Bundle Quality, Safety & Experience Committee 19 May 2023

1	QS23.24 Welcome, introductions and apologies for absence - Chair
2	15:00 - QS23.25 Declarations of interest on current agenda - All
3	15:05 - QS23.26 Minutes of the last meeting and action log - Chair 1.3a QSE Minutes 20.01.23 - V0.2AW.doc
3	15:15 - QS23.27 Patient Story 1.4 Patient Story - Welsh Language Final May 2023.docx
4	15:25 - QS23.28 Patient Safety Report - Executive Director of Nursing & Midwifery 2.1 Patient Safety Report - May 2023.docx
5	15:40 - QS23.29 Patient and Carer Experience Report - Executive Director of Nursing & Midwifery 2.2 Patient and Carer Experience Report Dec 22 - March 23.docx
6	15:55 - QS23.30 Clinical Effectiveness Update Report - Executive Director of Nursing & Midwifery 2.3 Clinical Effectiveness Update report - May 2023.docx
7	QS23.31 Regulatory Assurance Report - Executive Director of Nursing & Midwifery 2.4 Regulatory Assurance Report - May 2023.docx
8	16:10 - QS23.32 Health and Safety Report - Deputy Director of People, Workforce & Organisational Development 2.5 QSE Health and Safety Report_Final_AW_JB Approved.docx
9	16:20 - QS23.33 Nurse Staffing Act - Executive Director of Nursing & Midwifery 3.1 Nurse Staffing QSE Presentation May 2023.pdf
10	QS23.34 Reflections on meeting
11	QS23.35 New Risks
12	QS23.36 Date of next meeting

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 20 January 2023
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl Carlisle	Independent Member – from 10:00
Jacqueline Hughes	Independent Member
John Gallanders	Independent Member
Hugh Evans	Independent Member

In Attendance:

Peter Bohan	Associate Director of Occupational Health Safety and Security
Gareth Evans	Acting Executive Director of Therapies & Health Science
Matthew Joyes	Associate Director of Quality
Phil Meakin	Associate Director of Governance
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Angela Wood	Executive Director of Nursing and Midwifery
Molly Marcu	Board Secretary
Mike Smith	Project Lead Mental Health
Gaynor Thomason	Programme Director for Clinical Safety Improvement (for part)
Paul Lumbsdon	Interim Director of Nursing Mental Health
Rod Taylor	Director of Estates (for part)
Ben Thomas	Consultant Nephrologist
Karren Mottart	IHC Medical Director (for Part)
Barbara Cummings	Interim Director of Performance
Fflur Jones	Audit Wales
Jackie Allen	CHC

Agenda Item	Action
OPENING ADMINISTRATION	
QS23.01 - Welcome, Introductions and Apologies for Absence **QS23.01.1** Apologies were received from Chris Stockport, Executive Director of Transformation and Planning, Sue Green, Executive Director of Workforce and Organisational Development, Dave Harries, Internal Audit and Iain Wilkie, Interim Director of Mental Health.	
QS23.02 - Declarations of Interest on current agenda **QS23.02** There were no declarations of interest noted.	
QS23.03 - Minutes of Previous Meeting Held in Public for Accuracy **QS23.03.1 It was resolved that** the minutes were approved as an accurate record of the	

meeting held on 1 November 2022	
QS23.04 - Matters Arising and Table of Actions **QS23.04.1** The Action log was reviewed in detail and where appropriate actions were removed. It was noted that actions should be completed before the next meeting and if this were not possible an update in the action log noted as to why. **QS23.04.2** The Committee reviewed the action log and closed actions where appropriate.	
QS23.05 - Patient Story **QS23.05.1** The Committee viewed a video on a patent who shared her experience through diagnosis and treatment of Pulmonary Embolisms (PE) in Ysbyty Glan Clwyd. The Associate Director of Quality thanked Catrin for sharing her story and highlighted the leaning identified in the paper. **QS23.05.2** The Executive Medical Director advised that improvement work needs to be undertaken in this area and advised that he would work outside the meeting to confirm that the patient was receiving the correct medication and support psychologically. **QS23.05.3** A discussion took place around different experiences of care with regards to PE experienced across the Health Board and the Executive Director of Nursing and Midwifery advised that training, information and communication would be replicated across the Health Board to ensure consistency but that the management of PE varies across the UK. **QS23.05.4** It was agreed that actions from the patient stories would be reviewed at the new Oversight and Assurance Group and report back into QSE through the Executive Director of Nursing and Midwifery's Chair's Assurance Report. **QS23.05.5** It was agreed that there would be a ~~year end~~year-end report received at QSE on Patient Stories. **QS23.05.6 It was resolved that** the Committee receive and reflect upon the story	NL AW AW
QS23.06 - Corporate Risk Register [Director of Estates joined the meeting] **QS23.06.1** Attendees discussed the Health and Safety risks in depth around Estates discussing in detail the risk around the likelihood of a legionella outbreak. It was noted that there are controls and mechanisms in place to reduce the exposure but that there was an inherent challenge with water quality, management and usage but that the likelihood was low but the impact would be great. Questions were raised in relation to the score of the risk and it was noted that this risk rating had been identified by Corporate Health and Safety but that it would be reviewed to see if the scoring could be reduced through evidence. The Board Secretary queried the methodology applied, that there was a lack of tangible justification for the risk rating. The Director of Estates agreed to review the risk rating. **QS23.06.2** Attendees discussed the fire safety risk noting that the issue with this risk was the level of consistency across all sites and ownership on each site. The Board Secretary clarified the identification of a risk exposure due to certain things not taking	RT

place, noting that there had not been any reportable incidents, she queried what was within the gift to implement and that there was a need to do something differently. It was acknowledged that a lot of the issues were in relation to capital funding. It was agreed that the Board Secretary and the Director of Estates would meet to identify what risks were in relation to capital funding and report back to the committee. An Independent Member declared an interest as a Health and Safety Representative.	MM/RT
QS23.06.3 Attendees noted that the Risk Management Group was stood down in December due to Industrial Action and that papers had been circulated by email but that they had not been scrutinised in a meeting. It was agreed that the role of the Risk Management Group was to challenge the score and that what was not being identified was site ownership of risk management.	
QS23.06.4 Attendees discussed the de-escalation of two vascular risks and that due to the Risk Management Group being stood down these had not been considered in detail despite recommendations being received by members of the Risk Management Group and then the HBLT. The Associate Director of Governance advised that it was his proposal to look at the risks in detail at these groups.	
QS23.06.5 The Executive Medical Director clarified the reasoning behind the de-escalation of the Vascular Risks advising that following consultation with colleagues, in his opinion it was correct that they be reduced. It was noted that there should however be a new risk that the Vascular Steering Group have raised which relates to the wider sustainability of the Vascular Service.	
QS23.06.5 Attendees discussed due process and that evidence was required and submitted to the QSE Committee should any risk being proposed for downgraded. The Board Secretary endorsed the process, that it was the Committees responsibility to challenge and hold the ring on de-escalation and that when this was being considered timing is identified. It was agreed that there was a need to ensure that there was a consistent approach. The Board Secretary suggested that a template was produced to alleviate the requirement of going toing and froing between meetings and that the challenge was with the Risk Management Group to ensure evidence was clear when risks are changing status.	PM
QS23.06.5 It was agreed that at the next QSE Committee there would be a deep dive on the Vascular Risks.	PM
QS23.06.X It was resolved that the Committee reviewed and discussed the report and agreed that Vascular risks should not be downgraded and reinstated at its previous level until it had been through due process.	
QS23.07 Polices for Approval [Consultant Nephrologist joined the meeting] **QS23.07.1** The Consultant Nephrologist presented the policy advising that he had been the National Lead for Consent. It was noted that the narrative on the coversheet supported how the policy would be implemented. Clarification around the data was shared with regarding compliance around peer auditing. The Consultant Nephrologist advised attendees that the concerning statistic was the 75% of the time that the patient leaflets had not been provided. The Executive Medical Director thanked those who had been involved in producing the policy noting that due to the national leadership role the Health Board was ahead of the curve.	

QS23.07.2 Attendees noted that the track changes were showing in the document to show that comments had been included in the most up to date version. It was discussed that a policy is only as good as it's usage and that it was a very long policy but clear that was the reason an executive summary had been produced. **QS23. 07.3 It was resolved** that the Committee approved the Consent to examine or treatment Policy	
QUALITY SAFETY AND IMPROVEMENT	
QS23.08 - Mental Health Outcomes and Improvement **QS23.08.1** The Executive Nurse Director shared that she thought the paper was very informative but questioned the data source on page four and the length of time that the work identified on page six was going to take. The Interim Nurse Director agreed to review page 4 of the report where it said "data source" rather than the dates and review the HCA numbers and amend the report for the next Committee. It was noted that with reference to the work being undertaken on page 6, that the timing of 10 months to triangulate was too long. **QS23.08.2** It was noted that the outstanding actions are the focus and that a risk assessment would be completed on the actions and notify the Committee if there are any concerns that deadlines would not be met. **QS23.08.3** The Committee were informed that by the end of February all band 5 staff will be given training on risk assessment and suicide training and that this would be documented. **QS23.08.4** The work on auditing risk assessments is ongoing and a weekly meeting takes place to understand how improvements can be made. It was noted that some beds which were identified as anti-ligature are now not and that to mitigate the capacity around health and safety this is now being bought in. **QS23.08.5** A discussion took place around staffing and training, noting that the 100% figure for staff being trained in risk assessment and suicide was for those in post. The Executive Director of Nursing advised that clinical ownership was essential and the Project Lead Mental Health confirmed that the Ward Managers, Matrons and Heads of Nursing were doing the spot checks. It was noted that a lot of hooks had been put on walls given the increase in corridor nursing and that these should be included in risk assessments. **QS23.08.6** It was requested that with regards to the outstanding actions for the Notice of Contravention outcomes were required and the Project Lead for Mental Health agreed to review the digital patient record system to ensure that all those who needed access to the system would be able to access it. **QS23.08.7 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	PL PL MS
QS23.09 - YGC Improvement Plan **QS23.09.1** Attendees received the YGC Improvement plan noting that it had been scrutinised in a lot of detail at Cabinet. Patient bounce back is a measure that is being recorded and this was being done over a 72-hour period without concerns currently being	

raised. What was being identified as the main concern was the closure of nursing homes and staffing. It was noted that what was once best practice is now no longer supported but the Health Board is looking at home support and maximising Community Hospitals. Clarity was given in relation to rehabilitation, care homes and hone setting discharge. Concern was raised in relation to Local Authority budgets **QS23.09.2** An Independent Member queried whether there was an improvement in documentation being seen, and if cancer patients in crisis were being able to be seen at the cancer centre. The Programme Director for Clinical Safety Improvement advised that the IHC's were doing documentation audits and improvement has been seen but there is further work to be done. **QS23.09.3** The Executive Medical Director advised that there was a requirement to look at multidisciplinary team notes on cancer and though improvements were being seen further work was being done, specifically around weekend and bank holidays and that the information was being reviewed at the forthcoming Cancer Partnership Board. **QS23.09.4** An Independent Member queried consultants and recruitment in terms of overall safety and assurance and how often the Health Board was running below capacity and what impact that was having on patients. The Executive Medical Director advised that there was some ongoing debate as to whether the traditional staffing model is effective~~active~~, however, it was noted that the Health Board is below RCEM Standards and that it was mitigate through a high volume of agency staff, which introduced its own risk and problems, however, if the Health Board were to benchmark it was in a better place than others. **QS23.09.5** The Programme Director for Clinical Safety Improvement advised that there is work ongoing to look to appoint consultant nurses and are consultant physiotherapists. **QS23.09.6** An Independent member questioned medical oversite on the Emergency Department at YGC and Paediatrics, given that it was now common practice to see patients waiting outside of the waiting room. The Executive Director of Nursing and Midwifery advised that from a nursing perspective, t~~T~~here is a Nurse in place and Health Care Support Workers are there providing refreshments. Audits are taking place to ensure that this is taking place and nurses are speaking to patients outside. It was acknowledged that the workforce is under extreme pressure. **QS23.09.7 It was resolved** that the Committee noted the progress made to date on the YGC Improvement Plan.	
QS23.10 - Vascular Improvement Plan **QS23.10.1** The Committee received the Vascular Improvement Plan an Independent Member highlighted that it was documented that there were still some issues with regards to record keeping and that he had heard that some patients were moving from a vascular route to an orthopaedic route. Clarification was sought on the proposed reduction of the staffing risk down to a tier 2 and if this identified that there were now enough consultants recruited. Finally, clarification was sought on the timing of the HIW report. **QS23.10.2** The Executive Medical Director advised that there had not been a change in policy with regards to the treatment of patients. With regards to the workforce, the consultant workforce is at establishment but with locum reliance. Attendees noted that a middle grade rota was now in place. Further recruitment around nursing, phycology etc has been paused at the current time due to funding. Finally, the Executive Medical	

