

Bundle Quality, Safety & Experience Committee 1 March 2022

- 1 OPENING BUSINESS
 - 1.1 09:30 - QS22/36 Patient Story: Gill Harris
QS22.36 - Patient Story - Mar 2022.docx
 - 1.2 09:45 - QS22/37: Apologies For Absence
 - 1.3 09:50 - QS22/38: Declarations of Interest
 - 1.4 09:51 - QS22/39: Minutes of Previous Meeting Held in Public on 11.1.22 - FOR ACCURACY
QS22.39 - Minutes QSE 11.01.22 Public - V0.6.docx
 - 1.5 09:52 - QS22/40: Matters Arising and Table of Actions - FOR REVIEW
QS22.40 - Summary Table of actions QSE Public 22.2.22.docx
 - 1.6 09:57 - QS22/41: Report of the Chair: Lucy Reid - FOR INFORMATION
QS22.41 - Chair's Assurance Report QSE 11.01.22 V0.2.docx
 - 1.7 10:07 - QS22/42: Report of the Lead Executive: Gill Harris
QS22.42 - Executive Lead Paper - Mar 2022.docx
- 2 STRATEGIC ITEMS FOR DECISION - THE FUTURE
 - 2.1 10:17 - QS22/43: Recommend Quality aspects of IMTP: Chris Stockport - TO CONSIDER
QS22.43 - IMTP-quality V0.03.docx
 - 2.2 10:32 - QS22/44: Quality Priorities : Gill Harris - TO CONSIDER
QS22.44 - Quality Priorities - Mar 2022.docx
 - 2.3 10:42 - QS22/45: Workshop Feedback Update - Verbal: Gill Harris and Lucy Reid - FOR INFORMATION
 - 2.4 10:52 - QS22/46: Vascular Steering Group update : Nick Lyons - TO CONSIDER
QS22.46 - Vascular March QSE Cover Paper V0.1.docx
QS22.46a - Copy of Vascular Improvement Plan 16 February 22.pdf
QS22.46b - Extract of improvement plan reflecting RCS Part 2 report.pdf
 - 2.5 11:22 - QS22/47: Urology Service Review Terms of Reference - TO CONSIDER
QS22.47 - Urology Review - Cover Paper - Mar 2022 v2.docx
QS22.47a - Urology Review - TOR - Mar 2022 (004).docx
- 3 QUALITY SAFETY AND PERFORMANCE - THE PRESENT
 - 3.1 11:32 - QS22/48: Harms Report: Matthew Joyce - FOR INFORMATION
QS22.48 - QSE - Harms Paper - Mar 2022.docx
 - 3.2 11:42 - QS22/49: Corporate Risk Register Exception Report relating to Quality Risks: Simon Evans-Evans - TO CONSIDER
QS22.49 - CRR Cover Sheet NL JW approved.docx
Appendix 1 - Full Corporate Risk Register.pdf
Appendix 2 - Full List Corporate Risks.pdf
Appendix 3 - Corporate Risk Register Key Field Guidance.pdf
- 4 LEARNING FROM THE PAST
 - 4.1 11:52 - QS22/50: Patient Safety Report - focus on Never Events/Regulation 28: Matthew Joyce - TO CONSIDER
QS22.50 - Patient Safety Report - Mar 2022.docx
 - 4.2 12:02 - QS22/51: Quality Awards, Achievements and Recognition : Gill Harris - FOR INFORMATION
QS22.51 - Quality Awards Paper - Mar 2022.docx
 - 4.3 12:04 - QS22/52: Patient and Carer Experience Report - TO CONSIDER
QS22.52 - Patient and Carer Experience Report - Mar 2022.docx
 - 4.4 12:14 - QS22/53: External Serious Incident Reviews - MHLD - TO CONSIDER
Having taken advice, the papers associated with this item have now been removed pending the inquests.
- 5 CHAIRS ASSURANCE REPORTS
 - 5.1 12:44 - QS22/54: Chairs Assurance Reports - Strategic and Tactical Delivery Groups - FOR INFORMATION

- a - Patient Safety Quality Group (Dawn Griffiths)
- b - Clinical Effectiveness Group (to include mortality and NICE updates) (Jane Christmas)
- c - Strategic Occupational Health and Safety Group (includes Corporate Health at Work updates) (Peter Bohan)
- d - Patient Carer Experience Group (Dawn Griffiths)

QS22.54a - PSQ Chair Report - Mar 2022.doc

QS22.54b - CEG - Chairs Assurance Report QSE March 2022 - v3.docx

QS22.54c - SOHSG Advisory Group Chairs' Report 01.02.2022.doc

QS22.54d - PCE Chair Report - Mar 2022.doc

6

POLICY MATTERS

6.1

12:54 - QS22/55: NU06 - The Prevention and Management of Adult In-patient Falls: Gill Harris - TO CONSIDER

QS22.55a NU06_Falls Policy.docx

QS22.55b NU06 - BCUHB Falls Policy DRAFT - V3.4 (February 2022) post consultation.docx

QS22.55c EQIA NU06 The prevention and management of Adult in Patient Falls.pdf

6.2

12:59 - QS22/56: Infection Prevention & Control Policy : Hand Hygiene - Gill Harris - TO CONSIDER

QS22.56 - Hand Hygiene Policy_revised April 2021_v5.3 231121.doc

QS22.56a - Equality Impact Assessment Screening_August 2021 v1.2_080921.docx

6.3

13:04 - QS22/57: Health & Safety Policy : CCTV Policy - Sue Green - TO CONSIDER

QS22.57 - Draft CCTV Policy Jan 2022.pdf

QS22.57a - 17. EqIA Screening CCTV Policy October 2021 0.02.pdf

6.4

13:09 - QS22/58: Complaints Policy and Procedure: Matt Joyce - TO CONSIDER

QS22.58 - Complaints Policy and Procedure - Cover Paper - Mar 2022 v2.docx

QS22.58a - Complaints Policy and Procedure - Mar 2022 (1).docx

QS22.57b - EQIA - BCUHB Genral Concerns and Complaints Handling Procedure - 23.4.21.docx

7

CLOSING BUSINESS

7.1

13:14 - QS22/59: Issues Discussed in Previous Private Session - FOR INFORMATION

QS22.59 - Issues discussed in previous private session.docx

7.2

13:19 - QS22/60: Documents Circulated to Members - FOR INFORMATION

7.3

13:21 - QS22/61: Agree Items for Chair's Assurance Report to Board - FOR AGREEMENT

7.4

13:26 - QS22/62: Review risks highlighted in the meeting for referral to Risk Management Group - FOR AGREEMENT

7.5

13:31 - QS22/63: Review of Meeting Effectiveness - TO CONSIDER

7.6

13:33 - QS22/64: Date of Next Meeting 3.5.22

7.7

13:34 - QS22/65: Exclusion of Press and Public

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Patient Story - Baby Hunter						
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Associate Director of Quality Carolyn Owen, Assistant Director of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality						
Atodiadau Appendices:	Patient Story View full-length video by clicking embedded link (19 minutes) – this is accessible to anyone on the NHS Wales Network: Hunter's Story						
Argymhelliad / Recommendation:							
The committee is asked to receive and reflect upon the patient story.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	Y
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	

Betsi Cadwaladr University Health Board Patient Story

Baby Hunter's Story

A shortened video the story, told by Antonia and Aaron, will be played at meeting

Overview of Baby Hunter's Story told by Antonia

On 14 May 2021, I had an emergency C Section, 3 months before my due date and my baby boy was taken straight to the Neonatal Unit at Ysbyty Glan Clwyd.

My partner and I were unable to visit baby Hunter together, and were told we could not even be in the same building at the same time.

Our son was extremely poorly. I was sat by his side all day and night, and was on my own when emergency alarms were pulled for my son. I was on my own when his SATS started to drop drastically. I was on my own for all the procedures our son had to have.

We held our baby boy once, just once, and now we will never get the chance to hold him again after he passed away on 15 June 2021 at Liverpool Women's Hospital.

I would like to do what I can to push for other parents to be allowed to be together in the Neonatal Unit because that time is so precious. Some parents may not be lucky enough to have any other time with their babies.

Summary of learning and improvement

On 01 November 2021, Baby Hunter's parents met with Matthew Joyes, Acting Associate Director of Quality Assurance and Carolyn Owen, Acting Assistant Director of Patient and Carer Experience, to share their experience.

Their video story was captured shortly after and shared with Women's Services and the Area Division.

On 07 January 2022, baby Hunter's parents met Rachel Wright, Patient and Carer Experience Lead, Angie Martin, Head of Children's Services, Catherine Hegarty, Lead for Maternity Clinical Governance and Julie Reeve, Matron for Women's Services to hear what changes have been implemented since they had shared their experience.

The following improvements have been made since May 2021:

- The Bereavement Midwife Team has grown from one member of staff to three Bereavement Midwives, one across each site. The Bereavement Midwife will provide support up until the discharge process including after care.

- A robust handover and clear plan is now in place for when a baby is transferred outside of the Health Board. This involves regular communication between Foetal Medicine Departments to ensure the Health Board is made aware of when a baby passes away.
- A daily telephone call between Neonatal and Maternity services now happens to provide updates of any babies transferred out of area or to inform the team when a baby passes away. This will also ensure records are kept up to date so parents can be contacted and offered timely support from Bereavement Midwives and to ensure parents are not contacted unnecessarily.
- An Incident Investigation was commissioned looking into the care baby Hunter received. This report was produced in collaboration with Liverpool Women's Hospital. Baby Hunter's parents did not get the opportunity to be involved in this report to put their experiences across. They have now been offered a meeting with a consultant to talk through this report and to discuss the care baby Hunter received. The role of the Bereavement Midwives is to ensure parents have the opportunity to be involved in this process and the new Incident Policy and Procedure, Investigation Toolkit and Investigation Training developed the concept of "patients as partners" in the investigation process.
- The establishment of Rainbow Clinics, a specialist service for women and families following stillbirth or neonatal death. This service provides specialist support to parents, helping to reduce parents having to share their story several times to different health professionals.
- An information/support leaflet has been produced by the Bereavement Midwives Service, which will now be distributed to parents in the event of baby loss.
- On 16 June 2021, the Health Board changed their visiting guidance on Neonatal Units, in response to the amendments of Welsh Government guidance. As a result of this change, two parents are permitted to visit Neonatal at once. Parents are now being asked to undertake lateral flow tests when visiting Neonatal Units.
- A programme of training will be implemented to support junior nurses in these circumstances. As part of the training nurses will help encourage parents to have as much skin-to-skin contact with their baby where possible.
- Individual staff attitudes and behaviours have been addressed. The recording Baby Hunter's story has been shared with staff from Maternity, Neonatal Services and the Ultra Sound Department to continue to raise awareness of the issues raised.
- Access into the Neonatal Unit is to be improved by the introduction of finger print entry so parents do not have to wait for a staff member to buzz them in. Work is due to start on finger print entry very soon.
- The Patient and Carer Experience Team will continue to monitor and review all maternity related feedback to ensure the voices of parents continue to be heard.
- An opportunity has been presented to Baby Hunter's parents to meet a consultant to review the care given.
- Support has been offered to Baby Hunter's parents from the Bereavement Midwife Service.
- Support has been offered to Baby Hunter's parents concerning pre-conception advice and support throughout mum's next pregnancy.

At the meeting held on 07 January 2022, Baby Hunter's parents expressed concern around the following areas:

- They are aware that one parent visiting remains ongoing across the Health Board as shared by other parent's experiences. They do not feel there is a consistent approach adopted. They feel it has been down to individual staff discretion or staff interpretation of the visiting guidelines.

- They would like to see positive changes happen around ultra sound experiences, in particular for partners to be able to be present at the scans and to be able to sit closer so they can provide support.

The Associate Director of Quality has asked that the Visiting Policy, currently being reviewed, specifically addresses this issue to resolve the concerns of consistent application raised by Antonia and Aaron.

The Patient and Carer Experience Team have shared this feedback with services and will seek assurance from departments by way of evidence that changes have been embedded.

The Patient and Carer Experience Team extend their gratitude and appreciation to Antonia and Aaron for sharing Baby Hunter's Story.



Quality, Safety and Experience (QSE) Committee
DRAFT Minutes of the Meeting Held in public on 11.2.22 via Teams

Present:

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member

In Attendance:

Gareth Evans	Chair of Healthcare Professional Forum (<i>part meeting</i>)
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Dave Harris	Internal Audit
Richard Hayward	Health Inspectorate Wales
Medwyn Hughes	Independent Member
Matthew Joyes	Acting Associate Director of Quality Assurance
Molly Marcu	Interim Deputy Board Secretary
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Mike Smith	Interim Director Of Nursing Mental Health
Chris Stockport	Executive Director Primary Care and Community Services
Conrad Wareham	Interim Deputy Medical Director
Berwyn Owen	Chief Pharmacist (for agenda item 22.18)
Louise Howard-Baker	Assistant Director of Pharmacy (East) (for agenda item 22.18)

Agenda Item Discussed	Action By
It was noted that the meeting was being recorded in Teams for administrative purposes.	
QS22/01 Patient Story	
QS21/01.1 Attendees noted the patient story outside of the meeting. No comments were raised.	
QS22/002 Apologies for Absence	
QS22/02.1 Apologies had been received for Nick Lyons, Adrian Thomas and Louise Brereton	

<p>QS22/03 Declarations of Interest</p> <p>QS22/03.1 There were no declarations noted.</p>	
<p>QS22/04 Minutes of Previous Meeting Held in Public on 2.11.21 for Accuracy</p> <p>QS22/04.1 The minutes were agreed as an accurate record subject to Jo Whitehead being in attendance for part of the meeting.</p>	
<p>QS22/05 Matters Arising and Table of Actions</p> <p>QS22/05.1 Updates were provided to the summary action log and actions were agreed as closed where highlighted</p> <p>QS22.05.2 The Executive Director of Nursing and Midwifery highlighted that the meeting agenda has been streamlined in response to the system pressures from Covid and unscheduled care aligned with the step up of Gold response. The Chair added that the meeting was utilising a consent agenda where members have been able to raise questions in advance which will be appended to the minutes on publication for openness and transparency.</p>	
<p>QS22/06 Report of the Chair - CONSENT</p> <p>QS22/06.1 It was noted that this paper was being taken as a consent item and there were no questions raised. The Committee noted that this report had already been reported to Board.</p>	
<p>QS22/07 Report of the Lead Executive</p> <p>QS22/07.1 The Executive Director of Nursing and Midwifery updated on the Patient Safety Group highlighting that the approach to 24 hour reviews and never events are being reviewed to ensure actions are closed down and thematic learning is shared. As part of the new approach a weekly Executive update will be given. Investigations are being reviewed to ensure that the person investigating is the right person to lead the investigation. It was noted that due to recent system pressures some meetings have had to be stood down.</p> <p>QS22.07.2 The Executive Director of Nursing and Midwifery advised that duty of Candour work would be led by Acting Associate Director of Quality Assurance. The Committee noted the requirements of this work, the detail and staffing required to undertake it. It was noted that significant progress in this area had already been made across the Health Board</p>	
<p>QS22/08 Clinical Services Strategy</p>	

<p>QS22/08.1 The Interim Deputy Medical Director, updated the Committee on the Clinical Services Strategy. It was noted that the Clinical Strategy is currently in draft format and the initial timescale for publication is on track to come to the Board Workshop in March <i>[post meeting note the Workshop is scheduled for April]</i>. The Strategy will be supported through the establishment of a Clinical Senate. Further work is ongoing to ensure that the Senate comprises of the future multi-disciplinary Clinical Leaders, not just Doctors, who will be delivering the Strategy across the Health Board. Other Health Board's strategies were being reviewed to ensure that we are consistent with the requirements from Welsh Government whilst also ensuring that the Strategy reflects what is required for the local population in North Wales.</p> <p>QS22/08.2 The Chief Executive joined the meeting advising that the Strategy would be a broad clinical strategy with the ability to undertake individual service reviews with the intention of being able to consult as needed. It was noted that this would be with the intention, that if any service reconfiguration was required, then an agreed framework would be in place in which to make the decisions subject to a public engagement consultation. It will provide a benchmark and enable more effective decision making and give the Health Board the ability to have senior Local Authority conversations with regards strategies and reviews going forwards.</p> <p>QS22/08.3 The Clinical Senate configuration was discussed and it was noted currently medical representation was across both Primary and Secondary Care but further input was required from other professional fields and that this was being addressed. It was noted that it will link in with the transformation work to enable a multi professional approach as well as the Population Needs Assessment which is currently being undertaken at the same time.</p>	
<p>QS22/09 Covid 19 Update</p> <p>QS22/09.1 The Executive Director of Nursing and Midwifery / Deputy Chief Executive gave a presentation to the Committee based on the latest update coming out of the Gold Meetings, taking place three times a week, and highlighted that this was the reason the slides had been published the day before the meeting, to ensure up to date information was given.</p> <p>It was noted that the objective for stepping up Gold was to:</p> <ul style="list-style-type: none"> • reduce harm from SARS-CoV2 infections, • reduce harm due to surge pressures on the health and social care system, • reduce harm from population based health protection measures, • reduce harm from economic harms and reduce harm from health inequalities as a result of SARS-CoV2 infections. <p>The Committee were reminded that the step up was initially to facilitate the roll out of the enhanced vaccination programme. The Executive Director of Nursing and Midwifery / Deputy Chief Executive thanked everyone and the teams involved that have stepped aside from their day jobs and forfeited leave to be able to support the vaccination programme to protect our population and our staff.</p> <p>QS22/09.2 The Committee noted that there were no new decisions to make by Gold this week. At Cabinet and Board Briefing there had been Infection Prevention and Control</p>	

(IPC) support for reducing the isolation timescales from 15 days down to 10 days in extenuating circumstances where there was a risk of contacts on a ward and that would be with senior IPC sign off and Gold sign off.

QS22/09.3 The Committee noted that Gold has asked Silver to review the visitor status in line with the current infection rate across the Health Board and the impact that it was having on the services.

QS22/09.4 The Committee also noted that Planned Care was being reviewed on a week by week basis and that Planned Care was not stepped up in the previous week because of the general upsurge in activity within unscheduled care. This resulted in all available beds were taken up by unscheduled care and some surge beds were opened.

QS22/9.5 Surveillance and Trigger information was reviewed and The Executive Director of Nursing and Midwifery / Deputy Chief Executive and Executive Director of Public Health highlighted that schools going back may have an impact on community infection rates and that these are being monitored.

QS22/9.6 It was noted that there has been an improvement in ICU capacity and what is being seen in critical care is as would be normal for this time of year, there is capacity and the four surge plans have not been required. Whole Health Board surge plans are being drawn up for the whole year.

QS22/9.7 Bed occupancy remains high and the Committee noted that surge plans are being drawn up to address this. The Executive Director of Workforce and Organisational Development updated what impact the change in testing guidance would have on the workforce.

QS22/9.8 The Chief Executive raised a question in relation to Planned Care asking that the Sites are encouraged to maintain as much activity as possible and if there could be the option of designating one of the sites as a green site to be able to commence planned care. It was noted that the Planned care team are taking a forward look at planned care activity on a weekly basis and reviewing risks if one area were identified to commence Planned Care.

QS22/9.9 The Committee raised a question around the number of locums being employed from England and if they are being tested prior to their shift commencing. The Committee noted that all staff numbers had reduced over the previous weeks, and that the guidance remained that all staff should test prior to coming into work.

QS22.9.10 The Committee asked if all offers for vaccination programme volunteers are being accepted and that pre-employment checks were taking place. The Director of Workforce described that there are two different pathways in place, details around systems to capture offers and deployment were shared and that pre-employment checks were in place.

