, other Clinicians and Health Professionals on the Care of Gender Variant People (DoH) • The Gender Agenda (CEHR) • BCU Workforce information • Information relating to North Wales characteristics provided through Public Health Wales. No compelling evidence of positive or negative impact. There needs to be a careful assessment and appropriate mitigating actions for any detailed project where negative impacts are identified. Data on gender reassignment is not routinely collected. The Gender Identity Research and Education Society estimates of the trans* community in the UK range from 65,000 to 300,000. This includes people who have transitioned to a new gender role via medical intervention, and the broader trans* community. The absence of official estimates makes it difficult to ascertain the level of discrimination, inequality or social exclusion faced by the trans community. 'Is Wales Fairer?' Identifies there is still the need to eliminate violence, abuse and harassment against LGBT people. This is supported by Stonewall's new research, based on research with 871 trans and non-binary people by YouGov, it highlights the profound levels of discrimination and hate crime faced by trans people in Britain today.	

					Proposals for the development of a new primary care-led Gender Identity Care pathway in Wales for trans* people have been a positive step forward in relation to care and support. A group at the Health Board, including members of the trans community is working to implement proposals.	
Pregnancy and Maternity	x		x		**Additional Evidence Considered:** • Feedback from Maternity Services Liaison Committees, 2017 • Outcome Report, Consultation on temporary changes to Women's Services, 2015 • Prudent Maternity Care Report, BCUHB • National Service Framework for Children, Young People and Maternity Services, 2005 • Information about North Wales characteristics provided through Public Health Wales. • All Wales Maternity Strategy – local implementation plan (supported by EqIA screening). The Annual Plan has the potential to deliver increased and improved services around pregnancy and maternity. The overall aim of the Women's Strategy is to secure safe, high quality, sustainable services for the future. Programme action plans that positively impact this characteristic include: • Family Centred Care Scheme • Implement HEIW National review of maternity services	

					• Birth Plus compliance • Continuation of the Smoking Cessation – “Help Me Quit for Baby”. • Children from all Backgrounds are Given the Best Start in Life programme	
Race / Ethnicity	x		x		**Additional Evidence Considered:** The COVID-19 pandemic has highlighted a number of pre-existing health inequalities for people from black and ethnic minority backgrounds. Take immediate action to improve the quality of recording of ethnicity data in the NHS and across health and social care services to ensure parity of BLACK AND ETHNIC MINORITY data collection, monitoring and reporting. It is recommended that this is supported by qualitative research into the best methods for this, including lobbying to include ethnicity on death certification and birth certificates. The Ogbonna Report[5] outlined a number of actions that must be immediately undertaken by NHS providers in Wales. Take immediate action to improve the quality of recording of ethnicity data in the NHS and across health and social care services to ensure parity of BLACK AND ETHNIC MINORITY data collection, monitoring and reporting. It is recommended that this is supported by qualitative research into the best	

[5] first-ministers-Black and ethnic minority-covid-19-advisory-group-report-of-the-socioeconomic-subgroup.pdf (gov.wales)

					methods for this, including lobbying to include ethnicity on death certification and birth certificates. BLACK AND ETHNIC MINORITY people are over-represented in some sectors of the NHS, comprising over a third of medical and dental staff in Wales . Concerns in the group were raised specifically about risks to Filipino staff. Approximately 18,500 Filipino nationals work in the UK's National Health Service (NHS), the third-largest group after white and Indian groups. Out of more than 100 healthcare workers who have died after contracting the virus in the UK, at least 25 have been from the Philippines, according to Kanlungan, an umbrella organisation for Filipino community support groups across the country. That includes health and social care workers and hospital staff. Targeted actions include the rollout of the Diverse Cymru mental health workplace good practice certification scheme across Wales, health boards evidencing their efforts to improve access to information in accessible formats, Treat Me Fairly training, consideration of HESR findings and support to a range of programmes and initiatives protecting vulnerable groups such as refugees and asylum seekers. BCUHB is rolling out a programme of engagement with the good practice certification scheme including mental health and district general hospitals. The implementation of BLACK AND ETHNIC MINORITY Staff Networks/Groups supported by Trade Unions in Local Health Boards should be set up to allow a safe space for BLACK AND ETHNIC MINORITY Staff members to express concerns without	

					the threat of unfair action by Line Managers and above. Through the Strategic Equality Plan the Health Boards plans to continue supporting and grow its BCUnity black and ethnic minority and overseas staff network, which meets regularly and is supported by the Equality Team. It was clear that health and social care messages had not been effectively disseminated to BLACK AND ETHNIC MINORITY communities. Discussions at a number of meetings highlighted the need to fund BLACK AND ETHNIC MINORITY groups that have strong grassroots connections to help (among other things) in disseminating key public health messages like social distancing and Vitamin D supplementation and forthcoming testing and contact tracing measures. Under this annual plan the Health Board is employing an additional Engagement Officer to engage specifically with black and ethnic minority people and communities in North Wales. 'Is Wales Fairer?' 2018 found there are concerns about the quality of translation and interpretation services for migrants, refugees and asylum seekers, which may act as a further barrier to accessing health and social care services. Access to mental health provision is particularly poor for refugees and asylum seekers. 55. It also found that Gypsy, Roma and Traveller families continue to experience difficulties in accessing quality health and social care services. Poor access to health and social care provision, combined with mistrust and reluctant	

					uptake of health and social care services, has a negative impact on Gypsy, Roma and Traveller health and well-being. Around 19,000 people reported being from a non-white background in 2016 (Stats Wales, WG); the percentage of the population varies considerably, from 1.1% in Anglesey to 4.7% in Wrexham. A full breakdown of population numbers by ethnic group is given in the North Wales Local Authority Profiles. Morbidity and mortality data have identified a number of inequalities across ethnic groups as described in the Living Healthier, Staying Well: Equality Information paper. This includes health inequalities experienced by vulnerable groups including Gypsy, Roma and Travelling communities. Programme action plans that positively impact this characteristic include: • The Strategic Equality Plan objective 9 states that we will work to reduce race inequality in Wales. We have provided a detailed response to the consultation on the An Anti-Racist Wales – a Welsh Race Equality Action Plan and are committed through the SEP to delivering our part of this plan. • Delivery of the Welsh Race Equality Action Plan; • COVID19 workplace Risk assessment • Development and continued support of the BCUnity Staff Network.	
Religion, belief and non-belief	x				**Additional Evidence Considered:** • Is Wales Fairer?, CEHR, 2015	

					• Religion and Belief: A Practical Guide for the NHS • Information about North Wales characteristics provided through Public Health Wales No compelling evidence of positive or negative impact. There needs to be a careful assessment and appropriate mitigating actions for any detailed project where negative impacts are identified. Census data identifies those people who describe themselves in relation to a religious denomination. Christianity is still the largest religion in Wales, although the proportion has decreased alongside an increase in those stating no religion. Muslim, Hindu and Buddhist populations have approximately doubled since 2001, remaining the next three largest religions in Wales. The vast majority of the population of North Wales describe themselves as Christian. There are communities of different religious denominations across North Wales, such as the significant Muslim population in Gwynedd and Wrexham; and slightly higher numbers of Buddhists in Gwynedd. 'Is Wales Fairer?' Identifies that there is a need to encourage fair recruitment, development and reward in employment and close pay gaps for some religious groups, particularly Muslim people. The report also identifies the need to eliminate violence, abuse and harassment, again particularly against Muslim people.	

					The Health Board is reviewing its Hate Crime Policy under this annual plan and will continue to work in partnership with North Wales Police Diversity Unit to identify and tackle hate crime and hate incidents based on religion.	
Sex	x				Additional Evidence Considered: • Feedback from meetings with organisations and individuals with an interest in gender health inequalities • Evidence provided by organisations such as Fair Treatment for Women in Wales • Addressing Inequalities in Men's Health in a Rural Community, Dolgellau Hospital OPD team • Information about North Wales characteristics provided through Public Health Wales • Census 2011 No compelling evidence of positive or negative impact. There needs to be a careful assessment and appropriate mitigating actions for any detailed project where negative impacts are identified. There remain differences in outcomes experienced by men and women in specific circumstances, and differences in the way that they access health advice, information and support. Overall, men have lower life expectancy (78 years, compared to 82 years for women); there are more premature deaths from	

					cancer, more deaths from cardiac disease and a three times higher risk of death from suicide. Women may experience different barriers to access in healthcare and health services. More women are unpaid carers. **Is Wales Fairer?** identifies the need to eliminate violence, abuse and harassment, including against women. The partnership working needed to address violence against women and domestic abuse is identified within the SSWB population assessment and action plan. Programme action plans that positively impact this characteristic include: • The Strategic Equality Plan includes plans to support a Women in to Leadership Masterclass and the development of a Women's Staff Network to provide peer support. • Transformation programme Gynaecology and Specialist Services • Implement pathway for Heavy Menstrual Bleeding and Continence.	
Sexual Orientation	x				**Additional Evidence Considered:** • Unhealthy attitudes: the treatment of LGBT people within health and social care services, Stonewall • Don't look back? Improving Health and Social Care Delivery for older LGB Users, Ward, R., Pugh, S. and Price, E, 2010	

					• Double Stigma (Stonewall Cymru 2009) • Improving sexual orientation monitoring (Equality and Human Rights Commission 2010) • Don't look back? Improving health and social care delivery for older LGB users (Equality and Human Rights Commission 2010). The 2015 Annual population survey found that 1.7% of the UK population identified themselves as lesbian, gay or bisexual, with Wales having a lower percentage than the UK overall. The population aged 16 to 24 years is the age group with the largest percentage identifying themselves as LGB. Government figures estimate 6% of the population is lesbian, gay or bisexual. National reports highlight the barriers experienced by Lesbian, Gay and Bisexual (LGB) people accessing and using services. Our plan presents an opportunity to raise awareness of the needs of LGB people. For example, BCU are working with Stonewall Cymru and were recently assessed as one of the top 100 employers within the UK. Programme action plans that positively impact this characteristic: The Health Board will continue to support its Celtic Pride LGBTQ+ staff network and will continue to participate in awareness raising events across Wales.	

					The all Wales refresh of the Treat Me Fairly Training will include training on issues facign LGBTQ+ people in Wales.	
Marriage & civil Partnership (Marital status)	x				No impact identified	
Low-income households	x				Please refer to the Socio Economic Assessment.	

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

Human Rights:
Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at**:** **http://howis.wales.nhs.uk/sitesplus/861/page/42166**

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)			
					Additional Evidence Considered: • How Fair in Wales, 2011, Equality and Human Rights Commission • From safety net to springboard: A new approach to care and support for all based on equality and human rights, Equality & Human Rights Commission • The Human Rights Act: Changing Lives • Welsh Government: Standards for Improving the Health and Well-Being of Homeless People and Specific Vulnerable Groups The Living Heathier Staying Well strategy confirms that amongst our principles, in everything we do: ✓ we promote equality and human rights. The document confirms that human rights represent all the things that are essential to us as human beings, such as being able to choose how to live our life and being treated with respect and dignity. This principle will be woven throughout all plans.	

					The Plan has been developed in line with local and national policy. It aims to actively eliminate inequalities where they may exist and improve access to high quality, safe and sustainable healthcare. The plan recognises that we must deliver services for the health economy of North Wales, to meet the population needs of North Wales safely, whilst ensuring that appropriate, sustainable community services are delivered within locality / county areas. The plan acknowledges the growing prevalence in the population of people with cognitive impairment / dementia (and also learning disabilities where care for premature babies and life expectancy for adults with LD is increasing), who are at the greatest risk of having their human rights breached. On-going training and awareness raising amongst all staff groups through our mandatory Equality and Human Rights training is key to mitigating this risk.	

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		x		The Health Board's Welsh Language Strategic Plan ensures that changes in the legislative landscape are reflected in our approach to planning high quality, language appropriate care. The Welsh Language Standards and the 'More than just words' Framework provides the foundation on which we continue to build and improve upon. The plan therefore has the potential to deliver increased and improved access to Welsh Language services, particularly through its focus on community based services – recognising that services delivered within local communities are more likely to be able to respond in the medium of Welsh. Where a patient's first language is Welsh all efforts to accommodate the patient's wishes utilising Welsh speaking staff members will be made. Should this not be	

					possible, then Language line can be used or WITS for face to face interpretation.	
Treating the Welsh language no less favourably than the English language	x				**Additional Evidence Considered:** • Welsh Language Measure, 2011 • Welsh Language Standards, effective from 2016 • BCUHB Welsh Language Scheme The 2011 Census showed that 27% of residents in Conwy could speak Welsh and 20% could speak, read and write in Welsh. Across the region, the percentage of Welsh speakers ranges from 12.9% in Wrexham to 65.4% in Gwynedd. Ensuring the safety, dignity and respect of Welsh speakers is integral to the provision of health services in Wales. The Welsh Language Standards under the Welsh Language (Wales) Measure 2011 establishes the legislative requirements for the Health Board and whilst the Health Board is committed to achieving its legal requirements, it has also set a greater level of ambition that will be driven by the desire to improve the quality of care provided for patients in their first language.	

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.	Regular updates have been given to the Board's statutory committees and advisory forums including stakeholder Reference Group and Local Partnership Forum.
Have any themes emerged? Describe them here.	The main themes that have emerged for the Health Board to consider have been communication and digital exclusion.
If yes to above, how have their views influenced your work / guided your policy / proposal, or changed your recommendations?	Due to the transformational nature of the initiatives planned, initiatives will not be assessed collectively, but each initiative will require Equality Impact Assessment Screening to determine whether full Equality Impact Assessment is required. By screening individual initiatives, detailed analysis of the potential impacts will be undertaken in relation to specific plans. Mitigating actions will be considered as part of this.

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)**	Betsi Cadwaladr University Health Board 2021/22 Annual plan shaped by a three year transformation plan

2. **Brief Aims and Objectives (Copy from Form 1)**	This is the overarching plan describing the key strategic themes for the organisation between 2021/22 and describes the key initiatives for action in 2021/22. The Plan aims to provide a recovery plan from COVID19 and excellent care, which means that our focus for the next year will be on developing a network of high quality services, which deliver safe, compassionate and effective care based on what matters to our patients. We will ensure our work is closely aligned with Welsh Government's long-term vision for achieving a 'whole system approach to health and social care', which echoes the 'Quadruple Aim'. We will: ▪ Improve population health and well-being through a focus on prevention ▪ Improve the experience and quality of care for individuals and families ▪ Enrich the well-being, capability and engagement of the health and social care workforce ▪ Increase the value achieved from funding of health and care through improvement, innovation, use of best practice, and eliminating waste

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	√
3b. **Could the impact of your policy or proposal be discriminatory under equality legislation?**	Yes		No	√
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	

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 √
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. **If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?**	Yes	No
	Moving services online can create additional barriers for people with sensory loss, neurodiverse people, and people with carers. Detailed mitigating actions picked up in individual programme EQIAs. (Attend Anywhere; Virtual Visiting). These include additional support for those unfamiliar with or unable to use devices (virtual visiting) and alternative pathways and contacts for those unable to access online outpatient appointments (Attend Anywhere).	
6. **Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?**	Yes √	No
	How is it being monitored?	The Board and its Sub Committees will be responsible for providing the necessary scrutiny through regular updates on the operational plan
	Who is responsible?	Mark Wilkinson, Executive Director of Performance and Planning has overall responsibility for the Strategy and Three Year Plan with delivery linked to respective Executive Directors
	What information is being used?	Subcommittee information relating to Quality, Performance, Finance and Engagement
	When will the EqIA be reviewed? **(Usually the same date the policy is reviewed)**	The EqIA will be subject to ongoing review and further supporting EqIA work as detailed proposals are developed for Health Communities.

7. **Where will your policy or proposal be forwarded for approval?**	SPPH Committee and BCU Health Board

8. **Names of all parties involved in undertaking this Equality Impact Assessment: please note EqIA should be undertaken as a group activity** **Senior sign off prior to committee approval:**	**Name**	**Title/Role**
	Kelsey Rees Dykes	Corporate Planning Manager
	John Darlington	Assistant Director, Corporate Planning
	Mark Wilkinson	Executive Director, Planning and performance
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:**	Not applicable	Not applicable	Not applicable
2. **What changes are you proposing to make to your policy or proposal as a result of the EqIA?**	Due to the transformational nature of the initiatives planned, initiatives will not be assessed collectively, but each initiative will require Equality Impact Assessment Screening to determine whether full Equality Impact Assessment is required.	Individual project leads will undertake this action.	In line with project milestones
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?**	By screening individual initiatives, detailed analysis of the potential impacts will be undertaken in relation to specific plans. Mitigating actions will be considered as part of this.	Individual project leads will undertake this action.	In line with project milestones
3b. **Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.**	Not applicable	Not applicable	Not applicable
4. **Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.**	It is recommended that the draft plan and EQIA screening are considered by Strategy & Planning Equality Scrutiny Group.		

SOCIO ECONOMIC IMPACT ASSESSMENT TEMPLATE

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

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

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

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

Policy / Strategy / Proposal/Procedure Title	BCUHB Annual Plan
Lead Manager	Director of Planning and Performance
Approval Committee	Board
Date form completed	30.06.21
What are the aims and objectives of the policy/strategy/proposal?	The Annual Plan puts patients, carers and staff at the centre of what we do through changing the way we work, with organisational development, stronger governance, effective and sustainable use of resources and our workforce being the key enablers. The plan reflects key organisational priorities to improve health and deliver excellent health care across North wales, including the recovery from COVID 19. Last year has undoubtedly been the most challenging in the history of the many NHS organisations that have served the people of North Wales. Responding to the pandemic has required us to develop and implement new services such as Test Trace and Protect (TTP), mass COVID-19

	vaccination, and establish three Enfys hospitals at high speed. To achieve our priorities we will engage with our workforce, partners, and the wider communities of North Wales in new and innovative ways over the next 12 months and beyond.

STAGE 1: PLANNING					
Is the decision a strategic decision? See definition	**YES**	Please provide a brief explanation for your answer	Our Plan is focused on managing and recovering from the impact of the pandemic and aligned to our strategic priorities to deliver health care services for our North Wales population. This means establishing current requirements and recovery assessments across our services that have identified areas of improvement. This plan supports the delivery of our strategic priorities in Living Healthier, Staying Well and the Welsh Government 10 year strategy plan 'A Healthier Wales'.		
Have you identified key stakeholders groups? Please detail below	**Yes**	**Can you identify relevant communities of interest?** See guidance Please detail below	**Yes** / No	**Can you identify relevant communities of place?** See guidance Please detail below	**Yes** / No
It covers primary care, secondary care, community care and mental health. Stakeholder groups primarily cover three areas: - Patients and their friends and families - Staff - Partner organisations		All residents of North Wales Carer's and families of North Wales residents All staff and volunteers Older People Black and ethnic minority people Disabled People, people with mental health issues		All areas across North Wales	

STAGE 2: EVIDENCE	
What evidence have you considered about socio-economic disadvantage and inequalities of outcome in relation to this decision?	The duty is a key mechanism in planning our services in BCUHB's recovery from the impact of Covid-19, making sure that we support the most vulnerable people in our communities across North Wales. Our shorter term includes recovering access to planned care services e.g. primary care and hospital appointments, whilst enabling us to develop and test longer term recovery plans to meet the needs reflected in the socio economic duty. This will enable us to move towards the reconstruction of a fairer and more prosperous Wales. Features of socio-economic disadvantage are complex and are often interlinked, for example health outcomes get progressively poorer across the socio-economic gradient; no or low accumulated wealth leads to households having no or limited access to basic goods and services such as transport, education and health care services; a lack of social mobility in terms of higher education and career prospects; and discrimination faced by some individuals who have protected characteristics. 23% of all people in Wales were living in relative income poverty between 2016 to 2017 and 2018 to 2019. The UK's exit from the European Union continues to bring immense uncertainty, not least in relation to equality and human rights. Decades of EU membership have produced a legacy of benefits covering many aspects of daily life in Wales, for example employment and environmental rights and health and safety regulations. Additionally, COVID-19 is increasing the current inequalities which exist in Wales. The evidence shows there is an indisputable link between inequality and socio-economic disadvantage (by socio-economic disadvantage we mean living in less favourable social and economic circumstances than others in the same society). The COVID-19 outbreak has brought huge challenges to our communities. It has become clear that certain groups have been affected more than others. For example, ethnic minority communities, disabled people,

	women, and young people. In its latest state of the nation report, Poverty in Wales 2020, the Joseph Rowntree Foundation cites that: Before coronavirus hit, almost a quarter of people in Wales were living in poverty. After a decade of stalling progress, in which that proportion has barely changed, Wales now faces a rising tide of poverty as the Covid recession gathers pace. The pandemic has hit low-paid workers in Wales particularly hard: industries with a large proportion of low-paid jobs, such as the accommodation, food and beverage sector, have seen 78% of jobs furloughed. Those same sectors are most likely to see widespread job losses, and in some areas of over 40% of jobs are in these high risk, low paid industries1 In North Wales, 12% of the population live in the most deprived communities in Wales compared to 19% across Wales; however, this masks considerable pockets of deprivation across the region, some of which are among the highest levels of deprivation in Wales. Rhyl West 2 (Denbighshire) and Queensway 1 (Wrexham) are the second and third most deprived areas in Wales. Three further areas in Rhyl (Rhyl West 1, Rhyl West 3 and Rhyl South), are in the top twenty most deprived areas in Wales (Welsh Government, 2014). People living in the most deprived areas live on average shorter lives than those living in the least deprived areas. Gwynedd has the lowest inequality gap in the whole of Wales for males (3.4 years); Denbighshire has the fourth highest in Wales (11 years). This suggests that men in the most deprived areas of Denbighshire live, on average, 11 years less than those in the least deprived areas in the same county. The difference for women is also largest in Denbighshire, where women in the most deprived areas of the county live, on average, 8.4 years less than those in the least deprived areas of Denbighshire (Public Health Wales, 2016b). Educational outcomes have an impact on income and living standards, which in turn impact on physical and mental health. Across North Wales, the percentage of residents aged 16 to 74 years who have no academic or

[1] Impact of commencing the Socio-economic Duty: integrated impact assessment [HTML] | GOV.WALES

	professional qualifications is lower than the average for Wales (25.9%), with the exception of Wrexham (26.7%). There is considerable variation at local level within counties (Office for National Statistics, 2011). North Wales population assessment: Introduction Page 15 of 361 Unemployment is associated with financial problems, distress, anxiety, depression and poor health related behaviours. Just over 5% of working age residents in Wales have never worked or are long-term unemployed. Across North Wales, all six local councils are below the average for Wales; however, there is considerable variation within counties (Office for National Statistics, 2011). Housing has an important effect on health, education, work, and the communities in which we live. Across Wales, 77% of people in owner occupied houses were very satisfied with their accommodation, compared with 52% of people in private rented accommodation and 48% of people in social housing (Welsh Government, 2015a). The majority of people in Wales report having enough money to heat their home; however, there is a difference across tenure type with 96% of people in owner-occupied housing having enough money to heat their home compared to 89% of private rented tenants, and 87% of those in social housing (Welsh Government, 2015a). There has been a rapid rise in homelessness in Wales, with a 16 to 25% increase between 2007 and 2012. This then presents an average in Wales of 39 households accepted as homeless per 10,000 households (Public Health Wales, 2016a). A safe environment, free from crime, contributes significantly to community cohesion and people's sense of well-being. Anxiety over crime can impact people's mental health. Deprived neighbourhoods with empty properties, unmaintained housing, graffiti and visible signs of criminal activity are strongly related to the fear of crime, which is associated with poor self-rated health and well-being. Across North Wales, almost 81% of residents feel safe after dark, the same as the Wales average. Local council levels range from 74% in Wrexham

	to 89% in Gwynedd. In North Wales, 74% of residents are satisfied with the local area, which is just above the average for Wales, 71%. Local council satisfaction levels range from 70% in Wrexham to 77% on the Isle of Anglesey (Public Health Wales Observatory, 2015).2
Have you engaged with those affected by the Policy / Strategy Proposal / Policy?	Our current Living Healthier Staying well strategy is being reviewed with the Socio economic duty used as a framework to shape and re work our Organisational strategy to ensure compliance and fairer services, this is detailed within the annual plan as a focus piece of work for 2021/22. The refresh of the strategy will include engagement with partners, staff and patients across North Wales. This will include anyone who is living with socio economic disadvantages taking into consideration their needs.
What engagement with people living with socio economic disadvantage will be / has been undertaken?	
How has / will this influence your work/guided your policy/proposal, or changed your recommendations?	Finding from the engagement sessions and further research into our service users, will provide us with knowledge and a needs assessment to influence the development and constructer of the health board policy.

[2] NW-Population-Assessment-1-April-2017.pdf (llyw.cymru)

Stage 3: ASSESSMENT AND IMPROVEMENT		
What are the main socio economic impacts of the proposal? Consider evidence from both research and any engagement already carried out. Who is being affected? Refer to the North Wales Population Health Directory Are some communities of interest or communities of place more affected by disadvantage than others? The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain these areas include: • Education • Work • Living standards • Health • Justice and personal security • Participation It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regards to each of these areas, evidence is provided below and issues for consideration suggested.		
Education A literature review by the Centre for Research in Early Childhood (CREC) finds that evidence they examined indicates that in the UK, especially, parents' socio-economic status continues to be the primary predictor of which children prosper in adult life. They report that the magnitude of early childhood inequality in the UK is	**In Practice** Overall school children in Wales attain scores in reading, science and mathematics below those in England, Scotland and most other developed countries. Since schools closed during lockdown, children from better-off families have been	

well-documented; some estimates suggest that half the attainment gaps for pupils are already present at the start of primary school. Using Millennium Cohort study data, this research shows large gaps exist in the UK for vocabulary tests between children aged 4 and 5 from families with middle incomes and those from families with lowest fifth of incomes. Data for Wales also shows pupils eligible for free school meals and children in care have poorer educational outcomes in schools on average with the gap widening as pupils get older.	spending 30 per cent more time on home learning than poorer children How does your proposal take account of the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have or have had access to training opportunities and qualifications? Think about how careers support at BCUHB and with partners, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.	Numerous programme's of work across the health board service delivery plan, focus on the improvement of health service delivery within the education sector. Including supporting children and adults with additional learning needs, basic literacy levels. Plans to improve access to neurodevelopmental services for example The delivery of some of the workforce elements of the plan will create opportunities for people to volunteer and create employment and vocational training opportunities in North Wales.
Health There is a clear social gradient in terms of health outcomes as documented by the Marmot Review (2010 and 2020 update). It makes it clear that health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources (i.e. the social determinants of health). Indeed, data for Wales shows that adults and children living in the poorest areas are	**In Practice** How does your proposal take account of the expected health outcomes of the local population? What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors.	Current health needs of the North wales population have been researched and used as drivers in many cases for new services and service improvements. In doing so, we are considering the longer term expected health outcomes we want to achieve for the population of north Wales. As our services are designed, we will develop mitigations to meet needs, such as transport and travel to services in hard to reach areas, e.g. our more rural

having poorer health outcomes. Adults living in the most deprived areas of Wales have lower life expectancies than those living in the least deprived areas. There is reasonable evidence that people in poverty or living in deprived neighbourhoods have a higher risk of addiction and mental illness and it's also known that many patients struggle financially and socially.	What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?	communities such as Llyn Peninsula where we work to be able to deliver services closer to home, or virtually. Working as part of North Wales Regional Partnership Board and Public service boards across North Wales and at a cluster level with statutory and voluntary sector to deliver more integrated health and social care services for our population.
Living standards 3% of all people in Wales were living in relative income poverty between 2016-17 and 2018-19. This figure has remained relatively stable for the past 16 time periods. At 23%, the figure is slightly lower than last year's. Children were the age group most likely to be in relative income poverty (at 28%) and this has been true for some time. 11% of children living in Wales between 2016-17 and 2018-19 were in material deprivation and low income households.	**In Practice** How does your proposal take account of the impact of poverty and deprivation? Can you identify which groups are disproportionately impacted by poverty e.g. disabled people? Think about the UK-wide reforms to social security and the impact on the poorest in society, particularly women, disabled people, ethnic minorities and lone parents in Wales.How have the needs of people with caring responsibilities been considered? What is the incidence of rough sleeping and levels of homelessness? Twice as many people expect their financial situation to get worse as those who expect it to get better, with this rising to three times in the bottom income quintile, and more than three times for single parents.	A number of programmes are geared towards delivering Care Closer to Home. This will support people in rural areas and people without access to transport, as well as people with physical impairments to be able to access. The Well North Wales Programme includes workstreams designed to reduce homelessness and support people living with homelessness.

	Think about the availability and accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces. As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?	
Work When considering all children in Wales, the likelihood of being in relative income poverty is much greater, and the gap is increasing for those living in a workless household compared to living in a working household (where at least one of the adults was in work).	**In Practice** As one of the largest employers in Wales BCUHB provides numerous opportunities for people to access work, the Step into Work programme is a great example. Think about how careers support including apprenticeships and volunteer work placements can be promoted to support those who are furthest from the job market, those who are in households where no one is in employment, young people who are not in employment or training and other seldom-heard groups. Think about people in terms of their income and employment status, consider the impact on the availability and accessibility of work, paid and unpaid employment, wage levels, job security and working conditions. What are the implications of the proposal for people on low income, those who are economically inactive, unemployed,	As one of the largest employers in Wales BCUHB provides numerous opportunities for people to access work, the Step into Work programme is a great example. We have and continue to employ local people to support our COVID Recovery programmes such as TTP and the vaccination programme.

	workless, and people who are unable to work due to ill-health. Consider people living in work poverty. During the pandemic lower earners are three times as likely to have lost their job or been furloughed as high earners. How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage? As part of your proposal what are the opportunities to increase employment opportunities for people who experience socio-economic disadvantage?	
Justice and personal security The National Survey for Wales (2018-19) shows that people who were not in material deprivation were found to be more likely to feel safe in their local area, compared with those who were in material deprivation. Research by the University of Bristol shows that, notwithstanding some significant methodological limitations, existing analyses in the UK and internationally have consistently found vulnerability to domestic violence and abuse to be associated with low income, economic strain, and benefit receipt. This association is underpinned by a complex set of relationships and interdependencies.	**In Practice** How does your proposal take account of local crime rates and exposure to crime? What are the hate crime statistics? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control. How can your proposal promote and protect people's rights and increase their access to justice and personal security?	The annual plan includes provision for updating Hate Crime policy and hate crime and its causes are to be included in Equality and Human Rights training packages. Ongoing partnership work is in place to tackle hate crime in higher risk areas. This is addressed in the Strategic Equality Plan Objective BCUHB Equality Objective 5: We will prioritise action to address personal security for people sharing different protected characteristics accessing health services in North Wales.

Participation The National Survey for Wales (NSW) shows that in 2018-19, 87% of households had access to the internet. Household internet access varies by WIMD levels of area deprivation. In 2018-19, 92% of households in the least deprived areas had internet access, compared to 83% of households in the most deprived areas. The NSW also shows households in social housing were less likely to have internet access (75% of such households) than those in private rented (90%) or owner occupied (89%) accommodation. Those in employment were more likely to have internet access at home (96%) than those who were unemployed (84%) or economically inactive (78%).	**In Practice** How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal?	The Strategic Equality Plan contains BCUHB Equality Objective 6: We will increase engagement with individuals and groups sharing different protected characteristics in North Wales. The Health Board is formalizing the terms of reference to ensure the sustainability of its Equality Stakeholder Group and has broadened the scope of this group to include reference to the socio-economic duty. The Health Board is employing an engagement officer with particular focus on engaging with black and ethnic minority people in North Wales, who we know are more likely to be living with socio-economic disadvantage.

What actions will you undertake to minimise any adverse impacts identified during this Socio Economic Duty Impact Assessment?			
Impacts Identified	**Mitigating Action to be Taken**	**Action Owner**	**Monitoring Arrangements**

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

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15.7.21
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Welsh Language Standards – Standard 37 – Translation of Board Papers – Six-month update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Miss Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad **Report Author:**	Mrs Eleri Hughes-Jones, Head of Welsh Language Services
Craffu blaenorol: **Prior Scrutiny:**	No prior scrutiny at Committee level
Atodiadau **Appendices:**	No attachments

Argymhelliad / Recommendation:

The Board is asked to:

(1) note the six-month update relating to the translation of specific Board papers following the decision at the Health Board meeting held on 12 November 2020.

(2) approve next steps in line with progressing compliance with Standard 37 of the Welsh Language Standards.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this paper is to feedback on the six-month review of translating specific Board papers and to outline proposed next steps.

Cefndir / Background:

The Welsh Language Commissioner (the Commissioner) issued the Health Board with its Welsh Language Standards Compliance Notice on 30 November 2018. This places a legislative requirement on the Health Board to comply with the Welsh Language (Wales) Measure 2011 through the form of Welsh Language Standards. The legislation gives the Welsh language official status in Wales, with the Welsh language not being treated less favourably than the English language. One hundred and eleven Welsh Language Standards came into force for the Health Board on 30 May 2019, with a further ten on 30 November 2019.

One Standard (Standard 37) makes specific reference to providing Welsh versions of specific documents available to the public:

Welsh Language Standard 37

If you produce a document (but not a form) which is available to one or more individuals, you must produce it in Welsh - (a) if the subject matter of the document suggests that it should be produced in Welsh, or (b) if the anticipated audience, and their expectations, suggests that the document should be produced in Welsh.

This Standard is applicable to the availability of Board papers in Welsh.

Discussion were held at the November Health Board meeting with regard to progressing compliance with this Standard, with the decision taken to translate all Standing Items (not including documents in pdf format such as the Annual Plan Performance Monitoring Report, Integrated Quality and Performance Report etc.). With the Health Board's Translation Service working beyond full capacity, it was agreed to outsource translation initating a pilot approach (service provided by Cymen Cyf), with a six month update to review progress.

Asesu a Dadansoddi / Assessment & Analysis

Three Board meetings were held during the six-month review period. Previous arrangements were upheld with regard to the translation of the agenda, minutes and any presentations. These were undertaken by the in-house translation service.

The figures below demonstrate the additional words translated per meeting and associated costs.

Board meeting	Number of additional words translated	Cost
21.1.2021	10,575	£911.00
11.3.2021	10,853	£922.53
20.5.2021	22,806	£1259.82

A meeting was held with the Office of the Board Secretary (OBS), the Welsh Language Team and 'Cymen Cyf' to review progress, acknowledge outcomes (positive and negative), and highlight any areas of concern from either side. No concerns were raised by the parties involved.

Authors of the Standing Items on the Health Board agenda were also approached for feedback. Comments with regard to timescale and turnaround, as well as accessibility and efficiency of service, were all positive, and no issues raised. One issue was highlighted with regard to the interpretation of specific terminology within the context of papers. This issue was broached with 'Cymen Cyf', with the outcome for 'Cymen Cyf' to verify the context with authors in cases of undefined frameworks. The OBS also provided a glossary of terms to faciliatate interpretation of abbreviations.

The Health Board acknowledges its duty to move towards fully achieving the Standard, and in order to do this, progressing this line of work requires further consideration.

Opsiynau a ystyriwyd / Options considered

The Standard does not outline a blanket-translation approach across all Health Board documentation. Rather, it requires organisations to review the "subject matter" and the "anticipated audience" to determine whether there is an "expectation" or "suggestion" that it should be produced in Welsh.

From a next steps perspective, the OBS have already explored the option of conducting an assessment of the overall Board Cycle of Business in order to estimate translation requirements. The assessment considered criteria such as, but not limited to, whether the subject of the document related to Welsh Language issues, or whether a percentage of the predicted audience would be Welsh speakers. Focusing on the next six months (i.e. three Board meetings), applying the assessment to each Board meeting would produce a detailed analysis to determine the papers that would require translation.

The outcome of the analysis would allow for the measuring of findings against the:

- effect, if any, it would have on turnaround timescales for submission of Board papers;
- requirement to factor in translation time beforehand to ensure bilingual papers are submitted to the OBS ten calendar days ahead of meetings;
- effect that retaining the work in-house would have on translation demand / capacity;
- cost implications of further outsourcing

The Board would subsequently be in a position to make an informed decision as to the best way to achieve next steps.

Goblygiadau Ariannol / Financial Implications

If non-compliance is identified, the Commissioner will undertake an investigation, presenting the final conclusions in a written report. If adequate action is not taken to address shortfalls, the Commissioner is able to impose a civil penalty of up to £5000 on the organisation.

The findings of the analysis would stipulate and explore revenue demand, and expore budget sources and impact.

Dadansoddiad Risk / Risk Analysis

The main consideration is the timeliness aspect, which would be taken into consideration during the assessment process.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Welsh Language (Wales) Measure 2011 was approved by the National Assembly for Wales and was given royal assent on 9 February 2011.

This legislation gives the Welsh language official status in Wales, and reinforces the principle that the Welsh language should not be treated less favourably than the English language in Wales.

The Measure also:

- created the procedure for placing duties on organisations in the form of Welsh Language Standards (“the Standards”)
- established the role of the Welsh Language Commissioner (“the Commissioner”) to scrutinise compliance
- gave the Commissioner power to investigate any allegations of interference with someone’s freedom to use the Welsh language

Asesiad Effaith / Impact Assessment

An impact assessment was not required in connection with the production of this report. The purpose of the report itself is to ensure and confirm that due regard is given to the delivery of Welsh language services across the Health Board.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15 July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Proposed Integrated Governance Framework
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Executive Director of Nursing and Midwifery, Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Simon Evans-Evans Interim Director of Governance
Craffu blaenorol: **Prior Scrutiny:**	Executive Leadership Team Board Workshops Audit Committee 10 June 2021
Atodiadau **Appendices:**	1. Proposed Governance Framework v1.18 2. Audit Committee Terms of Reference 3. Charitable Funds Committee Terms of Reference 4. Mental Health Capacity and Compliance Committee Terms of Reference 5. Performance, Finance and Information Governance Committee Terms of Reference 6. Partnerships, People and Population Health Committee Terms of Reference 7. Quality Safety and Experience Committee Terms of Reference 8. Remuneration and Terms of Service Committee Terms of Reference 9. Equality Impact Assessment (EQIA)

Argymhelliad / Recommendation:

The Board is asked to approve the suite of documents for implementation from September 2021

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**							**N**

Sefyllfa / Situation:

The Health Board and Welsh Government have identified governance as an area that needs improvement. The Interim Director of Governance has conducted a review, building on previous reviews, utilising interviews with Board members and support from internal teams including the Office of the Board Secretary, the office of the Chief Executive, the Executive Leadership Team and the Equalities Team. The proposed framework intends to

- Ensure that the governance, performance management and risk structures are effective, efficient and robust.
- Ensure clear accountability at all levels and that the Health Board creates an environment for learning and safety.
- Ensure that governance standards are consistent through the organisation.

Cefndir / Background:

This proposed Integrated Governance Framework covers a range of structural and behavioural issues and has been developed in partnership with the Executive Directors, Committee chairs ,Independent Members and the wider BCUHB team.

The framework sets out the objectives and rationale and gives some worked examples and context. The proposals are relatively simple and designed to:

- Support the Board in balancing its responsibilities in relation to strategy, setting the culture and holding the organisation to account for the service it provides
- Improve the focus, co-ordination and relevance of Board and Committee papers with built in assurance levels
- Develop greater oversight of the People and Transformation agendas
- Give the Board assurance of delivery structures and lines of accountability
- Improve information flow, no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

The Board set objectives for the framework which are addressed as follows:

<u>Objective 1: Ensure that the work of the Board and Committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.</u>

By undertaking some of the analytical, research, and evaluation work the Committees, Executive Delivery Groups and associated Tactical Groups will create space for the Board Committees to balance their agendas. Proactive use of the Cycles of Business, associated agendas and meeting evaluation will highlight the balance of time a Committee spends in each area. The quality of the evidential reports provided by Executive Delivery Groups and Executive Management Groups will be key to ensuring the pitch of oversight vs detailed investigation is met. Where aligned, the Executive Delivery Group will take lead responsibility for co-ordinating reporting from Executive Management Groups and Executive Delivery Groups to ensure consistent reporting between the present and the progress along the transformation route.

Draft Cycles of Business for the three “strategic” Board Committees are drafted in Annexes 18-20 of the Proposed Governance Framework

<u>Objective 2: Develop a greater focus on strategy in Committees – delivering for the future.</u>

Incorporating relevant strategies into each Committee’s terms of reference, combined with defining Committee responsibilities within the corporate strategy will clarify ownership of strategy; this

together with an aligned delivery structure reporting into the Committees should provide the framework to appropriate focus on strategy.

Objective 3: Improve the focus, co-ordination and relevance of Board and Committee papers with built in assurance levels.

The effect of consistent use of the Chairs' Assurance Reports, together with the strategic, tactical, operational delivery structure and no orphaned groups rule will improve accountability (linked to the Performance and Accountability Framework) and ultimately assurance in that where challenges, celebrations, concerns and commendations are not escalated will be easier to trace back, understand why and learn.

The effective use of cycles of business and Committee agendas will also allow for a balance of Committee business within the meeting, and across the year to support Independent Members to get a deeper understanding of the challenges, celebrations, concerns and commendations within the operational teams.

Proposed agenda and chairs' assurance report templates allow for levels of assurance to be quantified, aligned to the assurance levels used in the Board Assurance Framework (BAF) based on the three lines of defence model that board members are familiar with.

Objective 4: Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

The structure aims to give a clear line of accountability for performance through the Executive Management Groups, supported by the Performance and Accountability Framework and the Performance Oversight Group. Enabling the Chief Executive to hold Executive Directors to account for performance and the Board to hold the Executive Leadership Team to account for performance management. (Also this partly meets objective 4).

Objective 5: Develop greater oversight of the People / Transformation agenda.

Covered within the Terms of Reference for the Partnerships, People and Population Health Committee.

Objective 6: Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

This will be resolved through having clear reporting lines for groups and Committees, linked to consistent use of the Chairs' assurance reports, which will highlight areas of challenges, celebrations, concerns and commendations. Committees and Board will also have the opportunity to hear first-hand from the front line during the programmed directorate reviews within the cycles of business.

Asesiad / Assessment & Analysis

The attached frameworks are intended to support BCUHB out of Targeted Intervention and focus the organisation on delivery of key priorities, Executive Delivery Groups will be able to support Board and Committees develop strategy, including the prioritisation of improvement metrics.

Draft reporting and agenda templates have been delivered to help operationalise the framework

Summary Changes:

- The Welsh and English titles have been separated to facilitate easier reading
- Assurance level has been incorporated within “report purpose” to align to the BAF
- Annual Plan priorities have been included as a drop down
- Annual Plan enablers have been included as a drop down
- Targeted Intervention Improvement Framework (TIIF) priorities have been included as a drop down
- Direct reference to current BAF / Tier 1 risks included
- New section on Engagement included
- New sections on Public Sector Equality Duty (PSED) / Socio-Economic Duty (SED) included

Draft Agenda Template

This template has changed six sections to mirror Cycles of Business within the governance proposals (following the Hywel Dda UHB model)

Summary Changes:

- The Governance section to include verbal / written report from Chair and Lead Director, and notification of matters referred from Board or another Committee
- Strategic items for decision – both strategy development and monitoring will appear here
- Quality, Safety and Performance – the present – performance reports etc. will appear here
- Learning from the past – investigation reports etc. will appear here
- Chairs’ assurance reports – to provide line of sight and assurance
- Closing business to include a review of risks highlighted during the meeting as well as a review of the meeting effectiveness.

A Draft PowerPoint slide deck is being prepared for the rolling Directorate reporting to Committees

Draft Chairs’ Assurance Report

Summary Changes:

- Assurance level has been incorporated within “Key assurances” to align to the BAF

Draft Terms of Reference

Summary Changes:

- Requirement to meet Public Sector Equality Duty (PSED) and Socio Economic Duty (SED)
- Right of attendance to the Chair of the Board and Audit Committee and Board Secretary
- Focus on developing and monitoring strategy

The development of the proposed governance framework has been iterative, with comments from Board, Executive Leadership Team, Executive Management Group, Office of the Board Secretary, Office of the Chief Executive, and the equalities team.

Options considered

There is no single right solution to governance frameworks, these models have been designed and developed following conversations with senior personnel within BCUHB and will need the support of leaders within BCUHB to be successful.

Financial Implications

No analysis has been made of the financial impact, although the frameworks are designed to make the organisation more efficient in its decision making and more robust in its financial and performance management, which should have a positive impact in the accounts. No assessment has yet been made on the levels of corporate support that could be required to support news ways of working, understand risk etc.

Risk Analysis

Detailed risk analysis has not been undertaken although the do-nothing option would appear high risk in the eyes of the Board and Welsh Government; there may be risks that will need to be managed in the socialisation and implementation stages.

Legal and Compliance

Specific legal advice has been sought on the relationship of the Power of Discharge Group, the model being adopted follows Cardiff and Vale UHB.

Impact Assessment

An Equality Impact Assessment has been completed (appendix 9)

Embedding the principles of equality and human rights at heart of the Integrated Governance Framework enables and promotes compliance with the three aims of the Public Sector Equality Duty. The framework explicitly states that one of the core purposes of the Health Board is to reduce inequality and promote equality and human rights.

Given the nature of Committee membership and therefore of strategic decision making consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible.

Appendix 1

Proposed Integrated Governance Framework 2020

Simon Evans-Evans

v1.18

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1. Executive Summary

This proposed Integrated Governance Framework covers a range of structural and behavioural issues and has been developed in partnership with the Executive Directors, committee chairs and Independent members and the wider BCUHB team.

The framework sets out the objectives and rationale and gives some worked examples and context. The proposals are relatively simple and designed to:

- Support the Board balance its responsibilities in relation to strategy, setting the culture and holding the organisation to account for the service it provides
- Improve the focus, co-ordination and relevance of Board and Committee papers with built in assurance levels
- Develop greater oversight of the People and Transformation agendas
- Give the Board assurance of delivery structures and lines of accountability
- Improve information flow, no orphan groups - improve the line of sight from Floor to Board through increased governance discipline

The changes are grouped into three main categories

Board structure - summarised in figure 2 on page 15 which:

- Reduce the number of formal committees and sub committees from 9 to 7
  - Four focused on culture and compliance / assurance
    - Audit
    - Charitable Funds
    - Remuneration & Terms of Service
    - Mental Helth Capacity and Compliance
  - Three focussed on transformation, culture & assurance (including developing corporate and supporting strategies)
    - Performance, Finance and Information Governance
    - Quality Safety and Experience
    - Partnerships, People and Population Health
- Mainstream quality in Mental Health and Primary and Community Care in the Quality Safety and Experience Committee
- Improve visibility of the frontline for Board members

Changes to the **Delivery and assurance model** – figure 5 page 19

- The Executive is the delivery arm of the board, and will head up Executive Delivery Groups for strategic delivery and Executive Director Management Teams for business as usual
- Board committees will be supported by these Executive groups and the Tactical Delivery Groups sitting underneath them – consistent across the structure; they will be able to do some of the heavy lifting for the committees

- the Strategic Tactical and Operational groups are replicable within the divisions to plug into the pan-BCU structure

Governance discipline

The operationalisation of the framework includes:

- Supporting sight from Floor to Board section 4.3.1.1 page 21
    - Patient / staff stories at Board and Committees.
    - Directorate Reports at Board and Committee on a rotational basis covering challenges, celebrations, concerns and commendations.
    - Deep dive into areas programmed across the business year to give a depth of focus in a meeting rather than a shallow overview at every meeting.
    - This is in addition to the escalation and cascade process in within the Performance and Accountability Framework
- Groups relationships
    - Groups will be responsible for the effectiveness of sub-groups and their reporting to ensure no orphaned groups, and consistency of delivery actions through strategic, tactical and operational groups.
    - All groups to provide a Chairs Assurance Report as a route for matters to rise through the organisation as well as an audit trail and learning process for when they don't
- Agendas / Cycles of Business
    - Report of Lead Executive at Committees to make members aware of issues not suitable for a full paper.
    - Formal process to refer matters to other committees and receive matters from Board.
    - Identification of risks arising within a meeting for referral to the Risk Management Group.
    - Formal reporting (via the lead Executive) from formal partnership arrangements and advisory groups to appropriate committees.
    - Reviews of meeting effectiveness to capture learning and improvement.

Strategy Development and monitoring

- Proposal that the development of the Corporate Strategy is co-ordinated through PPPH but the QSE and PFIG own their relevant elements of the strategy.
- Proposal that the redeveloped Corporate Strategy identifies strategies for Board ownership (tier 1) and sub-strategies for Board information and committee ownership (tier 2). All strategies will be aligned to a Board Committee for ownership (where a strategy crosses the work of more than one committee the Board shall decide which committee takes primacy over the strategy).
- Inclusion of a tactical planning and strategy group for co-ordination and alignment of strategies

2. Rationale

2.1. Background

The Welsh Government placed the Health Board into Special Measures on 8 June 2015 with the intention that we would be able to demonstrate progress and move down through the four 'escalation' levels:

- Special measures.
- Targeted intervention.
- Enhanced monitoring.
- Routine arrangements.

In May 2019, maternity services and GP out-of-hours were taken out of Special Measures and on 24 November 2020, following advice and recommendation from the tripartite meeting of NHS Wales, Audit Wales and Healthcare Inspectorate Wales the Welsh Government stepped the Health Board down from 'Special Measures' to 'Targeted Intervention'.

During Special Measures and Targeted Intervention, the Welsh Government has highlighted Governance as an area that the Health Board needs to improve.

2.2. Findings

In this review process during a series of one to one interviews, board members raised a number of concerns including, but not limited to:

- Lack of sight from the Board through the organisation to the front line.
- Too much board and committee time focused on detailed operational matters.
- Not enough time at board and committee to focus on developing strategies.
- Lack of clear building blocks for governance (corporate strategy, performance management, road map out of special measures, prioritised medium and long term planning).
- Holding execs to account is important, but developing strategy and culture is more important and is missing.
- No co-ordinated oversight from the Board in relation to "our greatest asset" – our people.
- No visibility from the Independent Members in the operational support structure to give assurance against statements made by Executives.
- Lack of confidence from the Independent Members that Executives are delivering what has been agreed.
- Visibility of Executives through the organisation.
- Inadequate individual performance management.
- The board has two groupings (Independent Members and Executive Directors), is not acting as a unitary Board and there is a lack of trust.
- Lack of a patient focus at Board level.
- Committees need clear structure and process to allow a balance of day to day versus strategic.

- Inadequate links between Board and organisational governance.
- Too much time spent on governance and oversight on writing reports and presentations.
- Too many meetings that Independent Members are required to attend.
- Board and committee meetings are too long and less productive towards the end.
- Poor information flow, inadequate use of information, data and analytics.
- No performance culture and lacking in consequence poor reporting culture.
- Need more transformational leadership and succession planning.

2.3. Governance outcomes within the Targeted Intervention Improvement Framework (TIIF)

The TIIF sets out outcomes the Welsh Government expect to see and reflects some of the comments made by Board Members and highlighted in section 1.2.

The TIIF states that the Health Board will need to agree its own approaches to the development and implementation of the matrices; however, as a guide the following section sets out the themes and challenges that the Welsh Government expects to be addressed. The overriding expectation of the framework is to ensure that:

- Ongoing transformation, improvement and innovation leads to improved trajectory of outcomes, patient experience and financial performance year on year.
- A revised accountability and performance framework delivers improvements in performance and patient safety.
- The health board builds on relationships and existing partnership structures and fully engages and involves the public, staff, trade unions and partners on the transformation and reshaping of services.
- A sustainable vision for the future is agreed and communicated to the public, staff, trade unions and partners.
- The development of a medium term plan, incorporating a robust three-year financial plan to meet its financial duties.
- The development and implementation of a long term integrated clinical services strategy.
- Strengthen leadership capacity and enhanced governance supports organisational development, decision making and resilience.
- Improvements will be celebrated, leading to de-escalation, as assessed by the maturity matrix approach.

The specific Governance and Leadership outcomes are indicative of the building blocks that need to be reflected in the transformation journey.

- Develop and embed a compelling vision for the Health Board that is understood, recognised and accepted throughout the organisation.
- Demonstrate visible clinical leadership engaging patients, partners and staff.

- An effective, integrated Board setting a clear strategic direction for the organisation.
- An open and transparent culture and willingness to learn.
- Consolidation of executive leadership supported by a development programme for the Executive Team.
- Collective responsibility for quality and patient safety across the executive team and clearly defined roles for professional leads.
- A revised accountability and performance framework, underpinned by a robust governance structure.
- Visibility and oversight of clinical audit and improvement activities across divisions/groups/directorates and at corporate level.
- A strong approach to organisational learning supported by a culture of high quality care.

2.4. What is the Integrated Governance Framework trying to achieve?

Organisational governance, culture and behaviour are inextricably linked. Colloquially governance can be described as "the way we do things around here"; culture can be described as "the way we do things around here – when no-one is watching". The proposed framework therefore needs to be supported by the Organisational Development Programme to address the behavioural and cultural issues raised by Board Members and the Welsh Government.

The framework also needs to align to the emerging corporate strategy, as the framework is the delivery and assurance structure for the strategy.

The framework aims to support the Board in its key functions of leading the Health Board to be effective and to deliver the principal role of a Health Board:

To ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes human rights.

2.5. What are the objectives?

The governance proposals are designed to meet the follow objectives agreed by the Board:

Objective 1:

- Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

Objective 2:

- Develop a greater focus on strategy in committee – delivering for the future.

Objective 3:

- Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

Objective 4:

- Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

Objective 5:

- Develop greater oversight of the People / Transformation agenda.

Objective 6:

- Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

3. The Integrated Governance Framework

3.1. What is the Integrated Governance Framework?

The Integrated Governance Framework sets out the means by which the Board and staff ensure that they are doing the right things, in the right way, for the right people, in a manner that upholds the values set for the Welsh public sector.

3.2. What do we mean by Integrated Governance?

Integrated governance can be defined as:

'Systems and processes by which we lead, direct and control our functions in order to achieve organisational objectives, safety, and quality of services, and in which we relate to the wider community and partner organisations.'

For the Board (and the organisation) to be effective, it has to be assured that integrated governance systems are closely intertwined. Each decision has to focus closely on the requirements of the different aspects of governance, in particular five governance arrangements collectively known as Integrated Governance or as a system just Governance:

- Clinical governance.
- Corporate governance.
- Research governance.
- Information governance.
- Financial governance.

The main features of an integrated governance model are:

- Integrating risk assessment with the initial objective setting.
- Developing a process for reporting progress against objectives.

- Aligning the various governance systems so that they complement each other without overlap.
- Developing an effective assurance framework.
- Ensure the committee structure is fit for purpose.

Governance provides a focus on:

- Vision.
- Strategy.
- Leadership.
- Assurance.
- Probity.
- Stewardship.

3.3. What is the purpose of Integrated Governance Framework?

Integrated Governance is the system that allows the Health Board and the Board to ensure the Health Board delivers its core purpose, namely:

- Effective planning and delivery of healthcare for people for whom it is responsible.
- A robust governance framework.
- Achievement of the highest standards of patient safety and public service delivery.
- Improve health.
- Reduce inequalities.
- Achieve the best possible outcomes for its citizens.
- Promote human rights.

Our Board is an Integrated Board which functions as a corporate decision making body. Executive Directors and Independent Members are full members and share corporate responsibility for all the decisions of the Board. However, for committees with a primary scrutiny function, membership is limited to Independent Members, with Executive Directors in attendance:

The three key roles through which effective Integrated Boards demonstrate leadership are:

- Formulating strategy.
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

Key Board Role	Independent Members' role	Executive Directors' role
Formulating Strategy	Joint Responsibility	Joint Responsibility
Ensure Accountability and Delivery	Support and Assurance	Delivery and Assurance
Shape Culture	Joint Responsibility	Joint Responsibility

3.4. What is assurance?

Academi Wales describes assurance as:

Providing: 'Confidence' / 'Evidence' / 'Certainty'.
To: Directors / Non-executives / Management.
That: What needs to be happening is actually happening in practice.

NHS Boards may seek and receive assurance from a wide range of sources within their organisation, both directly and through the operation of its committees, notably those responsible for Audit and for Quality & Safety. The key challenge for Boards is understanding each link in the assurance chain, what part it plays in the overall framework of assurance, and the value they should place on it. The Audit Commission (2009b) describes an approach to internal assurance as a "three lines of defence" assurance model:

First line of defence: Responsibility lies with healthcare staff and teams working at the 'frontline' to understand their roles and responsibilities and to carry them out properly and thoroughly. If working practices (the 'systems and processes') are well designed, and staff are equipped to follow them, compliance with the arrangements should mean risks in day-to-day activities are routinely managed.

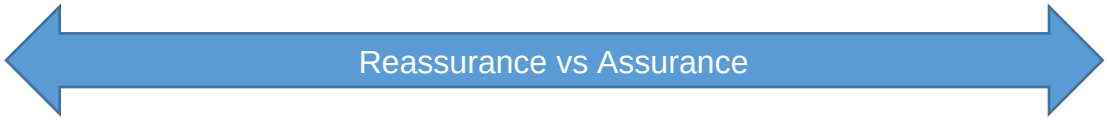
Second line of defence: This typically comprises executive/management arrangements established to ensure compliance with the standards, policies and working practices set through active oversight of the operation of the first line of defence. Typically, this includes holding them to account for the effectiveness of their activities, and may include routine assessment, inspection and review activity to ensure the achievement of standards and compliance with policies and procedures.

Third line of defence: This is independent review, designed to assess the overall adequacy and effectiveness of the first and second lines of defence. The key source of this 'independent' assurance is through functions such as internal audit, although there are other sources of independent review that can also be used, including inspectorates and review bodies. (Academi Wales)

NOTE: The Board Assurance Framework defines the levels of assurance on controls as

0 – Policies in place but not actively managed
1 – 1st Line: Department.
2 – 2nd Line: Organisational.
3 – 3rd Line: Independent.

The three lines of defence are sometimes referred to as the reassurance versus assurance continuum:



It is OK because management says it is	It is OK because management have responded to questions from the board and this has given me confidence	It is OK because I have reviewed various reliable sources of information

3.5. What are the principles in this Integrated Governance Framework?

- Set clarity for the Board and staff within the Health Board in relation to:
  - Assurance.
  - Accountability.
  - Decision making and approval.
  - Roles and Responsibilities.
  - Effective segregation of duties.
- Have clear alignment to:
  - The Health Board's principle role and purpose.
  - Welsh Government expectations.
  - Targeted Intervention Improvement Framework.
  - Health Inspectorate Wales expectations.
- Provide a model that aligns to:
  - Quality management (Patient experience, Patient safety and Clinical effectiveness).
  - Innovation, learning and modelling new ways of working.
  - Risk Management and Board Assurance Framework.
  - Performance and Accountability Framework.
  - Strategy delivery.
  - People management.
  - Financial management.
  - Data management.
  - Process and policy development.

3.6. Framework design

To aid clarity of purpose in groups and committees. The model is intended to provide transparency on where and how we obtain assurance, responsibility for delivery, it takes into account the wider health systems and requirements in Wales and aligns wider governance structures (as listed above). The framework also

guides groups as to their purpose in the Health Board, Assurance or Delivery, Strategic, Tactical or Operational.

The proposed BCUHB model has the Integrated Board supported in its assurance and culture setting roles by good and solid **Process Management** (including Risk, quality systems, Equality Impact Assessments to assure the promotion of human rights etc.). Good **Performance Management** (helping to give sight from floor to Board and to see outcomes) and a co-ordinated focus on **prevention**.