Director advised that it was anticipated that the HIW report would be received in March. **QS23.10.3** The Executive Medical Director advised that the report received was a little sparsce due to a number of meetings being stepped down due to industrial action and that a fuller report would be received at the Vascular Steering Group and then onto the March QSE meeting. **QS23.10.4** An Independent Member advised that he would email the Executive Medical Director his operational queries outside of the meeting. **QS23.10.5** The Executive Director of Nursing and Midwifery updated on the conversations taking place with Welsh Government noting that what the Health Board is experiencing with regards to vascular is the same as ~~what~~ other Health Boards ~~are handling~~. **QS23.10.6** A discussion took place with regards to the pathways matching the improvement plan, it was noted that a meeting had been scheduled to review what has been achieved with regards to the pathways and what is still yet to do [The Programme Director for Clinical Safety Improvement left the meeting] **QS23.10.7 It was resolved** that the Committee noted the summary of actions taken since the last update.	JG
QS23.11 - Urology Improvement Plan [The IHC Medical Director joined the meeting] **QS23.11.1** The IHC Medical Director presented the report. An Independent Member raised concerns around harm and waiting lists. It was noted that optimising pathways and centres of excellence would be utilised to reduce patient harm, an example of how this is being undertaken with the prostrate cancer pathway was shared. **QS23.11.2** The IHC Medical Director advised that with regards to streamlining waiting lists this was in relation to reducing steps that do not add value, for example following GP referral a patient should be able to go straight to diagnostics rather than via a consultant. **QS23.11.3** The Executive Medical Director advised that since the production of the paper two issues have been identified and that a response was being drafted to HIW around urology cancer wait lists. **QS23.11.4** Attendees discussed the robotic surgery, consultant training and the choice of robot purchased. It was noted that further conversations around procurement and the Urology HIW response would be taken outside of the meeting.	NL
QS23.12 Patient Safety Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.13 - Patient and Carer Experience Report	

This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.14 - HIW Update This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.15 - Quality/Safety Awards and Achievements This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.16 - Health and Safety Report including HSE Update **QS23.16.1** The Committee received the Health and Safety Report an Independent Member queried if there was any way to highlight racially motivated incidents, it was noted that this was done and submitted to the equities group. **QS23.16.2** Attendees discussed walk abouts and inspections, it was noted that a range of areas ae reviewed and that a detailed plan could be brought back to QSE Committee with clarity around Primary Care. **QS23.16.3** The Board Secretary highlighted the Health and Safety gap analysis plan and noted that given this was the basis on which work was prioritised it needed to be seen. The Associate Director of Occupational Health Safety and Security advised that the gap analysis was used to develop the three year strategy which had been shared at QSE in the past. **QS23.16.4** The Committee noted that further work was ongoing around falls given the data was not showing sufficient improvement. The Executive Director of Nursing and Midwifery advised that her senior team were looking at how to take this forward.	
QS23.17 - Nurse Staffing Act This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
REPORTS	
QS23.18 - Chair's Assurance Reports This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.19 - Infection Prevention Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.20 – Quality & Performance Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	

CLOSING BUSINESS	
QS23.23 - Issues Discussed in Previous Private Session **QS23.21** The Committee noted that the items that were discussed in the private session on 1 November 2022 were: • Update on Mental Health Investigations presented by the Executive Director of Public Health • Incident Report presented by the Executive Director of Nursing and Midwifery • Health & Safety Executive Compliance Update presented by the Executive Director of Workforce and Organisational Development	
QS23.22 - Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 7 March 2023.	
QS23.23 Exclusion of Press and Public **QS23.23.1 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.	

Teitl adroddiad: ***Report title:***	Patient and Staff Story			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 19 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	A patient or carer story is presented to Quality Safety and Experience Committee (QSE) to bring the voice of the people we serve directly into the meeting. The audio story will be played at the meeting, which includes the feedback of a staff member. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	The Quality Safety and Experience Committee (QSE) is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Rachel Wright, Patient and Carer Experience Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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

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

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: Conwy Approved 5.mov ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board
Patient Story: Mrs Morris's Story

"The Welsh language made me feel comfortable and reassured"

An audio-visual story told by Mrs Morris will be played at the meeting.

Overview of Patient Story

Mrs Morris shares her experience of her care in Ysbyty Gwynedd, in particular Conwy Ward.

Mrs Morris has lived away from North Wales for 50 years. Returning for Christmas, Mrs Morris became unwell on Christmas Eve, unable to catch her breath and needing help. Following triage and treatment in the Emergency Department, Mrs Morris was admitted and spent Christmas on Conwy Ward.

Mrs Morris would like to share this experience with the aim of highlighting the importance of the opportunity to speak her first language Welsh with nursing staff and other patients and how this made her feel 'more comfortable and reassured' and safe.

Mrs Morris highlights the exemplary nursing care that she received and her positive experience of patient nutrition and hydration.

The Deputy Ward Manager for Conwy Ward describes the importance of offering every patient on the ward the ability to communicate in their first language of choice to ensure patients understand every aspect of their treatment and feel empowered to make choices and decisions regarding their care.

Key Messages

- Positive experience of patient care in Ysbyty Gwynedd and in particular, Conwy Ward
- Importance of the opportunity to speak first language Welsh with both nursing staff and other patients to support patient comfort and reassurance
- Importance of the Welsh Active Offer and the promotion of Cymraeg on the ward to support patient communication
- Importance of identifying Welsh speaking staff on wards
- The helpfulness and professionalism of staff
- An example of exemplary care by a Health Care Assistant
- A positive experience of patient nutrition and hydration

Summary of Learning and Improvement

This Patient Story has been shared with the Surgical Matron and Ward Manager of Conwy Ward. The positive feedback regarding Thomas the Health Care Assistant on Conwy Ward highlights the important role of HCA's in patient care and aligns to the Health Board hosting its first conference dedicated to celebrating the contribution of Healthcare Support Workers in April 2023.

This Patient Story has been shared with BCUHB's Head of Welsh Language Services and Welsh Language Officer. The Welsh Language Team run a number of schemes to help support and promote the use of the Welsh language for patients and carers across BCUHB. One way the team do this is with the 'Language Choice Scheme'. The scheme utilises orange magnets with the 'Cymraeg' logo to identify Welsh speaking patients who would prefer to speak Welsh. Wherever possible, these patients are paired with Welsh speaking staff to help facilitate the delivery of care through the medium of Welsh.

The Welsh Language Service have also recently relaunched the 'Ffrind*iaith*' scheme, which pairs fluent Welsh speakers with staff who are learning Welsh. The aim of this scheme is to give Welsh learners the chance to practice and to gain enough confidence to use their spoken Welsh in the workplace and to use it regularly with colleagues, patients and service users.

It states in the Welsh Government's More Than Just Words (2022-27) framework that all NHS staff in Wales must complete a language awareness course. BCUHB's Welsh Language Team were tasked by Welsh Government to construct an online mandatory training course for all NHS Wales staff. The 'Welsh Language Awareness' e-learning module launched across Wales in February 2023 and all BCUHB staff are now required to complete the course. After completing the course, all BCUHB staff will develop an awareness of the Welsh language and an understanding of how it can be used in the workplace. The importance of patient experience is highlighted within this training. Another vital part of the More Than Just Words framework is the Active Offer. 'An Active Offer simply means providing a service in Welsh without someone having to ask for it'. It simply puts the emphasis on staff to be proactive and ensure that a Welsh-medium service can always be provided for our patients without them having to ask for it. All of the above aligns with BCUHB'S legal obligation to comply with the Welsh Language Standards. The Welsh Language Standards are a set of statutory requirements which are specific to the Health Board. They state clearly our responsibilities to provide bilingual services to patients and the public. Under the standards, we must not treat the Welsh language less favourably than the English language.

The BCUHB Welsh Strategic Forum operate a Bilingual Monitoring Scheme to monitor Welsh language compliance across the organisation. This includes methodologies such as mystery shoppers reviewing patient facing information and resources such as letters, signage and greetings by staff. Findings of the Bilingual Monitoring Scheme are reported to the BCUHB Welsh Strategic Forum and local Integrated Health Community Patient and Carer Experience Groups.

Future priorities include the development of Welsh language key performance measures around patient experience metrics. This will be reported to Patient and Carer Experience Groups within regional Integrated Health Communities, to offer local information that will align to service improvement where necessary. It will also enable BCUHB to highlight areas of good practise. This information will be reported to the Patient and Carer Experience Group.

This Patient Story has been shared with the Head of Dietetics (Central), BCUHB Professional Lead for Dietetics and Chair of the Health Board 'Fundamentals - Improving Nutrition Catering and Hydration Standards' (FINCHS) Group. The BCUHB FINCHS Group provides a forum for multi-professional stakeholders to discuss and action issues relating to the provision of oral nutrition and hydration to patients at ward level. The group aims to

promote continual improvement, ensure that health care standards are met through the systems and processes established for BCUHB and that they are aligned to Welsh Government standards which have been developed to drive such quality. The group is well represented across North Wales by an engaged and enthusiastic team of professionals, passionate about meeting FINCHS' aims. Patient and carer experiences are reported into FINCHS Group on a quarterly basis to help inform organisational learning and improvement. This story will be shared with the group to reinforce the importance of the comfort provided to patients of integrating excellent nutrition and hydration structures into ward care.

The Health Board supported International Nutrition and Hydration Week (13th - 19th March 2023). Staff across BCUHB joined together to highlight great areas of nutrition and hydration practice, promote related quality improvement initiatives within their area of work and support patients and carers with key nutrition and hydration messages.

Next Steps

The Patient and Carer Experience Team will share this feedback and seek assurance from departments by way of evidence that learning has been embedded. The Patient and Carer Experience Team extend their gratitude and appreciation to Mrs Morris for sharing her experience.

Teitl adroddiad: ***Report title:***	Patient Safety Report			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 19 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with information and analysis on significant patient safety issues arising during the prior three month period, alongside longer-term trend data, and information on the improvements underway.			
Argymhellion: ***Recommendations:***	The Committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Tracey Radcliffe, Head of Patient Safety			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report, however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A			

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Patient Safety Report February to April 2023	

INTRODUCTION

Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are reduced, learning occurs from the errors that do occur, and a culture of safety is fostered.

This report aims to provide assurance to the Quality, Safety and Experience Committee with information and analysis on significant patient safety issues arising during the period noted.

NATIONALLY REPORTABLE INCIDENTS (NRI)

From February to April 2023, 28 National Reportable Incidents (NRIs) occurred and 64 notifications were submitted, the difference relates to incidents occurring in prior months that have been awaiting outcomes from harms meetings. The total number of NRI investigations that are overdue is 34 out of the 57 that are open.

The NRIs reported during this period can be themed as follows:
Grade 3 or above Health Acquired Pressure Ulcer = 5
Falls resulting in harm = 12
Assessing and recognising patient/service user deterioration = 2
Delays in clinical assessment or treatment = 5
Infection prevention = 2
Injury of unknown origin – 1
Death of patient known to MH services – 1

The Deputy Director of Nursing for patient safety continues to lead weekly improvement meetings with services and the patient safety team are targeting support to facilitate completion. There has been an improvement in most areas but the patient safety team are currently focusing on Central IHC as an outlier for numbers overdue.

The following incidents are the recurring identified themes:

Falls - Key actions:

- Mandatory Falls E learning modules are under review to ensure the modules are up to date with current evidence/practice. ESR data cleanse underway to provide an accurate level of compliance with the competency.
- Falls champions job descriptor currently being developed; with bespoke training for falls champions role for implementation in Q2.
- NU06 Falls Prevention and Management of Adult Inpatients Currently in progress of being reviewed and will be available for comment via Health Board consultation process by end of Q1.
- Weekly IHC harms meeting established to review all Inpatient Falls. Membership includes colleagues from Health and Safety.
- The implementation of the bedside learning model, has been introduced to each IHC in Autumn of 2022. Each IHC are required to identify dedicated resources to support the bed side learning and capacity/engagement of their Practice Development Nurses with the implementation of the model.

Healthcare acquired pressure ulcers (HAPU) – key actions

- NU03 prevention and management of pressure ulcers approved to be ratified at patient safety group in May 2023.

- HAPU audits being undertaken
- Pressure ulcer prevention training
- WNCR repositioning and skin assessment section launched Feb/Mar 23
- Collaborative working across the IHC although more work required on implementation of pressure ulcer passport to improve handover
- Improved completion of focused reviews on datix
- Weekly harms meetings for shared learning
- Equipment issues to be escalated locally

Recognition and escalation of deteriorating patient – key actions

- Improvement work is being led by the STEAR (Sepsis Triggers, Escalation and Antibiotic Stewardship Review) group. Delay in recognition and enactment of sepsis 6 in mitigating patient deterioration has been identified as a theme. Rollout of the updated sepsis screening tool and triggers including staff education is on hold pending alignment with All Wales clinical group.