QS22.9.11 The Committee discussed the requirement for integrated working with Local Authorities and a combined health and social care workforce and how this would work given the shortage of staff across the piece. It was noted that conversations around

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<p>mitigation of totality of risk needed to be undertaken and that a system wide business continuity response is required.</p> <p>QS22.9.12 It was resolved that the Committee: Received the Covid 19 update and that the slide pack would be uploaded after the meeting.</p>	
<p>QS22/10 Corporate Risk Register</p> <p>QS22/10.1 The Chair introduced the agenda item noting that the paper had been received late. The Interim Director of Governance advised that at review at the Executive Team meeting prior to Christmas it was requested that wherever big risks are asking for extensions to timelines then extensions should be accompanied by a full explanation as to why it has not been possible to deliver. These updates had been requested over the Christmas period and the paper updated to reflect these.</p> <p>QS22/10.2 The Committee commented that discussion had taken place at the Audit Committee around working arrangements with Local Authorities, for example, where buildings don't belong to us, and that a Memorandum of Understanding be drawn up with regards to Health and Safety. It was noted that this action had been taken forward and would be triangulated between the two Committees.</p> <p>QS22/10.3 The Chair raised the action around the Executive Team discussing consistency of the risk ratings. It was noted that due to pressures in the system this had not taken place but would do so as soon as possible.</p> <p>QS22/10.4 The Chair advised that, whilst being aware of the reasons the report was delayed, this should not be repeated as publication of a report as late as this was made it difficult to scrutinise. It was noted that should the Committee feel they need to ask further questions this can be done outside of the meeting and would be handled in the same way as the Consent items.</p> <p>QS22/10.5 The Chair raised concerns about the lack of clinical risks on the corporate risk register. The Chief Executive noted that once internal audit have issued their brief, and any early sight would be helpful, it will identify the gap in clinical risk and the new Executive Director responsible for risk will be able to take this matter forward. The Executive Director of Nursing & Midwifery was able to advise that the Acting Director of Quality would be escalating the following new clinical risks at the next RMG - falls, WHO check list adherence and pressure ulcers. The Executive Medical Director has separately requested sepsis be added to these. It was noted that the management of risk and escalation needs to be reviewed to ensure that the high level risks are the right ones and to ensure that there is a route for Board level oversight which highlights patient safety culture.</p> <p>QS22/10.6 It was resolved that the Committee:</p> <ul style="list-style-type: none"> Note the Risk Management Group was stood down on the 13 December 2021 to allow Gold Command and the vaccination management to be progressed. 	<p>SG</p> <p>SEE</p> <p>NL/ SEE/ JP</p>

<ul style="list-style-type: none"> • Note the Risk Management Group Chair's Actions process was followed to approve the risks for presentation to the Executive Team, before onward presentation to Board Committees. • Note the Key Field Guidance Document has been updated following Audit Committee members feedback and is attached as Appendix 3. • Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set in detail at Appendix 1: 	
<p>QS22/11 Quality and Performance Report</p> <p>QS22/11.1 The Chair noted that this item was down for consent, however there were a number of concerns with the report including inaccurate data. As a result, the Committee would not be accepting the report. The lead Executive is working on an amended report taking into consideration comments made from the Committee outside of the meeting.</p>	SH
<p>QS22/12 Patient Safety Report – CONSENT</p> <p>QS22/12.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p>	
<p>QS22/13 Quality/Safety Awards and Achievements - CONSENT</p> <p>QS22/13.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p>	
<p>QS22/14 Hergest HIW Report and Action Plan</p> <p>QS22/14.1 It was noted that this paper was being taken as a consent item as there was an overlap with the Serious Incident Review. The Chair noted that any questions raised on this item should focus on the HIW Report and Action Plan, it was noted that the report was disappointing to read with reference to recurring themes from previous inspection reports. It was noted that a 'whole system' response was required with regards to learning.</p> <p>QS22/14.2 The Interim Director Of Nursing Mental Health agreed with the comments made by the Chair. The context to the inspection was noted, that it took place on a day immediately following a bank holiday on the back of an extremely difficult weekend. The Committee noted that the inspectors were given some inaccurate information from staff on arrival which was clarified when they returned.</p> <p>QS22/14.3 The Interim Director of Nursing Mental Health updated the Committee on the staff deployment decision making group and the decisions they had had to take around moving staff from across the Health Board to give cover given the bank holiday, summer holidays and the impact of Covid 19 on staffing levels.</p>	

QS22/14.4 The Chair highlighted the reoccurring themes being referenced in the report and questioned sustainable learning and what change was happening as a result of that learning. It was noted this would be discussed in the Private session in conjunction with the serious incident review report. The Executive Director for Public Health highlighted the action plan and noted that learning, moving at pace and cascading across the service was essential. The Committee noted that some of the comments made in the report were positive specifically around the caring nature of the staff, engagement with patients, dignity and respect.

QS22/14.5 Richard Hayward from Health Inspectorate Wales noted that it was positive that the report had been taken very seriously and was interested on the emphasis that there was learning cascading across. The Committee noted that there were some positive parts to the report including the significant improvements that had taken place between the first and second visit.

QS22/14.6 The Chief Executive advised that there had been a meeting with divisional representatives and most of the Executive Directors, the Chair, Vice Chair and an Independent Member. The meeting focussed on the improvement reports received within the Mental Health Services and across the organisation, and was to ensure that the range of issues that each of the reports have highlighted are reviewed and address and improvement and change methodologies are undertaken. The Chair highlighted that the need to evidence change was required.

QS22/15 Vascular Services

QS22/14.6 The Chair opened the item noting the content of the paper and taking it as read opening up for questions. An Independent Member raised concerns that historically the Committee had been informed that comparisons had not been due to the lack of information available but that subsequently that information had been provided. The Interim Deputy Medical Director advised that in his opinion the challenge is understanding what the information is identifying and that the way historical data has been compiled and classified has raised difficulties in comparison to current data. An example of mortality and amputation figures was shared with the Committee and good clinical practice was explained. It was noted as the action plan is worked through, further questions are being raised. The Interim Deputy Medical Director advised that his objective was to get a sustainable and effective service to ensure that it is understood what can be done going forwards.

QS22/14.6 An Independent Member raised an historical staff survey and whether building up resilience was being included in the action plan. The Executive Director for Workforce advised that a specific piece of work, as part of the Discovery Phase, is going to take place with the team similarly to that undertaken with Mental Health colleagues.

QS22/14.6 The Committee raised concerns on the point raised in the report about being an outlier in post amputation mortality and asked who was taking responsibility for this. The Interim Deputy Medical Director advised that there may be some data issues that contributed towards this, however, there has been an improvement in the figures in recent times. It was noted that the team are working through the recommendations, ensuring that MDTs are taking place and that individuals are being given the best possible care by meeting best practice standards. The Interim Deputy Medical Director

<p>advised that he was attending the Vascular Governance meetings and was able to put direct challenge to discussions taking place. It was noted that improvement on the quality of data had been raised with the group and the post amputee mortality rates were being reviewed very closely at the monthly meetings. It was confirmed that there has been no evidence of unnecessary amputations but scope to improve on the package of care to meet best practice standards.</p> <p>QS22/14.7 The Chief Executive advised that performance and data issues are the same issues already being worked on in response to the Royal College of Surgeons first stage review and a cross reference would help give assurance. It was noted that the format of the document being reviewed had not uploaded effectively and that a single improvement plan format was being produced based on improvement methodologies that will return to a QSE workshop. The Chair agreed to decide how best to take assurance on this point after the meeting.</p> <p>QS22/14.8 It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Note progress in delivery of the Vascular Improvement Plan. 	<p>NL</p> <p>LR</p>
<p>QS22/16 Safeguarding Q1/2 Report - CONSENT</p> <p>QS22/16.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p>	
<p>QS22/17 Learning from Morfa Ward (Llandudno)</p> <p>QS22/17.1 The Chair introduced the item opening up for questions. An Independent Member made an observation around the requirement for clear roles and lines for accountability and managerial support and looked forward to see evidence of this given the very disappointing situation that had occurred. The Executive Director of Nursing and Midwifery / Deputy Chief advised that this action plan has been drafted based on the learning from the HASCAS scrutiny and methodology. It was noted that the action plan was not final because there was a need for inclusivity with partners, carers and citizens that relates back to the Stakeholder Reference Group. It was noted that the report addresses the need for Health Board wide learning to be embedded.</p> <p>QS22/17.1 The Chair noted that although the action plan was not the final version, cross referencing and training needed to be reviewed going forward. It was noted that the Quality Improvement Group meeting at the end of this month would meet to improve the action plan and give it the check and balance that was required. This will need to feed back to QSE.</p> <p>QS22/18.2 It was resolved that the Committee received the report.</p>	<p>MJ</p>
<p>QS22/18 Learning from Medication Incidents</p>	

<p>QS22/18.1 It was noted that although this paper was being taken as a consent item there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p> <p>QS22/18.2 The Chair complimented the paper for being clear, easy to read and referencing human behaviours and that this would be welcome in other patient safety reports as well. The Chief Pharmacist and his colleagues were thanked for a well-produced paper.</p> <p>QS22/18.3 The Chief Pharmacist noted that he had joined the call with the Assistant Director of Pharmacy (East) who was retiring and wished to formally thank her for her significant contribution around medicine, safety both in North Wales and nationally. This was echoed by the committee.</p>	MJ
<p>QS22/19 Health and Safety - CONSENT</p> <p>QS22/19.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p>	
<p>QS22/20 Quality in General Surgery – Ysbyty Glan Clwyd</p> <p>QS22/20.1 The Committee noted the context for the report which had been provided following concerns arising from a thematic review of quality and safety in surgery at Ysbyty Glan Clwyd (YGC). These concerns included the results of the national bowel cancer audit which suggested a higher than expected mortality in the 2 years after surgery at YGC, which was discussed in private session at the last Committee meeting. The Committee noted the immediate, medium and longer term actions planned to address the issues identified and thanked the Executive Medical Director for a very clear and comprehensive paper addressing the matter.</p>	
<p>QS22/21 Quality Governance Self-Assessment Action Plan (Maternity Services) – CONSENT</p> <p>QS22/21.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.</p> <p>QS22.21.2 It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Approve closure of the Quality Governance Self-Assessment Action Plan 	
<p>QS22/22 Internal Audit Report into HASCAS - CONSENT</p> <p>QS22/22.1 The Chair queried why the whole report has not been received. Dave Harris from Internal Audit noted that there is a typographical error and Huw Jones should be replaced Huw Thomas and that it is a partial briefing paper because a number of steps had not been signed off due to actions pausing due to Covid 19. The Executive Director</p>	GH

of Nursing and Midwifery / Deputy Chief advised that those outstanding areas were going back through patient safety and quality group to be able to give assurance to QSE. It was agreed that if there were any areas that required escalation this would be done in the usual process through to QSE.	
QS22/23 Chair's Reports from Strategic and Tactical Delivery Groups - CONSENT QS22/23.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/24 Nurse Staffing Levels Policy amendments - CONSENT QS22/24.1 It was noted that this paper was being taken as a consent item and there were no questions raised. Any questions raised outside of the meeting will be attached to the minutes as an addendum.	
QS22/25 Closing Business QS22/25.1 There was not closing business to note.	
QS22/25 Issues Discussed in Previous Private Session QS22/25.1 The Committee noted that the Report into the Mortality Post Bowel Cancer had been addressed under item QS22/20.	
QS22/26 Documents Circulated to Members QS22/26.1 The Chair highlighted the falls policy which had been circulated post publication for Chair's Action.	
QS22/27 Agree Items for Chair's Assurance Report QS22/27.1 The Chair agreed to give some thought as to how to pick up the Vascular action plan assurance.	
QS22/28 Review of risks highlighted in the meeting for Referral to Risk Management Group QS22/28.1 There were no risks highlighted in the meeting for referral.	
QS22/29 Review of Meeting Effectiveness QS22/29.1 The Committee and attendees discussed the use of the consent agenda. It was noted that a number of items that were too important not to discuss. It was noted any questions raised outside the meeting would be addendum to the minutes to ensure clarity and scrutiny.	
QS22/30 Date of Next Meeting	

QS22/30.1 1 March 2022	
QS22/31 Exclusion of Press and Public QS22/31.1 It was resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

Questions Raised outside of the meeting:

Question	Raised by	Answer	Answered by
<p>QS22/16 Safeguarding Q1/2 Report</p> <p>MHLD Division Adult at Risk reports are down by 26%, do you think this is because of targeted approach, or reduction in staffing capacity, and have you the evidence for this if so?</p>	<p>Cheryl Carlisle</p>	<p>The reduction in Adult at Risk reporting could be the result of a number of key activities which have been implemented to follow a targeted approach as a result of activity and supporting data, and the implementation of the Designated Safeguarding Persons role (All Wales Safeguarding Procedures 2019).</p> <p>This includes:</p> <ul style="list-style-type: none"> • Bespoke training, case specific desktop reviews, and a greater participation in ward level Multi-disciplinary Team Meetings (MDTs). • Increase in contact and communication between teams and Corporate Safeguarding as a result of the new Safeguarding Multi-agency statutory guidance. • Concerns are discussed with the Safeguarding Team and actioned immediately with consideration given to the Wales Safeguarding Procedures and specifically the Adult at Risk process prior to submission of the report to the LA. This supports the decision making regarding the Adult at Risk threshold and reduces inappropriate Adult at Risk Reports. • Where concerns are raised and do not meet the 'At Risk' threshold other action is 	<p>Michelle Denwood</p>

		considered to ensure any potential risks are reduced and the opportunity for clinical reflection/supervision and training is implemented.	
QS22/16 Safeguarding Q1/2 Report DoLS team report a 44% increase in applications – how are you recording the complexity and resource shortfall please?	Cheryl Carlisle	<p>The increase in DoLS applications is in line with the National picture. The increase in demand has been acknowledged by Welsh Government with non recurring funding provided to support BCUHB activity.</p> <p>The resource shortfall and the increase in complexity is monitored and recorded by the following:</p> <ul style="list-style-type: none"> • The collation of data and activity follows a National programme of collation and submission to WG. This evidences the compliance aligned to the legal time frames against each application and highlights the delay in process at each step of the activity. • DoLS - Court of Protection activities are recorded, timeframes documented and the analysis of each case. • Case Supervision of the Best Interest Assessors (BIAs). • Desktop reviews, learning events and the engagement in statutory safeguarding reviews and untoward incidents supports the collation of evidence and reporting. 	Michelle Denwood

		<ul style="list-style-type: none"> DoLS is a Tier 1 Risk on the Corporate Risk Register. Controls and actions are monitored by the MHACC & C and by the Safeguarding Reporting Framework. 	
QS22/16 Safeguarding Q1/2 Report CAMHS – increase of 22% in Section 136 assessments, but downward trajectory in the number of assessments in this period. Could you explain further please?	Cheryl Carlisle	The increase of 22% is the result of the significant increase in S136 presentations during May and June 2021. This is associated with the increased acuity and complexity of patients that are receiving support within the community and CAMHS services. Clinical activities by specialist services are reported by their quality and assurance processes.	Michelle Denwood
QS22/16 Safeguarding Q1/2 Report IRIS – please can you expand on the current challenges regarding which GP Primary will participate, and the funding fall out of this problem, and how it is being handled?	Cheryl Carlisle	BCUHB Safeguarding Team are fully engaged and have been promoting and supporting this valuable project. During Q1/2 the Domestic Abuse Safety Unit (DASU) had discussions with Wrexham and North Denbighshire Primary Care Clusters. Both decided not to take on the project which caused a delay and the potential for DASU to use the funding for another activity outside of BCUHB. 18th January 2022. An update was received from the Regional Domestic Abuse and Sexual Violence Coordinator. Central and South Denbighshire Primary Care Clusters have agreed and are to commence the IRIS project.	Michelle Denwood

		Progress to date is that the Clinical Lead and Educator Advocate have been appointed. Training of General Practitioners has commenced.	
QS22/16 Safeguarding Q1/2 Report Audit Quality of Adult Safeguarding Documentation - an improvement, but how are we embedding learning? The same for the Child at Risk please? (it says 'Child at Report')	Cheryl Carlisle	Both Adult at Risk Reports and Child at Risk Reports undertake a Quality Assurance process. <ul style="list-style-type: none"> • Report documentation and content is analysed on a weekly basis with any concerns in the documentation highlighted to the author or manager. • The Corporate Safeguarding team work with wards and teams to support the implementation of any improvements to the quality of the reporting and the decision making. • This activity can be addressed following a variety of activities; Governance /Quality & Safety Meetings, Safeguarding Forums, and/or directly with the individual or service. • Findings and areas for improved practice are reinforced using different approaches and methodology for example; 7 Minute Briefings, Individual and Group Safeguarding Supervisions, and the monthly Corporate Safeguarding Bulletin that is shared across BCUHB, feedback from reviews. 	Michelle Denwood

		<ul style="list-style-type: none"> • Key themes and trends which require improvement are highlighted and supported by bespoke training. • To evidence any improved practice (Learning) is measured by a number of methods including; audit, case supervision, and the result of the review and analysis of best practice, incident reviews, patient stories, feedback and face to face engagement. 	
<p>QS22/11 Quality and Performance Report</p> <p>Going through the QP report, I'm not quite sure what has happened. It seems to have gone backwards in terms of quality and meeting the needs of the Committee. We have new indicators included that we don't normally have and it's not clear why.</p> <p>For example, on page 7 there is an indicator for "European standardised rate of alcohol attributed to hospital admissions for individuals [sic] resident in Wales", a number 357.6 and an upwards arrow. There is no context provided and so it's difficult to see why it's before the Committee. In contrast, the patient safety alert indicator is still missing, despite this having been identified as not only an issue that needs reporting but also a contributory factor to recent Never Events.</p>	Lucy Reid	<p>I apologise that the report is not the previously agreed version and I have asked Gavin Halligan Davies (Interim Director of Performance) to identify what has occurred.</p> <p>I completely understand your frustration with these matters, as the suite of reports do not provide the assurance the Committee(s) require and have not done so for an extended period.</p> <p>With regards to your specific queries:</p> <ol style="list-style-type: none"> 1. I am investigating why the content of the report has changed. 2. The colour and direction of the arrow is not indicative of the status of the measure, but represent a trend line which shows whether performance is improving or declining. We are looking to 	Sue Hill

<p>A number of arrows appear to be green rather than red, for example on page 12, the percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment is reported as 31.90% against a target of ≥ 80 but has a green upwards arrow - why?</p> <p>There is a narrative for Adult Psychological Therapy but it is reported as now being above target. The narratives should be by exception to explain why the HB is below target - hence the headings "issues affecting performance" and "actions".</p> <p>As I said, the report is listed for consent in the meeting and so was not going to be discussed. However, I am inclined to announce in the meeting that the Committee is not accepting the report due to the number of issues in it and the fact that it does not assist us to focus on the business/safety critical performance indicators which is what we have repeatedly asked for.</p>		<p>revise the current style of reporting (subject to agreement) to graphical reporting which will resolve the ambiguity of the arrows.</p> <p>3. As part of the Governance and PAF we are looking to identify success as well as issues around performance, but I will check in this instance why this was included.</p>	
<p>QS22/14 Hergest HIW Report and Action Plan</p> <p>It is concerning that the report specifically calls out the recurring themes and lack of learning evident from that. I would like to be better assured as to how HIW reports are being</p>	<p>Lucy Reid</p>	<p>Paper received in the Private Session with the External SIR and the Action Plan</p> <p>The Morfa Ward current action plan populated, noting further work would be required and this will be monitored through the Quality Improvement Group meeting at the end of this month and then report into QSE.</p>	<p>Matt Joyce</p>

monitored - they seem to have fallen off the radar again, albeit I understand the pressures.			
<p>QS22/14 Hergest HIW Report and Action Plan</p> <p>In terms of the HIW report - this is very disappointing but concurs with my concerns in terms of culture, governance and learning as key areas that still need to be addressed.</p> <p>Looking at the actions arising from the recommendations, they are very transactional rather than focusing on the why in order to address the how. This will hinder sustainable learning. An example being the recording of capacity assessments - the action refers to sending a bulletin and then undertaking audits. Have you looked at why the assessments aren't being undertaken/recorded? The purpose of the audit is to check compliance but first you have to address why they are not complying. A further action refers to "Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed" - how will this be "ensured"?</p> <p>In terms of the OPMH pathway, some of the actions aren't actions that meet the</p>	Lucy Reid	<p>The Chair raised a number of these questions in the meeting the below minute highlights how change and improvement methodologies are required and are being drawn up.</p> <p>The Chief Executive advised that there had been a meeting with divisional representatives and most of the Executive Directors, the Chair, Vice Chair and an Independent Member. The meeting focussed on the improvement reports received within the Mental Health Services and across the organisation, it was to ensure that the range of issues that each of the reports have highlighted are reviewed and address and improvement and change methodologies are undertaken. The Chair highlighted that the need to evidence change was required.</p>	Response given in meeting

<p>recommendation - it is progress towards completing the action.</p> <p>I note that there is reference to encouraging the engagement with the Stronger Together programme but given some of the cultural issues raised in the HIW report, what is the plan for a wider cultural piece for the Division?</p> <p>Fundamentally, how can we be assured that the change required from any learning arising from these incidents is happening and is sustainable?</p>			
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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
	4th May 2021				
1	L Brereton	QS21/78.2 A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	<p>29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21.</p> <p>31.8.21 Governance review complete and new Integrated Governance Framework approved by Board. Further work required to identify and determine approval groups for different categories of documents (policies/procedures etc.). The review of the Policy on Policies (PoP) has commenced. However, due to significant staffing issues within the Office of the Board Secretary, the expected completion date has been put back. Provisional target date for approval at Audit Committee is now December. A project support manager has been appointed to support policy work (start date pending recruitment checks).</p> <p>4.1.22 The interim Deputy Board Secretary is currently reviewing the Policy on Policies which will determine a more appropriate approval route for all policies.</p> <p>18.2.22 The next iteration of the policy is being submitted to the CPPG in March, and subsequently the QSE</p>	<p>September</p> <p>February</p> <p>May</p>

