

## Bundle Quality, Safety & Experience Committee 25 July 2023

- 1 QS23/61 OPENING BUSINESS  
QS23.61 QSE Agenda 25.07.23 v.f
- 2 QS23/62 Welcome, Introductions & Apologies for Absence
- 3 QS23/63 Declarations of Interest
- 4 QS23/64 Minutes of Previous Meeting Held in Public for Accuracy and Action Log  
QS23.64a Draft QSE Minutes 22.06.23 v0.4  
QS23.64b Summary Action Log QSE Public – 25.07.23
- 5 QS23/65 QUALITY SAFETY AND IMPROVEMENT
- 6 QS23/66 Patient/Carer/Staff Story – learning  
QS23.66 Patient Story – My Vascular Story Final
- 7 QS23/67 Health & Safety Report  
QS23.67 July 2023 QSE Health and Safety Report (002)
- 8 QS23/68 Patient Safety Report  
QS23.68 Patient Safety Report for QSE July 2023 (002)
- 9 QS23/69 Mental Health Update  
QS23.69 MHL D QSE Report 20230717 VFINAL
- 10 QS23/70 IHC (East) Report  
*As required :*  
*Endorsing of Quality policies requiring Board approval*  
*Approval of quality policies for committee approval*  
*Twice yearly policy update status report*
- 11 QS23/71 SPECIAL MEASURES
- 12 QS23/72 Special Measures Report  
QS23.72 FINAL – 2023–07–25 – QSE Special Measures Update
- 13 QS23/73 CLOSING BUSINESS
- 14 QS23/74 Reflections on meeting
- 15 QS23/75 New Risks
- 16 QS23/76 Date of Next Meeting (22 August 2023) and draft agenda  
QS23.76 Draft QSE Agenda 22.08.23 v.1



## Agenda Quality Safety Experience Committee

**Date** 25 July 2023  
**Time** 12:00 -14:00  
**Location** Boardroom, Carlton Court, St Asaph  
**Chair** Rhian Watcyn Jones

Agenda item	Item	Lead	Action	Paper/Verbal
<b>1.0 OPENING ADMINISTRATION</b>				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report [2 mins]
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of the last meeting and action log	Chair	Decision	Paper [8 mins]
<b>2.0 QUALITY SAFETY AND IMPROVEMENT</b>				
2.1	Patient/Carer/Staff Story – learning	Executive Director of Nursing & Midwifery	Assurance	Paper [10 mins]
2.2	Health & Safety Report	Deputy Director of Workforce	Assurance	Paper [15 mins]
2.3	Patient Safety Report	Executive Director of Nursing & Midwifery	Assurance	Paper [15 mins]
2.4	Mental Health Update	Executive Director of Public Health	Assurance	Paper [15 mins]
2.5	IHC (East) Report	Director for IHC (East)	Assurance	Paper [15 mins]
<b>3.0 SPECIAL MEASURES</b>				
3.1	Special Measures Report	Director of Transformation and Improvement	Assurance	Paper [10 mins]
<b>4.0 CLOSING BUSINESS</b>				
4.1	Reflections on meeting	Chair	Information	Verbal
4.2	New Risks	Chair	Information	Verbal
4.3	Date of Next Meeting and agenda	Chair	Information	Paper [5 mins]



<b>MEMBERS</b>	
<b>Name</b>	<b>Title</b>
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
<b>In attendance</b>	
Jason Brannon	Deputy Director of Workforce
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Michelle Denwood	Director of Safeguarding & Public Protection
Dyfed Edwards	Independent Member/Health Board Chair
Gareth Evans	Acting Executive Director Therapies & Health Science
David Jenkins	Independent Advisor (observing)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation, Strategic Planning & Commissioning
Jane Wild	Associate Member of the HB/Chair of HPF
Angela Wood	Executive Director of Nursing & Midwifery

## Betsi Cadwaladr University Health Board

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

Present	
Name	Title
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member (part)
In attendance	
Jason Brannon	Deputy Director of Workforce
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Michelle Denwood	Director of Safeguarding & Public Protection (item QS23.44 only)
Dyfed Edwards	Independent Member/Health Board Chair (observing)
Gareth Evans	Acting Executive Director Therapies & Health Science
David Jenkins	Independent Advisor (observing)
Gavin Jones	Lead, Health & Wellbeing Intervention (item QS23.51 only)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation, Strategic Planning & Commissioning
Angela Wood	Executive Director of Nursing & Midwifery

Agenda item	Action
<b>OPENING BUSINESS</b>	
<b>QS23.37 Welcome introductions and apologies</b>	
<p>QS23.37.1 Rhian Watcyn Jones, Independent Member and Chair (Chair) of the Quality, Safety &amp; Experience (QSE) Committee welcomed everyone. She especially welcomed Clare Budden, (CB) Independent Member to her first meeting as a member.</p> <p>QS23.37.2 There were no apologies.</p>	
<b>QS23.38 Declarations of interest on current agenda</b>	
<p>QS23.38.1 There were no declarations of interest noted.</p>	
<b>QS23.39 Minutes of the last meeting and action log</b>	
<p>QS23.39.1 Angela Wood, (AW) Executive Director of Nursing confirmed that she had approved the minutes of the meeting held on the 20 January 2023 and Nick Lyons, (NL) Executive Medical Director, agreed that the actions accurately reflected what was discussed at the meeting. David</p>	



<p>Jenkins, (DJ) Independent Advisor stated that the Committee could take assurance from the Executives who were present at the meeting that the minutes in their view accurately reflected what was discussed and agreed. There was nothing contentious in the actions and on that basis the Committee approved the actions being implemented.</p> <p>QS23.39.2 The Chair asked for the minutes of the meeting held 19 May 2023 to capture more of the discussion as appropriate:</p> <ul style="list-style-type: none"> <li>• Patient Safety Report, incorporate primary care</li> <li>• Root causes and what is underneath and what we are doing</li> <li>• What is the timeline for the Quality Strategy?</li> <li>• Attitude and Behaviour behind complaints – a better understanding. How do we change ingrained attitudes?</li> </ul> <p>QS23.39.3 It was noted that Teresa Owen, (TO) Executive Director of Public Health and Jason Brannan, (JB) Deputy Director of Workforce had not received invitations to the last meeting.</p> <p>QS23.39.4 AW stated that she would review the draft minutes in future.</p> <p>QS23.39.5 The Chair requested that an action log be created to ensure actions were monitored.</p> <p>QS23.39.6 Papers should be brief with a clear purpose and ask from the Committee. Links to background information and full reports could be given to provide more context and detail. It is important that analysis of data leads to improvement activity and embedded learning and that these, along with timescales, are presented to Committee.</p>	<p>AW</p> <p>RC</p>
<p><b>QS23.40 QUALITY SAFETY AND IMPROVEMENT</b></p>	
<p><b>QS23.41 Explanation of Quality Governance - Process and Ownership</b></p>	
<p>QS23.41.1 The Chair asked for some clarity on the function of the QSE Committee and Phil Meakin, (PM) Interim Board Secretary quoted from the Terms of Reference which says ‘The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to the quality of services including clinical effectiveness, patient safety and patient and carer experience whether delivered directly or through a partnership arrangement, and health and safety issues’.</p> <p>QS23.41.2 Matt Joyes (MJ) Associate Director of Quality gave an overview of Quality Governance reporting in the organisation. Six groups report into QSE:</p> <ul style="list-style-type: none"> <li>• Quality Delivery Group chaired by AW, a senior level decision making group to which all the divisions</li> <li>• Safeguarding Group</li> <li>• Infection Prevention and Control Group</li> <li>• Health and Safety Group</li> </ul>	



<ul style="list-style-type: none"><li>• Clinical Effectiveness Group</li><li>• Patient and Carer Experience Group</li></ul> <p>QS23.41.3 The six groups all report upwards to QSE and are primarily there to provide the health board with coordination, oversight and direction when it comes to that particular domain. This provides quality assurance for each domain for the organisation.</p> <p>QS23.41.4 The IHC's, MHLD and Women's Services also each have a quality group and a reporting structure, which for an organisation of this size works well. However more work needs to be done on reporting in a more succinct way. A workshop to review is to be agreed.</p> <p>QS23.41.5 NL reported that the Quality Delivery Group the previous week had discussed reporting and risk. PM stated that as part of Special Measures, Welsh Government was reviewing the function of the Office of Board Secretary (OBS) including the meeting structure for the organisation. The report and recommendations were expected shortly and would be shared. PM agreed to develop a workshop for the Committee on Quality with the outputs from the OBS Review.</p>	<p>MJ</p> <p>PM</p>
<p><b>QS23.42 NICE Guidance Report</b></p> <p>QS23.42.1 NL introduced the NICE Guidance Report and noted that the cover sheet to the report was not the one he had approved. He stated the report did not give assurance that the organisation had implemented all NICE Guidance Report that applied to the organisation.</p> <p>QS23.42.2 The organisation has a statutory responsibility to disseminate, implement and monitor its compliance with NICE guidance. IHCs and the Specialised Clinical Services/Mental Health/Womens Health Divisions are responsible for assessing and incorporating NICE and National Guidance into their practice.</p> <p>QS23.42.3 The report gives oversight of where information is received and disseminated and a tool is being trialled in the organisation on monitoring implementation. It was noted that some NICE guidance does not apply to the Welsh NHS system only to NHS England.</p> <p>QS23.42.4 In response to a question from the Chair it was noted that 25% of NICE guidance would not apply to the organisation as other Welsh Government guidance supersedes it. NL responded to Mike Larvin (ML), Independent Member, that the organisation compared quite well with other Health Boards in Wales in its processes.</p> <p>QS23.42.5 AW reported that other organisations where she had worked had introduced the category of 'not applicable' to record more accurately against. NL noted that such a process had been implemented but there was not a past record of what had been followed. The team will review to</p>	