It is supported in is strategic and culture setting roles by focusing on 4 domains;

- **Population Health** (improving health, reducing inequalities).
- **Patients** (best possible outcomes).
- Our **People** (not just well-being and recruitment, but planning for the future, education enabling the organisation to deliver on a Transformation programme etc.).
- Finances **(Pounds).**

All of the above is evidenced or enabled by the **Operational Delivery, Digital Enabler, Learning Innovation and Best Practice** and by **Working in Partnership**

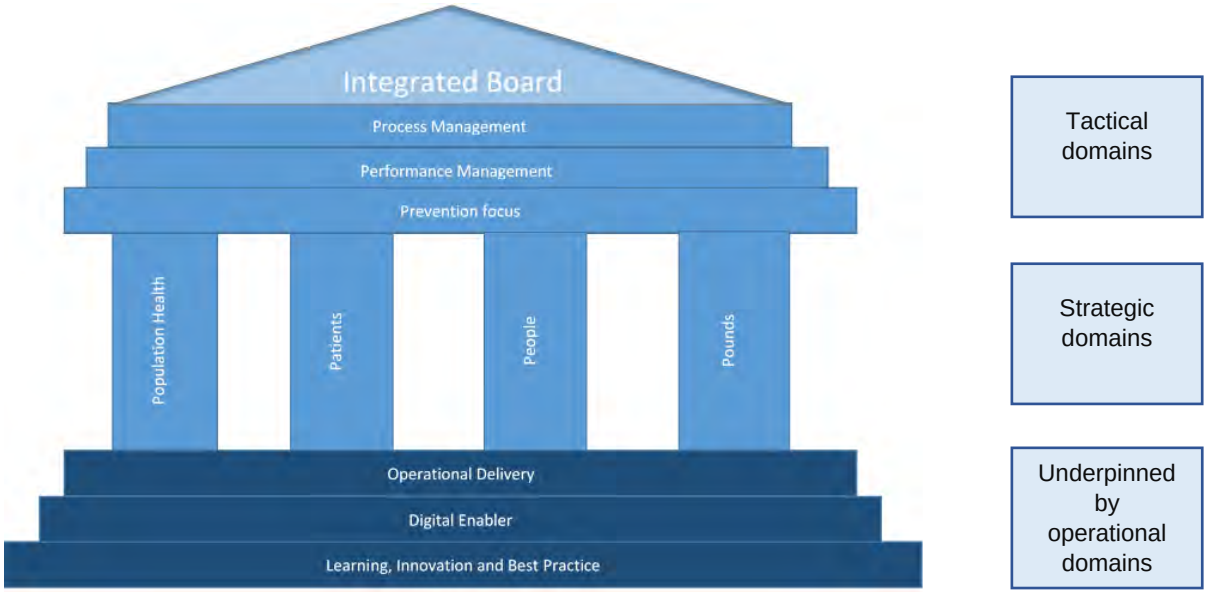


Figure 1 : The Betsi Model of Governance

4. The Integrated Governance Framework in practice

The Good Governance Guide for NHS Wales is clear where independent Members and Executive Directors have joint endeavour and where they have different roles. Board committees are formed to support the Board develop strategy, set culture and hold the Executive arm of the Board to account for delivery.

The Board as a whole is responsible for the WHAT and the Executive for the HOW. The Integrated Board agrees and sets the vision, goals and priorities and the executive develop the strategies to deliver them. We can define strategy as "the high level blueprint that articulates the vision and sets key milestones and measures of success". Once the strategies are approved, the Executive then develop the detailed plans for delivery and the Board measures and monitors progress and performance against the plan.

4.1. Board Structure

4.1.1. Purpose of Board committees

Board Committees are charged with supporting the Board to deliver on its purpose by:

- Setting and embedding culture.
- Developing and monitoring strategy.
- Holding the Executive Leadership to account for delivery (both operational delivery and strategic delivery).

Therefore, Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board.

4.1.2. Board committee structure

The Board has three joint committees with other health boards in Wales to support pan Wales delivery and three advisory Groups as laid out in regulation, other Board committees are at the discretion of the Board (provided that certain functions are fulfilled[1]). In this model, all committees have a duty to support the Board in setting the culture of the organisation. There are:

- Three committees primarily focused on proving assurance and supporting the organisational culture within a relatively narrow remit.
    - Mental Health Compliance and Capacity Committee (MHCC).
    - Remuneration and Terms of Service Committee (RaTS).
    - Charitable Funds Committee (CC).
- Three committees primarily focused on strategy development & monitoring, supporting organisational culture and assurance. These committees also reflect the four strategic domains in the governance model (Patients, Pounds, People and Population Health).
    - Quality, Safety and Experience (QSE).
    - Performance, Finance and Information Governance (PFIG).
    - Partnerships, People and Population Health (PPPH).
- Audit Committee (AC) to review governance and assurance processes critically on which the Board places reliance.

[1] Oversight of: Audit; Quality and Safety; Information Governance; Charitable Funds; Remuneration and Terms of service; Mental Health Act Compliance

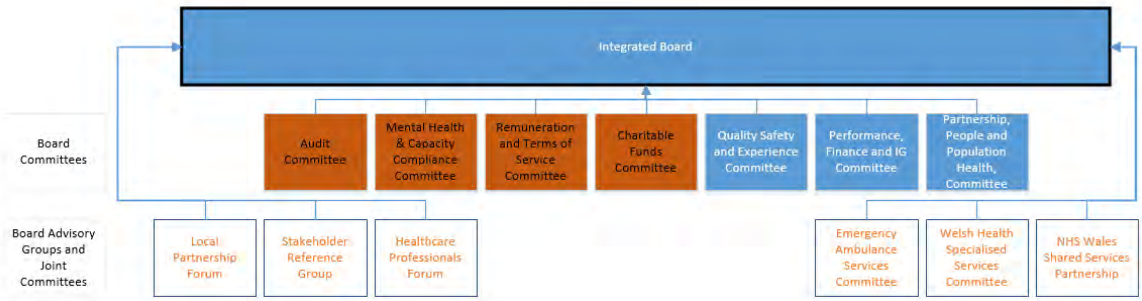


Figure 2 - Betsi Board and committee structure

4.1.3. Segregation of responsibilities

Whilst all members of the Board have joint responsibilities and all Board committees have joint responsibility in relation to setting and embedding culture and in ensuring organisational compliance and assurance, responsibilities are segregated to allow for effective check, challenge and assurance in relation to strategic and operational delivery. This ensures that Independent Members remain independent of operational matters and Executive Directors can be held to account for organisational performance. Figure 3 demonstrates the relevant roles and responsibilities of Board Committees and the Executive Leadership Team.

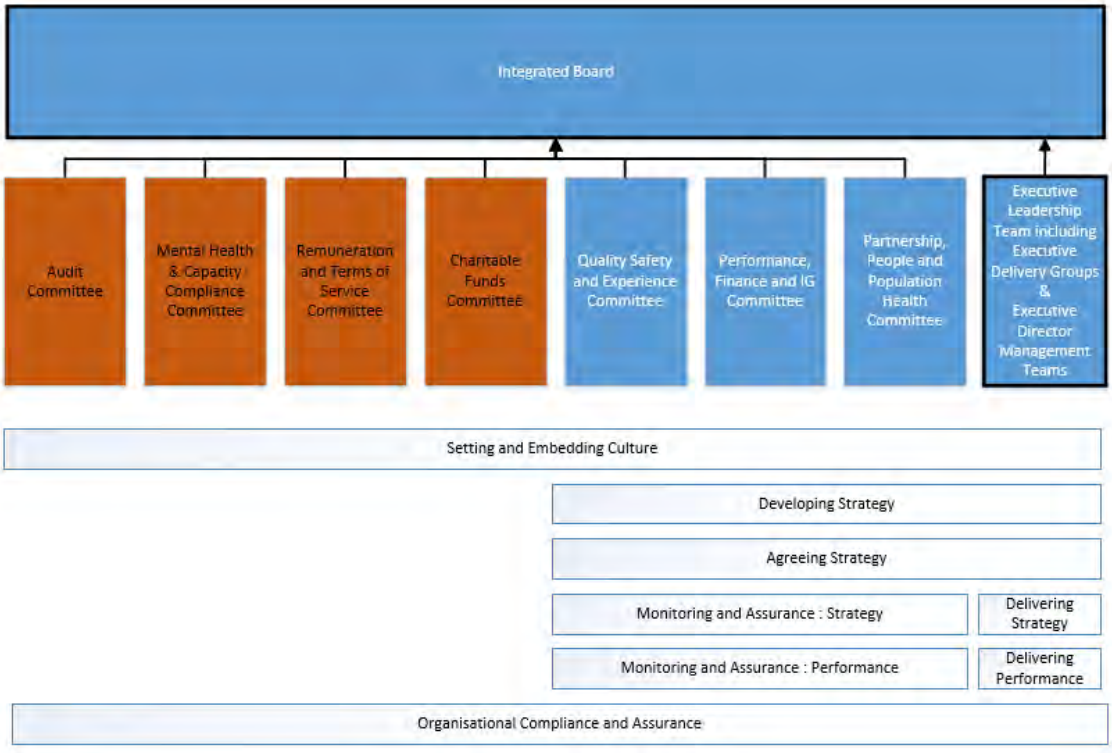


Figure 3 - Segregation of responsibility

4.1.4. What is different from the current model?

Current Committee	New Committee	Changes
Audit	Audit	No Change
Mental Health Act	Mental Health & Capacity Compliance	Focus on compliance with the Mental Health Act Removed mental health divisional quality assurance to 'mainstream' quality of mental health services and provision within the QSE
Power of Discharge Sub-committee	None	Changed form a formal sub-committee to a Power of Discharge Group for Hospital Managers reporting to MHCC Committee quarterly *(in line with CAVUHB)*
Remuneration and Terms of Service	Remuneration and Terms of Service	No change
Charitable Funds	None	No Change
Digital and Information Governance	None	Digital agenda moved to PHPP as an enabling strategy (although alignment of enabling strategies already in Strategy, Partnerships, Population Health Committee ToR) IG moved to PFIG
Quality, Safety and Experience	Quality, Safety and Experience	Wider focus to include quality of MH and primary care services, and quality related strategies
Finance and Performance	Performance, Finance and IG	Removed people agenda, focus to include IG and PFIG related strategies
Strategy Partnerships and Population Health	Partnerships, People and Population Health	removed Quality and Finance strategies, focus to include people and enabling strategies
Board Advisory Groups and Joint Committees		No Change

Other changes

- Remove the Joint Quality and Audit Committee meetings. QSE have clear ownership of the outcomes of audits and setting a risk based approach to the scope and number of audits. Audit committee to seek assurance on the process. Specific concerns / recommendations relevant to each committee can

be addressed through the committee by the role of the Independent Member link members and if necessary conversations between committee chairs.

- Chair and Chair of the Audit Committee to have right to attend all committees for assurance purposes.
- Reduce the frequency of the Board Secretary led Chairs business meetings to twice yearly.

The Board uses a committee structure to support its work.

The Executive Leadership Team is the delivery arm of the integrated Board responsible for delivering business as usual and strategy. Board committees are supported by Executive Delivery Groups (to delivery Strategy) and Executive Management Groups (to deliver operational performance). In turn, these are supported by Tactical Delivery Groups that will provide assurance reports to committees and undertake some of the detailed work for the committee; they will review and produce evidence to enable the Board committee to focus on its priorities during meetings. Tactical Delivery Groups will also be able to undertake and evaluate research to support the board develop strategies.

Figure 4 shows these groups and the assurance & information flows (in tan dotted lines) and reporting lines (in black lines). (See annexes 1-3 for individual committee details)

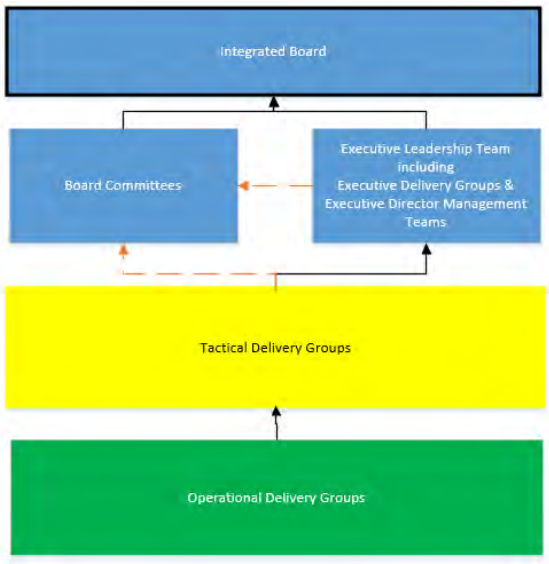


Figure 4 - Board and Executive Groups interface

4.2. Delivery Structure

The Executive Leadership Team heads the delivery arm of the Board in terms of both operational and strategic management. The Executive Leadership Team meets twice-weekly one meeting to focus on strategy the other to focus on operational delivery.The model creates three cross-functional Executive Delivery Groups (EDG) for delivery of strategy. The Executive Delivery Groups are in effect an extension of the Executive Leadership Team, they derive their authority from the Executive

Leadership team and are therefore accountable to the Executive Leadership team. However, they will work closely with Board committees and will provide reports and assurance directly to the Board Committees, for instance the Chair's Assurance Report will be a standing item on Board committee agendas (see section on Cycles of Business). The three EDGs are:

- Executive Delivery Group People and Culture.
- Executive Delivery Group Quality Improvement.
- Executive Deliver Group Transformation and Finance.

Each Delivery group will take on responsibility for co-ordinating and providing Board with evidence based strategic thinking in strategy development and providing evidence based assurance on delivery and impact.

The Delivery Group's responsibilities are configured differently to those of the Board Committees; this is to allow a different focus of challenge from at development and sign off stage.

These groups will drive the transformation agenda. They will ensure that the tactical and operational groups beneath them are functioning effectively (this is to become a standard role for each group wherever it sits in the structure which will enhance the effectiveness of meetings, line of sight from floor to board and support the functioning of the performance and accountability framework). Each Executive Delivery Group Chair will provide a Chairs Assurance Report for the relevant Board committee, which may be shared with other committees for information to support common understanding of strategy delivery across the Board Committees.

To support the Executive Leadership Team and strategic Board Committees there will be a tactical Planning and Strategy Group to coordinate planning, strategy development and alignment of strategic delivery. Time limited groups are in place to deliver on Board operational priorities.

Operational management will be conducted through the Executive Management Groups, which in essence are the current Senior Management Team meetings in each directorate. The purpose of these groups is to provide evidence-based plans for improvement and evidence based assurance on operational delivery and outcomes, the Executive Management Groups will also provide evidence and assurance directly to Board Committees.

This structure will enable the Executive Leadership Team (ELT) to manage and balance its working arrangements in relation to strategic leadership and operational leadership.

The Executive Leadership Team will be responsible for ensuring that there are no "orphaned" groups so a proper governance and reporting structure beneath them for Tactical and Operational delivery. To avoid a renewed meeting culture any new group within the corporate structure will need ELT sign off.

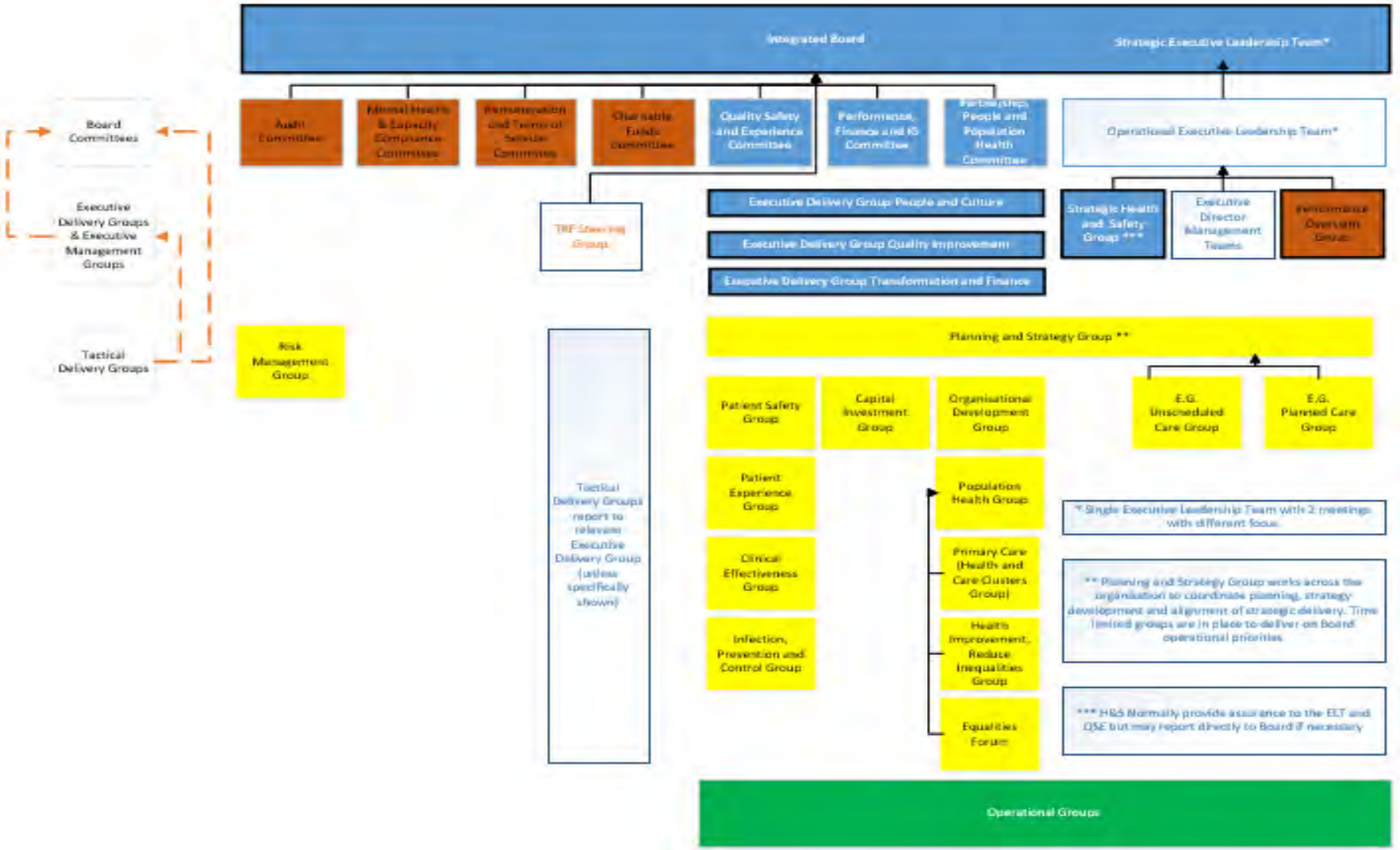


Figure 5 - Integrated Board Schematic

4.2.1. Strategic Tactical and Operational model

The Strategic Tactical and Operational model makes clear the purpose of groups, it limits the number of groups that can be seen as purely for assurance, moves away from groups having a purpose to 'assure' to groups having a purpose to 'deliver'. The evidence of delivery becomes the assurance. This model will be reflected in the Divisions, this structure, together with the Performance and Accountability Framework and the Chair's Assurance Reports starts to give more assurance of action and sight of front line teams to the Board.

4.3. Governance Handbook – ways of working

4.3.1. Cycles of Business

Cycles of business should be used to proactively manage the workload of committees and groups, streamlined to focus committee time to the most appropriate agenda's and comply with committee terms of reference.

Committees will be supported by an executive delivery structure to provide evidence and assurance and do some of the detailed work for the committees. The Cycles of Business are structure to support Board and committees balance their roles in strategy (the future), assurance (the present and learning from the past) while embedding culture. They are designed to cover all the Board and committee business over a year, but to give flexibility through Particular Areas of Concern Reports and the focus of the deep dives.

Innovations introduced in the attached committee cycles of business include:

- Having a patient story at Quality Committee.
- Standard report from the Chair to include feedback from Board.
- Standard report from the Lead Executive to inform members of matters that are important or innovative but would not require a full paper.
- Standard agenda item to receive feedback or notifications from other Board Committees.
- Inclusion of Directorate Operational Reports on a rolling basis to support the committee to get a broader view of activity within the organisation including challenges, celebrations, concerns and commendations and support the floor to board line of sight.
- Rolling Deep Dive Reports to allow meetings to focus on areas of responsibility and not take a shallow view at every meeting.
- Standard agenda item to refer matters to other Board Committees, if appropriate.
- Standard agenda item to review risks highlighted within the meeting and refer to the Risk Management Group if appropriate.
- Standard agenda item to agree items for the Chairs Assurance Report.
- Standard agenda item to review the effectiveness of the meeting.

4.3.1.1. Themes to support the Golden Thread from floor to Board

- Patient Story at Board and QSE Committee. This could be implemented immediately.
- Directorate Reports at Board and committee on a rotational basis covering challenges, celebrations, concerns and commendations. This could be implemented immediately.
- Deep dive into areas programmed across the business year to give a depth of focus in a meeting rather than a shallow overview at every meeting. This could be implemented immediately.
- Report of Lead Executive at committees to make members aware of issues not suitable for a full paper, this could be an oral or written report. This could be implemented immediately.
- Formal process to refer matters to other committees and receive matters from Board. This could be implemented immediately.
- Identification of risks arising within a meeting for referral to the Risk Management Group. This could be implemented immediately.
- Chairs Assurance Reports from relevant groups into committees for assurance and information. This could be implemented immediately.
- Formal reporting (via the lead Executive) from formal partnership arrangements and advisory groups to appropriate committees. This could be implemented immediately.
- Reviews of meeting effectiveness to capture learning and improvement.

4.3.2. Strategy Development and Monitoring

The Corporate Strategy (Living Healthier, Staying Well) is the top-level strategy that sets the direction for the organisation over the next period, a number of other strategies in specific areas will support the Corporate Strategy. Board oversight of the development and delivery of the Corporate Strategy will be via the Partnership, People and Population Health Committee, although other committees will have ownership of their section of the Corporate Strategy notably the Quality Safety and Experience Committee and the Performance, Finance and Information Governance Committee.

As the top-level strategy, the Corporate Strategy should identify the need for strategies for Board ownership (tier 1) and sub-strategies for Board information and committee ownership (tier 2). All strategies should be aligned to a Board Committee for ownership (where a strategy crosses the work of more than one committee the Board shall decide which committee takes primacy over the strategy).

Tier 1 (Board level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy endorse and recommend to Board.
- Once Strategies approved committee will monitor implementation 6-monthly and report to board.

Tier 2 (Committee level strategies)

- Committees to develop strategy in accordance with the Corporate Strategy and any superior strategy and approve and notify Board (through the Chairs Assurance Report).
- Committee will monitor implementation 6-monthly and report to Board (through the Chairs Assurance Report) unless an area of specific concern or recommendation requires a full Board paper

When a strategy is presented to Board or committee, it should have a clear assurance paper attached to demonstrate.

- Audit of engagement.
- Outcome from engagement and consultation with
    - Staff.
    - Patients.
    - Partners.
    - The Public.
- Golden thread from the corporate strategy.
- Equality Impact Assessment.
- Public Sector Equality Duty (including socio-economic duty)

Where a strategy may impact the work of another committee either the Lead Executive or the common Independent Member committee member may refer all or part of a strategy to another committee for review.

4.3.3. Policy development and monitoring

Policies will be defined as

- Polices reserved for Board Approval (to be endorsed by relevant committee).
- Policies reserved for committee approval (to be endorsed by relevant Executive).
- Policies reserved for Executive Approval.

Through the Chairs Assurance Report / Lead Executives report a list of approved policies from the tier below will inform the committee or Board of policies that have been approved for information and challenge (re level of sign off) as appropriate.

4.3.4. Other ways of working

- Coordinated Agendas and Cycles of Business, the future, the present and learning from the past.
- Consistency in use of the Cover Sheets.
- Agenda setting: Independent Member Chair and lead Executive Director should draft the agenda based on the Cycle of Business and noting Particular Area of Concern reports, deep dives, directorate presentations and Chair s Assurance reports from junior Groups. Once the draft agenda is approved by the committee chair it cannot be changed without the express permission of the committee chair.
- Agenda to link risks identified in meetings back to the Risk management Group and have formal information flow between committees.

- Consistent use of Chair's Assurance Reports to parent group for assurance and accountability.
- Consistent Terms of Reference: parent groups responsible for:
    - The governance structures beneath them.
    - Regularly testing the information cascade / escalation.
    - Identifying 'orphaned' groups within their remit.

4.4. Governance in practice – Scenarios

4.4.1. Risk – Primary and triangulation routes

A member of staff in primary care identifies a significant risk. The member of staff discusses the risk with their line manager and raises it on Datix.

- Primary Route – Datix - the risk should then be discussed at team meetings and depending on the risk score will rise to divisional risk meetings through to the Risk Management Group, Executive Leadership Team and relevant Board Committee.
- Route 2 – Performance and Accountability Framework – all performance meetings (throughout the organisation) should discuss risks – not just those currently on the risk register but also emerging risks, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee. A regular meeting is in place between the Performance Team and Risk Team to cross-reference risks that have been reported on Datix and those raised in performance meetings.
- Route 3 – Standard Meeting Practice - risk should be a standard agenda item on all meeting agendas (including the identification of new risks within the meeting (see proposed Board Cycles of Business (annexes 18-20)). Appropriate risks should be included in the Chairs Assurance Report for information or escalation and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered a risk was raised but not escalated this route also provides the evidence trail to better understand and learn why the risk was not escalated.

In principle, this also triple route also applies to incidents.

4.4.2. Floor to Board – Primary and triangulation routes

A member of staff in a hospital identifies an area of innovation or best practice. The member of staff discusses this with their line manager.

- Route 1 – Performance and Accountability Framework – all performance meetings throughout the organisation should discuss items to celebrate and things to be proud of, this route should rise through to the Performance Oversight Group and thereon to Executive Leadership Team and relevant Board Committee.
- Route 2 – Standard Meeting Practice – items to celebrate should be encouraged for discussion on all meeting agendas. Appropriate items should

be included in the Chairs Assurance Report for information and through either line management or strategy delivery route to the appropriate Executive Director, Executive Leadership Team and Board Committee. If it is later discovered best practice was raised but not escalated this route also provides the evidence trail to better understand and learn why it was not shared.

- Route 3 - Board Committee Directorate Operational Reports – these will be designed to support Independent Members gain a more holistic oversight of the challenges, celebrations, concerns and commendations throughout the organisation.

4.5. How does this meet the objectives?

4.5.1. Objective 1: Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability.

By undertaking some of the analytical, research, and evaluation work the committees Executive Delivery Groups and associated Tactical Groups will create space for the Board Committees to balance their agendas. Proactive use of the Cycles of Business, associated agendas and meeting evaluation will highlight the balance of time a committee spends in each area. The quality of the evidential reports provided by Executive Delivery Groups and Executive Management Groups will be key to ensuring the pitch of oversight vs detailed investigation is met. Where aligned, the Executive Delivery Group will take lead responsibility for co-ordinating reporting from Executive Management Groups and Executive Delivery Groups to ensure consistent reporting between the present and the progress along the transformation route.

4.5.2. Objective 2: Develop a greater focus on strategy in committee – delivering for the future.

Incorporating relevant strategies into each committee terms of reference, combined with defining committee responsibilities within the corporate strategy will clarify ownership of strategy; this together with an aligned delivery structure reporting into the committees should provide the framework to appropriate focus on strategy.

4.5.3. Objective 3: Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels.

The effect of consistent use of the Chairs Assurance Reports, together with the strategic, tactical, operational delivery structure and no orphaned groups rule will improve accountability (linked to the Performance and Accountability Framework) and ultimately assurance in that where challenges, celebrations, concerns and commendations are not escalated will be easier to trace back, understand why and learn.

The effective use of cycles of business and committee agendas will also allow for a balance of committee business within the meeting, and across the year to support Independent members to get a deeper understanding of the challenges, celebrations, concerns and commendations within the operational teams.

4.5.4. Objective 4: Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication.

The structure aims to give a clear line of accountability for performance through the Executive Management Groups, supported by the Performance and Accountability Framework and the Performance Oversight Group. Enabling the Chief Executive to hold Executive Directors to account for performance and the Board to hold the Executive Leadership Team to account for performance management. (Also this partly meets objective 4).

4.5.5. Objective 5: Develop greater oversight of the People / Transformation agenda.

Covered within the Terms of Reference for the Partnerships, People and Population Health Committee.

4.5.6. Objective 6: Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

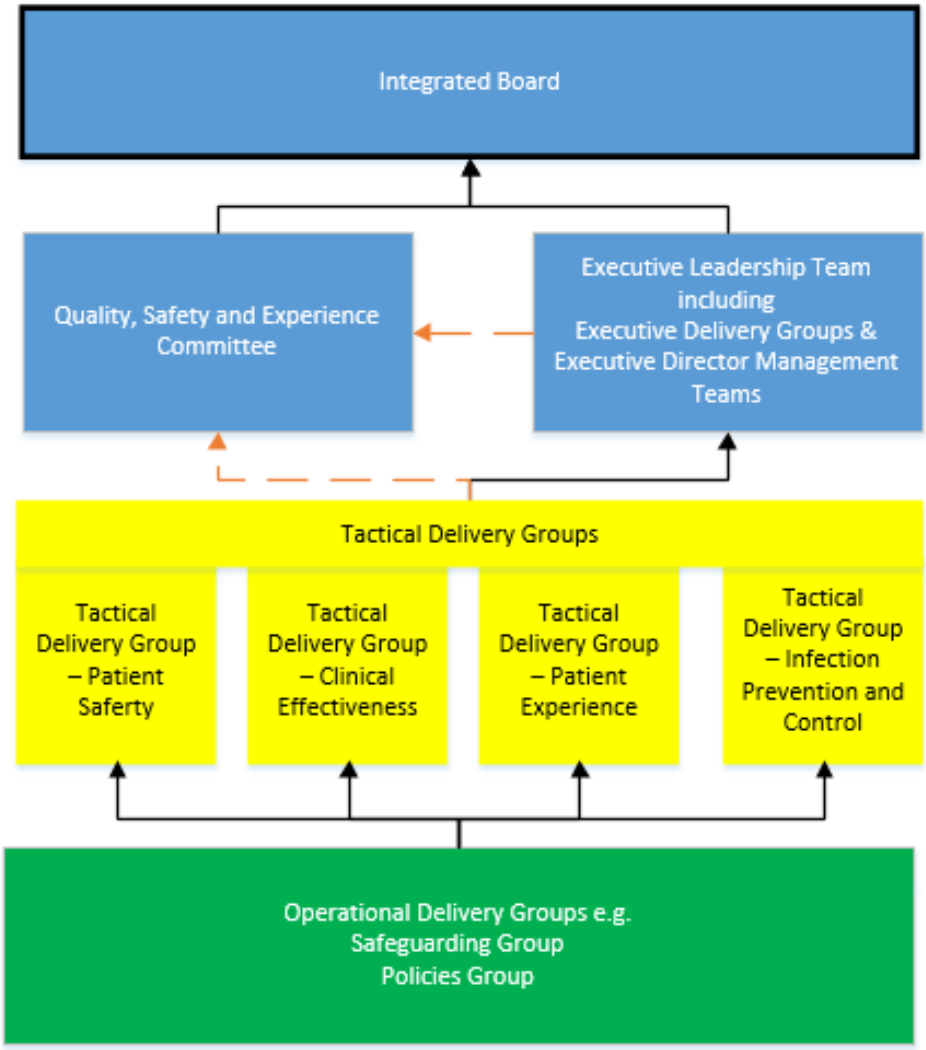
This will be resolved through having clear reporting lines for groups and committees, linked to consistent use of the chairs assurance reports, which will highlight areas of challenges, celebrations, concerns and commendations. Committees and Board will also have the opportunity to hear first-hand from the front line during the programmed directorate reviews within the cycles of business.

5. Indicative Timeline

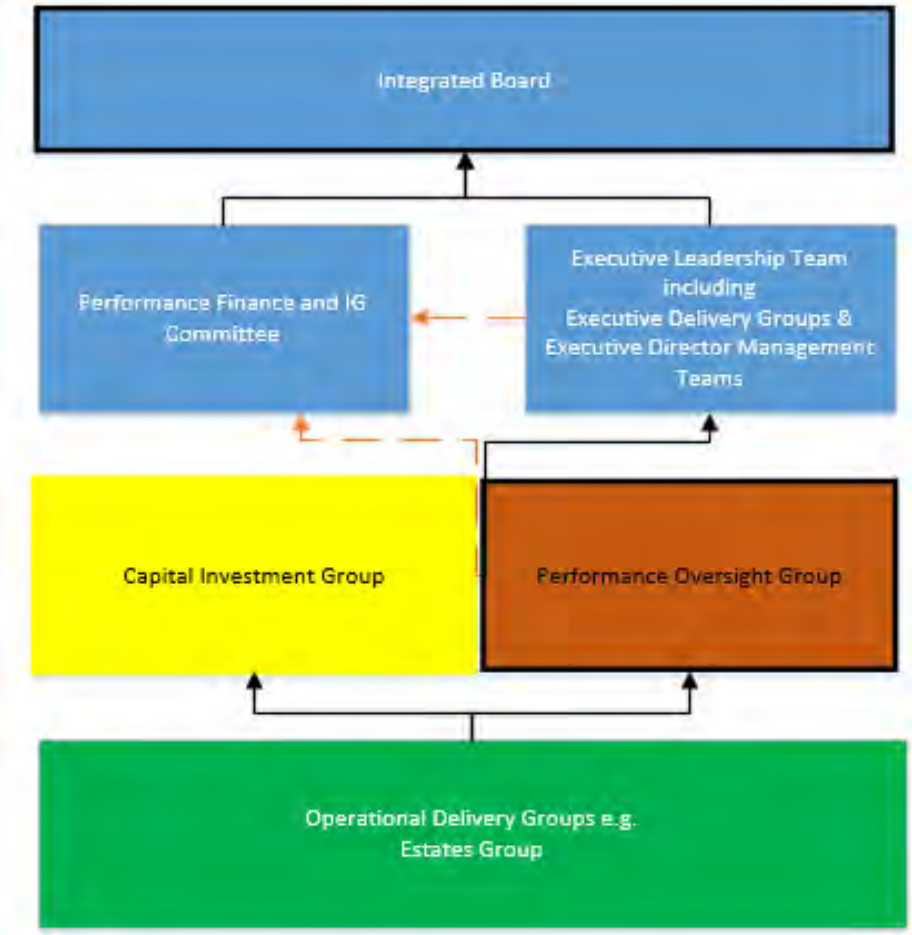
- 20 May 2021 Board Approval in principle
  Full Workup
- 10 June 2021 Audit Committee – Detailed workup approval (SO / ToR etc.)
- 01 September 2021 Implementation

Annexes 1 – 3 Committee support structures

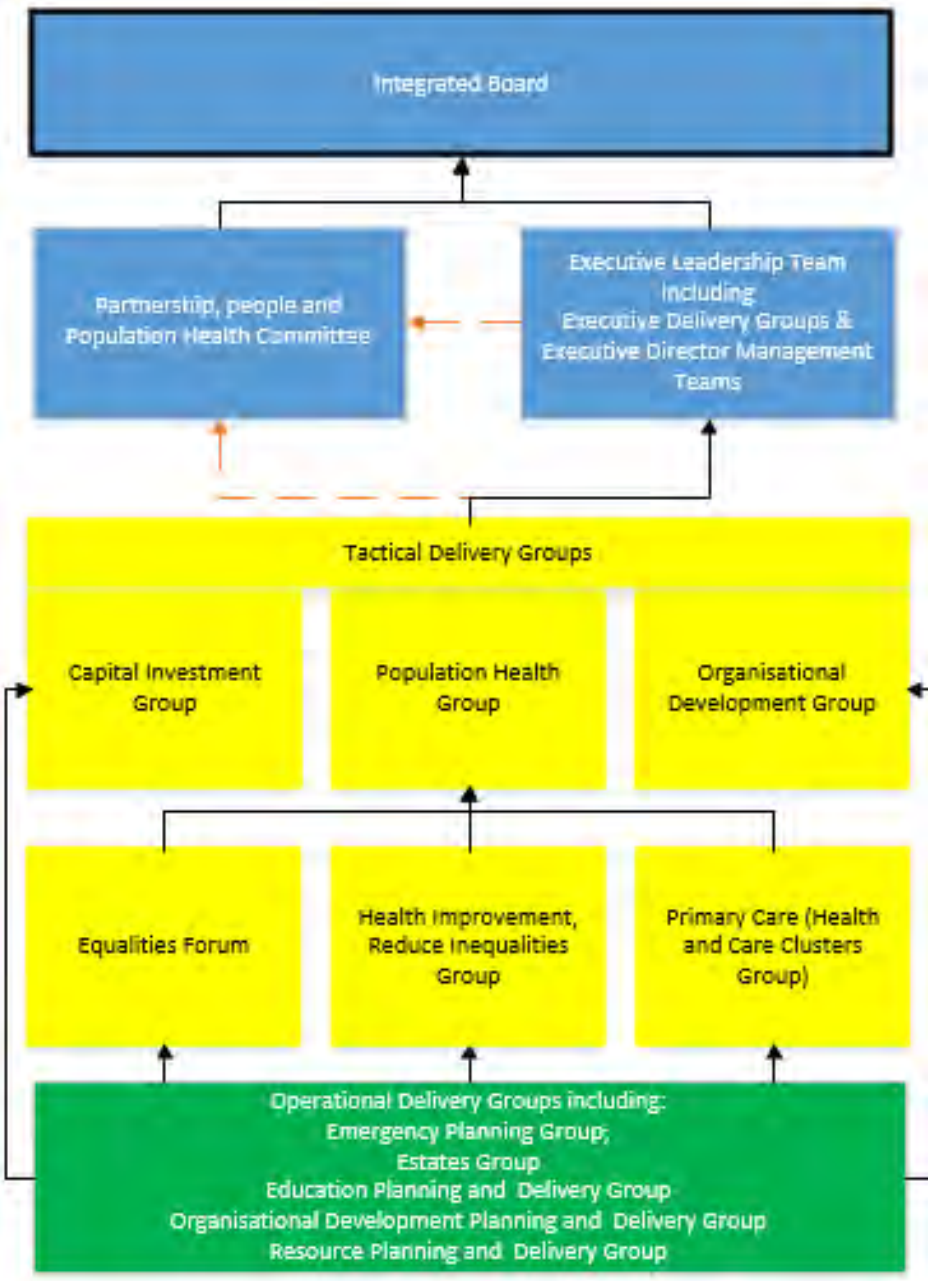
Annex 1 – Quality, Safety and Experience Committee Supporting Structure.



Annex 2 – Performance, Finance and Information Governance Committee Supporting Structure.



Annex 3 – Partnerships, People and Population Health Committee Supporting Structure.



Annexes 4 – 17 Outline Terms of Reference.

Annex 4 - *Commonality – Board Committees.*

Designation	WG requirement – Strategic Board Assurance Committee or BCUHB requirement – Strategic Board Assurance Committee

Purpose	Within the remit of the committee:
	1. Provide evidenced based assurance that there is compliance with:
	    1. The Equalities Act 2010.
	    2. In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
	    3. In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.
	    4.
	    5. The Human Rights Act 1998.
	    6. The United Nations Convention on the Rights of People with Disabilities.
	    7. BCUHB Policy.
	2. Provide evidence based and timely advice to the Board on developing strategies.
	3. Provide evidence based and timely advice to the Board on the delivery of strategies.
	4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.
	5. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.
	        1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient
	6.

Attendance	Board Secretary, by invitation any Executive Director, Chair of the Audit Committee to have a right of attendance

Reports to	Board – Annual report on the work of the committee, plus Chair's Summary Assurance report to the Board following each meeting of the committee
Gains assurance from	Executive Leadership Team, Executive Delivery Groups, Executive Management Groups
Sub-Groups	None

Annex 5 - *Audit Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely advice to the Board and the Accountable Officer on the assurance frameworks to support them in their decision taking and in discharging their accountabilities for securing the achievement of BCUHB's objectives 2. Evidence based assurance to the Board and the Accountable Officer on whether effective arrangements are in place through the operation of the UHB's assurance framework 3. Evidence based assurance to the Board and the Accountable Officer on the effectiveness of Risk Management, Performance Management and other areas as defined by the Board or Accountable officer from time to time
Scope	All activities undertaken, provided or commissioned (clinical and non-clinical) by the Health Board
Membership	4 x Independent Members (one of whom shall be the committee chair)
Attendees	Chief Executive, Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Director of Governance, Head of Internal Audit, Local Counter Fraud Specialist, External Auditor.
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	(i) Risk Management Group

Annex 6 - *Mental Health & Capacity Compliance Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) 2. Provide evidence based assurance to the Board that Hospital Managers' duties under the MHA, the functions and processes of discharge under section 23 under the MHA, the provisions laid out in the MCA and the Measure are all exercised in accordance with statute and that there is compliance with the MHA and Code of Practice for Wales and the MCA Code of Practice and the DoLS Code of Practice and the associated regulations
Scope	All services provided to patients with mental health mental health, wherever the setting.
Membership	3 x Independent Members (one of whom shall be the vice-chair of the Board who shall chair this committee)
Attendees	Executive Director of Public Health (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Primary Care and Community Services, Medical Director for Mental Health, Nurse Director for Mental Health, Director of Mental Health, representatives from Hospital Managers, Service Users, Carers, North Wales Police, Welsh Ambulance Service, IMCA, IMHA, DoLS Manager, MCA Manager.
By invitation	Any Executive Director
Frequency	Bi-monthly
Reporting Group(s)	None

Annex 7 *Charitable Funds Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	BCUHB is the Corporate Trustee of its charitable funds and the Board serves as its agent in the administration of the charitable funds held. 1. Evidenced based and timely advice to the Board and the Accountable Officer in the discharge of its duties for Charitable Funds 2. Discharge delegated responsibility from the corporate Trustee for the control and management of Charitable Funds 3. Evidence based assurance to the Board and the Accountable Officer on compliance with Trustee Act 200, The Charities Acts 1993, 1996, 2011 & 2016, and the Terms of the Funds' Governing arrangements
Scope	Administration of all existing charitable funds, fundraising, priorities and spending criteria
Membership	3 x Independent Members (one of whom shall be the committee chair) and Executive Director of Finance (Lead), Executive Director of Planning and Performance, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Attendees	Head of Financial Services, Charitable Funds Accountant, Charitable Funds Fundraising Manager, Investment Advisor
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 8 *Remuneration and Terms of Service Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidenced based and timely advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; 2. Evidence based assurance to the Board and the Accountable Officer in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales
Scope	All employment contracts entered into by BCUHB, additional payments (e.g. redundancy, retention), professional registrations
Membership	4 x Independent Members (one of whom shall be the committee chair) and one of whom shall be the Chair of the Audit Committee. A Trade Union Partner Chair of the Local Partnership Forum will attend at meetings held in public as an ex-officio member.
Attendees	Chief Executive, Executive Director of Workforce and Organisational Development (Lead), Executive Medical Director
By invitation	Any Executive Director
Frequency	Quarterly
Reporting Group(s)	None

Annex 9 *Quality, Safety and Experience Committee.*

Designation	WG requirement – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on quality, safety & experience of Health Services 2. Evidence based and timely advice to the Board on quality, safety & experience of public health, health promotion and health protection 3. Evidence based assurance on safeguarding and improving the quality the quality and safety of patient and citizen centred health 4. Evidenced based assurance to the Board on improving patient, care and citizen experience, including services deliver by partnership 5. Development and oversight of patient related strategies including quality, clinical effectiveness, patient safety and patient experience
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Medical Director, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director of Primary Care and Community Services, Assistant Director of Patient Safety and Quality, Assistant Director of Patient Experience. Associate Director of Quality Assurance Director of Mental Health & Learning Disabilities. Senior Associate Medical Director. Chair of Healthcare Professionals Forum. Associate Board Member Representative of Community Health Council.
By invitation	A patient representative, a staff representative, Executive Director of Planning and Performance.
Frequency	Bi-monthly
Reporting Group(s)	(i) Executive Delivery Group for Quality Improvement (ii) Clinical Effectiveness Group; (iii) Patient Experience Group; (iv) Patient Safety Group; (v) Health and Safety Group

Annex 10 *Performance, Finance and IG Committee.*

Designation	IG is WG requirement other functions BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on the financial performance of the Health Board and developing the IMTP 2. Evidence based and timely advice to the Board on operational performance of the Hearth Board and associated Impact Improvement Plans 3. Evidence based assurance on the financial position, forecasting, and the capital programme 4. Evidence based assurance to the Board and accountable officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management 5. Development and oversight of finance and performance related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Director of Finance, (Lead), Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Planning and Performance, Executive Medical Director
By invitation	A patient representative, a staff representative,
Frequency	Bi-monthly
Reporting Group(s)	(i) Capital Investment Group

Annex 11 Partnerships, People and Population Health Committee.

Designation	BCUHB Discretion – Strategic Board Assurance Committee
Purpose	1. Evidence based and timely advice to the Board on our staff and potential staff matters 2. Evidence based and timely advice to the Board on population health outcomes and prevention strategies 3. Evidence based assurance on transformation capacity, delivery and planning 4. Evidenced based assurance to the Board on corporate strategy delivery improving outcomes for citizens, including services deliver by partnership 5. Development and oversight key enabling strategies of people, transformation and digital related strategies
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	3 x Independent Members (one of whom shall be the committee chair)
Attendees	Executive Director of Planning and Performance (Lead), Executive Director of Workforce and OD, Executive Medical Director, Executive Director of Nursing and Midwifery/Deputy Chief Executive, Executive Director of Therapies and Health Sciences, Executive Director of Public Health, Executive Director Primary and Community Services .
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Bi-monthly
Reporting Group(s)	(i) Population Health Group (including Equalities Forum / Health Improvement Reduce Health Inequalities Group / Primary Care (Health and Care Clusters Group): (ii) Organisational Development Group

Annex 12 *Executive Leadership Team Meeting.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	The executive decision making group of the organisation: 1. Ensuring the effective operational co-ordination of all organisational functions, and supporting the Chief Executive to discharge the responsibilities delegated to the Accountable Officer. 2. Provide evidenced based assurance to the Board that there is compliance with 1. The Equalities Act 2010 2. The Human Rights Act 1998 3. The United Nations Convention on the Rights of People with Disabilities 4. BCUHB Policy 3. To provide evidence based advice and assurance concerning all aspects of setting and delivering the strategic direction for the Board, the delivery of its associated strategies, plans the delivery of national requirements and the quality of services, performance and financial management, and associated operational planning and delivery of the Health Board; 4. To support and advise the Board and its Committees in exercising its key functions; 5. To ensure effective operational management of the Health Board, enabling critical issues to be anticipated, discussed, action plans agreed and that there is appropriate integration, connection and liaison between individual services, clinical and corporate functions and between strategic and operational matters; 6. To ensure the organisation remains fit for purpose by continuously reviewing effectiveness and efficiency of the organisational structure and support functions; 7. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
Attendance	All Executive Directors, the Board Secretary
Reports to	Board
Gains assurance from	Executive Leadership Team members and sub groups
Sub-Groups	(i) Executive Delivery Group - People and Culture,

	(ii) Executive Delivery Group - Transformation & Finance (iii) Executive Delivery Group - Quality Improvement, (iv) Performance Oversight Group, (v) Strategic Health and Safety Group (vi) Risk Management Group

Annex 13 *Commonality – Executive Delivery Groups.*

Designation	BCUHB requirement – Strategic Delivery Group

Purpose	Within the remit of the committee:
	1. **Oversight of delivering the board strategy form current state to future state**
	2. Provide evidenced based assurance to the Executive Leadership Team that there is compliance with
	  1. The Human Rights Act 1998
	  2. The United Nations Convention on the Rights of People with Disabilities
	  3. BCUHB Policy
	3. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sections of the Corporate Strategy
	4. Provide evidence based and timely advice to the Executive Leadership Team on developing, implementation, monitoring, and impact of relevant sub-strategies
	5. Oversee and provide evidence based and timely advice to the Executive Leadership Team on relevant Risks including BAF Risks
	6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant provide the Executive Leadership Team with evidence based impact assessment of the implementation of the recommendations
	7. Approve or endorse relevant policies

Attendance	TBA
Reports to	Executive Leadership Team (ELT) –Chair's Summary Assurance report to ELT following each meeting of the Group
Accountable to	Executive Leadership Team,
Provides evidence	Provide assurance reports to the Board Committees

Annex 14 *Executive Delivery Group People and Culture.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Health and Safety, Equality, Education, Organisational Development and resource planning 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Workforce and OD Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Workforce and Organisational Development (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, Planning
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Health & Safety (ii) Equalities (iii) Education (iv) Organisational Development (v) resources (vi) Secondary Care (vii) Mental Health (viii) Community & Primary Care

Annex 15 *Executive Delivery Group Transformation & Planning.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Transformation Programmes, Financial Sustainability Planning and Capital 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function and performance metrics of the Finance Directorate and the Strategy and Planning Directorate 4. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group. 5. Prime responsibility to develop the corporate strategy and IMTP plans 6. Evaluation of the impact of the strategy on public health and prevention 7. Innovation and the Digital Agenda
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Strategy and Planning (Chair), 1 other Executive Director, Chair of Each Tactical Sub Group, Senior representatives from Nursing, Medical, Therapies, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Capital Investment (ii) Transformation Oversight (a) Planned Care) (b) Unscheduled Care (c) Mental Health (iii) Planning Oversight (a) Civil Contingencies (iv) Digital Driver

Annex 16 *Executive Delivery Group Quality Improvement.*

Designation	BCUHB requirement – Strategic Delivery Group
Purpose	1. Strategy development, implementation, monitoring and evaluation within TOR 2. Development and oversight of Clinical Effectiveness, Patient Experience and Patient Safety 3. Addressing relevant concerns from the Performance Oversight group in relation to the operational function & performance metrics of the Nursing, Medical and Therapies Directorates 4. Provide evidence based assurance and advice to the Executive Leadership Team in relation to safeguarding 5. Provide evidence based assurance and advice to the Executive Leadership Team to ensure effective governance arrangements are in place to enable the cascade and escalation of issues pertinent to the purpose of this group.
Scope	All services provided or commissioned by the Health Board, including acute, community, primary care, and mental health services
Membership	Executive Director of Nursing (Chair), Executive Medical Director, Executive Director of Therapies and Health Sciences, Chair of Each Tactical Sub Group, Senior representatives from, PH, Finance, WOD
Attendees	TBA
By invitation	A patient representative, a staff representative, any other Executive Director
Frequency	Monthly or 6 weekly
Sub-Groups	(i) Patient Experience (ii) Clinical Effectiveness (iii) Patient Experience

Annexes 17-20 Draft Cycles of Business

Annex 17 - DRAFT Health Board CYCLE OF BUSINESS / Information flow

Agenda Items	**Notes**	**Committee**	**May**	**July**	**July AGM**	**Sep**	**Nov**	**Jan**	**Mar**
Patient Story						✓	✓	✓	✓
Governance									
Minutes of previous meeting			✓	✓	✓	✓	✓	✓	✓
Review of action log			✓	✓	✓	✓	✓	✓	✓
Declarations of Interest			✓	✓	✓	✓	✓	✓	✓
Ratify Chair's Actions			✓	✓	✓	✓	✓	✓	✓
Report of the Chief Executive			✓	✓	✓	✓	✓	✓	✓
Minutes of All Wales Committee meetings: Welsh Health Specialised Services Committee (WHSSC) Emergency Ambulance Services Committee (EASC)	*Via CEO report*		✓	✓		✓	✓	✓	✓

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
NHS Wales Shared Services Partnership (NWSSP) NHS Wales Collaborative Leadership Forum (CLF)									
Chair's Assurance Reports from Committees and Advisory Groups		All	✓	✓		✓	✓	✓	✓
Committee and Advisory Group Annual Reports		All	✓	✓		✓	✓	✓	✓
Maintaining Good Governance during Covid 19			✓			✓		✓	
Minutes of Annual General Meeting (AGM)						✓			

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
Audit Wales Structured Assessment								✓	
Audit Wales Annual Audit Report/ Letter								✓	
Review of Standing Orders/ SFIs									✓
Annual Consultations Summary						✓			
Annual Review of Business Cycle									✓
Annual Report, Accounts inc. Annual Governance Statement and Annual Quality Statement		AC	✓ to request delegated authority to AC		✓				
Charitable funds audited accounts and annual report	*Requirement under Charities Act*	CFC						✓	

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
Agency & Locum Deployment in Wales (reporting TBC)	*WG requirement WHC2017/042*								
Approved Clinicians and Section 12(2) Doctors	*WG requirement* *NB – Chair's Action will be taken to ensure more timely approvals following Internal audit recommendation March 2021*	MHAC	✓	✓		✓	✓	✓	✓
Documents signed under seal	*WG requirement as set out in SOs*	-		✓				✓	
Delivering the Strategy/ Strategic items									
Finance report		F&P *(PFIG)*	✓	✓		✓	✓	✓	✓
Annual Plan/ Finance Strategy/ IMTP	*WG requirement*	F&P *(PFIG)*		✓				✓	
Monitoring the delivery of the Annual Plan			✓	✓		✓	✓	✓	✓
Living Healthier, Staying Well Strategy refresh		SPPH*(PPPH)*					✓		

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
Tier 1 Strategies for approval (as defined in LHSW strategy)			✓	✓	✓		✓	✓	✓
Winter planning/ seasonal plan						✓			
Equality & HR Annual report inc Strategic Equality Plan progress	*WG requirement*	QSE / SPPH*(PPPH)*		✓					
Quality, Safety and Performance- Delivering the present									
Board Assurance Framework (principal risks)		All		✓				✓	
Corporate Risk Register	*WG requirement*	All		✓				✓	
Civil contingency and business continuity update (via SPPH Chair's report)	*WG requirement*	SPPH *(PPPH)*		✓					
Director of Public Health Annual Report	*WG requirement*	SPPH *(PPPH)*					✓		

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
Funded Nursing Care Inflationary Uplift	*Comes through All Wales CEOs for Board decision*								✓
Health and Safety Annual Report	*Statutory requirement (HSE regulations)*	QSE		✓					
Health Care Inspectorate Wales (HIW) reports (as appropriate)	*WG requirement*	QSE	✓	✓		✓	✓	✓	✓
Infection Prevention and Control reports	*WG requirement*	QSE	Annual report				✓		
Medicines Management	*Requirement of national WAO Audit into medicines management*	QSE							✓
Nurse Staffing	*Nurse Staffing Act requirement*	QSE	✓						
Primary Care Updates	*Advice from All Wales Board Secretaries and WG that regular*	QSE	✓				✓		

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
	reports should be taken								
Prison Health Annual Report *(via QSE Chair's Report)*		QSE					✓		
Putting Things Right Annual Report (incorporating link to Ombudsman Annual Report)	*WG/Ombudsman requirement*	QSE		✓					
Quality & Performance Report	*WG requirements*	QSE/ F&P*(PFIG)*	✓	✓		✓	✓	✓	✓
Research & Development update report		SPPH *(PPPH)*					✓		
Risk Management Strategy	*WG requirement*	A		✓					
Safeguarding Annual Report *(via QSE Chair's Report)*	*WG requirement*	QSE		✓					
Staff Survey		SPPH		✓					

Agenda Items	Notes	Committee	May	July	July AGM	Sep	Nov	Jan	Mar
		(PPPH)							
Targeted Intervention for Improvement Framework Steering Group Progress Reports and Self-Assessment	*WG requirements*		✓	✓		✓	✓	✓	✓
Tissue and Organ Donation Annual Report *(via QSE Chair's Report)*		QSE					✓		
University status of the Health Board	*WG requirement every 3 years (due in 2021)*					✓			
Vascular Services update	*Agreed monthly update for 21/22*	QSE	✓	✓	✓	✓	✓	✓	✓
Well-being of Future Generations Act	*WG requirement*	SPPH *(PPPH)*			✓ as part of corporate annual report				
Welsh Language Annual Monitoring Report	*WL Commissioner requirements*	SPPH *(PPPH)*				✓			

Key:

A	Audit Committee
CFC	Charitable Funds Committee
F&P/ (PFIG)	Finance and Performance Committee/ *Performance, Finance and Information Governance Committee – post governance review)*
DIG	Digital Information and Governance Committee
MHAC	Mental Health Act Committee
PoD	Power of Discharge Sub-Committee
R&TS	Remuneration and Terms of Service Committee
SPPH	Strategy, Partnerships and Population Health Committee / *(PPPH- post governance review)*
QSE	Quality, Safety and Experience Committee

Annex 18 - DRAFT Performance, Finance and Information Governance CYCLE OF BUSINESS / Information flow.

Also meets in January and March specifically to consider the annual plan.

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Governance						
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Annual Financial Plan	ToR					✓
Corporate Strategy - Financial						
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Financial aspects of corporate strategy • Financial Aspects of IMTP • Financial / Sustainability Strategy • Information Governance Strategy						✓
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Estates • Environmental • Performance Management Framework • Decarbonisation Strategy				✓	✓ ✓ ✓	
Monitoring Existing Strategies or plans						
Corporate Strategy (Financial Monitoring Report)						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy • Financial aspects of corporate strategy • Financial Aspects of IMTP					✓	

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
• Financial / Sustainability Strategy • Information Governance Strategy						
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Estates • Environmental • Performance Management Framework • De-carbonisation Strategy	✓			✓	✓ ✓ ✓	
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Financial Instructions						✓
Annual Capital Programme	✓					
Transforming Services - Outcomes • Mental Health • Planned Care • Primary and Community Care • Unscheduled Care	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Recommendations from the Primary Care Panel to take on new GP practices	#	#	#	#	#	#
Quality Safety and Performance – The Present (for Assurance)						
Board Assurance Framework		✓			✓	
Corporate Risk Register		✓			✓	
Finance Report (including workforce cost report)						
Divisional Operational Finance Reports • Finance • Mental Health • Primary and Community Care (including Therapies) • Public Health • Secondary Care (including North Wales Managed Services) • Strategy and Planning • Women's and Children's • Workforce and OD	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Integrated Performance Report (incorporating seeing services from the front line) • Finance • Performance	✓	✓	✓	✓	✓	✓
Report from Performance Oversight Group	✓	✓	✓	✓	✓	✓
Financial Planning process						✓
Capital Programme Monitoring Report			✓			✓
External Contracts Assurance Report	✓			✓		
Shared Services Partnership Assurance Report		✓			✓	
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Welsh Government Monthly Monitoring Return	✓	✓	✓	✓	✓	✓
Capital and Estates Business Cases	#	#	#	#	#	#
Benefits Realisation Gateway Reviews	#	#	#	#	#	#
Medical Locum Doctors including Junior Doctors rota, medical and dental agency locums report	#	#	#	#	#	#
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Relevant Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports / Lead Executive Triple A Report						
Chairs Assurance Reports (for assurance) • Executive Delivery Group – Transformation and Finance • Capital Investment Group • Performance Oversight Group	✓	✓	✓	✓	✓	✓
Chairs Assurance Reports (for information) • Executive Delivery Group – People and Culture • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Other						
Annual Work plan						✓
						✓
						✓
Closing Business						

Agenda item	Apr	Jun	Aug	Oct	Dec	Feb
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 19 DRAFT PPPH CYCLE OF BUSINESS / Information flow.

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Opening Business						
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Corporate Strategy	✓	✓				
Tier 1 Strategies for Board Approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • IMTP • Transformation (TBC) • Digital • Partnership (TBC) • Organisational Development	✓	✓	✓ ✓ ✓	✓		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Recruitment and Retention (TBC) • Equalities • Third sector engagement strategy (TBC)					✓	
Monitoring Existing Strategies or plans						
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • IMTP • Transformation • Digital • Partnership • Organisational Development	✓ ✓	✓	✓ ✓ ✓	✓ ✓	✓	✓ ✓ ✓
Monitoring Tier 2 Strategies for committee approval – as defined in the corporate strategy) • Recruitment and Retention • Equalities	✓	✓		✓	✓	

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Other						
Endorse relevant policies reserved for Board approval	#	#	#	#	#	#
Agree relevant polices reserved for committee approval	#	#	#	#	#	#
Policy status update including relevant policies reserved for Executive approval			✓			✓
Staff Survey						
Winter Plan			✓	✓		
Major Incident Plan / Civil Contingencies Act		✓			✓	
Regional Partnership Board	✓			✓		
Partners Strategy Presentations	#	#	#	#	#	#
Quality Safety and Performance – The Present						
Board Assurance Framework related to committee	✓			✓		
Corporate Risk Register	✓			✓		
Directorate Operational Reports (incorporating seeing services from the front line) • **Public Health (Including Adverse Child Experience, Smoking Cessation, Healthy Lives, Well North Wales Inequalities, Alcohol Use, Vulnerable Groups)** • **Workforce and OD** • **Strategy and Planning** • **Population Health (including Primary Care Clusters, Health Inequalities, and Public Sector Equality Duty)**	✓	✓ ✓	✓	✓	✓ ✓	✓
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Staff Survey and quarterly Pulse Reports		✓	✓		✓	✓
Workforce Report		✓			✓	
Population Health Report			✓			✓
Freedom to Speak Up Guardian Report	✓			✓		
Corporate Health at Work	✓			✓		
IMTP - Annual Plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015)		✓			✓	✓
Welsh Language			✓			✓
Partnership Governance Arrangements	✓			✓		
Test and Trace Programme Update (short life)	✓	✓	✓	✓	✓	✓

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Consultations and Engagement Outcomes Report		✓			✓	
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Community Health Council Annual Report		✓				
Equality Annual Report		✓				
Workforce Annual Report		✓				
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Public Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports / Lead Executive Triple A Report						
Chairs Assurance Reports from Strategic and Tactical Delivery Groups (for assurance) • Executive Delivery Group – People and Culture • Executive Delivery Group – Transformation and Finance • Population Health Group • Capital Investment Group	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
Chairs Assurance Reports (for information) • Executive Delivery Group - Quality Improvement	✓	✓	✓	✓	✓	✓
Partnership Meetings • Regional Partnership Board • Public Service Board – Gwynedd and Anglesey • Public Service Board – Flintshire • Public Service Board – Wrexham and Denbighshire • Public Service Board – Conwy • Together for Mental Health Partnership Board • Mid Wales Collaborative Agreement	✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓	✓ ✓ ✓	 ✓ ✓	 ✓ ✓ ✓
Other						
Closing Business						

Agenda item	Apr	June	Aug	Oct	Dec	Feb
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Annex 20 DRAFT Quality, Safety and Experience Committee CYCLE OF BUSINESS / Information flow.