	6th July 2021				
2	K Williams S Hill	QS21/97.4 QPR The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this	August	<p>31.8.21 the separate COVID reports routinely include information on GP consultations.</p> <p>7.9.21 L Reid did not feel the update above answered the original point which was that the QaPR included a narrative comment about GP consultation performance but did not include actual data. She felt this reduced the integrity of the report. This to be fed back to the Acting Director of Performance.</p> <p>2.11.21 S Hill to follow up and ensure this action can be closed off.</p> <p>05.01.22 The Performance team will include actual GP consultation activity in the next report.</p>	<p>Closed</p> <p>January</p> <p>May</p>
3	S Evans-Evans	QS21/99.5 CRR Arrange for ET discussion around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete.	August	<p>7.9.21 S Evans-Evans to progress</p> <p>2.11.21 G Harris confirmed is progressing with risk owners and support teams. Chair asked that the action be left open until further assurance given around ability to close it down.</p> <p>05.01.22 A meeting is being scheduled before the end of January with SEE, GH, SH & CS to agree a consistent RAG rating for all documents.</p>	<p>November</p> <p>January</p> <p>February</p>
4	M Smith A Thomas	QS21/105.4 Mental Health Provide a thematic analysis on psychological services to the November meeting.	November	<p>21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format.</p> <p>7.9.21 C Stockport clarified this would be a joint report.</p>	November

				<p>22.10.21 Paper deferred to January meeting</p> <p>2.11.21 L Reid wished to clarify that the paper would address psychological services across the Health Board as a whole, not just within MHLDS. A Thomas confirmed the paper would be ready for the January meeting.</p> <p>Due to staff sickness, it has been necessary to defer the report again</p>	<p>January</p> <p>March May</p>
7th September 2021					
5	S Green	<p>QS21/130.2 BAF</p> <p>Consider whether the psychological impact of staff returning to work post-isolation should be built into a relevant risk either on the BAF or Corporate Risk Register</p>	November	<p>14.10.21 Staff who are returning to work who have been shielding have a site specific risk assessment (RA) undertaken on their return with adjustments made to ensure a Covid safe environment is in place with enhanced PPE if required. A consultant medical practitioner, the manager, HR Team and OH&S, supports the RA process. The staff wellbeing support service provides a range of emotional/psychological support services brought together to meet a range of needs for staff encompassing counselling (through the Occupational Health and Wellbeing service and RCS), clinical psychology, coaching and the support of a network of Wellbeing Champions. A pathway to support staff in crisis is also being finalised with the MHLD Division. A Strategic Lead for the Staff Wellbeing Service has been recruited – who is a Consultant Clinical Psychologist – who will manage and continue to further develop the staff wellbeing service across the Health Board, working with and leading a multi-disciplinary</p>	Closed

				<p>Wellbeing Cell to take forward this work, the latter reporting to the newly re-established Health and Wellbeing Group, which met in September 2021. Reports and risks identified are escalated via the WOD Risk Management Group and report to the Strategic Occupational Health and Safety Group. If significant risks are identified, they will be escalated through the governance structure.</p> <p>2.11.21 J Hughes suggested that the update above did not answer the question. S Green commented that she would reopen the action to ensure this was more explicitly built into the Covid risk.</p> <p>05.01.21 This is being updated on the risk register.</p> <p>22.02.22 Following discussion with Jackie F Hughes, it has been agreed that if further evidence of staff requiring additional psychological support than that provided due to the psychological impact of returning to work, this would be assessed and either the associated risks already recorded would be amended or a new risk will be placed on the risk register and escalated through the governance structure if necessary to the BAF.</p>	End of January
6	L Brereton S Evans- Evans	QS21/130.3 BAF Take BAF21-04 (planned care) back to RMG for deep dive comparison alongside different approach taken with security risk	November	25.10.21 Deep dive on planned care BAF risk planned for December RMG. Deep dive on Security and H&S BAF risks undertaken at the October RMG.	December

				The last RMG was stood down due to Gold Command pressures.	March
7	N Lyons	QS21/137.3 Pharmacy & Medicines Management Follow up the issue of pharmacy support to mental health teams	November	25.10.21 Recruitment has been progressed and an update will be provided in Jan 2022 05.01.22 In progress, final dates for interview still to be confirmed.	January March
8	G Harris [R Gerrard]	QS21/139.5 YG Outbreak review Consider learning from human factors perspective in developing guidance for staff on coping mechanisms and techniques, on a scale wider than just Covid.	November	2.11.21 G Harris confirmed that the new IPC lead had just taken up her post and would pick up on this action. The transformation work led by C Stockport in terms of human factors would also be related.	January March
2nd November 2021					
9	G Harris	QS2/169.3 Nurse Staffing A comment was also made that the format and structure of the report made it difficult to identify harms that might have occurred as a result of staffing issues, and the Executive Director of Nursing and Midwifery undertook to look at identifying these in a separate appendix for future reports.	January	05.01.22 Noted, this will be updated on the next report.	May
10	G Harris	QS21/170.3 Falls Policy Refreshed policy to take on board the comments made with the involvement of the Independent Member (Trade Unions), and	December	05.01.22 The Policy has been updated in line with Chair's comments, GH's comments and IM comments. Is now being taken forward as Chair's Action	End of January

		progress through Chair's Action to provide Committee level approval.		18.02.22 On the March QSE Agenda	March
11	N Lyons	QS21/173.3 QaPR Provide assurance to the committee that sepsis performance issue was purely a data capture issue, and not a care intervention issue.	December	Further review of the Management of Sepsis shows that there is both a quality of data issue and also improvement needed in clinical management. The improvements needed are currently being developed and will be brought to QSE in March.	March
12	M Joyes	QS21.180.1 Quality Governance Assessment Cross reference the original self-assessment against the Audit Wales report when received.	January	Dec 2021 – The Audit Wales Report has not yet been received. Feb 2022 – The report will be finalises during Feb/March and therefore will be brought to the May meeting.	March May
13	S Green	QS22/10.2 The Committee commented that discussion had taken place at the Audit Committee around working arrangements with Local Authorities, for example, where buildings don't belong to us, and that a Memorandum of Understanding be drawn up with regards to Health and Safety. It was noted that this action had been taken forward and would be triangulated between the two Committees.		22.02.22 In relation to LA premises or others where E&F are involved in securing accommodation needs for BCUHB staff, it is regulated either through a licence to occupy or for more longer term solutions through a Lease. These arrangements ensure that the duty holder role is clear and that responsibilities are discharged. For example we would review the Gas Electrical, Fire, Security, Asbestos, Maintenance provision and ensure the premises are suitable for our staff. We would ensure whatever equipment and activity undertaken is risk assessed to ensure our staff are safe. We have a number of tenancies with LA's across North Wales. The landlord has duties under Section 3 to ensure premises are safe to those not in their employment such as BCUHB staff.	

14	S Evans- Evans	QS22/10.3 The Chair raised the action around the Executive Team discussing consistency of the RAG rating terminology. It was noted that due to pressures in the system this had not taken place but would do so as soon as possible.		A review of the Risk Management Strategy has commenced.	
15	N Lyons S Evans- Evans	QS22/10.5 The Chair raised concerns about the lack of clinical risks being reviewed at the Committee. The Chief Executive noted that once internal audit have issued their brief, and any early sight would be helpful, it will identify the gap in clinical risk and the new Executive Director responsible for risk will be able to take this matter forward. It was noted that the management of risk needs to be reviewed to ensure that the high level risks are the right ones and that a process of escalation needs to be reviewed to ensure that there is a route for Board level oversight which highlights patient safety culture.		18.02.22 Clinical Executive Directors have committed to supporting clinical teams identify risks in a more systemic way. A review of the Risk Management Strategy has commenced.	
16	S Hill	QS22/11.1 An updated Quality and Performance report is being working on the lead Executive to take into consideration the comments made from the Committee outside of the meeting.		18.02.22 The development of the new performance reporting system is underway and incorporates the detailed feedback received as part of the engagement with Board members. The current timeline will deliver an integrated	April

				<p>report on clinical and operational performance from April 2022.</p> <p>There is a multi- disciplinary project team in place to deliver the new system, with the clear expectation that the new report will meet the specific requirements of the three Sub-Committees of the Board which receive the performance report.</p>	
17	N Lyons	QS22/14.7a Cross reference the Vascular Action plans to ensure that they show as joined up.		18.02.22 Revised Vascular improvement Plan on agenda	
18	L Reid	QS22/14.7b The format of the HIW Report did not uploaded effectively, a single improvement plan format was being produced based on improvement methodologies that will return to a QSE workshop. LR to decide how best to take assurance on this point after the meeting.		This is being taken forward outside of the meeting and will return.	May
19	M Joyce	QS22/17.1 MJ to feedback to QSE from the Quality Improvement Group in relation to the Conwy Morfa Ward Action plan.		The Committee's comments have been fed back and the Monitoring and Oversight Group met for the first time on 09 February 2022. Regular reporting to the Committee on progress will commence.	Suggest close
	G Harris	QS22/22.1 Amend a typographical error on the cover paper for Internal Audit Report into HASCAS - Huw		The amendment was made after the meeting	Suggest close

		Jones should be replaced Huw Thomas			
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Health Board
10.03.22



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Quality, Safety and Experience (QSE)
Meeting date:	11 January 2022
Name of Chair:	Lucy Reid, Committee Chair and Independent Board Member
Responsible Director:	Gill Harris, Executive Director of Nursing / Deputy CEO
Summary of business discussed:	<p>The Committee received the following:</p> <ul style="list-style-type: none"> • Two videos were produced to explain the work done to allow more visitors to attend inpatient wards safely supported by lateral flow testing. • A verbal update on the Clinical Services Strategy • Covid-19 Vaccination Programme Report from Gold Command • Corporate Risk Register • Patient Safety Report • Quality/Safety Awards and Achievements • Hergest HIW Report and Action Plan • Vascular Services progress in delivery of the Vascular Improvement Plan. • Safeguarding Q1/2 Report • A report on the learning from Morfa Ward (Llandudno) • A report on learning from medication incidents • A Health and Safety Report • A report on the quality of General Surgery at YGC • The Quality Governance Self Assessment Action Plan (Maternity Services) • Internal Audit report into HASCAS for information • Nurse Staffing Levels Policy amendments <p>It should be noted that a revised approach to the use of a consent agenda was utilised in this meeting in response to the Covid pressures across the service.</p>
Key assurances provided at this meeting:	<ul style="list-style-type: none"> • The Committee received a report on medication incidents and associated learning across the organisation. The report noted the level of under reporting across the Health Board which is not therefore reflective of the level of harm. The report explored the reasons for under reporting and the human factors contributing to medication errors including plans to address these.
Key risks including mitigating actions and milestones	<ul style="list-style-type: none"> • The Chair raised concerns about the lack of clinical risks being reviewed at the Committee. The Chief Executive noted that once internal audit have issued their brief, and any early sight would

	<p>be helpful, it will identify the gap in clinical risk and the new Executive Director responsible for risk will be able to take this matter forward. The Executive Director of Nursing & Midwifery was able to advise that the Acting Director of Quality would be escalating new clinical risks at the next RMG, falls, WHO check list adherence and pressure ulcers. The Executive Medical Director has separately requested sepsis be added to these. It was noted that the management of risk needs to be reviewed to ensure that the high level risks are the right ones and that the process of escalation needs to be reviewed to ensure that there is a route for Board level oversight which highlights patient safety culture.</p> <ul style="list-style-type: none"> • The HIW report was received following an unannounced inspection of the unit. The Committee were concerned about the recurring themes identified within the report by HIW which had not been addressed. A mental health summit meeting had taken place to discuss sustainable learning which will take into account the findings from the Hergest Serious Incident Review report and the investigation for Ty Llewellyn. Both will be discussed at the March QSE Committee meeting. • The Committee received an update on the Vascular Improvement Plan and discussed recent information received noting that the organisation was an outlier in terms of post amputation mortality rates. The Committee were informed that there were data quality issues that were being investigated. The need for a consistent improvement plan format was discussed to provide confidence in the progress being reported. It was agreed that the Chair would consider how the Committee could receive assurance in future meetings. <p>The Quality Performance Report was not received by the Committee due to a number of errors having been identified.</p>
Targeted Intervention Improvement Framework Domain addressed	<ul style="list-style-type: none"> • Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	No issues to be referred
Matters requiring escalation to the Board:	No issues to escalate noting that vascular services are already on the Board agenda
Well-being of Future Generations Act Sustainable Development Principle	<p>The Committee gave adequate consideration to the sustainable development principles:</p> <ol style="list-style-type: none"> 1. Balancing short term need with long term planning for the future; 2. Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4. Putting resources into preventing problems occurring or getting worse; and

	5.Considering impact on all well-being goals together and on other bodies)
Planned business for the next meeting:	Range of regular / standing items plus: <ul style="list-style-type: none"> • Quality Aspects of IMTP • Workshop Feedback Update • Vascular Progress against Action • Patient Safety Report to focus on Never Events and Regulation 28 • Hergest External Review and Action Plan • Ty Llewelyn Report
Date of next meeting:	1.3.22

V0.2



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Executive Lead for Quality – Briefing Paper						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery						
Awdur yr Adroddiad Report Author:	Mathew Joyes, Associate Director of Quality						
Craffu blaenorol: Prior Scrutiny:	Mathew Joyes, Associate Director of Quality Gill Harris, Executive Director of Nursing and Midwifery						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Committee is asked to note this report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This paper provides the Committee with the Executive Lead for Quality Briefing Paper.							
Cefndir / Background:							
<p>This paper offers a summary of key quality information for the preceding period between meetings. Detailed information is contained within the reports presented to the Committee. The Committee is advised this report is live to the point of finalisation and therefore may present more detailed information than that within reports that cover a set reporting period.</p> <p>Patient Safety Incidents</p> <p>The Patient Safety Report provides details of Nationally Reportable Incidents and Never Events during December 2021 and January 2022. There have been zero additional Never Events to the point of this paper being written.</p> <p>There have been 7 executive led incident review panels.</p>							

The key themes from these include:

- Failure to escalate
- Timely observations and recognition of the deteriorating patient

Alongside local learning the following is being taken forward corporately:

A safety alert has been circulated regarding the need to escalate and further work is being led by Mandy Jones (Acting Deputy Director of Nursing) to inform the future role of the Acute Intervention Team

A mapping of cardiac arrest calls has been requested to review incidence to inform management of deteriorating patients

Wider record keeping is being included within the future clinical audit plan and professional body sessions are being planned to reiterate responsibilities.

Independent Investigations

Two independent investigations are being reported to the Committee. A third independent investigation remains underway and is expected to be completed for the next meeting.

Falls and Healthcare Acquired Pressure Ulcers

A separate paper has been produced for this Committee meeting providing a context for the risks being managed and the potential consequence of harm. Whilst focussing on falls and pressure ulcers the principals apply elsewhere.

Inquests

There has been one Regulation 28 (Prevention of Future Death) Notices issued since the last meeting. This has not been received at the time of writing and full detail will be provided when available. The Health Board's response to the two recent two notices is detailed in the Patient Safety Report.

Ombudsman

There have been no Public Interest Ombudsman Reports received since the last meeting.

The Chief Executive and Associate Director of Quality held their annual meeting with the Ombudsman and their Head of Complaints Standards on 01 February 2021. This will be reported in the Chief Executive's Report to the Health Board. The meeting noted the positive working relationship between the two organisations and no issues of concern were discussed.

The Ombudsman, Nick Bennet, completed his term of office at the end of March 2022. Michelle Morris has been confirmed by the Senedd as the next Public Services Ombudsman for Wales.

Royal College of Surgeons - Vascular Review

The Committee will be aware of the publication of the second stage of the Royal College of Surgeons Invited Review of vascular services. An extra-ordinary Board meeting was held on 15 February 2022 where the Board discussed the actions being taken and additional actions to be taken.

Quality Grand Rounds

The Quality Directorate has continued its successful new programme of Quality Grand Rounds. In January a session was held on statement writing and in February on the role of the Medical Examiner. Both sessions were facilitated by expert speakers and staff from across the Health Board attended.

Morfa Ward Review

The Improvement and Monitoring Group formed following the Morfa Ward review met for the first time on 09 February 2022. The group includes staff from across the Health Board and external partners including the Community Health Council, University, Age Cymru and Local Authority Safeguarding.

Duty of Candour and Quality

The Health Board is actively engaged in the national work to develop the guidance and requirements for the two duties coming into force next year. The Health Board's Associate Director of Quality represents NHS Wales' quality leads on the national steering group. Further detail will be provided to the Committee during the year as the guidance develops.

Patient Safety Programme

An initial workshop was undertaken in February 2022 with clinical leaders to review and discuss the priorities for the new Patient Safety Programme. This programme, with the support of the new Transformation and Improvement Directorate, will strengthen the delivery of improvement work in relation to patient safety priorities.

Leading for Safety Improvement Programme

Improvement Cymru is commissioning an internationally recognised senior leadership safety improvement programme. This programme, launching on 17 March, is aimed at Assistant/Deputy Directors of Nursing, Therapies and Assistant/Deputy Medical Directors/clinical leads who have a key role in Health Boards and Trusts for quality. The programme will be delivered and facilitated by internationally proven safety improvement experts.

Two to three funded places are available to Health Board staff. Applications were opened on 14 February 2022 for Health Board staff to apply.

WHSSC Workshop

The Health Board's Associate Director of Quality, and the Committee Chair, attended the Quality and Patient Safety Workshop held by Welsh Health Specialist Services Commissioning (WHSSC). The workshop provided an opportunity to be updated on developments in WHSSC.

Head of Legal Services

The Health Board has appointed to its new role of Head of Legal Services. Anna Reid will commence in post during late April 2022.

The Head of Legal Services reports to the Associate Director of Quality and oversees the functions relating to healthcare law (i.e. claims, inquests, Mental Health Act, Court of Protection, etc). A service review is underway to create the new team supporting Anna.

Quality Recognition

The Quality Awards and Achievements Paper highlights a range of successful quality initiatives and improvements.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Contained within separate papers on the agenda.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Patient Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	QS22/43 Recommend Quality aspects of IMTP						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport Executive Director, Transformation, Strategic Planning and Commissioning						
Awdur yr Adroddiad Report Author:	Mr John Darlington, Assistant Director - Corporate Planning Mr Matthew Joyes, Acting Associate Director of Quality						
Craffu blaenorol: Prior Scrutiny:	The plan has been discussed by Executive Team, Executive Management Group (EMG), Stakeholder Reference Group (SRG), Local Partnership Forum (LPF), Healthcare Professionals Forum (HPF) and Partnerships, People and Population Health Committee (PPPH)						
Argymhelliad / Recommendation:							
It is recommended that the Committee:							
1. Receive this report outlining quality aspects of the draft Integrated medium Term Plan (IMTP)							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	√	Ar gyfer sicrwydd For Assurance	√	Er gwybodaeth For Information	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						Y	
The plan is subject to Equality Impact (EqIA) and socio-economic duty (SED) impact assessments being completed.							
Sefyllfa / Situation:							
The purpose of this report is to highlight quality aspects of the IMTP							
Cefndir / Background:							
Integrated Medium Term Plan (IMTP) planning arrangements have been re-established across NHS Wales for 2022/25 following a pause due to the pandemic. Subsequently, the NHS Wales Planning Framework was received on 9 th November 2021 and re-affirms Ministerial priorities outlined in July 2021:							
<ul style="list-style-type: none"> • A Healthier Wales - as the overarching policy context • Population health • Covid - response • NHS recovery • Mental Health and emotional wellbeing • Supporting the health and care workforce • NHS Finance and managing within resources • Working alongside Social Care 							

The planning framework emphasises the importance of the Primary Care Model for Wales which sets out how primary care will work within the whole system to deliver a place based approach (primary care is defined as primary and community health care services). Cluster working is at the core of this as it brings together local health and care services to ensure care is better co-ordinated to promote the wellbeing of individuals and communities.

Our plan has been developed in the context of the unique challenges and health needs of our population arising from the pandemic, which face all public services and society at large. It reflects the challenges the Health Board has to address in delivering health services, whilst supporting and protecting staff.

A key aspect to this recovery is ensuring that care is as safe as possible, and that harm is minimised. The five harms we describe in health and care in Wales, are:

1. Direct harm from COVID-19 itself
2. Indirect harm from COVID-19 due an overwhelmed health and social care system and reduction in healthcare activity as a result
3. Harm from population based health protection measures i.e. educational harm
4. Economic harm both directly and indirectly as a result of COVID-19 i.e. unemployment as a result of lockdown
5. Harm as a result of exacerbation or introduction of new inequalities in society

As reported to the Health Board in January, we have re-cast our planning timeline in light of current system pressures and following correspondence received from Welsh Government (WG) on 21st December confirming the national deadline for the submission of plans, extended as a result until 31st March 2022.

A number of key schemes/main priorities for 2022/23 were tested and refined throughout January following our prioritisation work in December to ensure plans are realistic and robust. From this, our priorities for delivery have been identified and aligned to our financial allocation which was received in December to ensure our plan is financially balanced.

Asesu a Dadansoddi / Assessment & Analysis

In June 2020 new legislation gained royal assent: the Health and Social Care (Quality and Engagement) (Wales) Act. The Act introduces a new duty of quality placed on NHS bodies and Welsh Ministers (in relation to their health-related functions). This enhanced legal duty sets out that all decisions that are made are done so as to secure improvement in the quality of the services provided within the Welsh NHS, and to deliver improved outcomes for the people of Wales. This legislation emphasises the need for organisations to go beyond simply maintaining their services, and to strive for continuous improvement and excellence with as much focus on health improvement and protection as sickness management.

Welsh Government Quality and safety Framework: learning and Improving (2021), Action 8 identifies: NHS organisations demonstrate through their plans that patient care and experience is central to their approach and delivery and that their governance arrangements support this requirement.