The Patient Safety Improvement Programme is in development to support the priority areas and key improvement metrics and trajectories will be reported to the QSE in Q2.

NEVER EVENTS

Within the reporting period, one Never Event was reported in Ysbyty Gwynedd where a guidewire was retained in a patient. There was no long-term harm to the patient. An investigation is underway. At the time of writing, this incident may be downgraded from a Never Event following discussion with the NHS Wales Executive.

It is positive to note a reduction in the last financial year of Never Events (from 12 to 6), and the reduction in theatre related incidents which suggests the extensive improvement work in theatre safety has had an impact. The primary theme remains surgical safety however the nature of incidents has shifted from within theatre to out of theatre.

PATIENT SAFETY ALERTS AND NOTICES

The Health Board has no overdue alerts. PSN066 (Safer Temporary Identification Criteria for Unknown or Unidentified of patient who attend ED.) is due for compliance by Sept 23. This is being progressed by the Patient Safety Team to ensure standardisation of compliance across Emergency Departments (EDs).

CONCLUSION

This report provides the Health Board with information and analysis on patient safety matters including Nationally Reportable Incidents, Never Events and Patient Safety Alerts

The key points of note are:

- The overall rate of overdue NRIs has demonstrated some improvement but the number of overdue incident investigations, and consequently closure within the target timeframe is still below expectation. Services report clinical and operational pressure as being the main cause. Support is being provided.
- The main themes remain falls, healthcare acquired pressure ulcers, and the recognition and escalation of deteriorating patients. Improvement work for all these areas is progressing under the leadership of senior clinical staff.
- The rate of surgical safety NRIs (specifically Never Events) has reduced.
- No Safety Alerts are overdue compliance.

Teitl adroddiad: ***Report title:***	Patient and Carer Experience Report			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 19 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with information and analysis on significant patient and care experience feedback arising during the time period under review, alongside longer-term trend data, and information on the improvements underway.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Rachel Wright, Patient and Carer Experience Lead Manager Kim Warrington-Davies, Complaints Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this: There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Considerations in this report cover compliance with the Putting Things Right Regulations and Ombudsman requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	N/A

Reason for submission of report to confidential board (where relevant)	
Next Steps: N/A	
List of Appendices: Patient and Carer Experience Report – December 2022 to March 2023	

1. INTRODUCTION

1.1 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient and carer experience activity arising during the period under review. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.

2. COMPLAINTS - PERFORMANCE

2.1 During December 2022 to March 2023 the Health Board received 756 complaints of those 585 were complaints managed under the Putting Things Right Regulations (PTR). Of the 756 complaints received 171 were initially classified as Early Resolutions, and of these, 11 cases were upgraded to 'managed under PTR' due to the service involved not managing resolution within 2 working days.

2.2 The majority of the complaints relate to Secondary Care Services. The top themes relate to: clinical treatment and assessment, poor communication, appointments and medication. Pro-active work is ongoing with the Patient Advice and Liaison Service (PALS) to coordinate with services, addressing recurring themes. Attitude and behaviour issues are common themes across all services.

2.3 Performance remained below the All Wales target of 75% for complaints closed within 30 working days. The number of complaints closed within the timeframe was 30% during the months of December 2022 to March 2023. This performance level is a slight improvement in comparison to previous reporting months. To support the achievement of the key performance indicators, each Integrated Health Community (IHC) has adopted weekly meetings to manage the progress of complaints received. In addition, a new weekly scrutiny meeting to manage the overdue complaints backlog has been established chaired by the Deputy Executive Director of Nursing.

2.4 There were 290 overdue complaints at the end of March 2023. This is a significant reduction in overdue complaints through overtime and considerable efforts by both the Complaints Team and the services involved to investigate their complaints and complete their reports within PTR timescales.

2.5 It is important to reflect on the Health Board's current position in relation to overdue complaints, there has been a focus on addressing the backlog by way of weekly scrutiny meetings, local complaint management meetings and support for timely local resolution for new concerns. The pro-active approach adopted has contributed to a further decrease in the overdue complaint number as well as improvements in complaints being managed formally under Putting Things Right where they are low level concerns.

The current position as of the 12th of May 2023 is as follows:

- Number of complaints overdue (this includes Grade 4 and 5 Complaints over 180 days+) = 220 Complaints overdue

- The total number of open Complaints are 440 which is much improved from last quarter

2.6 The Health Board continues to meet the acknowledgement of Complaints within PTR timescales of 2 working days and therefore meeting the defined KPI Target from Welsh Government of 95%. Below, is performance data for the reporting period:

- December 2022 98.5%
- January 2023 99.3%
- February 2023 98.84%
- March 2023 100%

3. PATIENT AND CARER EXPERIENCE

3.1 Patient feedback and listening to the voices of patients, carers and service users is key to ensure effective service improvement. During December 2022 to March 2023, PALS dealt with 2107 enquiries. Below are the top three enquiry themes:

1. Delay in appointment (negative)
2. Clinical treatment and assessment (negative)
3. Communication (negative)

3.2 To assist improving communication and staff supporting service users, the Patient and Carer Experience Team have continued to deliver a series of face-to-face Patient and Carer Experience Training with staff from Ysbyty Glan Clwyd Emergency Department and to student nurses. The training includes effective communication, empowering staff to resolve issues locally to encourage early resolution of complaints and raising awareness of the role of PALS.

3.3 There has been an increase in GP enquiries relating to delays in appointments and poor communication. To help support the resolution of early enquiries to reduce them escalating to a formal concern, the PALS Team are working with GP Managed Practices across Integrated Health Communities to deliver local resolution training and guidance to staff.

3.4 CIVICA All Wales real time feedback system is one method used to provide assurances that the Health Board is listening and learning from patient and carer feedback. Over the past 12 months there has been a significant increase in the number of monthly patient feedback returns from 748 total feedback returns collected across BCUHB in April 2022 to 1866 total feedback returns collected in February 2023. The Health Board is working towards launching SMS feedback surveys by May 2023. Text messages will be sent to all patients attending outpatient appointments and who have recently been discharged. A web link sent in a SMS text will take the patient/carer direct to a feedback survey for the service they have received care from.

3.5 During December 2022 to March 2023, 6927 patient feedback surveys were completed. In March 2023, 87% of patients who completed the survey felt always listened to and 85% of patients always felt involved in decisions about their care (80% always target).

3.6 The Patient and Carer Experience Team are supporting services to understand their feedback data, empowering them to pull their own data reports to help inform learning. The Patient & Carer Experience Team have launched monthly automated patient feedback data reports that are now sent to a designated staff member who is aligned to

a ward, service or department so they can manage this feedback. The Patient and Carer Experience Team have recently completed a pan-BCU project with regards to QR codes. As a result, every ward, department, and service that see/treat patients will be able to display their own QR codes which will take enquirers straight to the most relevant feedback survey. The advantage of this is that the QR codes provide a quick method of survey selection, empowering and encouraging patients, relatives and carers to provide feedback on their recent experience, which in turn, provides BCUHB with a significant amount of data to use for service improvement and sharing good practice.

3.7 BCUHB is working with Small Business Research Initiative (SBRI) funded by Welsh Government to explore innovative digital solutions to improve communication between relatives when their loved one is in hospital. To support the Small Business Research Initiative, the Patient and Carer Experience Team interviewed 99 patients to capture feedback on what matters most to them. This feedback will shape the future digital solution to support families' communication with their loved ones' progress in care. Two organisations have been selected to work with the Health Board for one year to develop and test their innovation. Throughout the year staff, patients and carers will continue to be involved in focus groups and to test digital platforms and to share their experiences as to what may work well.

3.8 The Health Board has received confirmation from Welsh Government of £213,000 Regional Integrated Fund grant allocation for 2023/2024 to support unpaid carers with a specific focus around supporting carers to be more involved in the discharge planning and process. The Patient and Carer Experience Team are currently liaising with services to identify how NEWCIS and Carers Outreach can work closer together with services to support un-paid carers.

4. CONCLUSION

4.1 This report provides the Quality, Safety and Experience Committee with information and analysis on patient and carer experience. It highlights a range of positive areas of practice as well as some challenges such as complaints performance.

4.2 Services need to become increasingly pro-active in complaints management supported by the Complaints Team and their service managers. A targeted plan, developed in collaboration with the Directors of Nursing, is under development and will be implemented over the remainder of the year.

4.3 Significant patient experience improvement activity is underway as detailed in the report.

4.4 The QSE Committee is requested to note the report.

Teitl adroddiad: ***Report title:***	**Clinical Effectiveness Update Report**			
Adrodd i: ***Report to:***	**Quality Safety Experience Committee (QSE)**			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 19 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of the paper is to provide assurance in relation to the Strategic Clinical Effectiveness Group 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.			
Argymhellion: ***Recommendations:***	The Committee is asked to note: • The content of the report and the interaction of various work streams which contribute to clinical effectiveness and that within strategic CEG meetings, the Chair will ensure that each of the IHCs and divisions have the opportunity to escalate an issue requiring action or decision.			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr James Risley, Deputy Executive Medical Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Delivery of high-quality clinical care and patient experience.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no known regulatory or legal implications for Betsi Cadwaladr University Health Board.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Any risks pertaining to the Clinical Effectiveness Group specifically, are now managed through Datix.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no direct financial costs associated with this update. Individual projects or pathways may generate added cost pressures, but these are dealt with through the operational delivery teams.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no current workforce implications associated with the delivery of clinical effectiveness, though these may be identified during the process of undertaking reviews and will be shared if so.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been written specifically for the Quality, Safety and Experience Committee, and will be reported back to the strategic Clinical Effectiveness Group's next meeting
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** For the Committee to provide advice and assurance on issues requiring action and decision and to confirm agreement with regard to strategic Clinical Effectiveness Group (CEG) structure and reporting processes.	
Rhestr o Atodiadau:	

Friday 19th May – Strategic Clinical Effectiveness Group - Chair's Report to Quality, Safety and Experience Committee (QSE)

The purpose of the Strategic Clinical Effectiveness Group (CEG) is to identify clinical risk via oversight and review of the following programs:

- National and Local Clinical Audits
- Mortality Reviews
- NICE Guidance

- **Issues for escalation – Requiring Action/Decision**

BCU Hospital Transfusion Committee:

- Transfusion survey feedback has identified that medical staff have not undertaken any transfusion related training. Currently there is no format available for transfusion training for medical staff (apart from F1s) – support is required from clinical specialities to be able to link in with clinical governance days in order to deliver this training.

Major Haemorrhage Procedure (MHP) training:

- No formal clinical training regarding MHP currently in place. Recommendation is that Transfusion training should be mandatory for all staff involved in the transfusion process.

Resuscitation Committee:

- Risk remains at Tier 1 (Risk score of 20) due to highest scoring component of the overall risk outstanding – no dedicated training venue on site in YGC despite the identification of potential on site (YGC) venue (LoR). The Service provides a monthly Pan BCU Resus training activity and progress updates to the Executive Medical Director and Chair of RMG who reports to Board. We await a move in date and confirmation of funding for estate works to make the best use of the building for teaching more than a group of 6 at a time.

Mitigations in place:

- Use of alternative venue for groups up to 12 (OpTIC).
- Advanced courses being held East & West so Central IHC staff need to travel.
- Making staff aware they can book courses at East and West to improve availability of course places - Outstanding actions sitting with Central HMT require resolution before progression and risk score reduction become possible.

- **Issues for escalation – For Information**

Trauma Board Subgroup –Spinal injury repatriation:

- Lack of capacity at specialised Spinal Injury rehab units across England has resulted in long waits for patients waiting at Major Trauma Centres (over 12 week waits).
- Patients are now repatriated directly from Stoke back to the local district hospital to wait for beds at spinal injury rehab units (Robert Jones and Agnes Hunt Oswestry for North Wales patients)
- Risk that lack of specialised knowledge and expertise at BCUHB acute sites could result in complex spinal injury cases coming to harm (e.g., Skin Bundles, bowel care, autonomic dysreflexia) and that spinal patients become stranded on general wards on the three acute sites adding to poor patient flow and worse patient outcomes.

- As interim mitigation, Claire Lamb (Consultant Nurse spinal Injuries) will provide outreach and education package to ward-based staff caring for repatriated patients at local hospitals. Issue will be discussed at next BCU/WHSCC meeting.

- **Trauma Board Subgroup: EMRTS /Air ambulance**
  Rebasing of EMRTS /Air ambulance now on hold. Awaiting wider public consultation and engagement. Change of airbases will have timeline implications for Major Trauma /vascular and cardiac network transfers. RSUH (Major Trauma Centre) developing enhanced teleconferencing system to improve communication between referring clinicians at local Trauma units and receiving clinicians (Awaiting NHS England funding). South Wales Trauma network introducing Welsh Government **Landing Pad** model for patients repatriated from major trauma centres. Implications of rolling out model to North Wales requires discussion with Therapies/rehab services.