<p>QS23.43.5 The Committee received the report.</p>	
<p><b>QS23.44 Safeguarding Report</b></p> <p>QS23.44.1 Michelle Denwood, (MD) Director of Safeguarding &amp; Public Protection presented the Safeguarding Report which was taken as read.</p> <p>QS23.44.2 In response to a question on staff mandatory safeguarding training, it was noted that training is delivered in numerous ways to make it more accessible to staff. Some staff do mandatory training in their own time through e-learning and are compensated for that and this had increased compliance. The organisation is improving in this respect and areas of non-compliance can be targeted. However there were challenges which are being addressed.</p> <p>QS23.44.3 It was noted that this was an overview report and a six month more detailed report was due in greater detail. AW reported that a review earlier that year was very positive but staff training was an ongoing corporate issue. Gareth Evans (GE), Acting Executive Director Therapies &amp; Health Science noted that some staff were away on annual leave, maternity leave or sick leave so achieving 100% compliance might be unachievable. A check on how the compliance is calculated would clarify this.</p> <p>QS23.44.4 The Committee received the report.</p>	<p>MD/GE</p>
<p><b>QS23.45 Risk Report</b></p> <p>QS23.45.1 PM reported that the Risk Report had been circulated to the Committee prior to the meeting and was taken as read. There were two risks from the previous QSE Committee (pre-April 2023) regarding a deep dive of Vascular risks and this had been done. There was also an action regarding the development of a template which had been agreed at the Risk Management Group (RMG), The template ensures that all processes were completed which has been added to DATIX for monitoring purposes.</p> <p>QS23.45.2 NL confirmed that the two Vascular risks concerned the sustainability of the service and recruitment of staff. Consultants are now fully appointed and middle grade rota implemented. These risks can now be downgraded as they have been addressed.</p> <p>QS23.45.3 The Chair noted that work was underway to manage risk and refashion the Risk Register. The Health Board Development facilitated Workshop on the 22 June 2023 would be discussing and reviewing Risk Appetite for the organisation. The Risk Management Strategy would be circulated so that a Risk Appetite Statement could be agreed as part of Special Measures work. This would then be taken to the July Health Board meeting for approval.</p>	



QS23.45.4 The Committee noted the report.	
<b>QS23.46 Review of 111*2 service – withdrawn</b>	
QS23.46.1 TO reported that the request for a report was too short notice and a patient story on this topic would be at the next Health Board meeting.	
<b>QS23.47 SPECIAL MEASURES</b>	
<b>QS23.48 Special Measures Report</b>	
QS23.48.1 Chris Stockport, (CS) Executive Director of Transformation, Strategic Planning & Commissioning presented the report which was taken as read.	
QS23.48.2 It was noted that the organisation was in the first 90-day cycle approach of Special Measures and there were 41 deliverables. A proposal for 11 of the 41 to come to QSE for review to try not to duplicate across committees. This was the first Committee to review the report and proposals.	
QS23.48.3 The Chair noted that some deliverables had been allocated to Partnerships, People, Population and Health (PPPH) Committee which is not currently operating. It was agreed that these deliverables would be reviewed and reallocated.	
QS23.48.4 The Committee thought the report was useful and was comfortable with the approach. There was scope for adjustment as other Committees consider. Dyfed Edwards (DE) Independent Member/Health Board Chair stated that it was important that the Committee meeting dates aligned as much as possible with the most up to date information. PM agreed to take forward sequencing of information.	PM
QS23.48.5 The Committee received the report.	
<b>QS23.49 POLICIES</b>	
QS23.49.1 MJ stated that it was current practice to bring all clinical policies through QSE Committee for approval. He suggested delegating the approval to the relevant Executive Director to avoid a delay in approving policies. Any policies approved would be reported back to the Committee.	
QS23.49.2 PM agreed that this could be incorporated into the OBS review and planned workshop.	PM
<b>QS23.50 Clinical Audit Policy</b>	
QS23.50.1 The Committee noted the changes to the Clinical Audit Policy and agreed to delegate approval to the Executive Medical Director.	



<p><b>QS23.51 Smoke Free Policy for the Health Board</b></p> <p>QS23.51.1 The Committee noted the changes to the Smoke Free Policy for the Health Board and agreed to delegate approval to the Executive Director of Workforce and Organisational Development. It was noted that this would be taken to the Health Board meeting for approval on 22.06.23.</p> <p>QS23.51.2 CB wanted to highlight that the report stated that smoking was a lifestyle choice but the majority of people would say it was an addiction. She would be interested in finding out more about cultural work being undertaken to support staff and leadership approach.</p> <p>QS23.51.3 TO thanked everyone for their comments. Progress would be reported to Committee in due course.</p>	
<p><b>QS23.52 Restricted Items Policy</b></p> <p>QS23.52.1 The Committee noted the changes to the Restricted Items Policy and agreed to delegate approval to the Executive Director of Public Health and Mental Health and Learning Disabilities.</p>	
<p><b>QS23.53 Searching Patients &amp; their Property Policy</b></p> <p>QS23.53.1 The Committee noted the changes to the Searching Patients &amp; their Property Policy and agreed to delegate approval to the Executive Director of Public Health and Mental Health and Learning Disabilities.</p>	
<p><b>QS23.54 Restrictive Interactions Policy</b></p> <p>QS23.54.1 The Committee noted the changes to the Restrictive Interactions Policy and agreed to delegate approval to the Executive Director of Nursing and Midwifery.</p>	
<p><b>QS23.55 RP02: Non-Ionising Radiation Protection Policy v3</b></p> <p>QS23.55.1 The Committee noted the changes to the RP02: Non-Ionising Radiation Protection Policy v3 and agreed to delegate approval to the Executive Director of Therapies and Health Sciences.</p>	
<p><b>QS23.56 CLOSING BUSINESS</b></p>	
<p><b>QS23.57 Reflections on meeting</b></p> <p>QS23.57.1 There were no reflections on the meeting.</p>	
<p><b>QS23.58 New Risks</b></p> <p>QS23.58.1 There were no new risks identified during the meeting.</p>	
<p><b>QS23.59 Date of Next Meeting</b></p>	



QS23.59.1 The date of the next meeting to be agreed. Chair requested the Committee meet monthly for two hours, alternating between face-to-face meetings and virtual meetings. It was noted that this would be discussed at the agenda and forward work planning meeting the following week. This was supported by the Committee.

QS23.59.2 The Chair asked for face to face be held late morning or early afternoon if possible.

QS23.59.3 The Chair would like to hear more about the following as agenda items:

- Duty of Candour
- Three IHC's – how they feed in
- Mental Health
- Primary Care
- Community Care
- Partnership Working

**QS23.60 Exclusion of Press and Public**

BCUHB QUALITY, SAFETY & EXPERIENCE COMMITTEE - Summary Action Log Public Version					
	Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
1	MJ	<b>QS22.270 - Patient Story</b> MJ to clarify the funding for the patient falls work.	March	The falls car service in Flintshire and Wrexham has secured funding for five years and has now expanded from a four-day service to a seven-day service.	
2	PM	<b>QS22.272 Corporate Risk Register</b> PM to feed back into the RMG the discussions around policies identified in the paper not having been received at QSE and wider discussions on H&S policies plus the need for more clinical risks to feature	March	This was discussed at the QSE meeting on the 20 June 2023 and the review policies by committees are being as part of Governance review of Office of Board Secretary function and committee structures.	
3	SG/AW	<b>QS22.272 Corporate Risk Register</b> SG to feedback to the falls group around mandatory training being required to be undertaken by those who have no clinical contact.	March	<p><b>Update 09.01.23</b> - This competency has been added to all staff, including non-clinical staff, mandatory training records and the current compliance (December 2022) for Level 1A Prevention of Adult In-patient falls is 80.22% across BCUHB.</p> <p><i>[Feedback from meeting – the update does not answer the question]</i></p> <p><b>Update 11.07.23</b> - Compliance with the mandatory Falls E learning modules (1a and 1b) is currently 86%. The modules are under a planned evaluation to ensure guidance is up to date with the current evidence/practice. The Health Board has been commended by the all-Wales Inpatient Falls network who are recommending the BCU developed E learning</p>	

				modules are implemented by all Health Boards in Wales as the standard for E learning. Falls training continues as part of Module E patient handling refresher day or part of induction. Training covers the Falls and Bone health Multifactorial assessment tool and post fall protocol. All clinical staff are required to attend the Patient Handling session as part of the all-Wales Patient Handling Passport.	
4	NL	<b>QS22.280 – Human Tissue Act</b> Consider who should be the licence holder a HBLT member or an Executive.	March	David Fletcher, Associate Director, North Wales Managed Clinical Services is licence holder.	
5	NL	<b>QS23.05 - Patient Story</b> Ensure that the patient highlighted in the patient story was receiving the correct medication and support psychologically.	March	This was followed up with clinical team that are looking after patients care who confirmed that patient is receiving correct medication and psychological support.	
6	AW	<b>QS23.05 - Patient Story</b> Ensure that all patient stories 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.	March	The patient stories that are reviewed and collated by the Patient and Carer Experience and appropriate 'learning' stories will be brought to QSE.	
7	AW	<b>QS23.05 - Patient Story</b> Ensure that there is a year-end report received at QSE on Patient Stories.	September	Update - This will come to the September QSE meeting.	
8	RT	<b>QS23.06 - Corporate Risk Register</b> Review the Legionella risk rating.	March	This has been reviewed as part of work around the updated Corporate Risk Register.	
9	PM/RT	<b>QS23.06 - Corporate Risk Register</b> The Board Secretary and the Director of Estates to meet to identify what risks are in relation to capital	March	This has been reviewed as part of work around the updated Corporate Risk Register.	