These characteristics of quality align with our prudent health and care principles:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production (person centred)

- Care for those with the greatest health need first, making most effective use of all skills and resources (timely, efficient, effective)
- Do only what is needed - do no less, do no harm (safe, efficient)
- Reduce inappropriate variation using evidence-based practices consistently and transparently (equitable, effective, efficient)

The following tables outline examples of key schemes within the plan (table 1) to illustrate their contribution to the aim of the NHS Wales quality act domains (table 2):

- Improving safety
- Clinical Effectiveness
- Patient experience

Table 1: Example of schemes within our plan and initial outcomes to be achieved

Scheme	Initial outcomes
Community Pharmacy Enhanced Services - Alcohol and Blood Borne Viruses	To help the public recognise the risks associated with their personal alcohol consumption behaviours and de-normalise risky alcohol consumption and the inevitable burden on primary care workload, hospital admissions and subsequent expenditure.
Eye Care	People receive appropriate access to on-going care and management of their eye condition.
Further development of the Academy	Wider range of professionals able to support patients with complex primary care presentations. Greater awareness outside of north Wales of rich training, academic and employment opportunities in Primary Care in BCU, resulting in an increase in applicants from forward thinking healthcare practitioners
Mental Health Improvement scheme - CAMHS Transition	Providing consistent equity of access to services across North Wales and provide opportunity for peer support and the sharing of best practice, where children, young people, and their families have access to early help and emotional support when they need it the most
Implementation of Audiology pathway	Greater and quicker access to audiology led care for hearing loss and ear wax management, resulting in <ul style="list-style-type: none"> • increase in positive interventions to manage hearing loss • quicker intervention to manage hearing loss • less unwarranted use of antibiotics less ear perforation, scarring
Health & Safety Statutory Compliance	<ul style="list-style-type: none"> • Improved staff awareness of health and safety in the workforce • Staff can easily apply health and safety training in their daily working practice • Systems are implemented across the Health Board to ensure staff are safe at work
Video consultations	Reduction in patient time spent travelling, when video consultation provides an acceptable alternative to a face to face consultation.
Home First Bureaus	Increase in the number of people returning to their own home following a hospital admission

	Increased number of assessments outside of a hospital setting, leading to a more accurate assessment of need and ability, as well as leading to shorter lengths of stay
Improving minimal access surgery in gynaecology and north Wales specialist endometriosis care	Ability to provide more advanced gynaecology treatment, including for endometriosis in north Wales. This means less patients will have to travel for specialist treatment.
Suspected cancer pathway improvement	Improved efficiency through the patient journey leading to improved patient experience. Cancer pathways revised and aligned to achieve the national standard. Improved cancer waiting times.
Vascular	Increase capacity through provision of Middle Grade cover
Care Home support	Improved care, assured against an evidence based quality framework, in those care homes in which the QAF has been deployed to.

Table 2: Delivering upon the aims of the NHS Wales quality act: Improving safety; Clinical Effectiveness and Patient experience

Ref	Scheme	Safety	Clinical effectiveness,	Patient experience
b.2022.7	Community Pharmacy Enhanced Services - Alcohol and Blood Borne Viruses	●		
a.2022.6	Eye Care		●	●
a.2022.7	Further development of the Academy		●	●
a.2022.16	Mental Health Improvement scheme - CAMHS Transition and Joint working			●
a.2022.10	Implementation of Audiology pathway			●
a.2022.8	Health & Safety Statutory Compliance	●		
a.2022.40	Video consultations			●
a.2022.9	Home First Bureaus			●
a.2022.11	Improving minimal access surgery in gynaecology and North Wales specialist endometriosis care		●	
a.2022.36	Suspected cancer pathway improvement			●
a.2022.39	Vascular		●	
a.2022.1	Care Home support			●

Opsiynau a ystyriwyd / Options considered

Our plan is underpinned by robust business cases and priority schemes are identified which in turn consider potential options for delivery.

Goblygiadau Ariannol / Financial Implications

The plan integrates service, activity, financial and workforce implications within resources available.

Dadansoddiad Risk / Risk Analysis

All schemes will be required to identify key risks and a risk analysis undertaken to demonstrate how these will be managed.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The development of an approvable Integrated Medium Term Plan is a critical organisational aim going forwards as this forms a key component of our targeted improvement work and a statutory requirement under the NHS Finance Act. Further improvements are being introduced against targeted intervention areas, using a maturity matrix approach to assess progress and leading to de-escalation.

Asesiad Effaith / Impact Assessment

Underpinning schemes and business cases will take into account any potential equality/Welsh Language/quality/data governance/digital/children's rights implications which may require an impact assessment to be carried out.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality Priorities						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery						
Awdur yr Adroddiad Report Author:	Mathew Joyes, Associate Director of Quality						
Craffu blaenorol: Prior Scrutiny:	Mathew Joyes, Associate Director of Quality Gill Harris, Executive Director of Nursing and Midwifery						
Atodiadau Appendices:	None.						
Argymhelliad / Recommendation:							
The Committee is asked to note this report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This paper provides the Committee with an update on the interim quality priorities agreed for 2021/22 and proposed priorities for 2022/23.							
Cefndir / Background:							
<p>The Health Board is working to develop its new Quality Strategy however the work has been delayed due to the clinical pressures encountered impacting on the ability to meaningfully engage and due to the wish to align with other priority work taking place such as the refresh of Living Healthier, Staying Well, the Integrated Medium Term Plan and Stringer Together.</p> <p>The pace of work on the Quality Strategy will now be expedited following the recent winter and pandemic pressures.</p> <p>In the meantime, the interim quality priorities have been refreshed and are detailed on the attached document for ratification by the Committee.</p>							

The overarching aim of the interim quality priorities is:

We will provide healthcare that is person centred, safe and effective for all

The aim is divided into three priorities, organised around the definition of quality from the Quality Act:

Priority 1: We will provide safe healthcare

Priority 2: We will provide clinically effective healthcare

Priority 3: We will put patients and carers at the heart of our services

Under each of these priorities is a set of actions. This is detailed on the attached “plan on a page.”

This plan on a page includes some of the previously agreed priorities from 2021/22 however some of the previously agreed interim quality priorities have been removed due to their completion – these are detailed below (in all cases the work continues to further enhance and develop this achievements as part of a continuous improvement approach):

Domain	Concluded Quality Action	Closing Position Update
Priority 1: We will provide safe healthcare	A new Speak out Safely process will be implemented	The Speak out Safely process has been launched, as has the Work in Confidence platform and recruitment of Speak out Safely Guardians. A Multi-Disciplinary Team is in place to oversee. Reporting to the RaTS Committee is in place.
Priority 2: We will provide clinically effective healthcare	A new Transformation and Improvement Service will be created	A new Director of Transformation and Improvement has come into post and the new Service has been formed and is developing. A new Transformation and Improvement Strategy is in development and has been presented to the Board.
	A clinical lead for mortality review will be appointed	A new Associate Medical Director of Mortality Review has come into post and the national framework is being implemented (this includes close working with the new Medical Examiner Service). Close collaboration is developing with the Patient Safety team to align learning.

	Corporate and local quality teams will be aligned	All teams have now been aligned from 01 December 2021 except Womens which is currently underway. Work is now commencing to maximise the benefit of a single integrated function and to strengthen professional standards and development.
	Board Member Quality Walkabouts will be introduced	A programme has been developed and implemented. Further refinement is underway to maximise the programme.
Priority 3: We will put patients and carers at the heart of our services	The complaints process will be strengthened and improved	The new process has been implemented following co-design with stakeholders and an external review and there are early positive indications of chance. Significant ongoing focus and scrutiny is in place.
	A new patient information process and Readers Panel will be implemented	A new process has been implemented, supported by a new Procedure and a new Readers Panel. Work is now underway to develop the central library and catalogue all existing information. The EIDO platform has been embedded.
	A new real-time patient feedback system will be implemented	The new Once for Wales real-time patient feedback system has been implemented. A new Patient and Carer Feedback Framework is in development.
	Digital patient stories will be introduced	Digital patient stories (audio and video) have been implemented. A central library is being developed.
	Patient and Carer Experience Champions will be introduced	Over 100 Champions are now in place with regular engagement and development sessions. Recruitment and development will continue as a rolling programme.
	Patient use devices will be rolled out	Patient use devices have been rolled out and will continue to be actively offered and supported.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Contained within separate papers on the agenda.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Interim Quality Priorities – 2022/23

Quality Vision		
We will provide healthcare that is person centred, safe and effective for all		
Quality Priorities	Improvement Actions	Expected Outcomes
Priority 1: We will provide safe healthcare	The incident process will be strengthened and improved in co-design with patients, partners and colleagues	The aim of this work is to provide a more streamlined process, which has a focus on high quality learning and improvement – the expected outcome is a reduction in the repeated underlying causes of incidents
	The safety alert process will be reviewed and improved in co-design with patients, partners and colleagues	It is expected the new process will provide a more streamlined approach using technology alongside a greater level of assurance from team/ward-to-Board (note: Internal Audit recently gave very positive assurance to the new processes rolling out)
	A new safety management system (Datix) will be implemented as part of the Once for Wales Project	The new system will be implemented and the transition from old to new will be complete with minimal disruption and no data loss – the new system will provide an enhanced user experience and better quality data to support learning
	Conduct a safety improvement project on surgical safety including a focus on WHO Checklist & LocSSIPs using a human factors based intervention	There will be a reduction in the number of surgical incidents where the underlying causes relate to standard safety requirements
	Conduct a safety improvement project on falls reduction	There will be a reduction in falls where the underlying causes are the same across services

	Conduct a safety improvement project on pressure ulcer prevention	There will be a reduction in pressure ulcers where the underlying causes are the same across services
	Conduct a safety improvement project on managing deteriorating patients	There will be a reduction in incidents of patient deterioration where the underlying causes are the same across services
	The ligature risk reduction process will be improved	All ligature assessments will be completed, maintained up to date, and assurance reporting through the governance structure
	Deliver the Safe Clean Care project to ensure high standards of infection prevention and control	The project will support the effective prevention and management of infections
	Develop a human factors expert faculty to support safety improvement projects and investigations	A human factors faculty will be established and trained to a Health Board specified level with the faculty members supporting improvement projects and investigations
Priority 2: We will provide clinically effective healthcare	A new approach to the development of patient pathways will be developed	The new BCUPathways approach will be finalised and resourced to support the ongoing work required
	Strengthen the clinical audit programme using a risk-informed approach with greater link to improvement projects	The new clinical audit programme will be evidently risk informed and clearly linked into governance and improvement structures
	Strengthen the NICE implementation assurance programme	The NICE process will provide greater assurance on the cascade, assessment and completion of baseline assessments reporting through the governance structures
	Fully embed the new Learning from Deaths Mortality review Framework	The framework will be fully developed including roll-out of the new Once for Wales Datix Mortality Module
	A Learning from Excellence process will be introduced to recognise and learn from exceptional practice	A Learning from Experience system will be in place with reporting fed back into services
	The Quality Dashboard will be developed to improve patient-to-Board quality insight	The Quality Dashboard will be reviewed and strengthened to provide greater triangulation of data and improved risk-based reporting
	Engage with the Getting It Right First Time (GIRFT) programme in key specialities	Improvements will be seen in patient pathways and clinical practice, to reduce unwarranted variation

Priority 3: We will put patients and carers at the heart of our services	Develop a new Patient and Carer Feedback Framework and toolkit to set-out consistent expectations on using feedback to drive improvement	A new framework will be in place, alongside a toolkit, to support staff use patient feedback
	Develop a new Patient and Carer Involvement Framework and toolkit to set-out consistent expectations and tools for involving patients in delivery and improvement	A new framework will be in place, alongside a toolkit, to support staff use in the involvement of patients in areas such as recruitment, quality improvement, governance meetings, etc
	Develop a Carer Experience Assessment Toolkit and Accreditation process to consistently improve the experience of carers and the support offered to them	A toolkit and accreditation process will be developed in co-design with carers, with roll-out commencing as part of a multi-year programme
	Conduct a patient experience improvement project on compassionate care	Training and support will be in place to support a compassionate care based culture in clinical services
	Develop a Co-design and Co-production Toolkit and internal training offer to strengthen the organisation's maturity around patient experience and engagement	A toolkit and internal training offer will be made available to support greater patient and carer engagement

Note: A Patient Safety Programme is in development that will provide the framework for many patient safety improvement projects

These interim quality priorities will apply for 2022/2023 whilst the new Health Board Quality Strategy for 2022-2025 is developed. These priorities and actions reflect the work being done in 2022/23 to improve quality, based on identified risks and concerns and feedback from strategy development work so far. They will become part of the new strategy with clear outcome measures developed. Therefore they are expected to be priorities for the first half of 2022/23 only.



Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience (QSE) Committee 1 st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Vascular Steering Group Update						
Teitl yr Adroddiad Report Title:	Vascular Steering Group Update						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director						
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director (YGC) Sally Morris, Vascular Implementation Plan Adviser						
Craffu blaenorol: Prior Scrutiny:	None						
Atodiadau Appendices:	Vascular Improvement Plan updated in response to Part 2 of RCS report and a separate summary of Part 2 actions for ease of reference						
Argymhelliad / Recommendation:							
The committee is asked to receive the update from the Vascular Steering Group							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	X
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>In September 2020, the Health Board commissioned the Royal College of Surgeons (RCS) to carry out an invited review of the BCUHB Vascular Service to include a review of clinical records. The Terms of Reference were agreed in December 2020. The purpose of the review was to consider the standard, safety and quality of care provided by the vascular surgery service under the integrated Network arrangements in place since Spring 2019. A key focus was on the effectiveness of the multidisciplinary team (MDT) to provide continuous and optimal patient care.</p> <p>The first part of that report was received by the Health Board in March 2021 and has been monitored by the Vascular Task and Finish Group and more recently, the Vascular Steering Group. This has been overseen by QSE.</p> <p>The Vascular Oversight Group, an informal group to provide operational pace, continues to meet on a fortnightly basis. This group is chaired by the Executive Medical Director and includes senior medical leadership from all 3 acute sites. One of the responsibilities of this group is to unblock any obstacles to ensure the smooth implementation of the agreed patient pathways.</p> <p>The action plan has been reviewed to ensure that the actions are correctly owned, mitigations are in place, and that these are appropriate and sufficient. The revised action plan attached to this report has been reviewed at the Vascular Steering Group on 25th January 2022, and will be reviewed monthly thereafter. The current version of the action plan has evolved and has been formed from recommendations from parts 1 and 2 of the RCS reports, the National Vascular</p>							

Registry (NVR) audit and internal observations from within the vascular service and supporting services. The principle is to manage against one plan encompassing all improvement work required, rather than to create multiple plans.

The implementation of the work continues to be overseen and supported by the Vascular Oversight Group, but formal reporting will remain with the Steering Group (which includes Community Health Council and patient representation) with reporting through to QSE.

In November 2021, the Board received the annual National Vascular Registry (NVR) report highlighting concerns about the lack of prior validation of previous data submitted for the national audit, and the long-standing concerns in vascular outcomes. It noted some improvements in those outcomes in the most recent year as part of the three year rolling average, although care needs to be taken with regard to looking at small numbers in isolation and drawing any conclusions.

On 20th January 2022, the organisation received the second part of the RCS report, following the completion of the review of clinical notes. This report, which should be read alongside the first part of the RCS report for context, makes additional recommendations. These are summarised in this paper, and are now integrated and overseen via the overall Vascular Improvement Plan. The second part of the report reviews notes that document pathways of care from 2014-2021, covering the period before the changes to the service were implemented in Spring 2019, as well as care undertaken within the current hub and spoke model.

A report from CHKS has been commissioned to consider outcomes within the vascular service both before and after the implementation of the current networked solution for vascular services. The methodology and detail of this report is currently being reviewed and it is expected that this will be presented at the next steering group in March 2022.

Cefndir / Background:

In 2020 Health Board commissioned an external, independent review of the vascular service from the Royal College of Surgeons of England (RCS). The first stage of this culminated in a report which was provided to the Health Board in March 2021.

The second stage of this review, based on the analysis of 44 sets of case notes, began in July 2021, but the report was not made available to the organisation until January 2022. This report makes a further 9 detailed recommendations, based on the review of notes from 2014 – 2021.

The North Wales Vascular Network which is currently in place remains in keeping with the Board's decision for the adoption of a hub and spoke model, with appropriate capacity for patients at all 3 acute sites.

External reviews, continue to support the “consolidated service” implemented in 2019 This model is in line with services that have been in place across other parts of the United Kingdom for many years.

Asesiad / Assessment & Analysis

In 2021, the first part of the RCS report made 22 recommendations related to patient safety and service improvement. The recommendations were fully accepted by the Health Board, and progress has been made in delivering this service by the North Wales Vascular Network. However, more work is needed to ensure consistent and sustainable delivery of the highest quality vascular pathways across North Wales.

The Vascular Improvement plan is appended to this report , but the 9 recommendations from the second stage of the RCS review are:

1. The need to provide follow up and communication with some patients as a result of the case review
2. The need to review the care and outcomes for some patients to ensure that the Health Board is aware of the position
3. The need to review in detail the findings of the reviewers in relation to the cases reviewed
4. The need to review the multidisciplinary team (MDT) arrangements for patients undergoing vascular surgery
5. The need to review the consent-taking practices and recording of those consent discussions in keeping with latest standards
6. The need to carry out an audit of the clinical notes and standards of clinical note keeping
7. The need to improve the quality of the clinical record
8. Consideration of closer working with Liverpool University Hospitals NHS Foundation Trust
9. The inclusion of Liverpool University Hospitals NHS Foundation Trust in the MDT discussions, particularly in relation to the vascular aneurysm pathways

These recommendations, particularly in relation to MDT working, build on the previous recommendations received as part of the first stage of the report in 2021 but also provide additional areas on which to focus improvement. Some, but not all, of these recommendations are already addressed within the existing Vascular Improvement Plan.

In Appendix 1 to this paper is an updated Vascular Improvement Plan in response to these recommendations. Also included are additional early actions developed with clinical and operational teams to ensure that actions are effective and that lessons are learned not only in the vascular service but also more widely across the Health Board.

These actions include

- The development of a Vascular Quality Panel that will, with external support and validation, review the clinical notes and carry out additional thematic review of notes as necessary across BCUHB. The group will also look to provide assurance that a representative sample of notes has been considered. It is expected that an independent Chair for this panel will have been appointed by the time the Committee receives this paper
- Review of current notes and consent in vascular services (all sites) as well as development of further clinical leadership capacity to oversee and implement standards
- Agreement in principle to work more closely with Liverpool, particularly in relation to MDT discussions but also in terms of wider standards developed and clinical support. It is expected that Memorandum of Understanding to support this service is formalised in the near future
- Development of an open and transparent communication plan in line with Caldicott Principles, including engagement with families and patients within the Quality Panel review process
- Discussions with Welsh Government and regulators of professional practice which may result in regulatory action
- Support for staff involved in the vascular service but also more widely across the Health Board.

NVR action plan

Actions formulated following the MDT major amputation mortality review are ongoing and audits are underway to ensure that priority actions are embedded and demonstrate a change in practice.

Pathway work

The Diabetic foot pathway has now received sign off from each site and agreement has been gained for an initial 3 month 'soft launch' implementation to allow effective ownership from within clinical teams. There will be a quarterly review to determine incidents of deviation from the pathway or poor patient outcomes to allow for amendments to pathway or process as needed. The Diabetic Foot meetings will continue to ensure that operational and clinical support is not lost

All other pathways have been realigned as of 20th January 2022 to the Medical Directors for the spoke sites, to discuss and agree with their respective specialty teams and progress will be updated for the next paper.

The remaining pathways consist of repatriation of patients post vascular intervention back to local hospitals, management of vascular day case patients completed at spoke sites requiring overnight stays, and management of patients with groin swelling and a history of IVDU (previously signed off at CAG Dec 2021).

There were 57 actions that stemmed both from the 1st stage RCS report and from gaining understanding for the specialty once the action plan was revised, 33 of those are now complete with further work remaining in the areas of governance, theatre, communications and pathways between the hub and spoke sites. A number of the actions are reliant upon funding from the vascular improvement funding scheme submitted to IMTP but the confirmation of funding is not impeding progress

The risk register has been reviewed for vascular service with the interim Clinical Director and the vascular networks managers and is in need of updating which will be completed before the end of February. The identified risks all relate to actions and recommendations within the vascular improvement plan from the 1st stage RCS report and the NVR actions relating to theatre access and bed or ITU bed availability.

Opsiynau a ystyriwyd / Options considered

The need to ensure external validation and assurance of the effectiveness of actions within the Vascular Improvement plan is currently being considered.

Goblygiadau Ariannol / Financial Implications

A detailed proposal of additional workforce requirements to ensure sustainability of the vascular service is currently being developed for the Integrated Medium Term Plan (IMTP).

Dadansoddiad Risk / Risk Analysis

The risk register is currently being reviewed following receipt of this plan.

Reputational risk – high and likely

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Any legal implications in relation to the quality of consent are currently being considered. The Health Board is working closely with regulators in relation to professional standards.