Teitl adroddiad: ***Report title:***	Regulatory Assurance Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	19/05/2032			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with an updated position in relation to quality related regulatory activity for the period January 2023 to April 2023.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Erika Dennis, Quality Governance Lead Manager Debbie Kumwenda, Healthcare Law Lead Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Developing Health Board quality systems, processes, policies and procedures are a key objective as this will strengthen assurance through improved systems for monitoring compliance and driving learning and improvement.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality Governance			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Healthcare Inspectorate Wales (HIW), Care Inspectorate Wales (CIW), the Public Services Ombudsman for Wales (PSOW) and HM Coroners are regulators or similar bodies with statutory oversight powers. As such, the Health Board has a requirement to ensure that we meet minimum standards, learn and improve, and provide assurance – which is			

	further reinforced in the Statutory Duty of Quality.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** None	

INTRODUCTION

The Quality Directorate aim to support the Health Board and its staff to deliver the highest quality services to our patients and communities, by continuously developing, assessing and driving quality across all areas of the Health Board. This includes ensuring regulatory compliance.

Key to achieving these objectives is the establishment of the Regulatory Assurance Group (RAG), chaired by Angela Wood, Executive Director of Nursing and Midwifery. The RAG is a formal sub group of the Quality Delivery Group and is the single point of focus for all quality related regulation oversight and assurance activity across the Health Board and will seek assurance on progress and ensure actions are delivered in a timely fashion. The RAG has a direct line of accountability to the Quality Delivery Group with its reports being received at QDG, and to the Quality, Safety and Experience (QSE) Committee of the Health Board via this Regulatory Assurance Report.

HEALTHCARE INSPECTORATE WALES

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services, and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

Services Requiring Significant Improvement (SRSI)

The Health Board has two services identified as SRSI:

1. **Emergency Department at Glan Clwyd Hospital**
   Inspection: 08-10 March 2022, 03-05 May 2022, 28-30 November 2022.
   Amalgamated figures for all three inspections and improvement plans below:
   71 Recommendations
   304 Service Improvement actions
   116 actions completed and awaiting approval
   4 completed
   37 actions in progress
   122 actions partially complete (overdue)
   18 actions overdue
   3 actions unable to complete
   4 actions rejected
   Accountable Director: Simon Newman, IHC Director of Nursing, Central

2. **Vascular Services**
   The Royal College of Surgeons Clinical Record Review Report**,** published 20 January 2022, identified a number of concerns that indicate a risk to patients using the vascular service. HIW is undertaking a review and conducted onsite field work across all sites in November 2022 with follow up remote evaluation of data and information, for which the Health Board awaits feedback.

New inspections (January – April 2023)

1. **Foelas Mental Health Unit, Learning Disabilities, Bryn y Neuadd Hospital**
   Inspection 22 March 2023
   Draft report not received by HIW as of 10 May 2023; no immediate concerns raised.
   Accountable Director: Paul Lumsdon, Director of Nursing, MHLD

CARE INSPECTORATE WALES (CIW)

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services. As the Health Board is one legal entity, it is a registered provider for multiple services which includes Enhanced Community Residential Services (MHLD) and Tuag Adref (across all three Integrated Health Communities). The Health Board updated its registration in February 2023.

In accordance with the Social Care (Wales) Act 2016, the Health Board has appointed a Responsible Individual who has legal obligations to undertake assurance activity. In addition, there is a legal requirement to undertaken an Annual Return for the services, which is on track and due with CIW no later than 26 May 2023.

The Health Board has also established a Task and Finish Group to undertake the responsibility of ensuring all domiciliary care staff are registered with Social Care Wales.

PUBLIC SERVICES OMBUDSMAN WALES (PSOW)

PSOW has legal powers to look into complaints about public services and independent care providers in Wales. During January to April 2023, the Ombudsman contacted the Health Board regarding 64 new concerns. The Health Board has received notification that a further 16 new complaints will be fully investigated by the Ombudsman.

The Health Board currently has 91 Ombudsman Investigations ongoing. Across the Health Board, there are currently 29 cases within Central, 38 cases within East and 24 cases within West.

Public Interest Reports (PIR) (January – April 2023)

The Health Board received one PIR:

1. Ysbyty Glan Clwyd
   Issued on 13 April 2023

The Ombudsman's investigation considered the management and care between May 2019 and May 2020, in particular surgical delays in fitting of stents into a kidney which led to post-operative complication and also the management and care at the hospital following a further admission which included inadequate bowel care. The complainant said this contributed to her sister's death. The recommendations are being implemented:

- Apology and redress payment have been actioned
- Clinical and nursing actions in progress to be implemented by 29 September 2023
- One Quality assurance action to be implemented by 29 September 2023

LITIGATION

Between January 2023 and April 2023, 114 claims or potential claims were received against the Health Board. Of these, 100 related to clinical negligence and 14 related to personal injury. During the same period last year, 100 claims or potential claims were received against the Health Board.

During this 4-month period, 16 claims were closed. Of these, 13 related to clinical negligence and 3 related to personal injury.

As expected, the largest number of open clinical negligence claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The following themes have been identified for personal injury: Slips/trips and Violence &

Aggression. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

PI claims savings due to discontinued or favourable settlements for this period amount to £241,206.65. These are financial savings for providing evidence to L&R, which allows for a denial of Health Board liability in a matter leading to a claim being discontinued or in the case of favourable settlements; we have been able to negotiate a lower compensation payment due to the investigative work of the Healthcare Law Team.

It is also recognised there are a number of outstanding LFER's that are currently overdue. In addition, there are a significant number (26) of Case Management Reports (CMR's) that are overdue for submission.

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state if at any time during the investigation of a complaint or patient safety incident it is considered that a qualifying liability exists or may exist, that would attract financial compensation of £25,000 or less, it must be determined whether or not an offer of redress should be made.

Redress can include one or more of the following: a full explanation of what happened, an apology, an offer to provide care or treatment (where appropriate), a report on action which has been or will be taken to prevent similar cases arising and financial compensation.

Between January and April 2023, 47 cases were concluded which involved Redress:

- 12 offers of financial compensation as redress were accepted totalling £81,200
- 12 offers of financial redress were made and are waiting to be accepted totalling £70,250
- 1 offer of an apology only as redress was made
- 3 redress cases progressed to becoming clinical negligence claims
- 18 were issued with a response not addressing qualifying liability and advised to pursue a clinical negligence claim, as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.
- 1 was issued a response denying liability following receipt of an independent expert report.

To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool (WRP) requires the Health Board to submit a Learning from Events Report (LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation. The LFER will be considered by the WRP Committee who will approve reimbursement to the Health Board for the costs entailed in each redress case, once satisfied with the evidence of learning provided. Between January and April 2023, the Welsh Risk Pool approved 14 Redress Learning from Events Reports.

All settled claims and redress cases require completion of a Learning from Events Report. This records the findings of investigation and any actions taken and is jointly developed by the claims manager and relevant clinical lead. This report must be submitted to the Welsh Risk Pool to reclaim costs.

The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required.

INQUESTS

An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered. HM Coroner notifies the Healthcare Law Team within the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board.

During January to April 2023, 148 new inquests or requests for information from the Coroners. During the same period last year, 128 new inquests or requests for information were received from the Coroners in North Wales.

86 inquests were concluded during this 4-month period. The distribution of the inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this. During the same period last year, 49 were concluded.

There are currently 53 inquests with NWSSP Legal and Risk Services support in progress across the health board. Some are in initial stages and others are awaiting inquest date, and various stages in between.

Regulation 28 (Prevention of Future Death) Reports

In the period of this report, there were 6 Regulation 28 Reports issued by HM Coroner to the Health Board. The Health Board has a duty to provide a response to the Coroner within 56 days. The response must contain details of action taken or proposed action taken, setting out the timetable for action. Otherwise, the Health Board must explain why no action is proposed.

The matters of concerns are as follows:

- Assessment delays, waiting lists for MH support and lack of a standardised process (LPMHSS) for referring low risk patients for interim support.
- Ambulance delays/handovers and the multifactorial issues effecting it.
- Lack of a protocol in place to ensure the prompt and secure delivery of radiology reports to a receiving hospital when transferring a patient.
- Lack of overall strategic direction to investigations and learning.
- Lack of strategic management of internal investigations and lack of timeliness.
- Lack of procedure governing patients who are referred to the Home Treatment Team and who decline their services or who are deemed not suitable.

In addition to issuing Regulation 28 reports, HM Coroner can raise concerns in a variety of ways. A Schedule 5 notice gives the Coroner power to compel the production of further evidence for the purpose of an investigation or inquest. In addition, the Coroner can also ask for further information to assist with the investigation known as a Direction which is legally binding. Normally the Health Board has 28 days to provide the requested information, however this can be less depending on what is required. The Coroner can also request further information in a non-legally binding way during an investigation or prior to making a decision on issuing a PFD report.

A Schedule 5 notice was issued to a Health Board witness during an Inquest. The documents requested were in relation to the investigation (e.g. ward handovers, ward staff training, MCHP command log etc.). The documents were collated and submitted ahead of the scheduled deadline.

The number of additional assurance requests from the Coroner has increased in recent months, as have the number of Directions received.

Teitl adroddiad: ***Report title:***	Summary of Q4 Health and Safety report			
Adrodd i: ***Report to:***	QSE			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 26 May 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The report has been completed to provide a summary of key health and safety team activities and areas for escalation since 01 January 2023. It is a brief report and not intended to replace the full 2022/23 Q4 or annual report. The aim is to highlight areas of interest or escalation to QSE			
Argymhellion: ***Recommendations:***	The Committee is asked to: note the recommendations within the report which include:- ▪ Ensure adequate staffing is available to provide an appropriate Health and Safety, Security, Fit Testing and Manual Handling function to BCUHB. ▪ Ensure appropriate trainers are available to ensure the Manual Handling risk is reduced from the current level. ▪ Ensure adequate training rooms are available for Manual Handling training. ▪ Review ligature risk assessments in all service areas ▪ Ensure patient falls assessments are completed to a high standard ▪ Ensure staff who may require the use of FFP3 respirators attend fit testing			
Arweinydd Gweithredol: ***Executive Lead:***	Jason Brannan, Deputy Director of People			
Awdur yr Adroddiad: ***Report Author:***	Peter Bohan, Associate Director of Health, Safety and Security Sue Morgan, Head of Health, Safety and Security			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	High level of confidence/evidence in delivery of existing mechanisms/objectives	mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	/ amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	No all policies and procedures have EQiA as part of the evaluation process
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No Health and Safety legislation does not directly relate to the socio economic duty.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The report should be cross referenced with the Board Assurance Frmework (BAF) Security Services No 21-12 and Health and Safety BAF Reference No 21-13.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There is significant financial risk as it is anticipated the possible prosecution of BCUHB will result in fines of between £1.5M and £6M
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Staff not trained in specific Health and Safety issues may result in ill health and injury to staff and patients

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has not been reviewed at other groups.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	The report should be cross referenced with the Board Assurance Framework (BAF) Security Services No 21-12 and Health and Safety BAF Reference No 21-13.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

Health and Safety Update

The report has been completed to provide a summary of key health and safety team activities and areas for escalation since 01 January 2023. It is a brief report and not intended to replace the full 2022/23 Q4 or annual report. The aim is to highlight areas of interest or escalation to QSE.

1.1 Health and Safety Executive

HSE investigation, Hergest Unit

A notification of contravention letter was received 9 May 2022, to detail material breaches identified following the investigation of the death of a patient by ligature in the Hergest Unit. The material breaches detailed the standard of the ligature risk assessment, the bed and the ligature used. A letter was also received 15 May 2022 requiring the Health Board to provide a statement of explanation to accompany the HSE case to their independent legal team for consideration of further enforcement action. A further letter was received 15 March 2023 confirming the HSE intention to take further enforcement on this matter, namely a prosecution case.

HSE Investigation, Patient Falls

The HSE are actively investigating two patient falls; in the CDU in Wrexham and Gogarth Ward, Ysbyty Gwynedd. There is a further patient fall that remains an open investigation in Aran Ward, Ysbyty Gwynedd. Further reports are being submitted to the HSE following patient falls where an inadequate falls assessment was completed or identified controls not implemented. The HSE have confirmed that they are also reviewing falls training completed by agency staff is in-line with the BCU falls policy.

HSE Investigation Hand-Arm Vibration

A diagnosis of RIDDOR reportable Hand Arm Vibration Syndrome was received from our Occupational Health and Safety Consultant following health surveillance for staff at risk from vibration. This remains under current investigation by the HSE

1.2 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

Since 01 January 2023 there have been 15 reports submitted under RIDDOR. This includes eight staff ‘over 7 day’ related injuries with three falls, two assaults, one head injury and two musculoskeletal injuries. There were seven patient related specified injuries following falls.

1.3 Health and Safety Reviews

Health and Safety reviews of BCUHB wards and departments are part of the ‘check’ process of the plan, do, check, act cycle. There have been 97 formal reviews completed to date this year.