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Opening Business						
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Apologies	✓	✓	✓	✓	✓	✓
Declaration of Interests	✓	✓	✓	✓	✓	✓
Minutes from previous meeting	✓	✓	✓	✓	✓	✓
Matters Arising & Table of Actions	✓	✓	✓	✓	✓	✓
Report of the Chair • Chair's Action • **Feedback from Board**	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Report of the Lead Executive	✓	✓	✓	✓	✓	✓
Notification of Matters referred from other Board Committees on this or future agendas	#	#	#	#	#	#
Strategic Items for Decision – The Future						
Developing New Strategies or Plans						
Quality Elements of the Corporate Plan		✓	✓	✓		
Tier 1 Strategies for Board – to be defined in the corporate strategy (Living Healthier, Staying Well) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy			✓ ✓	 ✓ ✓		
Tier 2 Strategies for committee approval – to be defined in the corporate strategy (Living Healthier, Staying Well) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy		 ✓	 ✓	✓ ✓ ✓		
Agree Quality aspects of IMTP • Agree Annual Quality Plan - The Health and Social Care (Quality Engagement) (Wales) Act	✓ ✓					
Monitoring Existing Strategies or plans						
Corporate Strategy (Quality Monitoring Report)	Board		✓			✓
Quality aspects of IMTP • Annual Plan		✓ ✓		✓ ✓		✓ ✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
Monitoring Tier 1 Strategies on behalf of the Board – as defined in the corporate strategy) • Quality Improvement Strategy • Clinical Strategy • Engagement Strategy • Health and Safety Strategy	 ✓ ✓		 ✓ ✓	 ✓ ✓		 ✓ ✓
Monitoring Tier 2 Strategies for committee Approval – as defined in the corporate strategy) • Patient Experience Strategy • Safeguarding Strategy • Carers Strategy • Dementia Strategy • Mental Health Strategy	 ✓ ✓ ✓	 ✓	 ✓	 ✓ ✓ ✓	 ✓	 ✓
Other						
Endorse Quality Policies reserved for Board approval	#	#	#	#	#	#
Agree Quality Polices reserved for QSE approval	#	#	#	#	#	#
Policy status update including policies relevant reserved for Executive approval			✓			✓
Quality Safety and Performance – The Present						
Board Assurance Framework (relevant to QSE)		✓			✓	
Corporate Risk Register (relevant to QSE)	✓	✓	✓	✓	✓	✓
Directorate Operational Reports (incorporating seeing services from the front line) • **Mental Health** • **Primary and Community Care (including Continuing Health Care & Therapies)** • **Public Health** • **Secondary Care (Including North Wales Managed Services)** • **Women's and Children's**	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓	 ✓ ✓
Integrated Performance Report (incorporating seeing services from the front line) • Quality (including numbers of incidents)	✓	✓	✓	✓	✓	✓
Deep Dive reports • **Clinical Effectiveness (including Clinical Audit)**	✓		✓		✓	

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• **Patient Safety (including learning from incidents)** • **Patient Experience** • **Health and Safety** • **Safer Staffing**	✓	 ✓ ✓ ✓	✓	 ✓ ✓	✓ ✓	 ✓ ✓
Quality in partner or commissioned services • Welsh Health Specialised Services • Welsh Ambulance Services • Care Homes		✓		✓		✓
Prevention • Annual Flu planning and implementation • Immunisation report	✓ ✓			✓ ✓		
Assurance reports on Particular Areas of Concern – time limited	#	#	#	#	#	#
Annual Reports						
Committee Annual Report to Audit Committee	✓					
Review Committee Terms of Reference	✓					
Quality Annual Report		✓				
Putting things Right Annual Report		✓				
Safeguarding Annual Report			✓			
Infection Prevention and Control Annual Report			✓			
Accessible Healthcare Annual Report				✓		
Radiation Protection Annual Report				✓		
Tissue and Organ Donation Annual Report				✓		
Learning from – The Past						
Independent Assurance Reviews	#	#	#	#	#	#
Internal Assurance Reviews	#	#	#	#	#	#
Quality Improvement Team Annual Report	#	#	#	#	#	#
Health Inspectorate Wales Reports	#	#	#	#	#	#
Health Inspectorate Wales Annual BCU report			✓			
Public Ombudsman reports	#	#	#	#	#	#
Chairs Assurance Reports						
Chairs Assurance Reports from Strategic and Tactical Delivery Groups (for assurance) • Executive Delivery Group - Quality Improvement	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓

Agenda item	Mar	May	Jul	Sep	Nov	Jan
• Patient Safety • Clinical Effectiveness Group • Health and Safety Group • Patient Experience Group	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Chairs Assurance Reports (for information) • Executive Delivery Group – Transformation and Finance • Executive Delivery Group – People and Culture	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓
Partnership meetings (for information) • Regional Partnership Board		✓			✓	
Advisory Groups (for information) • Health Care Professionals Forum • Local Partnership Forum • Stakeholder Reference Group	✓	✓	✓	✓	✓	✓
Other						
Closing Business						
Agree Items for referral to Board / Other committees	✓	✓	✓	✓	✓	✓
Review of Risks highlighted in the meeting for referral to Risk Management Group	✓	✓	✓	✓	✓	✓
Agree items for Chairs Assurance Report	✓	✓	✓	✓	✓	✓
Review of Meeting Effectiveness	✓	✓	✓	✓	✓	✓

Audit Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Audit Committee. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the 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) to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Boards objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its assurance framework may be strengthened and developed further.

3. DELEGATED POWERS

3.1. The Audit Committee is required by the Board, within the remit of the Committee to:

3.1.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.2. Provide evidence based and timely advice to the Board on developing strategies.

3.1.3. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to risk management.

3.1.4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.5. Provide relevant evidence based and timely advice to the Board on:

3.1.5.1. Evidenced based and timely advice to the Board and the Accountable Officer on the assurance frameworks to support them in their decision taking and in discharging their accountabilities for securing the achievement of BCUHB's objectives.

3.1.5.2. Evidence based assurance to the Board and the Accountable Officer on whether effective arrangements are in place through the operation of the BCUHB's assurance framework.

3.1.5.3. Evidence based assurance to the Board and the Accountable Officer on the effectiveness of Risk Management, Performance Management and other areas as defined by the Board or Accountable officer from time to time.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Audit Committee is authorised by the Board to:

3.2.1. Comment specifically in its Annual Report upon the adequacy of the Health Board's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical). It is also intended to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement and the Annual Quality statement, providing reasonable assurance on:

3.2.1.1. the organisation's ability to achieve its objectives;

3.2.1.2. compliance with relevant regulatory requirements, standards, quality and delivery requirements and other directions and requirements set by the Welsh Government and others;

3.2.1.3. the reliability, integrity, safety and security of the information collected and used by the organisation;

3.2.1.4. the efficiency, effectiveness and economic use of resources; and

3.2.1.5. the extent to which the organisation safeguards and protects all its assets, including its people.

3.2.2. Ensure the provision of effective governance by reviewing

3.2.2.1. the Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

3.2.2.2. the effectiveness of the Board's Committees

3.2.2.3. the accounting policies, the accounts, and the annual report of the organisation (as specified in the Manual for Accounts as issued by Welsh Government), including the process for review of the accounts prior to submission for audit, levels of errors identified, the ISA260 Report and with Management's letter of representation to the external auditors;

3.2.2.4. the, Annual Audit Report and Structured Assessment

3.2.2.5. financial conformance and the Schedule of Losses and Compensation;

3.2.2.6. the planned activity and results of both internal and external audit, clinical audit, the Local Counter Fraud Specialist and post payment verification work (including strategies, annual work plans and annual reports);

3.2.2.7. the adequacy of executive and managements responses to issues identified by audit, inspection, external reports and other assurance activity;

3.2.2.8. proposals for accessing Internal Audit services via Shared Service arrangements (where appropriate);

3.2.2.9. anti fraud policies, whistle-blowing processes and arrangements for special investigations; and

3.2.2.10. any particular matter or issue upon which the Board or the Accountable Officer may seek advice.

3.3. The Committee will support the Board with regard to its responsibilities for risk and internal control by reviewing:

3.3.1. the adequacy of the Board Assurance Framework and Corporate Risk Register;

3.3.2. all risk and control related disclosure statements, in particular the Annual Governance Statement and the Annual Quality Statement

together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

3.3.3. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

3.3.4. the policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements, including declarations of interest and gifts and hospitality; and

3.3.5. the policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the Counter Fraud and Security Management Service;

3.3.6. regular tender waiver reports to ensure compliance with the Standing Financial Instructions.

3.4. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions. It will also seek reports and assurances from directors and managers as appropriate in response to the recommendations made, monitoring progress via the Audit Tracker tool.

3.5. This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

3.5.1. the comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Health Board's activities, both clinical and non clinical; and

3.5.2. the reliability and integrity of these assurances.

3.6. To achieve this, the Committees programme of work will be designed to provide assurance that:

3.6.1. There is an effective Internal Audit function that meets the standards set for the provision of Internal Audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

3.6.2. there is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

3.6.3. work with the Quality, Safety and Experience Committee to ensure that there is an effective clinical audit and quality improvement function that

meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer;

3.6.4. there are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees;

3.6.5. the work carried out by key sources of external assurance, in particular, but not limited to the Health Board's External Auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

3.6.6. the work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

3.6.7. the systems for financial reporting to the Board, including those of budgetary control, are effective; and that the results of audit and assurance work specific to the Health Board, and the implications of the findings of wider audit and assurance activity relevant to the Health Board's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

4. AUTHORITY

4.1. The Head of Internal Audit, the Auditor General and his representatives and the lead Local Counter Fraud Specialist (LCFS) shall have unrestricted and confidential access to the Chair of the Audit Committee and vice versa.

4.2. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

4.2.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

4.2.2. Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.3. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.4. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business.

4.5. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. **Members**

6.1.1. Four Independent Members of the Board to include a member of the Quality, Safety and Experience Committee.

6.1.2. The Chair of the Health Board shall not be a member of the Audit Committee.

6.2. **In attendance**

- Board Secretary (Lead Director).
- Executive Director of Finance
- Chief Executive.
- Deputy Chief Executive/Executive Director of Nursing and Midwifery.
- Director/Head of Governance
- Head of Internal Audit.
- Head/individual responsible for Clinical Audit.
- Local Counter Fraud Specialist.
- Representative of Auditor General (External Audit).

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.

6.4. **By Invitation**

- A patient representative.
- A staff representative.

6.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the

Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors/Board Secretray will also attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held quarterly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

7.4.2. The Committee will meet with Internal and External Auditors and the nominated LCFS without the presence of officials on at least one occasion each year.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

8.5.1.1. Risk Management Group.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Committee shall provide a written annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement and the Annual Quality Statement, specifically commenting on the adequacy of the assurance framework, the extent to which risk management is comprehensively embedded throughout the organisation, integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

9.1.4. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.01	
Committee	**Date of approval**
Audit Committee	**10.6.21**
Health Board	

Charitable Funds Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Charitable Funds Committee. The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The Betsi Cadwaladr University Health Board (BCUHB) was appointed as the corporate trustee of the charitable funds by virtue of Statutory Instrument and its Board (acting as The Board of Trustees) serves as its agent in the administration of the charitable funds held by BCUHB.

2.2. The purpose of the Committee is to make and monitor arrangements for the control and management of BCUHB's Charitable Funds.

3. DELEGATED POWERS

3.1. The Charitable Funds Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with:

- Provide evidenced based assurance that there is compliance with The Equalities Act 2010.
    - In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
    - In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.
- Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.2. Provide evidence based and timely advice to the Board on developing strategies.

3.1.3. Provide evidence based and timely advice to the Board on the delivery of strategies.

3.1.4. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.5. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.1.6. Within the budget, priorities and spending criteria determined by BCUHB as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents, including the "Declaration of Trust" (Trust Deed).

3.1.7. To ensure that BCUHB policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds, managing the risk of any loss in capital value alongside producing a return consistent with prudent investment in the long term and ensuring compliance with:-

- Trustee Act 2000
- The Charities Act 1993
- The Charities Act 2006
- Terms of the fund's governing documents

3.1.8. To receive at least four times per year reports for ratification from the Executive Director of Finance, and to make and enact investment decisions taken through delegated powers upon the advice of BCUHB's investment adviser.

3.1.9. To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.1.10. To respond to, and monitor the level of, donations and legacies received, including the progress of any Charitable Appeal Funds.

3.1.11. To monitor and review BCUHB's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.1.12. To ensure that funds are being utilised appropriately in line with both the instructions and wishes of the donor. To ensure such funding provides added value and benefit to patients and staff, and that all expenditure is reasonable, clinically and ethically appropriate.

3.1.13. To keep the reserve policy under review to ensure that balances are not inappropriately retained.

3.1.14. To receive reports from the Chair of the Advisory Group at each Committee meeting for scrutiny and ratification.

3.1.15. To ensure that there is a clear strategy and framework for decision making, agreed by the Board of Trustees, against which bids for funding can be evaluated by Fund Advisors, other Health Board staff, the Charitable Funds Advisory Group and the Committee.

3.1.16. To receive, scrutinise and approve the Charity's Annual Report and Accounts on behalf of the Health Board.

3.2. The Charitable Funds Committee is authorised by the Board to seek assurance over the specific powers, duties and responsibilities delegated to the Executive Director of Finance namely to:

3.2.1. Administer of all existing charitable funds;

3.2.2. Identify any new charity that may be created (of which BCUHB is trustee) and to deal with any legal steps that may be required to formalise the trusts of any such charity;

3.2.3. Provide guidelines with respect to donations, legacies and bequests, fundraising and trading income;

3.2.4. Responsibility for the management of investment of funds held on Trust;

3.2.5. Ensure appropriate banking services are available to BCUHB;

3.2.6. Prepare reports to the BCUHB Board including the Annual Accounts and Annual report;

3.2.7. To monitor the balance of monies held within the Fund

3.2.8. To ensure that all expenditure (where appropriate) is ordered through the procurement process

4. AUTHORITY

4.1. The Committee is empowered with the responsibility for:-

4.1.1. Day to day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the trustee and the requirements of the LHB's Standing Financial Instructions.

4.1.2. The appointment of an investment manager to advise it on investment matters. The Committee may delegate day-to-day management of

some or all of the investments to that investment manager. In exercising this power the Committee must ensure that:

4.1.2..1. The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it;

4.1.2..2. There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently;

4.1.2..3. The performance of the person or persons exercising the delegated power is regularly reviewed;

4.1.2..4. Where an investment manager is appointed, that the person is regulated under the Financial Services Act 1986;

4.1.2..5. Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

4.1.3. Ensuring that the banking arrangements for the charitable funds should be kept entirely distinct form the LHB's NHS funds.

4.1.4. Separate current and deposit accounts should be minimised consistent with meeting expenditure obligations.

4.1.5. The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

4.1.6. The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Health Board for applying accrued income to individual funds in line with charity law and Charity Commissioner guidance.

4.1.7. Obtaining appropriate professional advice to support its investment activities.

4.1.8. Regularly reviewing investments to see if other opportunities or investment managers offer a better return.

4.2. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.3. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.4. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business.

4.5. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

5.1.1. The Committee shall establish and approve the Terms of Reference and Scheme of Delegation for a Charitable Funds Advisory Group to review specific funding applications.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of seven (7) members of the committee comprising up to four (4) Independent Members, plus three (3) Executive Members

6.1.2. The Chair of the committee shall be an Independent Member of BCUHB.

6.1.3. Vice Chair of the committee shall be an Independent Member of BCUHB.

6.1.4. Executive members

- Executive Director of Finance (Lead Director)
- Executive Director of Planning and Performance
- Executive Medical Director

6.2. **In attendance**

- Charitable Funds Accountant
- Charitable Funds Fundraising Manager
- LHB Investment Advisor

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. By Invitation

- A patient representative.
- A staff representative.

6.4.2. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Board of Trustees, based on the recommendation of the BCUHB Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. .

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to **4** years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of **8** years.

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6.5.3. In order to demonstrate that that there is a visible independence in the consideration of decisions and management of charitable funds from the BCUHB's core functions, the Board of Trustees should consider extending membership to the Charitable Funds Committee to individuals outside of the Board.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a

programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least three Members must be present to ensure the quorum of the Committee, two of whom should be Independent Members (including the Committee Chair or Vice-Chair) and one of whom should be an Executive Directors.

7.1.2. Independent Members must hold the majority of votes at a meeting:

7.1.2..1. Where there are an equal number of Independent Members and Executive Members, the Committee Chair shall cast a deciding vote in the event of a tied vote.

7.1.2..2. Where there are more Executive Members than Independent Members one or more Executive Members will relinquish their right to vote to create an equal number of Independent Members and Executive Members

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held quarterly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.2. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and

- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.3. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.4. Receive assurance and exception reports from

- Charitable Funds Advisory Group.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.00	
Committee	**Date of approval**
Charitable Funds Committee	
Audit Committee	**10.6.21**
Health Board	

Mental Health and Capacity Compliance Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Mental Health & Capacity Compliance Committee (MHCC). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- The functions and processes of discharge under section 23 of the Act;
- The provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice

3. DELEGATED POWERS

3.1. The Mental Health & Capacity Compliance Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to Mental Health Act compliance.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Mental Health & Capacity Compliance Committee is authorised by the Board to:

3.2.1. Ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities.

3.2.2. Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated.

3.2.3. Monitor the use of the legislation and consider local trends and benchmarks.

3.2.4. Consider matters arising from the Hospital Managers' Power of Discharge Committee.

3.2.5. Ensure that all other relevant associated legislation is considered in relation to Mental Health and Capacity legislation.

3.2.6. Consider matters arising from visits undertaken by Healthcare Inspectorate Wales (HIW) Review Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports [NOTE: HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE), however, any specific recommendations relating to Mental Health or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

3.2.7. Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation.

3.2.8. Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;

3.2.9. Consider and approve on behalf of the Board any policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate.

3.2.10. Receive and review Depravation of :Liberty reports regarding authorisations and associated reasons;

3.2.11. Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved.

3.2.12. Receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure.

3.2.13. Receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations.

3.2.14. Consider any other information, reports, etc. that the Committee deems appropriate.

3.2.15. Approve the appointment of Associate Hospital Managers.

4. AUTHORITY

4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

4.1.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

4.1.2. Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning workforce, Partnerships and Population Health matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in

place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

5.2. Sub-Committee - In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Group, terms of reference for which are attached as Annex 2.

5.3. Panel -Three members drawn from the pool of designated Associate Hospital Managers will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to Supervised Community Treatment Order (SCT).

5.4. The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Betsi Cadwaladr University Local Health Board, as well as the Power of Discharge Group.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Public Health (Lead).
- Executive Director of Nursing and Midwifery.
- Executive Director of Primary Care and Community Services.
- Medical Director for Mental Health.
- Nursing Director for Mental Health.
- Mental Health Director.
- Mental Health Act Manager
- Service User Representative.
- Social Services Representative.
- North Wales Police Representative.
- Welsh Ambulance Services.
- IMCA Advocacy provider Representative.
- IMHA Advocacy provider Representative.
- Associate Director of Safeguarding (director lead for MCA team)
- Associate Director of Quality Assurance (director lead for MHA team)
- DoLS representative.

- Two Associate Hospital Managers (as nominated by the Power of Discharge Group) appointed for a period of four years with re-appointment not to exceed a maximum of eight years in total.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. By Invitation

- A patient / Carer representative.
- A staff representative.

6.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a

programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also attend.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1.1. Joint planning and co-ordination of Board and Committee business; and

8.3.1.2. Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

8.5.1.1. The Power of Discharge Group

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.01	
Committee	**Date of approval**
MHCC	
Audit Committee	**10.6.21**
Health Board	

Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 covers the legal framework to allow the care and treatment of mentally disordered persons to be detained if deemed to be a risk to themselves or others. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

The MHA introduced the concept of “Hospital Managers” which for hospitals managed by a Local Health Board are the Board Members. The term “Hospital Managers” does not occur in any other legislation. Hospital Managers have a central role in operating the provisions of the MHA, specifically they have the authority to detain patients admitted and transferred under the MHA.

For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient’s case is dealt with in line with associated legislation. With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board’s Scheme of Delegation.

Mental Health Measure

The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came In to force in April 2009.

The MCA covers three main issues:

- The process to be followed where there is doubt about a person's decision-making abilities and decisions therefore where 'Best Interest' may need to be made on their behalf (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS) and/or where Court of Protection judgements are required.

Thus the scope of MCA extends beyond those patients who have a mental disorder.

Performance, Finance and Information Governance Committee

Terms of Reference and Operating Arrangements

Red text = changes
Green Text = imported from DIGC

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Performance, Finance and Information Governance Committee (PFIG). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position, performance and delivery, and information governance. This includes the Board's Capital Programme and Workforce activity costs.

3. DELEGATED POWERS

3.1. The Performance, Finance and Information Governance Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to finance, performance and information governance.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Provide relevant evidence based and timely advice to the Board on:

3.1.6.1. The financial performance of the Health Board and developing the IMTP

3.1.6.2. The operational performance of the Hearth Board and associated Impact Improvement Plans.

3.1.6.3. Evidence based assurance on the financial position, forecasting, and the capital programme.

3.1.6.4. Evidence based assurance to the Board and accountable officer on whether effective arrangements are in place through the operation of the governance framework for data processing and information management

3.1.6.5. Development and oversight of finance and performance related strategies

3.1.7. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Performance, Finance and Information Governance Committee is authorised by the Board to:

Financial Management

3.2.1. Seek assurance on the Financial Planning process and consider Financial Plan proposals.

3.2.2. Monitor financial performance and cash management against revenue budgets and statutory duties.

3.2.3. Consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions.

3.2.4. Monitor turnaround and transformation programmes' progress and impact/pace of implementation of organisational savings plans.

3.2.5. Receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.

3.2.6. To determine any new awards in respect of Primary Care contracts

Performance Management and accountability

3.2.7. Approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).

3.2.8. Ensure detailed scrutiny of the performance and resources dimensions of the Quality and Performance Report (QAP);

3.2.9. Monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;

3.2.10. Review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);

3.2.11. Review and monitor performance against external contracts

3.2.12. Receive assurance reports arising from Performance and Accountability Reviews of individual teams.

3.2.13. Receive assurance reports in respect of the Shared Services Partnership.

3.3. Capital Expenditure and Working Capital

3.3.1. Approve and monitor progress of the Capital Programme.

3.4. Workforce

~~3.4.1.~~ ~~Monitor performance against key workforce indicators as part of the QAP;~~

3.4.2. Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

~~3.4.3.~~ ~~Receive assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors.~~

3.4.4. To consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

3.5. Information Governance

3.5.1. Oversee the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales;

3.5.2. Oversee the direction and delivery of the Health Board's ~~**digital and**~~ information governance strategies to drive change and transformation in line with the Health Board's integrated medium term plan that will support modernisation using information and technology.

3.5.3. Consider the information governance ~~**and digital**~~ implications arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners;

3.5.4. Consider the information governance ~~**and digital**~~ implications for the Health Board of internal and external reviews and reports;

3.5.5. Oversee the development and implementation of a culture and process for data protection by design and default (including Privacy Impact Assessments) in line with legislation (e.g. General Data Protection Regulation);

3.5.6. Oversee the direction and delivery of the Health Board's Cyber security policy (details of which will be taken in private session of the committee);

3.5.7. Oversee the direction and delivery of the Health Board's Patient records management;

3.5.8. Oversee the direction and delivery of the Health Board's National systems and programs.

AUTHORITY

3.6. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

3.6.1. Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,

3.6.2. Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.7. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.8. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business.

3.9. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

4. SUB-COMMITTEES

4.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

5. MEMBERSHIP

5.1. **Members**

5.1.1. A minimum of three Independent Members of the Board.

5.2. **In attendance**

- Executive Director of Finance / Senior Information Risk Owner (SIRO) (Lead Director).
- ~~Chief Executive~~
- Executive Medical Director / Caldicott Guardian
- ~~Executive Director of Workforce and Organisational Development~~
- Executive Director of Planning & Performance.
- Executive Director Nursing and Midwifery.
- Lead Director of Information Governance Department.
- Assistant Director Information Governance & Assurance/ Data Protection Officer (DPO).

5.3. Right of Attendance

5.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

5.4. **By Invitation**

- A patient representative.
- Chair of Stakeholder Reference Group
- A staff representative.

5.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

5.4.2. Trade Union Partners are welcome to attend the public session of the Committee

5.5. Member Appointments

5.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

5.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

5.6. Secretariat

5.6.1. The Secretariat will be determined by the Board Secretary.

5.7. Support to Group Members

5.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

6. COMMITTEE MEETINGS

6.1. Quorum

6.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also attend.

6.2. Frequency of Meetings

6.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

6.3. Withdrawal of individuals in attendance

6.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6.4. Conduct of Meetings

6.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

7. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

7.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

7.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

7.3.1.1. Joint planning and co-ordination of Board and Committee business; and

7.3.1.2. Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

7.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

7.5. Receive assurance and exception reports from

7.5.1.1. Executive Delivery Group Transformation and Finance.
7.5.1.2. Executive Delivery Group People and Culture
7.5.1.3. Capital Investment Group
7.5.1.4. Estates Group
7.5.1.5. Information Governance Group
7.5.1.6. Caldicott Guardian.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1. The Committee Chair shall:

8.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

8.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

10. REVIEW

10.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.00	
Committee	**Date of approval**
PFIG	
Audit Committee	**10.6.21**
Health Board	

Partnerships, People and Population Health Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as Partnerships, People and Population Health Committee (PPPH). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the Committee is to provide advice and assurance to the Board with regard to the development and oversight of the Health Board's enabling strategies. ~~and plans for the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.~~ The Committee will do this by ensuring that the workforce strategies are aligned and that strategic collaboration and effective partnership arrangements are in place to improve population health and reduce health inequalities.

3. DELEGATED POWERS

3.1. The Partnerships, People and Population Health Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies including those relating to digital, workforce and transformation.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Provide relevant evidence based and timely advice to the Board on:

- Staffing matters
- Population health outcomes and prevention strategies.
- Transformation capacity delivery and planning.
- Delivery of the Corporate Strategy (improving outcomes for citizens), including in services delivered in partnership.
- **Digital development**

3.1.7. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Partnerships, People and Population Health Committee is authorised by the Board to:

3.2.1. Ensure that current and emerging service strategies adhere to national policy and legislation , the priorities of the Health Board and are underpinned by robust population health needs assessment, workforce and financial plans and provide for sustainable futures.

3.2.2. Receive regular assurance reports on health and care clusters and primary care development, recognising the central role played by primary care in the delivery of health and care.

3.2.3. Advise and assure the Board in discharging its responsibilities with regard to the development of the Health Board's medium and long term plans, together with the Annual Operating Plan;

3.2.4. Ensure the Health Board's response to new and revised legislative requirements in relation to service planning and delivery, providing assurance that statutory duties will be appropriately discharged, ensuring strategic alignment between partnership plans developed with Local Authorities, Universities, third sector and other public sector organisations;

3.2.5. Receive regular performance and assurance reports from the Public Service Boards and Regional Partnership Board, Mental Health Partnership Board and other key partnerships as agreed by the Board.

3.2.6. Ensure that the Health Board meets its duties in relation to Welsh language, civil contingencies legislation and emergency preparedness.

3.2.7. Ensure the alignment of supporting strategies such as Workforce, ~~Capital Planning, Estates infrastructure~~ and **~~Information Communications and Technology (ICT)~~ Digital** in the development of the strategic delivery plans;

3.2.8. Ensure that the partnership governance arrangements reflect the principles of good governance with the appropriate level of delegated authority and support to discharge their responsibilities; and monitor sources of assurances in respect of partnership matters ensuring these are sufficiently detailed to allow for specific evaluations of effectiveness **including but not limited to Digital Health Care Wales**.

3.2.9. Ensure appropriate arrangements for continuous engagement are in place; and review assurances on Consultation feedback

3.2.10. Monitor performance against key workforce indicators as part of the Quality Report;

3.2.11. Receive assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors.

4. AUTHORITY

4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning workforce, Partnerships and Population Health matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Planning and Performance (Lead Director).
- Executive Director of Workforce and Organisational Development.
- Executive Director of Public Health.
- Executive Director Primary and Community Services.
- Executive Director of Therapies and Health Sciences.
- Executive Medical Director.
- Executive Director of Nursing and Midwifery.
- Finance Director – Strategy and Commissioning.
- **Chief Information Officer (for relevant sections)**

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.
- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- Chair of Stakeholder Reference Group.
- A staff representative.

6.4.2. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This

includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

- Executive Delivery Group People and Culture
- Executive Delivery Group Transformation and Finance.
- Organisational Development Group.
- Population Health Group.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.00	
Committee	**Date of approval**
PPPH	
Audit Committee	**10.6.21**
Health Board	

Quality, Safety and Experience Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Quality, Safety and Experience Committee (QS&E). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to the quality of services including clinical effectiveness, patient safety and patient and carer experience whether delivered directly or through a partnership arrangement and health and safety issues.

3. DELEGATED POWERS

3.1. The Quality, Safety and Experience Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that there is compliance with The Health and Social Care (Quality and Engagement) (Wales) Act 2020.

- In discharging its duty the Committee will have 'due regard' to the duty of quality.

3.1.3. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.4. Provide evidence based and timely advice to the Board on developing strategies.

3.1.5. Provide evidence based and timely advice to the Board on the delivery of strategies including quality, clinical effectiveness, patient safety and patient and carer experience.

3.1.6. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.7. Provide relevant evidence based and timely advice to the Board on quality of citizen centred health in relation to patient services, public health, health promotion and health protection including (but not limited to):

- Clinical effectiveness
- Patient Safety
- Patient and carer experience
- Safeguarding
- Health and Safety
- Infection, prevention and control

3.1.8. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Quality, Safety and Experience Committee is authorised by the Board to:

3.2.1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient.

3.2.2. Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Strategy and the principle of continuous quality improvement including organisational learning.

3.2.3. Ensure the adequacy of safeguarding and infection, prevention and control arrangements.

3.2.4. Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.

3.2.5. Provide assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement.

3.2.6. Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects affecting patient care, quality and safety and experience.

3.2.7. Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that.

- Sources of internal assurance (including clinical audit) are reliable.
- Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
- Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.

3.2.8. Receive assurances from the Quality Strategy ~~and Legislation Assurance Framework~~ to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.

3.2.9. Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).

3.2.10. Review and seek assurance on the appropriateness of the quality indicators defined within the Integrated Quality and Performance Report (IQPR) [tbc] and scrutinize the quality dimensions contained within the IQPR.

3.2.11. Review the sustainability of service provision across the Health Board in terms of quality of service, patient and carer experience and model of care provided.

3.2.12. Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.

3.2.13. To receive periodic updates in respect of the workforce flu vaccination.

4. AUTHORITY

4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning quality, safety, patient and carer experience matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.2. **In attendance**

- Executive Director of Nursing and Midwifery (Lead Executive).
- Executive Medical Director.
- Executive Director of Therapies and Health Sciences.
- Executive Director of Primary Care & Community Services.
- Executive Director of Workforce & Organisational Development.
- Executive Director of Public Health.
- Director of Performance.
- Associate Director of Quality Assurance
- Director of Mental Health & Learning Disabilities.
- Senior Associate Medical Director.
- Chair of Healthcare Professionals Forum.
- Associate Board Member Representative of Community Health Council.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.

- Board Secretary.

6.4. **By Invitation**

- A patient representative.
- A staff representative.
- Executive Director of Planning and Performance.

6.4.2. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair

or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

8.5. Receive assurance and exception reports from

- Executive Delivery Group for Quality Improvement.
- Clinical Effectiveness Group.
- Patient and Carer Experience Group.
- Patient Safety and Quality Group.
- Health and Safety Group.
- Infection Protection and Control Group.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.00	
Committee	**Date of approval**
QSE	
Audit Committee	**10.6.21**
Health Board	

Remuneration and Terms of Service Committee

Terms of Reference and Operating Arrangements

Red text = changes

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee (RaTS). The detailed terms of reference and operating arrangements in respect of this Committee are set out below..

2. PURPOSE

2.1. The purpose of the Committee is to provide

2.1.1. Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

2.1.2. Assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales; and

2.1.3. Specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS

3.1. The Remuneration and Terms of Service Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Remuneration and Terms of Service Committee is authorised by the Board to:

3.2.1. Comment specifically upon:

- The remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- And to be sighted on the objectives set by the Chief Executive for his immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place
- Proposals to make additional payments to consultants;
- Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- Removal and relocation expenses

3.2.2. Consider and approve Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.2.3. Monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and registered professionals.

3.2.4. Monitor and review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

3.2.5. Consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.2.6. Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

3.2.7. Consider reports on behalf of the Board giving an account of progress on performers list regulatory cases.

3.2.8. Consider reports on behalf of the Board on the position as regards whistleblowing and Safe haven.

4. AUTHORITY

4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board.

6.1.2. The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

6.2. **In attendance**

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)
- Executive Medical Director

6.2.1. Directors/Officers should leave the meeting when their personal remuneration or terms of service are being discussed.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Board Secretary.

6.4. **By Invitation**

- A staff representative.

6.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee.

6.4.3. The Executive Director of Finance may be invited to attend as required, and will be consulted on any paper to be submitted to the Committee that may have financial implications.

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and

- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 1.00

Committee	Date of approval
RaTS	
Audit Committee	10.6.21
Health Board	

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

Appendix 9

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

For:	*Proposed Integrated Governance Framework*
Date form completed:	*13.5.21*

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

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	**Proposed Integrated Governance Framework**
2.	Provide a brief description, including the aims and objectives of what you are assessing.	*What is the Integrated Governance Framework trying to achieve?* *Organisational governance, culture and behaviour are inextricably linked. Colloquially governance can be described as "the way we do things around here"; culture can be described as "the way we do things around here – when no-one is watching". The proposed framework therefore needs to be supported by the Organisational Development Programme to address the behavioural and cultural issues raised by Board Members and the Welsh Government.* *The framework also needs to align to the emerging corporate strategy, as the framework is the delivery and assurance structure for the strategy.* *The framework aims to support the Board in its key functions of leading the Health Board to be effective and to deliver the principal role of a Health Board:* *To ensure the effective planning and delivery of healthcare for people for whom it is responsible, within a robust governance framework, to achieve the highest standards of patient safety and public service delivery, improve health, reduce inequalities and achieve the best possible outcomes for its citizens, and in a manner that promotes equality and human rights.*

Part A Form 1: Preparation

Please answer all questions

		The governance proposals are designed to meet the follow objectives agreed by the Board: Objective 1: • Ensure that the work of the Board and committees are pitched at the right level and balance their responsibilities in strategy, culture and accountability. Objective 2: • Develop a greater focus on strategy in committee – delivering for the future. Objective 3: • Improve the focus, co-ordination and relevance of Board and committee papers with built in assurance levels. Objective 4: • Give the Board clear line of sight over business as usual and strategic delivery structures, including lines of accountability to provide better assurance and reduce duplication. Objective 5: • Develop greater oversight of the People / Transformation agenda. Objective 6: • Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline.

Part A Form 1: Preparation

Please answer all questions

3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	The Health Board
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Proposed Equality Accountability Framework Maturity Matrices Guidance Document
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	All staff
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Key risks from an Equality and Human Rights perspective can be broadly broken down in to two categories: - Consistency and line of sight - Diversity of thought and experience in leadership. Consistency and line of site concerns the consistent application of the principles of equality and human rights and compliance with the Public Sector Equality Duty "from Board to Ward". Clear direction, leadership, accountability and a consistent approach to audit and evidence are required in order to minimise this risk. Diversity of thought and experience in leadership concerns the quality and consistency of the application of the principles of Equality and Human Rights and compliance with the Public Sector Equality Duty. It is an evidenced and documented issue within the NHS that there is a lack of

Part A Form 1: Preparation

Please answer all questions

		diversity at Board and Senior Management level. there is also well documented evidence that a lack of diversity at board level poses a risk of lack of understanding of issues faced and solutions to those issues for people with protected characteristics. Evidence summarised in the Health Services Journal in 2019 showed that **boards of NHS organisation have become less diverse over the last 15 years.** There is strong evidence for the positive impact that diversity and equality in leadership has on organisational performance and culture. This is the case across the private, not-for-profit and public sectors. Diversity in leadership is important for the future of the NHS, particularly in light of the need to implement the new NHS long-term plan which promotes greater integration between staff and expresses the need for transformational change across health services. The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved in the last decade – from 15 per cent in April 2010 to 8 per cent today. The percentage of women in chair and non-executive roles has fallen from 47 per cent in 2002 to 38 per cent now. At the same time there has been no increase in the proportion of non-executive leaders with a disability – this has remained static, between 5 and 6 per cent.The problem with decreasing diversity on boards is particularly obvious in the NHS because it has a large proportion of female employees and BME staff who play key roles. T*he evidence for this much-needed change is clear: diversity and equality in leadership has a positive impact on organisational performance and culture. This is the case across the private, not-for-profit and public sectors.* Equality, diversity and inclusion leadership in the NHS is about having best practice in the governance of NHS organisations, better engagement with the staff which will lead to better

Part A Form 1: Preparation

Please answer all questions

		and significant improvements in the standards of care to patients delivered within its institutions.[1]
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	• the proposed framework proposes to Improve information flow: no orphan groups - improve the line of sight from Floor to Board through increased governance discipline. Equality and human rights are considered as part of the core function of the Health Board and this improvement in information flow is an opportunity to include our delivery of the Public Sector Equality Duty and the Socio-Economic Duty throughout the organisation, producing a more transparent, evidence based approach to eliminating discrimination and advancing equality. It provides an opportunity to align the new Equality Accountability Framework with the Performance Accountability Framework giving Board visibility of divisional delivery of our statutory equality duties.

[1] NHS is moving backwards in terms of board diversity | Comment | Health Service Journal (hsj.co.uk)

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

Please answer all questions

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. 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

Please answer all questions

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) *for further direction on how to complete this section please click here training vid p13-18)*	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?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** Hint/tip: do not say: "not applicable", "no impact" or "regardless of...". If you have identified 'no impact' please explain clearly how you came to this decision.		

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

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here					
	Yes	No	(+ve)	(-ve)		
Cross-characteristic issues	x		x	x	Embedding the principles of equality and human rights at heart of the Integrated Governance Framework enables and promotes compliance with the three aims of the Public Sector Equality Duty. The framework explicitly states that one of the core purposes of the Health Board is to reduce inequality and promote equality and human rights. The embedding of Equality and Inclusion within the framework is present, as the outline Terms of Reference include explicit reference to the Equality Act within *Commonality – Board Committees* *Commonality – Executive Delivery Groups.* There is a commitment for Tier 2 (Committee level strategies) to evidence Equality and Diversity principles. "When a strategy is presented to Board or committee, it should have a clear assurance paper attached to demonstrate a robust approach to Socio-economic and Equality Impact Assessment"	

Please answer all questions

					The Strategic Tactical and Operational model makes clear the purpose of groups – it is positive that the Equality and Human Rights Strategic Forum is identified as a tactical group with a clear reporting line to the Partnership, People and Population Health Committee However, the consistent application of the principles may be at risk due to the lack of diversity in the demographics of the key components of the framework. the benefits of diversity at board level are well researched and evidence. A 2012 study by the NHS Leadership Academy found that having a more diverse board: • Creates a Board with shared values; and with an understanding and commitment about the role and importance of Equality, Diversity and Inclusion in commissioning and providing positive health outcomes, excellent patient experience for all and in working to reduce health inequalities. • Ensures that right from the start Equality, Diversity and Inclusion is built into the way of thinking and decision making with regards to the business of Board. • Places Equality, Diversity and Inclusion as a core value at the heart of the business of the Board.	Named protected characteristic leads at board level with a responsibility to understand and represent the specific issues faced by people with that protected characteristic. Board cover sheet strengthened board sheet to specifically request evidence of EqIA and SEIA Implementation of the proposed Equality Accountability Framework and integration of this framework with the Performance and Accountability Framework.

Please answer all questions

					• Ensures the Board is equipped to address the business of reducing health inequalities and improving health outcomes for all patients, leading to improved quality and cost effective service delivery. Clearly the converse represents a significant risk, i.e. a lack of diversity at board level – and this is shown to be an NHS-wide issue – poses a risk to embedding equality, diversity and inclusion as a way of thinking and decision making with regards to the business of the board through a lack of diversity of thought and experience,.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.
Age	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. a 2018 report in to the make up of NHS Boards in England showed that Over 90% of NEDs (equivalent to an Independent Member) are aged 50 or above compared to just 65% of Executive Directors.[2]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu

[2] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p26

Please answer all questions

						invitation of oA patient representative, a staff representative, any other Executive Director.
Disability	x		x	x	Section 3.1.1 states that “Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board”. There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.

Please answer all questions

					the committees. At an average of 5.3%, the proportion of disabled people on NHS provider boards is well below that of the general population (17.6%).[3] The documentation and communication of this framework could be inaccessible to people with sensory loss or neuro diversity.	Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director The documentation and communication to be made available in a range of accessible formats.
Gender Reassignment	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the	Proactive recruitment strategies for Independent Member recruitment,

[3] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p27

Please answer all questions

					UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Pregnancy and maternity	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu

Please answer all questions

						invitation of oA patient representative, a staff representative, any other Executive Director
Race	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. The 2016 Workforce Race Equality Standards (WRES) report indicated that the proportion of ethnic minority staff in the NHS is 17.7%. The proportion of ethnic minority clinical very senior managers (VSM) is 7.9% (compared to 6.8% of ethnic minority EDs). The report also found that the only position on a Health Board where the % held by somebody identifying as an ethnic minority matches that of the NHS Workforce is Medical Director.[4] *The percentage of chairs and non-executives of NHS trusts from a BME background has nearly halved in the last decade – from 15 per cent in April 2010 to 8 per cent today*[5]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director

[4] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p21-24

[5] NHS is moving backwards in terms of board diversity | Comment | Health Service Journal (hsj.co.uk)

Please answer all questions

Religion, belief and non-belief	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. The range of faith of NHS provider board members broadly reflects that of the wider population, except that people of Muslim faith are under-represented.[6]	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Sex	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees. A 2018 report on NHS providers in	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations.

[6] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p29

Please answer all questions

					England showed that Of NHS provider boards 43% are women, whereas 77% of the NHS workforce are women.[7] It also showed that the greatest disparity between the representation of men and women on NHS provider boards is in the non-executive director cohort.	Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director
Sexual orientation	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient

[7] NHSI_board_membership_2017_survey_findings_Oct2018a_ig.pdf (england.nhs.uk), p13

Please answer all questions

						representative, a staff representative, any other Executive Director
Marriage and civil Partnership (Marital sctatus)						
Socio Economic Disadvantage	x		x	x	Section 3.1.1 states that "Board Committees can only have membership drawn from the Independent Members so as not to conflict Executive Members of the Board". There is a potential risk here as we know there is an issue across the UK of a lack of diversity at Board level – this will inevitably filter down in to a lack of diversity in the demographics of the committees.	Proactive recruitment strategies for Independent Member recruitment, advertising through third sector organisations. Consideration should be given to ensuring inclusive representation to reflect the diverse demographic of North Wales where possible, this should be included in the Terms of References, bu invitation of oA patient representative, a staff representative, any other Executive Director

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

Please answer all questions

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

Please answer all questions

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*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

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

Please answer all questions

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)			
						Please explain how you intend to remove or reduce any negative impacts you have identified. ***Be specific.***

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

Please answer all questions

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						*Please explain how you intend to remove or reduce any negative impacts you have identified.* ***Be specific.***
Treating the Welsh language no less favourably than the English language						*Please explain how you intend to remove or reduce any negative impacts you have identified.* ***Be specific.***

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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. *for further direction on how to complete this section please click here training vid p13-18)*	*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 people with protected characteristics.* *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*
Have any themes emerged? Describe them here.	*Describe here any information and/or themes that have emerged from your engagement. This could be any previously unidentified potential negative impacts identified by stakeholders or staff, or could be suggestions to strengthen positive equality impacts.*
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*Describe any changes you have made to the policy/proposal due to feedback from your engagement and consultation.*

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

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	*Copy from Form 1*

2. Brief Aims and Objectives: (Copy from Form 1)	*Copy from Form 1*

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: **This is as indicated on form 2 and 3**	Yes	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, y**ou should be able to answer 'No' to this question.**	Yes	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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? High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	
	Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes	No
	How is it being monitored?	*What monitoring arrangements are to be used. By its very nature, an EqIA is an assessment of how people may be affected if we do what we are proposing to do. We therefore need to monitor actual outcomes compared to our assessment. This is not about creating new systems for monitoring but should use whatever systems are already in place. E.g. will you be using existing reports/data or do you need to gather your own information?* *Please describe how this will be built in to the policy document review process.*
	Who is responsible?	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	*E.g. will you be using existing reports, data etc. or do you need to gather your own information? Liaising with engagement officer for stakeholder feedback.*
	When will the EqIA be reviewed?	*This will be the same date the policy, strategy, project or service change is reviewed*

7. Where will your policy or proposal be forwarded for approval?	*Usually a committee / group.* ***Please note it is not the role of the Equality team to approve your EqIA.***

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity	Name	Title/Role
	Names of people completing the EqIA. NB: this should ***not*** *be a lone individual.*	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Senior sign off prior to committee approval:	*Name of senior sign off prior to committee approval*	
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 **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	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:			
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	*Please detail any changes you have made as a result of negative impacts identified. ,*		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
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?	*As indicated above, minor negative impact on one or two groups may well be an acceptable outcome. There may also be significant cost implications involved in removing minor impact for small groups but bear in mind that this minor impact could be 'disproportionate' to the group(s) involved.*		
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.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	*We have a specific legal duty to 'advance equality of opportunity' so record here anything you have discovered during your assessment that might contribute towards meeting this duty.*		

Cyfarfod a dyddiad: Meeting and date:	Health Board 15th July 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Programme Business Case for an All Wales Positron Emission Tomography (PET) Service
Cyfarwyddwr Cyfrifol: Responsible Director:	Adrian Thomas, Executive Director of Therapies and Health Sciences
Awdur yr Adroddiad Report Author:	Sian Lewis, Managing Director , Welsh Health Specialised Services (WHSCC)
Craffu blaenorol: Prior Scrutiny:	Chief Executive Group (CEG) of the NHS Wales Health Collaborative
Atodiadau Appendices:	1. Programme Business Case for an All Wales Positron Emission Tomography (PET) Service (*please note the 15 associated appendices are available on request*) *2.* Health impact assessment form

Argymhelliad / Recommendation:

The Board is asked to approve the Programme business case for an all-Wales Positron Emission Tomography (PET) Service, including the spending objectives, scope, and resource requirements as set out in the financial case.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N to indicate whether the Equality/SED duty is applicable							**Y**

Sefyllfa / Situation:

On review of the full business case, the Chief Executive Group (CEG) of the NHS Wales Health Collaborative confirmed their support for the All Wales Positron Emission Tomography (PET) Programme Business Case (PBC) on 18 May 2021. At the meeting, the Chief Executives agreed to a request for letters of support from their organisations (being the seven Health Boards and Velindre NHS Trust) to accompany submission of the PBC to Welsh Government (WG).

The Capital, Estates and Facilities team at WG indicated that they were willing to accept the PBC immediately following this endorsement by CEG. As such, the PBC has been submitted.
The mandate for this Programme was issued by Andrew Goodall in March 2019, following publication of key strategic reports on both PET and the wider imaging provision in Wales. WHSSC host the Programme Board for this strategic Programme and have used HM Treasury Green Book methodology and extensive engagement to develop the All Wales PET PBC.

The preferred way forward for the programme seeks to have four projects that will, over the course of five years, update the existing fixed facility at Cardiff, replace mobile scanners with fixed scanners at the Swansea and North Wales sites and at a fourth location (to be defined).

The PBC is primarily a capital funding request business case (£24.881 million) and has focused on the supporting infrastructure for PET-CT service delivery over the next ten years, thus ensuring deliverability and sustainability is at the heart of the overall strategic approach.

There has been wide engagement on the Programme and there is representation from each Health Board and Velindre NHS Trust on the PET Programme Board, in addition to regular updates at the NIPSB. There will be no fundamental change to any referral pathways and the revenue costs required to fund the increase in PET scanning capacity in the future, set out in the business case, will be funded by the commissioning health boards through the usual Integrated Commissioning Plan process.

We kindly request that Boards issue a letter of support to accompany the PBC submission to WG, addressed to Sian Lewis (Programme SRO). We understand from discussions at the CEG meeting (18 May) that some Health Boards may be able to expedite this. To facilitate the process, we ask that a letter of support is issued as soon as possible, but no later than the week following your July Board meeting.

Cefndir / Background:

- Wales is at the bottom of the list for European countries in terms of PET scans per 100,000 population
- WHSSC currently supports a fixed site (static) PET/CT scanner in Cardiff (5 days/week), and a mobile PET/CT scanner service (2 days/week) each in Wrexham and Swansea
- WHSSC commissioned a PBC for PET in Wales which recommends three fixed site PET/CT scanners in Cardiff, Swansea and North Wales (and a future PET/MRI at a to be determined site)
- The full costs of the BCUHB service development will be £6,573 million capital (with revenue income of £572 per scan) and will be delivered through commissioned funding from WHSSC should the FBC be approved. This will cover all our costs of the development
- A separate BCUHB business case is progressing in respect of modernisation of Nuclear Medicine services along with the current BCUHB PET service, and is fully consistent with the aims of this PBC.

PET-CT has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions. Its role and the evidence base continue to evolve. Although it is a relatively expensive investigation, when used appropriately, PET-CT can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments.

This is supported by an increasing body of high-quality evidence outlining the contribution of PET to improved patient outcomes. There are many studies that demonstrate the role PET-CT has in accurately determining the staging of certain cancers and subsequent treatment plans, which enables reduction of inappropriate patient management and allows for best prognosis and patient care.

Demand for PET-CT is growing with England realising an approximate 18% rise in demand per annum. However, in Wales, scanning activity levels are low compared with the rest of the UK. It is estimated that in 2020 Wales was performing approximately 33% of the PET scans per head of

population compared to England. In addition, NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. The picture becomes bleaker when comparing performance with the rest of Europe and beyond.

Continuing to meet growing demand by relying on external providers is likely to cost an additional £25.6 million p.a. revenue by 2031/32. This approach would not only prove expensive but would deliver no improvements to the existing service structure. Indeed, without investment, the PET service in Wales would likely be served by expensive external providers, using mobile scanners, and the Welsh NHS would miss the opportunity to build a future-proofed network of centres of excellence.

Shortly after the Welsh Government published the Imaging Statement of Intent (March 2018), the All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) produced a report “Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations” (November 2018). One of its five key recommendations was that WHSSC should be commissioned to produce a Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

These reports clearly demonstrates that much like other imaging modalities in Wales, there is an obvious and clear need to address the multifactorial issues facing the PET service including staffing, equipment age, facilities and research, development and innovation (RD&I).

In March 2019, the Director General, Health and Social Service/NHS Wales Chief Executive, Welsh Government endorsed the 2018 AWPET/WSAC report recommendations and outlined the expectations for NHS Wales to collaborate on their implementation. As there was recognition that additional capital investment would be required to develop the service, the Director General requested that WHSSC develop the PBC, with support from the National Imaging Strategic Programme Board (NIPSB), to guide the development of future service provision for the whole of Wales.

Asesiad / Assessment & Analysis

Strategy Implications

WHSSC has led the All Wales PET Programme development and produced this Programme Business Case (PBC) which justifies the rationale to invest in the All Wales PET service.

The resulting PBC assesses future Welsh PET scanning demand needs and focuses on the surrounding infrastructure of PET scanning delivery. As such, it provides a ten-year strategic view of service delivery, in addition to describing the business change and technical aspects of implementation.

Following a robust assessment of options, the PBC identifies the preferred way forward which involves investing in four fixed PET-CT scanners which will reduce the cost pressure by £6.8 million p.a. by providing sufficient capacity for NHS Wales and PETIC to meet demand. WHSSC therefore seeks capital funding of £24.881 million from Welsh Government over five years to invest in equipment and building works required to deliver the preferred way forward.

Financial Implications

Delivery of the preferred way forward, which involves implementing a programme that will deliver four fixed digital scanners in Wales requires capital investment of £24.881m for which funding is sought from Welsh Government.

As well as delivering a wide range of non-financial benefits in relation to service improvements and patient experience and outcomes, this will enable three of the scanners to reduce the average cost per scan to £572, compared with an average cost from external providers of £935. This will result in an overall average cost per scan for all four scanners over a 10-year period to £729.

Indicative modelling suggests that revenue costs could increase by £25.6m per annum by 2030/31 based on predicted demand growth. This investment will contribute to mitigating the ongoing cost pressure associated with growing demand including:

- Reduction in average cost per scan resulting in £6.6m annual financial benefit by 2030/31.
- Opportunities to deliver system-wide financial benefits due to increased PET-CT scanning reducing the need for high-cost late stage interventions. There is insufficient detail available on specific demand by patient pathway to calculate this at this stage.
- Opportunities for income generation from RD&I activities which, based on 7% of predicted demand, is estimated at around £3.3m by 2030/31.

Revenue funding for PET scanning is currently provided via WHSSC on a price-per-scan basis, with existing service providers charging WHSSC an agreed price for each scan carried out. WHSSC has included projected growth in PET scanning demand within the WHSSC ICP plan. It is expected that each local organisation that will host a PET-CT scanner will make clear how they, as service providers commissioned by WHSSC, will incorporate the additional revenue implications i.e. staff and running costs, into the price-per-scan that they charge WHSSC.

Risk Analysis

The major risks associated with the full business case are:

Risk category	Risk
Resilience	Risk of insufficient scanning capacity to meet demand resulting in increased waiting times and impacting on patient outcomes
	Risk of cancellations and downtime of service
Demand	Risk that demand and capacity requirements have been under or over-stated
Workforce	Risk of insufficient workforce available to provide high quality service
	Risk of challenges recruiting workforce
Implementation	Risk of programme delays resulting in insufficient capacity during transition period
	Risk of programme delays resulting in increased programme costs
Funding and finance	Risk of insufficient capital funding available to deliver programme
	Risk of increasing revenue costs
	Risk that programme costs have been understated

Legal and Compliance

It is a legal requirement under IR(ME)R 2017 for employers to hold an Administration of Radioactive Substances Advisory Committee (ARSAC) licence at each medical radiological installation (hospital, etc.) where radioactive substances are to be administered to humans, and additionally for practitioners to hold individual ARSAC licences in order to justify the administration of those substances. A nuclear medicine service cannot therefore operate without these licences in place. These needs are included in the PBC and a Workforce workstream will be set-up to support the Programme and Projects within.

The Programme proposes that the installation of a PET scanner at BCUHB is done so as a Project that reports into the wider Programme Board. As such, the PBC notes the need for a BCUHB Project Manager to work with a Project SRO at BCUHB. Considering that the PET scanner is encompassed within the Nuclear Medicine Consolidation Programme at BCUHB, there may be an opportunity to utilise existing expertise on this:

Project Boards		Lead
Project 1, 2, 3 and 4 Installation of new PET scanner and equipment	Responsible for leading the planning and development of the relevant business cases at the preferred site location for PET services at the relevant PET site organisation and subsequent implementation. Each Project Board should have membership from: Project SRO, Project Manager and representatives from planning, procurement, estates, IM&T, legal & risk, communications and engagement and finance.	Project SRO

Impact Assessment

WHSSC must ensure that any new investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. To do this WHSSC runs an annual prioritisation process to determine the relative prioritisation of new interventions within

specialised services. The process is facilitated by the WHSSC Clinical Impact Assessment Group (CIAG) and their recommendations (or priorities) are subsequently presented in the WHSSC ICP.

WHSSC commission and approve funding of PET scans for the population of Wales in line with the criteria presented in commissioning policy CP50a [1] and specification CP50b [2] (which covers requirements for both fixed site and mobile scanners). This defines the requirements and standard of care essential for delivering PET-CT for people of all ages who are resident in Wales. This policy has been subjected to an Equality Impact Assessment. The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

WHSSC is committed to regularly reviewing and updating all of its clinical commissioning policies based upon the best available evidence of both clinical and cost effectiveness. In September 2016, WHSCC established the multidisciplinary All Wales PET Advisory Group (AWPET). This Group is tasked to review the evidence base for PET-CT and advise WHSSC on the introduction of new indications (including non-oncological indications), ensuring that all decisions are made following a systematic review of the available evidence.

The All Wales PET Programme aligns directly with the objectives of the commissioning policy by seeking to deliver a sustainable high-quality PET service for the people of Wales, ensuring there is equitable access to PET-CT and improving outcomes for those accessing PET-CT services.

In line with Capital Business Case submission requirements, a Health Impact Assessment screening has been carried out and is attached at Appendix 2.

Programme Business Case
for an All Wales Positron Emission Tomography (PET) Service

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Document control

Title	Programme Business Case for an All Wales Positron Emission Tomography (PET) Service
File ref	Y:\WHSSC Y Drive\Medical 08\PET Programme\PET Programme\2. Programme Business Case\PBC for All Wales PET_FINAL.docx
Prepared by	Sarah McAllister
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Version control

Version	Date	Description of change/s	by
FINAL	10.05.2021	Final minor amends following proof read	SM
V0.2	09.05.2021	References amended	SM
V0.1	08.05.2021	Collated version of PBC generated	Archus

Glossary of Abbreviations and Acronyms

ABUHB	Aneurin Bevan University Health Board
AML	Alliance Medical
ARSAC	Administration of Radioactive Substances Advisory Committee
AWPET	All Wales PET Advisory Group
BCUHB	Betsi Cadwaladr University Health Board
CRB	Cash Releasing Benefit
CSFs	Critical Success Factors
CT	Computerised Tomography
CUBRIC	Cardiff University Brain Research Imaging Centre
CTMUHB	Cwm Taf Morgannwg University Health Board
CVUHB	Cardiff and Vale University Health Board
DHCW	Digital Health and Care Wales
EA	Environment Agency
EPSRC	Engineering and Physical Sciences Research Council
FBC	Full Business Case
HDUHB	Hywel Dda University Health Board
GDNF	Glial cell-derived neurotrophic factor
GIRFT	Getting It Right First Time
GMP	Good Manufacturing Practices
HCA	Health Care Assistant
HEIW	Health Education and Improvement in Wales
IMP	Investigational Medicinal Product
IPEM	Institute of Physics and Engineering in Medicine
LSHW	Life Sciences Hub Wales
MA	Marketing Authorisation
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare Products Regulatory Agency
MPE	Medical Physics Expert
MRC	Medical Research Council
MRI	Magnetic Resonance Imaging
NCRI	National Cancer Research Institute
NIAW	National Imaging Academy Wales
NIPSB	National Imaging Strategic Programme Board
NRW	National Resources Wales
OBC	Outline Business Case
ONS	Office for National Statistics

PACS	Picture Archive System
PBC	Programme Business Case
PET	Positron Emission Tomography
PET-CT	Positron Emission Tomography combined with Computerised Tomography
PETIC	Positron Emission Tomography Imaging Centre
PTHB	Powys Teaching Health Board
QA	Quality Assurance
RCR	Royal College of Radiologists
RCP	Royal College of Physicians
RD&I	Research, Development and Innovation
RIS	Radiology Information System
RISPP	Radiology Information System Procurement Programme
RPA	Radiation Protection Adviser
RWA	Radioactive Waste Adviser
SLA	Service Level Agreement
SOC	Strategic Outline Case
SBUHB	Swansea Bay University Health Board
SPB	Strategic Programme Board
SPECT	Single-Photon Emission Computerised Tomography
SRO	Senior Responsible Officer
SWOT	Strengths Weaknesses Opportunities Threats
UHB	University Health Board
VUT	Velindre University NHS Trust
WSAC	Welsh Scientific Advisory Committee
WHSSC	Welsh Health Specialised Services Committee
WTE	Whole Time Equivalent
18F-DOPA	Fluoro-3,4-dihydroxyphenylalnine - radiopharmaceutical
18F-FDG	Fluorodeoxyglucose – radiopharmaceutical
18PSMA	Prostate-specific membrane antigen – radiopharmaceutical

Executive Summary

Introduction

PET-CT has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions. Its role and the evidence base continue to evolve. Although it is a relatively expensive investigation, when used appropriately, PET-CT can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments.