Asesiad Effaith / Impact Assessment

Currently under consideration.

Vascular Improvement Plan (Revised October 2021)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Contents

Action Plan	Founded upon RCS review part 1 &2, NVR performance report and internally guided improvement actions
Action Log	Driven by workstream meetings and internal actions
Issue Log	Driven by workstream meetings and internal actions
Risk Log	Relating to risks of not having RCS recommendations in place and their impact

Current Performance for Actions		
Complete	36	35%
In progress	39	38%
Not yet commenced	29	28%

Total	104
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[illegible]

Spoke Vascular presence	8	Vascular presence at Spoke Sites	Full capacity and demand exercise requires completion across all sites.	Vascular Network manager supported by DGM Surgery YGC and Vascular Clinical Lead	Medical Directors	01/04/2021	30/06/2021	30/04/2022		In progress		Pending BCUH8 Demand data and 1st draft capacity by due date	Demand work is currently ongoing from informatics to support this review		All sites are covered with locum backfill for shortfalls in the short term. 24/10/21 Recruitment of additional consultant to cover spoke site will alter the current working pattern for surgeons based at the spoke site 16 November update - requested demand data from informatics - work will shortly commence to review the current capacity and the potential capacity with recruitment and MG cover 25 November update - Capacity work has commenced 17 January update - This action will be delayed due to capacity issues along with leave			
	4.2.17		Gap analysis of Junior / middle grade and Consultant vascular staff to be included in BCU pan business case. Additional Deanery and non-training grade vascular surgeons required to allow for learning opportunities at spoke sites and to reduce reliance on general surgery trainees	Vascular Clinical Lead supported by Vascular network manager and DMG Surgery YGC	Medical Directors	01/04/2021	30/06/2021	31/03/2022		In progress		1st draft capacity by due date	Use of Locum middle grades to support aspects of the vascular service		16 November update - Middle grade rotation inclusive of long day on call, weekend on call and spoke site rotation is underway. Supported by Medical workforce, a rolling job plan has been created to identify the number of MGs, the PA allocation and therefore the salary can be reviewed on this basis. Funding approval will be required and lead time for recruitment and start dates. 1 PA has been factored into the establishment requirements for ward and Junior Dr support. 17 January update - further work has been requested from workforce to model a 24/7 on call for vascular model			
Audit	4.2.14	6 Audits identified by vascular T&F group to be undertaken using national vascular registry (NVR) data should be progressed as part of assessment, evaluation and shared learning	<p>Audits on the following for completion:</p> <ul style="list-style-type: none"> * Same Day discharge following endovascular intervention (FS) Complete * Timeframes for lower limb bypass or endovascular revascularisation procedure for patients admitted with CUI as emergency (AR) * Below, through and above knee amputations since centralisation (AR) Completed * Carotid endarterectomy - time from symptoms to referral, referral to surgery and outcomes (RF) Completed * AAA timelines for referral to surgery open & EVAR and outcomes (UP) Deferred to March 22 * Complex aneurysm repairs EVAR / Open and outcomes (SS) Awaiting * Conversion of below knee amputation to through and above knee (AR) Completed 	Vascular Clinical Lead	Executive Medical Director	01/04/2021	30/06/2021	31/03/2022		In progress	Vascular CG	Annual Leave prevented presentation of all outstanding audits at December meeting	There is audit progress overall that are presented at the clinical governance meetings however the two identified remain outstanding		<p>Awaiting details on the outstanding audit subjects. New Audit lead appointed given Mr Taha's leave. Faissal Shaikh now leading.</p> <p>15/10/21 Same Day Discharge following endovascular intervention - complete / presented</p> <p>24/10/21 - Update from Soroush 4/7 completed and potential further 2 awaiting presentation, awaiting confirmation from audit leads</p> <p>10 November update - 3 audits outstanding completion / presentation - aim to be presented 10/12/21</p> <p>13 December update - 4 audits to be presented at January 18th 2022. Need to extend meeting from half to full day to accommodate.</p> <p>17 January update - 1 audit presented from the list, 2 more remaining to be presented.</p>			
Additi onal Reco	4.3.20	Additional Recommendations	Develop an action plan to maintain stability and attract further clinicians given the relatively rapid turnover of vascular surgeons within the service	Deputy Director operational Workforce	Medical Director	01/04/2021	30/06/2021			In progress			Locum use in place to cover existing shortfalls		Advert to be placed for Vascular Surgeons by Medical Director as a rolling 6 monthly action			
Communication	9	Completion of Comms section on Intranet	The dedicated vascular services page on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available and is expected to be finalised by the end of November.	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021	30/04/2022		In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review			Work is currently being undertaken to migrate the current intranet platform to a new one - no additions will be made until this work is completed with a potential start date for early next year. 17 January update - work is currently on hold pending seconded RCS report.			
		Development of Communications plan	To support the North Wales vascular service and highlight the progress being made, a communications plan is under development and will be reviewed by the Vascular Steering Group.	Communication Lead	Acute Site Director YGC	01/04/2021	30/06/2021	30/04/2022		In progress	QSE via Vascular steering group	Risk to delivery by due date On hold pending report from notes review			Further information required from the clinicians to complete the works for comms to share. Progress to date has been filming in the hybrid theatre an supply of 2 of the clinicians bios and photographs. 17 January update - work is currently on hold pending seconded RCS report.			
Action Plan	10	Review of all risks to ensure captured in the risk log	Risk from all of the above actions are to be logged in the risk log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021		ongoing		In progress / Ongoing	QSE via Vascular steering group		ongoing action		24/10/21 Revised action plan in 1st draft for review at the vascular steering group 25th October 2021 30 December - updated action plan reviewed at VSG 16 December			
	11	Review of all issues to be added to the issue log	Issues from all of the above actions are to be logged in the issue log and scored accordingly as to impact with current mitigations detail	Vascular Network Manager supported by Project support	Acute Site Director YGC	01/04/2021		ongoing		In progress / Ongoing	QSE via Vascular steering group		ongoing action		Risks and issues to be fixed agenda item on the CG meeting.			
NVR Actions	12	Review of higher than UK average Mortality for major amputations (3 year rolling calculation)	Ensure that ongoing annual review of major amputation mortality rates for the BCU population compared to rates seen in other Welsh Health Boards and the UK generally	Vascular Clinical Lead	Medical Director			01/12/2021	ongoing	In progress			CHKS data will be reviewed to see a more relative view of performance based on clinical coding		Suggest quarterly requests from CD to NVR			
			Report of cases including lessons learned to be completed and shared with wider MDT	Vascular Clinical Lead	Medical Director			07/12/2021	31/03/2022	In progress	Vascular CG	20 Jan for remaining cases review	Learning shared from first review with little variation to discuss from the second review		Discussed at CG meeting 10/12/21 MDT mortality review part 2 to be completed 20 January and will be shared at Vascular CG March 22			
	13	Incomplete data entry for NVR submissions	Improve data entry for IR cases across BCU	BCU Radiology Lead	Executive Medical Director			01/12/2021	31/05/2022	In progress		Requires resource from vascular improvement scheme	BCU radiology lead exploring options to improve		IR consultants required to add NVR data / funding approval and recruitment required to support the B2 data entry person for vascular entry. 30 December - emailed Helen Hughes to escalate the issue. 21 January update - meeting held with Helen Hughes - she will speak to clinicians re data entry for vascular patients. NVR data entry person would need to support - see below point in line with funding requirement for Band 2 data entry clerk			
			Require NVR data entry person	Vascular Network Manager	Acute Site Director YGC			01/12/2021	31/03/2021	In progress		Requires resource from vascular improvement scheme	None until resource available		Funding approval and recruitment required, submitted as part of vascular improvement for IMTP 17 January 2022 - SBAR to be submitted to acute site director for funding to expedite			
	14	Cross ref to action point 6	Improve access to emergency theatres for Lower limb revascularisation / carotid endarterectomy / carotid patients / major amputation	YGS Surgical DGM	Acute Site Director YGC			01/12/2021	30/04/2022	In progress	QSE via Vascular steering group	On hold for covid	The use of CEPOD lists in addition to theatre L for emergencies is in place		Discussed with Neil Rogers - need to review the possibility for additional emergency theatres. Additional CEPOD list in place Fridays although not specific to vascular but increased access. Escalated at oversight meeting 21/1/22 the need for the alternate Monday all day DC list to be returned to free up a little capacity from renal access patients Meeting held with Elaine Hodgson 10 February and assured that all efforts to be made to return the pre-covid alternate Monday list. Require resource approval for vascular improvement scheme and recruitment to allow for additional all day emergency list			
	4.1	Cross ref to pathways above	Repatriation pathway to be completed, signed off and utilised for admission to spoke sites from the hub	HoNs supported by DGMs and Clinical Leads	Acute Site Directors	01/04/2021	31/05/2021	31/03/2022		In Progress	QSE via Vascular steering group	Re-allocated to MDs	As above - patient being repatriated as capacity allows		Document previously completed and presented to CAG but anecdotally heard of some nursing concerns. For SM to pick up with HoN and liaise with counterparts at spoke sites 6/10/21 25th November update - requested CAG information to address all stakeholders and gain approval 3 December update - recirculated to Rhian Hulse, Keeley Twigg, Lesley Walsh and Ellie Kite for circulation again as been a year since agreement. It was held up at CAG as lack of evidence to support nursing involvement. Nursing clear involvement this time.			
	3	Cross ref from above for theatres	Review theatre capacity and ensure all pre-covid lists are returned	YGC Surgical DGM supported by Theatre Manager	Acute Site Director YGC			01/11/2021	30/04/2022	Not yet commenced	QSE via Vascular steering group	Covid 4th wave - issues with staffing	Cases previously completed on daycase list now being added to hybrid theatres		Alternate Monday all day case list removed during covid 25th November update - issues with theatre staffing prioritising lists in place due to staffing. 11 February update - meeting with Theatre manager and DGM YGC - to aim to have the all day alternate week Monday list back with additional staffing.			
	16	Prophylactic Antibiotics	Review the use of prophylactic antibiotics for amputees	Vascular Clinical Lead supported by microbiology lead	Medical Director				31/05/2022	In progress	Vascular CG		Previous audit shows good performance. Possibly relates to NVR data entry		Refer to major amputation audit 18 January 2021 - 100% patient had prophylactic antibiotics. Performance through to be linked to data entry. Will re-audit later this year to confirm.			
	17	MDT Review	All emergency patients to be discussed with intensivist, anaesthetics and relevant acute medical specialty prior to surgery taking place if unable to discuss at MDT meetings. Out of hours to use on call.	Vascular Clinical Lead supported by specialty leads	Medical Director				31/03/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting		11 Feb 22 update - Patient details and MDT outcomes received - need table top exercise to review the notes for confirmation.			
			All amputation decisions taken outside of the NW MDT forum are to be discussed at the following MDT and documented	Vascular Clinical Lead supported by specialty leads	Medical Director				31/03/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting					
			Non-vascular amputations should ideally be performed by the orthopaedic team where skill allows to prevent inclusion in the NVR data	Vascular Clinical Lead supported by specialty leads	Medical Director				31/03/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting					
			Consider patients with significant co-morbidities carefully by the full MDT for either conservative treatment of above knee amputation to reduce the risk for further interventions ,	Vascular Clinical Lead	Medical Director			10/12/2021	31/03/2022	In progress	Vascular CG		Audit to be completed on cases since 10/12/21 when team informed at CG meeting					
	18	Reporting	Ensure action plans monitored through vascular steering group and clinical effectiveness groups	Vascular Clinical Lead supported by Sally Morris	Neil Rogers				TBC	In progress / ongoing			Monitored at VSG monthly					
	4.1.1	Initial review of 44 notes in RCS report to ensure clinical follow up provided where needed	Formation of Vascular Quality panel to be formed to carry out a review of cases, open actions and map pathway and team where any additional action needed	Safty and Quality Lead	Medical Director			31/01/2022	25/02/2022	In progress	QSE via Vascular Steering Group		Plan is progressing		Highlight report to QSE March 2022 Quality panel formation in progress currently - Patient identifiers and electronic copies of notes in the process of being provided to the governance team			
	19 Internal	Initial thematic review of SI and current Datix complaints	Current work in Quality team to be included in Vascular Quality Panel and to map by pathway and team where any additional action needed	Safty and Quality Lead	Medical Director			In process 31/1/22	25/02/2022	In progress	QSE via Vascular Steering Group		Plan is progressing		Highlight report to QSE March 2022			
	20 Internal	Further review of cases informed by (1) and (2) for identified pathways or team including an assessment of whether the cases reviewed were representative	TBC by initial review	Safty and Quality Lead	Medical Director			TBC	TBC	Not yet commenced	QSE via Vascular Steering Group		Plan is progressing	1.Consider external validation of summary from Vascular Society or Liverpool 2. Methodology for review process to be approved at QSE	ToR and scope to be confirmed by initial review			

2nd Stage RCS notes review	4.1.1	Ensure patients receive communication in line with regulatory responsibilities	Patients and/or families within (1), (2) and (3) receive updates and clear communication on any need for further treatment and duty candour fulfilled where care has fallen below expectations	Safety and Quality Lead	Medical Director			In progress	TBC		In progress	QSE via Vascular Steering Group		Plan is progressing																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																														
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ACTION LOG

The purpose of this template is to record all actions from Programme-related meetings, and to record the action's owner, status and any further notes.

Action Number	Work stream	Action Description	Action Owner	Action Date	Action Deadline	Revised Action Deadline	Issues affecting delivery	Remedial Action - In Place or Planned	Action Complete Date	Action status	Comments	Assurance (how do we know the action has been delivered and embedded?)
61021-04	DFP East	Agreement to support an initial once per month MDT on a Tuesday pm. Managers to review activity and protect time to allow this to take place within specialty	Nicola Joyce / Anthony / Laszlo / Patrick	17/11/2021	01/12/2021	28/02/2022	Patrick / Hassan and Anthony planned to attend with Nicola once per month			Not yet due OR In Progress	Managers to meet and arrange a Tuesday pm once per month (wk. 1 or wk. 3 ideally for vascular). Room etc. to be arranged by NJ following determination of what will be completed in the session once a month	
120122-01	DFP East	Need to ascertain Patrick / Orthopaedic availability for MDT and ensure capacity is sourced within Fracture clinic to house the MDT	Claire Poole	12/01/2022	26/01/2022	28/02/2022				Not yet due OR In Progress		
160222-01	DFP East	Ensure that platforms are available to allow all specialists to have sight of clinical notes and photographs. GLH to link in with Thearpy manager etc to allow access for relevant people	Gareth Lloyd-Hughes	16/02/2022	02/03/2022					Not yet due OR In Progress		
160222-02	DFP East	Orthopaedics use EPOC and electronically to GPs. Manual notes must be entered into the medical notes to briefly outline the discussion and outcome of the ODP attendance to enable all to see	All clinicians	16/02/2022	02/03/2022					Not yet due OR In Progress		
160222-03	DFP East	Review ALAC for potential of base for MDFS clinics	Sarah Mazzone / Claire Poole	16/02/2022	02/03/2022					Not yet due OR In Progress		
160222-04	DFP East	Review the average number of those diabetic foot patients who require the use of the plaster room versus those that are managed by the podiatry team / orthotics etc	Gareth Lloyd Hughes	16/02/2022	02/03/2022		For consideration of how much of a burden this may be on existing fracture clinic			Not yet due OR In Progress		
160222-05	DFP East	Development of SOP from all specialties	Gareth Lloyd Hughes / Anthony Dixon / Patrick Laing / Laszlo Papp supported by ops lead and Nicol Joyce	16/02/2022	16/03/2022					Not yet due OR In Progress		

ISSUE LOG

The purpose of this document is to record all Programme-related issues and their mitigation

Definition of issue:

A relevant event that has happened, was not planned, and requires management action. It can be any concern, query, request for change, suggestion or off-specification raised during a Programme. Programme issues can be about anything to do with the project.

Issue ref	Work stream	Date issue raised	Description of the issue	Description of the cause and impact	Severity - Catastrophic/Major/Moderate/Minor/Negligible <i>please use dropdown</i>	Issue response action
1	DFP	01/12/2021	Failure to determine a single pathway across BCUHB for signposting the DFP patients into the correct specialties from ED	Failure to agree on a single pathway is preventing implementation of NICE guidance for managing patients with the diabetic foot	Major	East are liaising directly with Nick Lyons and West have signed off. Centre are raising some issues in relation to vascular and orthopaedics. Medical Director involved in trying to reach a consensus
2	DFP	01/12/2021	Failure to determine the resource required for DFP implementation due to no final resolute pathway	unable to commence business case without the identified resource gap and hence delay in delivery of patient pathway	Moderate	Fortnightly meetings continue. Escalation to DGMS. Awaiting only confirmation from Orthopaedics at Centre
3						
4	Pathways	01/12/2021	Repatriation pathway progressed through CAG but then didn't receive Exec endorsement. Re-circulating 1 year on to progress through CAG / Execs	Patients remain longer than clinically necessary on ward 3 impacting upon cancellations on the day due to lack of bed availability and vascular patients being managed in non-vascular beds	Major	COTE team at West now have concerns - meeting to be planned for discussion with them and also General Surgery as to whom the patients will fall to if no rehab potential.
5	Pathways	30/12/2021	Failure to agree consensus on managing day case vascular patients requiring an overnight stay following general anaesthesia at East	Potentially meaning that patients would need to be transferred to YGC for the overnight stay prior to discharge.	Minor	Pending meeting with Andrew Baker at East as only area with concerns for housing vascular day case patients overnight. Pathway being drafted for meeting.
6	Pathways	09/01/2022	IVDU disseminated, agreed and passed through CAG. Gen Surg at West then raised objection.	Potentially meaning that patients will not be in receipt of standardised care across 3 sites. Likelihood of all patients being transferred to YGC putting pressure on beds.	Minor	Meeting 18 Jan to discuss at clinical governance meeting
7						
8	Governance	01/12/2021	Lack of robust capture and sharing of learning outcomes from vascular governance / practice	Lengthy meetings and discussions but not captured succinctly and shared which could prevent learning from incidents	Moderate	
9	Governance	09/01/2022	Lack of resource to allow for accurate and timely data entry onto the national vascular registry	Risk of inaccurate data being reported annually reflective of BCUHB performance benchmarked against other organisations	Major	Data entry clerk resource added to the vascular improvement programme
10						