1.4 Fit testing

Challenges for the fit testing programme include staff feeling they no longer require a fit test as they are no longer using FFP3 respirators. This programme remains in place to ensure that the Health Board are prepared in case there is another outbreak or similar where staff are required to use FFP3 respirators in the future. Uptake for local department fit tester training has improved and the Health and Safety (fit testing) advisors who are fit2fit accredited are now looking to get the course they run accredited. This is not a legal requirement however will continue to evidence the importance of this programme following two separate HSE enforcement actions.

1.5 Manual Handling

The training is continuing in external training rooms however, the two year agreed contracts will start to end in December 2023. Alternative accommodation on the DGH sites is being sought however, this may need escalating back to the Executive team if this is not available. Confirmation received that there is no space available on the Ysbyty Gwynedd site although an alternative may be available in BYN. There is a second training room now available in the Abergele residents building, it is understood this building has been identified for rationalisation so this may not be a long term solution. Patient Handling refresher training compliance remains low at 53% (April 2023) as there has been a significant requirement for foundation training with large recruitment drives.

1.6 Personal Safety / Violence and Aggression V&A

The V&A team are currently rebranding to the Personal Safety team to promote a more positive image of supporting both staff and patients. The Personal Safety training programme (V&A module C) has commenced again for all clinical staff on the orientation programme.

1.7 Security

The security advisory team are working closely with the communications team to raise staff awareness and improve reporting. Improvements will be made to the BetsiNet pages and other platforms. Security awareness days are being planned on the DGH sites in July 2023 to increase the profile of the security and personal safety teams. There will be further plans to take this to the community hospital sites

1.8 Recommendations

- Ensure adequate staffing is available to provide an appropriate Health and Safety, Security, Fit Testing and Manual Handling function to BCUHB.
- Ensure appropriate trainers are available to ensure the Manual Handling risk is reduced from the current level.
- Ensure adequate training rooms are available for Manual Handling training.
- Review ligature risk assessments in all service areas
- Ensure patient falls assessments are completed to a high standard
- Ensure staff who may require the use of FFP3 respirators attend fit testing

2 Goblygiadau Cyllidebol / Ariannol / Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

3. Rheoli Risg / Risk Management

There are two risks on the Board Assurance Framework (BAF) Security Services No 21-12 and Health and Safety BAF Reference No 21-13.

4. Goblygiadau Cydraddoldeb ac Amrywiaeth / Equality and Diversity Implications

EqIA compliance is required in accordance to Procedure WP7 to ensure equality and human rights are embedded into organisational decision-making and policy development processes. All Occupational Health, Safety and Security policies are reviewed in accordance with EQIA requirements.

Nurse Staffing Levels Presentation
19th May 2023

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

Introduction / Background

Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

The Act has two key requirements:

1. **A duty to calculate and take steps to maintain nurse staffing levels**
2. **Apply triangulated methodology to nurse staffing level calculations i.e. Professional Judgement / Patient Acuity / Quality Indicators**

In line with the Act, nurse staffing calculations are to be approved by a ***designated person*** who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

Section 25C: Nurse staffing levels: method of calculation

Section 25C of the Act describes the triangulated method of calculation that must be used for calculating the nurse staffing levels. The triangulated methodology involves collecting, reviewing and interpreting data relating to:

- **Professional Judgement** - applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making

- **Patient Acuity** - an estimate of the amount of care a patient requires based on the intensity, complexity and unpredictability of their holistic needs. In Wales the Welsh Levels of Care is the tool used to assist nurses in measuring the acuity and dependency of their patients.

- **Quality Indicators** – a measure of factors that relate to the delivery of nursing care and are used to demonstrate whether the department delivers good outcomes for patients and staff.

During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence with equal weighting given to all the information that informs this process. The designated person will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

Nurse Staffing Levels Calculations Process

Ward Level Data Collection & Review

Ward Manager presentations to Associate Director of Nursing/Director of Nursing outlining ward acuity/care quality indicators/and applied professional judgement.

Discussion takes place regarding current workforce issues/temporary staffing usage/future workforce needs/staff development & innovation.

Health Board Wide Multi-site, Service Specific Reviews

A Health Board wide (multi-site) review is undertaken to ensure a consistent approach, share good practice/lessons learned/opportunity to improve patient care pathways.

Autumn 2022 reviews were undertaken during the week commencing 12/09/2022. Spring 2023 reviews were undertaken during the week commencing 13/03/2023.

Review & Approval by Designated Person

Formal presentations are made to the Executive Director of Nursing and Midwifery. In attendance are the Executive Directors Workforce & Organisational Development; & Finance or their nominated deputies.

Autumn 2022 agreed Nurse Staffing Level calculations were formally presented to the Board on 24/11/2022. Spring 2023 agreed Nurse Staffing Level calculations will be formally presented to the Board on 25/05/2023.

All Wales Acuity Audit

Acuity Audit data

During the months of January and June each year a national acuity audit is held as directed by the Chief Nursing Officer. The acuity audit is used to collect data relating to patient acuity, patient flow and nurse staffing levels.

Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

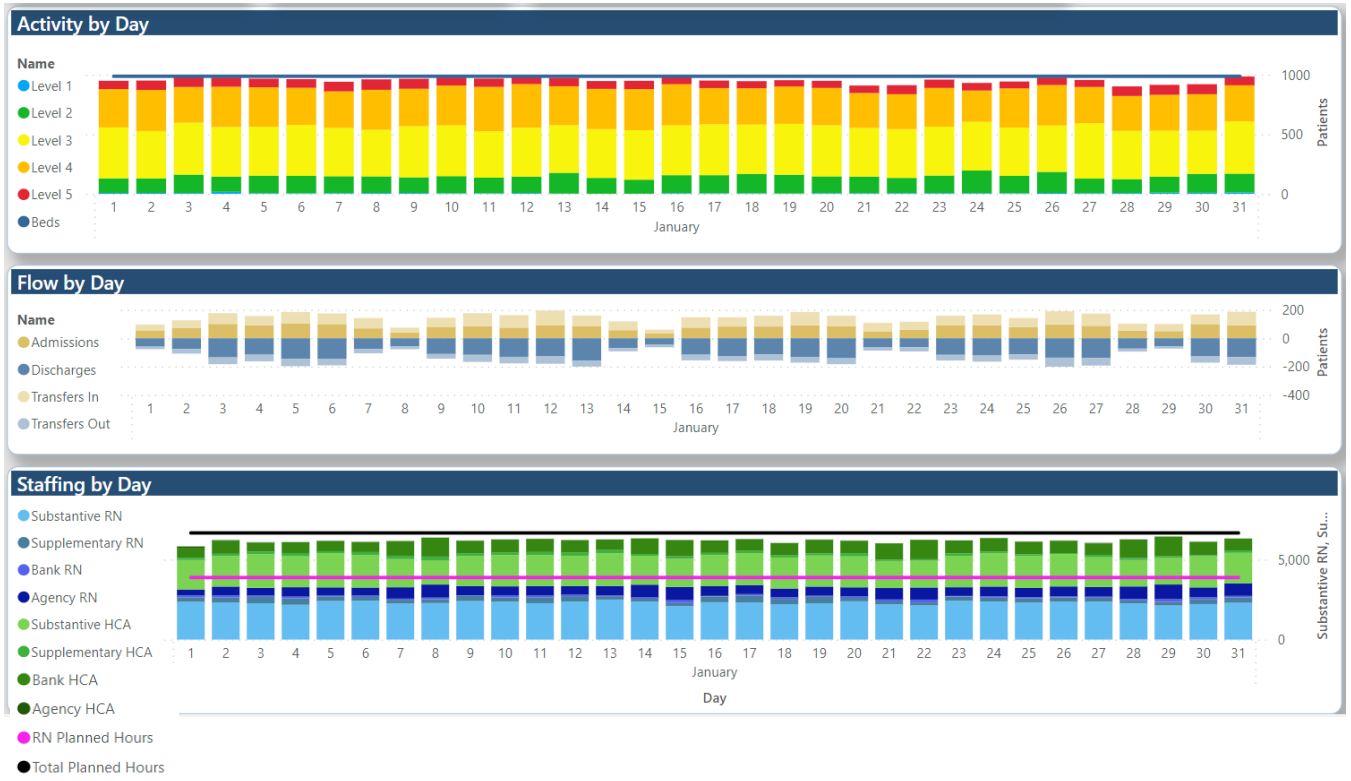
This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

Welsh Levels of Care

The Welsh Levels of Care are summarised below, further detailed information can be found **here**

Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

BCUHB January 2023 Acuity Audit data



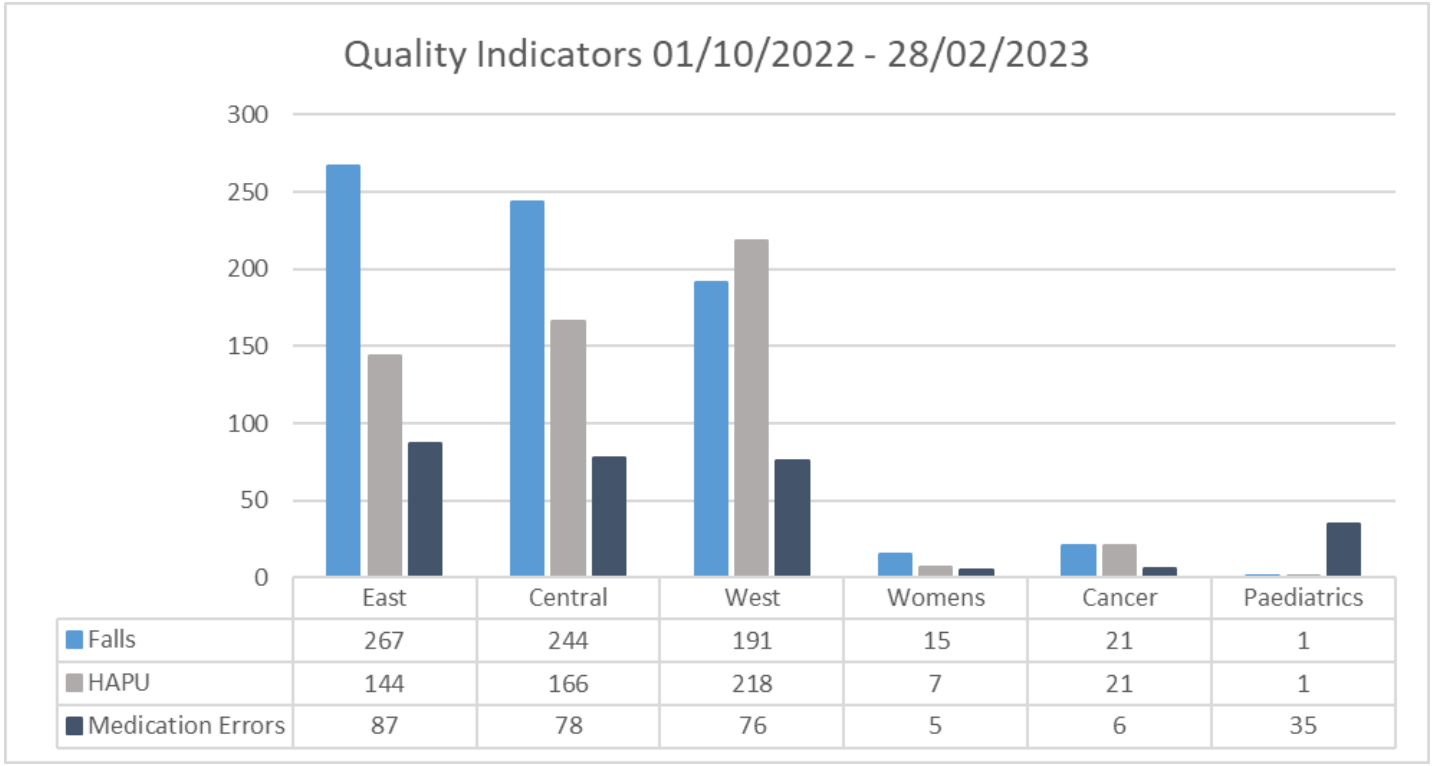
Data Source – E-Rostering & HCMS Systems

Quality Indicators sensitive to care provided by a nurse

Nurse staffing level calculations must take into account:

- pressure ulcers
- medication administration errors
- patient falls
- infiltration / extravasion injuries (paediatric wards)

Other indicators that are sensitive to nurse staffing levels may also be considered, such as complaints



	East	Central	West	Womens	Cancer	Paediatrics
Falls	267	244	191	15	21	1
HAPU	144	166	218	7	21	1
Medication Errors	87	78	76	5	6	35

The chart above details by Integrated Health Community / division the total number of patient falls, pressure ulcers and medication errors recorded within DATIX for the period 01/10/2022 – 28/02/2023. No Infiltration/Extravasation injuries were reported during this period.

Data is based on only those wards to which Section 25B of the 2016 Act pertains.