		funding and report back to the committee.			
10	PM	<b>QS23.06 - Corporate Risk Register</b> Develop a consistent approach to risk and produce a template to track risks through meetings.	March	The Risk Register is being reviewed and has been agreed and discussed at Health Board	
11	PM	<b>QS23.06 - Corporate Risk Register</b> Vascular risks to be the focus of the next QSE Committee Risk deep dive	March	Vascular Services have been reviewed at now Health Board and are now	
12	PL	<b>QS23.08-Mental Health Outcomes and Improvement</b> Review the data source on page four of the report and the length of time that the work identified on page six was going to take.	March	An update on the divisional improvement plan was presented to the IQPD meeting on 11 July 2023. A report from MHL D is being presented to the 25 July 2023 meeting.	
13	PL	<b>QS23.08- Mental Health Outcomes and Improvement</b> To undertake a risk assessment on actions and notify the Committee if there are any concerns where deadlines would not be met.	March	An update on the divisional improvement plan was presented to the IQPD meeting on 11 July 2023. A report from MHL D is being presented to the 25 July 2023 meeting.	
14	MS	<b>QS23.08- Mental Health Outcomes and Improvement</b> Review the digital patient record system and ensure that all those who needed access to the system are able to access it.	March	A pilot is being led this year to consider if WCCiS is appropriate for inpatient MH records.  Suggest close	
15	JG	<b>QS23.10 - Vascular Improvement Plan</b> Email the Executive Medical Director the operational queries.	March	This has been discussed in detail at Health Board meetings on 30.03.23 and 25.05.23 and is now part of Special Measures reporting and monitoring.	

16	NL	<b>QS23.11 - Urology Improvement Plan</b> Identify a way of sharing conversations around procurement and the Urology HIW response.	March	The HIW report is expected on the 26 July 2023 and we can reopen in light of whatever that report recommends.	
17	AW	<b>QS23.39.4</b> AW stated that she would review the minutes before Chair	July	Action completed and on agenda.	
18	RC	<b>QS23.39.5</b> The Chair requested that an action log be created to ensure actions were monitored.	July	The action log has been updated and amended on agenda	
19	MJ	<b>QS23.41.5</b> The IHC's, MHL D and Women's Services also each have a quality group and a reporting structure. , which for an organisation of this size works well. However more work needs to be done on reporting in a more succinct way. A workshop to review is to be agreed.	July	A workshop took place on the 10 July 2023. As a result we will now undertake further engagement and work up a plan to improve the quality reporting through the structure.	
20	NL	<b>QS23.42.5 NICE Guidance Report</b> AW reported that other organisations where she had worked had introduced the category of 'not applicable' to record more accurately against. NL noted that such a process had been implemented but there was not a past record of what had been followed. A review once new software is being used will be carried out to incorporate where possible.		Update - The current process by spreadsheet does not note any guidance when "not applicable" (with comment from specialty). Going forward when the new software- Audit Management and Tracking (AMaT) is rolled out ( August) this will still be the process. The software will allow more detail to be captured if necessary as to why "not applicable" for future reference. Exec DPH met with Exec MD on 17.7.23 to talk through the PH NICE guidance approach. The Exec DPH shared a note prepared by a Consultant on Public Health detailing the current approach in place.	
21	NL	<b>QS23.42.9 NICE Guidance Report</b> NL to bring an update on NICE Guidance report to the Committee.		Next report to QSE will incorporate recommendations as above.	

22	MD/GE	<b>QS23.44.3 Safeguarding Report</b> It was noted that this was an overview report and a six month more detailed report was due in greater detail. AW reported that a review earlier that year was very positive but staff training was an ongoing corporate issue. Gareth Evans (GE), Acting Executive Director Therapies & Health Science noted that some staff were away on annual leave, maternity leave or sick leave so achieving 100% compliance might be unachievable. A check on how the compliance is calculated would clarify this.	July	Update – The safeguarding training target for compliance is 85% as some staff will be away on annual leave, maternity leave or sick leave so achieving 100% compliance would be unachievable for those very reasons.	
22	PM	<b>QS23.48.4 Special Measures Report</b> It was important that the Committee meeting dates aligned as much as possible with the most up to date information. PM agreed to take forward sequencing of information.	July	The sequencing of Special Measures reporting to committees and Board has been completed.	
24	PM	<b>QS23.49.2</b> Policies approval delegation. PM agreed that this could be incorporated into the OBS review and planned workshop.	August	This will take place next month	

RAG Status	
P	Complete
G	On track
A	Slippage on delivery
R	Delivery not on track

<b>Teitl adroddiad:</b> <i>Report title:</i>	Vascular Service Patient Story			
<b>Adrodd i:</b> <i>Report to:</i>	Quality Safety and Experience Committee (QSE)			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Tuesday, 25 July 2023			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	A patient story is presented to Quality Safety and Experience Committee (QSE) to bring the voice of the people we serve directly into the meeting. The digital story will be played at the meeting. A short summary is included in the attached paper.			
<b>Argymhellion:</b> <i>Recommendations:</i>	Quality Safety and Experience Committee (QSE) is asked to note this report.			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh, Head of Patient Experience Rachel Wright, Patient and Carer Experience Lead Manager			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>  Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>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:</b> <b><i>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:</i></b>				
In line with best practice, 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, 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.				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b><i>Link to Strategic Objective(s):</i></b>	Quality			
<b>Goblygiadau rheoleiddio a lleol:</b> <b><i>Regulatory and legal implications:</i></b>	N/A			
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b>	N/A			
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b>	N/A			



<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b> <i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i>	BAF21-10 - Listening and Learning
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <i>Financial implications as a result of implementing the recommendations</i>	N/A
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <i>Workforce implications as a result of implementing the recommendations</i>	N/A
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <i>Feedback, response, and follow up summary following consultation</i>	N/A
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b> <i>Reason for submission of report to confidential board (where relevant)</i>	N/A
<b>Camau Nesaf: Gweithredu argymhellion</b> <i>Next Steps: Implementation of recommendations</i> N/A	
<b>Rhestr o Atodiadau:</b>  <a href="#">Vascular Story Approved 2.mov</a> <b>List of Appendices:</b> Appendix A- Patient Story Summary	

## **Betsi Cadwaladr University Health Board Patient Story: My Vascular Story**

*A digital story told by Hugh will be played at the meeting.*

### **Overview of Patient Story**

Hugh has been an inpatient of three hospitals within BCUHB for the last three years, spending time as a patient in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Llandudno General Hospital.

A diabetic from the age of seven, Hugh has managed his condition for the last 68 years. Following a diagnosis of Chronic Osteomyelitis, increased infection of his foot and shinbone and not responding to antibiotic treatment, Hugh opted for a bi-lateral amputation of both legs below the knee as the only possible treatment plan to improve the situation.

Hugh describes his experiences as a patient within the Vascular Service, in particular with the Vascular Surgeons at Ysbyty Glan Clwyd.

Hugh praises the high level of 'excellent' nursing care across all three hospitals; Ysbyty Gwynedd, Ysbyty Glan Clwyd and Llandudno Hospital and feeling looked after 'superbly well' throughout his stay as an inpatient.

Hugh would like to share his story to express his deepest gratitude to the teams involved in his care and describes the positive impact of the surgery, hopefully leading to a 'pain-free existence' in the future. Hugh gave his story on the day of discharge and describes that "it will be lovely to get home" and start a new chapter.

### **Key Messages**

- Praise for BCUHB Vascular Services.
- An experience of a patient undergoing bi-lateral amputation of both legs below the knee and its impact on pains, phantom pains and use of painkillers.
- The positive impact of the surgery and the patient's recommendation of the surgery.
- Patient feels looked after 'superbly well' and describes 'magnificent' and 'excellent' nursing care, expressing deep gratitude for the care received.
- Patient describes good communication and felt involved in all aspects of care and treatments, with patient centred care at the heart of the service.

**Summary of Learning and Improvement** BCUHB Vascular Service has developed a Vascular Integrated Improvement Plan to measure improvement within the Vascular Service. As part of the Vascular Integrated Improvement Plan transformation work continues to improve patient pathways of care and overall patient experience.

## Pathway Redesign

Work has commenced on reviewing and updating the current written vascular and diabetic foot pathways. The diabetic foot pathway mapping process is in the process of being co-produced with involvement from multi-disciplines across all three sites and actions to address the gaps in service compared to National Institute for Clinical Excellence (NICE) guidance with a focus initially on the West Integrated Health Community. The diabetic foot pathway is a long-term transformation process and may take up to 12 months to complete. The management of diabetic patients with foot tissue loss, with or without infection, and unknown vascular status is in the process of being drafted into a standard operating procedure (SOP) and will include a pathway. The patient follow-up and discharge processes between hub and spoke sites is being considered through the transformation work and will cover processes, roles and responsibilities to design safer discharge between hospital sites and into the community.