RISK LOG - The Risk Register provides a record of identified risks relating to the Programme, including its status and history. It is used to capture and maintain information on all of the identified threats and opportunities relating to the Programme. Please link into the milestones listed for this Programme and ensure that any risks which could impact on the delivery of the milestones is included in the risk register, and mitigation considered and recorded.																		
Risk No	Risk Description	Impact Description	Risk Category	Inherent risk (score before)			Date risk raised	Action Owner	Actionee	Mitigation in place or required description	Residual risk (Target score)			Further Action Planned. (Who, What, Why and When anything more will be done to deduce the Residual risk)	Risk Open or Closed	Date Risk Closed DD/MM/YYYY	Risk uploaded /updated on Date	What is a risk?
				Probability Score 1-5	Impact Score 1-5	Overall Score					Probability Score 1-5	Impact Score 1-5	Overall Score					
1	Lack of resource within the vascular team across all grades	Currently unable to deliver required activity across all 3 sites as providing cover for VCOW and OC commitments in the first instance. Lack of Junior support for the ward, lack of MGs to provide sufficient support for all activity. ANP currently being absorbed into ward 3 to support due to junior staffing. Interim and permanent solution to admin support for the above will also be required to achieve timely outcomes	Quality/Sa fety	4	2	8	01/09/2021	Soroush Sorabi / Sally Morris	Sally Morris	2 Consultant Locums sourced to provide backfill cover. 1 for YGC / WMH (4/10/21) and on for YGC / YG (1/11/21) to ensure robust cover for spoke sites. Searching for locum Juniors / MGs to bolster YGC support Actions underway to determine activity for ANP to support OPO WL and patient management. New starting Consultant 10/1/22 who will support following induction	2	2	4	Capacity and demand review along with review of job plans for all clinicians within vascular is required to build into the business case to manage the hub and spoke model robustly	Open			• A risk is an event, or a set of related events
2	Lack of resource of all supporting disciplines to support implementation of the DFP	All sites have so far been requested to provide estimates of what they think is required to implement the DFP as without this we are not meeting NICE guidance for managing the patient with a diabetic foot and creates delays for the patient journey	Quality/Sa fety	4	3	12	01/04/2020	Leads / DGMS all areas across BCU	DGMS BCU Sally Morris to pull together	Current mitigation of non-adherence to a single pathway is that patients are managed through YGC if not at spoke sites although not managed by standardised protocols	3	3	9	Business case approval and recruitment will be required across all disciplines BCU wide to achieve the DFP implementation	Open			• It must be possible, but not necessary, for the event(s) to occur
3	Cultural and political issues currently posing a risk to delivery of the hub and spoke model of care	There is still a lot of frustration across the spoke sites that followed centralisation for vascular services and a feeling of being 'done to'. This is leading to some negative behaviour which is hindering development of robust processes between specialties across BCU. Some of this extends to teams refusing to sign up to pathways to improve patient experience / quality / reputation.	Quality/Sa fety	4	3	12	01/09/2021	Acute Site directors / Medical Directors	Leads / DGMS/ Specialist Nurses / Sally Morris	A Vascular Oversight group has been established led by the SRO with Medical and directors and the vascular Lead to expedite delivery of the action plan and manage obstacles. Meetings are currently in place between hub and spoke sites to attempt to alleviate issues. New Ops meetings with secretarial / specialist nurses / renal nurses have been implemented as of 7/10/21 in an effort to pull together to alleviate some bottlenecks in the service and work collaboratively.	4	2	8	Time and continued collaborative work will be required to further improve the situation. Escalation will be required for continued problematic behaviours to HMT and the SRO	Open			• The event(s), were it (or they) to occur, would impact on the objectives of the programme (i.e., whether, or how, they are achieved)
4	Reluctance to adopt a formal Shared Care model at spoke sites	There is apparent unease across all specialities to adapt a shared care model to enable non-emergent vascular patients to be managed at spoke sites. This means that demand outstrips the current bed base at YGC and entails vascular patients to be admitted to other wards. Furthermore, this increases the risk of theatre cancellations due to lack of vascular bed availability	Quality/Sa fety	4	3	12	01/09/2021	Executive Medical Director	All Medical Directors, Sally Morris to support	Karen Mottart has agreed to pull a meeting of all Medical Directors to outline the accountability and responsibility of both the admitting specialty (name behind the bed) and the supporting specialty to attempt to make the concept more palatable to clinicians involved. MDs will then disseminate the documents down their respective medical / nursing / operational teams.	3	2	6	YGC will need to ensure that cases transferred unnecessarily are captured and audited to feedback and address remaining issues	Open			• This impact can be either positive (an 'opportunity') or negative (a 'threat').
5	Delays in timely diagnostics and assessments i.e. CT/MRI/Sonography	At the time of the RCS report there were reported delays in accessing diagnostics. Information has been requested from informatics to understand what the current position of this is although an SBAR written by BCU radiology lead describes human resource being an issue to deliver optimally which could delay urgent procedures or increase complications	Quality/Sa fety	4	3	12	01/04/2021	Executive Medical Director	Kakali Mitra	CT / MRI waiting times are compliant with the HBs guidance of 2 wks. urgent and 8 wks. routine. Sonography cannot become compliant until resource has been sourced	2	2	4	Business case approval required and then lead time for recruitment	Open			
6	Repatriation pathway completion and sign off	This pathway has previously been taken to CAG but not approved. Further work is needed to ensure timely repatriation to spoke sites following vascular interventions. Central to this is agreement on terminology of shared care. This impacts on the number of vascular outliers at the hub site and could create a theatre cancellation on the day if no beds are available.	Quality/Sa fety	3	3	9	01/04/2021	DGMS supported by clinical Leads	Vascular network manager	Patients are being managed via bed managers across the sites but progress can be less than timely Repatriation pathway re-shared to both spoke sites for review given 1year since previous discussion. Minor comments only - expect to have to CAG before end of December 2021	2	2	4	Audit required for repatriation in terms of when bed requested and when repatriation occurred	Open			
7	Vascular bed resource and management	Ward 3 commonly has a high number of outliers (averages of 2.5 per day since April 2021) with regular high numbers of vascular outliers amongst other wards (average 5 per day since April 21) indicating the requirement of an increased bed base	Quality/Sa fety	5	2	10	01/04/2021	Acute Site Director	DGM supported by vascular network manager and HoN	Daily board rounds and escalation look to realign the beds but it doesn't make for an optimal patient journey. Ward 3 wish to ring-fence their beds for vascular patients in keeping with the emergency transfer pathways and to ensure the right patient in the right bed. Current figures indicate the requirement for an average of 23 beds per day for vascular patients and workforce would need to reflect this Agreement in principle to ring-fence 1 male and 1 female bed and to expand the bed base to 23	3	2	6	Ward 3 and HoN are keen to develop a high observation bay to 1) make the recruitment option more attractive ") give a wider ability to grow our own senior staff 3) allow earlier step down from HDU areas to free beds for theatre patients reducing delays and cancellations	Open			
8	Lack of access to emergency theatres	Lack of emergency theatre leads to delays in treatment and can negatively impact on outcomes and mean failure to achieve national targets. It also leads to cancellations of more planned procedures which can also negatively impact outcomes and failure to achieve targets	Quality/Sa fety	3	3	9	01/04/2021	Balasundaram Ramesh	Theatres DGM supported by vascular network manager and Soroush Sorabi	1 additional CEPD list has been provided Fridays at YGC although not for vascular sole use. Issues lie with physical space and staffing. Need to review with theatre DGM to source other opportunity	2	2	4	Review of whole theatre schedule to see if there is scope to increase access to emergency theatres				
9	Data accuracy for NVR submission	There is a risk that both the data submitted to NVR has not been fully accurate historically. This can lead to performance data being published which identifies the organisation as an outlier	Reputational	3	3	9				Consultants are requested to ensure that data is validated by NVR prior to benchmarking. NVR performance an data entry is a standard agenda item for clinical governance	1	3	3	NVR Data entry clerk has been factored into the resource requirements for Vascular improvement programme	Open			
10						0							0					
11						0							0					
12						0							0					
13													0					
14													0					

RISK REGISTER SCORING AND RATING

	LIKELIHOOD SCORING				
LIKELIHOOD SCORE	1	2	3	4	5
Frequency/How likely is it to happen?	This will probably never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Will undoubtedly happen/recur, possibly frequently

Category	Consequence (Impact) Scoring				
Consequence Score	1	2	3	4	5
Descriptor	Negligible (Very Low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Quality/Safety	Minor reduction in quality in treatment or service No or minimal effect on patients/staff/ others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients/staff/ others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients/staff/ others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/staff/ others if unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adverse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage Moderate amount of negative public interest	High impact on achieving organisational goals High level of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non-delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1 million
Regulation	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

	CONSEQUENCE				
LIKELIHOOD	Negligible (Very Low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Will undoubtedly happen/recur, possibly frequently	5	10	15	20	25
Will probably happen/recur, but it is not a persisting issue	4	8	12	16	20
Might happen or recur occasionally	3	6	9	12	15
Do not expect it to happen/recur but it is possible it may do so	2	4	6	8	10
This will probably never happen/recur	1	2	3	4	5

ISSUE CONSEQUENCE SCORING

	Consequence (impact) Scoring				
CONSEQUENCE SCORE	1	2	3	4	5
Descriptor	Negligible (Very low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Quality/Safety	Minor reduction in quality in treatment or service No or minimal effect on patients/staff/others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients / staff / others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients / staff / others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/ staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/ staff/ others in unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adverse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage moderate amount of negative public interest	High impact on achieving organisational goals High leve of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1m
Regulation	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

ISSUE SCORING MATRIX

Consequence scoring

5	Catastrophic
4	Major
3	Moderate
2	Minor
1	Negligible

RCS Report Reference/ Internal Reference	Recommendation/ Internal issue	Actions required	Action by	Owner	Start Date	Completion date	Reporting	Task Status	Risk	Mitigations	Assurance	Comments	Link to Part 1 RCS plan/ other reports
This draft action plan will be integrated with the existing Vascular Improvement Plan and actions mapped across to that plan													
1 4.1.1	Initial review of 44 notes in RCS report to ensure clinical follow up provided where needed	Formation of Vascular Quality Panel to be formed to carry out review of cases, open actions and map by pathway and team where any additional action needed	MJ	Med Director	31.1.22	25.2.22	QSE via Vascular Steering Group	VSG under development with lead identified and ToR agreed				Highlight report to QSE March 2022	
2 Internal	Initial thematic review of SI and current DATIX, complaints	Current work in Quality team to be included in Vascular Quality Panel and to map by pathway and team where any additional action needed	MJ	Med Director	In process	25.2.22	QSE via Vascular Steering Group					Highlight report to QSE March 2022	
3 Internal	Further review of cases informed by (1) and (2) for identified pathways or team including an assessment of whether the cases reviewed were representative	TBC by initial review Patients and/or families within (1), (2) and (3) receive updates and clear communication on any need for further treatment and duty candour fulfilled where care has fallen below expectations	MJ	Med Director	TBC	TBC	QSE via Vascular Steering Group	Timeframe to be established after initial review of the 44 notes			1.Consider external validation of summary from Vascular Society or Liverpool 2. Methodology for review process to be approved at QSE	ToR and scope to be confirmed by initial review	
4 4.1.1	Ensure patients receive communication in line with regulatory responsibilities	The outcome for patients in all 44 cases (and in addition where needed in patients in (2) and (3)) identified and duty of candour fulfilled	MJ	Med Director	In process	TBC	QSE via Vascular Steering Group	Timeframe to be established after initial review of the 44 notes					
5 4.1.2		Summary of outcomes to be reported and any impact on current audit outcome reporting considered	Clinical Lead Vascular Service	Med Director		31.3.22 (TBC)	QSE via Vascular Steering Group	Timeframe to be established after initial review of the 44 notes				External validation from NVR or CHKS to be considered	
6 4.1.3	The Health Board should ensure that current practice in patient record keeping meets national standards as set out by RCS	Initial assessment in vascular of current inpatient and outpatient record keeping including record of MDT discussions, consent and communication with patients	Clinical Lead Vascular Service	Med Director	28.1.22	4.2.22	QSE via Vascular Steering Group	Initial review of current notes in vascular service confirms quality concerns and weekly improvement cycle established 7.2.22					
7 4.1.3, 4.2.6, 4.2.7	The Health Board should ensure that current practice in patient record keeping meets national standards as set out by RCS	Detailed audit leading to clear improvement plans for notes and documentation including MDT discussions and consent and the development of internally owned professional standards	Clinical Lead Vascular Service	Med Director	7.2.22	31.3.22 (TBC)	QSE via Vascular Steering Group						
8 Internal, 4.2.7	The Health Board should ensure that current practice in patient record keeping meets national standards as set out by RCS, GMC, NMC and HCPC across BCUHB	Detailed audit leading to clear improvement plans for notes and documentation including MDT discussions and consent and the development of internally owned professional standards as a part of clinical audit plan 22/23	HMT and Clinical Effectiveness Lead	MD/DoN/DoTh	1.4.22	31.3.23	QSE through annual clinical audit programme	Interim lead appointed after the current clinical lead indicated desire to stand down from leadership		Interim additional leadership capacity appointed pending formal appointment and external validation/support			
9 Internal	Review of current Clinical Lead Vascular Service Role	Review to ensure capacity and expertise available to lead change in the service External support from Liverpool to support MDT arrangements including developing best practice, attending MDTs by TEAMS and active involvement in MDT governance	Med Director	Med Director	27.1.22	TBC	QSE	Informal commitment from Liverpool made and MoU under development				Agreement in principle agreed with Liverpool. MoU now to be formalised and implemented	
10 4.1.4, 4.2.9	Review of MDT arrangements for vascular	Quality assurance of MDT process	HMT	EDICS	28.2.22	31.3.22	QSE via Vascular Steering Group	Approach TBC with Liverpool team		Liverpool involved in shorter term before formal QA commissioned			
11 4.1.4	Review of MDT arrangements for vascular	Audit programme 22/23 to review standards of MDT across BCUHB	Health economies	EDICS	1.4.22	31.3.23	QSE through annual clinical audit programme					Use of MDHIT or similar validated tool	
12 Internal	Review of MDT arrangements across BCUHB	As in 6 above	Clinical Lead Vascular Service	Med Director	28.1.22	4.2.22	QSE via Vascular Steering Group						
13 4.1.5	Review consent taking practices in vascular surgery service	Audit programme 22/23 to review standards of MDT across BCUHB	Ethical lead	Med Director	1.4.22	31.3.23	QSE through annual clinical audit programme						
14 Internal	Review consent taking practices across BCUHB	Multidisciplinary workshops in acute and area teams	Ethical lead	Med Director	14.2.22	Ongoing	QSE					Refresher of current programme	
15 Internal	Deliver refresher consent training and best practice in response	Develop MoU to provide formal oversight and reporting on aneurysm pathways including use of eVAR	Clinical Lead Vascular Service	Med Director	27.1.22	25.2.22	EMG and Board					Agreement in principle agreed with Liverpool. MoU now to be formalised and implemented	
16 4.2.8	Consider oversight of aneurysm pathways by LUH	Transformation team to be involved in development and oversight of the Vascular Improvement Plan	Director of Transformation	Director of Transformation	1.2.22	TBC							
17	Improve oversight methodology to be consistent with the approach adopted across the wider Health Board	Prioritise vascular services for piloting of Digital Health Record (DHR)	Clinical Lead Vascular Service	Med Director/ Director of Digital	14.2.22	Ongoing	PPPH						
18 Internal	Improvement of clinical record keeping	Investigate the sampling and sign off of the notes to understand the practice followed	TBC	TBC	TBC	31.3.22							
19 Internal	Review the case sampling to ensure that the notes reviewed provide a representative sample of the service before and after centralisation												
20 Internal	Develop clinical workforce	Review of current establishment and roles	Clinical Lead Vascular Service	MD/ DWOD/ DoN/DoTh			Deputy Director WOD providing leadership and support					Under discussion with GMC and need to ensure regulatory role of GMC does not conflict with formative workshops	Need for workforce review in RCS report 1
21 Internal	Support for vascular service in understanding Good Medical Practice and professional standards	Workshop with GMC planned on Good Medical Practice	Site Medical Director	Medical Director	4.2.22	TBC	GMC developing proposal with the HB, potentially in partnership with NMC and HCPC					Initial discussion with GMC on 27.2.22	
22 Internal	Review of regulatory implications from review	Ensure follow best practice and work with PPAS and GMC	Deputy Medical Director	Medical Director	7.2.22	In response to issues as they arise	Initial meetings with GMC 4.2.22						
23 Internal	Review of escalation processes	Ensure best practice for escalation and early intervention	Site medical director and Site Nurse Director	DoN	4.2.22	TBC							
24 Internal	Develop clear levels of assurance for committee structure	Ensure proper scrutiny in place	Director of Governance	EDICS	TBC	TBC							
25 Internal	Develop clear governance arrangements for sign off of notes and data going outside the organisation	SOP developed and implemented	Clinical Effectiveness Lead	Exec Medical Director	3.12.21	TBC					For review at end of March at time of national audit submissions		
26 Internal	Understand any learning for the Board regarding visibility of, and escalation of, issues within a service under close scrutiny	Detail TBC	DoN/MD	Board TBC	TBC	TBC							

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Urology services review update						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery Dr Nick Lyons, Executive Medical Director						
Awdur yr Adroddiad Report Author:	Dr Conrad Wareham, Deputy Medical Director Matthew Joyes, Associate Director of Quality						
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery						
Atodiadau Appendices:	Draft Terms of Reference						
Argymhelliad / Recommendation:							
The Committee is asked to approve the enclosed draft terms of reference.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The Committee is asked to approve the draft terms of reference for the Royal College of Surgeons invited review into urology services.							
Cefndir / Background:							
<p>At its September 2021 meeting, the Committee received an update on urology services from Dr Gary Francis (Secondary Care Medical Director), Clive Walsh (the previous Regional Delivery Director) and Matthew Joyes (Associate Director of Quality). The report provided an update on quality and performance issues in urology services. The Committee supported the recommendation that an invited review is commissioned by the Royal College of Surgeons. The attached terms of reference have been developed by the Office of the Medical Director, under the guidance of the Deputy Medical Director, and in consultation with the Urology Steering Group set-up to coordinate improvements and by the Executive Director of Integrated Clinical Services.</p>							

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Invited supportive review of urology services in North Wales

Terms of Reference **18.02.2022**

Aim

In conducting the supportive review, the review team will work with the Health Board to consider the standard, safety and quality of the current service configuration and provision, and advice on ways that the Health Board could improve and sustain a resilient, high quality urology service in North Wales.

Specific reference should be made to:

1. Clinical Pathways

In considering the above aim, a review of the established and developing clinical pathways across the healthcare system in providing optimal clinical care will be considered, including:

- (i) The effectiveness of the management of the urology Suspected Cancer Pathways (SCPs) in-line with national standards, for all key urology cancer sites.
- (ii) The effectiveness of referral pathways across the healthcare system in enabling timely access for patients to effective interventions.
- (iii) Clinical decision-making and MDT effectiveness.
- (iv) Access and waiting times for cancer and non-cancer pathways.
- (v) Frequency and adequacy of follow-up arrangements for patients on these pathways.
- (vi) Arrangements for Health Board contracted outsourced pathways including governance and quality assurance.

2. Clinical Governance

Clinical governance, including sustainable improvement in the effectiveness of:

- (i) Mortality and Morbidity (M&M) – identifying and applying learning across the service.

- (ii) The processes in place for concerns and incidents (HB and service specific), to be reported and lessons learnt. This will include:

The robustness of recommendations made following Serious Incident Reviews.

The reliability of follow-up of outcomes from Serious Incident Reviews and external reviews.

The response to concerns raised in reports of the Public Services Ombudsman for Wales, Regulation 28s and/or other external reports relating to the service and Health Board process.

The commitment of the MTDs to implement consistent practice across teams and sites

3. Clinical Outcomes

Use of current clinical outcomes, and patient experience for both the service and individual surgeons in the context of accepted national and international standards/norms, and what changes the Health Board will need to ensure this continues within a revised service model.

Identify areas of good and exceptional practice:

Identify areas of practice that have utilised innovative and/or transformational methodologies.

Identify areas of practice, which could benefit from innovation and or transformation.

4. Robotic Surgery

Review the impact of the implementation plan for robotic surgery in terms of positive and negative impacts, risks and learning points for future implementation programs.

5. Workforce Model

The adequacy of the clinical staffing and facilities for the volume and type of clinical activity undertaken.

6. Infrastructure Support

The adequacy and the future requirements of the infrastructure supporting delivery of clinical services, which should include, but not be exclusive to Information Technology and Informatics.

7. Culture

In line with 'Stronger Together', identify ways to strengthen the team approach through a culture of openness, honesty, trust and shared values within and across:

The urology clinical team.

The wider urology service.

The multi-disciplinary team (MDT).

Other hospital services, primary care, tertiary referral services, external stakeholders, patients and partners.

8. Communications

Communication with patients and other health professionals, with specific reference to:

- (i) The effectiveness of providing information to patients in supporting and enabling shared decision-making.
- (ii) The adequacy and timeliness of the provision of patient clinical information to the appropriate primary and community health care teams.
- (iii) The interaction between primary and secondary care and the views of the primary care clusters.

9. Leadership

Leadership within the urology service, in particular:

- (i) Leading a coordinated urology service across all three sites and primary care.
- (ii) Encouraging the use of data to improve services.
- (iii) Managing waiting times.
- (iv) Strategic workforce and succession planning.
- (v) Governance processes.
- (vi) Robust accountability.

10. Reporting and reporting timelines

The review team will report to the SRO, Gill Harris, Deputy Chief Executive / Executive Director of Nursing and Midwifery.

The report will include clear recommendations for improvement.

The report must be written in such a way as to be made public without redactions

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 st March 2022					
Cyhoeddus neu Breifat: Public or Private:	Public					
Teitl yr Adroddiad Report Title:	Patient Safety – Focused Report on Harms					
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Executive Director of Nursing and Midwifery/Deputy Chief Executive					
Awdur yr Adroddiad Report Author:	Matthew Joyes, Associate Director of Quality Mandy Jones, Deputy Director of Nursing					
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality Mandy Jones, Deputy Director of Nursing Gill Harris, Executive Director of Nursing and Midwifery					
Atodiadau Appendices:	None.					
Argymhelliad / Recommendation:						
The Committee is asked to note this report.						
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N
Sefyllfa / Situation:						
This paper provides the Committee with a detailed position on current high occurrence harms and is supplemental to the Patient Safety Report.						
Cefndir / Background:						
<u>Introduction</u> This paper provides the Committee with a detailed position on current high occurrence harms and is supplemental to the Patient Safety Report. It is intended to supplement the Patient Safety Report by providing a more in-depth look at the highest occurrences of harm, and to provide some situation context as to the current pressures impacting upon delivering sustained improvement.						

Patient harm (which is synonymous with the term “adverse events” or “patient safety incidents”) is defined as unanticipated or unforeseen accidents (e.g. patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease.

Patient harm is preventable firstly when occurring as a result of an identifiable and modifiable cause, and secondly when the prevention of future recurrence of the patient harm is possible with reasonable adaptation to a process and adherence to guidelines.