Data source: DATIX system as at 08/03/2023

Extent to which the Nurse Staffing Levels are maintained

A real time view of staffing is provided by the Allocate E-Rostering SafeCare system. This provides the ward manager/shift lead with the opportunity to record whether or not staffing was appropriate to meet the needs of the patients on a shift by shift basis. Any concerns relating to nurse staffing levels are to be escalated in line with NU28 Nurse Staffing Levels Policy.

The table below details the extent to which the planned roster was met across all the adult medical & surgical wards pertaining to Section 25B of the Act 2016 and the appropriateness of the staff on duty to meet patient care needs. The table is based on the Early, Late and Night shifts and is inclusive of both substantive and temporary staffing as recorded on the rosters. This is exclusive of paediatrics as they are not currently using the SafeCare system however their information can be viewed on the paediatric specific slides.

Month	Total number of shifts	Shifts where planned roster met and appropriate		Shifts where planned roster met but not appropriate		Shifts where planned roster not met but appropriate		Shifts where planned roster not met and not appropriate		Data completeness	Shifts where planned roster met but no appropriateness recorded		Shifts where planned roster not met and no appropriateness recorded	
Apr-22	3000	18.43%	553	5.30%	159	27.00%	810	28.20%	846	78.93%	6.80%	204	14.27%	428
May-22	3720	20.05%	746	7.15%	266	25.99%	967	28.66%	1066	81.85%	7.28%	271	10.86%	404
Jun-22	3600	24.69%	889	7.47%	269	28.89%	1040	32.25%	1161	93.31%	3.11%	112	3.58%	129
Jul-22	3720	17.12%	637	7.88%	293	26.85%	999	33.68%	1253	85.54%	5.00%	186	9.46%	352
Aug-22	3720	17.39%	647	7.07%	263	25.48%	948	35.13%	1307	85.08%	5.32%	198	9.60%	357
Sep-22	3600	20.33%	732	6.75%	243	27.47%	989	29.33%	1056	83.89%	6.25%	225	9.86%	355
Oct-22	3813	20.38%	777	7.05%	269	27.69%	1056	28.69%	1094	83.82%	6.08%	232	10.10%	385
Nov-22	3780	24.58%	929	7.09%	268	26.24%	992	29.63%	1120	87.54%	5.50%	208	6.96%	263
Dec-22	3906	17.64%	689	7.68%	300	23.20%	906	34.90%	1363	83.41%	5.02%	196	11.57%	452
Jan-23	3906	23.99%	937	7.86%	307	30.03%	1173	29.37%	1147	91.24%	3.79%	148	4.97%	194
Feb-23	3528	22.79%	804	7.99%	282	27.38%	966	29.54%	1042	87.70%	5.33%	188	6.97%	246
YTD Running Total	40293	20.70%	8340	7.24%	2919	26.92%	10846	30.91%	12455	85.77%	5.38%	2168	8.85%	3565

Please note data presented is between 06/04/2022 – 28/02/2023 in line with national reporting guidelines

Approved Nurse Staffing Levels – Autumn 2022 (summary)

The nurse staffing level calculations undertaken during this reporting period (October 2021 – September 2022) identified a number of wards that require a change to their establishments with the overall proposed FTE changes summarised in the table below:

Integrated Health Community	Number of Act Wards	Funded Bed Numbers	Required Establishment at the start of the reporting period (October 2021)		Required Establishment at the end of the reporting period (September 2022)		Staffing FTE Changes during reporting period 2021-2022		Funded* Establishment (as at October 2022)		FTE Variance between current funded (October 2022) and required (September 2022)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YWM	14	327	268.83	208.52	277.14	219.9	8.31	11.38	272.68	178.8	4.46	41.1
YG	10	233	209.54	172.8	207.51	195.71	-2.03	22.91	196.46	138.62	11.05	57.09
YGC	13	310	276.53	238.53	261.51	253.56	-15.02	15.03	254.13	176.72	7.38	76.84
Oncology & Haematology**	2	39	N/A	N/A	33.3	31.27	33.3	31.27	33.61	26.74	-0.31	4.53
Womens Gynaecological**	1	14	N/A	N/A	11.37	5.69	11.37	5.69	11.93	6.32	-0.56	-0.63
Paediatric Inpatient Wards	3	64	83.46	31.27	83.46	31.27	0	0	79.47	30.37	3.99	0.9
BCUHB Total	**43**	**987**	**838.36**	**651.12**	**874.29**	**737.4**	**35.93**	**86.28**	**848.28**	**557.57**	**26.01**	**179.83**

*Funded establishment sourced from Finance Ledger
** Establishment in place pre meeting the definition pertaining to Section 25B
Note: The required and funded establishment figures exclude supernumerary ward sister/charge nurse and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requiring a change to nurse staffing levels

During this reporting period (October 2021 – September 2022) 23 wards requested changes to their establishments.

The summary of changes approved or unsupported following the review by the Executive Director of Nursing are summarised in the table below:

Integrated Health Community	Number of Act Wards	Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Adjustments Unsupported by Exec DoN	Comments
YWM	14	8	4	3	Bersham - a request to increase HCA staffing was not supported at this time, as acuity and quality indicators did not indicate a change was required. This request will be revisited in the Spring 2023 reviews. Morris - requested an increase in nurse staffing levels to support x 6 escalated beds. Change to establishment unsupported at this time and site HMT advised to submit a scheme to IMPT for the permanent funding of these beds. Pantomime - requested an increase in nurse staffing levels to support x 6 escalated beds. Change to establishment unsupported at this time and site HMT advised to submit a scheme to IMPT for the permanent funding of these beds.
YG	10	9	9	0	0
YGC	13	7	6	1	Ward 3 - a request to increase in RN staffing not supported at this time, as acuity and quality indicators did not indicate a change was required. This request will be revisited in the Spring 2023 reviews.
Oncology & Haematology	2	2	0	0	0
Womens Gynaecological	1	1	0	0	0
Paediatric Inpatient Wards	3	0	0	0	0
BCUHB Total	**43**	**23**	19	**4**	**0**

Approved Nurse Staffing Levels – Spring 2023 (summary)

The nurse staffing level calculations undertaken during this reporting period (October 2022 – March 2023) identified a number of wards that require a change to their establishments with the overall proposed FTE changes summarised in the table below:

Integrated Health Community	Number of Act Wards	Funded Bed Numbers	Unfunded Bed Numbers	Required Establishment at the start of the reporting period (October 2022)		Required Establishment at the end of the reporting period (March 2023)		Staffing FTE changes during reporting period (October 22 - March 23)		Funded* Establishment (as at March 2023)		FTE Variance between current funded and required (March 2023)	
				RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YMW	14	314	53	277.14	219.9	279.17	226.61	2.03	6.71	280.09	183.18	-0.92	43.43
YGC	13	310	12	261.51	253.56	261.51	254.98	0	1.42	249	176.72	12.51	78.26
YG	10	233	20	207.51	195.71	206.09	195.71	-1.42	0	196.46	139.05	9.63	56.66
Womens Gynaecological	3	31	6	33.87	19.79	33.87	21.9	0	2.11	33.57	15.74	0.3	6.16
Oncology & Haematology	2	38	2	33.3	31.27	33.3	31.27	0	0	33.61	26.74	-0.31	4.53
Paediatric Inpatient Wards	3	64	0	83.46	31.27	83.46	31.27	0	0	79.45	31.27	4.01	0
BCUHB Total	**45**	**990**	**93**	**896.79**	**751.5**	**897.4**	**761.74**	**0.61**	**10.24**	**872.18**	**572.7**	**25.22**	**189.04**

*Funded establishment sourced from Finance Ledger
Note: The required and funded establishment figures exclude supernumerary ward sister/charge nurse and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requiring a change to nurse staffing levels

During this reporting period (October 2022 – March 2023) 7 wards requested changes to their establishments.

The summary of changes approved or unsupported following the review by the Executive Director of Nursing are summarised in the table below:

Integrated Health Community	Number of Act Wards	Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Adjustments Unsupported by Exec DoN
YMW	14	4	4	0
YGC	13	1	1	0
YG	10	1	1	0
Womens Gynaecological	3	1	1	0
Oncology & Haematology	2	0	0	0
Paediatric Inpatient Wards	3	0	0	0
BCUHB Total	**45**	**7**	**7**	**0**

Example of Fully Approved Ward

Ward 1 YGC

Ward 1 is a 24 bedded COTE ward in Ysbyty Glan Clywd

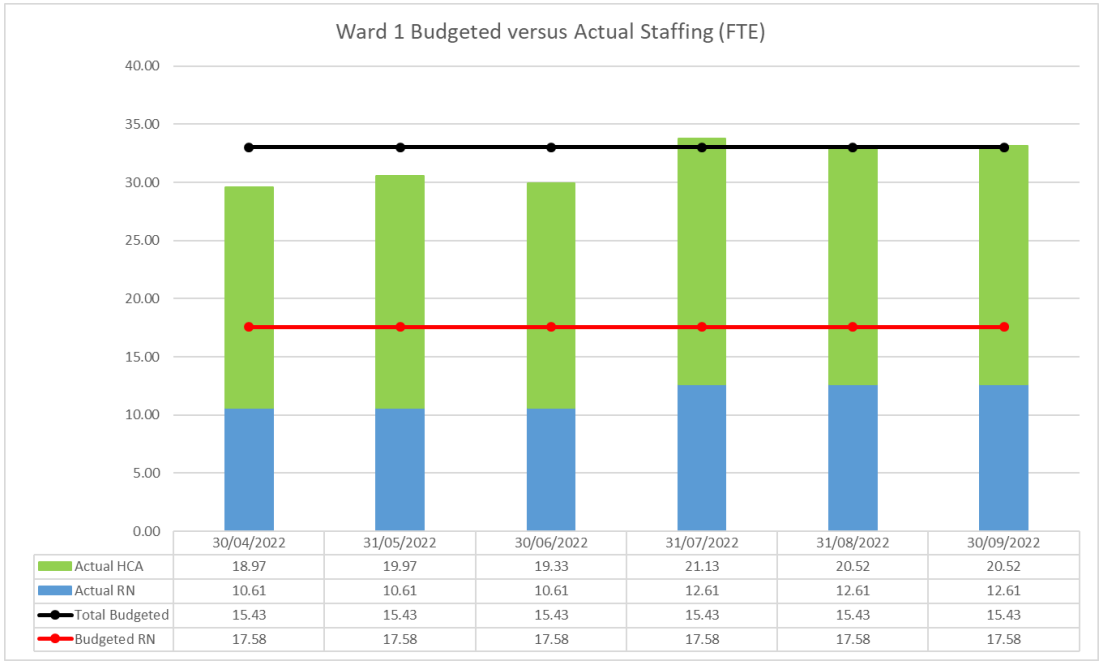
	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	4	4	4	4	0	1	3	3	Autumn 2022 review required an increase in HCA staffing during the day to support patient care acuity and harms profile.
Staffing agreed following Spring 2022 review	4	4	4	4	0	1	3	3	
Staffing requested at Autumn 2022 review	4	5	4	5	0	1	3	3	
Staffing agreed at end of reporting period (September 2022)	4	5	4	5	0	1	3	3	

During the staffing review it was established that the ward had RN vacancies, backfilled with HCA staff which meant that although overall vacancies were low there was an identified issue with skill mix on the ward. An action plan was in place regarding this which also included overseas nurses who were awaiting NMC PIN and currently working in Band 4 posts. Sickness absence on the ward was within BCU targets.

The ward had seen an increase in patient care acuity and also patient falls and were requesting additional HCA staffing during the day to support with this, having currently been utilising temporary staffing to support. On review the data and professional judgement supported the need for the increase in staffing to be agreed.