This is supported by an increasing body of high-quality evidence outlining the contribution of PET to improved patient outcomes. There are many studies that demonstrate the role PET-CT has in accurately determining the staging of certain cancers and subsequent treatment plans, which enables reduction of inappropriate patient management and allows for best prognosis and patient care.

Demand for PET-CT is growing with England realising an approximate 18% rise in demand per annum. However, in Wales, scanning activity levels are low compared with the rest of the UK. It is estimated that in 2020 Wales was performing approximately 33% of the PET scans per head of population compared to England. In addition, NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. The picture becomes bleaker when comparing performance with the rest of Europe and beyond.

Continuing to meet growing demand by relying on external providers is likely to cost an additional £25.6 million p.a. revenue by 2031/32. This approach would not only prove expensive but would deliver no improvements to the existing service structure. Indeed, without investment, the PET service in Wales would likely be served by expensive external providers, using mobile scanners, and the Welsh NHS would miss the opportunity to build a future-proofed network of centres of excellence.

Shortly after the Welsh Government published the Imaging Statement of Intent (March 2018), the All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) produced a report “Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations” (November 2018). One of its five key recommendations was that WHSSC should be commissioned to produce a Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

These reports clearly demonstrates that much like other imaging modalities in Wales, there is an obvious and clear need to address the multifactorial issues facing the PET service including staffing, equipment age, facilities and research, development and innovation (RD&I).

In March 2019, the Director General, Health and Social Service/NHS Wales Chief Executive, Welsh Government endorsed the 2018 AWPET/WSAC report recommendations and outlined the expectations for NHS Wales to collaborate on their implementation. As there was recognition that additional capital investment would be required to develop the service, the Director General requested that WHSSC develop the PBC, with support from the National Imaging Strategic Programme Board (NIPSB), to guide the development of future service provision for the whole of Wales.

WHSSC has led the All Wales PET Programme development and produced this Programme Business Case (PBC) which justifies the rationale to invest in the All Wales PET service.

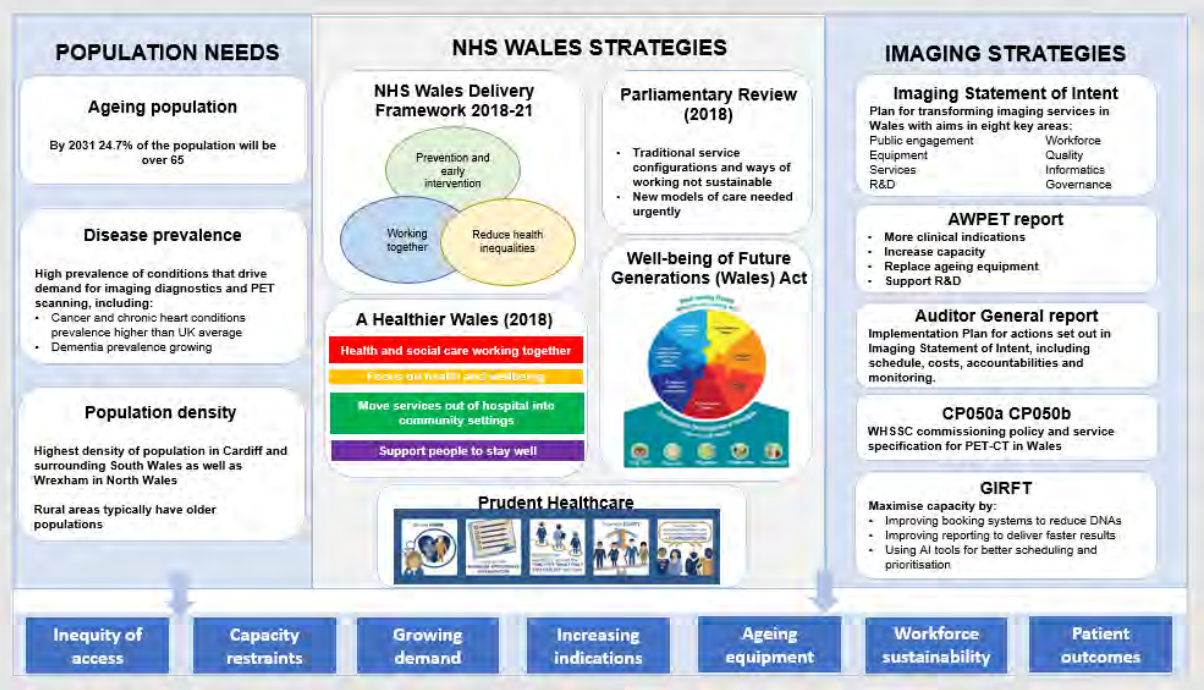
The resulting PBC assesses future Welsh PET scanning demand needs and focuses on the surrounding infrastructure of PET scanning delivery. As such, it provides a ten-year strategic view of service delivery, in addition to describing the business change and technical aspects of implementation.

Following a robust assessment of options, the PBC identifies the preferred way forward which involves investing in four fixed PET-CT scanners which will reduce the cost pressure by £6.8 million p.a. by providing sufficient capacity for NHS Wales and PETIC to meet demand. WHSSC therefore seeks capital funding of £24.881 million from Welsh Government over five years to invest in equipment and building works required to deliver the preferred way forward.

The Strategic Case

The Strategic Context

There are multiple strategic drivers for this Programme of work, which have been summarised in the figure below.



The Case for Change

The programme has run workshops and set up specific task and finish groups with subject matter experts to fully understand business requirements from clinical and operational perspectives. These have allowed the Programme to identify its core Spending Objectives and has defined programme implementation plans.

Spending Objectives

The Programme identified five spending objectives which articulate what the programme is seeking to achieve.

- **SO1** - To improve the quality of PET service provision for Welsh patients by delivering better patient outcomes.
- **SO2** - To ensure a sufficient workforce to deliver a high-quality service.
- **SO3** - To improve delivery of the All Wales PET Service by efficient use of PET-CT scanners, facilities, processes and infrastructure.
- **SO4** - To ensure that the future All Wales PET service provides a cost-effective service for patients and NHS Wales.
- **SO5** - To widen the scope of the All Wales PET service, to meet recognised international best practice.

Current Service provision

WHSSC commission and approve funding of PET scans for the population of Wales in line with the criteria presented in commissioning policy CP50a and service specification CP50b (which covers requirements for both fixed site and mobile scanners). WHSSC is committed to regularly reviewing and updating all of its clinical commissioning policies based upon the best available evidence of both clinical and cost effectiveness.

NHS Wales currently has three providers delivering PET-CT services:

- A fixed site at the University Hospital of Wales in Cardiff (the Wales Research and Diagnostic Positron Emission Tomography Imaging Centre; PETIC).
- A mobile service at Wrexham Maelor Hospital (2 days per week).
- A mobile service at Singleton Hospital, Swansea (2 days per week).

Patients are referred for a range of PET-CT scans by members of the relevant multi-disciplinary team (MDT).

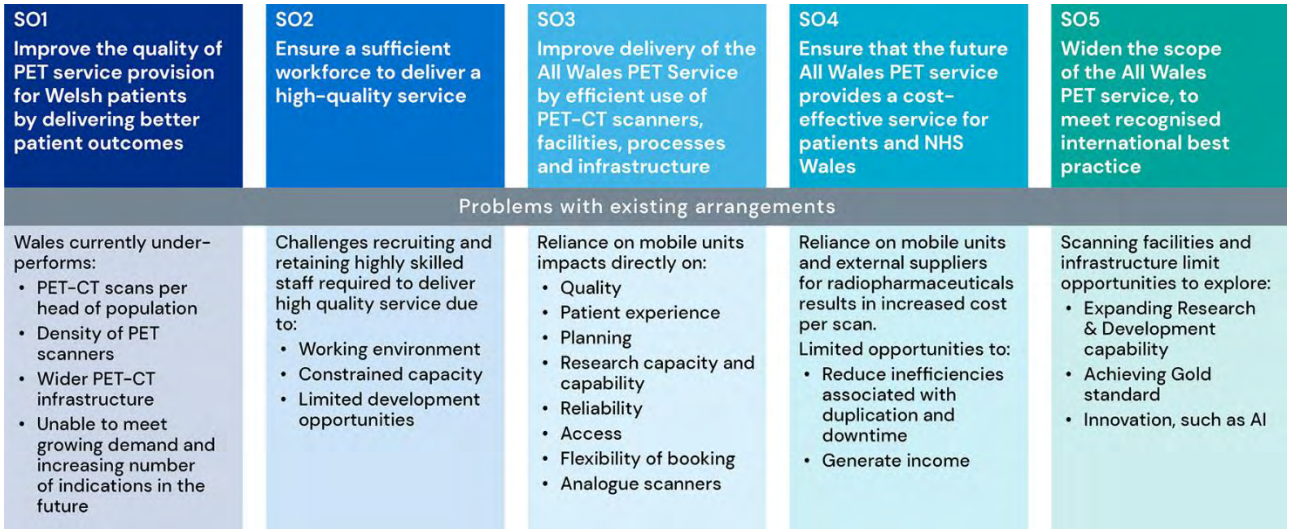
Business Needs

Continuing with existing arrangements is not feasible because there are some significant business needs which will result in deterioration of the service, growing costs and impact on clinical outcomes and patient experience. Specifically, these include:

- There is a growing and aging population, thus the demand for PET-CT is increasing substantially in countries across the world. Critically, in his 2020 report ‘Diagnostics: Recovery and Renewal’, Professor Sir Mike Richards indicated that between 2014/15 and 2018/19 demand for PET-CT in England increased by 18.7% per annum in England. He recommended that scanning equipment should, as a minimum, be expanded in line with current growth rates and that all imaging equipment older than 10 years be replaced.
- However in Wales, scanning activity levels are low compared with the rest of the UK. It is estimated that Wales is currently performing approximately 33% of the PET scans per head of population compared to England (2020). In addition, NHS Wales has a list of commissioned indications for PET-CT which is limited compared to England and Scotland. Furthermore, Wales has just 0.6 scanners per million population versus ~1.0 scanners per million population in other devolved nations. The picture becomes bleaker when comparing performance and infrastructure with the rest of Europe and beyond.
- Several other significant considerations for this programme are:

- there are patient experience and quality issues associated with mobile scanners that are currently used in South West and North Wales,
- the analogue fixed scanner at PETIC is older than its useful life, causing a significant service delivery risk,
- there are critical workforce issues facing the wider imaging and nuclear medicine professions, with staffing levels low and many core personnel being close to retirement,
- there are issues facing the assurance of radiopharmaceutical supply across Wales, with some but not all radiopharmaceuticals being produced at PETIC in Cardiff and the production facility requiring investment to update equipment, and
- there is a clear need for equitable patient access to research, development and innovation activity in Wales.

The spending objectives are therefore not achievable under current arrangements. Problems with the existing arrangements are described in relation to each of the spending objectives in the figure below.



Addressing the business needs and delivery of the spending objectives will deliver a range of benefits including:

- Improved quality and reduction in patient harm
- Workforce resilience
- Improved efficiency and economy
- Improved access reducing patient travel time
- Cost effective service supported by income generation
- Provide capacity that meets population needs in line with international best practice
- Increased opportunities for Research and Development
- Increased opportunities for innovation

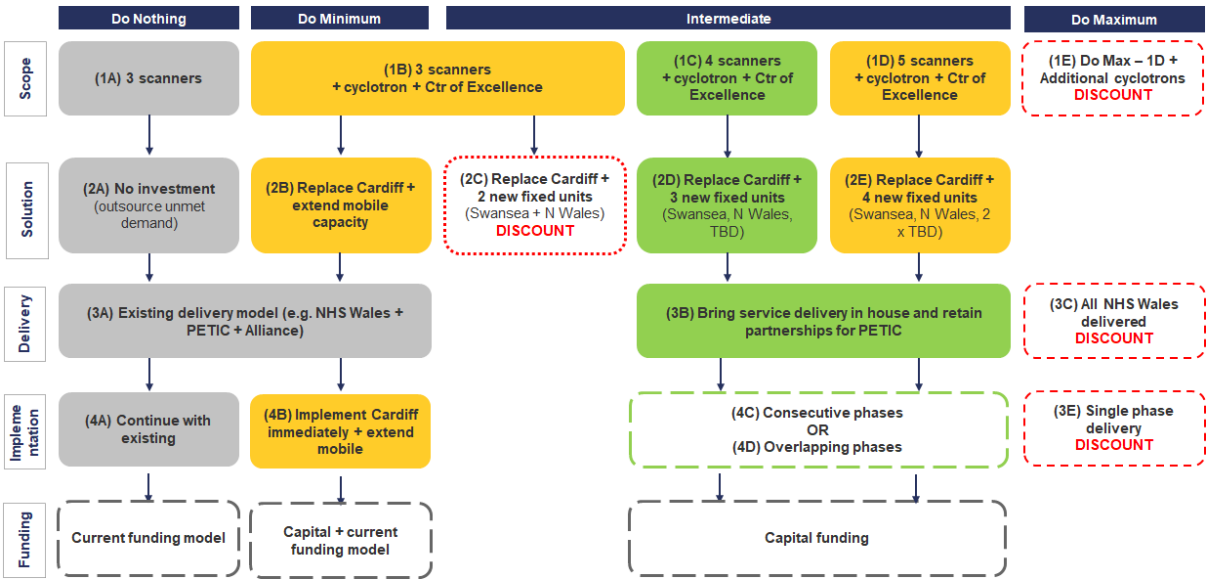
The PBC has a detailed benefits log as part of its appendices.

The Economic Case

In accordance with HM Treasury's Green Book 2020 (A Guide to Investment Appraisal in the Public Sector) and Better Business Case guidance, a wide range of options have been considered that could deliver the agreed spending objectives for the following five categories of choice:

- Scope (service and geographical coverage)
- Solution (including services and required infrastructure)
- Service delivery (who will deliver the required services)
- Timing and phasing of delivery
- Funding of the investment

Stakeholders identified a long list of options for each of these categories and assessed them in relation to how well each meets the agreed spending objectives and critical success factors. An overview of the long list is shown in the diagram below.



The results of this were aggregated into a shortlist of options as shown in the table below.

Options	Option 1 Business as Usual	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Scope	**3 Scanners (Core scope)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales	**3 Scanners (Core + Desirable scope)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff • Centres of Excellence facilities (with new scanners)	**4 scanners (+Desirable)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff • Centres of Excellence facilities • 1 additional PET-CT or PET-MR scanner (aligned to clinical model/demand)	**5 scanners (+Optional)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff Centres of Excellence facilities • 2 additional PET-CT or PET-MR scanner (aligned to clinical model/demand)
Solution	**No investment (Outsource unmet demand to mobile scanners)**	**Replace Cardiff equipment + extend mobile capacity in Swansea and North Wales**	**Replace Cardiff equipment + 3 new fixed units (Swansea, North Wales, 1 location to be determined)**	**Replace Cardiff equipment + 4 new fixed units (Swansea, North Wales, 2 locations to be determined)**
Delivery	**Existing delivery model** (e.g. NHS Wales + PETIC + Alliance)	**Existing delivery model** (e.g. NHS Wales + PETIC + Alliance)	**Bring service delivery in house and retain partnerships for PETIC**	**Bring service delivery in house and retain partnerships for PETIC**
Implementation	**Continue with existing arrangements**	**Deliver Cardiff replacement + extend mobile provision**	**Phased approach** • Cardiff 2021/22 • North Wales 2023/24 • Swansea 2023/24 • 4th scanner 2025/26	**Phased approach** • Cardiff 2021/22 • North Wales 2023/24 • Swansea 2023/24 • 4th scanner 2025/26 • 5th scanner 2028/29
Funding	**Current funding model**	**Capital and revenue**	**Capital funding**	**Capital funding**

The following shortlist was therefore carried forward to the economic appraisal to evaluate the costs, benefits and risks in order to identify the option that is most likely to offer best public value for money:

- Option 1 – Business as Usual: Do nothing.
- Option 2 – Do Minimum: Retain 1 fixed scanner and extend capacity of 2 mobile scanners.
- Option 3 – Preferred Way Forward: Provide 4 fixed scanners (10-year programme).
- Option 4 – More Ambitious: Provide 5 fixed scanners (10-year programme).

At Project business case stage, the development of detailed designs which will determine patient flows and resource requirements will allow costs, benefits and risks to be estimated with a greater degree of certainty. For the purposes of the PBC, indicative capital costs have been estimated by Specialist Estates Services and indicative revenue costs, benefits and risks have been estimated based on high-level assumptions which are outlined in detail in the Economic Case.

Based on these assumptions, the Comprehensive Investment Appraisal (CIA) model has been prepared to estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option. An overview of the results is presented in the table below.

	Option 1 **Business as Usual (BAU)**	**Option 2** **Do Minimum**	**Option 3** **Preferred Way Forward**	**Option 4** **More Ambitious**
Description	Do nothing	Retain 1 fixed and extend capacity of 2 mobile scanners	Provide 4 fixed scanners (10-year programme)	Provide 5 fixed scanners (10-year programme)
Incremental NPSV	-	£4.4m	£54.0m	£68.3m
Benefit Cost Ratio	-	0.00	2.30	2.38
Average cost per scan (10 year period)	£935	£898	£729	£708
Sensitivity and risks	Consistently ranks as worst value for money even with significant changes in assumptions	Consistently ranks as second worst value for money even with significant changes in assumptions	Ranks as best value for money if demand growth is lower than 17.5% year on year	If demand growth is lower than predicted 5th scanner will be significantly underutilised

The analysis concluded that although Option 4, which involves a programme to provide five fixed scanners within the next 10 years, results in the highest NPSV and Benefit Cost Ratio, this is relatively sensitive to changes in the demand growth assumptions. Option 3, which involves a programme to provide four fixed scanners within the next 10 years, delivers the second highest NPSV and Benefit Cost Ratio, while providing greater flexibility to review requirements as more evidence emerges about demand growth in the future.

It is therefore recommended that Option 3 is carried forward as the preferred way forward for delivering the programme and the potential need for a fifth scanner assessed at a later date.

The Commercial Case

The Programme will look to acquire four fixed, digital (Artificial Intelligence enabled) PET-CT scanners and install these key items of equipment at four locations across Wales. This procurement includes ancillary equipment, radiotherapy adaptations, in addition to an ion source and hot cell replacement for the cyclotron at the Cardiff site.

In line with clinical demand and workforce availability, the implementation of the Programme will need to be carried out in a phased manner. Dependent upon the timings of the phases and or the available funds, it may be possible to aggregate NHS Wales' purchasing requirements so as to generate additional value.

There are multiple procurement routes that can be followed, however all of the major items of equipment are available on a compliant pre-approved framework. NHS Wales has direct access to this framework and at the time of writing it is thought that Cardiff University can, through its own procurement department, access this same agreement.

Given the scale and impact on current Welsh NHS services that the All Wales PET Programme will deliver, it is imperative to ensure appropriate governance is in place for procurement. As such we propose that a multidisciplinary team will make up membership of a Procurement Workstream that will support the Programme.

The Procurement Workstream will be made up of specialist colleagues from both NWSSP-SES and NWSSP-PS, in addition to local procurement and estates and facilities teams to ensure that expertise and information is shared effectively and efficiently.

The Financial Case

Delivery of the preferred way forward, which involves implementing a programme that will deliver four fixed digital scanners in Wales requires capital investment of £24.881m for which funding is sought from Welsh Government.

As well as delivering a wide range of non-financial benefits in relation to service improvements and patient experience and outcomes, this will enable three of the scanners to reduce the average cost per scan to £572, compared with an average cost from external providers of £935. This will result in an overall average cost per scan for all four scanners over a 10-year period to £729.

Indicative modelling suggests that revenue costs could increase by £25.6m per annum by 2030/31 based on predicted demand growth. This investment will contribute to mitigating the ongoing cost pressure associated with growing demand including:

- Reduction in average cost per scan resulting in £6.6m annual financial benefit by 2030/31.
- Opportunities to deliver system-wide financial benefits due to increased PET-CT scanning reducing the need for high-cost late stage interventions. There is insufficient detail available on specific demand by patient pathway to calculate this at this stage.
- Opportunities for income generation from RD&I activities which, based on 7% of predicted demand, is estimated at around £3.3m by 2030/31.

Revenue funding for PET scanning is currently provided via WHSSC on a price-per-scan basis, with existing service providers charging WHSSC an agreed price for each scan carried out. WHSSC has

included projected growth in PET scanning demand within the WHSSC ICP plan. It is expected that each local organisation that will host a PET-CT scanner will make clear how they, as service providers commissioned by WHSSC, will incorporate the additional revenue implications i.e. staff and running costs, into the price-per-scan that they charge WHSSC.

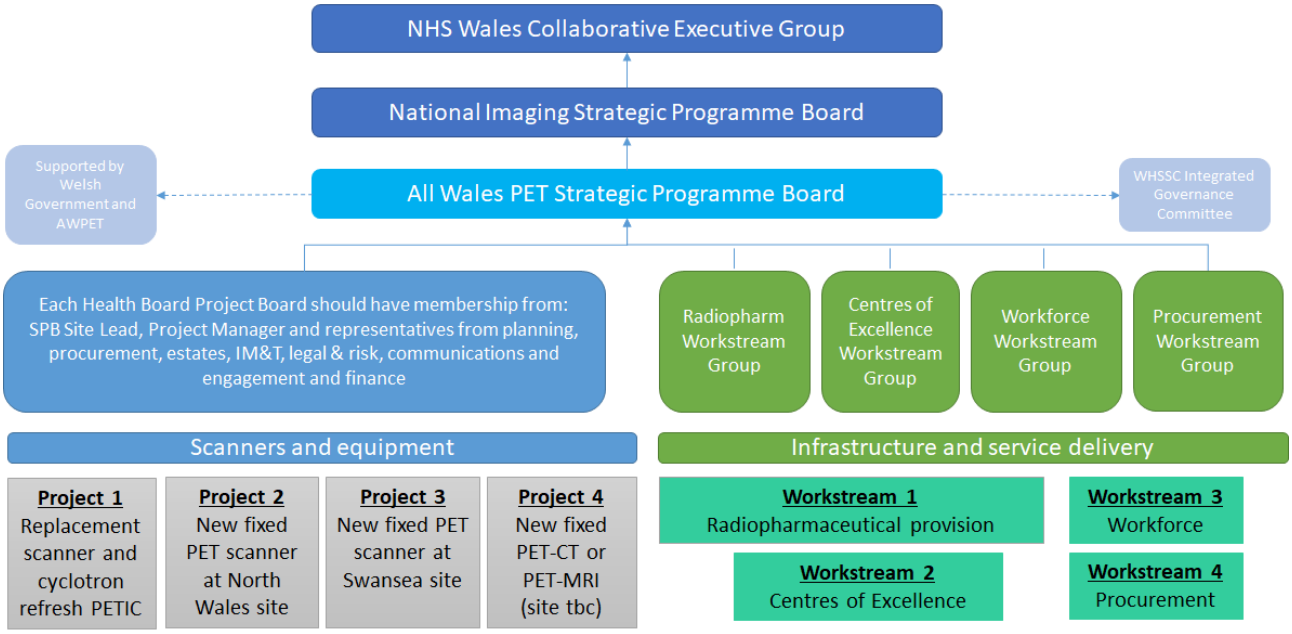
The Management Case

Programme structure

The All Wales PET Programme is a strategic Programme that is hosted by WHSSC and sits within the "Strategic Resource Planning" category of the National Imaging Programme Strategic Board (NIPSB). The NIPSB is hosted and supported by the NHS Wales Collaborative and the NHS Wales Collaborative Executive Group (CEG).

The All Wales PET Strategic Programme Board (SPB) is the formal decision making forum for the programme, and is chaired by the NHS Senior Responsible Officer (SRO), the Managing Director of WHSSC, Dr Sian Lewis.

The Programme structure as set out below ensures clear accountability and also deploys mechanisms to facilitate decision making, escalation, communication and alignment.



The scope of this Programme is limited to procurement of the following list of equipment:

- Four digital PET-CT Scanners (Artificial Intelligence enabled; one scanner at each site);
- Ancillary equipment and phantoms (robotic radiotracer dispenser);
- Radiotherapy adaptions (laser bridge, flat table top).

The equipment is to be located at Cardiff (replacement scanner), Swansea (new scanner) and North Wales (new scanner). The fourth scanner (new) placed at a location to be defined at a later date will be based upon clinical demand and population density. Associated build works for the PET site

facilities are also within scope. Furthermore, refresh of equipment connected with the cyclotron at Cardiff is within scope of this Programme, thus requiring procurement of:

- Ion source replacement within the cyclotron
- Hot cell replacement and associated GMP build.

Supporting infrastructure to PET has been identified as an essential consideration to the success of the PET Programme delivery, including workforce and research and development. As such, these elements have been considered as within scope and are addressed in the Programme structure, with a series of sub projects for implementation works and supporting workstreams.

Programme Plan

Programme implementation will be phased so that sufficient time is given to scrutinise supporting business cases for Projects. This will ensure supporting infrastructure requirements are solved at appropriate timings, in order to optimise delivery and ultimately PET service provision.

Business Case (BC)	Proposed date of Welsh Gov. BC approval	Proposed "go live" date	
Tranche 1			
Project 1			
BJC	July 2021	PET Scanner	March 2022
		Ion Source replacement	March 2022
		Hot Cell replacement	March 2023
Tranche 2			
Project 2			
SOC1	July 2021	January 2024	
OBC/FBC	March 2022		
Project 3			
OBC2	November 2021	November 2023	
FBC2	July 2022		
Tranche 3			
Project 4			
Appraisal Process	April 2023	June 2026	
OBC3	January 2024		
FBC3	December 2024		
Tranche 4			
		January 2027	

Further to endorsement of the PBC, the programme will expand to provide the capacity to procure, prepare and implement the programme solution. At the time of writing, the NHS Wales Collaborative

fund a programme manager that is hosted by WHSSC on a fixed-term basis. This role forms the core of the All Wales PET Programme Management arrangements and is funded until March 2022.

The anticipated annual staffing cost of the Programme Implementation is £115k and will consist of a national programme manager and administrator, providing a total cost of £575k over the five year total implementation and evaluation period. Local organisations that will host a PET-CT scanner will need to source a project manager from within their existing resource for the duration of local implementation and these arrangements should be outlined in subsequent project business cases.

External Programme Review and Assurance

This Programme has clearly defined internal governance arrangements and will be subject to the OGC Gateway™ Review processes. The Programme will also be subject to audit by the NWSSP (Audit and Assurance Services).

Benefits realisation

A detailed Benefits Register is included in the Appendices, alongside detailed Benefits Maps in in the full Management Case. On endorsement of this PBC, the baselining of these benefits will begin in advance of implementation of scanners.

Risk Management

The All Wales PET Programme will utilise its governance structure and arrangements to ensure the effective management of risk. The governance structures allow for risks to be escalated from Project boards and Workstream groups, through to the Strategic Programme Board and/or the Health Board/Trust, as appropriate.

Post Programme Evaluation

The All Wales PET Programme is committed to ensuring that a thorough Post-Programme Evaluation (PPE) is undertaken after the Programme has concluded, to ensure that positive lessons can be learnt. This is noted in tranche 4 of the Programme Plan.

The All Wales PET Programme is also committed to ensuring that lessons are learned at all key stages during implementation, so these can be fed into the wider Programme.

As such, there will be two Evaluation sessions held after each Tranche:

- **Lessons learned and post tranche review** – to be held two to three months post tranche completion.
- **Evaluation of benefits, outcomes & spending objectives** – to be held six to twelve months post tranche completion.

1 Strategic Case

1.1 Introduction

1.1.1 Purpose

The purpose of the Programme Business Case (PBC) is to set out the case for an All Wales Positron Emission Tomography (PET) Programme with sufficient capacity to meet the projected increased demand for PET scanning over the next ten years. It considers the requirements in terms of infrastructure, workforce, and research, development and innovation (RD&I).

This introductory section of the PBC provides an overview of:

- The context of the proposed investment.
- The governance arrangements for the programme.
- The structure and the content of the PBC.

1.1.2 Context of proposed investment

A PET-CT scan is where Positron Emission Tomography is combined with Computerised Tomography (CT) to produce a highly detailed image. This combination is the most commonly used approach in PET scanning and as such, scanning may be referred to as either PET or PET-CT throughout this document.

PET-CT scanning services in Wales are commissioned by the Welsh Health Specialised Services Committee (WHSCC) [1, 2]. NHS Wales currently has three providers delivering PET-CT services, and the respective University Health Board (UHB) where these are located are responsible for managing the service:

- A fixed site at the University Hospital of Wales in Cardiff (the Wales Research and Diagnostic Positron Emission Tomography Imaging Centre; PETIC) (Cardiff and Vale UHB).
- A mobile service at Wrexham Maelor Hospital (2 days per week) (Betsi Cadwaladr UHB)
- A mobile service at Singleton Hospital, Swansea (2 days per week) (Swansea Bay UHB).

PET-CT has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions. Its role and the evidence base continue to evolve. Although it is a relatively expensive investigation, when used appropriately PET-CT can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments.

There is an increasing body of high-quality evidence to demonstrate the contribution of PET to improved patient outcomes. There are many studies that have demonstrated the role PET-CT has in accurately determining the staging of certain cancers and subsequent treatment plans, which enables reduction of inappropriate patient management and allows for best prognosis and patient care [3, 4, 5].

Demand for PET-CT is growing, however in Wales, scanning activity levels are lower compared with the rest of the UK. It is estimated that in 2019 Wales was performing approximately 33% of the PET scans per head of population compared to England. In addition, NHS Wales has a list of funded

indications for PET-CT which is limited compared to England and Scotland. The picture becomes bleaker when comparing performance with the rest of Europe and beyond.

In November 2018, the All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) produced a report "Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations" [6].

A detailed summary of this report is available in section 2.11. One of its five key recommendations was that WHSSC should be commissioned to produce a PBC for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

In March 2019, the Director General, Health and Social Service/NHS Wales Chief Executive, Welsh Government endorsed the report recommendations and outlined the expectations for NHS Wales to collaborate on their implementation. As there was recognition that additional capital investment would be required to develop the service, the Director General requested that WHSSC develop the PBC, with support from the National Imaging Strategic Programme Board (NIPSB), to guide the development of future service provision for the whole of Wales.

This document sets out the PBC which:

- Explores the case for change in terms of the gap between existing arrangements and future business needs.
- Describes the appraisal undertaken to identify a preferred option for the future service model that will address this gap and deliver optimum public value for money.
- Assesses alternative procurement routes available to deliver the preferred way forward.
- Determines the overall capital and revenue requirements and assesses affordability.
- Sets out the programme management arrangements to deliver the preferred way forward.

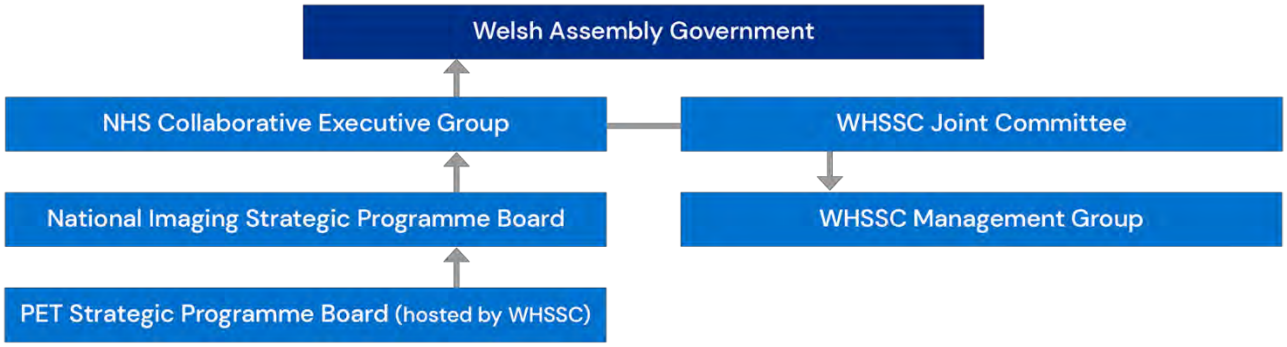
1.1.3 Programme governance

The PET Strategic Programme Board (SPB) was established to develop and implement the recommendations from the AWPET report (see section 1.3.8).

The Senior Responsible Officer (SRO) of the Programme Board is Dr Sian Lewis, Managing Director, WHSSC and Deputy SRO is Dr Andrew Champion, Assistant Director, Evidence Evaluation and Effectiveness, WHSSC.

The SPB is accountable to the National Imaging Strategic Programme Board (Figure 1).

Figure 1: Programme governance structure



1.1.4 Structure and content of the PBC

This PBC follows the Five Case Model in line with HM Treasury Green Book and Welsh Government best practice guidance as set out in 'Better Business Cases: Guide to Developing the Programme Business Case'[1]. The structure of the PBC is outlined in the table below.

Table 1: Structure of the Programme Business Case

Case	Section		Purpose
Strategic Case	1.1	Introduction	Sets out the background and programme governance.
	1.2	PET Scanning Context	Provides context for the proposals by describing what PET is, the steps involved in a PET-CT scan, an overview of the production of radiopharmaceuticals and specialist workforce.
	1.3	Strategic Context	Provides an overview of current services and explains how the programme is strategically placed to contribute to the delivery of organisational goals.
	1.4	Case for Change	Establishes the case for change by outlining the spending objectives, existing arrangements and business needs.
	1.5	Potential Scope	Identifies the potential scope of the programme in terms of the operational capabilities and service changes required to satisfy the identified business needs.
	1.6	Benefits and Risks	Identifies the benefits, risks, constraints and dependencies for the project.
Economic Case	2.1	Options Identification	Explores the preferred way forward by agreeing critical success factors (CSFs), determining the long list of options, and undertaking a SWOT analysis to identify a shortlist of options.
	2.2	Economic Appraisal	Appraises the economic costs, benefits and risks for the shortlisted options. Identifies the preferred way forward by reviewing the outputs of the economic appraisal, as well as consideration for the benefits and risks of each of the three shortlisted options to determine which option offers the best value for money
Commercial Case	3	Procurement Arrangements	Outlines the procurement strategy and the contractual arrangements for development of the deal that is required to deliver the preferred solution for the programme.
Financial Case	4	Financial Appraisal	Sets out the forecast financial implications of the preferred way forward.
Management Case	5	Management Arrangements	Sets out the arrangements put in place to manage the programme to successful delivery.

[1] https://gov.wales/better-business-cases-investment-decision-making-framework

1.2 PET scanning Context

1.2.1 Introduction

This section of the PBC provides context to the All Wales PET Programme by providing an overview of PET including:

- A description of PET.
- The steps involved in PET-CT scans.
- The production of radiopharmaceuticals.
- Specialist workforce for PET scanning.

1.2.2 What is PET?

Positron emission tomography (PET) is a scanning technique that produces detailed 3-dimensional (3D) images of the inside of the body. The images can clearly show the part of the body being investigated, including any abnormal areas, and can highlight how well certain functions of the body are working.

A PET-CT scan is most commonly used where PET is combined with Computerised Tomography (CT) to produce an even more detailed image. The main clinical benefit of using PET-CT scanning lies in its ability to link changes in metabolic activity (PET), with anatomical imaging (CT), allowing for more accurate identification of the location, size and shape of tumours through identifying abnormal cellular activity. PET can also be used alongside Magnetic Resonance Imaging (MRI).

PET-CT scans are particularly helpful for investigating cases of cancer, for example to determine how far the cancer has spread and how well it is responding to treatment. As PET is a functional technique, it can detect tumours and metastatic spread of cancer much earlier than other anatomical imaging techniques such as CT or MRI. Indeed, PET is more sensitive than either CT or MRI in the detection of cancer and results in more accurate staging and typically changes patient management in 30-40% of patients that are scanned.

The breadth of application of PET-CT scanning is expanding and it is increasingly being used to help plan operations, such as a coronary artery bypass graft or brain surgery for epilepsy. Some specific scanning can assist in the diagnosis of conditions such as dementia, Alzheimer's or Parkinson's disease.

PET scanners work by detecting the radiation given off by a substance that has been injected into the body as it is metabolised in different parts of the body. This substance is called a radiopharmaceutical. Radiopharmaceuticals consist of two components: a radionuclide and a biological molecule or "carrier". The radionuclide is chosen on the basis of the radioactive decay characteristics.

Positron emitting radionuclides decay via emission of positrons (particles with the mass of electrons but with a positive charge). Positrons interact with surrounding electrons in the body. This electron and positron interaction causes the annihilation of both particles, releasing energy in the form of two 511keV gamma photons which travel in opposite directions. The resulting gamma rays are detected by a ring of detectors - the PET camera - that surround a patient during a scan. The ring of detectors feeds into computer software that creates a 3D image of the radiopharmaceutical presence in the body.

The carrier molecule, for example glucose, is chosen to match a particular function within the body. Therefore, altering the carrier molecule means that clinicians are able to target specific organs, tissues or cells within the human body. In most PET scans a radiopharmaceutical called

fluorodeoxyglucose (18F-FDG) is used. The 18F is the radionuclide and the DG (deoxyglucose) is the carrier.

The deoxyglucose is metabolised by the human body in a similar manner to glucose. Tumours often demonstrate increased metabolism and as a result will show up as areas of increased 18F-FDG uptake on the PET scan.

By analysing the areas where the radiopharmaceutical is metabolised, it is possible to visualise how well certain body functions are working and identify any abnormalities. For example, a concentration of 18F-FDG in the body's tissues can help identify cancerous cells because cancer cells use glucose at a much faster rate than normal cells.

1.2.3 Steps involved in a PET-CT scan

Before the scan, the radiopharmaceutical is injected into a vein in the patient's arm or hand. The patient needs to wait quietly and keep warm for about an hour to give the radiopharmaceutical time to be absorbed by the cells in the body, a process known as 'uptake'. It is important to relax while waiting because moving and speaking can affect how and where in the body the radiopharmaceutical is absorbed.

Figure 2: a PET-CT scanner

During the scan, the patient lies on a flatbed that is moved into the centre of the scanner.

The duration of a scan depends on which part of the body is requested for imaging, and which radiopharmaceutical is being used.

On average and in general, scans typically take between 30 minutes for an 18F-FDG scan and 45 minutes for an 18F-PSMA scan.

Following the scan, a patient is asked to make use of a "hot toilet" where any radioactive material that may be present in the patient's body, may be safely expelled and managed.

For more details on the steps involved, please see Appendix 1: Service Operating Model.

1.2.4 Production and management of radiopharmaceuticals

Approximately 95% of PET-CT scans are currently performed using a radiopharmaceutical called fluorodeoxyglucose or 18F-FDG. Many other radionuclides are under development and are likely to see widespread use, both in the clinic and for research, within the next five years.

The decay of a radioactive substance is termed "half-life" and this refers to when the unstable radioactive nuclei has decayed. Typical half-life is a matter of hours, some are within minutes, and such preparations therefore have very short "shelf-lives". 18F has a two-hour half-life and, as a result, radiopharmaceuticals labelled with 18F require manufacture and use on the same day. Furthermore, the shelf-life of a radiopharmaceutical is dependent on the radiochemical stability and impurities

within the preparation. For example, 18F based preparations such as 18F-FDG and 18F-PSMA are normally intended to be used within 10 hours of preparation.

As a result of this short half-life, radiopharmaceuticals must be produced immediately prior to use in patients. This is a significant factor for consideration when planning the location of a PET scanner as it needs to be easily accessible for delivery of the radioactive material, to ensure that a sufficient dosage arrives in time for a patient's scan.

Radionuclides for PET radiopharmaceuticals are produced in cyclotrons. A cyclotron is a particle accelerator, an electrically powered machine which accelerates charged particles in a spiral path and produces a beam of charged particles. These particles are then processed in a clean room and combined with a pharmaceutical molecule to produce a radiopharmaceutical for use in patients.

The proximity of the PET-CT scanner to the cyclotron has a bearing on 'recovery' plans should the cyclotron or scanner fail at a given session. If a scanner is located near to a cyclotron, the more feasible it is for a rapid second delivery of radiopharmaceutical should the first batch be wasted due to scanner delays or faults or should the cyclotron fail to manufacture a first batch of suitable quality.

The production of radiopharmaceuticals is strictly controlled. Production centres must have a licence from the Medicines and Healthcare Products Agency (MHRA) to manufacture and supply radiopharmaceuticals for PET-CT imaging for both clinical and clinical trial use. There are three types of license:

- **Marketing Authorisation (MA):** supplying the product commercially. For example, ^{18}F-FDG.
- **Investigational Medicinal Product (IMP):** supplying the product to sites carrying out a research trial (cannot be administered to a patient outside of a clinical trial)
- **Specials License[2]:** this is where a production centre can manufacture to a specification, satisfy itself of the quality and supply other sites where a marketing authorisation is not in place. For example, ^{68}Ga or ^{18}F-PSMA and ^{18}F-DOPA.

The handling of radioactive materials and disposal of radioactive waste is also strictly controlled and is an important consideration in the planning and design of PET-CT facilities.

The radiological installation or operator organisations that use radioactive substances will inevitably produce such waste following the administration of PET radiopharmaceuticals to patients.

The keeping and use of radioactive materials, and the accumulation and disposal of radioactive waste or activities will be detailed in site-specific permits issued by the Environment Agency (EA) (Natural Resources Wales (NRW) in Wales). Radiological risk assessments will be required as part of the permit application process. An overarching procedure for managing PET radioactive waste at a radiological installation should describe the best available techniques to minimise the impact on the public and the environment from the use and disposal of such waste.

Operators who accumulate, dispose or manage radioactive waste must appoint a suitable radiation protection expert. Radioactive Waste Advisors (RWA) are specialists in radioactive waste management and environmental radiation protection. In particular, a designated 'hot' toilet is required for PET patients and a lockable shielded safe is required to decay-store PET radioactive waste.

[2] The Medicines Act 1968 allows a GMP facility to produce and sell unlicensed radiopharmaceuticals as 'specials' if they are not licensed in the jurisdiction of the UK. If they are licensed (have a MA) they can be made for local use but cannot be sold (or given) to another institution. All 'specials' radiopharmaceuticals can furthermore be subjected to a MA which (once granted) would preclude existing facilities to manufacture the product for sale

1.2.5 Specialist workforce for PET scanning

PET-CT is a complex imaging modality (sub-speciality of nuclear medicine) that requires a specialist skill mix for a service to run. The reasons that necessitate such a specialist skill mix include the handling and administration of radioactive material, dealing with radioactive waste and operating highly technical equipment. As such, it is a tightly regulated field of work (note IR(ME)R 2017, IRR17, Environmental Permitting Regulations 2016). These regulations govern the practice of PET-CT as well as the rest of nuclear medicine. Given the level of specialisation within PET-CT, most staff members start their careers in general SPECT nuclear medicine and specialise later in PET-CT. Therefore there is transferability of skills between PET and nuclear medicine.

It is a legal requirement under IR(ME)R 2017 for employers to hold an Administration of Radioactive Substances Advisory Committee (ARSAC) licence at each medical radiological installation (hospital, etc.) where radioactive substances are to be administered to humans, and additionally for practitioners to hold individual ARSAC licences in order to justify the administration of those substances. A nuclear medicine service cannot therefore operate without these licences in place.

It is the ARSAC who provides advice to the relevant licensing authority on the issue of these licences. Practitioners who wish to apply for a licence to enable them to support a comprehensive diagnostic nuclear medicine imaging service should have satisfactorily completed the Royal College of Radiologists (RCR) Radionuclide Radiology Subspecialty Training Programme, the Royal College of Physicians (RCP) Nuclear Medicine Speciality Training Programme or demonstrate an equivalent level of training.

1.3 Strategic Context

1.3.1 Introduction

This section of the PBC outlines the strategic context for the All Wales PET Programme by providing an organisational overview and explaining how the proposals are strategically placed to support the delivery of organisational goals. It includes:

- An overview of the lead organisation and stakeholders.
- An analysis of population needs including demographic growth and disease prevalence.
- An outline of how the programme is essential to achieving the overall business strategies and aims of NHS Wales.
- A description of how the programme contributes to strategic goals within the context of the Imaging service.
- An overview of interdependencies with other relevant programmes and strategies.

1.3.2 Organisation overview

The All Wales PET Programme is led by Welsh Health Specialised Services Committee (WHSSC). WHSSC is responsible for the joint planning of Specialised and Tertiary Services on behalf of local health boards in Wales.

WHSSC Commissioning policies define the specialised services commissioned by WHSSC on behalf of the seven Welsh Health Boards and the criteria that must be met for Welsh patients to access the treatment.

WHSSC Service specifications are important in clearly defining what WHSSC expects to be in place for providers to offer evidence-based, safe and effective services and importantly, sets equitable access to services for Welsh patients.

WHSSC supports NHS Wales and the Health Boards by ensuring that there is equitable access to safe, effective, and sustainable specialist services for the people of Wales, as close to patients' homes as possible, within available resources. WHSSC has an established Prioritisation Process and Risk Management Framework to help identify the priorities for the WHSSC Integrated Commissioning Plan (ICP) [7].

WHSSC must ensure that any new investment decisions are affordable, offer value for money and are supported by convincing evidence of safety and effectiveness. To do this WHSSC runs an annual prioritisation process to determine the relative prioritisation of new interventions within specialised services. The process is facilitated by the WHSSC Clinical Impact Assessment Group (CIAG) and their recommendations (or priorities) are subsequently presented in the WHSSC ICP.

The WHSSC ICP 2020-23, which was approved by Joint Committee in February 2021, included investment in a number of new key clinical areas recommended by CIAG. This included a recommendation to support 20 new or updated PET indications across six disease areas that will account for an additional 679 scans per year across Wales.

Other stakeholders for the programme are:

- All Health Boards in NHS Wales;
- Velindre University NHS Trust;
- Cardiff University;
- PET providers in NHS England commissioned by WHSSC;
- National Imaging Strategic Programme Board (NIPSB);
- Welsh Government;
- Imaging Workforce and Education Group (IWEG);
- NHS Health Collaborative;
- Wales Cancer Network and other relevant specialist groups or organisations (e.g. Royal College of Radiologists);
- National Imaging Academy Wales (NIAW);
- Health Education and Improvement Wales (HEIW);
- Digital Health and Care Wales (DHCW; formerly the NHS Wales Information Service).

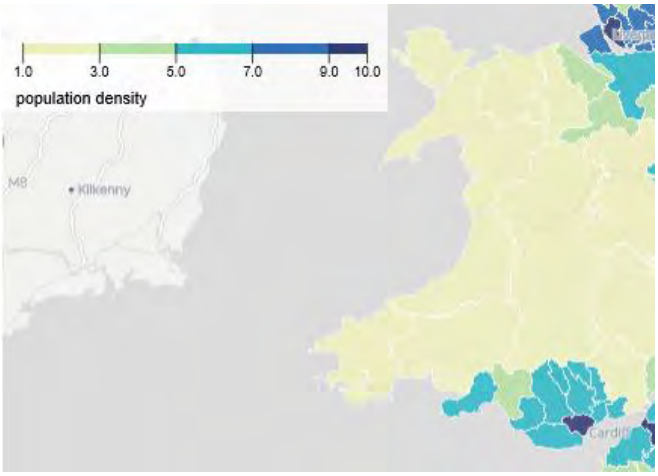
Collaboration with:

- Consultant Radiologists;
- Nuclear Medicine;
- Medical Physics;
- Cancer MDTs and non-cancer MDTs;
- Planning and Estates departments.

1.3.3 Population needs: Demographic growth

The mid-2019 population of Wales was 3,152,879 (1,554,678 males at 49.3%, and 1,598,201 females at 50.7%) (Dataset: Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland, ONS, June 2020).

Figure 3: Population density



Map sourced from Dataset: Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland, ONS, June 2020

Predicted population growth for Wales over the next 10 years is 0.25% p.a. ("Stats Wales: Population projections by local authority and year", 2018), which suggests that the population of Wales is likely to be 3.2 million by 2031.

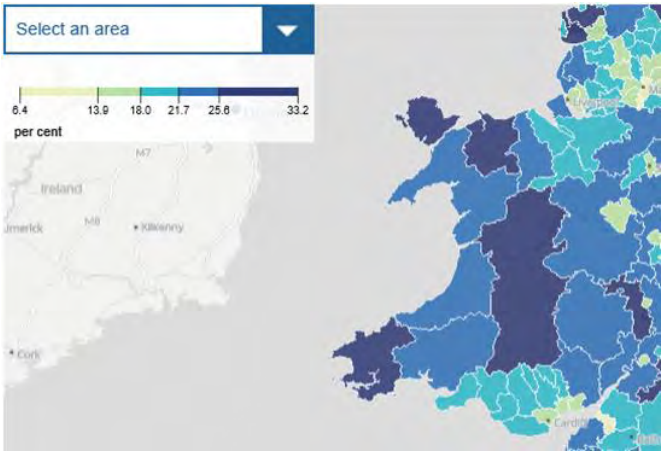
This is a modest growth and is in line with the 2018 National Population Projections by the Office of National Statistics.

The 2020 population density across Wales can be seen in Figure 3, where Cardiff and the surrounding South Wales areas have the highest density of people. The highest density of Welsh citizens in North Wales is centred on Wrexham.

The population aged 65 years and over experienced the highest level of growth of any broad age group in 2019 (ONS, Dataset: Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland). There was a relatively uniform increase in the number of people aged 65 years and over in the year to mid-2019 across the constituent countries of the UK, with England

(1.7%), Scotland (1.8%), Wales (1.6%) and Northern Ireland (2.1%) all experiencing a similar proportion of growth.

Figure 4: Proportion of population 65 or older



Map sourced from Dataset: Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland, ONS, June 2020

The 2019 ONS Dataset critically demonstrated how Welsh rural areas typically have older populations than cities. This is an important consideration in service provision and access to key clinical services (Figure 4).

More detail on population growth estimates can be found in Appendix 2.

1.3.4 Population needs: Disease Prevalence

Although Welsh population growth over the next 10 years will be modest, Wales is projected to realise growth in the 65+ population of around 130,000 by 2031, which is a significant demographic shift. An aging population will mean increased overall demand for health and care services (Future of an Ageing Population, Government Office for Science, 2016).

Population ageing will mean a greater prevalence of age-related conditions, such as dementia and chronic conditions affecting the heart, musculoskeletal and circulatory system. Data from Cancer Research UK correlates increased incidence of cancer with age at diagnosis (Cancer Research UK, https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/age#heading-Zero, Accessed January 2021).

Wales has a higher prevalence of cancer and chronic heart disease than the UK average. Although dementia in Wales is at a slightly lower prevalence to the UK average, projections are for a substantial increase in the overall number of cases from 822,000 to 940,000 by 2031 in the UK, and more than 1.7 million by 2051 (Alzheimer's Society (2014) Dementia UK: Update, https://www.alzheimers.org.uk/dementiauk, Accessed January 2021). Therefore dementia rates in Wales will likely rise in line with the rest of the UK, and as a marker of an aging population of Wales.

This disproportionate demand on services will include increased requests for imaging diagnostics, which is an important consideration when looking to predict future demand for PET-CT scans. In particular, conditions such as cancer, chronic heart disease and dementia are believed to be the biggest drivers for future PET scanning.

1.3.5 NHS Wales business strategy and aims

The proposals outlined within this PBC are aligned with the national strategic context, supporting a broad range of national strategies and policies. An analysis of these is provided in the table below, showing how the programme will support their delivery.

Table 2: Programme alignment with national strategies

Strategy/Policy	Summary	How the All Wales PET Programme supports this
The NHS Wales Planning Framework 2020-23 [8]	The Framework sets high quality as a key priority which underpins all aspects of services, settings and contacts with the NHS in Wales. It states the need for health organisations to focus on the populations for which they are responsible, with an emphasis on prevention and early intervention, reducing health inequalities, timely access to care and working with wider partners to deliver the best possible services for citizens in Wales.	Patients across Wales will have equitable access to PET-CT services. There will be sufficient capacity within the service to cope with anticipated demand for PET-CT. High-quality, detailed scanning will lead to more accurate diagnosis, improved treatment planning and improved outcomes for patients.
The Parliamentary Review of Health and Social Care in Wales. Final Report. (January 2018) [9]	The Parliamentary Review set out a vision for the future, to include health and social care moving forward together and developing primary care services out of hospitals. The Review's recommendations focus on key themes around seamless care, a great place to work and maximising the benefits of technology and innovation.	Providing seamless care. Improving facilities. Providing greater opportunities in order to attract a highly skilled workforce Maximising the benefits of technology and innovation.
A Healthier Wales: Our Plan for Health and Social Care (June 2018) [10]	'A Healthier Wales' is the Welsh Government's response to the Parliamentary Review. It sets out the vision of a 'whole system approach to health and social care' which is focused on health and wellbeing, and on preventing physical and mental illness. It focuses on 'providing more joined-up services, in community settings', and shifts the emphasis from treating illness to prevention and supporting people to stay well and lead healthier lifestyles.	Addressing the recommendations set out in the Parliamentary Review as described above Focusing on improving access to services that will enable earlier interventions.
The Wellbeing of Future Generations (Wales) Act 2015 [11]	The Wellbeing of Future Generations Act is about improving the social, economic, environmental, and cultural wellbeing of Wales. It makes the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.	Deliver a sustainable service that focuses on Addressing health inequalities Improving outcomes for patients Attracting and developing a highly skilled workforce.

1.3.6 Imaging Service strategic aims

There are a range of strategic aims related specifically to Imaging services that are relevant to the programme including:

- Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations, All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) (November 2018) [6].
- Imaging Statement of Intent, Welsh Government (March 2018) [12].
- Radiology Services in Wales, Auditor General for Wales (November 2018) [13].

- Specialised Services Commissioning Policy: CP50a Positron Emission Tomography, WHSSC and Specialised Services Service Specification: CP50b Positron Emission Tomography - Fixed and Mobile Site [1, 2].

An overview of each of these is provided in sections 1.3.7-10 below.

1.3.7 Imaging Service strategic aims: Imaging Statement of Intent

Imaging services in Wales face a number of significant challenges, for example:

- Increasing demand for non-invasive and accurate imaging modalities.
- Workforce issues related to recruitment, training, and retirement.
- The need to diagnose conditions quicker.
- New imaging techniques and technologies.

Such challenges can lead to unnecessary delays in diagnoses and treatment and there is compelling evidence of the need to transform the provision of imaging services in Wales. To respond to these challenges, it is essential that a coordinated implementation plan for imaging services in NHS Wales is developed. To prepare the ground for this, a Welsh Government-led Imaging Taskforce prepared a strategic, forward looking, Statement of Intent [12].

The table below shows how the All Wales PET Programme supports some of the Statement's key priorities.

Table 3: Programme alignment with Imaging Statement of Intent priorities

Statement of Intent Priority	How the All Wales PET Programme supports this
Workforce development	Makes the case for a well-trained and highly qualified PET-CT workforce, which is flexible and has the correct skill mix. Ensures that the PET-CT service in Wales can attract, retain and develop staff.
Equipment	Sets out the case for new, state-of-the-art equipment to replace ageing facilities, including latest generation digital PET-CT scanners to meet forecast demand for services and a new cyclotron to support the supply of radiopharmaceuticals.
Quality	Improves access to services that will enable earlier interventions and improve clinical outcomes. Provides, through new digital scanners, high quality, detailed images leading to more accurate diagnosis, improved treatment planning and improved clinical outcomes.
Services	Ensures that patients across Wales will have equitable access to PET-CT services. Increases capacity to meet the forecast growth in demand for scanning services.
Research, development and innovation	Provides modern and updated facilities that will create centres and a network of RD&I excellence for staff and will ensure that patients have equitable access to participate in clinical trials.

1.3.8 Imaging Service strategic aims: the AWPET Advisory Group 'PET in Wales' report

The AWPET report [6] provided the strategic vision for Welsh PET Services and outlined, in broad terms, a strategic plan for PET development in Wales. The table below shows how the All Wales PET Programme supports some of the report's recommendations:

Table 4: Programme alignment with AWPET report

Recommendation	How the All Wales PET Programme supports this
Indication list should be expanded based on best clinical evidence	Increases capacity to meet the forecast growth in demand for scanning services, which comes partly from a growing list of clinical indications.
Provide an outline business case (OBC) for the replacement of the end of life machine at PETIC	Sets out the case for new, state-of-the-art equipment to replace ageing facilities, including latest generation digital PET-CT scanners to meet forecast demand for services and a new cyclotron to support the supply of radiopharmaceuticals.
Produce a Programme Business Case for PET-CT capacity in Wales	This PBC forecasts capacity based on increased demand projections, and also considers the requirements for estates, staffing and research and innovation. It also ensures patients across Wales will have equitable access to PET-CT services.
Review the licensing of radiopharmaceuticals	Describes the need for an expanded supply chain for radiopharmaceuticals to support the expansion of PET-CT facilities in Wales. Sets out the case for the replacement of the cyclotron at PETIC. Provides a radiopharmaceutical enabling workstream that will fully assess requirements for the programme, including needs to contractually assure supply outside of PETIC remit, potential MA licensing of the cyclotron at PETIC, horizon scanning of the future of radiopharmaceuticals.
Establish a Welsh PET innovation strategy to support RD&I	Provides modern and updated facilities that will create centres of R&D excellence for staff and will ensure that patients have equitable access to participate in clinical trials. Provides an RD&I enabling workstream and group to lead and support implementation of the programme.

1.3.9 Imaging Service strategic aims: Radiology Services in Wales, Auditor General

Given the challenges facing imaging services in Wales, the Auditor General began a review of radiology services at all health boards in late 2016. The work examined each Health Board's arrangements to meet demand for radiology examinations and made recommendations for service improvements.

Table 5: Programme alignment with Auditor General – Key findings

Key findings	How the All Wales PET Programme supports this
Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results.	Providing the appropriate capacity to meet growing demand for PET-CT services
Recruitment, retention and an ageing workforce are threatening the sustainability of the service and limiting Health Boards' ability to train staff	Developing a PET-CT service and development opportunities that will attract and retain highly skilled staff
Ageing and underutilised equipment are making it harder for health boards to meet demand and health boards do not have the staffing resources to extend opening hours.	Replacing ageing equipment and mobile scanners with new generation digital scanners that can meet the growing demand for PET-CT services

Key findings	How the All Wales PET Programme supports this
Wales-wide radiology IT system challenges and weaknesses in local IT infrastructures inhibit radiology services' efficiency.	Replacing ageing equipment with new generation digital scanners that are enabled for future IT developments.

1.3.10 Imaging Service strategic aims: PET commissioning policy

WHSSC commission and approve funding of PET scans for the population of Wales in line with the criteria presented in commissioning policy CP50a [1] and specification CP50b [2] (which covers requirements for both fixed site and mobile scanners). This defines the requirements and standard of care essential for delivering PET-CT for people of all ages who are resident in Wales.

WHSSC is committed to regularly reviewing and updating all of its clinical commissioning policies based upon the best available evidence of both clinical and cost effectiveness. In September 2016, WHSCC established the multidisciplinary All Wales PET Advisory Group (AWPET). This Group is tasked to review the evidence base for PET-CT and advise WHSSC on the introduction of new indications (including non-oncological indications), ensuring that all decisions are made following a systematic review of the available evidence.

The All Wales PET Programme aligns directly with the objectives of the commissioning policy by seeking to deliver a sustainable high-quality PET service for the people of Wales, ensuring there is equitable access to PET-CT and improving outcomes for those accessing PET-CT services.

1.3.11 Interdependencies and other relevant programmes and strategies

In developing the proposals within this PBC, a number of other relevant programmes and strategies were considered. These are summarised in the table below.