To improve communication and engagement across the Vascular Service questionnaires have been developed for all staff groups to complete to identify positive elements of the vascular network and identify areas of improvement. Findings from the staff survey will identify how robust holistic planning for patient care is and what is required to strengthen it. The Vascular Service will also take into consideration feedback from patients who have completed a feedback survey as there are specific questions relating to involvement in care planning.

An amputation referral pathway has been developed in partnership with the Posture and Mobility Service (Artificial Limb and Appliance Centre (ALAC) and key stakeholders. This pathway will feed into the wider rehabilitation/repatriation pathway work and aims to provide a holistic approach much earlier in the patient journey. A SOP to support the amputation referral pathway has also been developed. The SOP also includes a redesigned patient referral form for prosthetic assessment pre/post amputation and a link to a Posture and Mobility Service patient feedback survey to ensure feedback is captured along the patient's journey.

The development of the pain management, psychology and therapy pathway has been established to support both vascular inpatient and outpatients. The pain management pathway transformation will meet 6-weekly with key stakeholders including; vascular, diabetes pharmacy, psychology, pain management, medical, nursing therapy and pre-operative teams. The pain management pathway includes, drug therapy, physical therapy, psychology and surgical intervention.

A diagnostic pathway is being developed to support avoiding unnecessary admission for a Ward 3 hospital bed in Ysbyty Glan Clwyd. This will recommend that urgent (non-emergency) patients who may require angioplasty will have their angiogram at the patient's local hospital first and if not urgent, as an out-patient.

## Patient and Carer Feedback

The Patient and Carer Experience Team are working with the Vascular Service across North Wales to increase patient and carer feedback by delivering patient and carer experience

awareness sessions using real-time scenarios to support the relevance and understanding for attendees.

SMS patient feedback survey delivery has commenced with the Civica feedback system sending surveys via text messages to patients who have attended a recent Vascular outpatient appointment. Trends and themes as well as statistics and satisfaction rates from the survey will be shared with the relevant staff members for their review and action where appropriate. Kiosks have been installed in our Outpatient Departments across North Wales to promote the collating of feedback using the same survey that is disseminated via the Civica system.

Ward teams work closely with the team to gather the views of patients and their families. The senior ward nurses provide opportunities for patients and their families to discuss patient care and make an appointment to see a doctor during the patient's stay.

PALS Officers provide support to patients and families on the ward for example; a PALS Officer visited a patient on the ward who was anxious about having her procedure and inpatient stay on Ward 3, at Ysbyty Glan Clwyd, due to previous experiences. PALS Officers have attended Ward 3 to help facilitate patient/family resolution on concerns they may have.

The team are currently working closely with Ward 3 to increase the number of completed feedback surveys recommending this is undertaken weekly. The team allocated Ward 3 an iPad and iPadstand to support the collection of patient feedback surveys and virtual visiting, with both Therapy and Nursing teams encouraging patients and families to complete. Vascular specific posters with QR codes that direct patients to the online all Wales real time feedback survey are now displayed around hospital bays to encourage patients to give feedback on their experience.

In addition a member of staff from Ward 3 is a Patient and Carer Champion. This role allows the member of staff to support the team to drive change and understand patient feedback. Patient and Carer Champions work closely with the Patient and Carer Experience Team by sharing information and engaging in patient feedback collection. Patient and carer champions are a point of contact to improve engagement between the team and clinical services.

Patient Stories continue to be collected with a Patient Stories Toolkit which supports and empowers staff to take Patient Stories themselves. Our Patient & Carer Experience Manager has also met with Site Specialty Management teams across BCUHB to highlight the work of the PALs Team with regards to how we can support patients, relatives and carers with enquiries relating to their hospital journey.

The Vascular Service and the Patient and Carer Experience Team are working with the Limbless Association who are a charity who provide support to amputees, and are signposting patients to the services.

The team will continue to provide guidance and support to the Vascular Service to help capture and learn from patient and carer experience.

The team will share this feedback and seek assurance from departments by way of evidence that learning has been embedded, and extend their gratitude and appreciation to Hugh for sharing his experience.



<b>Teitl adroddiad:</b> <i>Report title:</i>	Health and Safety report			
<b>Adrodd i:</b> <i>Report to:</i>	QSE			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Tuesday, 25 July 2023			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The report has been completed to provide a summary of key health, safety and security team activities for quarter one (Q1) and areas for escalation.			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Committee is asked to note the following:</p> <ul style="list-style-type: none"> <li>▪ The updated status of the current HSE investigations</li> <li>▪ The incidents reported to the HSE in Q1 under RIDDOR</li> <li>▪ Compliance with the Health and Safety Policy to undertake Corporate Health and Safety Reviews</li> <li>▪ Updates from the Face Fit Testing programme and Manual Handling Training programme</li> <li>▪ The recommendation to have a BCUHB risk register entry for Patient Restraint training</li> <li>▪ An update on the security business case</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Jason Brannan, Deputy Director of People			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Sue Morgan, Head of Health, Safety and Security			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau /	Rhannol <i>Partial</i> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence/evidence</i>

	<i>High level of confidence/evidence in the delivery of existing mechanisms/objectives</i>	amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<i>Some confidence / evidence in delivery of existing mechanisms/objectives</i>	<i>confidence in the delivery</i>
<p><b>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:</b></p> <p><i>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:</i></p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>		Improve the safety and quality of all services		
<b>Link to Strategic Objective(s):</b>				
<b>Goblygiadau rheoleiddio a lleol:</b>  <b>Regulatory and legal implications:</b>		Failure to comply with Health and Safety legislation can lead to an increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims.		
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b>		No, all policies and procedures have EQiA as part of the evaluation process		
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>		No, Health and Safety legislation does not directly relate to socio-economic duty.		
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>  <b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>		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.		
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b>  <b>Financial implications as a result of implementing the recommendations</b>		There is significant financial risk as it is anticipated that the possible prosecution of BCUHB will result in fines of between £1.5M and £6M		
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b>		Staff not trained in specific Health and Safety issues may result in ill health and injury to staff and patients		

<b>Workforce implications as a result of implementing the recommendations</b>	
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <b>Feedback, response, and follow-up summary following consultation</b>	This paper has yet to be reviewed by other groups.
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)  <b>Links to BAF risks:</b> (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.
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	Not applicable
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b>  <b>Next Steps:</b> <b>Implementation of recommendations</b>	
<b>Rhestr o Atodiadau:</b> Dim  <b>List of Appendices:</b> None	

## Health and Safety Update

The report has been completed to summarise key health and safety team activities and areas for escalation.

### 1.1 Health and Safety Executive

HSE investigation, Hergest Unit

A notification of contravention letter was received on 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 further letter was received on 15 March 2023 confirming the HSE's intention to take further enforcement on this matter, namely a prosecution case. A task and finish group led by the MHLD team has been working through a detailed action plan to comply with the breaches identified.

HSE Investigation, Patient Falls

The HSE is actively investigating two patient falls; in the CDU in Wrexham and Gogarth Ward, Ysbyty Gwynedd. A further patient fall remains an open investigation in Aran Ward, Ysbyty Gwynedd. The HSE has confirmed that they are also reviewing falls training completed by agency staff is in-line with the BCU falls policy. The temporary staffing team are investigating agency staff access and compliance.

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. The HSE has issued the Health Board with a Notification of Contravention letter, and a group has been set up to respond to the material breaches identified. Significant work has been undertaken since 2019 to monitor vibration exposure and to reduce the risk with a tools replacement programme. The Health Surveillance system is in place, and Estates are working with Occupational Health and Health and Safety to identify staff at risk. A response to the HSE is required by 27 July 2023.

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

In Q1 23/24, there have been eight reports submitted under RIDDOR. This includes four staff 'over seven days' related injuries with one fall, an assault and an impact injury. A staff-specified injury (fracture) was reported following an incident moving racking. There were two patient-related specified injuries reported 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 73 reviews completed in Q1 23/24. The reviews are scored, and these scores are shared with the relevant Divisions and the Health and Safety Leads forum.

### 1.4 Fit testing

The team continue to undertake audits to check that staff are wearing their badges with information on the respirator they should be using. This was agreed as an action following an HSE Notification of Contravention, and auditors have advised that they have been met with hostility in some areas. Additional communication on the continued importance of having a face fit test and wearing the identification badge will be sent out. Across the Health Board, 650 fit

tests were completed in Q1 23/24, with a further fifteen staff completed the training to be a fit tester.

### 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 to be escalated back to the Executive team if this is not available. As of May 2023, there were 4,365 staff not compliant with their patient handling refresher training on ESR. The Did Not Attend (DNA) rate at the end of June was 35%, significantly impacting the patient handling refresher training programme. The Health Board is currently showing as 56.55% compliant with this training. DNA's for patient handling foundation training for new starters is also high at 30%,

### 1.6 Personal Safety / Violence and Aggression (V&A)

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

The MHLD Physical Restraint Policy has been updated and ratified. This policy has been extended outside the Division to all staff where restraint may be used. It confirms that Managers will be responsible for ensuring their employees (including external employees) receive training. The current training programme is available for MHLD staff; however, no programme is in place to deliver this outside this Division. To undertake the train the trainer course, trainers need to have a health and social care qualification which is not required for the Personal Safety training team. This is recommended to be escalated onto the BCUHB risk register until a suitable clinical training programme is identified.