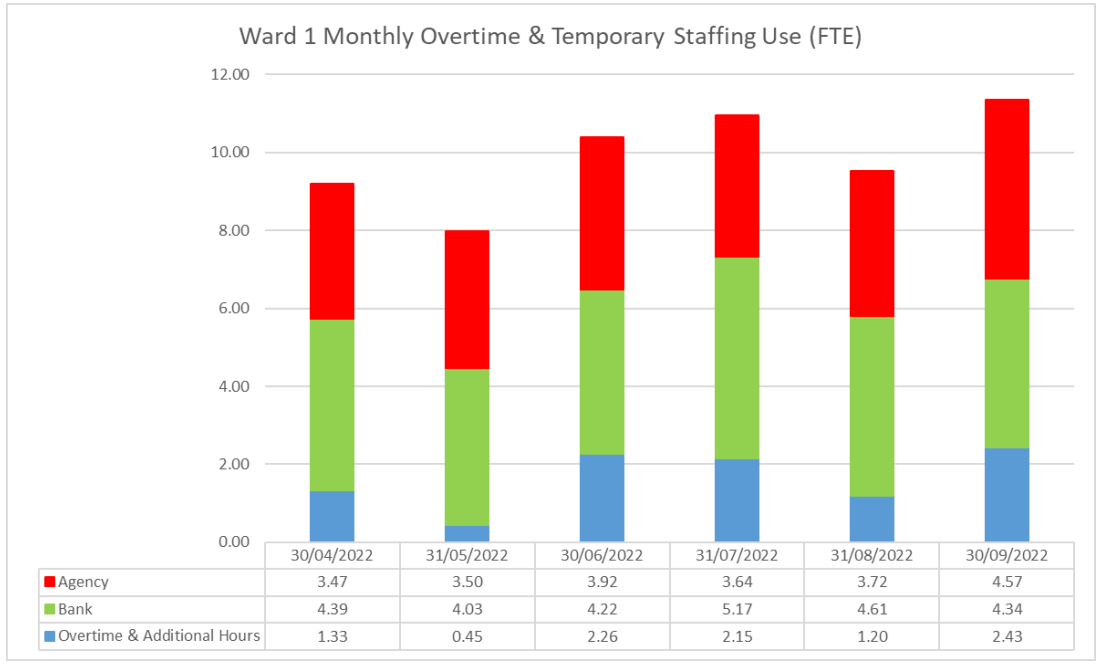
Ward 1 Staffing Data

Ward 1 staffing data demonstrates that the ward has significant RN vacancies over the months preceding the Autumn review, however overall staffing is in line with budget. Staffing reviews identified that a plan is in place regarding the skill mix.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	18.97	19.97	19.33	21.13	20.52	20.52
Actual RN	10.61	10.61	10.61	12.61	12.61	12.61
Total Budgeted	15.43	15.43	15.43	15.43	15.43	15.43
Budgeted RN	17.58	17.58	17.58	17.58	17.58	17.58

Ward 1 temporary staffing data demonstrates a sustained use in temporary staffing over the reporting period which is reflective of the need for additional staffing to meet increased patient acuity care needs.

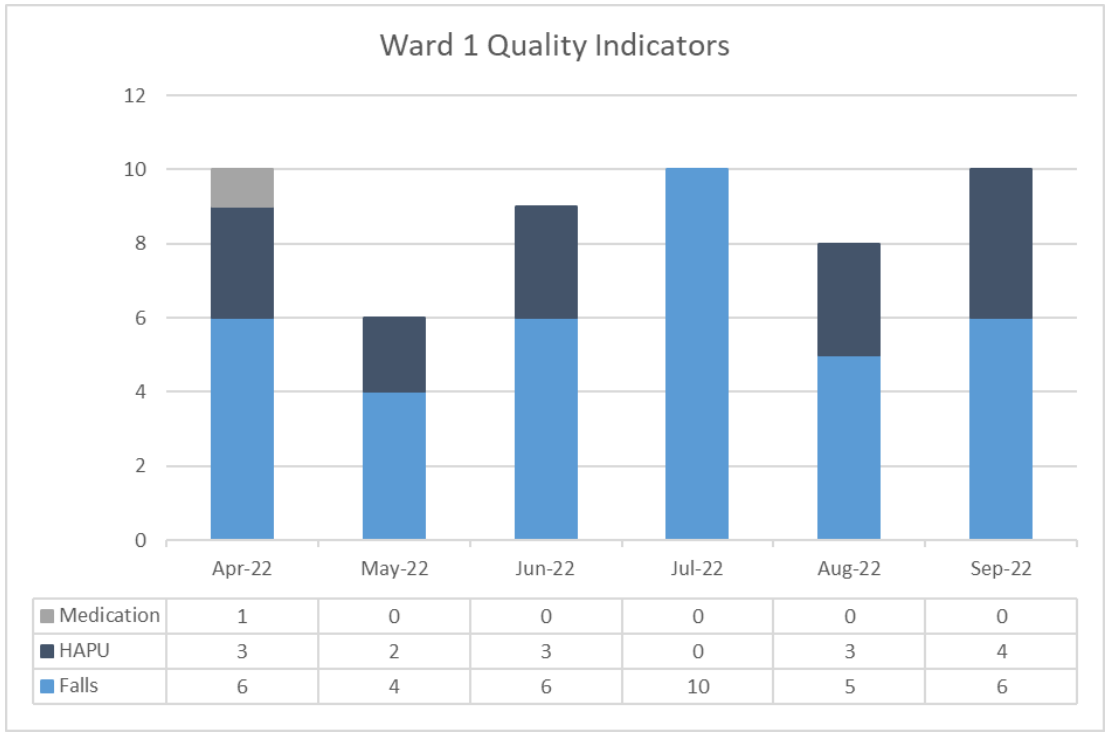


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	3.47	3.50	3.92	3.64	3.72	4.57
Bank	4.39	4.03	4.22	5.17	4.61	4.34
Overtime & Additional Hours	1.33	0.45	2.26	2.15	1.20	2.43

Data Source – WOD Workforce Dashboard

Ward 1 Patient Data

Ward 1 quality indicator data demonstrates a relatively consistent number of falls over the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	1	0	0	0	0	0
HAPU	3	2	3	0	3	4
Falls	6	4	6	10	5	6

Ward 1 acuity data evidences the reported increase in patient acuity with higher levels of patients requiring Level 5 (one to one care) with an average of 5 patients a day requiring the highest levels of care

Data Source – Datix & HCMS Systems

Example of Partially Approved Ward

Tryfan YG

Tryfan is a 24 bedded gastro ward in Ysbyty Gwynedd

	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	4	4	4	4	0	0	3	3	RN & HCA staffing had been adjusted during Spring 2022 review following a skill mix review and in response to harm profile to be Early 4/5 Late 4/5 Night 3/3. Further increase of HCAs requested in Autumn review due to patient care acuity and harm profile.
Staffing agreed following Spring 2022 review	4	5	4	5	0	0	3	3	
Staffing requested at Autumn 2022 review	4	6	4	6	0	0	3	3	
Staffing agreed at end of reporting period (September 2022)	4	5	4	5	0	0	3	3	

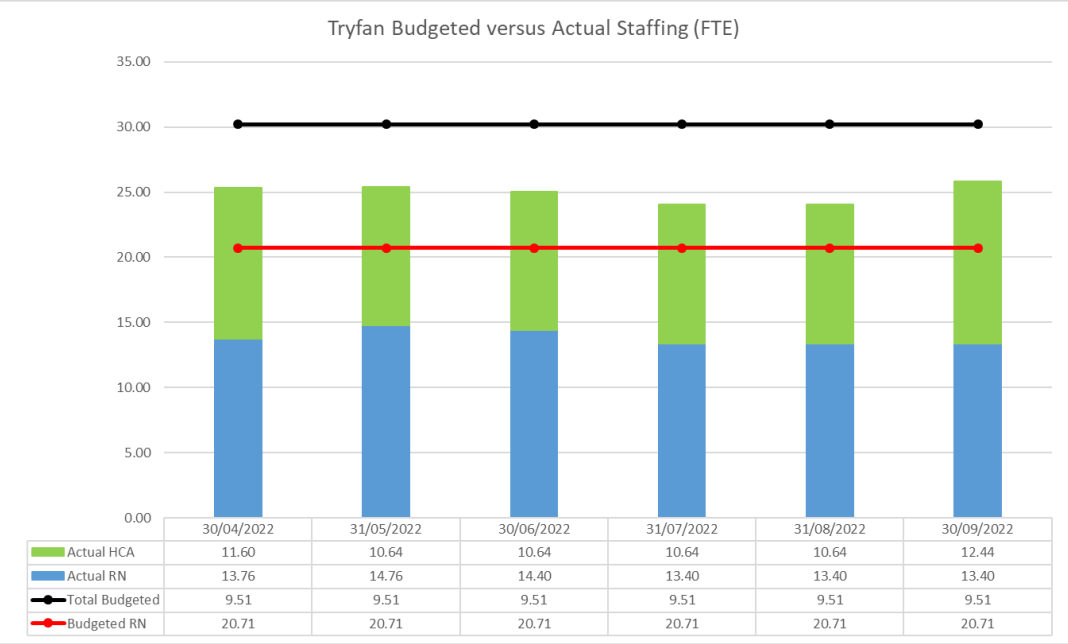
During the staffing review it was established that the ward had not achieved the increased staffing levels agreed during the Spring 2022 due to vacancies, absence levels and reliance on temporary staffing. A new Ward Manager had recently started in post and this was reported as beginning to bring some stability to the ward.

On review of the data and utilising professional judgement it was felt that the ward needed a further period of time to focus on staff recruitment and absence management and therefore the Spring 2022 staffing levels were deemed to be appropriate, with a further review due in Spring 2023.

The YG site has an ongoing improvement plan in place for Tryfan ward and will continue to monitor this.

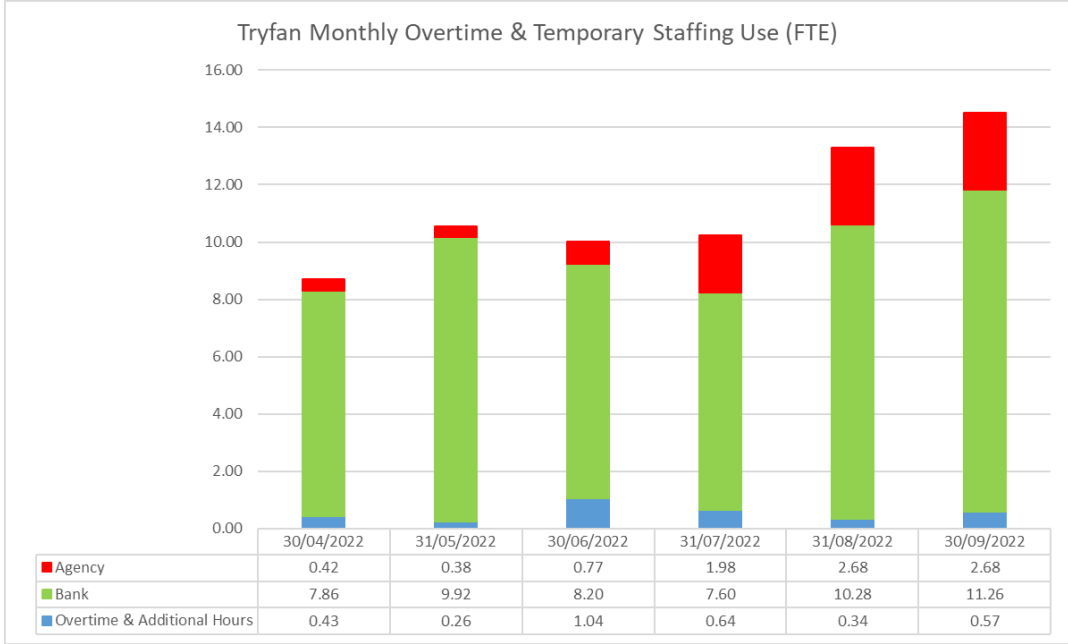
Tryfan Staffing Data

Tryfan ward staffing data demonstrates that the ward has a significant level of RN vacancies over the months prior to the Autumn review.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	11.60	10.64	10.64	10.64	10.64	12.44
Actual RN	13.76	14.76	14.40	13.40	13.40	13.40
Total Budgeted	9.51	9.51	9.51	9.51	9.51	9.51
Budgeted RN	20.71	20.71	20.71	20.71	20.71	20.71

Tryfan ward temporary staffing data demonstrates an increasing use of temporary staffing which is reflective of the vacancies within the ward.