Table 6: Other relevant strategies and considerations

Strategy Summary	How the All Wales PET Programme supports this
Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England, Professor Sir Mike Richards (December 2020) [14]	
Demand for PET-CT scanning in England grew by 18.7% per annum between 2014/15 and 2018/19. Major expansion and reform of diagnostic services is needed over the next five years to facilitate recovery from the COVID19 pandemic and to meet rising demand for all diagnostic services. The review recommends: • scanning equipment should, as a minimum, be expanded in line with growth rates prior to the pandemic and all imaging equipment older than 10 years should be replaced; • a major expansion in the workforce with an additional 2000 radiologists and 4000 radiographers [in England]; • improving connectivity and digitisation to deliver seamless care across traditional boundaries and facilitate remote reporting.	Increases capacity to meet the forecast growth in demand for scanning services. Sets out the case for new, state-of-the-art equipment to replace ageing facilities, including latest generation digital PET-CT scanners and a new cyclotron to support the supply of radiopharmaceuticals Ensures that the PET-CT service in Wales can attract, retain and develop staff.

Strategy Summary	How the All Wales PET Programme supports this
The Single Cancer Pathway, Next Steps To Achieve Earlier Diagnosis In Wales, Cross Party Group on Cancer (November 2020) [15]	
Inquiry into cancer waiting times in Wales to consider how the new Single Cancer Pathway was being implemented during its first year, as well as develop recommendations to identify next steps for cancer diagnosis in Wales. The report made a series of recommendations including: • developing a comprehensive cancer strategy to support the Cancer Delivery Plan; • re-starting reporting against the Single Cancer Pathway, which was paused during the Covid-19 pandemic; • increasing the amount of diagnostic equipment to ensure adequate capacity to manage rising demand for diagnostic services.	Increases capacity to meet the forecast growth in demand for scanning services. Sets out the case for new, state-of-the-art equipment to replace ageing facilities, including latest generation digital PET-CT scanners to meet forecast demand for services and a new cyclotron to support the supply of radiopharmaceuticals
Rapid Diagnostic Centres [16]	
Following a study tour to Denmark to investigate their initiatives to improve cancer diagnosis, Wales is now testing the Danish model by piloting access to rapid diagnostic centres. The centres take referrals for patients who present to primary care with serious but non-specific symptoms, where the GP suspects this could be due to cancer and needs further investigation.	The Programme will engage with this initiative.
Radiology Informatics System Procurement Programme (RISPP) [17]	
The Radiology Informatics System Procurement (RISP) Programme is supporting the modernisation of imaging services across Wales. From 2020 to 2024 the Programme aims to procure an innovative system that will provide a seamless end-to-end electronic solution, from receipt of a referral to the delivery of a radiology report. This will include: • a Picture Archive System (PACS) - storing all diagnostic imaging files; • a Radiology Information System (RIS) - allowing users to track patient records	Will be considered in developing the Programme and in implementation. The All Wales PET Programme will engage with the RISPP where appropriate and required.
The National Imaging Academy Wales (NIAW)	
Established in 2018, the Academy is Wales' flagship purpose-designed, state-of-the-art facility which will meet the increasing need to train radiologists and imaging professionals across the UK.	The Programme supports the aims of the National Imaging Academy by creating centres of excellence to attract and retain highly trained and qualified staff.
Heart Conditions Delivery Plan 2017, Welsh Government [18]	
Plan to both minimise the incidence of preventable heart disease and ensure patients have timely access to high quality pathways of care, irrespective of where they live. Diagnostic tests should be provided as early (within 8 weeks) and as locally as possible. Health Boards should ensure that diagnostic procedures, technologies, treatment and techniques are in line with the latest evidence.	Range of clinical indications may be in scope of PET scanning. Will be considered when developing the Programme.

Strategy Summary	How the All Wales PET Programme supports this
Dementia Delivery Plan 2018-2022, Welsh Government [19]	
Currently only around 53% of individuals in Wales with dementia have a diagnosis. The plan therefore sets targets for health boards to increase diagnosis rates by at least 3% a year.	Range of clinical indications may be in scope of PET scanning. Will be considered when developing the Programme further.
Neurological Conditions Delivery Plan 2017, Welsh Government [20]	
There are around 100,000 people with a neurological condition in Wales. All GPs should have direct access to a range of diagnostic tests and procedures where a neurological condition is suspected. Health Boards should ensure research findings result in service change to improve clinical practice and patient outcomes so patients get quicker access to innovative new diagnostic tools, treatments and medical technologies.	Range of clinical indications may be in scope of PET scanning. Will be considered when developing the Programme further.
Getting it Right First Time Programme National Speciality Report, Radiology (2020) [21]	
The GIRFT report examines ways of meeting the ever-increasing demand on radiology units in England at the same time as shaping a better service for those who use it.	Provides examples of the ways in which existing capacity can be maximised and services expanded. Suggests patient-centred measures that are of interest to the All Wales PET Programme.

1.3.12 Relevant regional issues

There are a number of initiatives taking place across the Welsh Health Boards and other organisations that will have an impact on the Programme.

Betsi Cadwaladr UHB

Initiatives to be considered by the programme:

- The restructure of nuclear medicine in north Wales.
- The Nuclear Medicine service in north Wales, which includes gamma cameras and the mobile PET service, is being consolidated. Currently the service is provided utilising three gamma cameras - one on each of the three main acute hospital sites - and one mobile PET-CT, which is located in Wrexham for two days a week. A Strategic Outline Case (SOC) was submitted to Welsh Government in October 2020 and identifies a series of issues with the Nuclear Medicine service configuration which make it unsustainable in the short and long term, in particular:
  - difficulties in staffing three separate services;
  - obsolete equipment;
  - falling demand for the gamma camera service; and
  - increasing demand for PET-CT.
- The SOC notes that there is an opportunity to improve the quality of the service, make it more resilient and reduce revenue costs.
- The preferred way forward identified in the SOC is to consolidate services in a single Centre of Excellence for Nuclear Medicine at one of the three acute sites across North Wales. The Centre would consist of two gamma cameras and one permanent fixed PET-CT scanner, and would be housed by a combination of new building and refurbishment work. The gamma camera and PET-

CT service would be run by the same radiographers and administrative staff. The programme is currently out to public consultation and the outcome of this is a clear interdependency to delivering this All Wales PET Programme.

Velindre NHS Trust

Initiatives to be considered by the programme:

- Re-provision of the Velindre Cancer Centre on a new site in Cardiff may affect the patient flow to PETIC and may offer opportunities to the All Wales Programme.

Swansea Bay UHB

Initiatives to be considered by the programme:

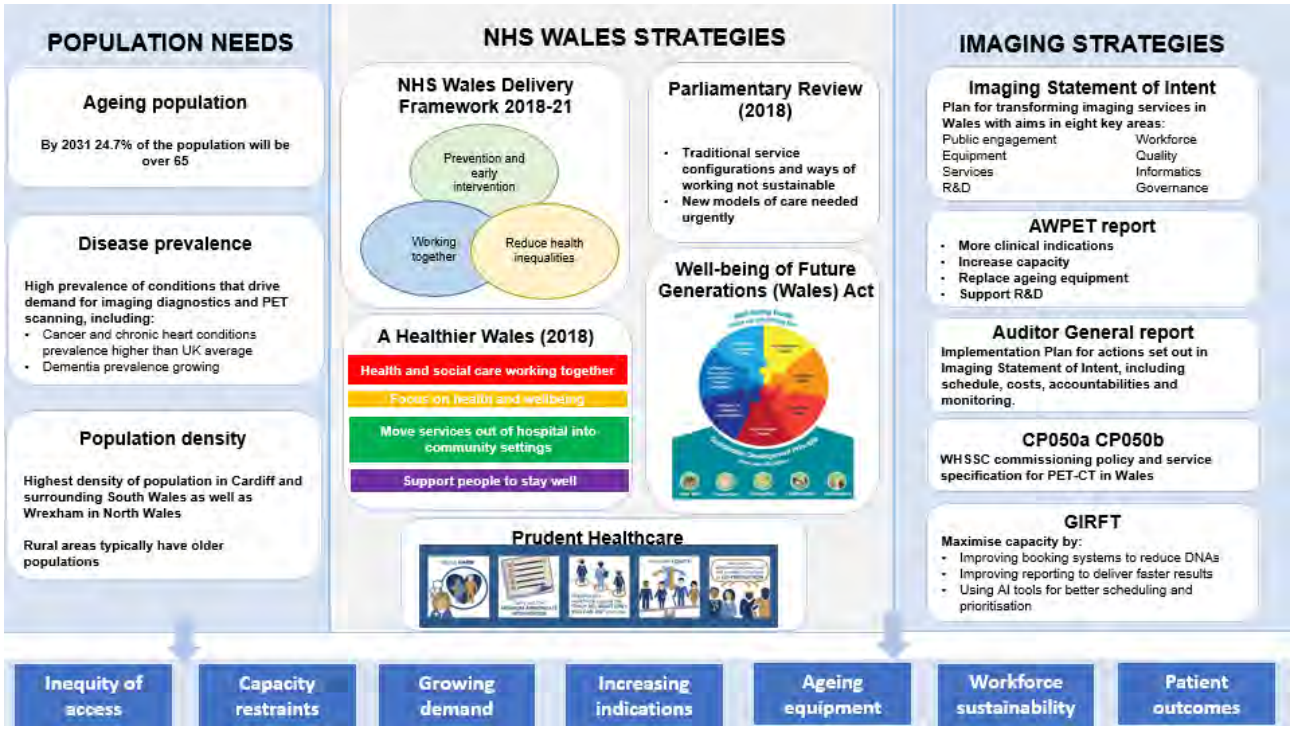
- Currently has an active project that is putting in place two new SPECT cameras and associated facilities.

1.3.13 Summary

The All Wales PET Programme seeks to address population needs while aligning with the strategic direction of Wales and addressing specific strategic issues within the Imaging service. Other relevant strategies and interdependencies with related programmes have been considered in developing these proposals.

An overview of the overall strategic context is provided in the illustration below (Figure 5).

Figure 5: Strategic context



1.4 The Case for Change

1.4.1 Introduction

This section of the PBC establishes the case for change that is driving the All Wales PET Programme, providing a clear understanding of:

- The spending objectives (what the programme is seeking to achieve).
- Existing arrangements (what is currently happening).
- Business needs (what is required to close the gap between existing arrangements and where the service needs to be in the future).

1.4.2 Spending objectives

Spending objectives describe what the programme is seeking to achieve and provides a basis for post-programme evaluation.

The spending objectives were partly informed through early engagement with service providers. A clinical questionnaire was sent to healthcare professionals at all PET providers in Wales and asked the following questions:

- In general terms, what are we not doing now that we should? This could include additional clinical indications for a PET scan, more research, further investment in infrastructure, education and training etc.
- What would you perceive to be the main clinical areas where the demand for PET scans (new indications) will change over the next 5 years, for example cardiology, dementia etc. and to what extent?
- What are the likely technical developments in the pipeline we need to be aware of and factor into future PET imaging services? This maybe to do with advances in technology (more efficient machines, all body PET, more sensitive/specific isotopes etc.)
- Considering the existing PET service across Wales, Is there anything we should not be doing/stop doing?

The questionnaire was sent to 23 clinicians, 12 of whom responded (six Medical Physicists, six PET Consultant Radiologists). The responses were also used to inform the clinical demand model. A summary of the responses is included in Appendix 3.

The final spending objectives were discussed as part of a workshop and subsequently approved by the PET Strategic Programme Board in February 2021 and these are outlined below.

- **SO1** - To improve the quality of PET service provision for Welsh patients by delivering better patient outcomes.
- **SO2** - To ensure a sufficient workforce to deliver a high-quality service.
- **SO3** - To improve delivery of the All Wales PET Service by efficient use of PET-CT scanners, facilities, processes and infrastructure.
- **SO4** - To ensure that the future All Wales PET service provides a cost-effective service for patients and NHS Wales.
- **SO5** - To widen the scope of the All Wales PET service, to meet recognised international best practice.

1.4.3 Existing arrangements

There are currently three PET-CT service providers in Wales, each with an analogue scanner:

- A full-time fixed site and cyclotron in Cardiff at the Wales Research and Diagnostic Positron Emission Tomography Imaging Centre (PETIC). This is a Cardiff University owned PET-CT scanner, which is situated at University Hospital Wales Cardiff site.
- A mobile service at Wrexham Maelor Hospital (2 days per week), provided by Alliance Medical.
- A mobile service at Singleton Hospital in Swansea (2 days per week), provided by Alliance Medical.

Referral routes

Patients are referred for a range of PET-CT scans by consultants or other members of the multi-disciplinary team (MDT).

Figure 6: PET services catchment areas, Wales

Patients in South East Wales (excluding Swansea Bay, Hywel Dda and West Bridgend) and parts of Mid Wales are referred to the Wales Research and Diagnostic PET Imaging Centre (PETIC) Cardiff. Patients in South West Wales, and parts of Mid Wales are referred to the mobile PET-CT service at Singleton Hospital, Swansea.

Patients in North Wales and parts of Mid Wales are referred to Nuclear Medicine, Wrexham Maelor Hospital, Wrexham. The patient flow for mid Wales generally follows the pattern for cancer referral to the north and south Wales specialist centres. Patients from mid Wales who would otherwise be referred to the Royal Shrewsbury Hospital for specialist treatment are referred to north Wales for PET scans.

Clinical indications

PET-CT scans are offered in line with the WHSSC Commissioning policy [1]. When treatments are not routinely available, patients who might get particular benefit can still access the treatment through a process called Individual Patient Funding Requests (IPFR).

Funding requests are considered by the all Wales IPFR Panel. The purpose of the Panel is to act as a Sub Committee of WHSSC and hold delegated Joint Committee authority to consider and make decisions on requests to fund NHS healthcare for patients who fall outside the range of services and treatments that a Health Board has agreed to routinely provide.

Each year the AWPET Advisory Group review evidence and advise WHSSC on new clinical indications that may be commissioned for PET scans. When considering requests for new indications, the AWPET Advisory Group will also review the list of recent IPFR applications and assess any trends in requests when advising WHSSC.

Activity levels

For Wales overall, under the current commissioning policy, 3,865 scans were completed in 2020-21, which equates to approximately 1,246 scans per million population. There was a significant drop in PET referrals during the period March-June 2020, related to the first wave of the COVID-19 pandemic, but this activity had returned to 'normal' levels by the end of 2020.

The table below shows current activity levels for each of the three individual PET-CT centres. Please note that Swansea PET scanning went "live" in July 2020, so the table includes just nine months of activity for 2020-2021. The annual equivalent would be 1,061 scans.

Table 7: Current and forecast activity levels

Year	PETIC, Cardiff (South East)		Wrexham (North Wales) 2 days per week		Swansea (South West) 2 days per week		Total no. PET scan
	NHS Scans	Growth	NHS Scans	Growth	NHS Scans	Growth	
2010-11	675	n/a					675
2011-12	1,285	90%					1,285
2012-13	1,417	10%					1,417
2013-14	1,619	14%					1,619
2014-15	1,920	19%					1,920
2015-16	2,119	10%	794	N/A			2,913
2016-17	2,263	7%	784	-1%			3,047
2017-18	2,318	2%	763	-3%			3,081
2018-19	2,667	15%	771	1%			3,438
2019-20	2,939	10%	819	6%			3,758
2020-21	2206	N/A*	891	9%	768#	N/A	3,865

*The figures for this table have been submitted to WHSSC by the service providers at each site. South East Wales are provided by Prof Chris Marshall, for South West Wales by Professor Neil Hartman, and for North Wales from Dr Mark Elias. *Fall in activity due to Covid-19 and provision of new capacity at Swansea from July 2020. #Scanner at Swansea was opened in July 2020.*

Commissioning beyond Wales

A very small number of patients from South Wales currently travel to London centres for Gallium DOTA-PET imaging (approximately 50 per year). Some patients from North Wales have PET scans in English centres but this number is low.

Supply of radiopharmaceuticals

All three Welsh sites offer 18F-FDG and 18F-PSMA PET scans. However, as PETIC benefits from an onsite cyclotron, it is able to offer a wider range of scans to patients.

The cyclotron at PETIC Cardiff is producing 18F-FDG, 18F-PSMA, 18F-Fallypride, 18F-DOPA and 18F-FMZ. PETIC is supplying 18F-FDG, 18F-PSMA, 18F-Fallypride, 18F-DOPA and 18F sodium fluoride to external providers and industry.

Under the Specials Licence, PETIC is supplying 18F-PSMA to Swansea, Bath, Poole, Plymouth and Bristol and 18F-DOPA to Manchester and London.

Under licensing rules, as PETIC does not hold Marketing Authorisation for 18F-FDG, it is currently unable to sell this product commercially to other sites within Wales. Instead, PETIC has a contract with Alliance Medical meaning PETIC can only supply other sites when/if Alliance Medical is unable to meet demand. Under the Specials License, PETIC is able to provide other UK sites products such as 18F-PSMA, 18F-DOPA and 18F-Fallypride.

Summary of current PET-CT facilities in Wales

The table below (Table 8) summarises PET-CT infrastructure, staffing and radiopharmaceutical position across each site.

Table 8: PET-CT centres summary

	PETIC	Wrexham	Swansea
Population served	1,661,810	711,946	777,008
Date site was established	2010	2015	July 2020
PET sessions per week (a session is considered to be half a day of scanning)	Nine - Two extended days (Tues and Wed), half day Fri	Four to five	Four
Cyclotron present (Y/N)	Y	N	N
Fixed or mobile	Fixed	Mobile (Alliance)	Mobile (Alliance)
Research activity undertaken at site (Y/N)	Y	Y (limited)	Y (limited)
Staffing	Onsite Clinical Radiologists from C&V, in addition to hub and spoke model for radiologists from Aneurin Bevan, Velindre and Cwm Taf (in discussion). Radiographers from C&V, Medical Physics staff from Cardiff University, radiopharmaceutical production staff from Cardiff University	Alliance staffing – comes with mobile scanner Local BCUHB team (Nuclear Medicine Dept.) undertake booking PET appointments and liaising with referrers, patients and Alliance Medical. Justification of the medical Exposures, reporting of the images and requisition of the PET Tracer from Cyclotron	Alliance staffing – comes with mobile scanner Swansea Bay UHB provides its own booking staff, clinical scientists, RPA, reporting, waste management, financial management.
Scan types offered / radiopharmaceuticals used	18F-FDG, 18F-PSMA, 18F-DOPA, 18F-Fallypride, 18F-FMZ	18F-FDG, 18F-PSMA	18F-FDG, 18F-PSMA
Sources of radioisotopes	Manufacture own 18F-FDG and 18F-PSMA External supply of 18F-FDG and 18F-PSMA as back up and cover for 4 service weeks per annum. Only site in UK manufacturing 18F-DOPA supporting specialised paediatric insulinoma clinical services in Manchester and London. Only site in UK manufacturing 18F-Fallypride and 18F-FMZ currently for research only. 18F-Fallypride also supplied for research purposes to London. Not possible to supply 18F-FMZ at moment but developing new production method in conjunction with commercial partner. Manufactures and supply 18F-sodium fluoride to a number of research institutions.	18F-FDG supplied by Alliance Medical as part of package with scanning 18F-PSMA sourced from PETNET and delivered from Nottingham	18F-FDG sourced from Alliance Medical and delivered from Guilford, London 18F-PSMA sourced from Alliance Medical, however manufactured and delivered by PETIC

	PETIC	Wrexham	Swansea
Referral pathways	WHSSC CVUHB ABUHB Mid and South Powys Mid and East CTMUHB Epilepsy service commissioned by C&V epilepsy service Epilepsy service commissioned by Bristol epilepsy service Paediatric Cancer for SW England commissioned by NHS England	WHSSC BCUHB & North Powys The following external referrers who see BCUHB / North Powys Patients on behalf of Welsh NHS: North Powys Shropshire (RJAH / SaTH NHS Trust) Countess of Chester Hospital Liverpool Heart & Lung Hospital Clatterbridge Cancer Centre	WHSSC Hywel Dda Swansea Bay West CTUHB
Site issues / strategic considerations	Several significant items of equipment are 11 years old and in need of replacement. Business Justification Case is in preparation.	Consolidation of Nuclear Medicine is underway across North Wales. SOC has been submitted to WG and is out to public consultation. One site is proposed to include Nuclear Medicine (SPECT-CT) and PET-CT and no site selection at time of writing this PBC.	

Information Technology

The existing arrangements in relation to the processing of referrals are as follows:

- Referrals are currently made using paper forms that are printed out and sent to the relevant PET site using email or fax.
- Administrators or “booking clerks” at each site need to manually update local data systems to make and track appointments and order materials for scanning, including radiopharmaceuticals. Booking clerks liaise with referrers directly via email or phone to clarify referral needs, where forms are not completed fully.
- In addition, the gatekeeping for referrals carried out by consultant radiologists is done manually and “off line”.
- Where relevant, administrators spend time retrieving previous scans from other sources to best inform clinical decision making.
- Post scan, a radiographer then sends scan data to the PACS system for the clinical radiologist to subsequently report on the PACS system.
- A frequent operational issue is the failure of data transfer from the mobile scanning units via a data cable to PACS for reporting which results in having to manually import studies from DVD which is slow and delays reporting.

Facilities

The fixed scanner and cyclotron at the PETIC site are now beyond their recommended useful age and urgently require replacing. Replacement parts for the PETIC scanner are no longer manufactured hence the site is currently functioning “at risk”.

The sites at Wrexham and Swansea make use of mobile scanners which also have significant limitations and issues (see Table 15: Mobile vs fixed scanners).

Workforce

The imaging workforce is in a critical situation across the UK. There is an increasing clinical demand across all imaging modalities, and capacity issues are exacerbated by difficulties in recruiting consultant radiologists[3], radiographers[4], radio pharmacists and other nuclear medicine staff - the level of difficulty varies according to geographical location [12, 13]. Clinical imaging remains a popular specialty for medical trainees but training capacity does not match current workforce deficits.

According to the Clinical radiology Wales workforce summary published by the Royal College of Radiologists (RCR; 2019) [22], "there are still not enough consultant radiologists to deliver safe and effective care", with this report further noting regional variation in staffing across Wales and shortages in clinical radiology specialists being areas of concern.

Wales has 7.8 consultant clinical radiologists per 100,000 population [22], compared to a European average of 12.8. Wales has the oldest demographic of consultant radiologists in the United Kingdom; based on a retirement age of 62 years, 26% are anticipated to retire by 2020 [12]. The number of ARSAC practitioners is reducing with retirement.

Indeed the situation facing the imaging workforce has been further highlighted in the recent RCR Clinical Radiology UK Workforce Census 2020 report (2021) [23]. This report clearly outlines how the demand for diagnostics is increasing faster than the demand for NHS services as a whole, how waiting times have lengthened due to the pandemic with 58% of Clinical Directors reporting insufficient Clinical Radiology consultants. Specifically, this report notes that how £8.1 million was spent by NHS Wales on outsourcing reporting (of all imaging modalities) to the independent sector and ad-hoc locums.

Critically, the RCR 2020 census [23] notes that over the past five years there has been an 11% decline in ARSAC license holders, with many professionals approaching retirement age or have retired and returned. Many service providers are soon to be reliant on contractual agreements with other trusts or health boards and the report highlights that "health boards must ensure succession plans are in place for ARSAC license holders".

The situation for radiographers and clinical scientists is no better. According to a 2019 workforce survey carried out by the Institute of Physics and Engineering in Medicine (IPEM), 33% of UK centres stated their current staffing provision was sufficient. 57% of UK centres felt their staffing provision was not sufficient. The IPEM report noted "the precarious nature of staffing this specialism, with most services stretched to capacity, and concerns were expressed of potential increase in demand or area of coverage". The report also highlighted the concerns expressed over future workforce supply, and the just-about-managing description of the workforce is not future-proof, and while safe, does not have sufficient capacity to research, develop, and implement new technologies.

As a result of the Imaging Statement of Intent the National Imaging Academy Wales (NIAW) was established in 2018 to "develop a sustainable and flexible imaging workforce to deliver a modern, responsive diagnostic imaging service for Wales". In addition, Health Education and Improvement Wales (HEIW) were tasked with facilitating the development of an integrated workforce training strategy for radiologists, radiographers, sonographers, advanced practitioners, assistant practitioners and other imaging healthcare professionals in Wales, including Medical Physics.

3 Also refers to Consultant Nuclear Medicine Physician throughout this document

4 Also refers to Nuclear Medicine Technologists throughout this document

Further information on the training routes for all professions included in PET scanning can be found in Appendix 7.

The three current PET sites in Wales are set up differently, so there is some variance in how staffing is currently structured.

PETIC makes use of a pool of 15 radiographers/nuclear medicine technologists in CVUHB, currently deemed competent and entitled to perform PET scans. These are typically cross trained from the nuclear medicine pool. Having a large pool of staff competent to scan in Cardiff provides some resilience with regard to service expansion.

A similar model is employed for administrative staff. There is currently a pool of three booking clerks who can book PET-CT scans at PETIC, again providing resilience. In addition, PETIC has several consultant radiologists, one clinical scientist and a business manager. As the site at PETIC consists of a cyclotron, there are multiple technical posts associated with radiopharmaceutical production. In addition, several research posts are at this site.

The appointment of researchers also provides an additional route for clinical scientist accreditation. Students who obtain a PhD in a suitable subject can obtain state registration as clinical scientists through the equivalence route (https://www.ahcs.ac.uk/equivalence/). In addition, researchers may also obtain practical skills in radiochemistry which can translate into technical posts supporting the production of radiopharmaceuticals in Wales, another area with significant staffing issues. The active PhD programme in PETIC offers another pool of staff that may be utilised to meet the increasing demands of the clinical service.

For the mobile scanning sites in South West and North Wales, Alliance Medical (AML) provide the mobile scanner and three scanning operators per scanner (two to three imaging technologists/radiographers, and one healthcare assistant) and the RPA (radiation protection advisor). The local “host hospital” then provides the booking staff, waste management, governance, management of the PET-CT service, consultant radiologist reporting of scans and finance business partner for the fiscal aspects. The Swansea site has a clinical scientist for dosimetry, however Wrexham does not. Dosimetry is part of the Medical Physics Expert (MPE) role, which is contractually provided by Alliance Medical in North Wales. Additionally, the RPA role is externally contracted by AML and the RPA is rarely on site, but available by phone to the mobile van staff.

Swansea has just written and agreed an SLA with Alliance Medical to allow existing local nuclear medicine staff (technologists/radiographers and clinical scientists) to gain experience/shadowing on the mobile PET scanner, with a view to ensure that staff are partially trained and developed for future needs, and to ensure a degree of resilience when an AML staff member is absent (sickness, etc.). Wrexham has a clause within the contract with AML to facilitate training of BCUHB staff when required.

Currently BCUHB (North Wales) has a Strategic Outline Case which is going through a consultation stage with the aim of consolidating Nuclear Medicine and converting the existing mobile PET-CT service to a fixed scanner, based at the consolidated site. It is expected that the workforce model will have staff working in both conventional gamma camera and PET-CT, and supplementary training will be required.

For further detail on existing arrangements for the PET workforce, please see Appendix 7.

1.4.4 Business needs

There are a number of challenges within existing arrangements that mean over the long term it will prove increasingly difficult to deliver a sustainable high-quality PET service for the people of Wales that ensures equitable access to PET-CT and improves outcomes.

The main challenges include:

- Insufficient capacity to improve the quality of provision and deliver better patient outcomes since:
- The service underperforms in relation to UK and international best practice in terms of number of funded indications, number of scanners and supporting infrastructure.
- Demand is growing and the list of indications is expanding.
- Challenges in training, recruiting and retaining the highly skilled workforce required to deliver a high-quality sustainable service.
- Limited ability to improve delivery by efficient use of scanners, facilities, processes infrastructure, due to the use of ageing analogue scanners and reliance on mobile units and outsourcing arrangements.
- Reliance on external suppliers which limits opportunities to reduce costs and improve efficiencies and deliver a service for patients and NHS Wales that offers best value for money.
- Current facilities and the reliance on mobile units which limit the ability to broaden RD&I opportunities.

These business needs are explored in greater detail in relation to each of the five spending objectives below.

1.4.5 SO1: To improve the quality of PET service provision for Welsh patients by delivering better patient outcomes

When compared to the devolved UK nations, Europe and the developed world, Wales significantly underperforms in terms of PET-CT scans per head of population, density of PET scanners and the wider PET-CT infrastructure.

Although the situation has improved in the last three years, with an expansion of funded indications [1] and the opening of a second WHSSC-commissioned mobile PET unit for two days per week in Swansea in the summer of 2020, there is still significant progress to be made.

Patient View on accessing a PET scan at Swansea

> “Before the scan the patient said ‘*I don’t want to drive to Cardiff*’ and his daughter said ‘*getting elderly patients to Cardiff is unsafe and unacceptable in these times*’.”

The table below provides a comparison of Wales to the number of scans carried out in England, per million of population. It is clear that Wales is currently carrying out significantly lower numbers (approximately 33%) of PET scans per head of population compared to England, despite having a higher prevalence of cancer and other chronic diseases (see Section 1.3.3 and 1.3.4, and Table 9). There are various reasons for this difference, including:

- fewer commissioned indications in Wales compared to England;
- lack of geographic access to PET-CT for North Wales and South;
- historic under-referral; and

- tighter gatekeeping in Wales compared to England.

Table 9: Number of PET-CT scans per million population

Country	2015/16	2016/17	2017/18	2018/19	2019-20
England	1,849	2,100	2,600	3,150	3,533
Wales	922	975	985	1,100	1,192

Welsh actual number of scans sourced from WHSSC. England number of scans sourced from Diagnostic Imaging Dataset Annual Statistical Release 2019/20 *Number of scans divided by population numbers from ONS.

In the Royal College of Radiologists (RCR) 2005 strategy document "PET-CT in the UK: a strategy for development and introduction of a leading-edge technology within routine clinical practice" [24] the working party recommended initially, one PET-CT per 1.5 million population is planned to reflect the current role in cancer management.

Progress has been made in other devolved nations since 2005, and according the NCRI and local intelligence, there are now 1.05 PET scanners per million population in England (Table 10).

Table 10: Comparison of number of scanners within the UK

Country	Fixed PET CT	Mobile PET CT	PET MR	Scanners per million
England	37	20	1	1.05
NI	2	0	0	1.05
Scotland	6*	0	1	1.27
Wales	**1**	**0.8**	**0**	**0.60**

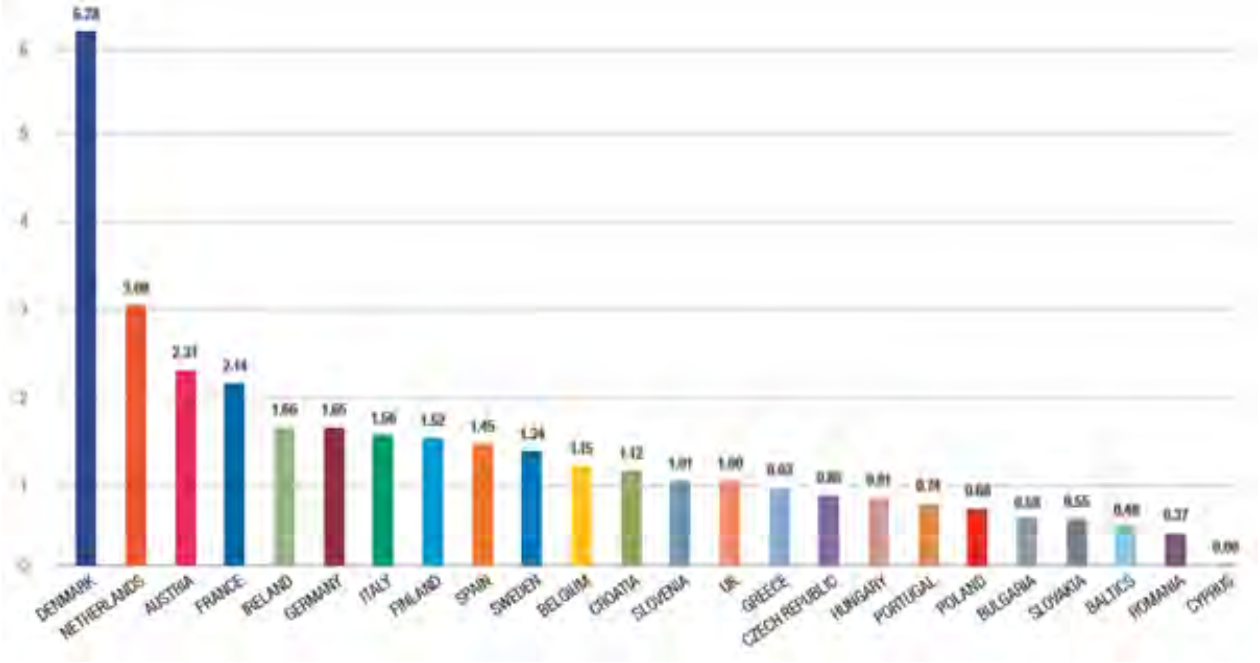
Data sources from: http://www.ncri-pet.org.uk/pet_scanning_and_cyclotron_facilities.php and informal communication between Clinical Programme Board Chairs and Regional Chairs for Scotland, Northern Ireland and England. *5 NHS PET-CT. 1 research PET CT

In the rest of the UK, PET-CT has moved out of specialist commissioning and tertiary centres to become a routine part of the equipment available in nuclear medicine departments of teaching hospitals and large District General Hospitals.

It is clear from Table 10 that the number of scanners per head of population in Wales is significantly lower than the rest of the UK. The picture becomes worse when comparing the number of scanners in Wales to the rest of Europe and beyond.

The 2016 edition of the European Coordination Committee of the Radiological, Electromedical and Healthcare IT Industry report on "Medical Imaging Equipment Age Profile and Density" [25] shows the UK position to be a density of 1 PET-CT scanner per million. Welsh provision is 0.60 scanners per million population, which is comparable to Bulgaria and Poland (Figure 7).

Figure 7: Density of PET-CT scanners in the EU (scanners per million population)



According to “Healthcare resource statistics - technical resources and medical technology” (Eurostat, 2020) [26], there has been “a notable increase in the number of positron emission tomography (PET) scanner units” across Europe, with France increasing its number of PET-CT scanners from 9 in 1998 to 156 in 2018. According to this publication, the number of PET-CT scanners ranged from 0.0 per 100,000 population in countries such as Liechtenstein, Romania and Serbia, to 0.8 per 100,000 population in Denmark (Figure 8).

A more recent publication explored PET-CT services across 21 jurisdictions in seven countries (Australia, Denmark, Canada, Ireland, New Zealand, Norway and the UK). It assessed service provision to better understand the impact any variation may have upon cancer services. The authors found that the number of PET-CT scanners per 100,000 population in Wales was the lowest (0.04 per 100,000 in 2017 with 1.2 scanners) (Lynch et al., 2020) [27]. Following the introduction of a mobile scanner in Swansea in 2020, the figure has risen to 1.4 scanners equating to 0.047 scanners per 100,000 population, which would still see Wales at the lowest ranking in this comparison (

Figure 9).

Lynch et al., (2020) noted that the growth in PET-CT in Denmark is likely to be reflective of changes brought about by the 2007 National Danish Invitation to Tender for Delivery of Cancer Scanners, as well as the introduction of national integrated pathways for cancer care [28]. Lynch et al., (2020) went on to highlight that recent ICBP research demonstrated improvements in cancer survival in Denmark, for example from 27.5% 1-year lung cancer survival (1995-1999) to 46.2% (2010–2014) [29].

This will have been influenced by a multitude of factors, one of which may well be the increase in capacity of PET-CT services based on more accurate cancer staging and treatment planning [27, 30].

Figure 8: Availability of imaging equipment – PET scanners 2013 and 2018 (per 100,000 inhabitants)

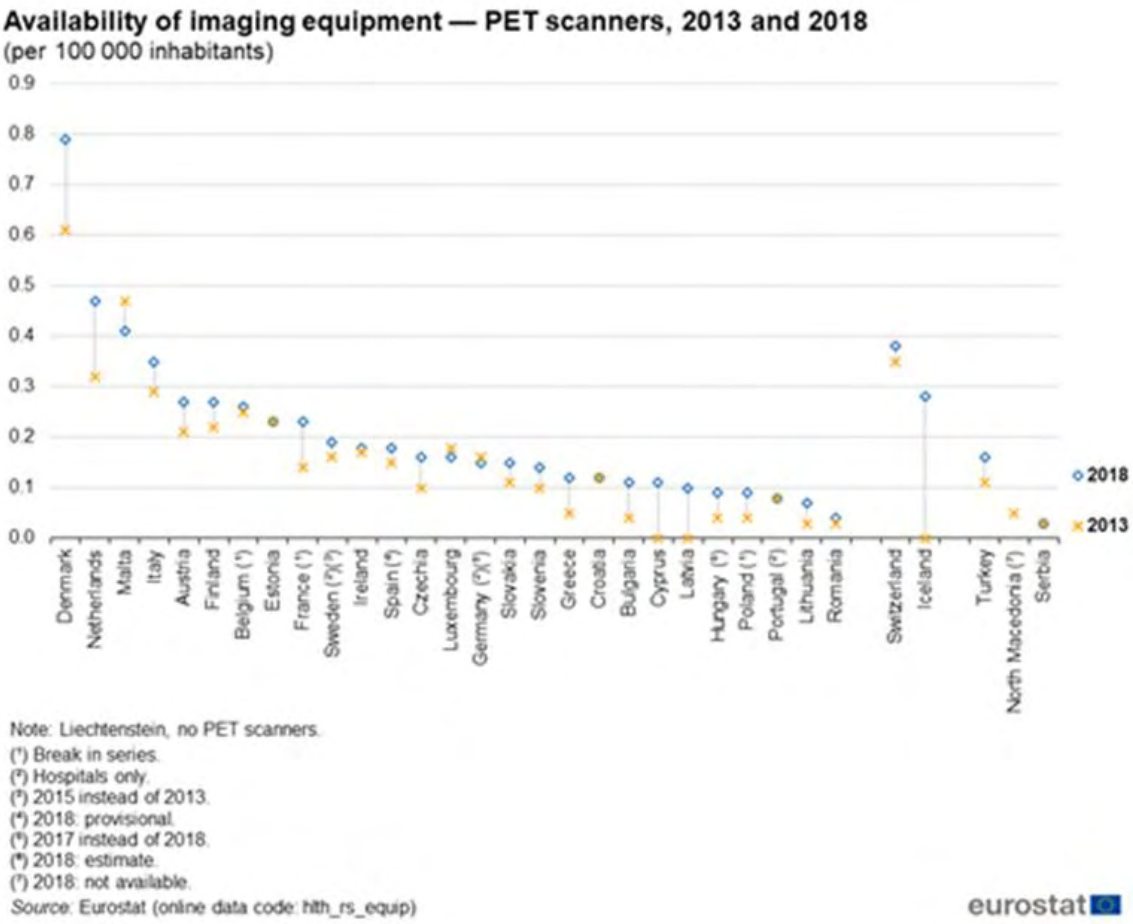
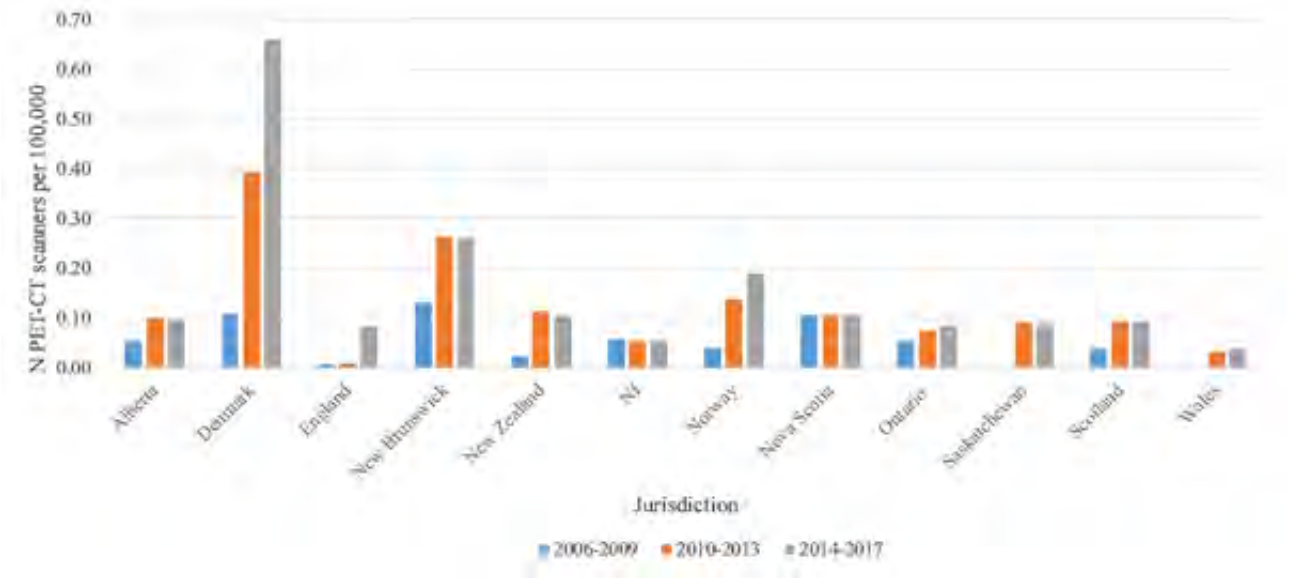


Figure 9: Comparative analysis



A comparative analysis: international variation in PET-CT service provision in oncology—an International Cancer Benchmarking Partnership study https://academic.oup.com/intqhc/advance-article/doi/10.1093/intqhc/mzaa166/6030987

Provide capacity to meet growing demand

As well as addressing the business need for provision of scanning capacity to meet the growing clinical demand for PET scans, there is also a need to increase and secure capacity of the wider infrastructure.

Expanded list of clinical indications

The number of clinical indications commissioned in Wales has historically lagged behind other devolved UK nations and comparable international healthcare systems. However, this discrepancy is improving and more indications have been funded and commissioned by WHSSC every year since 2016 (Table 11). Please see Appendix 5 and 6 for a full description.

Whilst the number of commissioned indications in Wales is increasing, greater progress still needs be made.

It appears that tighter 'gatekeeping' or reviewing of referrals in Wales compared with England may be an additional factor. The necessary widening scope of commissioned indications will undoubtedly add to the scanning capacity issues that face PET provision across Wales.

Table 11: Comparison of UK PET commissioning indications

		England	Wales (2016)	Wales (2018)	Wales (2020)	Wales (2021)
FDG Oncology	Brain	Covered	None	None	None	None
	Head and Neck	Covered	Some	Most	Covered	Covered
	Thyroid	Covered	None	Covered	Covered	Covered
	Lung	Covered	Some	Covered	Covered	Covered
	Pleura	Covered	Some	Some	Some	Some
	Thymus	Covered	None	None	None	None
	Oesophagogastric	Covered	Most	Most	Covered	Covered
	GIST	Covered	None	None	None	Covered
	Breast	Covered	None	Covered	Covered	Covered
	HPB	Covered	None	None	Some	Most
	Colorectal	Covered	Most	Most	Most	Most**
	Urology	Covered	None	None	Some	Most
	Gynaecology	Covered	Some	Most	Covered	Covered
	Testicular	Covered	None	None	None	None
	Anal and penile	Covered	Some	Some	Some	Some
	Lymphoma	Covered	Most	Most	Most	Most **
	Myeloma	Covered	Some	Most	Most	Most
	Skin	Covered	None	None	None	None
	Musculoskeletal	Covered	None	Most	Most	Most
	Paraneoplastic	Covered	Some	Some	Some	Most
	Carcinoma unknown primary	Covered	Some	Some	Some	Some
	Neuroendocrine	Covered	None	Covered	Covered	Covered
	Rare childhood	Covered	None	None	Most	Most
	Pre SABR	Not specifically covered	None	None	Covered	Covered
	Neurology	Covered	Some	Some	Some	Most

		England	Wales (2016)	Wales (2018)	Wales (2020)	Wales (2021)
Non oncology FDG	Cardiology	Covered	Some	Some	Some	Some
	Vasculitis	Covered	None	None	Covered	Covered
	Sarcoid	Covered	None	None	Most	Most
	Infection	Covered	None	None	Covered	Covered
	PUO	Covered	None	None	Covered	Covered
Non FDG	Methionine/ FET	Covered	None	None	Some	Some
	Ammonia	Covered	None	None	None	Nome
	Choline/ PSMA	Covered	None	Some	Most	Covered
	11 C Acetate	Covered	None	None	None	None
	Ga 68 DOTA	Covered	Most	Most	Covered	Covered
	F-DOPA	Covered	None	None	None	None
	18 F Fluoride	Covered	None	None	None	None
	Amyloid	None	None	None	None	None

Table 12 summarises the new indications that AWPET has recommended for inclusion within the revised WHSSC commissioning policy from May 2021. These indications have been selected based on careful assessment of the evidence base. Behind each overarching indication, specific criteria have been agreed to define the clinical circumstances in which patients should be referred (Appendix 5). Table 12 also shows the estimated annual volumes of referral for each indication (all Wales).

Table 12: New indications for PET-CT 2021: Estimated volume per annum (All Wales)

Indication	Volume
Colorectal cancer	40
Cholangiocarcinoma	24
Dementia	250
Gastrointestinal stromal tumours (GIST)	45
Lymphoma	40
Prostate cancer	280
TOTAL	**679**

Patient views on accessing a PET scan for the diagnosis of Alzheimer's

> "My wife had her PET Scan at the beginning of September last year. Her memory problems had been ongoing for sometime and the doctor had suspected the onset of Alzheimer's Disease.
>
> The PET Scan results gave a definite diagnosis of Alzheimer's which was a relief, in a strange way, to know what we were dealing with. Reading the Scan report and seeing which areas of her brain showed reduced activity, has been a great help to me in understanding her memory loss and other symptoms.
>
> Following the diagnosis the doctors have been able to persuade my wife to start on medication which has already had a positive effect. Her mood has improved and she is less anxious and agitated.
>
> All in all, the PET Scan has been of real benefit to us and I am so grateful that the doctors were able to refer my wife for it. I hope many more people will be able to gain from this amazing technology."

> "My husband had been having problems with his memory for some time before the scan but no diagnosis was given. He had a course of CAT therapy as they thought his problems might have been due to anxiety. During this time my husband became increasingly anxious.
>
> I was sure there was something else wrong with him, so when the diagnosis of Alzheimer's was given, it was a relief to me, even though I understood the terrible implications that were carried with the diagnosis. It enabled me to prepare for the future and to be more understanding of my husband's problems.
>
> I would strongly recommend the PET scan as it brought clarity to a situation which until then had been quite unclear and very disturbing."

Future projections for scanning demand in Wales

The NHS England report "Diagnostic Imaging Dataset Annual Statistical Release 2019/20" shows PET-CT scanning in England increasing year-on-year with a large proportional increase in 2019/20 (12.6%). The dataset also shows that PET-CT scanning is dominated by the 60-74 year old age group, accounting for 45% of total activity.

Critically, in his December 2020 report 'Diagnostics: Recovery and Renewal' [14], Professor Sir Mike Richards indicated that between 2014/15 and 2018/19 demand for PET-CT in England increased by 18.7% per annum. He recommended that scanning equipment should, as a minimum, be expanded in line with current growth rates and that all imaging equipment older than 10 years be replaced.

This is an exceptional consideration when estimating growth demand for PET-CT for Wales as scanner numbers, scans per population and commissioned indications are currently markedly below other UK devolved nations and Europe. In addition, Wales faces an increasing proportion of older people in the population and an associated increase in disease prevalence by 2031.

Essentially, Welsh PET-CT scanning provision first needs to "catch up" with developed world country comparators, then look to align with the estimated growth demand.

Developing the Welsh PET-CT demand model

The demand model has been developed by the Clinical Programme Board based on:

- The population growth estimates included in section 1.3.4.
- An expanded list of commissioned clinical indications in line with comparator countries;
- Feedback from the clinical questionnaire (see section 1.4.1 and Appendix 3).

Table 13 demonstrates the various aspects of growth and scenarios that were considered by the PET Programme Clinical Board.

A full range of modelled scenarios can be found in Appendix 4 and a full narrative in Appendix 6.

The Clinical Board presented all model scenarios to the Strategic Programme Board in August 2020. In consideration of the need for international benchmarking or "levelling-up", alongside the predicted expansion of commissioned clinical indications and the potential for additional modalities of use, a 20% activity growth model per annum for the next ten years was proposed as an appropriate figure that would fully account for the inputs noted above. This figure of 20% was agreed and confirmed by all members of the Strategic Programme Board as the most likely real-time demands, based on figures from the Richards report and anecdotal growth in England to date.

As well as cancer diagnostics, the demand model is inclusive of the expert consideration for the probable widening scope of indications such as dementia and scanning for modalities such as radiotherapy planning and generic cardiology. It also includes the additional scans that are estimated to result from the widened commissioning policy that will be in place from May 2021 (679 additional scans).

The Strategic Programme Board also considered the role and function of RD&I in their review of the activity growth in the clinical demand model. Advice from expert membership is that a PET scanning facility could dedicate no more than 10% of its annual scanning capacity to RD&I. Indeed, in the recent quarterly report from PETIC, it stated that 7% scans were associated with RD&I. As a result, RD&I scanning activity is included in all projected activity data and as part of the annual 20% estimates for growth.

Table 13: Summary of likely clinical demand for PET scans across Wales based on 20% underlying growth

Year	South East Wales	South West Wales	North Wales	Projected All Wales
2021	2629	1434	1144	5207
2022	3155	1721	1373	6249
2023	3786	2065	1647	7498
2024	4543	2478	1976	8998
2025	5452	2974	2372	10789
2026	6542	3569	2846	12957
2027	7851	4282	3415	15548
2028	9421	5139	4098	18658
2029	11305	6167	4918	22390
2030	13566	7400	5902	26868
2031	16279	8880	7082	32241

Modern digital PET-CT machines are capable of performing up to 5,500 times scans per annum. Assuming that a scanner is functional 50 weeks of the year (allowing two weeks for maintenance etc.) then a total of 5,288 scans per annum can be achieved.

The current analogue scanners that are in place within Wales (mobile and fixed at PETIC site) are capable of 2,884 scans per annum, when active for ten sessions per week (50 weeks per year, with

3,000 maximum annual capability). Based on a 20% growth model, it is possible to identify the years in which demand for PET scanning can no longer be met by existing service models and facilities. See Section 5.

The above information will assist in timing the installation of any approved PET-CT scanner and the associated building of any supporting facilities. However, the run-up time for writing and seeking approval of an OBC and FBC for each site should be factored into planning, in addition to ensuring sufficient workforce is present to run the facilities (see section 5). Indeed, in line with the Richards Report (2020), “expansion of the imaging workforce (combined with improvements in productivity will be vital in meeting the increasing demand, but very challenging. Actions will be needed on multiple fronts and by several organisations”. In Wales this will include NHS Wales Improvement, HEIW, NIAW, DHCW and higher education institutions and professional bodies.

Radiopharmaceutical supply

It is clear from the clinical demand model that the projected increase in scanning activity will lead to a significant increase in demand for radiopharmaceuticals over the coming years. This step change in demand needs to be carefully considered to ensure this essential resource is available and does not prove to be a limiting factor to roll-out.

The possibility of the cyclotron facility at PETIC obtaining an MA license should be considered, as there is merit in having an assured, Welsh resource for radiopharmaceutical supply.

Furthermore, the contractual arrangements with Alliance Medical should be further considered to mitigate against the fact that Swansea needs to purchase supply from Alliance Medical, despite a local Welsh-funded cyclotron manufacturing radiopharmaceuticals in close proximity to the Swansea site.

- The demand needs to be met in the most cost effective, rational and secure manner.
- Safeguarding provision and prices through long-term contracts with suppliers may be needed for sites where on-site production cannot be secured.
- Securing partnerships and political agreement in provision from within and from outside of Wales is needed.
- Critically, horizon scanning of new isotopes, pending MA for those currently considered under Specials license and identifying new ways of using existing isotopes should become part of an annual consideration for commissioners and clinicians.
- An All Wales Strategy for Research and Development should be developed so that all sites in Wales can be considered for research activity (in partnership with one another, and further afield) in a way that ensures radiopharmaceutical supply does not hinder patient access to clinical trials.

Information Technology

There is a clear and urgent need to update the way in which referrals, appointments and reporting is managed through the PET service.

Improve clinical outcomes

The superiority of PET-CT scanning in diagnosing and staging particular cancerous lesions, evaluating metastatic spread, optimising and evaluating treatment, and assessing prognosis has been well documented. 18F-FDG PET can upstage patients with cancer and can result in patients avoiding unnecessary surgical intervention. It can also downstage a cancer diagnosis and facilitate

a patient accessing more appropriate treatment. PET-CT is also being used in the diagnosis and treatment planning of an increasing range of other diseases.

However, the under referral of patients in Wales to PET-CT services means that these benefits are not being realised, and clinical outcomes are not as good as they could be.

Clinical outcomes could be further improved by the introduction of new generation digital scanners and new radioisotopes, both of which will increase diagnostic accuracy. Extending the range of clinical indications for PET-CT will also ensure patients receive the most clinically effective interventions.

1.4.6 SO2: To ensure a sufficient workforce to deliver a high-quality service

As noted in Section 1.4.3 (page 40), the imaging workforce is in a critical situation across the UK. There is increasing clinical demand across all imaging modalities, and capacity issues are exacerbated by difficulties in recruiting consultant radiologists, radiographers and sonographers. Clinical imaging remains a popular specialty for medical trainees but training capacity does not match workforce deficits. There is a clear and substantial need to attract, train and develop appropriate staff to the All Wales PET service to ensure deliverability.

PET-CT is not a stand-alone provision, and radiology services will typically not have staff solely dedicated to PET. Instead, staff typically work across several imaging modalities. This is certainly beneficial for skill mix and resilience in a workforce. However, this needs to be considered when planning workforce for future PET-CT services as the needs have to be fed in to wider radiology service on site.

The location of a PET-CT scanner is critical when considering the use of radiopharmaceuticals. A PET-CT scanner would ideally be co-located close to other nuclear medicine services and the specialist medical physics workforce.

The various reviews and reports on this topic suggest a variety of approaches that could facilitate skill-mixing and future-proofing of the PET-CT workforce. One possibility is for radiographers/technologists/physicists to train and become adept at reporting, thus facilitating/reducing consultant radiologist reporting tasks.

Indeed, clinical reporting (interpretation), by non-medical professionals, is established practice in conventional nuclear medicine imaging and other imaging modalities. It is likely that radiographers, clinical scientists and nuclear medicine technologists (with the necessary training/qualification in clinical reporting) can facilitate some limited PET-CT reporting capacity in future, by supplementing the role of the radiologist/nuclear medicine physician, by freeing up medical time for PET-CT reporting. This would be limited to reporting on site only under the guidance of the PET (IR(ME)R) practitioner in possession of an ARSAC licence. Therefore there is a potential route to building some additional resilience within a site team, which will undoubtedly be an interesting prospect for non-medical staff wishing to expand their skill-set.

There is potential for Artificial Intelligence to play a role and assist in many areas that could facilitate more efficient working practices (see Appendix 8). Some of this is being considered and is in scope of the RISP Programme.

The IT infrastructure supporting imaging in Wales requires further development and there is a programme now addressing these issues: the Radiology Informatics System Procurement (RISP)

Programme. It is anticipated (and considered necessary) for these developments to enable the reporting of PET-CT remote from the PET-CT sites. This would facilitate a potential shift toward a "hub and spoke" service model of reporting radiologists in Wales, where perhaps a consultant radiologist based in Hywel Dda could tele-report on scans carried out at Swansea without leaving their office. This must not be to the detriment of adequate on-site support. It is noted that ARSAC does not encourage remote practitioners, so a practitioner would still be expected to regularly attend the PET centre for which they provide primary support. However, this could be an attractive prospect for consultant radiologists looking to live and work in more rural areas of Wales, and still access the interesting field of PET-CT. This is in line with the 2019 RCR [22] recommendation to provide "innovative delivery models" and is dependent on the RISP Programme.

There is a potential risk to the surrounding radiology workforce in that new PET-CT sites could attract vital staff away from other sites. However, the added benefit of retaining and attracting high quality specialists may outweigh the potential risk. This would need to be considered in regional and local plans.

The PET-CT Workforce Board have made a set of recommendations regarding the ideal staffing state for a PET-CT scanning service and have listed their professional roles and WTE, see Table 14. Descriptions of each role and responsibilities are contained in Appendix 7.

As workforce provision is a clear constraint to implementation of this Programme, it is essential that the All Wales PET Programme works closely with existing training and education organisations, Health Boards and other groups to ensure that workforce needs are appropriately considered and planned for in the near and distant future. The PET Programme Workforce Board may be best placed to adjust into an advisory role/group in the future, to maintain expertise and momentum and continue to share and learn from one another.

A fixed, state of the art PET scanning site that has an active RD&I presence is likely to prove an attractive place to work, making it easier to recruit and retain staff from all professional groups and imaging modalities outside of PET.

Table 14: Professional roles required to run a PET-CT scanning service (based on a single scanner)

Role	Band	WTE (up to 6 patients per session)	WTE (7-12 patients per session)	Scalability with increased demand
Booking clerk / Administrator / Reception staff	3 or 4	1.5	2.5	In consideration of the patient interaction involved in this role, an increased throughput of patients will result in a need for additional staff members.
Radiographer / Technologist	6-8a	3.0	4.0	Increase in patient throughput is thought to be sufficiently covered by one additional post.
HCA/Clinical Support Staff	4	1.0	2.0	TBC
Clinical Scientist (physics) / Medical Physics Expert	8a-8c	2.0 (includes RWA & RPA roles)	(2.5 for >12 patients)	The scalability for this post is not linear, but there is a small increment per patient which will need to considered, alongside increased patient throughput.
Finance Business Partner	6-8a	0.2	0.2	Post is not felt to be scalable to patient numbers.

Role	Band	WTE (up to 6 patients per session)	WTE (7-12 patients per session)	Scalability with increased demand
Consultant Radiologist	Consultant pay scale	1.5	3.0	RCR literature denotes consultant radiologist reporting a range from 3.75 - 7.5 reports per session. Agreement from this group is that 5 reports is reasonable.*
PET-CT Manager	8a-8c	0.4	(0.8 for >12 patients)	There will be increased demand for management and HR support to the increased staffing numbers when PET sessions have 7-12+ patients.

** Comments from consultant radiologist workforce are: 1) a full time consultant will typically be at work 42 weeks of the year, to allow for necessary leave. 2) A full time consultant works 10 sessions on a 7:3 split in line with the National Consultant Contract in Wales. 3) An average of 5 PET-CTs would be reported per DCC session. A Royal College of Radiologists document of 2012 discussing clinical radiology workload and a Royal College of Physicians document of 2013 detailing the duties, responsibilities and practice of physicians both suggest 1-2 per hour i.e. 3.75 to 7.5 per session. 4) Studies won't routinely be double read or reported. 5) A full-time consultant would not devote all of their time to PET-CT duties, but most likely 2 to 4 sessions per week. The clinical lead(s) for a service may well provide more than 4 sessions. 6) If there are sufficient consultants to meet the reporting needs of the service then there are sufficient to meet the non-reporting duties. 7) MDT meeting commitments are to be funded separately.*

For future consideration: non-certificated support staff to supplement the radiographer/technologist role (1 WTE).

1.4.7 SO3: To improve delivery of the All Wales PET Service by efficient use of PET-CT scanners, facilities, processes and infrastructure

To achieve this spending objective there is a need to provide modern, up to date and high quality PET-CT scanners and supporting facilities in order to improve processes and infrastructure.

Replace analogue scanners with digital PET-CT scanners

Scanning technology has advanced significantly over the last 10 years which has led to markedly improved scan image quality, shortening of scan time and lower radiation doses. Although digital scanners are significantly more expensive, they offer the following additional benefits:

- significant gain in sensitivity;
- improved resolution;
- significantly reduced radiation dose or significantly reduce scan time: in practice, a combination of both; and
- faster scans – increasing patient throughput.

All three scanning sites in Wales currently have analogue scanners.

The analogue scanner at PETIC is now 11 years old and is beyond the end of its recommended life. In order to maintain access to a scanner for the population of South East Wales and provide service continuity, the scanner will need to be replaced. A business case to progress this is in preparation.

Replace inadequate mobile facilities with fixed ones

The two mobile centres provide access to North and South West Wales respectively and population modelling shows an ongoing need for geographical access to patients in these areas. In the short

term, this could be continued on the mobile fleet but there are significant issues associated with mobile scanners, as described in Table 15 below.