### 1.7 Security

The security advisory team have worked closely with the communications team to raise staff awareness and improve reporting. Improvements have been made to the Security and Personal Safety BetsiNet pages. Security awareness days planned on the DGH sites in July 2023 have commenced, with the first completed in Ysbyty Gwynedd on 12 July 2023. The police and SGC Security Management supported this event, and the feedback was positive. Two further events are planned in July, and the team will take this out onto community sites from September 2023. The security business case remains unresolved; a paper will be redrafted and submitted to the Executives. The CCTV policy requires IHC and Divisional Directors to complete a Standard Operating Procedure giving details of the staff authorised to view CCTV; this has only been returned to the Security Advisory Team by the East IHC to date.

## 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 in 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 with 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.

<b>Teitl adroddiad:</b> <b>Report title:</b>	Patient Safety Report			
<b>Adrodd i:</b> <b>Report to:</b>	Quality Safety and Experience Committee (QSE)			
<b>Dyddiad y Cyfarfod:</b> <b>Date of Meeting:</b>	Tuesday, 25 July 2023			
<b>Crynodeb Gweithredol:</b> <b>Executive Summary:</b>	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.			
<b>Argymhellion:</b> <b>Recommendations:</b>	The Committee is asked to receive this report.			
<b>Arweinydd Gweithredol:</b> <b>Executive Lead:</b>	Angela Wood, Executive Director of Nursing and Midwifery			
<b>Awdur yr Adroddiad:</b> <b>Report Author:</b>	Tracey Radcliffe, Head of Patient Safety			
<b>Pwrpas yr adroddiad:</b> <b>Purpose of report:</b>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <b>Assurance level:</b>	<b>Arwyddocaol</b> <i>Significant</i> <input type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input checked="" type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/>  Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>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:</b> <b><i>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:</i></b>				
<p>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.</p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b>Link to Strategic Objective(s):</b>	Quality			
<b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b>	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.			
<b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b> <b><i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i></b>	N/A			

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

## 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 May to June 2023, 40 notifications were submitted. Of these, 13 of the incidents were pre 1<sup>st</sup> April and have been awaiting a closure form to be completed following local harms review. The total number of NRI investigations that are overdue as of 07<sup>th</sup> July 2023 is 29 out of the 66 total open.

The NRIs reported during this period can be themed as follows:

Grade 3 or above Health Acquired Pressure Ulcer = 4

Falls resulting in harm = 5

Treatment/procedural issues = 7

The Deputy Executive 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 reporting themes:

### Falls - Key actions:

- Internal Audit are scheduling a review of the Health Board's compliance with Health Board Policy NU06 Falls Prevention and Management of Adult Inpatient Falls the scope of the review will include staff training, risk assessment completion and interventions and the Health Board governance and reporting arrangements for Inpatient falls;
- HSE currently investigating 2 Adult Inpatient falls from 2022;
- Updated Mandatory Falls E learning modules are with National ESR team awaiting uploading onto the ESR platform;
- ESR data cleanse completed;
- Draft generic Health Board Champions job descriptor and framework is currently being tested prior to launch and implementation in Q2;
- Risk ID 4562 -relates to accuracy and completion of the Falls and Bone Health Multifactorial Assessment for all Adult Inpatients this risk is for review by the Chair of the Strategic Inpatient Falls group, Patient Safety colleagues and Risk review group;
- Strategic Falls group will now be overseen and chaired by Patient Safety team.
- Falls champions job descriptor currently being developed; with bespoke training for falls champions role for implementation in Q2.

### Healthcare acquired pressure ulcers (HAPU) – key actions

- Welsh Nursing Care Record (WNCR) repositioning and skin assessment record launched Feb Strategic HAPU group to determine way forward with paper based Intentional rounding;
- SBAR submitted to Deputy Director of People outlining the benefits of making Tissue Viability training mandatory for Clinical Staff (currently it is optional or at manager discretion);
- Secondment post for HAPU lead (Matron) has been advertised interview scheduled for 14.07.23;

- Draft generic Health Board Champion role and framework currently being tested before Implementation in one area in IHC West for Tissue Viability Champion in preparation for implementation as part of the planned HARMS/HAPU Collaborative Autumn 23.

#### 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.

### **NEVER EVENTS**

Within the designated period, no Never Events have been reported.

It is positive to note a reduction in the last financial year of Never Events (from 10 to 5), and the reduction in theatre related incidents which suggests the extensive improvement work in theatre safety has had an impact.

### **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). There have been some issues identified from pathology reporting.

### **MATERNITY AND NEONATAL SAFETY PROGRAMME/PERIPREM WORK**

#### PeriPrem Cymru

PeriPrem (Perinatal Excellence to Reduce Injury in Premature Birth) was initially launched across the South West of England and South West Academic Health Science Network Regions in 2020. It is a unique perinatal care pathway of 10 evidence based interventions to reduce preterm mortality and brain injury. It uses a co-design and co-production approach rooted in Quality Improvement methodology. PeriPrem resources have since been used to inform the British Association of Perinatal Medicine (BAPM) perinatal optimisation pathway toolkits. PeriPrem Cymru Team comprises of a Quad National team and local quad Champion team embedded within each Health Board. The teams comprise of a Neonatologist, Obstetrician, Midwife and Neonatal Nurse. Baseline data from 2022 was collected by the local champions and inputted into a unique database. Since January 2023 the data is collected and inputted on a monthly basis by the champions to ensure that areas of excellence and improvements are highlighted.

#### Maternity and Neonatal Safety Support Programme

The Maternity and Neonatal Safety Support Programme's (MatNeo SSP) Discovery phase report has been published on the 11<sup>th</sup> July 2023. It outlines the path to improve the quality of care for mothers, babies and their families throughout the journey of new life in Wales. The key priorities and suggested actions are intended to promote collaborative working and support a creation of an improvement culture across NHS Wales. The key priorities for improvement are designed for actioning by Health Boards, other by individual agencies and some are system wide priorities with suggested time frames for completion. Some of the work is already underway which includes the work by Digital Maternity Cymru and HEIW workforce planning.

Welsh Government are currently deciding on the next steps for the programme and no formal announcement has been made yet. The MatNeo SSP team appreciate everyone's support and contributions during the Discovery phase.

## **LEARNING FROM NOSOCOMIAL COVID-19 REVIEWS**

A NNCP Learning Plan has been implemented in line with the National Programme with mechanisms to capture learning from Investigations, Scrutiny Panels, Families, Patients and Staff to be shared throughout BCUHB and to the NHS Executive Office for National Learning

### **Emerging themes from clinical investigations**

Poor/Incomplete Record Keeping  
Inadequate Social Distancing  
C19 Testing and Patient Status  
Coordination and Timely Care  
Movement of Patients  
Communication with Service Users and Between Services  
Effective use of PPE

### **Emerging themes form contact with families**

Communication  
Compassion care and Dignity (attitude)  
Patient Care (delays/failure to diagnose, delay in treatment)

### **Staff Feedback**

Recently shared the staff survey utilising Microsoft 365 on the BETSINet and ESR Carousel for 2 weeks periods over the period of June and July 2023

To date we have received 142 responses which demonstrates openness in the responses, this is still live therefore hasn't been coded and themed, approach shared at the NNCP Operational Group Meeting and the form has been requested by two health boards in a positive approach in capturing feedback.

### **Digital Story**

Over the autumn, a digital story will be presented by relative who sadly lost her mother during COVID to share her experience.

### **Planned work**

Capturing Feedback from patients via QR Code  
CIVICA National Survey

## **MEDICAL DEVICE REGULATIONS**

The 'Quick Start' collaboration with established expertise in Swansea Bay UHB was very successful. BCUHB now looking at a combination of further collaboration with Swansea Bay UHB and additional recruitment by BCUHB to manage the compliance journey efficiently and reliably. A paper will be presented to the executive team with a proposal for future development.

### Background

The UK is introducing new UK Medical Device Regulations (UK-MDR) to improve patient safety, and strengthen governance arrangements around medical devices. The Health Board has a legal duty to comply with the new requirements.

A clear Health Board management plan will be developed by the medical devices group to meet its emergent legal obligations and achieve and maintain the compliance required.

### Looking forward

Significant preparation is required including changing ways of working, and formal Quality Management Systems.

### Timetable

- Start time: The HB needs to start this work without delay to have a realistic chance of complying in time
- Duration: Fixed term – 2 years from start (arrangements needed for maintaining compliance long term)

Expertise in this area is likely to be in very short supply nationally.

- Fortunately the Health Board could rapidly access substantial expertise and experience by a collaboration with Swansea Bay UHB, combined with additional recruitment by BCUHB

## **ALL WALES MEDICAL EXAMINER SERVICE (MES)**

Since the establishment of the All Wales Medical Examiner Service (MES) in October 2020, there has been a huge growth and development in BCUHB around learning from mortality in the organisation with the explicit intention of improving care for the living.

A governance structure has been developed across the region to cascade learning and is currently being implemented in the newly established three Integrated Health Communities (IHC's). The focus is a monthly multi-disciplinary regional mortality meeting- the Learning from Mortality Panel (LFMP).