All patient harms require recording on the Health Board’s incident management system, Datix, and require review and in some cases detailed investigation. Some patients harms require external reporting. These are known as “nationally reportable incidents” (previously known as “serious incidents”) as required by the national Incident Management Policy and are described as follows:

“A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded Healthcare “

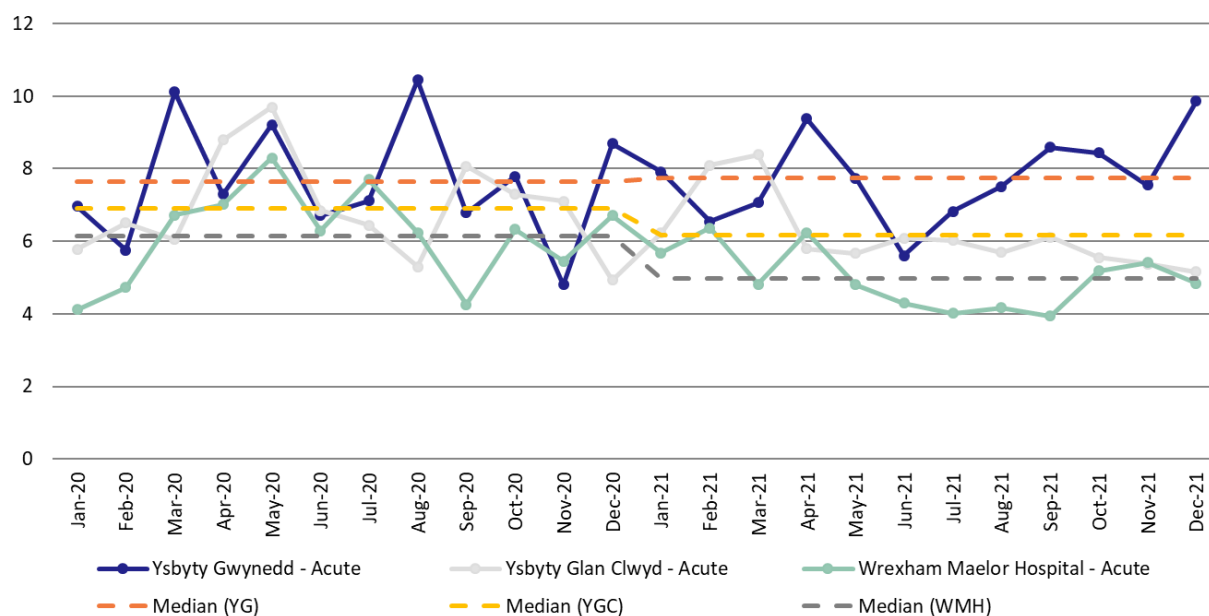
In general, the approach to dealing with patient harm is not focused on whether a harm was avoidable or unavoidable but rather on the candour, learning, improvement that takes place post-incident. Separate processes, such as redress (under the Putting Things Right Regulations) and clinical negligence, exist for determining issues of liability. However, the NHS Wales national standard for reviewing pressure ulcers does require a determination on whether each incident of pressure damage was avoidable or unavoidable. There is a national intention to review this approach which is unique to pressure ulcers.

Falls and pressure ulcers are the most frequently reported adult in-patient incident and are a significant patient safety challenge for the NHS in Wales. The Health Board has reported an increasing picture as such it is timely to ensure the necessary safeguards are in place and being carried out to minimise not just the number of falls but also the associated complications and distress for the individual across all the Health Board wards.

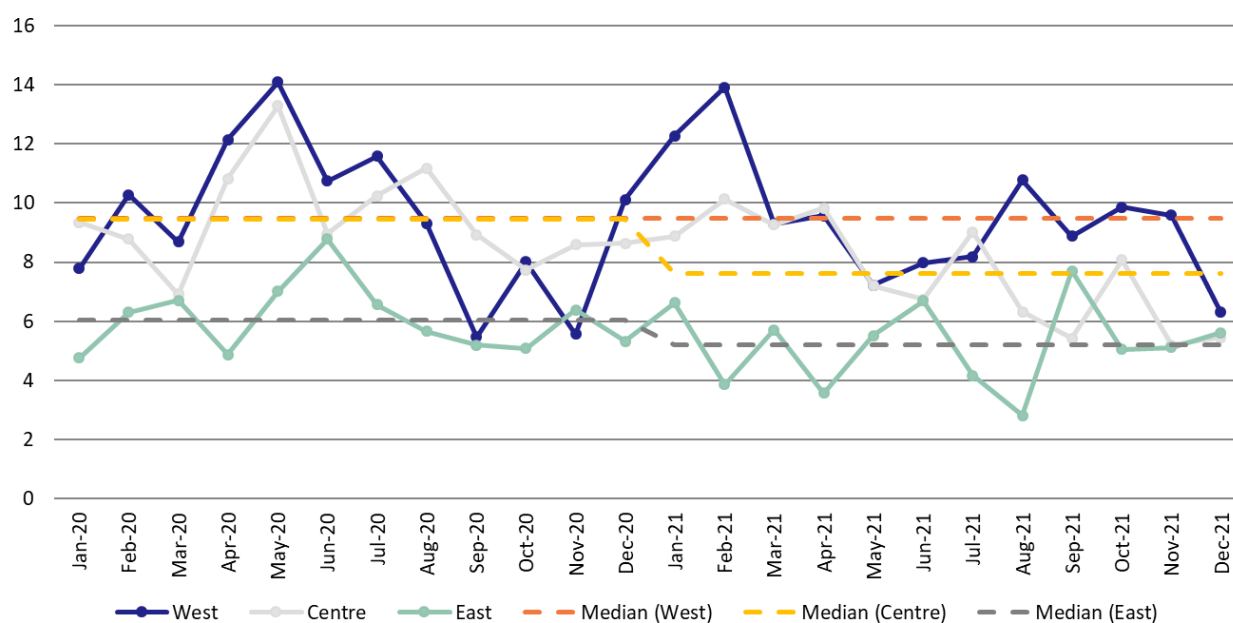
Falls

A fall is defined as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. Patient falls represents one of the highest occurrence patient incidents in the Health Board and a number of these are patient harms.

BCUHB - Acute - Jan 2020-Dec 2021
Rate of total inpatient falls per 1,000 bed days

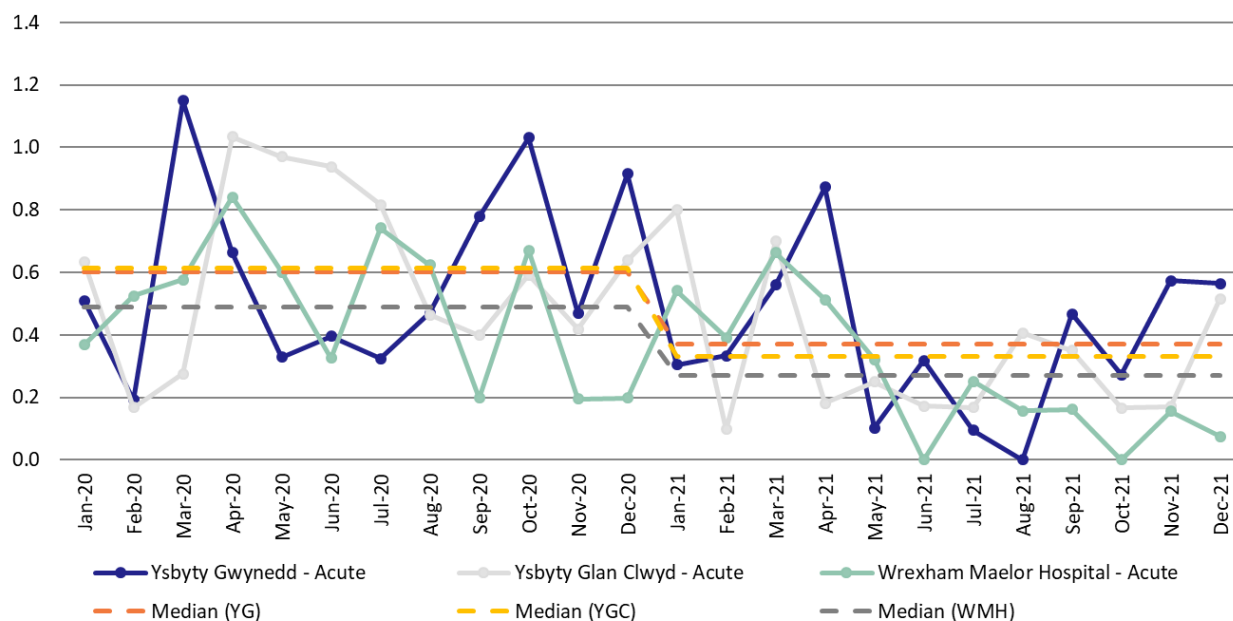


BCUHB - Community - Jan 2020-Dec 2021
Rate of total inpatient falls per 1,000 bed days

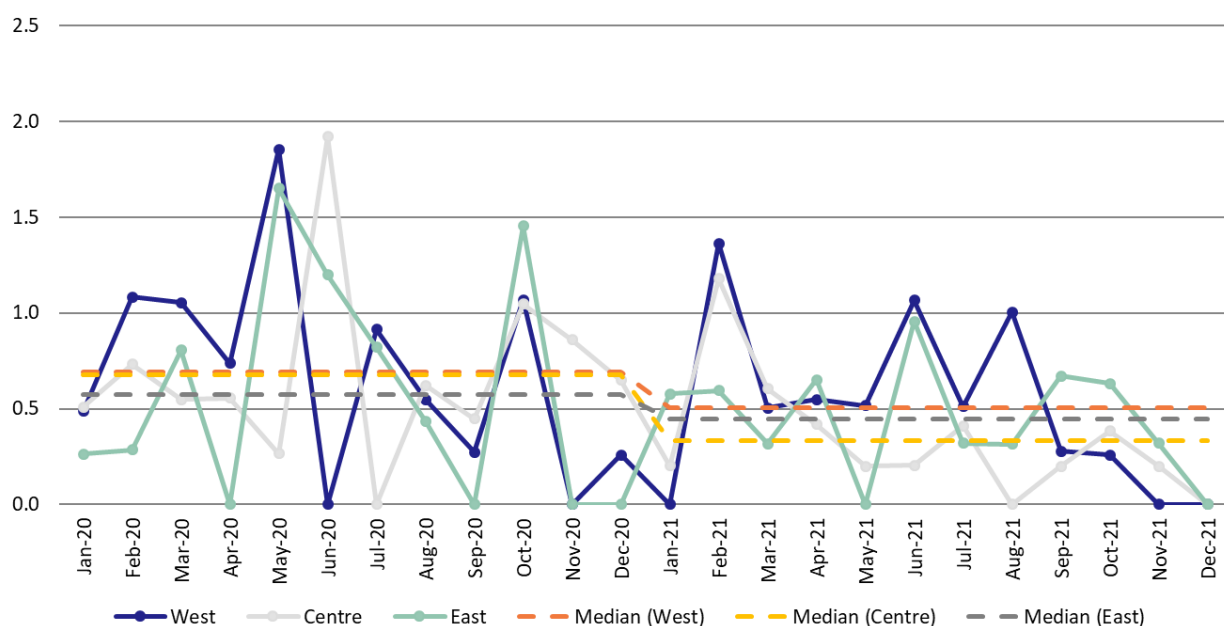


As the two charts above demonstrate, the overall rate of falls for East and Central acute and community hospitals demonstrates a reducing rate of falls. However, both West acute and community hospitals show an increasing and static position.

BCUHB - Acute - Jan 2020-Dec 2021
Rate of total inpatient falls with harm per 1,000 bed days



BCUHB - Community - Jan 2020-Dec 2021
Rate of total inpatient falls with harm per 1,000 bed days



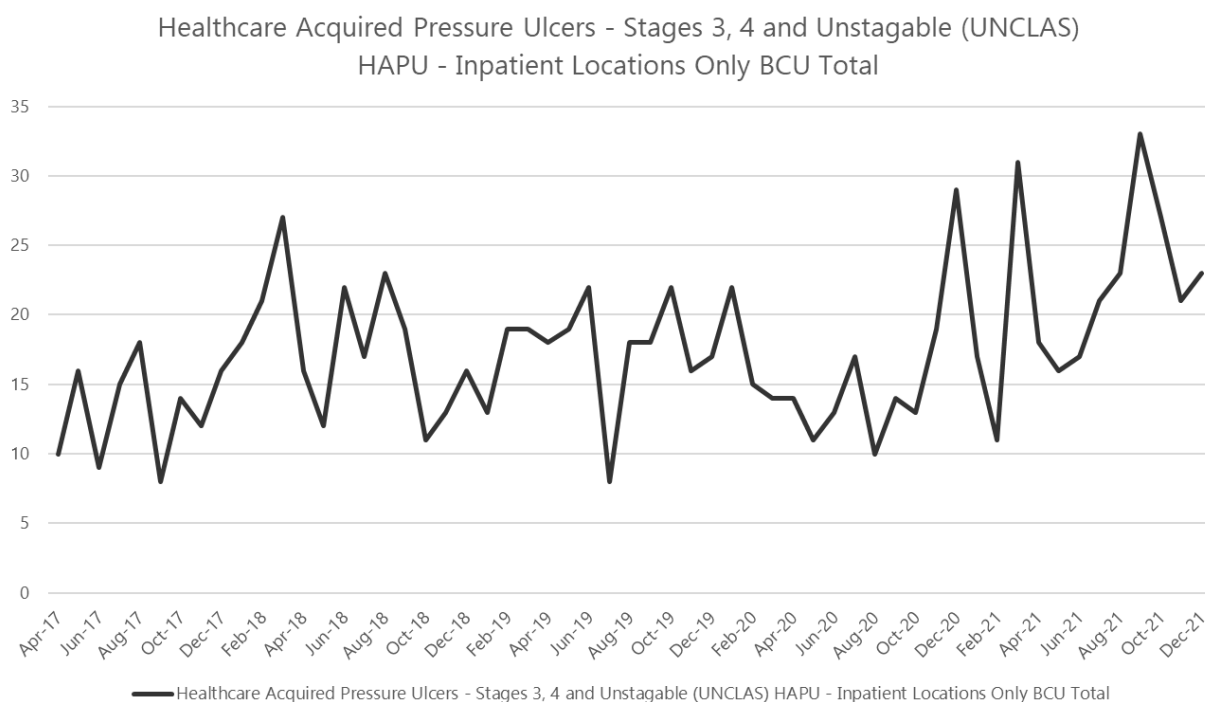
As the two charts above demonstrate, the rate of falls with actual physical injury have reduced in acute and community hospitals. However, of note is the increase in harm in West and Central acute hospitals towards the end of 2021. A further analysis of data has shown a cluster of wards at Ysbyty Gwynedd with higher rates of falls. This information has been shared with senior clinical leaders.

Healthcare Acquired Pressure Ulcers (HAPU)

Pressure ulcers (commonly known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affects people confined to bed or who sit in a chair or wheelchair for long periods of time. Early symptoms of a pressure ulcer include part of the skin becoming discoloured, or a patch of skin that feels warm, spongy or hard or pain or itchiness in the affected area. The skin may not be broken at first, but if the pressure ulcer gets worse, it can form:

- an open wound or blister – a grade 2 pressure ulcer
- a deep wound that reaches the deeper layers of the skin – a grade 3 pressure ulcer
- a very deep wound that may reach the muscle and bone – a grade 4 pressure ulcer

As stated above, a determination is made of grade 3, 4 and ungradeable pressure ulcers to determine if they were avoidable or unavoidable, using a national tool. The following chart shows the reporting date of avoidable grade 3, 4 and ungradeable pressure ulcers.



A further analysis of data has shown a cluster of wards at Ysbyty Gwynedd with higher rates of healthcare acquired pressure ulcers. Some of these wards also triangulate with wards seeing increases in falls as outlined above. This information has been shared with senior nursing leaders.

Context:

The current rates of falls and the increases seen in some areas must be seen in context of the current clinical position. This includes the significant impact of the pandemic – not just the direct context of COVID illness but the indirect impact of additional infection prevention and control measures and the impact of additional clinical pressure across the full health and social care system. These issues are summarised below:

Workforce:

- A current nurse staffing vacancy rate of 9.5%
- COVID related absences – 5.8%
- Non-CVID related absences – 6.17%
- Reduction in available staff as a result of shielding
- Variable temporary staffing position via bank and agency
- Decrease in registrant skills mix – down from pre-COVID 65% to 50%
- Urgent re-deployment of staff as needed – i.e. to vaccination centres

Clinical practice:

- Additional infection preservation and control measures reducing time to provide direct patient care
- Designated respiratory and non-respiratory areas impacting on staff availability
- Additional time constraints from donning and doffing personal protective equipment
- Additional COVID measures such as doors on bays reducing visibility and movement
- Reduction on staff movements to prevent the spread of COVID
- Reduced visitors adding additional demands on staff and less meaningful activity for patients
- Reduced availability of specialist support due to redeployment
- Reduced development opportunity due to clinical prioritisation and switch to virtual training

Operation pressures:

- Delays in ambulance response times – increasing the pressure ulcer risk
- Long waits in Emergency Departments
- Escalated beds (around 170) increasing pressure on services and staff
- Delays in internal and external assessments to support safe discharges
- Medically fit for discharge patients unable to be discharged (around 200)
- Frequent ward moves for patients
- Outbreak control measures creating unexpected additional demand and restriction

Collectively, these issues impact significantly on the ability of staff to effectively plan and consistently respond to all the care needs of patients. This means, as the Committee is aware, a significantly higher level of risk is carried.

Learning from the patient safety investigations completed into incidents, a number of themes arise from falls and healthcare acquired pressure ulcers. This includes failure to complete falls and pressure ulcer prevention plans and consistently sustain actions to mitigate the risks, failure to review and act on deterioration and failure to ensure intended observation due to staffing pressures.

There is a clear correlation between these themes and the impact of the above considerations. These collective pressures have contributed to the harms experienced by our patients. Of note, as the data shows, improvement has been made in many areas despite these challenges.

Improvement Plans

Work is underway to develop a Patient Safety Programme as part of the new priority programmes supported by the new Transformation and Improvement Directorate. This work will evolve over coming months in-line with the development of that capability.

Work has been underway in relation to falls improvement, particularly in response to the Improvement Notice from the Health and Safety Executive. This work includes:

- The Falls Policy has been rewritten with multi-disciplinary involvement. The policy is clear and easy to understand in terms of roles and responsibilities with clear actions for prevention and post fall management which complements the work that operational teams have been undertaking. This document is due for approval at the Committee in March 2022. An implementation plan has been developed and progress will be monitored through the strategic falls group.
- A Falls Prevention (Module 1a) E-learning has been developed and launched for all Health Board staff in January 2022.
- A Falls (Module 1b) E-learning covering risk assessment and post falls is soon to go live.
- The Patient Walking with Purpose Guideline has been written and shared for the management of patients who walk with purpose within the clinical setting as part of the Safe Clean Care Programme.

Work for pressure ulcer management been more localised within services in response to the learning from investigations.

Prior to the pandemic, the Health Board ran a successful Falls Collaborative and HAPU Collaborative to drive and support improvement across services. These are being re-launched from February 2022 onwards. The collaborative approach to patient safety enables a co-ordinated improvement framework supported by the improvement and specialist clinical teams. The forum supports clinical teams to

improve their knowledge, enhance proficiency with improvement methodology, shared learning and experiences within a learning cycle.

The Inpatient Falls Group and Community Falls Group have re commenced February 2022 with agreed priorities and work plan. The Inpatient Falls Group and Community Falls Group will be merged to maximise shared learning and collaboration. The HAPU Group will be re-launched.

Additionally, rollout of the Welsh Nursing Care Record System will improve the timeliness and quality of record keeping. Nursing staff will now have formats available in both paper and digital for documents including risk assessments and adult inpatient assessments. The digital versions of the forms mean nurses will be able to complete assessments, including at the patient bedside, on a hand-held tablet device, giving nurses more time to spend with patients and enabling quicker access to patient health records.

Collectively, this improvement work will form part of the Patient Safety Programme outlined above. Engagement with staff, patients and carers to take forward these improvements will be key to develop a clear and sustainable improvement plan. Clear, measureable outcomes will be defined as part of a strong programme and project management methodology. The Strategic Patient Safety Group will have close oversight of this work and the monitoring of improved outcomes, with reporting to the Committee via the Patient Safety Report.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – New risks for the Corporate Risk Register are being developed.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 1 st March 2022
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Justine Parry, Assistant Director: Information Governance and Risk David Tita, (Head of Risk Management)
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on 7 th February 2022
Atodiadau Appendices:	Appendix 1 – CRR Report for QSE Appendix 2 – Full List of Corporate Risk Register – Relevant to the QSE. Appendix 3 – Risk Key Field Guidance
Argymhelliad / Recommendation:	
That the Committee:-	
<p>1. Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1:</p> <p>CRR20-01: Asbestos Management and Control</p> <p>a) Note the progress that has been made in strengthening the controls and actions in place following completion of an audit by independent accredited body. Gaps in controls have also been reviewed and updated to align with current risk position.</p> <p>b) Note the significant work that has been undertaken to increase the training compliance as evidenced by 86% compliance achieved to date for asbestos awareness and 83% compliance on the higher-level duty to manage asbestos training course.</p> <p>c) Note request to close action ID 12248 as updated Asbestos Policy/Procedures is now available on the BCUHB Intranet</p> <p>CRR20-02: Contractor Management and Control</p> <p>a) Note the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position.</p> <p>b) Note delay to Action ID 12256 due to delays mobilisation and adoption of the SHE system in relation to Data Protection compliance checking, the anticipated implementation of the system is aimed for June 2022.</p> <p>c) Note request to close action IDs 12254 and 12255 (as processes are now in place), action ID 12259 (as processes have been reviewed and deemed fit for purpose) and action ID 12260 (as the review of all standard current procedures has now been completed).</p> <p>CRR20-03: Legionella Management and Control</p>	

- a) **Note** the progress that has been made in reviewing and updating this risk to reflect its current position.
- b) **Note** delay action ID 12268 (to enable BCUHB Water Safety Plan to be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group) and delay to action ID 19015 (due to business case needing to be re-presented to the Executive Team by March 2022).
- c) **Note** request to close action ID 12265 (as the escalation process has now been included in the Water Safety Policy), action ID 12270 (as a standardised maintenance strategy has now been adopted and in place) and action ID 19760 (as an authorising engineer has now been appointed).