When considering the number of scans that can be carried out by a digital scanner, their use will permit the service reaching full capacity requirements. Reaching this capacity will also require additional investment in the physical infrastructure to account for additional patient numbers. For instance, a digital scanner will scan between 7 and 12 patients in one session, compared to 6 in a typical analogue session. Therefore provision is required for more uptake rooms and more automation in dispensing to obtain greater yield per vial, for example the Tracis system. The same is true for workforce capacity (see Section 1.4.6).

Patient experience at a mobile PET scanner

> In autumn 2019, I had a PET scan, prior to my lung operation to make sure all areas affected by that particular cancer were visible. While I was delighted to be able to have such an expensive and useful procedure, it had its pros and cons.
>
> The actual procedure was painless, but I had no idea until I got the paper work that the radio isotope is so unstable. It only has a life of a few hours and sometimes a batch fails in the laboratory. The nearest labs to Wrexham are in Keele and Preston. Several batches are made each day and rushed to the places with the PET scanners. I find the theory fascinating, but the practicalities aren't so much fun.
>
> My appointment was in the morning at the mobile unit at Wrexham Maelor Hospital. Although I live in Wrexham, I arrived in plenty of time (i.e. very early) to avoid taxi problems at school times. Unfortunately, this meant I missed the phone call, saying that that morning's batch had failed.
>
> The nurse suggested that I went home and waited for a call in the afternoon to let me know if the next batch had been successful. I never met the other patient, who had travelled 3 hours to get to their appointment. There was no point in either of us saying we would come back another day because exactly the same thing could happen multiple times.
>
> I went home with my book and bag of warm clothes for the cold of the scanning lorry. I was hungry as I'd been fasting from the night before, but at least I could snuggle up on my sofa in my own misery. I wondered how the other poor patient was doing somewhere in the bowels of the hospital.
>
> I was fortunate, a phone call came to say that the isotope was on its way and when to come in to the hospital. I was torn between disappointment that I couldn't eat and delight that I wouldn't have to repeat the experience another day.
>
> It was damp and dusk when I went up the mesh stairs into the lorry. I was led into a large bright heated cupboard, mainly filled with a recliner chair and blankets. My warm clothes were redundant. I found a way to squeeze the bag beside my legs. I'm not small and I wondered how people larger than I am manage in the space.
>
> I was given the isotope and had to stay still for a certain length of time for it to work. I was very warm and comfortable in the recliner chair. I think I snoozed a bit to allay the gnawing hunger.
>
> To be honest, I can't remember much about the scan itself. I think it was well past five by the time I was being scanned. It wasn't uncomfortable. My main memory is of eating after an 18 hour fast!

> You're asked to stay warm but you could get rather cold on your way to the scanner.
>
> I really needed to go to the toilet after my scan so I had to be rushed to the toilet which was some distance away... having a toilet nearby would be better.
>
> There is space restriction on board the van. I use a wheelchair so had to use the lift to gain access to the van.

Patient view of a fixed PET scanner and updated facilities in North Wales

> “Discussions around a static PET scan in North Wales have suggested that people coming a distance could have their appointments in the afternoon, so they can be contacted if the appointment is cancelled.
>
> I don’t drive. If I had to travel from Bangor or the Lleyn to Wrexham or vice versa, for instance, I would probably have started my journey before I could be contacted. At least, if I had made a wasted journey, it would be nice to be greeted with a comfortable seat and a bite to eat before my return journey.
>
> Cafés aren’t always open when one wants them. Similarly, mobile phone reception can be bad on some journeys. Someone with a long road trip might well miss the call cancelling their appointment.
>
> I don’t want to denigrate Wrexham Maelor Hospital at all. It’s accessible, a huge bonus in this age of building hospitals at the back of beyond and it has been absolutely brilliant for me. It’s just that I can see so much more potential for a modern, static PET scan facility in North Wales.”

Table 15: Mobile vs fixed scanners

Issue	Mobile scanner	Fixed scanner
Quality	Manufacturers will not guarantee CT and PET alignment to <2.5mm on a mobile (i.e., that the couch movement is guaranteed linear throughout travel), as fundamentally these complex machines are not designed to be bounced around. Radiotherapy requires alignment of 0.2mm.	Fixed site scanner can be maintained, therefore offers fundamentally higher quality for all scans.
Patient experience	Cold, restricted space. Cannot accommodate patients on trolleys. A patient (possibly inpatient) would have to go outside to reach the mobile unit.	All facilities are co-located with the PET scanner, which means the patient does not need to leave the building until the scan is completed.
Maintenance considerations	Mobile units are serviced 3 monthly +/- when they break. This is often outside the control of the service provider.	A fixed site with pro-active medical physics will monitor and fine-tune performance frequently, continually maintaining the rigorous demands required for optimised clinical and research scans.
Future needs	Radiotherapy planning cannot be done on a mobile unit, nor can respiratory and cardiac gating. Diagnostic CT, with iv contrast, requires multiple phases. The staff are not trained or permitted by the mobile provider. This prevents ‘one-stop shops’ whereby patients can attend a hospital a single time for all required PET-CT, CT +/- radiotherapy planning, all fully integrated rather than multiple visits with associated time delays.	Fixed site scanner can be maintained to a standard to provide radiotherapy planning scans. Potential creation of a “one-stop shop” is possible with a fixed scanner.
Research	Very limited on mobile units due to quality assurance (QA) issues.	Accreditation for research is more easily obtained.

Issue	Mobile scanner	Fixed scanner
Uptake facility	Brown fat activation is triggered by exposure to cold temperatures. This impacts on uptake of FDG and could hinder interpretation in lymphoma and breast cancer patients, in particular. This is a significant issue in winter months.	Fixed sites generally have more uptake rooms available than mobiles, this facilitates a longer FDG uptake period, improving scan quality.
Reliability	Mobiles which are not 'static' mobiles suffer far more failures, often only discovered during warm-up when the first patients have arrived. Couch problems are a particular issue. This leads to patient delays.	
Access	Patient access is more difficult to mobile units compared to fixed sites. Space is limited for disabled patients who require a hoist. Scans on general anaesthetic patients cannot be performed on a mobile.	
Hospital/Staff Benefits	Staff radiation dose is higher on a mobile unit, where space is problematic.	Staff radiation dose is less within a static facility. A fixed unit helps with staff recruitment throughout nuclear medicine.
Booking flexibility	A mobile unit can only use contracted days with the mobile provider.	A fixed site can schedule patients over any days of the week. This not only permits more flexibility when booking patients, it allows for rebooking if there is an issue e.g., with radiopharmaceutical supply. This can also increase the range of radiopharmaceuticals that can be sourced i.e. Wrexham can only get PSMA on 3 out of 7 days. The scanner only on site for one of those days. This restricts access to that day.

Patient view of improved facilities

> "I needed a biopsy that was more easily performed in Liverpool Heart and Chest Hospital in Broad Green, than at Wrexham, simply because they have more patients with cancers in odd places than Wrexham does. It is a new hospital with new day care facilities, which they find improves patient safety and care. The new day unit at Liverpool HCH is the Holly Suite. Because I needed to fast and had to wear hospital clothes, I only saw the Atrium. It was spacious with recliner chairs. The chairs were far enough apart for privacy. Each patient had a good-sized locker. There were magazines and papers, but I'd brought my own books and music. The unisex toilets were nearby, clearly marked and large. I can't remember exactly, but I think they were all suitable for disabled people, though only one might be necessary in a more specialised unit.
>
> There was a water fountain and a light meal was provided after my procedure, before I was allowed home.
>
> There was usually someone on duty at the desk if one had queries.
>
> The only difference I would have made was to have individual earphones for the television, like they have on aeroplanes. It's a pet peeve of mine to be forced to watch and listen to TV shows that I don't like, in NHS facilities. I was fortunate, I attended on two full days, but the TV was only on for part of one of the days.
>
> A whimsical detail made a painful biopsy more cheerful. The X-ray waiting room and room with the CT scanners had, I think, a sky painted on the ceiling and natural green murals on the waiting room walls. I remember remarking on them and a staff member saying, '*Well this is a new hospital.*'
>
> I always enjoy seeing the woodland mural on the long corridor at Wrexham Maelor. I know it sounds a tiny thing and a bit daft, but it can make a difference."

1.4.8 SO4: To ensure that the future All Wales PET service provides a cost-effective service for patients and NHS Wales

As well as the service impacts outlined above, reliance on mobile scanners under existing arrangements results in increased cost per scan. As demand continues to grow this will create an ongoing and increasing cost pressure.

Similarly, reliance on external suppliers for radiopharmaceuticals results in increased and growing costs.

In addition, the existing arrangements limit opportunities for driving out inefficiencies associated with duplication and downtime. It is also not possible to take advantage of income generation opportunities which might emerge in relation to private practice, commercial research trials and supporting other nations.

1.4.9 SO5: To widen the scope of the All Wales PET service, to meet recognised international best practice

In 2018 the AWPET Advisory Group and Welsh Scientific Advisory Committee made the following recommendation in support of future PET research, development and innovation (RD&I) in Wales:

'Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications' (Recommendation 5, PET in Wales – overview and recommendations, 2018).

The aim is to enable and expand high quality RD&I using PET across Wales, whilst ensuring that every patient has the opportunity to access clinical research trials and to ultimately improve patient outcomes and clinical practice.

Internationally there is a large amount of clinical research activity involving PET currently planned or in progress. An independent literature search carried out in February 2021 by information specialists at Velindre Hospital, Cardiff on behalf of this Programme, identified a total of 812 clinical trials listed on the ClinicalTrials.gov register. Of these 352 were flagged as completed, terminated or cancelled. The vast majority of current trial activity using PET is set within oncology however there is an increasing desire to use PET in a variety of non-oncological indications.

It is clear that there is a breadth of research activity through which PET-CT scanning may be utilised:

- PET scans are being increasingly requested through oncological clinical trials as the gold-standard diagnostic tool for staging of cancer.
- PET-CT scanning is a field of research activity in its own right, with work dedicated to new radiopharmaceuticals and use of these in new clinical indications for diagnosis and even targeted treatment.
- There are studies focused on the use of PET-CT scanning in facilitation of radiotherapy planning / treatment and alternative targeted treatment of cancers.
- Currently PET-related RD&I activity is not consistently carried out across Wales, with almost all being carried out at PETIC in Cardiff. This is largely due to the differences between scanning facilities and infrastructure present at the three sites.
- Most clinical research studies involving PET-CT now require either National Cancer Research Institute (NCRI) or EANM Research GmbH (EARL) accreditation.

PETIC has a fixed scanner and a cyclotron facility. Since it was established over ten years ago, PETIC has made significant strides in the RD&I arena resulting in a dedicated research team and collaborations with high profile partners in academia and industry, such as the University of Oxford and National Physics Laboratory. PETIC has also secured funding from the Wellcome Trust, MRC, Cancer Research UK, EPSRC and Royal Society of Chemistry. Current research activity at PETIC includes:

- Six industry collaborations totalling £206,500 income per annum (2019/20);
- Providing PET-CT scans for 11 multi-centre clinical trials (2019/20);
- Running 9 Clinical Research Projects in Progress totalling income of £443,100;
- Running 12 Pre-Clinical Research Projects totalling income of £210,500;
- Running nine Chemistry and Pharmacy Research Projects totalling income of £1,136,000;
- Running six Physics Research Projects totalling income of £74,400.

There is no doubt that PETIC benefits from having a fixed scanner, on site cyclotron and ownership by an academic institution (Cardiff University). This opportunity is not apparent for Swansea and Wrexham sites, as a mobile scanner is not typically thought of as “ideal” for research PET scans, with research protocols usually highly restrictive and requiring levels of quality assurance that a mobile scanner cannot provide (See Section 1.4.7).

There is a clear link between an active research environment and attraction and retention of high quality staff. Indeed, the PETIC team recently attracted a leading UK radiologist, a radiochemist and a head of quality control as a result of the opportunities available at this site and their reputation for high quality research.

Since the Swansea PET mobile service started in August 2020 there has already some collaboration with PETIC through mentoring of PhD students and access to some clinical trials.

The AML mobile scanner at Singleton Hospital has recently achieved EARL accreditation, which is rare for a mobile scanning facility thus a significant achievement.

The Swansea site is currently open to receive patients for the SCOPE II and ADCT-402-103 studies. SCOPE II is a phase II/III trial to study radiotherapy dose escalation in patients with oesophageal cancer and the ADCT-402-103 study is an early phase trial evaluating loncastuximab tesirine and ibrutinib in patients with lymphoma.

Capacity issues of the mobile service and the specific needs of research trials means a number of studies are ineligible to open in BCUHB. This reduces BCUHB's reputation as a research organisation and denies local patients access to trial participation. This also has a negative effect on retention and recruitment of skilled staff.

There is a clear need for a pan-Wales research network, with membership spanning NHS, academia and industry to ensure that Welsh PET-CT services make the most of its population, geography and clinical expertise.

Critically, putting in place the appropriate scanners and associated facilities across Wales will not only create centres of RD&I excellence for staff retention and attraction, but ensure that patients have equitable access to participate in clinical trials. This is an important factor to consider for the needs of the service.

Over the past 10 years, PETIC has been a partner with Health Boards across Wales in 78 multi centre research studies. These studies have primarily been research into novel therapeutic agents where PET is used to monitor and assess the response of cancer and dementia patients to the novel therapeutic agent. This has also included a number of research studies in partnership with Bristol due to the fact that the private provider of PET scans in Bristol has been unwilling to support research scans.

PETIC also secured funding for a pilot study with clinicians in Aneurin Bevan UHB to investigate the use of FDG PET in the diagnosis of dementia. The result of the pilot study demonstrated that FDG PET significantly altered the differential diagnosis of dementia types and resulted in cost savings in other areas of patient management due to clearer diagnosis. Based on these data, evidence was submitted to AWPET in 2020 requesting the inclusion of new dementia indications in the WHSSC PET commissioning policy [1]. AWPET supported and recommended these new indications to WHSSC and they were subsequently approved and will be funded from June 2021. In addition, a national PET Dementia service is planned to go live in the summer of 2021.

PETIC has also led on the introduction of 18F-PSMA PET in Wales. PSMA PET is an emerging imaging modality with improved diagnostic accuracy (sensitivity and specificity) over conventional imaging for prostate cancer staging. PSMA PET identifies cancer that is often missed by current standard of care imaging techniques. Prior to 2019, PETIC offered a prostate cancer imaging service using F-Choline. Problems with the supply chain led PETIC to submit a business case to WHSSC to support an 18F PSMA scanning service. This was approved and PETIC began production of 18F

PSMA for human use in 2019. The service has proved to be hugely successful with PETIC now reliably scanning increasing numbers of prostate cancer patients in Cardiff and supplying PSMA to PET centres in Swansea, Bristol, Plymouth, Poole and Bath.

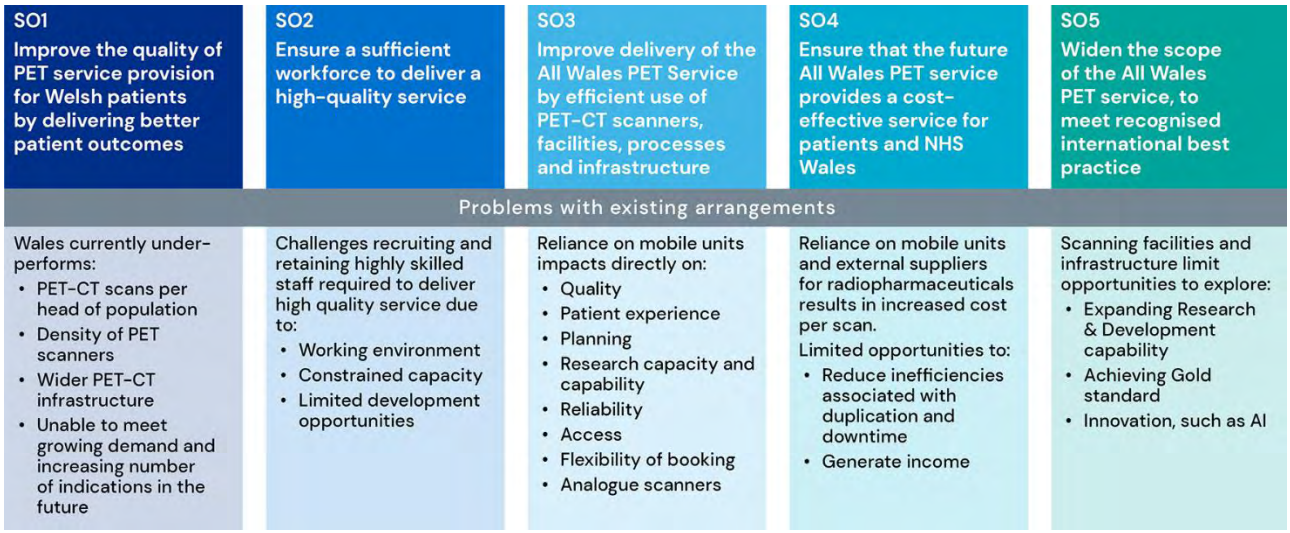
Other research interests and collaborations involving PETIC include:

- a validated method for the synthesis of 18F-DOPA in partnership with Pfizer and Bristol to investigate a potential cure for Parkinson's disease. PETIC is the only site in the UK manufacturing 18F-DOPA and is supplying specialist centres in London and Manchester who used 18F-DOPA to diagnose and treat paediatric insulinoma;
- the development and validation of Fallypride and Flumazenil radiopharmaceuticals. Fallypride is currently being used in Cardiff to assess the effectiveness of stem cell implants in Huntingdon's disease. Flumazenil is being used in partnership with CUBRIC to measure the neuroreceptor GABAA in epilepsy. In partnership with TRASIS, PETIC is planning to optimize the synthesis of Flumazenil with the aim of supplying Flumazenil across the UK;
- Artificial Intelligence (AI).

AI has been mentioned in many of the key documents referenced in the Strategic Context section of this PBC. Indeed, colleagues at the Life Sciences Hub Wales (LSHW) have used horizon scanning techniques to understand the possibilities of this advancing field of innovation, and ensure that the All-Wales PET service makes moves to the frontline of innovation (Appendix 9). There are clear and potential benefits of AI to PET-CT imaging ranging from improved image quality, reduced scan time, improved patient experience and improved efficiency, accuracy and insights. The key barriers to this innovation are the need for facilitation and collaboration. There are many suppliers with a range of technologies on offer.

The figure below summarises the case for change for this programme in relation to the five spending objectives.

Figure 10: Problems with existing arrangements



1.5 Potential Scope

1.5.1 Introduction

This section of the PBC identifies the potential scope of the All Wales PET Programme including the key service requirements that should be considered in designing the future service model and developing options.

1.5.2 Scope of programme

The overall scope of the programme is to plan, design, build and implement an All Wales PET strategy and associated business case for services up to 2031.

The aims of the Strategic Programme Board are to:

- Produce a Welsh PET services strategy that will incorporate multi-disciplinary workforce, research, clinical, technological and industry within a formal framework.
- Produce a strategic business cases for future PET-CT services in Wales.
- Establish a framework to ensure continuity of service and safe practice.
- Produce a business case for funding to replace obsolete PET-CT infrastructure.
- Consider if it is relevant to supply radiopharmaceutical tracers to other providers within NHS Wales outside of PETIC.
- Support the development of the capacity of the indication list.
- Develop a strategic business case to inform future PET service across Wales that incorporate enhancements to the indicators list, PETIC replacement scanner and radiopharmaceutical supply in line with the recommendations of the AWPET group report [6] for PET-CT in April 2019.

Areas that are excluded from this programme are:

- Ongoing maintenance of the service
- Implementing commercial products.

1.5.3 Potential scope of services

By considering the range of business functions, areas and operations to be affected and the key services required to improve organisational capability, ‘scope creep’ can be avoided during the options appraisal stage of the project.

Coverage and services are considered on the following continuum of need:

- **Core:** Essential elements that must be included in the programme to address immediate risks and ensure service continuity.
- **Desirable:** Additional elements that should be included in the programme to enhance the service and deliver greater value for money through additional benefits.
- **Optional:** Possible elements that could be included in the programme to maximise benefits providing they can be justified on a marginal low cost and affordability basis.

The Strategic Programme Board considered and agreed the potential scope of service coverage and categorised the main elements in line with this continuum of need. The results of this analysis is provided in Table 16 below.

Table 16: Potential scope - service coverage

	Core	Desirable	Optional
Number of scanners			
Provide access to 1 x PET-CT scanner to meet forecast South East Wales demand	✓		
Provide access to 1 x PET-CT scanner to meet forecast North Wales demand	✓		
Provide access to 1 x PET-CT scanner to meet forecast South West Wales demand	✓		
Provide access to 4th PET-CT or PET-MR scanner (Location and type to be determined according to future demand requirements)		✓	
Provide access to 5th PET-CT or PET-MR scanner (Location and type to be determined according to future demand requirements)			✓
Radiopharmaceutical provision			
Cyclotron co-located with SE Wales PET-CT scanner	✓		
Contract for supply of radiopharmaceuticals	✓		
Additional cyclotrons (Number and location to be determined according to future demand requirements)			✓
Additional service provision			
Centres of Excellence*		✓	

***** Centres of Excellence refer to RD&I activity and state of the art facilities. Having Centres of Excellence will result in reputational gain and the ability to attract and retain highly skilled workforce in addition to RD&I income.

1.5.4 Key service requirements

The key requirements associated with this potential scope were also considered and agreed by the Strategic Programme Board (Table 17). These will provide the basis for developing design specifications at project stage.

Table 17: Potential scope – key service requirements

	Core	Desirable	Optional
Scanner specification (where new scanners are acquired as part of the solution)			
Digital scanners	✓		
Inclusion of existing technologies - Robotic radiopharmaceutical dispenser	✓		
Inclusion of existing technologies – Radiotherapy Treatment planning	✓		
AI-enabled machines	✓		
Facilities requirements (where new scanners are acquired as part of the solution)			
Uptake rooms (Increase rooms at Cardiff and create rooms at new facilities such as Swansea and North Wales)	✓		
Dependencies (where new scanners are acquired as part of the solution)			
Integrated IT to ensure quick turnaround and clear coding	✓		
Electronic requesting	✓		

	Core	Desirable	Optional
Centres of Excellence			
Flat bed and lasers included in scanner specification	✓		
Active R&D with clear pathways available at all sites		✓	
Access to novel radiopharmaceuticals		✓	
Workforce requirements			
Hub and spoke model	✓		
Skilled workforce (Ensure expansion of workforce to deliver capacity – see section 5.5)	✓		
Training and development	✓		

1.5.5 Demand requirements

Capacity requirements, in terms of the number of PET-CT scanners required and the timescales for acquiring them, have been estimated based on the need to meet predicted demand of 20% growth per annum described in section 1.4.5 and the supporting Figure 13.

Modern digital PET-CT scanners are capable of scanning up to 5,500 times per annum. Assuming that a scanner is functional 50 weeks of the year (allowing two weeks for maintenance, breakdowns etc.), a total of 5,288 scans per annum can be provided.

The current analogue scanners that are in place within Wales (mobile and fixed at PETIC site) are capable of 2,884 scans per annum, when active for ten sessions per week (50 weeks per year, with 3,000 maximum capability).

Based on these assumptions, it is possible to identify the years in which demand for PET scanning can no longer be met by existing service models and facilities and this is shown in the table below.

Table 18: Summary of likely clinical demand for PET scans across Wales based on 20% underlying annual growth in activity

Year	South East Wales	South West Wales	North Wales	Projected All Wales
2021	**2629**	**1434**	**1144**	5207
2022	3155	1721	1373	6249
2023	3786	2065	1647	7498
2024	4543	2478	1976	8998
2025	5452	2974	2372	10789
2026	6542	3569	2846	12957
2027	7851	4282	3415	15548
2028	9421	**5139**	4098	18658
2029	**11305**	6167	4918	22390
2030	13566	7400	**5902**	26868
2031	16279	8880	7082	32241

Red cells highlight where clinical demand outstrips current service provision. **Amber** cells denote where clinical demand may outstrip mobile provision at SW and N Wales and digital scanning provision at PETIC. **Purple** cells denote where clinical demand may outstrip digital scanner provision at all three sites.

Based on this analysis, it is clear that significant capacity shortfalls will emerge as follows:

- **South East Wales:** Forecast demand will begin to exceed capacity of the existing analogue scanner in Cardiff by the end of 2021. Replacing it with a digital scanner would provide sufficient capacity to meet forecast demand until at least 2025. Introducing an additional scanner at that point would provide sufficient capacity until 2029.
- **South West Wales:** Forecast demand has already exceeded capacity of the existing mobile scanner which currently operates just two days each week. Expanding capacity to the equivalent of five days per week for a mobile analogue scanner would only create sufficient capacity to meet forecast demand until 2024. And expanding capacity to the equivalent of five days per for a digital scanner could only create sufficient capacity to meet forecast demand until 2028. Introducing an additional scanner in 2028 could provide sufficient capacity well beyond 2031.
- **North Wales:** Forecast demand has already exceeded the capacity of the existing mobile scanner which currently operates just two days each week. Expanding capacity now to the equivalent of five days per week for the analogue mobile scanner would only create sufficient capacity to meet forecast demand until 2025. And expanding capacity now to the equivalent of five days per week for a digital scanner would only create sufficient capacity to meet forecast demand until 2030.

It should be noted that this analysis is concerned with the scale of capacity requirements only and does not consider the implications of how this capacity may be provided (i.e. using a mobile or fixed scanner). These implications are considered within the options framework in the Economic Case.

It should also be noted that this analysis is inclusive of RD&I activity. It would be realistic to assume a lead time of two to three years before a new fixed digital PET scanning facility will be demonstrating RD&I activity of 10% of total annual scanning capacity.

1.5.6 Workforce requirements

The requirements for staffing should be considered carefully when planning the Programme, and concurrently with the clinical demand for PET scans. The information presented in the table below will need to be considered as a constraint in the phasing of the Programme plan.

If the All Wales PET Programme Business Case were to be endorsed, then the regional Project leads would be expected to work with local operational colleagues to ensure that more complex workforce planning is undertaken, so that future PET-CT scanners can be “manned” with a resilient workforce. Collaboration between IWEG, HEIW, NIAW and the Healthcare Scientist Board on this matter is essential.

Looking at the analysis of professional posts (Appendix 8), the indicative numbers of WTE posts needed on an All Wales basis to staff three analogue scanners is 28.8 WTEs, and three digital scanners is 45.0 WTEs.

As mentioned in Section 1.4.6, workforce will be a significant constraint to the successful implementation of this Programme. However, the gap analysis (Table 19) alongside the projected demand model (Table 18), provide sufficient data to form judgement and permit appropriate planning so that scanners can be installed at the right time to meet both clinical demand and workforce needs.

If fixed digital scanners were to be put at all three existing PET provider sites, Swansea would need to expand its workforce to that indicative of an analogue scanner by 2024-25 and North Wales by 2025-26. This should give sufficient time, if this PBC were to be endorsed by WG in 2021, to carry out detailed local workforce planning, train existing staff and advertise and attract staff needed for the new facility in advance. Conversely, PETIC would need to carry out local workforce planning to ensure the deliverability of the service as the demand gradually increases year-on-year.

Table 19: Professional posts gap analysis

	All Wales Current staffing (WTE)	All Wales Analogue Scanner requirements (WTE)	All Wales Analogue scanner gap (WTE)	All Wales Digital Scanner requirements (WTE)	All Wales Digital scanner gap (WTE)
Booking clerk/ Administrator/ Reception staff	4.4	4.5	0.1	7.5	3.1
Radiographer/ Technologist	6.2	9.0	2.8	12.0	5.8
HCA/Clinical Support Staff	0.0	3.0	3.0	6.0	6.0
Clinical Scientist (physics)/ Medical Physics Expert	2.1	6.0	3.9	7.5	5.4
Finance Business Partner	1.3	0.6	-0.7*	0.6	-0.7
Consultant Radiologist	3.9	4.5	0.6*	9.0	5.1
PET-CT Manager	1.6	1.2	-0.4*	2.4	0.8
TOTAL WTE	**19.5**	**28.8**	**9.4**	**45.0**	**25.6**

**The current consultant radiologist, finance business partner and PET-CT manager staffing level at PETIC is 2.1WTE, 1.0WTE and 1.0WTE, respectively - which is above the proposal for an analogue scanner. PLEASE NOTE THAT LOCAL/REGIONAL CONSIDERATIONS WILL BE REQUIRED AT OUTLINE AND FULL BUSINESS CASE SUBMISSION.*

It is clear from Table 19 that there will be a need for a fourth PET scanner in the South East region of Wales in 2026. This should be considered as part of the Options Appraisal and should be carefully and effectively planned. The programme should be phased in such a way that there is sufficient oversight from the SPB to review real-time scanning demand and provision for “stop/go” end of tranche reviews.

Should annual demand growth exceed 20% per annum, and this may be the case dependent on the rate of introduction of new services/indications, these timelines can be revised to an earlier date. Conversely, if the rate of growth in the next few years is not realised, the dates would be expected to be pushed back.

1.5.7 Radiopharmaceutical requirements

Radiopharmaceutical provision is an additional infrastructure factor for the All Wales PET Programme and this has been addressed in the Potential scope - service coverage (Table 5-1). However, during in-depth discussions at the SPB in development of the Programme, it became

evident that requirements for radiopharmaceutical provision for Wales may stretch beyond the scope of the All Wales PET Programme.

Therefore, it is possible that additional investment via a Project or Programme is identified for radiopharmaceutical provision for Wales after further horizon scanning and scope work. The Programme arrangement should allow space and structure for this work to be done and ensure that the radiopharmaceutical provision is future-proofed.

1.6 Benefits and Risks

1.6.1 Introduction

This section of the PBC identifies the benefits, risks, constraints and dependencies that should be considered in the All Wales PET Programme when developing and assessing the options for the optimal solution.

1.6.2 Benefits

The Preferred Way Forward should address all the business needs and achieve each spending objective identified as part of the review in order to deliver a range of benefits including:

- **Cash releasing benefits (CRB):** those that can be monetised and include improved economy (i.e. reduction in costs);
- **Non-cash releasing benefits (non CRB):** those that can be monetised and include improved efficiency (i.e. staff time released to focus on more value added tasks);
- **Quantifiable benefits (QB):** those that can be measured but not monetised (i.e. patient experience); and
- **Qualitative benefits (Qual):** those that cannot be measured or monetised.

The table below provides an overview of the main outcomes and benefits arising from achieving the spending objectives.

Table 20: Main benefits

Benefit	Description	Beneficiary	Type of benefit
Avoid high-cost late-stage interventions	Avoid surgical intervention	NHS Wales Patient	Financial
Reduction in harm	i. Increase the number of correct operations in those for whom it offers a potential cure and reduce the number of missed operations within this group. ii. Avoid the resource cost of futile operations in patients for whom it does not offer a potential cure. iii. Avoid the mortality and morbidity associated with futile operations. iv. Reduce the number of “open and close” operations for which the futility of the operation is realised during operation. v. Allow improved placement of radiation fields for curative treatment.	Patient Workforce NHS Wales	Quantitative (Unmonetised)
Reduced waiting times	Time to referral to time of scan	Patient	Quantitative (Unmonetised)
Increased certainty of treatment and planning	Increased certainty of treatment and planning through improved imaging in latest software and reduced risk of brown fat uptake in fixed units. Ensuring sufficient capacity and counter pathways.	Patient	Qualitative

Benefit	Description	Beneficiary	Type of benefit
Improved patient experience	Improved access, better facilities and greater convenience, better outcomes lead to better patient experience	Patient	Qualitative
Improved recruitment and retention	Greater ability to recruit and retain highly skilled workforce	NHS Wales Patient	Qualitative
Improved access to / uptake of training and education	Increased opportunities to provide access to training and education	Workforce	Quantitative (Unmonetised)
Improved staff satisfaction	Improved working environment, reduced stress and greater opportunities for development contribute to greater staff wellbeing	Workforce	Qualitative
Increased job opportunities contributing to Welsh economy	Ability to attract highly skilled workforce to Wales to deliver service model	Economy	Societal (monetised)
Increased capacity resulting in ability to meet demand	Ability to meet future demand - reducing cost per unit	NHS Wales	Cash releasing
Reduced downtime	Greater control of lists resulting in reduced cancellations and delays and better utilisation allowing greater throughput	NHS Wales	Non-cash releasing
Reduced reliance on mobile scanners	Reduced cost per scan due to establishing in house scanning facilities	NHS Wales	Cash releasing / cost avoidance
Reduced patient travel time - value to patients	Value to patient of reduced travel time for scans	Patient	Societal (monetised)
Reduced patient travel time - reduced greenhouse gases	Reduction in greenhouse gases as a result of reduced patient mileage	Environment	Societal (monetised)
Reduced road travel of mobile units	Reduction in greenhouse gases as a result of reduced mobile unit mileage	Environment	Societal (monetised)
Income generation opportunities	Increased opportunities to protect existing and generate additional income in relation to private practice, commercial trials, NHS England	NHS Wales	Cash releasing
Better equity of access	Increasing access in line with international best practice in terms of scanning capacity in relation to population needs ensures better equity of access which will result in improved patient outcomes	Patients	Quantitative (Unmonetised)
Increased proportion of staff research active	Centre of Excellence provides increased opportunities for staff to be involved in research and clinical trials ensuring the service is aligned with international best practice, leading to better outcomes in the long term	NHS Wales Workforce Patients	Quantitative (Unmonetised)

Benefit	Description	Beneficiary	Type of benefit
Increased proportion of patients on clinical trials	Centre of Excellence provides increased opportunities for patients to participate in clinical trials ensuring the service is aligned with international best practice, leading to better outcomes in the long term	NHS Wales Workforce Patients	Quantitative (Unmonetised)
Greater number of trials led by and participated in by PET site	Centre of Excellence provides increased opportunities for PET sites to be involved in a greater range of research ensuring the service is aligned with international best practice, leading to better outcomes in the long term	NHS Wales Workforce Patients	Quantitative (Unmonetised)
Improved access to a greater range of diagnostics to support greater range of therapeutics	Providing increased number of dedicated fixed PET-CT facilities provides opportunities to offer an increased range of diagnostics that will support more therapeutics that would not be possible using mobile units, such as - Radiotherapy planning - Cardiology - GA	NHS Wales Workforce Patients	Qualitative

1.6.3 Risks

Risk is the possibility of a negative event occurring that adversely impacts on the success of the future service model.

Identifying, mitigating and managing risk is crucial to successful programme delivery. The key risks are likely to be those that mean the programme will not deliver its intended outcomes and benefits within the anticipated timescales and spend.

The main risks identified are listed below.

Table 21: Main risks

Risk category	Risk
Resilience	Risk of insufficient scanning capacity to meet demand resulting in increased waiting times and impacting on patient outcomes
	Risk of cancellations and downtime of service
Demand	Risk that demand and capacity requirements have been under or over-stated
Workforce	Risk of insufficient workforce available to provide high quality service
	Risk of challenges recruiting workforce
Implementation	Risk of programme delays resulting in insufficient capacity during transition period
	Risk of programme delays resulting in increased programme costs
Funding and finance	Risk of insufficient capital funding available to deliver programme
	Risk of increasing revenue costs
	Risk that programme costs have been understated

1.6.4 Constraints

Constraints relate to the parameters that the programme is working within and any restrictions or factors that might impact on the delivery of the programme. These typically include limits on resources and compliance.

The main constraints that should be considered in developing a solution for future delivery of the All Wales PET Programme include the following parameters:

- Timescales for completion of the work.
- Availability of key human resource to deliver the programme of work due to existing work commitments.
- Availability of the highly skilled workforce to safely and effectively run a PET service at each site.
- Undefined financial models.

1.6.5 Dependencies

Dependencies include items that must be in place to enable the project or project phases to run successfully. Typically these include links to other projects and funding requirements that are likely to be managed elsewhere.

The success of the future service model relies on the following main dependencies:

- The strategic direction for PET services outlined in the Imaging Statement of Intent for NHS Wales.
- 'Buy in' from all Health Boards and stakeholders.
- Availability of capital funding.

1.6.6 Conclusion

Stakeholders have identified the benefits, risks, constraints and dependencies in relation to the agreed scope of the All Wales PET Programme. These together with the key spending objectives are used to develop and assess a shortlist of options. This option development process is covered in the Economic Case.

2 Economic Case

2.1 Options Framework

2.1.1 Introduction

The purpose of the Economic Case is to identify and appraise the options for the delivery of project and to recommend the option that is most likely to offer best value for money.

The first stage of this explores the preferred way forward by undertaking the following actions:

- Agree critical success factors (CSFs).
- Identify and evaluate the long list of options.
- Recommend the preferred way forward in the form of a shortlist of options.

2.1.2 Critical Success Factors

Critical success factors (CSFs) are the essential attributes for successfully delivering the project and are used along with spending objectives to evaluate the options. The CSFs for the project are crucial, not merely desirable, and not set at a level that could exclude important options at an early stage of identification an appraisal.

Table 22: Critical success factors

Critical Success Factor		How well the option
CSF1	Strategic fit and business needs	Meets the agreed spending objectives, related business needs and service requirements, and Provides holistic fit and synergy with other strategies, programmes and projects.
CSF2	Potential value for money	Optimises public value (social, economic and environmental), in terms of the potential costs, benefits and risks.
CSF3	Supplier capacity and capability	Matches the ability of potential suppliers to deliver the required services, and Is likely to be attractive to the supply side.
CSF4	Potential affordability	Can be funded from available sources of finance, and Aligns with sourcing constraints.
CSF5	Potential achievability	Is likely to be delivered given the organisation's ability to respond to the changes required, and Matches the level of available skills required for successful delivery.

2.1.3 Key elements of the options framework

The options framework, outlined in the Welsh Government Better Business Cases guidance, provides a systematic approach to identifying and filtering a broad range of options.

An overview of the key dimensions within the options framework is provided in Table 23 below.

Table 23: Key elements of the Options framework

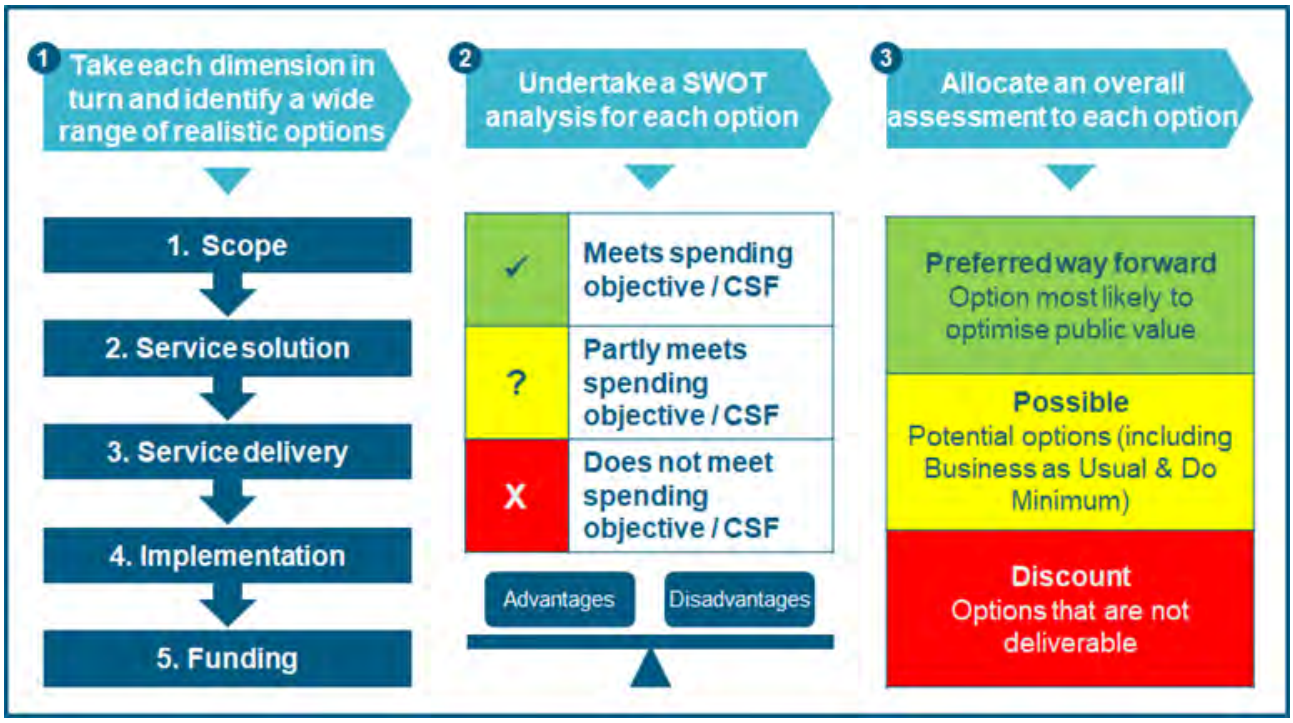
Dimension	Description
Scope	What to include in the future service model
Service solution	How to deliver the future service model
Service delivery	Who will deliver the future service model
Implementation	Timescales and phasing for delivering the future service model
Funding	Financing the future service model

The process for identifying and assessing options takes each of the key dimensions in turn and undertakes the following steps:

- Identify a wide range of realistic potential options within that dimension
- Undertake an analysis for each option to:
  - Assess how well the option meets the project's spending objectives and critical success factors; and
  - Identify the option's main strengths, weaknesses, opportunities and threats.
- Use the outputs of the analysis to determine whether the option will be carried forward as the preferred way forward, carried forward as a possible solution, or discounted at this stage.

A diagram illustrating this process is shown in Figure 11 below.

Figure 11: Process to identify and assess the long list of options



2.1.4 Identifying and assessing the long list

A long list of options for each of the five dimensions was developed by the Programme Board and evaluated to determine how well each meets the spending objectives and critical success factors at a series of workshops. The detailed analysis is provided in Appendix 1 and an overview in the sections below.

2.1.5 Scope

The options related to the project 'scope' are concerned with establishing the service coverage and key service requirements to be included within the programme over a ten-year period. The potential scope analysis outlined in section 5 provided a basis for developing these options. The evaluation results are provided in the table below.

Table 24: Long list - Scope

Dimension	Option		Description	Conclusion
Do nothing	1A	3 scanners	3 x PET-CT scanners located in Cardiff, North Wales and Swansea	**Carry forward (Baseline)**
Intermediate options	1B	3 scanners + 1 cyclotron + Centres of Excellence	3 x PET-CT scanners located in Cardiff, North Wales and Swansea 1 x Cyclotron co-located with Cardiff PET-CT Centres of Excellence facilities	**Carry forward (Do minimum)**
	1C	4 scanners + 1 cyclotron + Centres of Excellence	3 x PET-CT scanners located in Cardiff, North Wales and Swansea 1 x Cyclotron co-located with Cardiff PET-CT Centres of Excellence facilities 1 x additional scanner (PET-CT or PET-MR) in location to meet population needs	**Carry forward (Preferred way forward)**
	1D	5 scanners + 1 cyclotron + Centres of Excellence	3 x PET-CT scanners located in Cardiff, North Wales and Swansea 1 x Cyclotron co-located with Cardiff PET-CT Centres of Excellence facilities 2 x additional scanners (PET-CT or PET-MR) in location to meet population needs	**Carry forward (More Ambitious)**
Do maximum	1E	5 scanners + 1 cyclotron + Centres of Excellence + additional cyclotron	3 x PET-CT scanners located in Cardiff, North Wales and Swansea 1 x Cyclotron co-located with Cardiff PET-CT Centres of Excellence facilities 2 x additional scanners (PET-CT or PET-MR) in location to meet population needs Additional cyclotrons	**Discount**

2.1.6 Solution

The options related to 'solution' are concerned with establishing how the preferred scope for the programme can best be delivered. A range of options has been considered and the results of the evaluation of these options are provided in the table below.

Table 25: Long list - Solution

Dimension	Option		Description	Conclusion
Do nothing	2A	Do nothing	Outsource unmet demand	**Carry forward (Baseline)**
Intermediate options	2B	Replace Cardiff + extend mobile capacity	Replace PET-CT scanner and cyclotron in Cardiff Extend operating hours of Swansea and North Wales mobile sites	**Carry forward (Do minimum)**
	2C	Replace Cardiff + 2 new fixed units (Swansea, N Wales)	Replace PET-CT scanner and cyclotron in Cardiff Create 2 x facilities for fixed PET-CT scanners (Swansea and North Wales)	**Discount**
	2D	Replace Cardiff + 3 new fixed units (Swansea, N Wales, TBD)	Replace PET-CT scanner and cyclotron in Cardiff Create 2 x facilities for fixed PET-CT scanners (Swansea and North Wales) 1 x additional scanner (location, type and timescales to be determined based on demand)	**Carry forward (Preferred way forward)**
Do maximum	2E	Replace Cardiff + 4 new fixed units (Swansea, N Wales, 2 x TBD)	Replace PET-CT scanner and cyclotron in Cardiff Create 2 x facilities for fixed PET-CT facilities (Swansea and North Wales) 2 x additional scanners (location, type and timescales to be determined based on demand)	**Carry forward (More ambitious)**

2.1.7 Delivery

The options related to the programme 'delivery' are concerned with establishing the ways in which the preferred scope and solution can be delivered, specifically around who will deliver services in the future. The results of the evaluation of these options are provided in the table below.

Table 26: Long list - Delivery

Dimension	Option		Description	Conclusion
Do nothing	3A	Continue with existing arrangements	PETIC operates Cardiff facility External provider operates mobile facilities External radiopharmaceuticals contracts	Carry forward (Baseline / Do Minimum)
Intermediate options	3B	Bring service delivery in house for new facilities and retain PETIC partnership in Cardiff	PETIC operates Cardiff facility NHS Wales operates new fixed facilities External radiopharmaceuticals contracts	Carry forward (Preferred Way Forward)

Dimension	Option		Description	Conclusion
Do maximum	3C	Entire service delivered by NHS Wales	NHS Wales operates all facilities and radiopharmaceutical production	Discount

2.1.8 Implementation

The options related to the programme 'implementation' are concerned with establishing the phasing for delivering the preferred scope, solution, and delivery options.

This analysis in section 5 of the Strategic Case provides a clear indication at the tipping points at which capacity will be exceeded. Indicative assumptions can therefore be made about timescales for delivering the potential scope and these are outlined in the table below.

It would be prudent to put in place the PET scanners and associated facilities ahead of reaching the tipping points at each site, so as to avoid risks associated with potential service failure and avoid reaching a critical state in scanning provision. In addition, given the additional benefits to patient experience, realisation of wider Programme benefits, and in line with the strong case for change made within this Strategic Case, there is a strong argument to bring forward implementation to before the projected tipping points.

Table 27: Timescales for delivering the potential scope

Scanner requirements	Capacity exceeded	Timescale
Provide access to 1 x PET-CT scanner to meet forecast South East Wales demand	2021	2021
Provide access to 1 x PET-CT scanner to meet forecast North Wales demand	2025-2026	2023-2024
Provide access to 1 x PET-CT scanner to meet forecast South West Wales demand	2024-2025	2023-2024
Provide access to 4th PET-CT or PET-MR scanner (Location and type to be determined according to future demand requirements)	2026	2026
Provide access to 5th PET-CT or PET-MR scanner (Location and type to be determined according to future demand requirements)	2029	2028

The results of the evaluation of these options are provided in the table below.

Table 28: Long list - Implementation

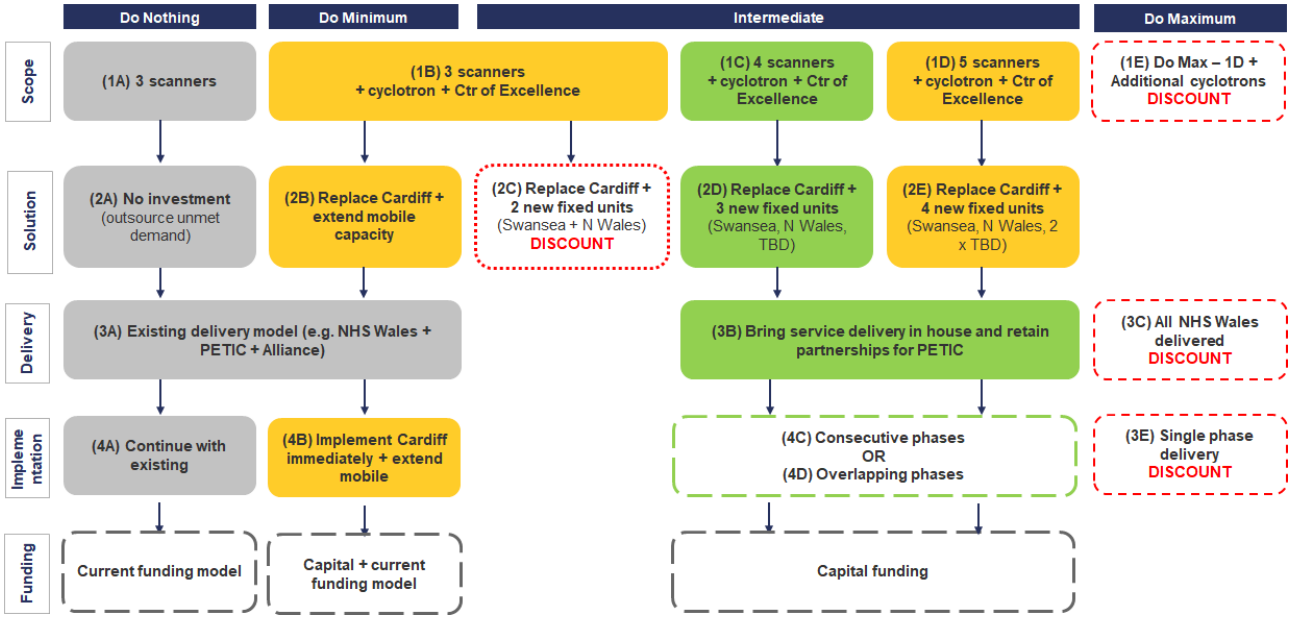
Dimension	Option		Description	Conclusion
Do nothing	1A	Continue with current arrangements	Ongoing asset replacement programme	Carry forward (Baseline)
Intermediate options	1B	Deliver Cardiff capital solution in tandem with extending mobile scanning capacity	Aligned to Do Minimum option	Carry forward (Do minimum)
	1C	Phased approach	Cardiff 2021/22 North Wales 2023/24 Swansea 2023/24 4th scanner 2026/27	Preferred way forward

Dimension	Option		Description	Conclusion
Do maximum	1D	Single phase approach	Full programme delivered simultaneously	Discount

2.1.9 Options Framework Summary

The figure below demonstrates a summary of the longlist using the options framework.

Figure 12: Options framework



2.1.10 Short Listed Options

The options framework can be used to filter the options considered at the long-list stage to generate the potential short-list for the project, as illustrated below.

Table 29: Shortlist of options

Options	Option 1 Business as Usual	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Scope	**3 Scanners (Core scope)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales	**3 Scanners (Core + Desirable scope)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff • Centres of Excellence facilities (with new scanners)	**4 scanners (+Desirable)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff • Centres of Excellence facilities • 1 additional PET-CT or PET-MR scanner (aligned to clinical model/demand)	**5 scanners (+Optional)** • Access to 3 PET-CT scanners in Cardiff, Swansea, North Wales • Cyclotron co-located Cardiff Centres of Excellence facilities • 2 additional PET-CT or PET-MR scanner (aligned to clinical model/demand)
Solution	**No investment (Outsource unmet demand to mobile scanners)**	**Replace Cardiff equipment + extend mobile capacity in Swansea and North Wales**	**Replace Cardiff equipment + 3 new fixed units (Swansea, North Wales, 1 location to be determined)**	**Replace Cardiff equipment + 4 new fixed units (Swansea, North Wales, 2 locations to be determined)**
Delivery	**Existing delivery model** (e.g. NHS Wales + PETIC + Alliance)	**Existing delivery model** (e.g. NHS Wales + PETIC + Alliance)	**Bring service delivery in house and retain partnerships for PETIC**	**Bring service delivery in house and retain partnerships for PETIC**
Implementation	**Continue with existing arrangements**	**Deliver Cardiff replacement + extend mobile provision**	**Phased approach** • Cardiff 2021/22 • North Wales 2023/24 • Swansea 2023/24 • 4th scanner 2025/26	**Phased approach** • Cardiff 2021/22 • North Wales 2023/24 • Swansea 2023/24 • 4th scanner 2025/26 • 5th scanner 2028/29
Funding	**Current funding model**	**Capital and revenue**	**Capital funding**	**Capital funding**

As a result of this the following shortlist of options is carried forward to explore in greater detail within the economic appraisal:

- Option 1 – Business as Usual: Do nothing.
- Option 2 – Do Minimum: Retain 1 fixed and extend capacity of 2 mobile scanners.
- Option 3 – Preferred Way Forward: Provide 4 fixed scanners (10-year programme).
- Option 4 – More Ambitious: Provide 5 fixed scanners (10-year programme).

2.2 Economic Appraisal

2.2.1 Introduction

The purpose of the economic appraisal is to evaluate the costs, benefits and risks of the shortlisted options in order to identify the option that is most likely to offer best public value for money. In line with current HM Treasury Green Book and Welsh Better Business Case programme business case guidance, this involves:

- Estimating indicative whole life capital and revenue costs for each option.
- Undertaking an assessment of benefits and risks for each option, outlining how these will be quantified in monetary-equivalent values at OBC stage.
- Using DHSC's Comprehensive Investment Appraisal (CIA) Model to prepare discounted cash flows and estimate the Net Present Social Value (NPSV) and Benefit Cost Ratio (BCR) for each option.
- Presenting the results, including sensitivity analysis, to determine the preferred way forward for the overall programme.

2.2.2 The Short List of Options

As outlined in the previous section, a short list of options has been identified. A comparison of the key features of each of the shortlisted options is provided in the table below.

Table 30: Comparison of shortlisted options

	Option 1 **Business as Usual (BAU)**	**Option 2** **Do Minimum**	**Option 3** **Preferred Way Forward**	**Option 4** **More Ambitious**
Description	Do nothing	Retain 1 fixed and extend capacity of 2 mobile scanners	Provide 4 fixed scanners (10-year programme)	Provide 5 fixed scanners (10-year programme)
Project 1 **Cardiff** **2021/22**		Replace PET-CT Upgrade of cyclotron	Replace PET-CT Upgrade of cyclotron	Replace PET-CT Upgrade of cyclotron
Project 2 **North Wales** **2023/24**		No capital investment Extend capacity of mobile unit	New PET-CT New build (260m2)	New PET-CT New build (260m2)
Project 3 **Swansea** **2023/24**		No capital investment Extend capacity of mobile unit	New PET-CT Refurbish an existing building (176m2) + new build extension (40m2)	New PET-CT Refurbish an existing building (176m2) + new build extension (40m2)
Project 4 **4th scanner** **2025/26**			New PET-CT New build (260m2)	New PET-CT New build (260m2)
Project 5 **5th scanner** **2028/29**				New PET-CT New build (260m2)

2.2.3 Estimating Initial Capital Costs

Indicative capital costs have been estimated by SES for the purposes of the PBC based on the following assumptions:

- Floor area required to create a facility to house a PET-CT including supporting areas, such as waiting areas and uptake rooms.
- Construction costs based on:
  - Refurbishment costs £2k per m2 + on costs; and
  - New build costs £4k per m2 + on costs.
- Allowance for lead lining.
- On costs at 35%.
- Fees at 16%.
- Non works as estimated.
- Equipment costs:
  - PET-CT scanner £2.9m (including ancillary equipment and Radiotherapy adaptions); and
  - Cyclotron refresh £1.75m (including ion source replacement and hot cells).
- Planning contingency 10%.
- VAT at 20% on all costs except fees.

The resulting capital costs estimates for the programme are summarised in the table below. Copies of the PBC Capital Cost Forms are provided in Appendix 2.

Table 31: Capital costs - Programme (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Construction	0	45	4,593	6,341
Fees	0	0	735	1,015
Non works	0	15	80	120
Equipment costs	0	4,673	13,553	16,513
Planning contingency	0	473	1,896	2,399
Subtotal	*0*	*5,206*	*20,857*	*26,387*
VAT	0	1,041	4,024	5,075
Total capital costs incl. VAT	**0**	**6,248**	**24,881**	**31,462**

Indicative capital costs for each of the individual projects is shown in the table below.

Table 32: Capital costs – By Project (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Project 1 - Replace Cardiff equipment	0	6,248	6,248	6,248
Project 2 - Fixed scanner North Wales	0	0	6,573	6,576
Project 3 - Fixed scanner Swansea	0	0	5,486	5,488
Project 4 - 4th fixed scanner	0	0	6,573	6,576
Project 5 - 5th fixed scanner	0	0	0	6,576
Total capital costs incl. VAT	**0**	**6,248**	**24,881**	**31,462**

Indicative cash flow profiles for each of the options are shown in the table below.

Table 33: Capital costs – By Project (£'000)

Date	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
2021/22		4,472	4,675	4,688
2022/23		1,775	2,026	2,040
2023/24		0	11,693	11,693
2024/25		0	152	152
2025/26		0	6,335	6,322
2026/27		0	0	94
2027/28		0	0	152
2028/29		0	0	6,322
Total capital costs incl. VAT	**0**	**6,248**	**24,881**	**31,462**

For completeness and ease of reference to capital cost forms, these figures are shown here including VAT and inflation adjustment. However, it should be noted that for the purposes of the economic appraisal all costs exclude VAT and are restated at base year prices in accordance with HM Treasury Green Book guidance.

More detailed design work will be required at Project Business Case stage and costs will be refined accordingly.

2.2.4 Estimating Lifecycle Capital Costs

Indicative lifecycle costs have been estimated over a 30-year appraisal period based on the following assumptions:

- Equipment replacement every 10 years.
- Building lifecycle costs based on typical average annual costs per m2 as follows:
- New build spaces at £29 per m2; and
- Refurbished spaces at £35 per m2.
- Allowances applied as follows:
- 10% management and fees; and
- 10% contingency.
- Costs applied where appropriate to option as follows:
  - Swansea 176m2 of refurbished space and 40m2 of new build space from 2023/24;
  - North Wales 260m2 of new build space from 2023/24;
  - 4th scanner 260m2 of new build space from 2025/26; and
  - 5th scanner 260m2 of new build space from 2028/29.

The resulting indicative lifecycle costs over the 30-year appraisal period are summarised in the table below. Detailed calculations are provided in the Economic and Financial Calculations in Appendix 3.

Table 34: Lifecycle during 30-year appraisal period (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Lifecycle for refurbished areas	0	0	173	173
Lifecycle for new build areas	0	0	442	624
Equipment replacement	0	14,019	31,779	37,699
Allowances	0	2,804	6,479	7,699
Total lifecycle costs (30-year period)	**0**	**16,823**	**38,873**	**46,195**
Equivalent annual cost	**0**	**543**	**1,254**	**1,490**

Lifecycle costs will be refined at Project Business Case stage based on detailed design.

2.2.5 Estimating Transitional Costs

Transitional costs will be incurred in relation to delivery of programme, including activities such as programme management and dual running costs during any disruptive works.

Indicative costs have been calculated based on the following assumptions:

- Programme team costs including:
- 1 WTE x Band 8b and 1 WTE Band 4.
- Mid-point of pay scale including on-costs.
- Incurred from 2021/22 until final project delivered (2025/26 for Option 3 and 2028/29 Option 4).
- Dual running costs:
- 3 months of dual running costs during replacement of Cardiff scanner.
- No other dual running costs required as the use of mobile scanners can continue during the construction of the new fixed scanner units.

The resulting indicative transitional costs are summarised in the table below.

Table 35: Transitional costs (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Programme team	0	0	502	804
Dual running costs	0	543	543	543
Total transitional costs	**0**	**543**	**1,045**	**1,347**

2.2.6 Estimating Recurring Revenue Costs

Baseline costs have been identified which demonstrate that it currently costs WHSSC £4.5m p.a. to deliver PET-CT services in Wales, based on 2020/21 budget. This equates to £872 per scan based on 2021 predicted demand.

An analysis of this is provided below.

Table 36: Baseline revenue costs

	Total costs	Basis
Betsi Cadwaladr University Health Board	1,105	2020/21 Budget
Swansea Bay University Health Board and PETIC (Cardiff)	2,937	2020/21 Budget
New indications Wales	500	2020/21 Budget
Total cost to WHSSC (£'000)	**4,542**	
Average number of scans	5,207	Predicted 2021 demand
Average cost per scan	**£872.29**	

Recurring revenue costs are anticipated to increase over the next 10 years in line with the demand modelling outlined in the Strategic Case section 5.5. Depending on the option, it may be possible to partly mitigate the increased costs by reducing the average cost per scan.