This provides a great opportunity to share learning from Medical Examiners Reports and inquests across the Health Board, present cases, or get a sounding board about particular issues prior to an Inquest. This opportunity requires enhancement which would be of great benefit. The LFMP has also developed a number of themes- DNACPR, Flow, End of Life etc. All have work streams, evidence and plans to improve care across BCUHB.

## **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.



<b>Teitl adroddiad:</b> <b>Report title:</b>	<b>Mental Health - Quality Safety and Experience</b>
<b>Adrodd i:</b> <b>Report to:</b>	BCUHB Quality, Safety and Experience Committee
<b>Dyddiad y Cyfarfod:</b> <b>Date of Meeting:</b>	Tuesday, 25 July 2023
<b>Crynodeb</b> <b>Gweithredol:</b>  <b>Executive Summary:</b>	<p><b>SUMMARY SECTION</b></p> <p>This paper provides a high level overview of the Quality, Safety and Experience issues in Adult Mental Health (as part of the Mental Health and Learning Disabilities - MHL- Division) for the new members of this Board Committee. Going forward the Division recommends the approach of “deep dive reporting” into subject areas to provide members greater clarity or assurances.</p> <p>Since the previous QSE reports from the division, progress has been made in the following key areas of the improvement plan.</p> <ul style="list-style-type: none"> <li>• There has been a “<b>key evidence review</b>” against the Divisional Improvement Plan (DIP) to ensure that the Division can check, challenge and demonstrate progress, including creation of a detailed evidence folder of improvement .</li> <li>• A <b>KPI dashboard</b> (for describing and presenting quality improvement) has been developed, to ensure that as a Division we are measuring progress in the 6 improvement work streams in the Divisional Improvement Plan.</li> <li>• The Division has delivered <b>engagement sessions with staff</b> across all areas to provide an overview of the improvement plan and encouraged contribution and feedback to the proposed measures, outcomes and dashboard creation for each of the 6 work streams in the improvement plan, namely -             <ul style="list-style-type: none"> <li>➤ Fundamentals of Care.</li> <li>➤ Leadership, Empowerment and Culture.</li> <li>➤ Safe and Effective Care.</li> <li>➤ Individual and Timely Care.</li> <li>➤ Environment, Resource and Workforce.</li> <li>➤ Audit, Outcome and Assurance.</li> </ul> </li> </ul> <p><b>UPDATE REPORT</b></p> <p>Updates on three areas of quality, safety and experience in Mental Health (adults) are described below:-</p> <p><b><u>Quality</u></b></p> <p>The division reports detailed and comparable quality data to the corporate Safety Groups for scrutiny and comparable reporting.</p> <p>There are two “Special Measure” deliverables from Welsh Government aligned to improving Mental Health Quality and Safety in the first 90 day cycle period:</p> <ul style="list-style-type: none"> <li>• The Mental Health Stocktake Review (further detail in this section), and</li> </ul>

- The National Commissioning Collaboration Unit (NCCU)/NHS Executive Inpatients Safety Review (see safety section below )

### **Mental Health Stocktake Review:-**

- Welsh Government have commissioned the Royal College of Psychiatry to undertake this task. This work is split into three phases -
  - Phase 1 includes a Mental Health review of progress made on the recommendations aligned to the Holden, Ockenden and HASCAS reports.
  - Phase 2 will include interviews with key stakeholders.
  - Phase 3 will involve site visits across MH&LD services.

### **Achievements at this stage -**

- A divisional lead has been identified aligned to Mental Health Stocktake Review.
- Weekly meetings are established between the divisional lead and the Royal College of Psychiatry lead.
- An initial draft report of review progress made on recommendations from the Holden report was submitted to the Royal College of Psychiatrists (16 June 2023), and an initial draft iteration report of review progress made on recommendations from the Ockenden report was submitted (7 July 2023).

The Betsi Cadwaladr University Health Board (BCUHB) **111\*2 crisis line** service for Mental Health commenced successfully in January 2023, with the aim of improved access to the right care at the right time in the right place by streamlining pathways into a range of mental health services. This new national 24hr service also aims to reduce the number of people using emergency services and unnecessarily attending Accident and Emergency Departments in a mental health crisis by improving access to support in the community. Data for 111\*2 is captured and collected in this programme. Early analysis of the data shows a positive impact on both the quality and timeliness of response for patients.

There has been ongoing activity aligned to the “**Just R**” **marketing and recruitment campaign** for staffing in MH&LD which has increased appointments to the MH&LD talent pool. There has been a “deep dive analysis” on vacancies in May 2023 by the Division which informed the development of a specific Recruitment and Retention plan. The Division is actively involved in the Boards’ processes for international recruitment for Health Care professionals and during the w/c 9/7/23, attended the Royal College of Psychiatrists convention to raise the profile of BCUHB the Division and also to attract and recruit key senior and junior doctors.

Staffing vacancies remains a pressure across all areas of the division especially for Nursing and Medical Registrants and recruitment and retention remains a focus for the Division.

### **Safety**

As part of the **Special Measures escalation** and for further assurance following the Health and Safety Notice of Prosecution the National Commissioning Collaboration Unit (NCCU) and NHS Executive was asked to report on in-patient safety in MH&LD.

The report was received in June 2023, following an inspection of all MH&LD Inpatient units during April and May 2023.

In the NCCU/NHS Executive report, the key message noted -

*“...the review found that a number of actions had been undertaken to improve the safety of inpatient services and across the locality areas. There were processes of escalation in place such as putting things right meetings that were consistently described and replicated across service areas and the Division”.*

It also found however-

*“There are a high number of staff vacancies across the inpatient services, with temporary (bank and agency) staff used regularly. There were examples given where temporary staff were unfamiliar with some of the health board policies and procedures or did not have suitable training to manage patient care such as safe hold techniques”*

The NCCU/NHS Executive report makes eight recommendations aligned to the key findings. The division has responded and established an Inpatient Safety Delivery Group to progress the development of an action plan. An initial meeting was held on 12/7/23 to develop draft Terms of Reference, including the group membership. Progress on this action plan will be reported through the Divisional Governance Framework and also weekly through the Special Measures reporting process

Pan-divisional learning events are now planned to occur quarterly. In May 2023 the Division held a Learning Event as part of its safety and quality improvements, to launch key policies and share good practice. The next event is planned for early September 2023, with the theme **“Improving the physical health of our patients”**. This event concurs with the Health Boards and Welsh Governments strategies to ensure parity of service, and health to those with a mental illness or Learning Disability (Together for Mental Health North Wales). The NCCU have been invited and have accepted to provide high level feedback directly to staff on the findings from the above inspection / In-Patient Safety report within this learning event.

With regards to physical health monitoring, a Task and Finish Group has been stood up to take forward how we address planned physical health monitoring in Mental Health. This Consultant led Physical Health group reports progress to the Divisional Service Quality Delivery Group. The purpose of this group is to ensure that physical health care monitoring is as important as the mental health care provided.

The **National Early Warning Score (NEWS)** is in use across the Division alongside a Divisional action plan developing closer links to the Acute Intervention Teams (AIT's) located at the IHC's. This will deliver timely care to physically deteriorating patients with engagement across our Health Board to improve patient Quality Safety and Experience outcomes in the event of acute medical urgency.

Following a Rapid Learning Panel and subsequent “Make it safe” processes, regarding a serious incident in 2022, the team in the Heddfan unit embedded the learning from this incident resulting in the establishment of a **Physical Health Suite**. The Physical Health Suite is located in Heddfan Unit with a Standard Operating Procedure (SOP) developed jointly with the East area AIT. This provides a safe space for acutely medically declining patients to be better treated by the AIT team and reduces the likelihood of the patient attending Wrexham Maelor Hospital. This learning cycle and action is being shared in the next learning event as a potential practical model for other areas in MH&LD and Integrated Health Communities (IHC's).

The Division received a **Notice of Contravention (NOC)** from the Health and Safety Executive (HSE) and a subsequent notice of prosecution for breaches of Health and Safety law relating to the death of an in-patient in 2021. The Division is focussed on the delivery of the 45 point action plan planned to remedy the above breaches. 44 actions have been completed, one remaining long term action is

progressing with the introduction a digital patient record. The concept of using WCCIS (the Welsh National IT project - Welsh Community Care Information System) is being piloted in the MH&LD community during 2023, to test the concept with a view to extending this to in-patient care.

The Divisions HSE NOC Improvement Delivery Group is now re-auditing prior completed actions, to assure itself of sustained learning and change for patients as a result of addressing these contraventions.

The MH&LD Division Senior Leadership has 100% attendance on the IOSH “**leading safely course**” recently facilitated by Health and Safety partners aimed at all senior Health Board staff.

The Division has invested in adopting the WARRN (**Wales Applied Risk Research Network**) training for staff to support us to comply with the all Wales approach to managing inpatient suicide risk. This training was made mandatory by the Division for 961 roles in December 2022 with an 85% mandatory level expectation. The final stages for adapting this change is being done jointly with the corporate ESR team and is planned to be “live” in ESR by the end of July 2023. Once fully electronic reporting is accomplished then effective reporting against the mandatory standard (85%) will be achieved. So the committee may understand the scope of this investment, 734 divisional staff have completed this 2 day training or a refresher by 4<sup>th</sup> July 2023. Only just over 200 in total had been trained in the 12 years from 2011-2023, we now have a planned trajectory to achieve full compliance by Mid-August 2023. This investment will contribute to a material improvement of patient safety by ensuring robust risk formulation by whole teams. Audit of its (WARRN) impact on care and treatment planning and patient safety planning is in progress.