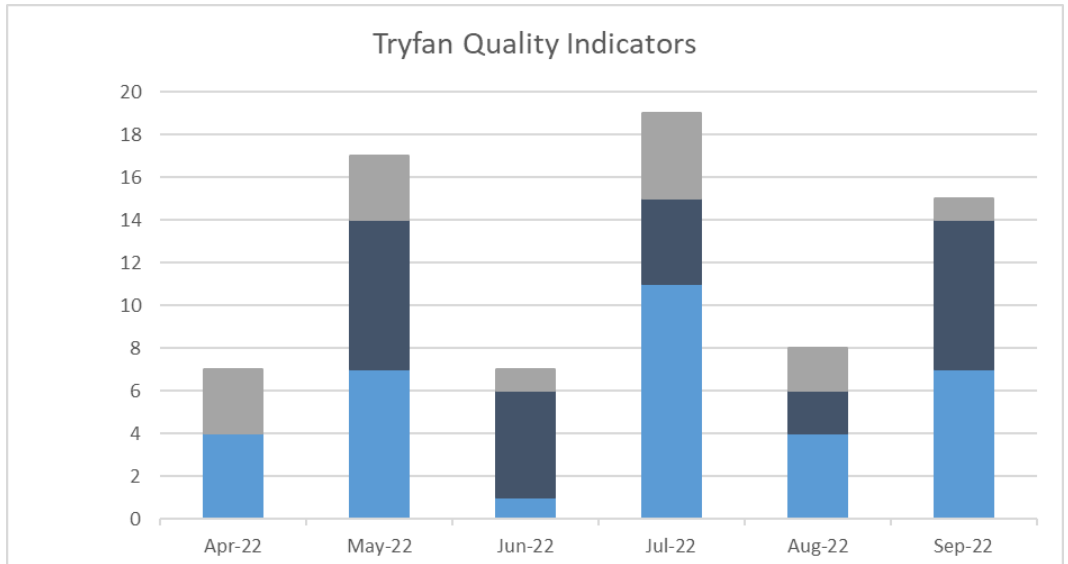


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	0.42	0.38	0.77	1.98	2.68	2.68
Bank	7.86	9.92	8.20	7.60	10.28	11.26
Overtime & Additional Hours	0.43	0.26	1.04	0.64	0.34	0.57

Data Source – WOD Workforce Dashboard

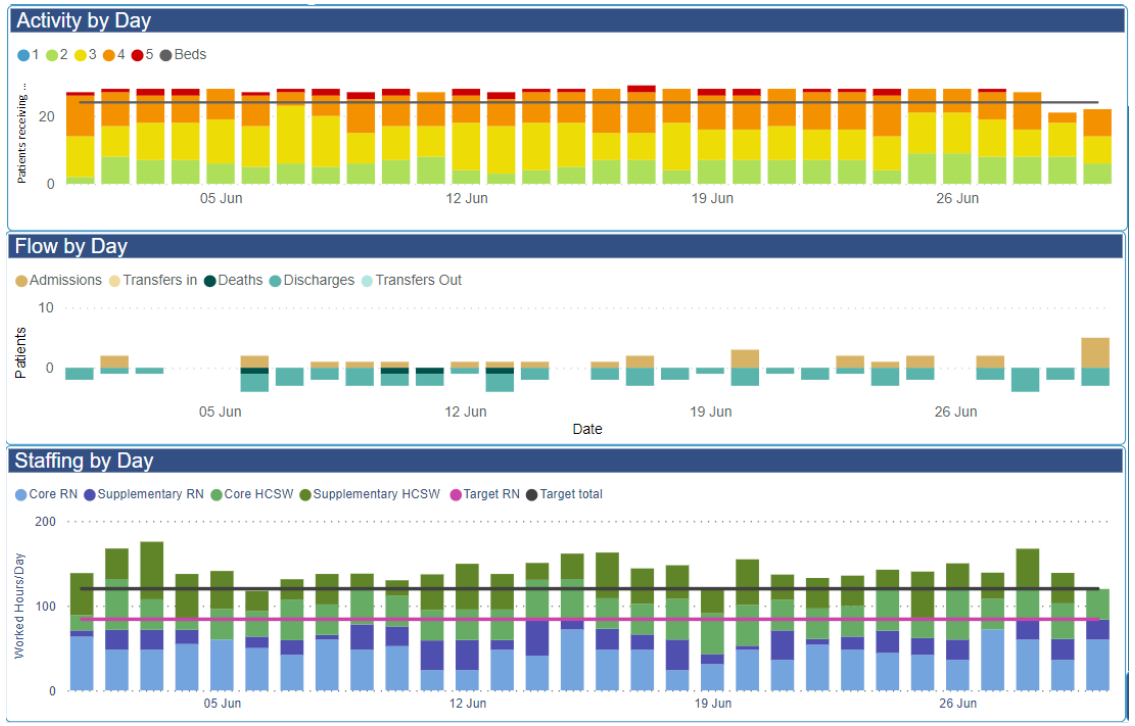
Tryfan Patient Data

Tryfan ward quality indicator data demonstrates a fluctuating number of incidents occurring throughout the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	3	3	1	4	2	1
HAPU	0	7	5	4	2	7
Falls	4	7	1	11	4	7

Tryfan ward acuity data shows the ward has high levels of patients at level 3 (complex care) & level 4 (urgent care)



Data Source – Datix and HCMS Systems

Example of Ward with changes unsupported at time of Autumn reviews

Bersham YMW

Bersham is a 27 bedded stroke ward in Ysbyty Maelor Wrexham, comprising of 10 acute and 17 rehabilitation beds.

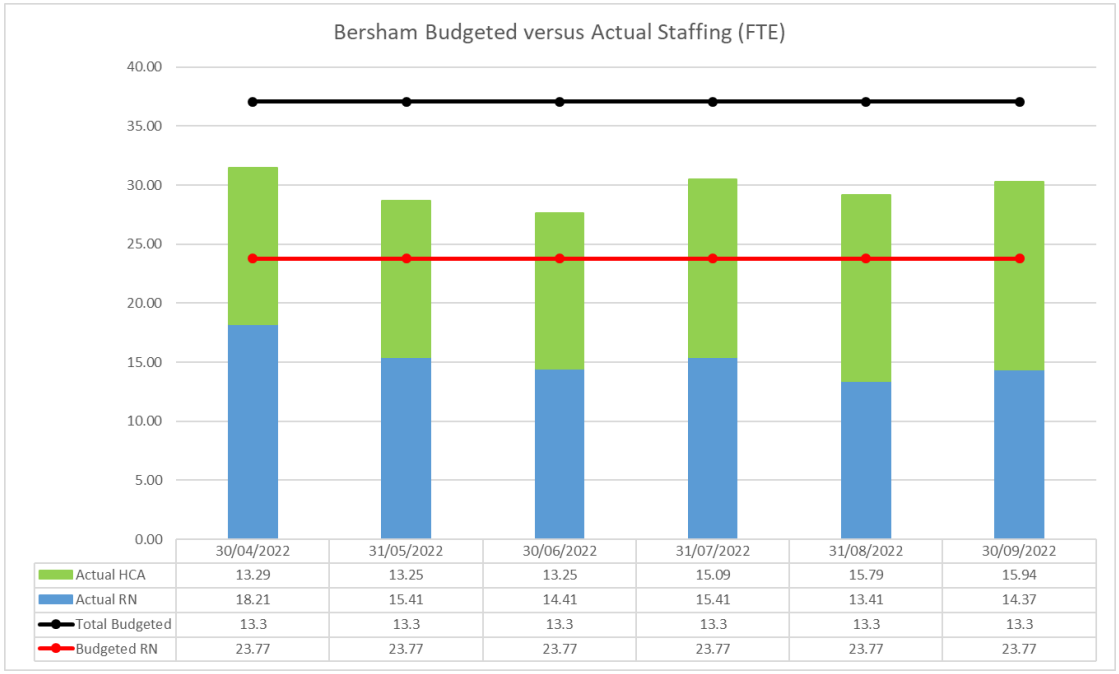
	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	5	3	5	3	0	0	4	2	Autumn 2022 review requested an increase in HCA staffing in response to harm profile
Staffing agreed following Spring 2022 review	5	3	5	3	0	0	4	2	
Staffing requested at Autumn 2022 review	5	4	5	4	0	0	4	3	
Staffing agreed at end of reporting period (September 2022)	5	3	5	3	0	0	4	2	

During the staffing review it was established that there were known issues with the ward leadership due to staffing changes and absences which had also resulted in recruitment & retention issues on the ward. The YMW site was supporting leadership; training and development of staff on the ward and there was also ongoing work relating to the BCU wide stroke services consultation process. The ward also benefits from high levels of MDT support.

On review of the data and utilising professional judgement it was agreed that the staffing levels of 5/3 5/3 4/2 were appropriate for the bed numbers (27) and comparable to the other stroke wards therefore at this time request for additional staffing was not approved. The site was advised to continue with the enhanced period of support, including falls quality work, monitor outcomes throughout and escalate issues as necessary. The ward will be reviewed further in Spring 2023.

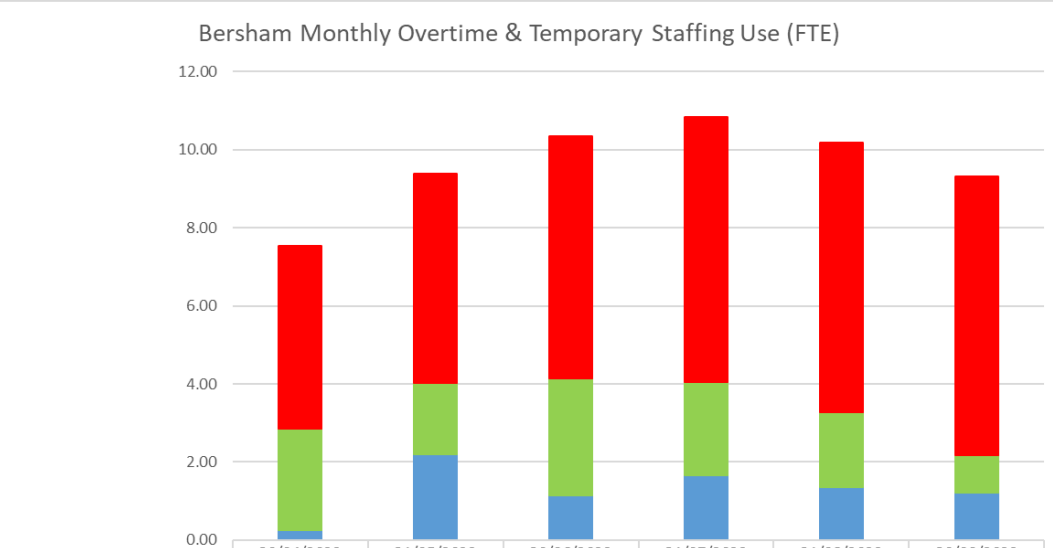
Bersham Staffing Data

Bersham ward staffing data demonstrates that the ward has a consistent and significant level of RN vacancies over the months prior to the Autumn review.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	13.29	13.25	13.25	15.09	15.79	15.94
Actual RN	18.21	15.41	14.41	15.41	13.41	14.37
Total Budgeted	13.3	13.3	13.3	13.3	13.3	13.3
Budgeted RN	23.77	23.77	23.77	23.77	23.77	23.77

Bersham ward temporary staffing data demonstrates a consistent and sustained use of temporary staffing which is reflective of the vacancies within the ward.

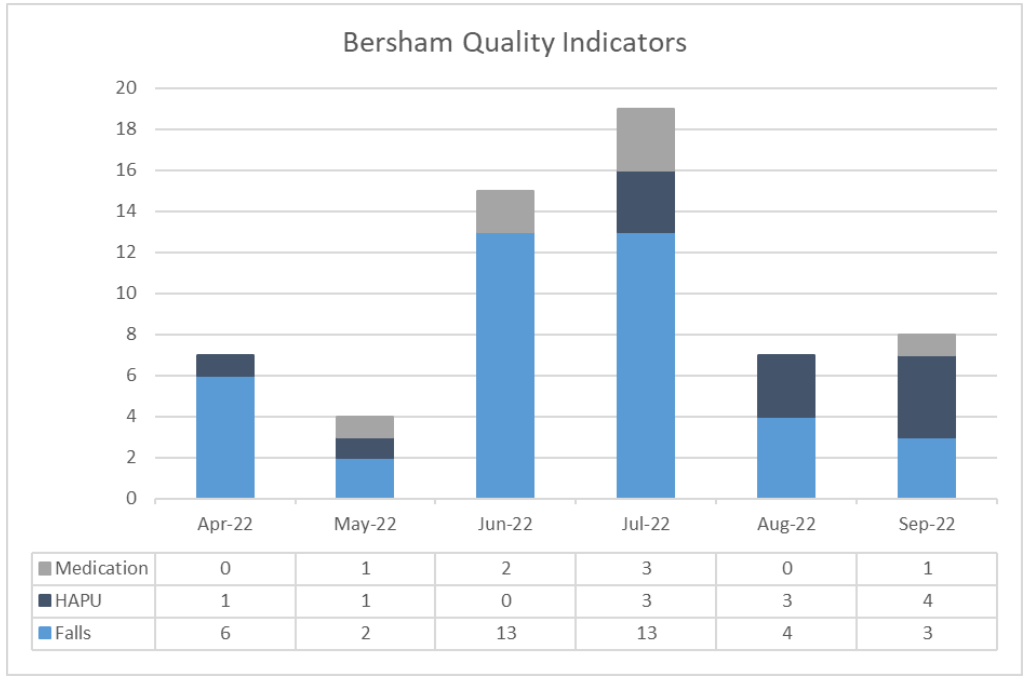


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	4.69	5.35	6.18	6.78	6.91	7.16
Bank	2.59	1.83	3.00	2.40	1.92	0.96
Overtime & Additional Hours	0.26	2.20	1.15	1.66	1.36	1.20

Data Source – WOD Workforce Dashboard

Bersham Patient Data

Bersham ward quality indicator data demonstrates a fluctuating number of incidents occurring throughout the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	0	1	2	3	0	1
HAPU	1	1	0	3	3	4
Falls	6	2	13	13	4	3

Bersham ward acuity data shows the ward has high levels of patients at level 4 (urgent care) with a significant number of patients requiring level 5 (one to one care).

Data Source – Datix and HCMS Systems

Diolch / Thank you

Any questions?