The current pricing model includes the following range of charges:

- The cost from PETIC is between £850 - £925 per scan.
- The mobile scanner at Wrexham costs between £806 - £896 per scan.
- The mobile scanner at Swansea costs around £950 per scan.
- The Christie tariff for 2020/21 is £846 per scan.
- The cost from external providers can increase to up to £1,500 per scan.
- PSMA scans cost between £1600 - £1825 per scan.

Initial work undertaken suggests that a fixed digital scanner operated by NHS Wales would provide opportunities to significantly reduce the cost per scan. Indicative costs have been calculated based on the following assumptions:

- Pay costs are based on the Workforce Group's agreed target staffing model. A preliminary workforce costing suggests that at mid-point of pay scale including on costs, this is likely to cost between £892k and £1,060k. For the purposes of the PBC, the maximum end of the range has been used.
- Non pay costs are based on the following assumptions:
- Equipment maintenance at 10% of capital costs.
- Radiopharmaceutical costs are based on estimated external provider prices which for the most common F-FDG scans typically range between £2580 - £3705 per day (equating to between 12-17 patient doses) plus £300 per delivery. F-PSMA radiopharmaceuticals are estimated to cost £950 per patient dose and have been applied to 6% of overall activity, in line with recent activity mix.
- Consumables and transport costs are based on the average cost per scan determined from total estimated costs outlined in the North Wales SOC revenue analysis.
- Building running costs are based on an overall average cost of £100 per m2 which includes Utilities, Soft FM and Hard FM.

Based on these assumptions it is estimated that it will cost NHS Wales £2.9m p.a. to operate each fixed digital scanner at full capacity. This is equivalent to £577 per scan, based on an average of 5,000 scans. An analysis of this is provided in the table below.

Table 37: Indicative revenue costs to operate digital scanner (£'000)

Element	Total annual costs (£'000)	Equivalent cost per scan
Workforce to operate digital scanner (7-12 patients per session)	1,060	£212.01
Pay costs	**1,060**	**£212.01**
Equipment maintenance	296	£59.20
Radiopharmaceuticals	1,308	£261.64
Consumables	47	£9.30
Delivery and transport	147	£29.45
Building running costs	26	£5.20
Non pay costs	**1,824**	**£364.80**
Total costs	**2,884**	**£576.81**

Indicative recurring revenue costs for each option in line with 10-year demand model have therefore been estimated based on the following assumptions:

- Digital scanner capacity is 5,288 scans.
- PETIC charges continue at £925 for first 2,150 scans, then £850 for 2150+ and are applied to South East Wales demand up to 5,288 scans.
- Operating costs for the new fixed scanners at North Wales and South West Wales, and the subsequent 4th and 5th scanners, where relevant to an option, are based on indicative operating costs outlined in Table 37 above and are applied as follows:
  - Variable costs (Radiopharmaceuticals, Consumables, Transport) applied based on the average cost per scan to predicted demand up to 5,288 scans.
  - Fixed costs (Equipment Maintenance, Building Running Costs) are applied in full from the year of opening.
  - Pay costs are also applied in full from the year of opening for the purposes of these calculations, although it should be noted than in reality pay costs are likely to be phased during the initial years of each scanner in line with activity. Further work will be undertaken at Project business case stage to develop detailed workforce plans and associated costs.
  - Any unmet demand assumed to be outsourced at average £935 per scan (to reflect range of fees including type and provider).

Detailed calculations are available in the PET-CT Revenue Workings in Appendix 4 and an extract provided below.

Table 38: Indicative 10-year recurring revenue costs (£'000)

Total costs £'000	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	10-year total
Option 1: BAU - Outsource all activity	4,869	5,843	7,011	8,412	10,096	12,115	14,537	17,445	20,935	25,122	30,145	156,529
Option 2: Do Minimum	4,806	5,736	6,850	8,187	9,268	11,287	13,709	16,617	20,107	24,294	29,317	150,179
Option 3: 4 scanners	4,806	5,736	6,850	8,125	8,546	8,714	11,251	12,185	14,327	18,279	23,303	122,122
Option 4: 5 scanners	4,806	5,736	6,850	8,125	8,546	8,714	11,251	12,185	14,688	16,305	21,329	118,536

Average cost per scan £	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	10-year total
Option 1: BAU - Outsource all activity	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00
Option 2: Do Minimum	£923.05	£917.89	£913.59	£910.00	£858.32	£871.10	£881.75	£890.62	£898.02	£904.18	£909.32	£897.07
Option 3: 4 scanners	£923.05	£917.89	£913.59	£903.07	£791.46	£672.53	£723.63	£653.09	£639.88	£680.32	£722.77	£729.47
Option 4: 5 scanners	£923.05	£917.89	£913.59	£903.07	£791.46	£672.53	£723.63	£653.09	£656.03	£606.86	£661.55	£708.06

This analysis demonstrates how the average price per scan is expected to change in relation to each of the options:

- Option 1 (BAU) – Average price increases to £935 per scan as all activity is outsourced.
- Option 2 (Do Minimum) – Average price increases to £898 as only the Cardiff scanner is replaced, for which PETIC pricing is retained, and there is significant reliance on outsourcing.
- Option 3 (4 fixed scanners) – Average price reduces to £729 due to the benefits of 3 new fixed scanners although there is some reliance on outsourcing from 2029/30 based on current demand predictions.
- Option 4 (5 scanners) – Average price reduces to £708 as there is no reliance on outsourcing during the 10-year period.

These costs have been incorporated into the economic appraisal for each option for the first 10 years. Costs are assumed to remain static from Year 11 onwards. This results in recurring revenue costs over a 30-year period as outlined in the table below.

Table 39: Recurring revenue costs (£'000)

Element	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Total revenue costs (30-year appraisal period)	759,436	759,374	588,176	545,115
Equivalent annual cost	25,315	25,312	19,606	18,171

2.2.7 Benefits

The delivery of the programme will deliver a range of benefits including:

- Improved quality and reduction in patient harm.
- Workforce resilience.
- Improved efficiency and economy.
- Improved access reducing patient travel time.
- Cost effective service supported by income generation.
- Provide capacity that meets population needs in line with international best practice.
- Increased opportunities for Research and Development.
- Increased opportunities for innovation.

Work will be required at Project Business Case to explore these benefits in detail and quantify them, where possible in monetary equivalent terms. Indicative methodologies and assumptions for doing so are provided in the table below.

Table 40: High level benefits assumptions

Benefit	Benefit type	Indicative methodology / assumptions for quantifying
Improved quality and reduction in patient harm		
B01 Avoid high-cost late-stage interventions	Cash releasing benefit	As the demand modelling is refined, identify the number of patients for which improved staffing would reduce the need for high cost interventions. Allocate potential cost saving based on current evidence base. For instance the Evidence Review outlined in Specialised Services Commissioning Policy CP50a suggests PET-CT is c.£1500 cheaper than a neck dissection. As an indication, if even 10% of overall predicted demand was associated with reducing late stage cost interventions, based on an indicative £1500 per patient, this would equate to £4.8m annual financial benefit by 2031/32.
B02 Improved diagnostic accuracy	Qualitative	It is anticipated that this benefit will be difficult to measure with any degree of certainty.
B03 Reduced waiting times	Quantitative (Unmonetised)	Determine baseline referral to reporting time and identify how many scans will achieve 10 day referral to report target.
B04 Improved patient experience	Qualitative	It is anticipated that it is difficult to demonstrate a direct correlation between the investment and patient experience.
Workforce resilience		
B05 Improved recruitment and retention	Qualitative	It is anticipated that it is difficult to demonstrate a direct correlation between the investment and recruitment and retention rates.
B06 Improved access to training and education	Quantitative (Unmonetised)	Based on learning needs analysis and evaluation data, identify baseline position and agree target improvement.
B07 Improved staff satisfaction	Qualitative	It is anticipated that it is difficult to demonstrate a direct correlation between the investment and staff satisfaction.
Improved efficiency and economy		
B08 Increased capacity resulting in ability to meet demand	Cash releasing	Estimate average cost per scan based on refined costs at Project stage. Based on indicative costs outlined in section 2.6, it is anticipated that this will result in a reduction to overall average from £873 to between £708 - £729 depending on the option.
B09 Reduced downtime	Non-cash releasing	At the time of developing the PBC, there was limited data showing a significant number of cancelled sessions that were impacting on utilisation, however this is likely to be as a result of additional efforts by local service leads. This should be revisited at Project Business Case stage to determine whether number of cancellations has changed or whether any estimation can be made of time spent by local teams to manage utilisation.
B10 Reduced reliance on mobile scanners	Cash releasing	Estimate average cost per scan based on refined costs at Project stage. Based on indicative costs outlined in section 2.6, it is anticipated that the average cost per scan for NHS Wales managed digital scanners will equate to £577 which is significantly below the average of £935 per scan associated with mobile scanners currently.

Benefit	Benefit type	Indicative methodology / assumptions for quantifying
Improved access reducing patient travel		
B11 Reduced patient travel time – value to patients	Societal (monetised)	Patient travel time analysis to be undertaken at Project business case stage. DfT TAG values of time can be used to estimate the economic value of any reduction in travel time.
B12 Reduced patient travel time – value to patients	Societal (monetised)	Converting the travel time analysis into mileage will enable a calculation to made using the HMT Green Book toolkit to estimate reduction in CO2e and corresponding economic value.
Cost effective service supported by income generation		
B13 Income generation opportunities	Cash releasing	Work should be undertaken at Project business case stage to estimate the value of additional income from RD&I activity. It is estimated that up to 10% of a scanner's capacity could be used for this purpose and the demand modelling includes an estimate of around 7%. As an indication, if 7% of activity generated income of £1500 per scan, that would result in a financial benefit of £3.3m by 2031/32.
Provide capacity that meets population needs in line with best practice		
B14 Better equity of access	Quantitative (Unmonetised)	At Project business case stage, determine the range of indications available at each centre and associated waiting times.
Increase opportunities for Research and Development		
B15 Increased proportion of staff research active	Quantitative (Unmonetised)	At Project business case stage, determine number of research posts at each site and potential impact in terms of publications, etc.
B16 Increased proportion of patients on clinical trails	Quantitative (Unmonetised)	At Project business case stage, determine number of patients able to participate at each site.
B17 Greater number of trails led by and participated in by PET site	Quantitative (Unmonetised)	At Project business case stage, determine number of potential trials at each site.
Increased opportunities for innovation		
B18 Improved access to a greater range of diagnostics to support greater range of therapeutics	Qualitative	It is anticipated that it is difficult to measure as dependent on a number of factors.

2.2.8 Risks

For the purposes of preparing an indicative cost benefit analysis for the PBC, a planning contingency of 10% has been incorporated into the capital costs.

At Project business case stage more detailed risk analysis will be undertaken and, where possible, risks will be quantified in monetary-equivalent values. This will include an analysis of:

- Optimism bias.
- Expected risk value.

2.2.9 Economic Appraisal Results

DHSC's Comprehensive Investment Appraisal (CIA) model has been populated with these indicative assumptions to support the appraisal of overall value for money and cost-benefit analysis of the shortlisted options.

The assumptions above have been incorporated into a discounted cash flow for each of the options. In line with HMT Green Book requirements:

- Costs, benefits and risks are calculated over a 31-year appraisal period including Year 0 (baseline year) + 30 years estimated useful life.
- Year 0 is 2021/22.
- Costs and benefits use real base year prices – all costs are expressed at 2020/21 prices in line with the baseline costs.
- The following costs are excluded from the economic appraisal:
- Exchequer 'transfer' payments, such as VAT.
- General inflation.
- Sunk costs.
- Non-cash items such as depreciation and impairments.
- A discount rate of 3.5%is applied.

A summary of the economic appraisal is shown in the table below.

Table 41: Economic appraisal overview (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Undiscounted inputs				
Initial capital costs	0	5,206	20,857	26,387
Lifecycle capital costs	0	16,823	38,873	46,195
Total capital costs	**0**	**22,029**	**59,729**	**72,583**
Transitional revenue costs	0	543	1,045	1,347
Recurring revenue costs	759,436	759,374	588,176	545,115
Total revenue costs	**759,436**	**759,917**	**589,221**	**546,462**
Undiscounted Net Present Cost	**759,436**	**781,946**	**648,950**	**619,045**
Discounted outputs				
Initial capital costs	0	5,156	19,453	23,813
Lifecycle capital costs	0	8,791	21,005	24,506
Total capital costs	**0**	**13,948**	**40,458**	**48,319**
Transitional revenue costs	0	543	1,012	1,258
Recurring revenue costs	428,611	428,548	333,182	310,723
Total revenue costs	**428,611**	**429,091**	**334,194**	**311,981**
Discounted Net Present Cost	**428,611**	**443,039**	**374,653**	**360,300**
Ranking	**3**	**4**	**2**	**1**

This analysis demonstrates that Option 4 (More Ambitious) results in the lowest Net Present Cost (NPC), closely followed by Option 3 (Preferred Way Forward).

The economic summary in the CIA model calculates the incremental costs and benefits (which in this case refers to reduction in revenue costs) in relation to the baseline option, Option 1 (BAU).

Table 42: Economic appraisal results (£'000)

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Incremental costs - total	0	(14,491)	(41,471)	(49,577)
Incremental benefits - total	0	62	95,429	117,888
Incremental Net Present Social Value	**0**	**(14,428)**	**53,958**	**68,311**
Benefit-cost ratio	**0.00**	**0.00**	**2.30**	**2.38**
Rank	**4**	**3**	**2**	**1**

This analysis suggests that, on the face of it, Option 4 (More Ambitious) provides the best value for money since it results in the following:

- Lowest Net Present Cost (£360.3m over 30 years).
- Lowest incremental Net Present Social Value (i.e. Net Present Cost is £68.3m lower than the baseline option).
- Highest Benefit Cost Ratio of 2.38.

However, this is closely followed by Option 3 (Preferred Way Forward) with the following results:

- Second lowest Net Present Cost (£374.7m over 30 years).
- Second lowest incremental Net Present Social Value (i.e. Net Present Cost is £54.0m lower than the baseline option).
- Second highest Benefit Cost Ratio of 2.30.

In addition to offering the second best value for money this option also provides greater flexibility since the need for the 5th scanner can be reviewed at a later date, reducing capital investment requirements and minimising risk. The impact of this is explored in the section on sensitivity analysis below.

2.2.10 Sensitivity Analysis

The ranking of the economic appraisal is highly dependent on the financial benefits associated resulting from the revenue costs. These have been calculated based on the current demand modelling which assumes 20% year on year demand growth.

The analysis below demonstrates that if actual demand growth is less than 17.5% year on year, Option 3 (Preferred Way Forward) consistently results in the highest Benefit Cost Ratio (BCR).

Table 43: Summary of Sensitivity analysis

	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
BCR - Results of economic appraisal	0.0	0.0	2.3	2.4
BCR - Scenario 1: Growth at 17.5%	0.0	0.0	2.3	2.3
BCR - Scenario 2: Growth at 15%	0.0	0.0	2.1	1.5
BCR - Scenario 3: Growth at 12.5%	0.0	0.0	1.4	0.9
BCR - Scenario 4: Growth at 10.0%	0.0	0.0	0.8	0.4

This demonstrates that the ranking of options is heavily dependent on demand modelling assumptions and, on this basis, Option 3 (Preferred Way Forward) results in best value for money given the additional flexibility.

2.2.11 Conclusion

A summary of the overall options appraisal results is provided in the table below.

Table 44: Options overview

Element	Option 1 Business as Usual (BAU)	Option 2 Do Minimum	Option 3 Preferred Way Forward	Option 4 More Ambitious
Description	Do nothing	Retain 1 fixed and extend capacity of 2 mobile scanners	Provide 4 fixed scanners (10-year programme)	Provide 5 fixed scanners (10-year programme)
Incremental NPSV	-	£(4.4)m	£54.0m	£68.3m
Benefit Cost Ratio	-	0.00	2.30	2.38
Average cost per scan (10 year period)	£935	£898	£729	£708
Sensitivity and risks	Consistently ranks as worst value for money even with significant changes in assumptions	Consistently ranks as second worst value for money even with significant changes in assumptions	Ranks as best value for money if demand growth is lower than 17.5% year on year	If demand growth is lower than predicted 5th scanner will be significantly underutilised

Based on the overall results, it is recommended that Option 3 (Preferred Way Forward) is carried forward as the preferred way forward for delivering the programme and the potential need for a 5th scanner assessed at a later date.

2.2.12 Preferred way forward

The preferred way forward is to implement a programme which will deliver 4 fixed digital scanners in NHS Wales. This will require capital investment of £24.9m to deliver the following projects:

Table 45: Preferred way forward programme

Project	Implementation	Investment requirements
Project 1 - Cardiff	2021/22	• Replace PET-CT • Upgrade of cyclotron

Project	Implementation	Investment requirements
Project 2 - North Wales	2023/24	• New PET-CT • New build (260m2)
Project 3 - Swansea	2023/24	• New PET-CT • Refurbish an existing building (176m2) + new build extension (40m2)
Project 4 - 4th scanner	2025/26	• New PET-CT • New build (260m2)

As a result of this investment the preferred way forward is expected to deliver the following:

- Capacity to meet predicted demand to 2028/29.
- Opportunities to reduce the cost per scan to an average of £729 per scan in the first 10 years, based on indicative operating costs of NHS Wales fixed digital scanners estimated at £577 per scan and continuing with current PETIC charging arrangements.
- Opportunities to reduce overall system costs due to avoiding late stage interventions. This could be significant since the evidence base suggests for certain diseases and patient pathways, such as the treatment of neck cancers, PET-CT scans are potentially £1,500 more cost effective. Further work will be required at Project business case stage to determine more accurate activity levels in relation to patient pathways. As an indication, if this sort of benefit was applied to 10% of activity, this would equate to a financial benefit of around £4.8m by 2031/32.
- Opportunities to generate income from RD&I activity. It is estimated that 7% of predicted demand relates to RD&I activity. Again, further work will be required at Project business case stage to identify accurate numbers but, as an indication, if research scans were charged at £1500, this would equate to an annual financial benefit of around £3.3m by 2031/32.
- Delivery of non-financial benefits including:
- Improved quality and reduction in patient harm including reduced waiting times, better diagnostic accuracy and improved patient outcomes and experience.
- Workforce resilience including improved recruitment and retention, greater access to training and education, and improved staff satisfaction.
- Improved access reducing patient travel time which benefits patient and reduces greenhouse gases.
- Provide capacity that meets population needs in line with international best practice.
- Increased opportunities for Research and Development.
- Increased opportunities for innovation.

In addition to this, there is flexibility to introduce a 5th scanner at a later date based on updated demand and capacity analysis at that time, reducing committed capital expenditure and minimising risk.

Plans to implement the preferred way forward and the commercial, financial and management implications are outlined in the subsequent chapters of this business case.

3 Commercial Case

3.1 Introduction

3.1.1 Purpose

The purpose of this section is to set out an initial high level Procurement Strategy to establish appropriate procurement and contractual arrangements in order to implement and deliver the Programme's Projects and key activities.

The Programme will look to acquire four fixed, digital (AI enabled) PET-CT (Positron Emission Tomography combined with Computerised Tomography) scanners and install these key items of equipment at four locations across Wales. This procurement includes ancillary equipment, radiotherapy adaptations, in addition to an ion source and hot cell replacement for the cyclotron at the Cardiff site.

3.1.2 Considerations

The Programme Manager has developed this commercial case with support and advice from specialist colleagues at NHS Wales Shared Services Partnership - Specialist Estates Services [NWSSP-SES] and Procurement Services [NWSSP-PS].

It should be emphasised that whilst the Programme is being hosted by WHSSC, capital funding will be given to the respective organisations, all of which have Estates & Facilities and Procurement teams that will have capability to carry out procurement activities. Dependent upon availability of a suitably experienced individual during the time period, there would be some benefit in an individual taking the procurement lead for this Programme.

Another key consideration is that the capital funding for the PETIC Cardiff site will be given to Cardiff University, and therefore this site will be subject to the University procurement processes and procedures. This will require a close working relationship with Cardiff and Vale University Health Board for effective implementation.

There are multiple procurement routes that can be followed, however all of the major items of equipment are available on a compliant preapproved framework. NHS Wales has direct access to this framework and at the time of writing it is thought that Cardiff University can, through its own procurement department, access this same agreement.

In line with clinical demand and workforce availability, the implementation of the Programme will need to be carried out in a phased manner. Dependent upon the timings of the phases and or the available funds, it may be possible to aggregate NHS Wales purchasing requirements so as to generate additional value.

Given the scale and impact on current Welsh NHS services that the All Wales PET Programme will deliver, it is imperative to ensure appropriate governance is in place for procurement. As such we propose that a multidisciplinary team will make up membership of a Procurement Workstream that will support the Programme.

3.2 Key Objectives of the Procurement

The key objectives of the procurement and its scope have been considered to ensure an optimum approach.

The key objectives are:

- a solution that delivers safe and effective clinical outcomes for patients;
- a solution that is capable of future development to meet expanding clinical needs, such as radiotherapy planning;
- a solution that is capable of answering research, development and innovation needs;
- a solution that offers value for money over its lifetime;
- a solution that is "*best in class*" (where technically, clinically and financially feasible);
- a solution that is fully interoperable across all elements;
- a solution that provides the requisite business management as well as clinical functions;
- a solution that, as far as possible, enables efficient, high quality diagnostic regimens to be introduced;
- a solution that offers full audit facilities for process development and research;
- a solution capable of meeting the needs of All Wales PET Service Clinical Model.

It is important to highlight that the objectives derive from the requirements of All Wales PET Programme.

3.3 Scope of Procurement

The Equipment/items covered under the procurement is:

- Four PET-CT Scanners (AI enabled; one scanner at each site)
- Ancillary equipment and phantoms (Robotic radiotracer dispenser)
- Radiotherapy adaptions (laser bridge, flat table top)

The Equipment must be interoperable, meet all relevant standards (as a minimum) and be demonstrably proven to operate as a complete technical and clinical solution.

The total estimated capital value of the Equipment for the Preferred Way Forward is circa £13.5 million. This will be profiled over the period of five years. This is supported by build works costs of circa £4.6 million, with fees and non-works costs circa £815,000. A quantified risk and contingency has been allocated at circa £1.9 million. Net VAT has been calculated at circa £4 million, with the total Programme cost being circa £24.9 million, inclusive of quantified risk and contingency.

Programme Management is based at the host organisation WHSSC and costs for this post are currently sourced via the NHS Wales Collaborative and have been agreed until 31st March 2022.

The revenue for staffing and maintenance/ongoing support is not included in these figures and are addresses in the Economic and Financial Cases.

Project Management support is expected to be funded by Health Boards and the Programme Management funding is to be confirmed.

The full extent of the capital and revenue costs will not be known until Full Business Cases are complete for each site. As such, implementation and roll out is not considered in any detail within this document.

The prospective timelines for the four projects within this Programme can be seen in Table 46.

Table 46: High level dates of the Projects and business cases

Business Case (BC)	Proposed date of Welsh Gov. BC approval	Proposed "go live" date	
Project 1			
BJC	July 2021	PET Scanner	March 2022
		Ion Source replacement	March 2022
		Hot Cell replacement	March 2023
Project 2			
SOC1	July 2021	January 2024	
OBC/FBC	March 2022		
Project 3			
OBC2	November 2021	November 2023	
FBC2	July 2022		
Project 4			
Appraisal Process	April 2023	June 2026	
OBC3	January 2024		
FBC3	December 2024		

3.4 Proposed Contractual Structure

The decision of supplier will sit with the procuring organisation following evaluation, which will enter into a contract with the organisation directly. However it should be noted that a collaborative approach may add additional value should this be deemed deliverable given the extended timeline of the phases.

The Procurement Workstream membership will consist of the specialists within NWSSP-SES, NWSSP-PS, organisations Procurement and Estates representatives, Programme Manager and Project Teams at relevant Health Boards, Trusts and Cardiff University.

The question as to whether the Equipment requirement should be procured as (i) single contract or (ii) a series of separate contracts, has been considered. As the procurement will utilise a compliant framework agreement to secure the requirements, then there will likely be separate contracts between suppliers and the organisation that will purchase the equipment.

It is possible that the Procurement Workstream will propose running one procurement for the NHS equipment, depending upon the timings. For instance if phasing of projects is less than two years apart, there may be option to fix the costs and place orders at the same time, deploying when needed at a future date.

It is anticipated that each organisation that subsequently hosts a digital PET scanner will enter into a contract with the supplier. This contract will be subject to the hosting organisations local governance, procurement and due diligence processes.

An initial assessment of the key risks, issues and options determined that procuring through separate contracts for the requirements would:

- be the most likely to achieve the key objectives
- allow the Programme to phase implementation, in line with clinical demand and infrastructure constraints
- allow Cardiff University to follow its procurement and contracting processes
- provide each NHS organisation with the least risk approach in terms of achieving a solution that delivers Equipment interoperability
- allow each NHS organisation to manage its procurement process more easily
- be less complex
- place risk in the most appropriate place

However, it should be noted that procuring through separate contracts may cause interoperability issues, result in a diminished value for money opportunity, a potential loss of consistency of approach across Wales and additional contract management burden. Therefore, these items will require additional consideration at the Procurement Workstream.

3.5 Evaluation

On conclusion of the procurement phase and final evaluation of the responses, the Procurement Workstream will make a recommendation based on the most economically advantageous tender(s). This recommendation will be recorded in a final evaluation report, which will set out the basis for the award decision, for the formal approval of the PET Strategic Programme Board and internal governance of the receiving organisation.

Any award will be subject to a mandatory 10-day Standstill period. Final award will also be subject to approval by the National Imaging Strategic Programme Board and Collaborative Executive Group, Full Business Case Approval and Notification being provided from the Welsh Government Cabinet Secretary for Sport, Health and Wellbeing.

Suppliers will be allowed an opportunity for a full debrief following the formal decision being ratified and approved.

The full evaluation methodology will be set out in the procurement strategy which will be developed post PBC approval and be consistent and in accordance with the requirements of the Framework Agreement being utilised.

3.6 Procurement Resources

The Procurement Workstream will consist of an experienced and suitably skilled multi-disciplinary team. They will be able to advise each PET scanning site procurement team and membership of this Workstream should include appropriate representation from each site procurement team.

Each local site procurement team could consist of the following membership:

- Organisation or Health Board responsible person
- Head of PET scanning Services (if applicable)
- PET Scanning Services Manager
- Organisation or Health Board Estates representation
- Organisation or Health Board Procurement representation
- End User Clinical lead
- Organisation or Health Board Finance lead
- NWSSP – Senior Advisor
- NWSSP – Procurement Lead
- PET site Project Manager.

A fully resourced, suitably experienced and structured Procurement Workstream and Project Team to oversee the procurement process would be a pre-requisite to achieving a successful outcome.

3.6.1 Procurement of Specialist Advisors

Each Organisation or Health Board will have in-house resources and expertise and experience in procuring this or similar equipment. Indeed, in-house legal support will be pertinent as a good reference point.

Additional support will be provided by colleagues from NWSSP-SES and PS.

3.7 Key Procurement Risks and Challenges

Set out in Table 47 below, is a non-exhaustive list of key risks and challenges which can compromise the outcome of the tender process in the absence of adequate preparation and governance arrangements

Table 47: Key Risks and Challenges

Key Risk & Challenges	Actions to Mitigate / Manage
Interfaces and requirements between the PET scanner Procurement and the Programme agreement for the scanners do not align	Sharing of key document and alignment of personnel.
Nuclear Medicine Consolidation Programme at North Wales site delayed – impact on All Wales PET Programme delivery	The Health Board would still be required to undertake appropriate procurement of equipment/solutions. Sharing of key documents between Programmes Boards.
Timeline between concluding procurement and the likely timeline for deployment into Health Boards	As above.
Issues stemming from insufficient numbers of staff and a lack of internal resources.	Each Health Board staffing and skill profile must be identified, understood, resourced and deployed effectively prior to procurement.
Adequate and appropriate engagement from senior management and operational staff	Ensure governance arrangements are in place to secure senior management and Health Boards key operational

Key Risk & Challenges	Actions to Mitigate / Manage
	staff engagement with, and commitment to, each project throughout to ensure that Programme needs are truly reflected in the final outcome.
Associated facilities are not up to service specification	Ensure breakpoints to review purchase are included in contract and ensure financial contingency is in place

3.8 Prospective Timeline

Table 48 below sets out the prospective timeline for the procurement at each site. The timescales are compliant with the relevant procurement procedures/regulations at the time of writing this Programme Business Case.

Soon after this Programme Business Case is endorsed by Welsh Government, the Procurement Workstream will hold a workshop that will include membership as noted above from Shared Services and local organisation. This will act as the catalyst to evaluating all aspects of procurement, as noted throughout this document.

Table 48: Prospective Timeline

Activity	Timeframe
Health Board approval of Outline Business Case	2 months
Welsh Government approval of Outline Business Case	2 months
Pre-tender market engagement	20 days
Time for Outline Tender returns/clarification	40 days
Time for final tender returns	25 days
Evaluate final tenders	20 days
Full Business Case drafting and submission	2 months
Welsh Government approval of Full Business Case	2 months
Contract Award	Minimum 10 days+

4 Financial Case

4.1 Financial Appraisal

4.1.1 Introduction

The purpose of the Financial Case is to consider the financial impact of the delivering preferred way forward and demonstrate affordability of the programme.

The preferred way forward identified in the Economic Case is to implement a programme that will deliver four fixed digital scanners in Wales and involves investing in the following projects:

- Project 1: To replace the PET-CT scanner and upgrade the cyclotron at the existing PETIC site in Cardiff during 2021/22.
- Project 2: To create a new fixed PET-CT scanner in North Wales by constructing a new build facility and procuring a PET-CT scanner by 2023/24.
- Project 3: To create a new fixed PET-CT scanner in South West Wales by refurbishing and extending an existing building and procuring a PET-CT scanner by 2023/24.
- Project 4: To create a fourth fixed PET-CT scanner in a location which will be determined in relation to demand needs at the time by constructing a new build facility and procuring a PET-CT scanner by 2025/26.

4.1.2 Capital Requirements

Capital funding of £24,881k is sought from Welsh Government to deliver the All Wales PET-CT programme.

This is based on indicative costs which have been estimated by SES based on the following high level assumptions:

- The floor area required to create a facility to house a PET-CT including supporting areas, such as waiting areas and uptake rooms has been calculated.
- Construction costs have been allocated to the floor areas as follows:
- Refurbishment costs £2k per m2 + on costs; and
- New build costs £4k per m2 + on costs.
- An allowance for lead lining has been included.
- On costs have been included at 35%.
- Fees have been included at 16%.
- An estimate for non-works has been estimated.
- Equipment costs are based on typical market costs:
- PET-CT scanner £2.9m (including ancillary equipment and Radiotherapy adaptions); and
- Cyclotron refresh £1.75m (including ion source replacement and hot cells).
- Planning contingency has been included at 10%.
- VAT has been applied at 20% to all costs except fees.

The PBC capital cost forms are provided in Appendix 10. The table below provides an overview of total capital costs for the delivering the overall programme.

Table 49: Capital costs - Programme

	Net Costs £'000	VAT £'000	Total Costs £'000
Construction	4,593	919	5,511
Fees	735	0	735
Non works	80	16	96
Equipment costs	13,553	2,711	16,264
Planning contingency	1,896	379	2,275
Total capital costs	**20,857**	**4,024**	**24,881**

Indicative capital costs for each of the individual projects are shown in the table below.

Table 50: Capital costs - By Project

	Net Costs £'000	VAT £'000	Total Costs £'000
Project 1 - Replace Cardiff equipment	5,206	1,041	6,248
Project 2 - Fixed scanner North Wales	5,525	1,048	6,573
Project 3 - Fixed scanner Swansea	4,600	886	5,486
Project 4 - 4th fixed scanner	5,525	1,048	6,573
Total capital costs	**20,857**	**4,024**	**24,881**

An indicative cash flow for capital costs is shown in the table below.

Table 51: Capital costs - Cash flow

	Net Costs £'000	VAT £'000	Total Costs £'000
2021/22	3,919	756	4,675
2022/23	1,719	307	2,026
2023/24	9,780	1,913	11,693
2024/25	145	7	152
2025/26	5,293	1,042	6,335
Total capital costs	**20,857**	**4,024**	**24,881**

More detailed design work will be required at Project Business Case stage and costs will be refined accordingly.

4.1.3 Transitional Costs

Non-recurring revenue costs of £1,045k are expected to be incurred in relation to delivery of the programme, including activities such as programme management and dual running costs during any disruptive works.

This has been estimated based on the following assumptions:

- Programme team costs including:
- 1 WTE x Band 8b and 1 WTE Band 4.
- Mid-point of pay scale including on-costs.
- Incurred from 2021/22 until final project delivered in 2025/26.
- Dual running costs:
- 3 months of dual running costs during replacement of Cardiff scanner.
- No other dual running costs required as the use of mobile scanners can continue during the construction of the new fixed scanner units.

The resulting indicative transitional costs are summarised in the table below.

Table 52: Transitional costs – Cash flow

	Programme team £'000	Dual running £'000	Total costs £'000
2021/22	100	545	645
2022/23	100		100
2023/24	100		100
2024/25	100		100
2025/26	100		100
Total capital costs	**500**	**545**	**1,045**

4.1.4 Estimating Recurring Revenue Costs

Baseline costs have been identified which demonstrate that it currently costs WHSSC £4.5m p.a. to deliver PET-CT services in Wales, based on 2020/21 budget. This equates to £872 per scan based on 2021 predicted demand. An analysis of this is provided below.

Table 53: Baseline revenue costs

	Total costs	Basis
Betsi Cadwaladr University Health Board	1,105	2020/21 Budget
Swansea Bay University Health Board and PETIC (Cardiff)	2,937	2020/21 Budget
New indications Wales	500	2020/21 Budget
Total cost to WHSSC (£'000)	**4,542**	
Average number of scans	5,207	Predicted 2021 demand
Average cost per scan	**£872.29**	

Demand is anticipated to increase by 20% year on year over the next 10 years as outlined in the demand modelling outlined in the Strategic Case section 5.5.

Given the existing capacity, this is likely to result in a significant cost pressure if no investment is made, particularly since the current cost model includes the following range of potential costs:

- The cost from PETIC is between £850 - £925 per scan.

- The mobile scanner at Wrexham costs between £806 - £896 per scan.
- The mobile scanner at Swansea costs around £950 per scan.
- The Christie tariff for 2020/21 is £846 per scan.
- The cost from external providers can increase to up to £1,500 per scan.
- PSMA scans cost between £1600 - £1825 per scan.

Investing in fixed digital scanners which are operated by NHS Wales provides opportunities to significantly reduce the average cost per scan and partly mitigate the cost pressure created by the growing demand.

Indicative costs for each new NHS Wales fixed scanner have been calculated based on the following assumptions:

- Pay costs are based on the Workforce Group's agreed target staffing model. A preliminary workforce costing suggests that at mid-point of pay scale including on costs, this is likely to cost between £892k and £1,060k. For the purposes of the PBC, the maximum end of the range has been used.
- Non pay costs are based on the following assumptions:
- Equipment maintenance at 10% of capital costs.
- Radiopharmaceutical costs are based on estimated external provider prices which for the most common F-FDG scans typically range between £2580 - £3705 per batch (equating to between 12-17 patient doses) plus £300 per delivery. F-PSMA radiopharmaceuticals are estimated to cost around twice as much and have been applied to 6% of overall activity, in line with recent activity mix.
- Consumables and transport costs are based on the average cost per scan determined from total estimated costs outlined in the North Wales SOC revenue analysis.
- Building running costs are based on an overall average cost of £100 per m2 which includes Utilities, Soft FM and Hard FM.

Based on these assumptions it is estimated that it will cost NHS Wales £2.9m p.a. to operate each fixed digital scanner at full capacity. This is equivalent to £577 per scan, based on an average of 5,000 scans. An analysis of this is provided in the table below.

Table 54: Indicative revenue costs to operate digital scanner (£'000)

Cost element	Total annual costs (£'000)	Equivalent cost per scan
Workforce to operate digital scanner (7-12 patients per session)	1,060	£212.01
Pay costs	**1,060**	**£212.01**
Equipment maintenance	296	£59.20
Radiopharmaceuticals	1,308	£261.64
Consumables	47	£9.30
Delivery and transport	147	£29.45
Building running costs	26	£5.20
Non pay costs	**1,824**	**£364.80**
Total costs	**2,884**	**£576.81**

Indicative recurring revenue costs for in line with the 10-year demand model have therefore been estimated based on the following assumptions:

- Digital scanner capacity is 5,288 scans.
- PETIC charges continue at £925 for first 2,150 scans, then £850 for 2150+ and are applied to South East Wales demand up to 5,288 scans.
- Operating costs for the new fixed scanners at North Wales and South West Wales, and the subsequent fourth scanners based on indicative operating costs above and are applied as follows:
- Variable costs (Radiopharmaceuticals, Consumables, Transport) applied based on the average cost per scan to predicted demand up to 5,288 scans.
- Fixed costs (Equipment Maintenance, Building Running Costs) are applied in full from the year of opening.
- Pay costs are also applied in full from the year of opening for the purposes of these calculations, although it should be noted than in reality pay costs are likely to be phased during the initial years of each scanner in line with activity. Further work will be undertaken at Project business case stage to develop detailed workforce plans and associated costs.
- Any unmet demand assumed to be outsourced at average £935 per scan (to reflect range of fees including type and provider).

Detailed calculations are available in the PET-CT Revenue Workings in Appendix 2 and an extract provided below.

Table 55: Indicative 10-year recurring revenue costs (£'000)

Business as Usual option (No investment; outsource unmet demand)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	10-year total
Total activity (Number of scans)	5,207	6,249	7,498	8,997	10,798	12,957	15,548	18,658	22,390	26,868	32,241	167,411
Total recurring revenue costs (£'000)	**4,869**	**5,843**	**7,011**	**8,412**	**10,096**	**12,115**	**14,537**	**17,445**	**20,935**	**25,122**	**30,145**	**156,529**
Total cost per scan	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00	£935.00
Variance to baseline costs 2020/21	**327**	**1,301**	**2,469**	**3,870**	**5,554**	**7,573**	**9,995**	**12,903**	**16,393**	**20,580**	**25,603**	**106,567**

Preferred way forward option (Provide 4 fixed scanners)

	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	10-year total
South East Wales (PETIC)	2,629	3,155	3,786	4,543	5,288	5,288	5,288	5,288	5,288	5,288	5,288	51,129
South West Wales (Fixed digital scanner)	1,434	1,721	2,065	2,478	2,974	3,569	4,282	5,138	5,288	5,288	5,288	39,526
North Wales (Fixed digital scanner)	1,144	1,373	1,647	1,976	2,372	2,846	3,415	4,098	4,918	5,288	5,288	34,363
4th scanner (Fixed digital scanner)	0	0	0	0	0	1,254	2,563	4,133	5,288	5,288	5,288	23,814
Capacity shortfall - Outsourced	0	0	0	0	164	0	0	0	1,608	5,716	11,089	18,577
Total activity (Number of scans)	5,207	6,249	7,498	8,997	10,798	12,957	15,548	18,658	22,390	26,868	32,241	167,411
South East Wales (PETIC)	2,396	2,843	3,379	4,023	4,023	4,023	4,023	4,023	4,023	4,023	4,023	40,801
South West Wales (Fixed digital scanner)	1,341	1,609	1,931	2,126	2,275	2,454	2,668	2,926	2,971	2,971	2,971	26,243
North Wales (Fixed digital scanner)	1,070	1,284	1,540	1,976	2,095	2,237	2,408	2,613	2,859	2,971	2,971	24,022
4th scanner (Fixed digital scanner)	0	0	0	0	0	0	2,152	2,624	2,971	2,971	2,971	13,687
Capacity shortfall - Outsourced	0	0	0	0	153	0	0	0	1,503	5,344	10,368	17,369
Total recurring revenue costs (£'000)	**4,806**	**5,736**	**6,850**	**8,125**	**8,546**	**8,714**	**11,251**	**12,185**	**14,327**	**18,279**	**23,303**	**122,122**
South East Wales (PETIC)	£911.34	£901.11	£892.59	£885.49	£760.74	£760.74	£760.74	£760.74	£760.74	£760.74	£760.74	£797.99
South West Wales (Fixed digital scanner)	£935.00	£935.00	£935.00	£858.13	£765.11	£687.64	£623.16	£569.33	£561.75	£561.75	£561.75	£663.93
North Wales (Fixed digital scanner)	£935.00	£935.00	£935.00	£999.82	£883.05	£786.01	£705.10	£637.65	£581.42	£561.75	£561.75	£699.03
4th scanner (Fixed digital scanner)						£0.00	£839.63	£634.79	£561.75	£561.75	£561.75	£574.76
Capacity shortfall - Outsourced					£935.00				£935.00	£935.00	£935.00	£935.00
Total cost per scan	£923.05	£917.89	£913.59	£903.07	£791.46	£672.53	£723.63	£653.09	£639.88	£680.32	£722.77	£729.47
Variance to baseline costs 2020/21	**264**	**1,194**	**2,308**	**3,583**	**4,004**	**4,172**	**6,709**	**7,643**	**9,785**	**13,737**	**18,761**	**72,160**
Varance to BAU option	**(62)**	**(107)**	**(161)**	**(287)**	**(1,550)**	**(3,401)**	**(3,286)**	**(5,260)**	**(6,608)**	**(6,843)**	**(6,843)**	**(34,407)**

This analysis demonstrates that over a 10-period, continuing to meet growing demand by relying on external providers is likely to cost an additional £25,603k p.a. by 2031/32 with average cost per scan increasing to £935.

Investing in the four PET-CT scanners will reduce the cost pressure by £6,843k p.a. by providing sufficient capacity for NHS Wales and PETIC to meet demand to 2028/29 which reduces the average cost per scan to £729.

In addition, this investment will deliver other benefits which will be explored at Project business case stage including:

- Opportunities to reduce overall system costs due to avoiding late stage interventions. This could be significant since the evidence base suggests for certain diseases and patient pathways, such as the treatment of neck cancers, PET-CT scans are potentially £1,500 more cost effective. Further work will be required at Project business case stage to determine more accurate activity levels in relation to patient pathways. As an indication, if this sort of benefit was applied to 10% of activity, this would equate to a financial benefit of around £4.8m by 2031/32.
- Opportunities to generate income from RD&I activity. It is estimated that 7% of predicted demand relates to RD&I activity. Again, further work will be required at Project business case stage to identify accurate numbers but, as an indication, if research scans were charged at £1500, this would equate to an annual financial benefit of around £3.3m by 2031/32.
- Delivery of non-financial benefits including:
- Improved quality and reduction in patient harm including reduced waiting times, better diagnostic accuracy and improved patient outcomes and experience.
- Workforce resilience including improved recruitment and retention, greater access to training and education, and improved staff satisfaction.
- Improved access reducing patient travel time which benefits patient and reduces greenhouse gases.
- Provide capacity that meets population needs in line with international best practice.
- Increased opportunities for Research and Development.
- Increased opportunities for innovation.

4.1.5 Balance Sheet Treatment and Impairment

The impact on organisations' individual Balance Sheets will be considered at Project business case stage.

This will include estimating non-cash funding requirements which will be sought from Welsh Government including:

- Impairment on completion of the resulting assets.
- Capital charges that represent an increase in organisations' baseline depreciation.

An overview of potential balance sheet impact and associated annual capital charges, excluding the impact of impairment, is provided in the table below, based on straight-line depreciation of 60 years for buildings and 10 years for equipment.

Table 56: Capital costs – By Project

	Balance Sheet Impact £'000	Annual depreciation £'000
Project 1 - Replace Cardiff equipment	6,248	494
Project 2 - Fixed scanner North Wales	6,573	356
Project 3 - Fixed scanner Swansea	5,486	338
Project 4 - 4th fixed scanner	6,573	356
Total capital costs	**24,881**	**1,544**

4.2 Conclusion and Overall Affordability

Delivery of the preferred way forward, which involves implementing a programme that will deliver four fixed digital scanners in Wales requires capital investment of £24.881m for which funding is sought from Welsh Government.

As well as delivering a wide range of non-financial benefits in relation to service improvements and patient experience and outcomes, this will enable three of the scanners to reduce the average cost per scan to £572, compared with an average cost from external providers of £935. This will result in an overall average cost per scan for all four scanners over a 10-year period to £729.

Indicative modelling suggests that revenue costs could increase by £25.6m by 2030/31 based on predicted demand growth. This investment will contribute to mitigating the ongoing cost pressure associated with growing demand including:

- Reduction in average cost per scan resulting in £6.6m annual financial benefit by 2030/31.
- Opportunities to deliver system-wide financial benefits due to increased PET-CT scanning reducing the need for high-cost late stage interventions. There is insufficient detail available on specific demand by patient pathway to calculate this at this stage.
- Opportunities for income generation from RD&I activities which, based on 7% of predicted demand, is estimated at around £3.3m by 2030/31.

5 Management Case

5.1 Introduction

This Management Case provides a summary of the arrangements that will be put in place to ensure the successful delivery of the All Wales PET Programme and its associated projects, and to ensure the programme realises the optimum benefits of the investment.

The case for change for the All Wales PET Programme has been clearly articulated within the Strategic Case. To achieve an effective implementation and full Benefits realisation, the Programme must manage, co-ordinate and oversee the delivery of all activities and key deliverables over the next ten years.

The All Wales PET Programme has a robust governance structure, well defined processes and has identified tranches and subprojects for the delivery of the Programme.

The All Wales PET Programme requires funding for Programme Management and Administration support in order to facilitate the oversight, governance and delivery of the programme. Projects requiring local implementation (for example at Health Board level) will need to ensure Project Management support from the respective organisation for the duration of the Project.

This PBC Management Case sets out the management arrangements that will successfully deliver the All Wales PET Programme to time, cost and quality. The Management Case outlines the following arrangements:

- Programme Scope;
- Projects within the Programme;
- Programme and Project Management Arrangements;
- External Advisors;
- Use of Special Advisors;
- Programme and Project Scrutiny and Assurance;
- Procurement and Contracts Management;
- Programme and Project Plan;
- Benefits Realisation;
- Risk Management.

5.1.1 Post Project Evaluation

This Management Case provides assurance on the capacity and capability of the management arrangements to deliver the Programme.

5.2 Programme Scope

The rationale and narrative that supports and defines the Programme scope is set out in detail within the Strategic Case (Section 5).

The purpose of the All Wales PET Programme is to plan, design, build and implement an All Wales PET strategy and associated business cases for services up to 2031.

The scope of this Programme is limited to procurement of the following list of equipment:

- Four digital PET-CT Scanners (Artificial Intelligence enabled; one scanner at each site)

- Ancillary equipment and phantoms (robotic radiotracer dispenser)
- Radiotherapy adaptions (laser bridge, flat table top)#

The equipment is to be located at Cardiff (replacement scanner), Swansea (new scanner) and North Wales (new scanner). The fourth scanner (new) placed at a location to be defined at a later date will be based upon clinical demand and population density.

Associated build works for the PET site facilities are also within scope.

Furthermore, refresh of equipment connected with the cyclotron at Cardiff is within scope of this Programme, thus requiring procurement of:

- Ion source replacement within the cyclotron
- Hot cell replacement and associated GMP build.

Programme implementation will be phased so that sufficient time is given to scrutinise supporting business cases for Projects. This will ensure supporting infrastructure requirements are solved at appropriate timings, in order to optimise delivery and ultimately PET service provision.

Supporting infrastructure has been identified as an essential consideration to the success of the PET Programme delivery, including workforce and research and development. As such, these elements have been considered as within scope and are addressed in the Programme structure.

Radiopharmaceutical provision is an additional infrastructure factor for the All Wales PET Programme and this has been addressed in the Programme structure. However, during development of the Programme, it was evident that requirements for radiopharmaceutical provision for Wales may stretch beyond the scope of the All Wales PET Programme. Therefore, it is possible that additional investment via a Project or Programme is identified for radiopharmaceutical provision, and the workstream structure of the Programme reflects this.

5.3 Projects within the programme

A Programme can be defined as a temporary and flexible organisation created to coordinate and oversee the delivery of a set of related Projects and activities in order to deliver outcomes and benefits related to Spending Objectives.

A “tranche” can be defined as a group of projects, transition activities and governance, structured around distinct step-change in capability and benefit delivery[5].

A “Project” can be defined as a temporary organisation that exists for a shorter duration, which will deliver one or more outputs in accordance with the business case. In this case, four Projects form the All Wales PET Programme.

A “workstream” is often used to describe the logical grouping of activities together to enable effective management. Workstreams concentrate dependencies and may run through a number of tranches.

[5] Sowden R et al., 2011, **Managing Successful Programmes**, 2011 Edition, Published by TSO Norwich

The All Wales PET Programme will consist of four tranches and four Projects. These are arranged to address installation of PET scanners and update a cyclotron. The output of each tranche will see a step-change in capability of the All Wales PET service (see Table 57).

Detailed information relating to the management arrangements for each of the Projects will be contained within the respective business cases. The business case plan can be noted in Table 58.

The host local organisation (Cardiff University, NHS Health Board, or NHS Trust) for Projects 1, 2, 3 and 4, will be responsible for taking forward the PET scanner installation at the relative site.

The supporting infrastructure is critical to the success of each tranche. As such, the Programme consists of four enabling workstreams which will be established to support the delivery of the programme and projects. The workstreams are thematic and manage deliverables across the programme and should ensure effective integration between the various projects (see Table 59 for a detailed breakdown of responsibilities and outputs of these workstreams).

As noted in the Strategic Case, there may be developments related to radiopharmaceutical provision in Wales that could need further investment. However, any requirement is not yet clear. Therefore, this Programme will expect the radiopharmaceutical workstream to include this aspect within its Terms of Reference and aims, with any additional Project development communicated clearly through the Programme Governance structure.

AWPET will maintain its advisory role and function, informing the SPB on potential changes to referral pathways and indications for commissioning.

WHSSC, as commissioners of the PET service in Wales and host of the PET Programme, will remain responsible for assessing the live and ongoing clinical demand for PET scans across Wales. This data is currently captured by data analysts and PET service planners at WHSSC and will be reported regularly to the SPB.

The location of the fourth scanner has not been identified at the time of writing this PBC. The clinical demand model noted in the Strategic Case (section 5.5) states that the likely population needs would benefit from the fourth scanner being positioned in south east Wales. The Programme has been designed so this can be reviewed with “live” demand and needs data at the appropriate time.

A robust appraisal process will be undertaken to identify to optimum location of the fourth scanner. Detailed plans are yet to be made; however the appraisal process will likely include two steps:

- expressions of interest to host a PET-CT scanner, and
- review of potential site(s) ability to answer population demand, have sufficient workforce, patient access, clinical alignment, estates and facilities considerations and costs.

Table 57: Structure of the All Wales PET Programme tranches, Projects and business cases

Description	Business Case	Deliverable	PET site Organisation	Accountable Officer
Tranche 1				
Project 1				
Replacement scanner at PETIC and cyclotron refresh (replacement of ion source and hot cells)	BJC (to be submitted alongside PBC May 2021)	To procure replacement digital scanner, replacement equipment associated with cyclotron and facilities on site and upgrade the cyclotron	Cardiff University responsible for business case delivery, with close engagement with C&VUHB	Chris Marshall (Project SRO)
Tranche 2				
Project 2				
New fixed PET scanner at North Wales site (part of a wider Nuclear Medicine Consolidation Programme	SOC1*, OBC / FBC combined (TBC by WG)	To deliver access and utilities to the site, build and procure a digital PET scanner and associated facilities	Site to be confirmed. Betsi Cad Health Board responsible for business case delivery	David Jones (Project SRO)
Project 3				
New fixed PET scanner at Swansea site	OBC2, FBC2	To deliver access and utilities to the site, build and procure digital scanner and associated facilities	Swansea Bay Health Board responsible for business case delivery	Neil Hartman (Project SRO)
Tranche 3				
Project 4				
New fixed PET scanner (PET-CT or PET-MR)	OBC3, FBC3	To deliver access and utilities to the site, build and procure digital scanner and associated facilities	Location is to be determined based on population needs. Host Organisation to be identified	To be confirmed during site selection
Tranche 4				
Programme Closure, PPE & Lessons Learned				Sian Lewis (Programme SRO)

***** *SOC was submitted to WG in October 2020*

Table 58: High level dates of the All Wales PET Programme tranches, Projects and business cases

Business Case (BC)	Proposed date of Welsh Gov. BC approval	Proposed "go live" date	
Tranche 1			
Project 1			
BJC	July 2021	PET Scanner	March 2022
		Ion Source replacement	March 2022
		Hot Cell replacement	March 2023

Business Case (BC)	Proposed date of Welsh Gov. BC approval	Proposed "go live" date
Tranche 2		
Project 2		
SOC1	July 2021	January 2024
OBC/FBC	March 2022	
Project 3		
OBC2	November 2021	November 2023
FBC2	July 2022	
Tranche 3		
Project 4		
Appraisal Process	April 2023	June 2026
OBC3	January 2024	
FBC3	December 2024	
Tranche 4		
		January 2027

Table 59: Scope of the All Wales PET Programme Enabling Workstreams

Workstream	Responsibilities	Key Outputs
Radiopharmaceutical Provision	Responsible to the SRO for leading the planning and delivery of radiopharmaceutical provision, in partnership NHS organisations and third sector partners, with a view to ensuring long-standing, cost-effective and assured supply of MA licensed radiopharmaceuticals across Wales. Responsible for informing the wider Programme on radiopharmaceutical supply under Specials or IMP licenses across Wales, for clinical use or research activity, to enable Centres of Excellence. Responsible for informing the wider Programme on horizon scanning.	Effective linkage with other key national programmes or projects. Have input into (where appropriate) developing robust and cost effective contracts with suppliers for radiopharmaceutical provision for non-PETIC sites. Carry out an in-depth horizon scanning exercise. Carry out a full assessment of needs, benefits, costs and risks associated with PETIC attaining MA license for FDG products and/or scope for an additional cyclotron in Wales. Write business case(s) for options (if appropriate).
Centres of Excellence	Responsible for developing and leading the planning and delivery of an integrated, collaborative and pan-Wales Research, Development and Innovation Group, focussed on PET scanning and radiopharmaceutical developments. This Workstream Group should have membership from all PET scanning sites, Cancer Network, Dementia Network (+others), Bangor University, LSHW, Health and Care Research Wales, and relevant academic institutions.	Build a network of key personnel and organisations both within and outside Wales. Develop a scope whereby an "all Wales research approach" is defined – ranging from basic, through to applied clinical trials. Create a virtual research hub where best practice is shared openly. Produce joint bids and advertise national capacity & capability.

Workstream	Responsibilities	Key Outputs
Workforce Provision	Responsible for advising the Programme on the strategic and operational planning and delivery of the future workforce, including ensuring that forecasted workforce gaps are accounted for in training needs. To include the management of key strategic and operational issues relating to skills-mix and commissioning of training places. This Workstream Group should have membership from HEIW, IWEG and NIAW to ensure deliverability is at the centre of all considerations. The Group should also have membership from all professional groups across the NHS.	Carry out constructive challenge for workforce planning at each site during business case planning phases. Ensure that training needs are appropriately fed into training providers, in a timely fashion. Ensure that relevant bodies are appropriately linked to facilitate Health Boards in attaining the relevant staffing levels for a PET scanning service. Link with the RISP Programme to assess how working behaviour can change for remote reporting.
Procurement	Responsible for making recommendations about providers that each organisation may use. The Procurement Workstream membership will consist of the specialists within NWSSP-SES, NWSSP-PS, PET site organisation Procurement and Estates representatives, Programme Manager and Project Teams at relevant Health Boards, Trusts and Cardiff University.	The Procurement Workstream will make a recommendation on the most economically advantageous tender. This recommendation will be recorded in a final evaluation report, which will set out the basis for the award decision, for the formal approval of the PET Strategic Programme Board.

Please note that at the time of writing this PBC, some leads for Workstreams are to be confirmed.

5.4 Programme and project Management Arrangements

5.4.1 Programme Roles and Responsibilities (The People)

The All Wales PET Programme is a strategic Programme that is hosted by WHSSC and sits within the “Strategic Resource Planning” category of the National Imaging Programme Strategic Board (NIPSB). The NIPSB is hosted and supported by the NHS Wales Collaborative and the NHS Wales Collaborative Executive Group (CEG).

At the time of writing, the NHS Wales Collaborative fund a Programme Manager that is hosted by WHSSC on a fixed-term basis. This role forms the core of the All Wales PET Programme Management arrangements and is funded until at least March 2022.

At the time of writing this document, the NHS Wales Collaborative and NIPSB are within Scope of the Rapid Review of Precision Medicine Programmes and the Consolidation of Precision Medicine Programmes Implementation Plan Phase 1, which is seeking to centralise hosting of Programmes and consolidate Programme budgets. It was agreed at a meeting of the NHS Wales Collaborative Executive Group (CEG; 16.03.2021), that the All Wales PET Programme will remain hosted by WHSSC. As such, this Management Case makes clear the governance arrangements.

The existing PET Strategic Programme Board (SPB) has the capacity and capability to facilitate the effective delivery of the Programme. Local Projects will rely on local organisational capacity and provision of project management, with facilitation from the SPB and Programme Manager.

If this Programme is endorsed by Welsh Government, the existing membership of the SPB will be expanded to include some additional roles noted in Table 60. Members of the SPB will provide

resource and specific commitment to support the Programme Lead and Programme Manager to deliver the Programme deliverables.

The key individual roles and responsibilities required to support the delivery of the All Wales PET Programme are set out in Table 60 below, and at the time of writing some of the membership is yet to be confirmed.

Table 60: All Wales PET Strategic Programme Board (SPB)

Role	Name	Responsibility
Senior Responsible Owner (SRO)	Sian Lewis (Andrew Champion Deputy)	Accountable for the success of the Programme and is responsible for enabling the organisation to exploit the new environment resulting from the Programme, meeting the new business needs and delivering new levels of performance, benefit, service delivery and value. The SRO owns the vision for the Programme and provides clear leadership and direction and secures the investment required to set up and run the Programme. The SRO is called upon at times of escalation.
Programme Lead	Andrew Champion	Responsible for providing the interface between Programme ownership and delivery, and is accountable for defining the Programme objectives and ensuring they are met within the agreed time, cost and quality constraints. Act as the link point for stakeholders at a strategic level.
Programme Manager	Sarah McAllister	Responsible for leading and managing the programme through to the delivery of new capabilities, realisation of benefits and programme closure. Responsible for providing the interface between Programme and delivery of Projects.
Clinical Lead	Martin Rolles	Responsible for providing clinical leadership to the programme, ensuring effective clinical engagement and securing clinical consensus within and outside of the organisation for the improvements identified within the programme.
PETIC site	Project SRO (Chris Marshall) and Project Manager (TBC)	Project SRO: Responsible for the development of business case(s) required to provide an effective PET scanning service at the site. Responsible for providing leadership to the delivery of Project 1. Project Manager: Responsible for managing the Project through to the delivery of outputs. Responsible for providing the Programme Board with updates on Project progress.
North Wales site	Project SRO (Adrian Hartman) and Project Director (David Fletcher)	Project SRO: Responsible for the development of business case(s) required to provide an effective PET scanning service at the site. Responsible for providing leadership to the delivery of Project 2. Project Manager: Responsible for managing the Project through to the delivery of outputs. Responsible for providing the Programme Board with updates on Project progress.
Swansea site	Project SRO (Neil Hartman) and Project Manager (TBC)	Project SRO: Responsible for the development of business case(s) required to provide an effective PET scanning service at the site. Responsible for providing leadership to the delivery of Project 3. Project Director: Responsible for managing the Project through to the delivery of outputs. Responsible for providing the Programme Board with updates on Project progress.
Fourth scanner site	Project Manager and Project SRO	Project SRO: Responsible for the development of business case(s) required to provide an effective PET scanning service at

Role	Name	Responsibility
	(TBC when site selection process is complete)	the new site. Responsible for providing leadership to the delivery of Project 4. Project Manager: Responsible for managing the Project through to the delivery of outputs. Responsible for providing the Programme Board with updates on Project progress.
Finance Lead	Mark Osland & Stuart Davies	The Finance Lead(s) is/are responsible for all financial aspects of the Programme. This includes the strategic financial planning for the Programme, financial reporting, and financial risk management.
Planning / Transformation Leads	Representation from all Health Boards and Trusts	Responsible for acting as an effective interface between the SPB and the Health Boards, ensuring that Site Leads and Health Boards are supported and informed.
Radiopharmaceutical workstream Lead	Neil Hartman	Responsible for acting as an effective interface between the SPB and the workstream, ensuring that Site Leads are supported and informed.
Centres of Excellence workstream Lead	TBC	Responsible for acting as an effective interface between the SPB and the workstream, ensuring that Site Leads are supported and informed.
Workforce workstream Lead	TBC	Responsible for acting as an effective interface between the SPB and the workstream, ensuring that Site Leads are supported and informed.
Procurement workstream Lead	TBC	Responsible for acting as an effective interface between the SPB and the workstream, ensuring that Site Leads are supported and informed.
Professional Leads	Where professional roles are not represented through existing pan-Wales membership to be sought	Professional leads that require representation: Clinical Radiologists, Clinical Oncologist, Clinical Scientists/Medical Physics Experts, and Radiographers.
PET Service Planning Manager	Luke Archard (WHSSC)	Responsible for reporting live PET scanning demand figures to the Board, assisting and advising on interim arrangements during implementation and other planning.
NHS Health Collaborative	Imaging Portfolio Lead (post being appointed)	Responsible for acting as an effective interface between the SPB and the NHS Health Collaborative.
Admin and Programme Support	TBC with funding decision	Responsible for providing high quality administrative and project management support to the Project across all phases.
Communication Lead	TBC	Responsible for providing high quality advice on Communications for the Programme.