### Experience

**Mixed co-horting** of adult and older adult patients in the Hergest unit ended as an urgent safety and patient experience issue in February 2022, with this patient cohort routine admissions now being into the East and Centre in-patient units. There have been no formal concerns raised about the impact of this from patients or their families that have not been able to be explained or resolved locally. There are exceptions and processes agreed for admission to Hergest in exceptional risk assessed circumstances, which number seven since February 2022. The Nurse Director and Heads of Nursing have frequently met and talked with patients from the West area who have been admitted into East and Centre areas wards. During walkabouts in the Heddfan unit in the east area, patients reported that they appreciated the modern environment and the kindness of the staff supporting them.

The **Therapeutic Engagement and Observation policy** was rewritten and relaunched following feedback, including our patient experience forums.

The MH&LD Division in its pursuit to drive service improvement, quality care and to give service users / patients and their significant others a voice, holds a bi-monthly **Patient and Carer Experience (PCE) Group**. Membership of this group includes the Divisional Senior Leadership Team, local SLT, organisational Patient Experience and Carers Service, Caniad, and other third sector services that promote the experience of patients, including those with Dementia/Alzheimer’s for example.

The Group receives updates from the Corporate PCE meeting including assurance reports from both Caniad, in relation to iCan activity, Big Chats, the co-occurring pathway, support for farming communities, Quality Governance Team complaints and incident activity, Ombudsman, and compliments. The Division is progressing its engagement with the Health Boards strategic approaches, for instance ‘*Civica*’, to

	<p>further strengthen corporate alignment and most importantly to capture feedback for planning activity. Alongside this, the new 'Greatix' system is in place and staff are being recognised where they have gone the extra mile to improve patient/carer experiences.</p> <p>With regard to compliance with "Putting Things Right" (PTR) processes there has been a significant improvement in the timeliness of responses with breaches reducing from 22 in June 2023 to 13 in July 2023. This has been achieved by a sustained effort to reduce unresolved complaints, some of which had been open for a considerable amount of time.</p> <p><b>Proposed Deep Dive areas:</b></p> <p>It is proposed that going forward the Division provides more focused updates aligned to progress made in the Improvement Plan within the 6 individual work streams. It is recommended that updates for two out of the six work streams are presented at the next three consecutive QSE Committee meetings, commencing in September 2023 with the Fundamentals of Care and Safe and Effective Care.</p>			
<p><b>Argymhellion: Recommendations:</b></p>	<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>• Note the contents of this report in relation to Mental Health and Learning Disabilities, Quality Safety and Experience and the Divisions commitment to the continuation of its (Adult mental Health)improvement journey</li> <li>• Acknowledge the challenge to the Division of on-going staffing recruitment issues and its potential impact on Quality and experience, described in the NCCU in-patient safety review noting its recruitment and retention approaches and international recruitment planned.</li> <li>• The Committee is asked to consider the proposal to receive deep dive reports to any areas where further assurance is required on the Quality Safety or Experience of MH (and also LD services) or direct any further reporting needed from MHLD division.</li> </ul>			
<p><b>Arweinydd Gweithredol: Executive Lead:</b></p>	<p>Teresa Owen, Executive Director of Public Health (and Executive Lead for MH&amp;LD)</p>			
<p><b>Awdur yr Adroddiad: Report Author:</b></p>	<p>Carole Evanson, MH&amp;LD Divisional Director of Operations Mike Smith, Interim MHLD Divisional Director of Nursing Adrienne Jones, MH&amp;LD Operational Business Lead</p>			
<p><b>Pwrpas adroddiad: Purpose of report:</b></p>	<p>I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i> <input type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i> <input type="checkbox"/></p>	
<p><b>Lefel sicrwydd: Assurance level:</b></p>	<p>Arwyddocaol <i>Significant</i> <input type="checkbox"/> <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i> <input type="checkbox"/> <i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i> <input checked="" type="checkbox"/> <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <i>No confidence / evidence in delivery</i></p>
<p><b>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:</b></p> <p><b><i>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:</i></b></p>				

- This Divisional Improvement Plan applies improvement methodology to assure the improvement in its quality safety and experience streams of work.
- The Plan has been constructed in collaboration with involvement of key stakeholders from “Ward to Board” and is owned by the Division. Evidence based approaches to improvement and programme management have been adopted throughout.
- As the Division is currently in Phase 1 of the plan and continuing to establish and mobilise a robust, evidence based and comprehensive Divisional Improvement an assurance score of ‘Partial’ has therefore been made. It is anticipated that there will be progress in delivery of the plan and that assurance will move to an acceptable level by Quarter 3 of 2023 and into 2024.

**Cyswllt ag Amcan/Amcanion Strategol:**

***Link to Strategic Objective(s):***

The strategic implications of the Divisional work streams relate to the following:

- Priorities within “A Healthier Wales: long term plan for health and social care”
- Together for Mental Health North Wales Strategy
- North Wales Learning Disabilities Strategy
- Alignment with the BCUHB Integrated Medium Long-term Plan
- Supports delivery against Targeted Intervention requirements
- Aligned with the Divisional Clinical Strategy/Clinical Effectiveness
- Supports integration agenda and aligns with BCUHB Operating Model
- Linkages with delivery of the Digital Strategy
- Covid-19 response and recovery
- Strengthen our wellbeing focus
- Recovering access to timely planned care pathways
- Improved Unscheduled Care Pathways
- Integration and targeted improvement of mental health services
- BCU Estates Strategy
- People Stronger Together Strategy
- Mental Health Measure Standards

**Goblygiadau rheoleiddio a lleol:**

***Regulatory and legal implications:***

There is a contravention of Health and Safety Legislation, with a Notice of Contravention formally received in May 2022 from the Health and Safety Executive to the Health Board and a subsequent prosecution of the Board on these charges in August 2024.

The MH&LD Division has planned to meet the requirements to remedy the contravention of law and has completed 44 out of 45 initial actions to improve patient safety related to the 3 areas of breach, all of which form part of the overarching Divisional Improvement Plan to ensure sustained and embedded learning and service change.

<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>EQIA impacts are considered in any of the necessary policy changes and adaptations.</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>SEIA impacts are considered in any of the necessary policy changes and adaptations.</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>	<p>Two tier 1 risks relate to this paper:</p> <ol style="list-style-type: none"> <li>1. Tier 1 risk 3929 - risk to patient safety from ligature.</li> <li>2. Tier 1 risk 4443 - risk of prosecution from the HSE.</li> </ol>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The financial impact of the actions taken in meeting the Notice of Contravention are ongoing (revenue and capital). They are not fully identified at this stage as they remain dynamic, but cost to date is known.</p> <p>The financial impact of the prosecution by the HSE and the guidance for fines, if guilty, are understood by the Health Board</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>There remains a high number of vacancies across the Division which could potentially impact on primarily patient experience but also the, the improvement plan and the embedding of the NOC actions. These could potentially impact upon the Division's delivery of the improvement plan outlined in this paper.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>The report has been reviewed internally by senior leadership members.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable</p>
<p><b>Camau Nesaf: Gweithredu argymhellion</b></p> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>• To continue to progress data capture and reporting which informs the outcome measures of the improvements and assurance of progression.</li> <li>• To continue evidence capture utilising the previously agreed Targeted Interventions mechanism now also aligned to the special measures reporting where of course Safety Quality and Experience are evident.</li> </ul>	

- To develop the wider engagement plan for the improvement and transformation within MH&LD, for sharing, discussing and engaging with the improvements for all staff in the complex scope of delivery of mental health, learning disability and specialist services across the whole of the Health Board. The engagement plan will be developed and the end of Q3 2023/2024, for implementation during Q4 2023/2024.
- Further development and in-depth exploration of divisional vacancies, to include reporting on the outcomes of the Just R Marketing campaign and the boards' approaches to international recruitment remains a focus for the Division. The principles of ensuring staff are in place to deliver safe levels of care, reviewing practice, investing in skills development to deliver the transformations and constantly reviewing the process for workforce design, including the development of a Divisional Recruitment and Retention plan, remain the guiding principles of the Mental Health Senior Leadership Team.
- The Health and Safety Executive Notice of Contravention Group will continue to provide the assurance against the delivery of the actions arising from the NOC during the fortnightly held meetings.

**Rhestr o Atodiadau:**

Dim

**List of Appendices:**

None

<b>Teitl adroddiad:</b> <i>Report title:</i>	Special Measures Update			
<b>Adrodd i:</b> <i>Report to:</i>	Quality, Safety and Experience Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	25 <sup>th</sup> July 2023			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
<b>Argymhellion:</b> <i>Recommendations:</i>	The Committee is asked to NOTE the progress to date along with the plans to bring the independent reviews to future meetings.			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Geraint Parry, Special Measures Programme Paolo Tardivel, Director of Transformation and Improvement & Special Measures Programme Director			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></small>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Rhannol <i>Partial</i> <input type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i></small>
<b>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:</b>  <b><i>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:</i></b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b>  <b><i>Link to Strategic Objective(s):</i></b>	To support Special Measures			
<b>Goblygiadau rheoleiddio a lleol:</b>  <b><i>Regulatory and legal implications:</i></b>	Not applicable			
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b>	Not applicable			

<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	Not applicable
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	Not applicable
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	Not applicable
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	Not applicable
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	Not applicable
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks: (or links to the Corporate Risk Register)</i></p>	Not applicable
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	Not applicable
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps: Implementation of recommendations</i></p>	
<p>Rhestr o Atodiadau: Dim</p> <p><i>List of Appendices: None</i></p>	

## Special Measures Update

### 1) Introduction

---

This report presents an update on the Special Measures deliverables aligned to this Committee, building on the approach outlined in the previous update.