5.4.2 Programme Management: Roles and Responsibilities

The Programme Management and Administration roles and responsibilities for the All Wales Programme are set out in Table 61 below.

The costs of the Programme Management and Programme Support have been included within the Finance Case. A Programme Manager will be responsible for the delivery of the Programme. It is

proposed that some Project Management support will be required at each PET site to manage the delivery and implementation at each site and it is expected that each Health Board/Trust/Cardiff University will make use of existing Project Management resource for implementation.

Table 61: Project Management and Administration Specific Roles and Responsibilities

Role	Responsibility
Programme Manager (based at WHSSC)	The Programme Manager will support the Programme Lead to deliver the overall Programme objectives and associated change. The role requires effective co-ordination of the Programme's Projects and management of their interdependencies including oversight and management of risks and issues that arise. The role is crucial for creating and maintaining focus, enthusiasm and momentum within the Programme and to support the workstream delivery. The Programme Manager has overall responsibility for the delivery of the Programme and all sub projects and workstreams. To ensure that they are delivered to time, cost and quality. Tasks also include day to day responsibility for the programme and subprojects and workstreams, to meet the parameters described within the programme business case. The provision of appropriate reports on status to the Programme Lead. The management of risks and issues and escalation of appropriate matters for executive direction/approval. Monitoring, co-ordinating and controlling the work of the Programme Working Groups.
Project Manager (based at local implementation site)	The Project Manager will have the overall responsibility for supporting the Project SRO with the successful initiation, planning, execution, monitoring, controlling and eventually closure of their project. They provide a structured approach to support the conveyance of the key deliverables and provide an escalation route for both Programme and work level risks.
Programme Support (based at WHSSC)	The Project Administration duties include all aspects of facilitating a programme: scheduling meeting times and locations, taking meeting minutes and capturing action points.

5.4.3 Programme and Project Management (The Methodology)

The Programme will be managed in accordance with 'Managing Successful Programmes methodologies, suitably adapted for local circumstances in order to meet the needs of this Programme. The constituent projects will be delivered utilising PRINCE2 ('PRojects IN in a Controlled Environment') methodology.

The Programme management arrangements will therefore be driven by outcomes, and Project management arrangements driven by outputs, or in PRINCE2 terminology, "Products".

This governance framework will ensure that appropriate oversight is present at all stages.

The All Wales PET Programme is predicated on the following principles:

- Decisions on the strategic direction and future needs of health care are only made after careful consideration;
- The views and interests of patients, staff and all stakeholders are fully considered;
- Appropriate behaviour with respect to the codes of corporate governance and policy are maintained;
- Guidance and good management practice is followed;
- Open and regular reporting of Projects progress and performance.

To ensure the quality of the outputs are maintained, objectives are met, and benefits are realised, the Programme Plan will be managed and undertaken on the basis of:

- Proven methodologies and standards;
- Effective monitoring procedures;
- Review and acceptance procedures;
- Effective change / issues / problem management;
- Appropriate documentation and record keeping.

In addition, the Strategic Programme Board and local PET site organisation(s) (where appropriate), will obtain specialist and professional advice as required during the life cycle of the Programme.

5.4.4 Programme Governance and Management Arrangements to deliver programme and projects

Key to the success of the Programme are the programme governance and management inputs required for the co-ordination of sub projects and their outputs. This will include reporting progress against plans, approvals and escalations of risks and issues. The governance and management processes have been designed to allow for approvals to occur at the most appropriate level.

Of particular importance is the uniting of the constituent Projects within the All Wales PET Programme and governance arrangements, in line with WHSSC Corporate Governance arrangements and that of Welsh Government's sponsorship, scrutiny and approvals process. In particular, this will allow for rapid approval and the effective escalation of risks and issues to a level where senior sponsors can intervene as necessary to support the delivery of this important project.

The Governance Arrangements are organised over five levels, namely:

- Level 1 – NHS Wales Collaborative Executive Group;
- Level 2 – National Imaging Programme Strategic Board;
- Level 2 – The All Wales PET Strategic Programme Board;
- Level 3 – Project Boards;
- Level 4 – Project Teams.

The Programme structure as set out below ensures clear accountability and also deploys mechanisms to facilitate decision making, escalation, communication and alignment.

Tranches and their projects can only commence once the SPB give approval to do so. The Programme Plan has been arranged so that end-of-tranche reviews are used as critical control points in the programme delivery cycle, where ongoing viability of the programme is evaluated and lessons learned are assessed.

Each Project will have a Project Board that will hold expert and local membership.

Workstream Groups will primarily consist of the membership from the task and finish groups that were used in the development of this Programme Business Case and will be reviewed and extended to ensure that appropriate stakeholders are included to successfully facilitate delivery.

Projects will be governed by the structures and processes that exist within the relevant PET site organisation (Cardiff University, Health Board or Trust). However, the Project Manager and Project SRO must regularly attend and update the SPB on progress for the duration of the Project.

The Programme Manager will sit on all Project Boards and Workstream groups for continuity.

All Project Business Cases will be formally signed off by the appropriate Project Board which may include the local Health Board governance structures, before being endorsed by the Strategic Programme Board (SPB). Once endorsed by the SPB, the Project Business Case(s) can be submitted to Welsh Government. This is to ensure that Project outputs are directly aligned to the Programme outcomes and benefits realisation plan.

All Projects will report to the SPB bi-monthly and issues should be escalated as appropriate.

The SPB will provide quarterly reports to the NIPSB and NHS Collaborative Executive Group, escalating issues as appropriate.

The Programme Plan includes all the management controls required to ensure the All Wales PET Programme and contracted firms meet their fiduciary obligations with respect to the development of the Business Cases, the implementation of the Programme, and the management of the Programme within a framework of acceptable risk.

Figure 13: Governance structure of the All Wales PET Programme

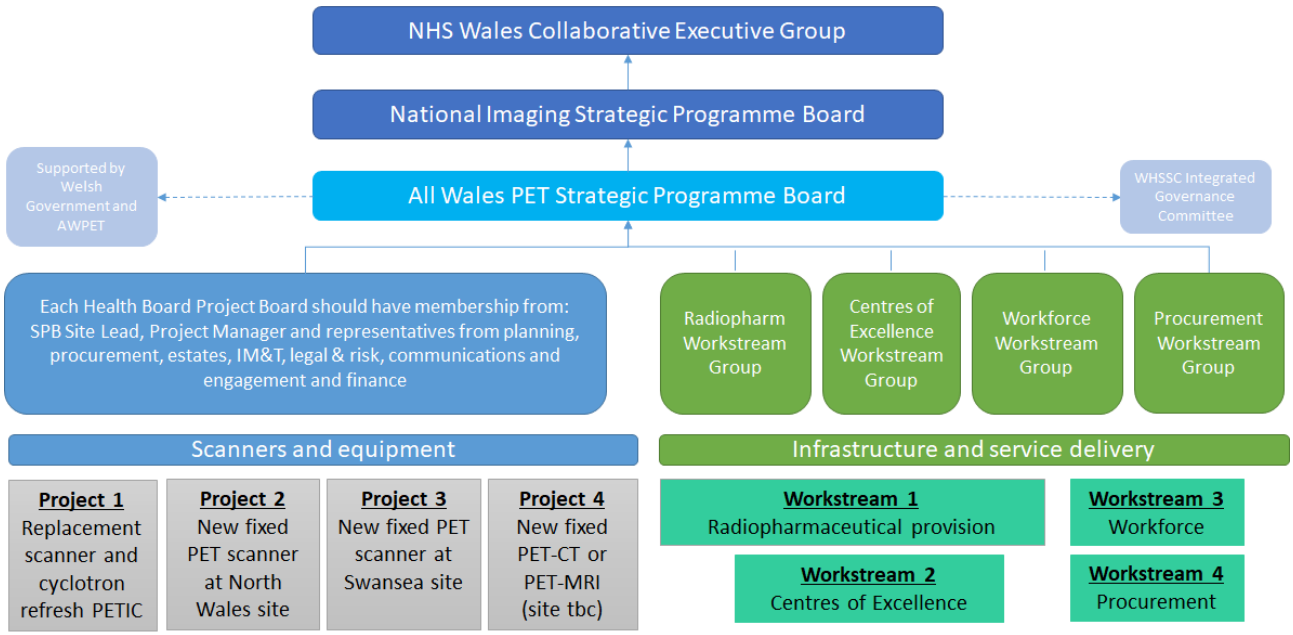


Table 62: Project Board Specific Role and Responsibilities

Project Boards		Lead
Project 1, 2, 3 and 4 Installation of new PET scanner and equipment	Responsible for leading the planning and development of the relevant business cases at the preferred site location for PET services at the relevant PET site organisation and subsequent implementation. Each Project Board should have membership from: Project SRO, Project Manager and representatives from planning, procurement, estates, IM&T, legal & risk, communications and engagement and finance.	Project SRO

5.5 Internal and External Advisors

5.5.1 Programme Roles and Responsibilities (The People)

The All Wales Programme is supported by a range of external advisors, these are listed in Table 63 below. The Programme Manager is responsible for coordinating the activity of the external advisors:

Table 63: External Advisors

Role	Name / Status	Responsibility
Head of Sourcing: Commissioning, Capital & IMT NWSSP-PS	Samantha Pennington (Deputy Head of Sourcing)	Responsible for providing professional leadership in matters relating to procurement. A pivotal role in advising on the delivery of an effective procurement process and subsequent contract development. Whilst Projects will be led by Health Boards, this role will be able to bring in resources as needed from NHS Wales Shared Services Partnership – Procurement Services (NWSSP- PS) as dictated by the needs of the Programme.
National Imaging Equipment Advisor NWSSP- SES	Andrew Ward (Senior Diagnostic Imaging Advisor)	Advisory role - supporting the SPB and Project Boards with technical, specialist equipment and Commercial advice. Responsible for advising on the delivery of optimum commercial deals and strategic partnerships with partners. Whilst Projects will be led by Health Boards, this role will be able to bring in resources as needed from NHS Wales Shared Services Partnership - Specialist Estates Team, as dictated by the needs of the Programme.
Radiation Protection	Matthew Talboys	Advisory role – supporting the SPB and Project Boards with technical and specialist advice, as required. Chair of the WSAC Medical Physics & Clinical Engineering Sub-Committee: Radiation Protection Standing Specialist Advisory Group.
External Clinical and Technical Assurance	Wai-Lup Wong (Chair of the National PET-CT Clinical Governance Board)	Responsible for providing independent and expert advice to assure the quality of project outputs and to advise on complex and challenging issues.

5.5.2 Use of Specialist Advisors (Non-NHS)

The All Wales PET Programme will utilise appropriate specialists / subject matter experts (SMEs) whom are listed in the table below and managed by the Programme Lead:

Table 64: External Advisors (non-NHS)

Company	Name / Status	Responsibility
Archus Limited	Anouska Huggins	Archus Ltd. have been appointed to support this PBC. This role includes benefits identification and quantification and economic analysis and preparation of the Financial Case.

5.6 External Programme Review and Assurance

To ensure that robust Programme Governance is achieved, clear governance arrangements are established and a range of reviews and audits will take place. These fall into the following categories:

- Internal governance arrangements;
- Gateway Reviews (Gates 0 - 5);
- Internal Audit.

5.6.1 Internal Governance Arrangements

Programme Governance arrangements are described in Section 4 of the Management Case.

As the Programme is hosted by WHSSC, it will be governed within the existing WHSSC arrangements, but with clear avenues for escalation to NIPSB which are described in Section 4 of the Management Case. For clarity, change management and risk management are further described in the following sections of the Management Case.

5.6.2 Gateway Reviews

The OGC Gateway Process examines Programmes and Projects at key decision points in their lifecycle. It looks ahead to provide assurance that they can progress successfully to the next stage. OGC Gateway Reviews deliver a 'peer review', in which independent practitioners from outside the programme/project use their experience and expertise to examine the progress and likelihood of successful delivery of the programme or project.

Programme Reviews are carried out under OGC Gateway™ Review 0: Strategic Assessment. A Programme will generally undergo three or more OGC Gateway Reviews 0: an early Review; one or more Reviews at key decision points during the course of the programme, and a final Review at the conclusion of the programme.

Project Reviews are carried out under OGC Gateway Reviews 1 - 5; typically a project will undergo all five of these Reviews during its lifecycle – three before commitment to invest, and two looking at service implementation and confirmation of the operational benefits.

It has been agreed with the Welsh Government Assurance Hub that Programme Gateway Reviews 0 will be carried out. The initial Gateway Review of the All Wales PET Programme will be a Programme Assessment Review, so that the Business Justification Case for the Cardiff site can be considered at the same time. This will take place in June 2021.

Gateway reviews relating to subordinate projects will be agreed with the Welsh Government Assurance Hub and reflected in respective business cases following endorsement of this PBC.

The likely profile of Gateway Reviews in the Programme is shown in the Table 65 below. The likely profile of Gateway Reviews for the Projects are shown in the Table 66 below.

Table 65: Programme Review Gateways

Type of Gateway (Gate)	Proposed Date
Programme Assessment Review	June 2021
Gate 0: Strategic Review	January 2023
Gate 0: Strategic Review	January 2025

Table 66: Project Review Gateways

Type of Gateway (Gate)	Proposed Dates			
	Project 1 - (Cardiff)	Project 2 - (North Wales)	Project 3 - (South West)	Project 4 - (4th scanner)
1. Business Justification				June 2022
2. Delivery Strategy				
3. Investment Decision		June 2022	June 2022	December 2024
4. Readiness for Service	April 2022			
5. Operations Review and Benefits Realisation	January 2023			April 2027

The proposed Project Review Gateways are aligned with key decision points that are applicable to each Projects individual local circumstance. For instance, there is urgency surrounding the need for update equipment at the Cardiff site which already has a fixed analogue scanner, therefore it would be appropriate to check on readiness for service here. In contrast however, the fourth scanner may benefit from more in-depth assurance as it will entail business justification based on live clinical demand data and a new site will need to be identified.

5.6.3 Internal Audit and Assurance

WHSSC is hosted by Cwm Taf Morgannwg University Health Board. There are established, existing governance processes in place at WHSSC. NWSSP (Audit and Assurance Services) carry out annual internal audits at WHSSC and internal audit reports are submitted to the Cwm Taf Morgannwg Audit Committee (Part 2) on a planned basis.

The benefit of effective internal audit is recognised within the NHS Wales Infrastructure Investment Guidance issued by Welsh Government. This expects Welsh NHS organisations to utilise internal audit to benefit from independent and objective opinions to Executives, Accounting Officers and respective Boards. This should be supplemented by regular and appropriate reporting to respective audit committees.

The team at NWSSP (Audit and Assurance Services) have reviewed implementation plans and assessed the best approach for audit of the Programme. Colleagues at Audit and Assurance Services have suggested a one-off initial audit at programme level to assess the overall risk, governance arrangements and engagement (a suggested brief can be found in Appendix 2).

At the time of writing this PBC, we are awaiting approval from the Audit Chair to add the PET Programme Audit to the 2021/22 Internal Audit Plan, following which it will be submitted to the audit committee for approval.

The NWSSP Audit and Assurance Services may progress further reviews of the programme via the internal audit plan or project audits via the respective UHB audit plans (or provisions within respective BJCs), should key issues arise and subject to risk assessment.

5.6.4 Other areas of Assurance

The need for other areas of assurance was discussed by the Strategic Programme Board in March 2021 and it was agreed that no additional assurances are required for this Programme.

5.7 Procurement and Contract Management

The All Wales PET Programme will use Capital funding via the All Wales Capital Programme.

All of the major items of equipment are available on a compliant preapproved framework. NHS Wales organisations have direct access to this framework.

The multidisciplinary team within the Procurement Workstream of this Programme will make recommendations on the most economically advantageous tender and which providers that each organisation may use. The decision of which provider will sit with the procuring organisation, and they will enter into a contract with the organisation alone.

It is possible that the Procurement Workstream will propose running one procurement for the NHS equipment, depending upon the timings. For instance, if phasing of projects is less than two years apart, there may be an option to fix the costs and place orders at the same time, deploying when needed at a future date.

Carrying out a procurement exercise at a national level will most likely make the process at local level much faster.

The Procurement Workstream membership will consist of the specialists within NWSSP-SES, NWSSP-PS, organisations Procurement and Estates representatives, Programme Manager and Project Teams at relevant Health Boards, Trusts and Cardiff University.

It is anticipated that each organisation that subsequently hosts a PET scanner will enter into a contract with the supplier. This contract will be subject to the hosting organisations local governance and review processes.

5.8 Change Control

5.8.1 Change Control and Configuration Management

The Change Control Procedure will be managed by the Programme Manager. The Change Control Procedure will comprise of:

- Change Management Document - which gives guidance of version control in regards to documents and the change control procedure;
- Change Management Log - captures all version-controlled documents/products and change requests;
- Change Form - is a formal process, which staff are required to follow to request change to a version-controlled document / products.

The Project Teams and external contractors are expected to comply fully with the Change Control Procedure.

5.8.2 Change Management Framework

This framework will underpin the change process. The framework will shape the way that the process is managed, reflecting the following change management philosophy and principals:

- Recognise the need to maximise the Benefits of the change for patients, who should be at the heart of the changes made;
- Phase the Programme implementation so that lessons learned can be appropriately ascertained and avoid risks related to a 'big bang' approach;
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before new PET scanning facilities are commissioned;
- Work in partnership with staff and other stakeholders both within and outside of the All Wales PET Programme to engage all those involved in the delivery of care in the change process;
- Work effectively with stakeholders of interdependent Programmes and Projects, to ensure that the impact of any items outside of the control of this Programme are considered in a timely fashion, and
- Focus on staff skills and development required so staff are both capable and empowered to deliver healthcare effectively and to a high-quality standard in the new facility through new models of care.

Once the PBC has been endorsed, these principles will be revisited and confirmed. The change management framework and change management principles will be communicated to all stakeholders and staff as part of the launch of the change management process.

5.8.3 The Project Change Management Approach

The Programme Manager will design a change management approach that will encompass the framework and principles outlined above.

The implementation of a change management process will progress well in advance of relevant FBC approval for implementation sub projects.

Where proposed changes to the service impact on the workforce, the NHS Wales, Organisational Change Policy will apply. This national document makes clear the onus upon the service to consult with staff affected and their individual employment rights.

5.8.4 The Change Control Plan

Once the PBC has been endorsed a Change Management Plan will be developed and three actions will occur:

- The Core Plan will be reviewed by the SPB to identify other relevant areas that need to be included;
- Detailed plans will be set up for each of the tasks in the Core Plan; and
- An overall timetable will be developed and the high-level milestones communicated as part of the launch of the Change Management Plan.

Table 67 below outlines the core plan and the main tasks identified to date.

Table 67: Core Change Management Plan

Area	Planned tasks
Planning phase	Appoint key Programme roles and Change Managers, confirming responsibilities and leadership Confirm stakeholders and interested parties both within and outside the Programme Develop core plan in more detail, identifying high level milestones for the Change Management Plan, mapped to the overall Programme Plan Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	Confirm communications lead and protocols (route and timing of approval of communications) Develop communications routes, including face to face briefings bulletins, intranet pages Formulate and agree key communications messages against high level milestones Set up stakeholder map and engagement plan Launch change Programme Ongoing communications work
Training and development	Work with HEIW, NIAW and national workforce groups for each professional role Work with staff through workshops and other training to clarify the workings of the new PET scanning Service Models and how these will impact in practice Identify national training and development required to fulfil roles and competencies Link training and development into communications plan and Workforce Workstream
Piloting	Identify and confirm areas where piloting of new models and practice will be implemented Confirm schedule of pilot work, mapped against high level project and change management milestones Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan Execute pilots, feedback and report progress
Full Implementation	Identify scheduling/phasing of full implementation Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing Discussion and agreement with key staff Execute implementation and transition plans

5.9 Programme Plan

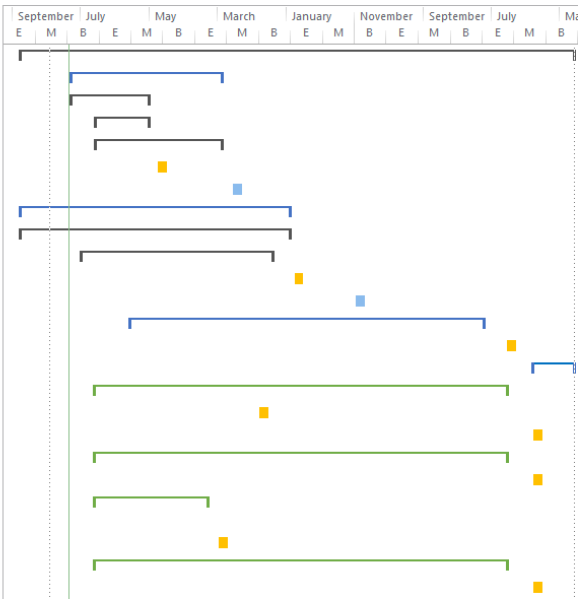
The Programme plan with details of milestones, durations of tranches and work streams is shown in Figure 14 below.

At the time of writing this Management Case many of the component Project plans are not substantially developed. This is a result of the level of infrastructure design maturity and the fact that no procurement activities have yet taken place. Please see Appendix 1 for a more detailed plan.

All programme time estimates have been based on advice from NHS Wales Shared Services Partnership and following benchmarking with other similar health schemes.

Figure 14: High level Programme Plan

Task Name	Duration	Start	Finish
All Wales PET Programme Implementation	1761 days	Mon 05/10/20	Mon 05/07/27
Tranche 1: PETIC scanner and cyclotron refresh	482 days	Thu 20/05/21	Fri 24/03/23
PET Scanner Replacement	247 days	Thu 20/05/21	Fri 29/04/22
Cyclotron refresh PETIC	170 days	Mon 06/09/21	Fri 29/04/22
Hot Cell refresh PETIC	405 days	Mon 06/09/21	Fri 24/03/23
LESSONS LEARNED AND POST TRANCHE REVIEW	30 days	Mon 06/06/22	Fri 15/07/22
EVALUATION OF BENEFITS, OUTCOMES & SPENDING OBJECTIVES	30 days	Mon 08/05/23	Fri 16/06/23
Tranche 2: PET Scanner installation (SW and North Wales)	860 days	Mon 05/10/20	Fri 19/01/24
Project 2: North Wales	860 days	Mon 05/10/20	Fri 19/01/24
Project 3: South West	610 days	Mon 05/07/21	Fri 03/11/23
LESSONS LEARNED AND POST TRANCHE REVIEW	30 days	Mon 05/02/24	Fri 15/03/24
EVALUATION OF BENEFITS, OUTCOMES & SPENDING OBJECTIVES	30 days	Mon 04/11/24	Fri 13/12/24
Tranche 3: Fourth Scanner (location TBD)	1125 days	Mon 07/02/22	Mon 01/06/26
LESSONS LEARNED AND POST TRANCHE REVIEW	30 days	Mon 07/09/26	Fri 16/10/26
Tranche 4: Programme Closure and Lessons Learned	131 days	Mon 04/01/27	Mon 05/07/27
Enabling Workstream 1: Workforce	1314 days	Tue 31/08/21	Fri 11/09/26
LESSONS LEARNED AND MID PROGRESS REVIEW	30 days	Mon 04/09/23	Fri 13/10/23
LESSONS LEARNED AND POST WORKSTREAM REVIEW	30 days	Mon 04/01/27	Fri 12/02/27
Enabling Workstream 2: Centres of Excellence	1314 days	Tue 31/08/21	Fri 11/09/26
LESSONS LEARNED AND POST WORKSTREAM REVIEW	30 days	Mon 04/01/27	Fri 12/02/27
Enabling Workstream 3: Radiopharmaceutical provision for Wales	364 days	Tue 31/08/21	Fri 20/01/23
LESSONS LEARNED AND POST WORKSTREAM REVIEW	30 days	Mon 06/03/23	Fri 14/04/23
Enabling Workstream 4: Procurement	1314 days	Tue 31/08/21	Fri 11/09/26
LESSONS LEARNED AND POST WORKSTREAM REVIEW	30 days	Mon 04/01/27	Fri 12/02/27



Key: Dark Blue lines denote a tranche, dark grey lines denote a Project, green lines indicate a workstream. Yellow bars denote mid-progress and end-progress evaluation, light blue bard indicates evaluation of benefits, outcomes and Spending Objectives.

5.10 Benefits Realisation

5.10.1 Benefits Realisation Strategy

The All Wales PET Programme team has worked closely with Welsh Government and other partners to ensure that management of the All Wales PET Programme benefits is robust. This work has included the identification and quantification of Programme benefits, where possible. This has allowed for the quantified benefits to influence the Economic Case where the selection of the preferred way forward was made. The quantification of benefits relating to the All Wales PET Programme reflect some wider societal benefits. These are included only where they can be directly attributable to the provisioning of the PET scanners.

The Blueprint for the Programme (Appendix 3) has been considered in developing the Benefits. Programme Benefits will be applied 100% in the PBC and then proportioned out across the subordinate business cases for Projects 1-4.

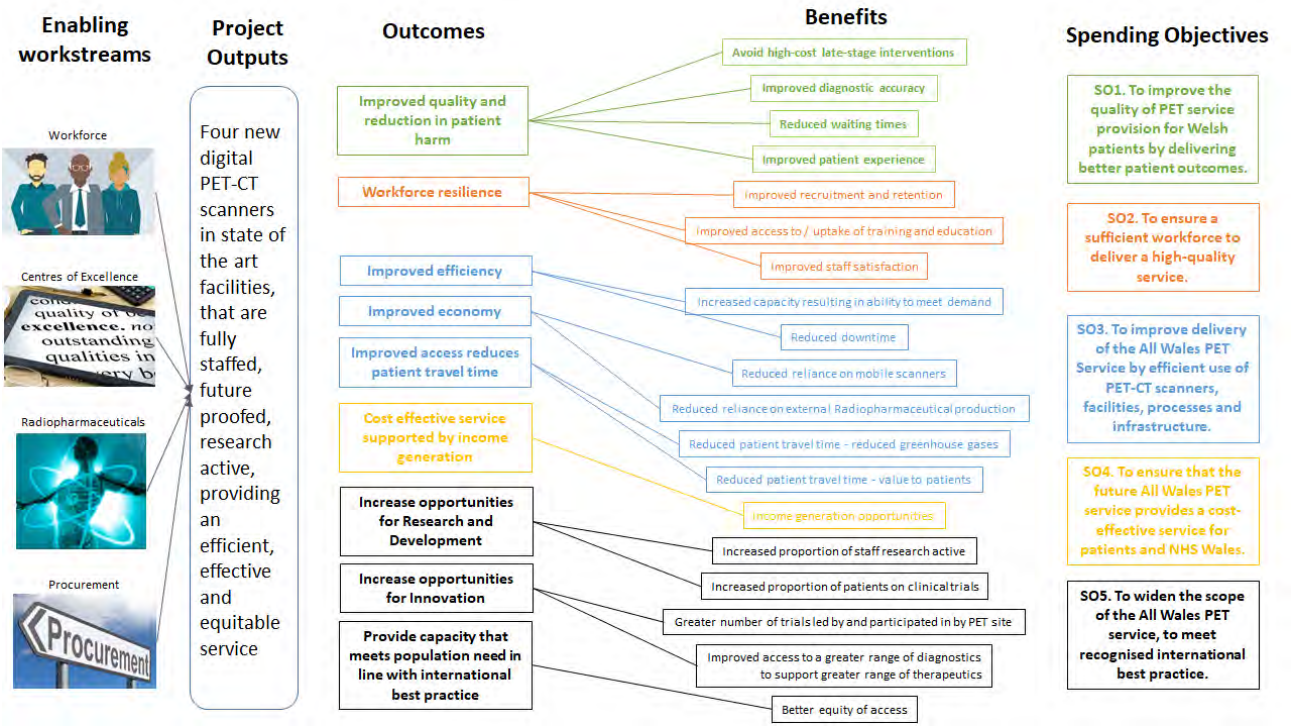
The Programme also contains non-quantifiable benefits and the Programme intends to maximise the delivery of all benefits, especially those that relate to improvement in the quality of patient outcomes.

All the Benefits identified in the Strategic Case and appraised in the Economic Case sections of the PBC are accounted for in the Benefits Register (Appendix 4). This Register notes timescales and ownership of benefits, in addition to how benefits will be measured.

5.10.2 Benefits Assurance and Mapping

One of the most important features in Benefits realisation is to ensure that the perceived benefits identified as part of the proposed investment will deliver the Spending Objectives. This can be visualised in Figure 15.

Figure 15: Benefits Map



As previously described in the Strategic Case the benefits associated with the programme have been identified and analysed, grouped by benefit criteria, and also matched to a beneficiary as illustrated in Figure 16 below.

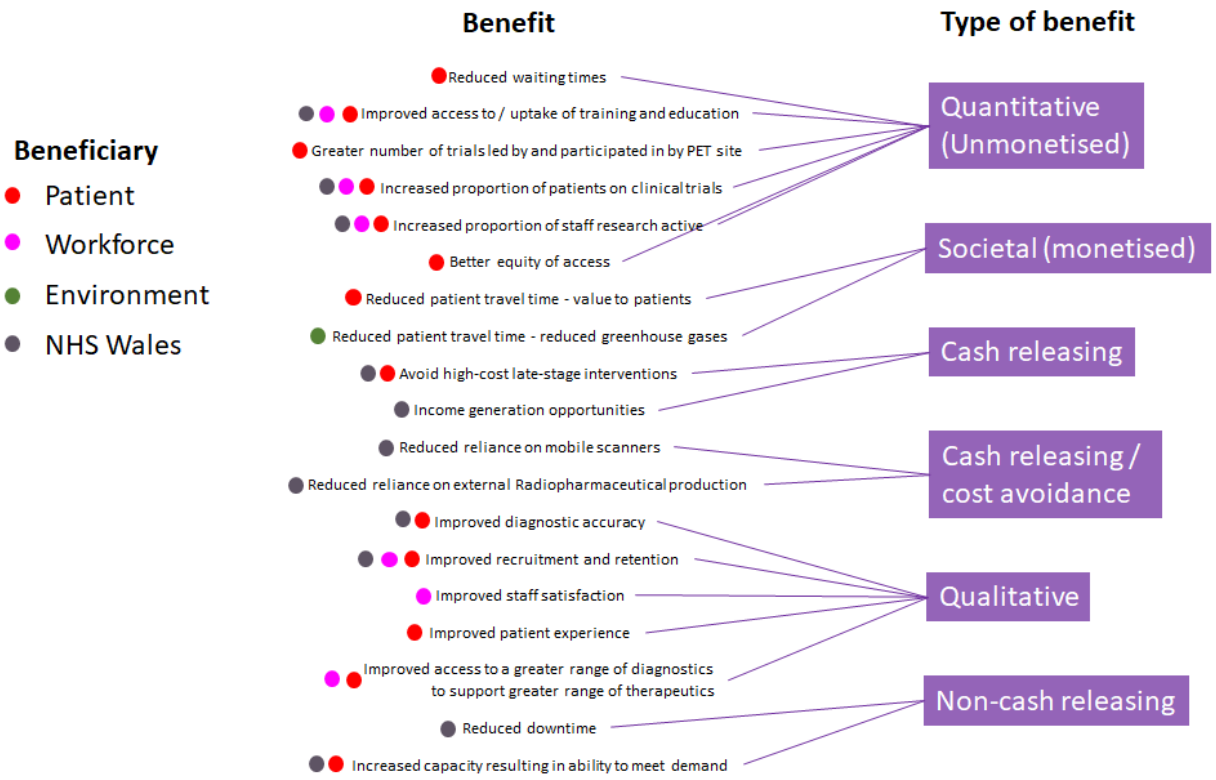
The outcome of the benefits mapping exercise demonstrated that there is a strong correlation between the five spending objectives and the benefits groups for the wider Programme. All Benefit Groups have been matched to a beneficiary, whether this be a patient, workforce, NHS Wales or the Economy.

5.10.3 Benefits Realisation Plan

Programme Benefits Realisation is intrinsically linked to Business Change delivery and as such, it requires a nationally agreed approach across all NHS Wales organisations. This must be supported by both local Project implementation teams.

A Benefits Realisation Plan will be prepared for the All Wales PET Programme. The plan will be designed to enable benefits that are expected to be derived from the Programme, to be planned for, managed, tracked and realised.

Figure 16: Benefit Criteria and Beneficiary



As part of the information required for the PBC, Benefits have been incorporated into a Benefits Realisation Register (Appendix 4) which details:

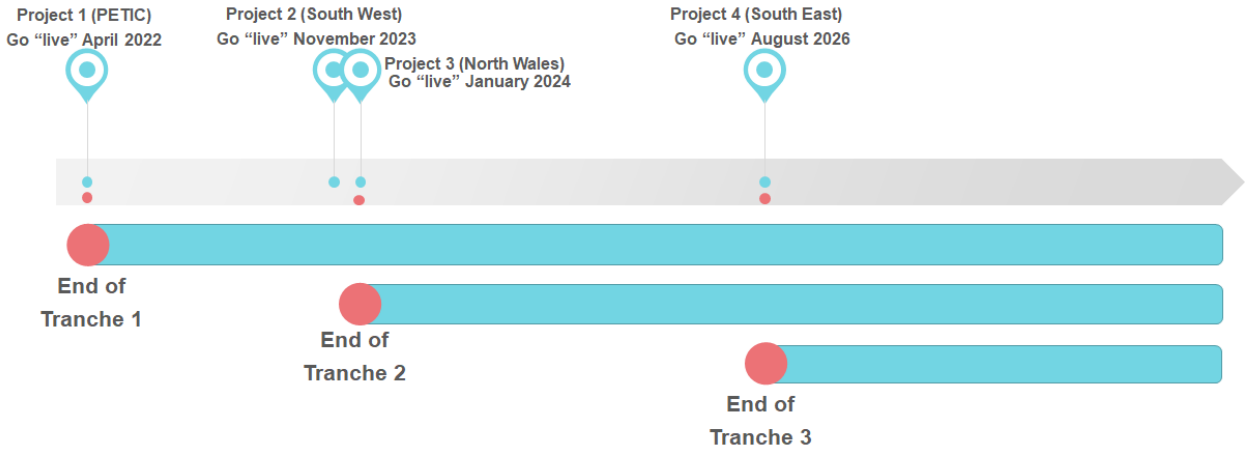
- Beneficiaries;
- Category of benefit;
- Baseline measure;
- Trajectory to target; and
- Benefit owners.

Each Project and their associated business cases will provide more detailed plans for Benefits Realisation.

Benefits will be baselined shortly after this PBC is endorsed and the Programme Manager will work with Project SROs and Project Managers to do this. As Benefits Owners, the Project SROs at each site will hold the responsibility for measuring the Benefits.

Completion of each Project will deliver a new (updated in Cardiff) PET scanning site. This will build and create core capability in each tranche, that will ultimately achieve the new operational state (or Outcome) when the scanners are “live”. Therefore, the All Wales PET Programme should begin to realise Benefits following completion of each tranche. This realisation phasing can be visualised as per Figure 17 below.

Figure 17: Benefits Realisation Timeline



5.11 Risk Management Plan

5.11.1 Risk Management Overview

The All Wales PET Programme will utilise its governance structure and arrangements to ensure the effective management of risk. The governance structures allow for risks to be escalated from Project boards and Workstream groups, through to the Strategic Programme Board and/or the Health Board/Trust, as appropriate.

Each Project will hold its own risk register and this will be updated dynamically but also formally reviewed on a monthly basis by Project Boards.

A bimonthly risk report for the Projects will be submitted by the Project SRO and Project Manager to the All Wales PET Programme SRO and local Health Board appropriate body. This risk register will highlight new risks, the movement in existing risks and issues and where appropriate, it will recommend the closure of resolved risks or issues.

A comprehensive Programme risk register and accompanying paper will be produced by the Programme Manager for all Strategic Programme Board meetings. This paper will highlight new risks across the Programme including the Projects and workstreams, the movement in existing risks and issues and recommends the closure of resolved risks or issues.

The All Wales PET Strategic Programme Board, upon receiving a Project risk register (via the Programme Manager), will consider if the mitigating actions are sufficient and if the identified risks are receiving the right level of treatment.

The Strategic Programme Board will consider the escalation of Programme Risks onto the NIPSB Risk Register, as appropriate. The remainder of this section sets out the detailed management of risks and issues.

5.11.2 Issue and Risk Management Philosophy

Managing risk is a holistic approach, seeing effective risk management as a positive way of achieving the Programme's wider aims, rather than simply a mechanistic 'tick box' exercise, to comply with guidance. The Programme regards risk as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the Programme.

Effective Risk Management supports the achievement of wider aims, such as:

- Effective Change Management;
- Enhanced use of resources;
- Better Programme and Project Management.

The programme will utilise WHSSC's Risk Management Framework to systemically identify, actively manage and minimise the impact of risk. This is done by:

- Identifying possible risks before they materialise and putting mechanisms in place to minimise the likelihood of them materialising with adverse effects on the project;
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions;
- Implement the right level of control to address the adverse consequences of the risks if they materialise; and
- Having strong decision-making processes supported by a clear and effective framework of risk analysis and evaluation.

Once risks are identified, the response for each risk will be one or more of the following types of action:

- **Prevention** - where countermeasures are put in place that either stop the threat or problem from occurring, or prevent it from having an impact on the business or Programme;
- **Reduction** - where the actions either reduce the likelihood of the risk developing or limit the impact on the business or Programme to acceptable levels;
- **Transfer** - where the impact of the risk is transferred to the organisation best able to manage the risk, typically a third party (e.g. via a penalty clause or insurance policy);
- **Contingency** - where actions are planned and organised to come into force as and when the risk occurs; and
- **Acceptance** - where the Programme Management Board decides to go ahead and accept the possibility that the risk might occur, believing that either the risk will not occur or the potential countermeasures are too expensive. A risk may also be accepted on the basis that the risk and any impacts are acceptable.

The All Wales PET Programme will adopt a proactive approach to the identification, assessment and management of risks throughout the whole Programme. The effective management of risk and the prevention of issues arising will support the timely delivery of the Programme, by preventing delays, avoiding costs and ensuring quality is upheld.

The management of Programme risk will be in accord with the principals of WHSSC's Risk Management Policy where the All Wales PET Programme holds a Risk Register which is regularly monitored and updated.

5.11.3 Recording and assessment of risk

The All Wales Programme has a Risk Register that is a dynamic document which will be updated with all new identified risks being assessed. All risks will have an individual identifier, an assigned owner and be scored using the standard 5 by 5 matrices to ascertain the risk rating colour.

It is worth reiterating that as set out in the Commercial Case a number of the risks associated with the procurement will be either wholly transferred or shared with the supplier.

Figure 18: Risk Scoring Matrix

Impact	Likelihood				
	1 = Rare	2 = Unlikely	3 = Possible	4 = Likely	5 = Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

5.11.4 Review and Escalation of Risk

WHSSC has a simple Risk Management Framework that focuses on effective identification, reporting and management of risks. There are only three roles in the risk management process that are summarised in Table 68 below.

Table 68: Risk Management Roles

Role	Responsibility	Reporting / accountability
Risk Management Lead	Manages the process for identifying and addressing risk, maintaining the risk register on a day to day basis	SRO
Risk Management Sub Group	Brings together key risk owners to co-ordinate the identification and assessment of risks plus the management of key risks	PET Strategic Programme Board
Risk Owner	Individual or group responsible for developing and implementing risk mitigation measures for individual risks they are responsible for	As defined in the relevant Risk Register

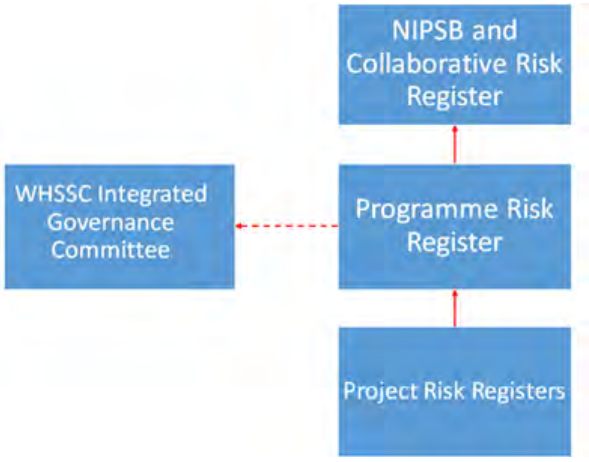
As mentioned above, Project risk registers will be reviewed monthly by the relevant organisation Project Team and by the PET Programme Board on a bi-monthly basis. Those risks that are marked as “Red” or “Amber” on a Project risk Register will be noted in the wider Programme Risk Register.

The Programme Risk Register will be reviewed once per quarter by the WHSSC Integrated Governance Committee for assurance purposes.

Programme risks noted as “Red” following countermeasure mitigation scoring will be escalated through the existing governance structure to the NIPSB at the monthly meeting.

Issues are Risks that have materialised. Similar to risk, the Strategic Programme Board will hold an Issues Register and follow the same escalation path. All issues should have an owner and an aligned action plan and will be reviewed during all Programme Project Board meetings. Issues that are outside the scope or authority of the Strategic Programme Board will be referred to the relevant Board or Group.

Figure 19: Risk Escalation Route



5.12 Arrangements for Post Programme Evaluation

The requirement to carry out a post programme evaluation is essential to determine if a Programme has (i) been successful; (ii) has it met the Spending Objectives and; (iii) realised its expected Benefits. Additionally, it ensures that lessons learned can be factored into future Projects and Programmes.

The All Wales PET Programme is committed to ensuring that a thorough Post-Programme Evaluation (PPE) is undertaken after the Programme has concluded, to ensure that positive lessons can be learnt. This is noted in tranche 4 of the Programme Plan.

The All Wales PET Programme is also committed to ensuring that lessons are learned at all key stages during implementation, so these can be fed into the wider Programme.

As such, there will be two Evaluation sessions held after each Tranche:

- **Lessons Learned and Post Tranche Review** – to be held two to three months post tranche completion.
- **Evaluation of Benefits, Outcomes and Spending Objectives** – to be held six to twelve months post tranche completion.

Immediately following implementation, all Projects will be reviewed against the usual measures for Projects: time, cost and performance, in addition to management and procurement processes. This will form the foundation of the “lessons learnt” sessions. The “lessons learnt” sessions will also provide benefits such as:

- An opportunity to improve the design, organisation, implementation and strategic management of projects and workstreams;
- An opportunity to ascertain whether the programme is running smoothly so that corrective action can be taken if necessary;
- Promote organisational learning to improve current and future performance;
- Avoid repeating costly mistakes;
- Improve decision-making and resource allocation;

- Improve accountability by demonstrating to internal and external parties that resources have been used efficiently and effectively, and
- Demonstrate acceptable outcomes and/or management action thus making it easier to obtain extra resources to develop healthcare services.

In addition to “lessons learned”, these post-tranche sessions will also provide an opportunity for the Programme to begin to assess and implement the Benefits Realisation Plan.

After a reasonable bedding-in period of six to twelve months, all Projects within a tranche will be subject to a more wide-ranging evaluation of costs and performance, as well as being reviewed against the Spending Objectives and the Benefits Realisation Plan.

It should be noted that as all Projects and Workstreams will report into the Strategic Programme Board on a bimonthly basis. In addition, the Board will remain open to comment and opportunities to determine lessons learned throughout the Programme life-cycle, and not just at the post-tranche formal reflection sessions.

The SRO will be responsible for ensuring that arrangements have all been put in place and that the requirements for PPE are fully delivered.

An Evaluation Steering Group (ESG) will be set-up and the Programme Manager will coordinate and oversee the Evaluation.

The costs of the final Post-Project Evaluation will be identified once the ESG and Evaluation Team are fully-established. These costs are therefore not currently included in the costs set out in this PBC.

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Appendices available on request

Appendix 1 – Service Operating Model

Appendix 2 – Population Growth Projections

Appendix 3 – Collated Clinical Questionnaire narrative

Appendix 4 – PET demand forecast 10 year with variable inflation

Appendix 5 – Clinical Indication Analysis

Appendix 6 - Clinical Demand Model narrative

Appendix 7 – Workforce Board Output

Appendix 8 – Life Sciences Hub Wales – Horizon Scanning of Artificial Intelligence

Appendix 9 – Options Framework

Appendix 10 – PBC Forms

Appendix 11 – Economic and Financial Calculations

Appendix 12 – Full Programme Delivery Plan

Appendix 13 – Suggested Audit Brief from NWSSP Audit and Assurance Services

Appendix 14 – Programme Blueprint

Appendix 15 – Programme Benefits Tracker

WHIASU
Wales Health Impact Assessment Support Unit
Uned Gymorth Asesu Effaith ar Iechyd Cymru

Health Impact Assessment record sheet: All Wales PET Programme

HIA Conducted by:

David Jones - Principal Radiographer (Nuclear Medicine & PET) Radiology, BCUHB

Neil Hartman - Head of Nuclear Medicine, SBUHB

Lianne Black - Project Manager, WHSSC

Luke Archard - Planning Manager (PET), WHSSC

Andrew Champion – Assistant Director, Evidence Evaluation, WHSSC

Sarah McAllister – All Wales PET Programme Manager, WHSSC

HIA conducted on: 23.06.2021 (via Teams)

Title of Programme: All Wales Positron Emission Tomography (PET) Programme

Description: WHSSC commissions PET as a specialised service on behalf of the seven health boards in Wales. For patients in south Wales this is commissioned from PETIC in Cardiff and a mobile scanning unit (2 days per week) at Swansea. For patients in north Wales this is commissioned from a mobile scanning unit at Wrexham (2 days per week).

Following publication of key strategic reports on both PET and the wider imaging provision in Wales, the mandate to develop a Programme Business Case for the All Wales PET Programme was issued by Andrew Goodall in March 2019. WHSSC host the Programme Board for this strategic Programme and have used HM Treasury Green Book methodology and extensive engagement to develop the All Wales PET Programme Business Case (PBC).

PET has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions such as Alzheimer's and cardiology. Its role and the evidence base continue to evolve and there is opportunity on the horizon for PET to play a role in radiotherapy planning and therapeutics. There is an increasing body of high-quality evidence outlining the contribution of PET to improved patient outcomes. There are many studies that demonstrate the role PET-CT has in accurately determining the staging of certain cancers and subsequent treatment plans, which enables reduction of inappropriate patient management and allows for best prognosis and patient care.

Demand for PET is growing with England realising an approximate 18% rise in demand per annum. However, in Wales, scanning activity levels are low compared with the rest of the UK. It is estimated that in 2020 Wales was performing approximately 33% of the PET scans per head of population compared to England, despite a growing and aging population. In addition, NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. The picture becomes bleaker when comparing performance with the rest of Europe and beyond.

Furthermore, Wales has just 0.6 PET scanners per million population which is comparable to countries such as Albania and realises the lowest scanner provision when compared to

the devolved nations. There is a reliance on mobile scanners in Wales which create a poor patient experience, constrain patient throughput and produce lower quality scans. Welsh NHS staffing levels are facing the same challenges as the wider imaging workforce, in that many key staff are facing retirement and lack of in-house professionals that are adequately trained in this highly specialised and technical diagnostic approach. There is an additional need to future-proof the radiopharmaceutical provision for Welsh PET services.

It is necessary to modernise, expand and develop the PET service within Wales to ensure that the Welsh population, NHS Wales Staff and the wider NHS Wales can realise the benefits of having an accessible and excellent diagnostic PET service.

The preferred way forward for the programme seeks to have four Projects that will, over the course of five years, update the existing fixed facility at Cardiff (PETIC), replace mobile scanners with fixed scanners at the Swansea and North Wales sites and at either a PET-CT or PET-MRI a fourth location (to be defined).

At the time of conducting this HIA, the All Wales Programme Business Case is undergoing scrutiny by Welsh Government.

Nature of evidence considered: All evidence that was included gathered to inform the All Wales Programme Business Case, which includes:

- clinical demand (current demand, modelled projected demand, likely future clinical indications, likely future developments of PET scanning)
- population information (growth, density, disease prevalence)
- scanner requirements (numbers, locations, additional ancillary equipment needs)
- staffing requirements (current and future)
- radiopharmaceuticals (current and future requirements)
- research, development and innovation (current and future)
- patient feedback on current service

Key Population Groups affected by the Programme:

- From the Population Groups Checklist, this HIA has identified:
    - Age related group - Older People
    - Age related group - Children and young people
    - Geographical groups – People living in rural, isolated areas
    - Geographical groups – People unable to access services or facilities
    - Other groups of note - Overall population **all equality groups would access the service based on clinical criteria according to the commissioning policy*[1][2][3].
    - Other groups of note – NHS Wales employees
    - Other groups of note – Wider NHS system

[1] WHSSC, *Specialised Services Commissioning Policy: CP50a, Positron Emission Tomography* (May 2021)

[2] WHSSC, *Specialised Services Service Specification: CP50b, Positron Emission Tomography (PET)*, (Fixed and Mobile Site) (September 2020)

[3] WHSSC, *Specialised Services Commissioning Policy, CP50a, Positron Emission Tomography*, Appendix 1 Evidence Review (2021)

Wider determinants of Health and Well-being Impacts identified: "How does the All Wales PET Programme impact upon the determinants in a positive or negative way?"

Behaviours affecting health i.e. Diet, physical activity, use of alcohol, cigarettes, non-prescribed drugs, sexual activity or other risk-taking activity			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply to, if not generic	Potential solution (where appropriate)
No impact.	Possible minimal unintended impact as a consequence of and an individual's reaction and response to waiting for a scan or diagnosis – use of alcohol/cigarettes etc.	Overall population.	A PET scan and associated diagnosis would be similar to a patient experience in waiting for other procedures and diagnoses. Patients receive general support from CNS in these situations. A PET scan would provide a faster and more accurate diagnosis. There is likely to be low incidence of this occurrence. It is expected that the referral-to-report time for PET-CT would typically not exceed 10 days.

Social and Community Influences on Health i.e. Family organisation and roles, Citizen power and influence, Social support and social networks, Neighbourliness, Sense of belonging, Local pride, Divisions in community, Social isolation, Peer pressure, Community identity, Cultural and spiritual ethos, Racism, Other social exclusion			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too, if not generic	Potential solution (where appropriate)
Potential minimal positive impact on local pride as a result of having a new fixed PET scanner facility locally.	Potential minimal negative impact on local pride as a result of not having a new fixed PET scanner facility locally.	Overall population.	If a fixed scanner is not directly within the locality, the population will still benefit by having access to a fixed scanner, in place of a mobile scanner. Accessing scans more readily through a fixed scanner service with capacity and better facilities should overcome any negative impacts. In addition, care pathways will ensure equal access.
Potential minimal positive impact to community through the attraction of staff/population.		Overall population. NHS Wales employees.	

Mental Well-being			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too, if not generic	Potential solution (where appropriate)
Potential significant positive impact from having an accurate diagnosis and an appropriate care pathway.	Possible low unintended impact as a consequence of and an individual's reaction and response to waiting for a scan or diagnosis – anxiety, depression etc.	Overall population. Wider NHS system.	A PET scan and associated diagnosis would be similar to a patient experience in waiting for other procedures and diagnoses. Patients receive general support from CNS in these situations. A PET scan would provide a faster and more accurate diagnosis.
Potential moderate positive impact through accessing highly technical and accurate diagnosis service.		Overall population.	
Potential significant positive impact to those patients that suffer with claustrophobia – a fixed scanner is much less claustrophobic than a mobile scanner and currently these patients need to travel great distances to a fixed scanner site where mobile provision is made.		Overall population. People unable to access services or facilities.	

Living and Environmental Conditions affecting health i.e. Built environment, Neighbourhood design, Housing Indoor environment, Noise Air and water quality, Attractiveness of area, Green space, Community safety, Smell/odour, Waste disposal, Road hazards, Injury hazards, Quality and safety of play areas			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too if not generic	Potential solution (where appropriate)
Potential moderate positive impact by replacing 43 tonne mobile scanner truck off site with new, more attractive buildings and less carbon emissions.		Overall population.	
	Potential minor impact of building works whilst fixed scanner sites are built or refurbished.	Overall population.	This will be mitigated by relevant building controls on the hospital sites and is temporary. A mobile service will continue to be supplied throughout.
	Potential of build of fourth scanner on green space.	Overall population. People living in rural, isolated areas.	The site of the fourth scanner is yet TBD. However there will be an in-depth review process undertaken and this issue will be considered in the review process – in line with regulations and legislation that may apply.

Economic Conditions Affecting health i.e. Unemployment, Income Economic inactivity, Type of employment, Workplace conditions			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too if not generic	Potential solution (where appropriate)
Potential significant positive impact of attracting highly skilled employees to the local area of each PET scanner and to other Health Board areas. This would positively impact on local economic activity.		NHS Wales employees. General population.	
Potential significant positive impact via training of existing staff.		NHS Wales employees.	
Potential significant positive impact on provision of excellent workplace conditions.		NHS Wales employees.	
Potential significant positive impact on provision of Research, Development and Innovation at PET sites – patients accessing clinical trials, latest technological advances and staff attracted to be involved in this.		NHS Wales employees. General population.	
Potential moderate positive impact of attracting staff to specialities outside Nuclear Medicine as they can access		NHS Wales employees. General population.	

advanced diagnostic techniques for their patients e.g. oncology, cardiology.			
Potential minimal positive impact to generate positive reputation and generate income from private scanning (NHS England and beyond).		Wider NHS system.	
	Potential moderate negative impact through the period of change while build and transition from mobile to fixed scanner facilities – may cause stress to local staff.	NHS Wales employees.	Local senior management will be aware of local staffing and will know individuals well as these are small teams. Change management techniques, open and proactive communication with staff, alongside a "team effort" should mitigate against these concerns. General attitude to the improvements noted in the PBC are positive.
	As PET is typically a more highly stressed function than other modalities within Nuclear Medicine (akin to an MRI or CT service, plus additional complexity via use of radiopharmaceuticals), there is a	NHS Wales employees.	Again, local management will be aware of local staffing and will know individuals well as these are small teams. It will be critical to ensure that there

	possibility that the increased capacity & throughput may cause a minimal-moderate impact on increased stress levels of staff.		are sufficient staffing levels at every banding, with resilience, to avoid staff burn-out. This is noted in detail throughout the PBC.
Access and quality of services i.e. Medical services, Other caring services, Careers advice, Shops and commercial services, Public amenities, Transport including parking, Education and training, Information technology			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too if not generic	Potential solution (where appropriate)
Potential significant positive impact through adequate access to the diagnostic medical PET service – not just for general population access high quality and accurate scanning provision, but for those that cannot access the service readily on a mobile scanner, such as children that require general anaesthesia for a scan, and claustrophobic/bariatric/bed bound patients.		General population. Older people. Children and young people. People unable to access services or facilities. Wider NHS system.	
Significant positive impact to patient experience through access to high quality, state of the art facilities (in place of mobile scanners that have issues with accessibility, space and		General population. Older people. Children and young people.	

throughput) in place of mobile scanners.		People unable to access services or facilities.	
Potential moderate positive impact by fixed PET sites having additional facilities (compared to mobile scanners) that permit patient access to additional modalities, such as radiotherapy planning.		General population. Older people. Children and young people. People unable to access services or facilities. NHS employees. Wider NHS system.	
Potential moderate positive impact of PET scanners being based at Nuclear Medicine Centres assisting future training of staff by providing critical mass big enough to have training spaces for all professional groups.		NHS employees. Wider NHS system.	
Potential moderate positive impact via increased R&D activity and patient access to clinical research.		General population. Older people. Children and young people. People unable to access services or facilities. NHS employees.	

		Wider NHS system.	
Potential minimal positive impact with PET services provided by and reported by local clinicians - making MDTs a simpler experience and generating closer professional working relationships.		NHS employees. Wider NHS system.	
Potential minimal positive impact with patients accessing local shops and commercial services at site.		General population. Wider NHS system.	
Potential minimal positive impact via improvement of general IT provision.		NHS employees. Wider NHS system.	
	Potential moderate negative impact to those needing to travel distance to have a PET scan.	People living in rural, isolated areas. People unable to access services or facilities.	Local sites to offer PET scan appointment that permits travel e.g. offer late afternoon appointment. HBs can provide hospital transport (although the qualification criteria for this could benefit from being widened). Could investigate the option of overnight accommodation

			for those travelling great distance e.g. for those having PSMA scans at end of list and too dark/long journey to travel back to rural area. Special access and consideration. Learn from North Wales process.
	Potential moderate negative impact through increased demand on local transport as local bus services are becoming more sparse.	People living in rural, isolated areas. People unable to access services or facilities.	HBs to consider specialised local service in further Project business case development and continue to coordinate location vs scan timings.
	Potential moderate negative impact through increased demand for local onsite parking.	General population. People living in rural, isolated areas. People unable to access services or facilities.	This will be considered in planning and writing of Project Business Cases. There is an opportunity to learn from North Wales service where parking spaces are reserved in advance.

Macro-economic, Environmental and sustainability Factors i.e. Government policies, Gross Domestic Product, Economic development, Biological diversity Climate			
Positive impacts/opportunities (significant/moderate/minimal impact)	Negative/unintended impacts (significant/moderate/minimal impact)	List specific population group the comments may apply too if not generic	
This Programme aligns with the following Welsh Government national strategies and policies: • Imaging Statement of Intent (2018) • AWPET/WSAC 2018 Report • Auditor General Report on Radiology Services (2018) • The NHS Wales Planning Framework 2020-23 • The Parliamentary Review of Health and Social Care in Wales (January 2018) • A Healthier Wales: Our Plan for Health and Social Care (June 2018) • The Wellbeing of Future Generations (Wales) Act 2015 Other relevant strategies and considerations: • Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England, Professor Sir Mike Richards (December 2020) • The Single Cancer Pathway, Next Steps To Achieve Earlier Diagnosis In Wales, Cross Party Group on Cancer (November 2020) • Heart Conditions Delivery Plan 2017, Welsh Government • Dementia Delivery Plan 2018-2022, Welsh Government • Neurological Conditions Delivery Plan 2017, Welsh Government			

• Getting it Right First Time Programme National Speciality Report, Radiology (2020)			
Potential significant positive impact because the existing service access is currently comparable to that in Albania. Significantly increasing the scanning throughput in Wales will contribute to the Welsh GDP and Economic development.		General population. Wider NHS system.	
Potential significant positive impact through creating more of the specialist and technical expertise, contributing to other radiopharmaceutically-based based programmes.			
	Potential moderate negative impact through the build of the facilities and use of the scanner – build using concrete is carbon heavy which may negatively impact the environment.		Once built, the facilities will last many years and fixed scanners removes the impact of mobile trucks driving around the country.
	Potential moderate negative impact through the transport of the radiopharmaceuticals needed for the scans - carbon heavy as they are		This is currently difficult to mitigate against at the moment. However there may be opportunities in the future to have a more local cyclotron/GMP

	transported from Nottingham, Keele, and Cardiff and beyond.		radiopharmacy facility to PET sites.

Cyfarfod a dyddiad: **Meeting and date:**	Health Board 15th July 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Mrs Kate Dunn, Head of Corporate Affairs
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

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

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:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Health Board considered the following matters in private session:

<u>20th May 2021</u>

- An update on Covid related variants of concern
- A paper on planned care recovery was deferred to a forthcoming Board Workshop