The report also includes progress to date around relevant independent reviews and outlines an approach for the Health Board to formally respond to them.

### 2) Background

---

The background to the Health Board escalation into Special Measures and the resultant organisational response was covered at Health Board on 25th May 2023. QSE was the first Board Sub Committee to receive an update at its June 20th meeting which outlined the outcome based approach and described how each of the deliverables from the first 90 day cycle had been mapped to a Committee.

It has been agreed with the Office of the Board Secretary that a brief summary will be provided each month and the committee will then invite relevant colleagues to attend for any particular deep dives that they wish to undertake.

### 3) Progress to date

---

The following table overleaf provides a brief update on the relevant deliverables taken from the weekly reporting and tracking against the milestones which have been agreed.

These deliverables also include 3 key independent reviews currently underway, namely:

- 4.1 – Patient Safety Review
- 4.4 – Vascular Review
- 4.7 – Mental Health Inpatients Safety Review

Each of these reviews are currently reaching conclusion and a report will be formally submitted. It is intended that each of the external reviewers are invited to the 22nd August meeting to present their findings, subject to the agenda timings permitting.

<b>Outcome 1: A well-functioning Board</b>				
<b>Deliverable</b>	<b>Lead Executive</b>	<b>Delivery Confidence</b>	<b>Delivery of Milestones</b>	<b>Update</b>
<b>1.6 Risk:</b> Commence review and revision of risk appetite and approach	Phil Meakin		1/1	A discussion regarding Board risk appetite, along with a new risk management framework were discussed at the Board workshop on the 22nd June. This has been built upon with a short-term approach instigated for reviewing risks > 15. A risk strategy workshop will take place on the 10th August.

<b>Outcome 3: Stronger leadership and engagement</b>				
<b>Deliverable</b>	<b>Lead Executive</b>	<b>Delivery Confidence</b>	<b>Delivery of Milestones</b>	<b>Update</b>
<b>3.8 Clinical Engagement:</b> Review mechanisms for clinical engagement, drawing up recommendations for improvement.	Gareth Evans		1/1	An initial project plan has been agreed with the executive lead and a series of interviews have been scheduled.
<b>3.10 Address the fragmented care record concerns:</b> Develop tactical and strategic plans for the development of an integrated electronic patient record to address issues of harms, inefficiency and quality of care.	Dylan Roberts		0/1	Good progress has been made with the appointment of 2 partners for the ED service Blueprint, however resourcing issues with one of the partners has delayed the planned start date by 2 weeks and will now commence on the 3 <sup>rd</sup> August. Discussions are underway to ascertain whether key tasks can be condensed without impacting on the overall output. The first milestone to appoint a partner for the Strategic Outline case has been missed whilst working through procurement processes. The framework for this has now been agreed with the procurement team. This delay does pose some risks to the overall deliverable being achieved within the 90 days and mitigations are currently being worked through.

<b>Outcome 4: Improved access, outcomes and experience for citizens</b>				
<b>Deliverable</b>	<b>Lead Executive</b>	<b>Delivery Confidence</b>	<b>Delivery of Milestones</b>	<b>Update</b>
<b>4.1 Patient Safety Review:</b> Support and enable the review of patient safety care.	Angela Wood		1/2	The review has concluded and an initial draft shared. The report is yet to reach the stage of formal submission to the Health Board for review by the Office of the Nurse Director. Once received, plans will be mobilised to address any concerns raised.
<b>4.4 Vascular Review:</b> Support and enable the Vascular Review	Nick Lyons		1/1	Good progress being made with site reviews undertaken in June, including from the Welsh Abdominal Aortic Aneurysm Screening Programme, and the reports are awaited.
<b>4.5 Service Improvements:</b> Review, revise and implement clear improvement plans for Vascular, Urology, Ophthalmology, Oncology, Dermatology and Plastics				
<b>4.5a Vascular</b>	Nick Lyons		None Due	Good progress being made in relation to the Vascular Access Nurses utilising the Renal Patient Tracker and further work also underway to progress the AAA treatment pathway. There is a risk that delay to approving the SOP and the pathway would mean that improvements are not fully embedded.
<b>4.5b Urology</b>	Nick Lyons		1/1	A North Wales Clinical Lead has been appointed and providing service direction and the development of the improvement plan.
<b>4.5c Ophthalmology</b>	Nick Lyons		None Due	All areas making good progress in delivering both core and additional activity. Pathway improvements for Diabetic Retinopathy underway and on track. Recruitment challenges along with unplanned absences have impacted on R1 clinical validation and thus reduced overall delivery confidence.
<b>4.5d Oncology</b>	Nick Lyons		1/1	A new Clinical Oncologist commenced on the 3rd July covering H&N, thyroid and skin. This is an important step in providing workforce stabilisation which is augmented by further progress around recruitment for further posts.
<b>4.5e Dermatology</b>	Nick Lyons		None Due	A range of discussions progressing regarding Minor Outpatient Procedures across BCU and review of potential cases for treatment in primary care has commenced.
<b>4.5f Plastics</b>	Nick Lyons		1/1	Progress being made with our partners at St Helens and Knowsley. Task and Finish group reviewing outstanding issues from a WHSSC perspective and developing process for harms review.

<p><b>4.7 MH Inpatients Safety Review:</b> Receive the report of the Mental Health Inpatient Quality and Safety Inspection and commence implementation of improvement actions.</p>	Teresa Owen		None Due	Leadership team is reviewing the safety inspection report from NCCU/NHS Executive and developing next steps. An Inspection Review Task & Finish Group is in formation stages.
<p><b>4.8a CAMHS Action Plan:</b> Agree and commence implementation of a CAMHS action plan to improve performance in the following area: CAMHS Mental Health Measure</p>	Carol Shillabeer		0/1	Review of job plans has commenced in order to inform the Recovery Plan, and forecasting of future demand underway. Initial performance trajectories have been missed which are being addressed through the recovery plan.
<p><b>4.8b Neurodiversity Action Plan:</b> Agree and commence implementation of an ND action plan to improve performance in the following area: ND Assessment waiting times</p>	Carol Shillabeer		None Due	Review of risks undertaken and Regional Partnership Board ensuring focus for ND in relation to Right Door Strategy. Tendering process underway for private provision of assessments, however the risk of no suitable supplier being found is impacting overall confidence.

Outcome 5: A Learning and self-improving organisation				
Deliverable	Lead Executive	Delivery Confidence	Delivery of Milestones	Update
<b>5.2 Learning from Incidents:</b> Ensure this is an effective procedure for learning from incidents, and preparations for inquests and HSE are clear and effective	Angela Wood		1/1	Good progress being made in collaboration with the Organisational Development team, and preparedness underway for HSE proceedings. Colleagues liaising closely with the NHS Executive to ensure alignment between local processes and the national approach.
<b>5.3 Clinical Governance Review:</b> Enable and support the NHS Executive to undertake a review of clinical governance	Angela Wood		None Due	An independent reviewer has been identified, however the review is yet to commence. As such this review is currently at risk of not delivering within the 90 days and is marked with low confidence of delivery.

#### 4) Recommendations

---

The Committee is asked to **NOTE** the progress to date along with the plans to bring the independent reviews to future meetings.



## Agenda Quality Safety Experience Committee

**Date** 22/08/23  
**Time** 11:00-13:00  
**Location** TBC  
**Chair** Rhian Watcyn Jones

Agenda item	Item	Lead	Action	Paper/Verbal
<b>1.0 OPENING ADMINISTRATION</b>				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of the last two meetings and action log	Chair	Decision	Paper
<b>2.0 QUALITY SAFETY AND IMPROVEMENT</b>				
2.1	Clinical Effectiveness Report	Executive Medical Director	Assurance	Paper
2.2	Patient Experience Report	Executive Director of Nursing & Midwifery	Assurance	Paper
2.3	Infection Prevention and Control Annual Report 2022/23	Executive Director of Nursing & Midwifery	Assurance	Paper
2.4	IHC Report – West/Mid Report?	Executive Director of Nursing & Midwifery	Assurance	Paper
2.5	Risk Register	Interim Board Secretary	Assurance	Paper
<b>3.0 SPECIAL MEASURES</b>				
3.1	Special Measures Report	Director of Transformation and Improvement	Assurance	Paper
<b>4.0 CLOSING BUSINESS</b>				
4.1	Reflections on meeting	Chair	Information	Verbal
4.2	New Risks	Chair	Information	Verbal
4.3	Date of Next Meeting	Chair	Information	Verbal



<b>MEMBERS</b>	
<b>Name</b>	<b>Title</b>
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
<b>In attendance</b>	
Jason Brannon	Deputy Director of Workforce
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Michelle Denwood	Director of Safeguarding & Public Protection
Dyfed Edwards	Independent Member/Health Board Chair
Gareth Evans	Acting Executive Director Therapies & Health Science
David Jenkins	Independent Advisor (observing)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation, Strategic Planning & Commissioning
Angela Wood	Executive Director of Nursing & Midwifery (Lead Executive)

DRAFT