CRR20-04: Non-Compliance of Fire Safety Systems

- a) **Note** the progress that has been made in reviewing and updating this risk to reflect its current position.
- b) **Note** request to close actions ID 12275 (as 80% compliance target rate has been achieved over the last three years) and 12279 (in recognition of the link to the Health & Safety team on Manual Handling compliance).
- c) **Note** the identification of new action ID 21491 to enable developing and implementing a Health Board-wide Fire Safety Strategy.

CRR20-05: Timely access to care homes

- a) **Note** the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position
- b) **Note** the request to close actions IDs 18646 and 18024 (as both actions are now captured within the current Multi-Agency Cell Action Plan, which is in place).
- c) **Note** delay to action ID 14949 due to staff re-deployment to help with the vaccination programme and the requirement to support Care Homes with infection prevention and control, implementation of action will resume once re-deployed staff return to post).
- d) **Note** request to delay action ID 20074 as resources within the Health Board were re-allocated to support the vaccination programme, the new completion date is 31/03/2022.

CRR20-08: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients

- a) **Note** the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position.
- b) **Note** request to close actions ID 14908 (as equipment is now in place across all three sites) and action ID 15662 following its completion.
- c) **Note** delay to action ID 20392 due to partial recruitment in the East Region as the process has not yet been completed.
- d) **Note** the identification of new action ID 20995 within the wider context of training additional non-medic Intra Vitreal Therapy (IVT) injectors in order to reduce waiting times, hence the likelihood of the risk crystallising.

CRR21-13: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)

Note that this risk has been taken out of this CRR report as it is currently going through Executive approval and rigorous governance following its recent complete revamp. This risk will be presented to the next QSE Committee meeting, in the meantime the risk continues to be actively managed.

CRR21-14: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients

Note that this risk has been transferred over to the Mental Health and Capacity Compliance Committee and will no longer be reported in the QSE CRR Report. Risk has thus been taken out of this CRR report.

CRR21-15: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014

- a) **Note** the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position
- b) **Note** request to extend the target risk due dates from 01/04/2022 to 31/10/202 to enable implementation of actions that have been delayed.
- c) **Note** delay to action ID 18113 due to limited resources and increased activity, along with a delay in the regional ratification of the Position of Trust Procedure, which influences operational activity. Anticipated internal BCUHB Standard Operating Procedure will be in place by the end of March 2022.
- d) **Note** delay to action ID 18116 due to re-deployment of Sexual Assault Referral Centre staffing to support with COVID management, which has delayed implementation of this action.

CRR21-16: Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients

- a) **Note** the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position.
- b) **Note** delay to action ID 17978 – to enable collection of the keys of the temporary accommodation in the West that will be rented for delivering manual training)
- c) **Note** delay to action ID 17979 – to enable recruitment to the post of Manual Handling Manager following re-advertisement of the post. Interviews are now planned for February 2022.
- d) **Note** delay to action ID 17980 – to enable the team to address the shortfalls pertaining to this risk that were identified by the HSE. Action plans to address these will be in place by 14th March 2022.
- e) **Note** delay to action ID 18859 – due to workload, capacity within the team and pressures resulting from staff supporting with COVID management.

CRR21-17: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours










- a) **Note** the progress that has been made as the controls and gaps in controls have been reviewed to align with current risk position.
- b) **Note** request to close action IDs 17961 (as Ligature point assessments have been received from East, West and Central) and 17962 (following successful commissioning of the “Just R” recruitment and ongoing campaign).
- c) **Note** delay to action IDs 17963 (due to COVID pressures and re-deployment of staff) and 19594 (due to COVID pressures and Paediatric Respiratory Surge along with capacity).
- d) **Note** the identification of new action ID 21236 (to enable implementation of recommendations following the Delivery Unit Crisis Care Review).

Ticiwch fel bo’n briodol / Please tick as appropriate

the Board will review and agree the total level of risk exposure or potential adverse impact that the Health Board is willing to accept in pursuit of its objectives detailed within Living Healthier Staying well and the Integrated Medium Term Plan (IMTP). The risk appetite statement will also form part of the risk management strategy refresh.

Summary Table of the Full Corporate Tier 1 Risk Report:

Current Tier 1 Risks for the Quality, Safety and Experience/Performance Committee oversight (full details and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	*Movement
CURRENT RISKS – Appendix 1				
CRR20-01 - Asbestos Management and Control	20	15	8	 unchanged
CRR20-02 - Contractor Management and Control	20	15	8	 unchanged
CRR20-03 – Legionella Management and Control	20	16	8	 unchanged
CRR20-04 - Non-Compliance of Fire Safety Systems	20	16	8	 unchanged
CRR20-05 – Timely access to Care Homes	25	20	6	 unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	25	20	6	 unchanged
CRR21-15 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	20	16	12	 unchanged
CRR21-16 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	20	16	4	 unchanged
CRR21-17 - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	20	16	8	 unchanged

*movement in risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions.

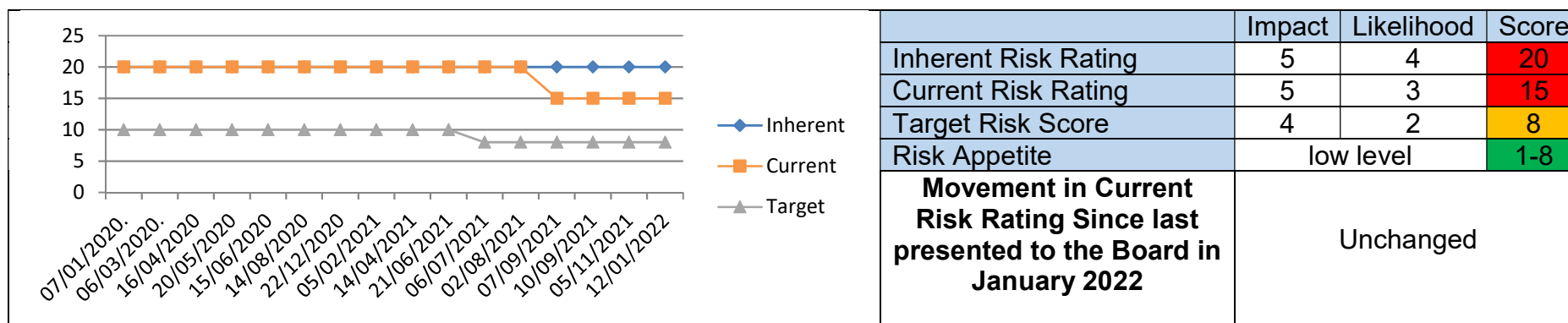
Below is a heat map representation of the current corporate risk scores for this Committee:

No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which CRR reports are aligned.

Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 – Full Corporate Risk Register

CRR20-01	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 12 January 2022
	Risk: Asbestos Management and Control	Date of Committee Review: 11 January 2022
		Target Risk Date: 31 March 2022
<p>There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, Health and Safety Executive enforcement action including fines, prosecution and reputation damage to BCUHB.</p>		



Controls in place	Assurances
<ol style="list-style-type: none"> Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. Annual programme of re-inspection surveys undertaken. 	<ol style="list-style-type: none"> Health and Safety Leads Group. Strategic Occupational Health and Safety Group.

3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body. 4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available. 6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place. 8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 9. 5 year programme for the removal of high risk asbestos with monitoring at the asbestos group is in place with oversight at the strategic health and safety group. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework.	3. Quality, Safety and Experience Committee. 4. Internal Audit review undertaken against the gap analysis. 5. Self assessment completed and submitted to Welsh Government which use specialist services to review the returns for consistence and compliance.
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Gaps in Controls/mitigations

Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 86%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by 31/03/2022.

Progress since last submission

1. Gap in control has been updated to address the mitigations in place.
2. Improved compliance with the asbestos awareness which remains on target to achieve the 95% target rate.
3. Action ID 19758 – Audit output reports to be presented to the asbestos management group for consideration and escalation during March 2022.
4. Action ID 12248 - Proposal to close the action. Updated Asbestos policy/procedures is available on the BCUHB Intranet, and communicated via across the Health Board via the corporate weekly bulletin.

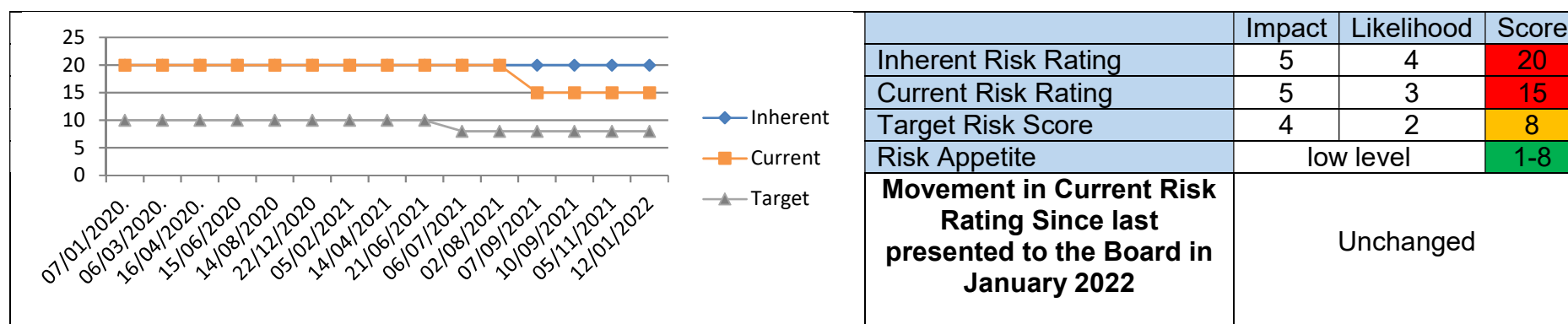
Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)		BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in the MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.</p> <p>January 2022 progress update - By the 31/03/2022 polylining of plans will have been completed in readiness for MiCAD System module implementation.</p> <p>This information is currently held by a third party. With the implementation of the MiCAD system, this will digitalise the information held locally by the Health Board.</p>	On track

	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>ACTION CLOSED 12/01/2022</p> <p>Creating staff awareness of the presence of asbestos thus reducing any potential impact.</p> <p>January 2022 Progress Update - Updated Asbestos policy/procedures is available on the BCUHB Intranet, and communicated via corporate weekly bulletin. Asbestos awareness is delivered by the Estates Team upon request. Internal Audit completed providing a level of assurance.</p> <p>Proposal to close the action.</p>	Completed
	18686	Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff.	Mr Arwel Hughes, Head of Operational Estates - Interim	31/03/2022	<p>Ensure compliance with training legislation and help to reach the target risk score.</p> <p>January 2022 progress update - Currently on 86% compliance.</p>	On track
	19758	Undertake audits by the independent asbestos consultant to audit	Mr Rod Taylor, Director of	31/03/2022	<p>Provide a level of assurance in terms of compliance with legislation and provide assurance in relation to</p>	On track

	compliance with legislation and provide assurance in relation to asbestos management.	Estates & Facilities	asbestos management to validate compliance and support the reduction in the risk score. January 2022 Progress update - Output reports will be presented to the Asbestos Management Group for consideration, escalation and sign off by March 2022.	
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CRR20-02	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 12 January 2022
	Risk: Contractor Management and Control	Date of Committee Review: 11 January 2022
		Target Risk Date: 30 September 2022
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



Controls in place	Assurances
<ol style="list-style-type: none"> Control of contractors procedure in place. Induction process being delivered to new contractors. Permit to work paper systems in place across the Health Board. Pre-contract meetings in place. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 	<ol style="list-style-type: none"> Health and Safety Leads Group. Strategic Occupational Health and Safety Group. Quality, Safety and Experience Committee.

<p>7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group.</p> <p>8. Establishment of an approved Contractors Framework for minor works across the Health Board.</p>	
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Gaps in Controls/mitigations
<p>Staff resources gap due to demand versus capacity. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors.</p>

Progress since last submission
<ol style="list-style-type: none"> 1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been updated to address the mitigations in place. 3. Action ID 12256 – Action delayed due to delays in mobilising the adoption of the SHE software which required Data Protection compliance checking to be completed. Anticipated implementation of the system is aimed for June 2022. 4. Action ID 12254 – Action completed and previously approved for closure at Executive Team on the 22/12/2021, closure to be included for noting on the next Quality, Safety and Experience Committee papers prior to being archived and removed from the next iteration of the report. 5. Action ID 12255 – Proposal to close the action as processes are now in place. 6. Action ID 12259 - Proposal to close the action as processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process. 7. Action ID 12260 – Proposal to close the action in relation to the lack of consistency and standardisation in implementation of contractor management procedure. A review of all standard current procedures has been undertaken and deemed them fit for purpose. New digital platform for the management of contractors also agreed.

Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus		BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and Health & Safety Management within Health & Safety Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to ensure compliance.	On track
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts.	Mr Rod Taylor, Director of	31/01/2022	ACTION CLOSED 05/11/2021 Implementation of SHE -	Completed

		Consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum Health & Safety requirements are implemented and externally checked prior to coming to site.	Estates & Facilities		<p>'Management of Contractor' software will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.</p> <p>05/11/2021 - Action closed ahead of the action due date.</p>	
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	<p>ACTION CLOSED 12/01/2022</p> <p>Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.</p> <p>January 2022 progress update - Processes are in place and current paper form completed and assessed.</p> <p>Proposal to close the action, system to be digitalised following the implementation of the SHE software.</p>	Completed
	12256	Identify the current system for signing in / out and/or	Mr Rod Taylor,	31/01/2022	Implementation of (SHE) - 'Management of Contractor'	Delay

		monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Director of Estates & Facilities		<p>software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board.</p> <p>January 2022 progress update - Current robust paper based system is in place. Delays in mobilising the adoption of the SHE system in relation to Data Protection compliance checking, anticipated implementation of the system in aimed for June 2022.</p>	
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	<p>Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.</p> <p>To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology</p>	On track

					etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes.	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.</p> <p>To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes.</p> <p>January 2022 progress update - Meetings scheduled to identify individuals with</p>	On track

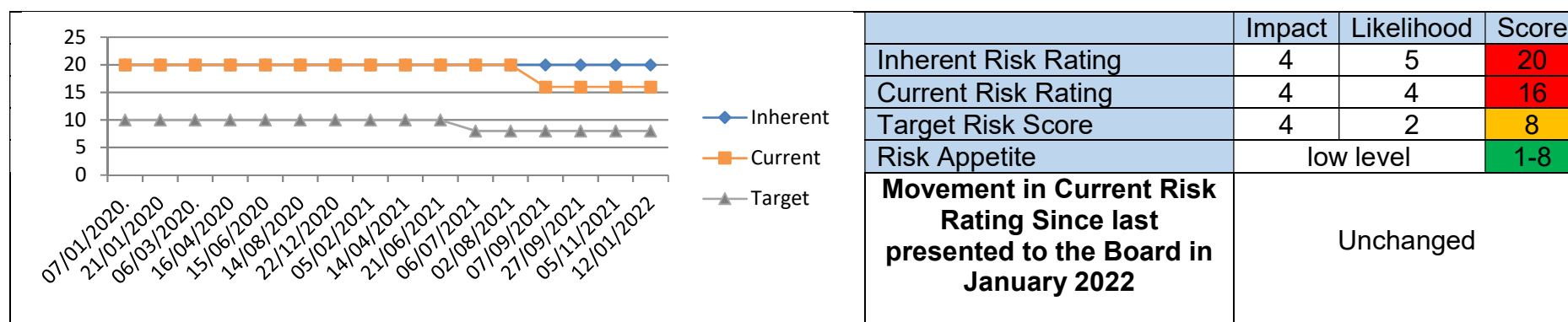
					Head of Services, recognising that this will require a further review once the digital system is in place and implemented.	
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>ACTION CLOSED 12/01/2022</p> <p>A Permit to Work system will be adopted as part of implementation of SHE software.</p> <p>January 2022 Progress update - Current paper based processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process.</p> <p>Proposal to close the action.</p>	Completed
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in Health & Safety Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/05/2022	<p>ACTION CLOSED 12/01/2022</p> <p>Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment</p>	Completed

				<p>criteria across the Health Board.</p> <p>To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes.</p> <p>January 2022 Progress update - Review of all standard current procedures undertaken and deemed them fit for purpose and improved standardisation of the contractor framework. New digital platform for the management of contractors also agreed.</p> <p>Proposal to close the action.</p>	
	12552	Induction process to be completed by all	Mr Rod Taylor,	30/09/2022	<p>Resources within Operational Estates have been reviewed</p> <p>On track</p>

		contractors who have not yet already undertaken.	Director of Estates & Facilities		<p>as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health and Inspection process to ensure compliance.</p> <p>January 2022 progress update - Regional framework of contractors for minor works in place, review of systems and procedures undertaken. Induction process is in place however potential gaps due to resources to align with capacity. Business case to be re-presented to the Executive Team.</p>	
	18688	An annual review of business as usual capacity	Mr Arwel Hughes,	31/03/2022	Create assurance that there is sufficient estates	On track

		to be developed to ensure estates project management capacity is not exceeded.	Head Of Operational Estates - Interim		management capacity and technology to ensure that projects can be delivered safely. January 2022 progress update - Capacity demand identified through the resources business case.	
	19759	Funding to be secured for additional authorised/competent persons to mitigate the resource gap.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	A revenue business case for additional authorised/competent persons has been prepared and has been put forward for financial/resource consideration on a recurrent basis and will address the gap identified and support the reduction in the risk score to achieve the target. January 2022 progress update - Capacity demand identified through the resources business case.	On track

CRR20-03	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 12 January 2022
	Risk: Legionella Management and Control.	Date of Committee Review: 11 January 2022
		Target Risk Date: 30 September 2022
There is a significant risk that BCUHB is non-compliant with Control of Substance Hazardous to Health Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

<p>8. Water safety Group has been established to better provide monitoring, oversight and escalation.</p> <p>9. Internal audit of compliance checks for water safety management regularly undertaken.</p> <p>10. Alterations to water systems are now signed off by responsible person for water safety.</p> <p>11. Local Infection Prevention Groups in place with oversight of water safety.</p>	
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Gaps in Controls/mitigations

1. There is a weakness that little used outlets are not reported to Estates for management and control. For example - ward shower temporarily used as a store, therefore it is not part of Estate flushing programme. Raising awareness with the Water Safety Group which has clinical representation.
2. BCUHB wide Water Safety Plan – Plan has been developed, consulted upon and final draft is being produced. Plan has also had approval from the authorising Welsh Government Appointed Engineer - Water Safety, which will provide the legal requirement under L8 for processes and controls for water safety systems. Final version to be completed by and submitted in March 2022 for ratification by Infection Prevention Sub-group.
3. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently unfunded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety, which forms part of the ongoing business case.

Progress since last submission

1. Clarification requested by Audit Committee whether the risk also covers staff operating from non-BCUHB premises. The role of the duty holder will be specified in the occupancy agreement which is considered as part of the due diligence assessment.
2. Controls in place have been reviewed and updated to reflect the current strategic position.
3. Gaps in controls have been reviewed with the identification of appropriate current mitigations.
4. Action ID 12268 – Action remains delayed with a BCUHB Water Safety Plan to be completed and submitted by March 2022 for ratification by the Infection Prevention Sub-Group.
5. Action ID 19015 - Business case to be re-presented to the Executive Team by March 2022, which will result in a delay to the action due date of the 31/03/2022 to appoint Senior Estates Officers for water safety.

6. Action ID 12265 - Proposal to close the action as water testing is carried out by Public Health Wales who store the information on their services.
7. Action ID 12270 - Proposal to close the action as a standardised maintenance strategy adopted and in place by means of single service provider.
8. Action ID 19760 - Proposal to close the action as Authorising Engineer for water safety appointed in December 2021.

Links to	
Strategic Priorities	Principal Risks
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	On track
	12263	Departments to have information on all outlets	Mr Rod Taylor,	30/06/2022	All water outlets within managed departments have	On track

		and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Director of Estates & Facilities		<p>outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.</p> <p>January 2022 progress update – Information reported through local Infection Prevention and Control Groups. Process for information collection has been described, with the collection of information underway.</p>	
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	This forms part of the Water Safety Plan to ensure water safety compliance. This will be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group.	On track
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	<p>ACTION CLOSED 12/01/2022</p> <p>Pseudomonas and Legionella sample testing carried out within augmented care areas,</p>	Completed

		dashboard/logging system (Public Health Wales).			<p>exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.</p> <p>January 2022 progress update - Water testing carried out by Public Health Wales who store the information on their servers, BCUHB keeps the information within log books for each area and accessible upon requests by departments.</p>	
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	<p>Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).</p> <p>January 2022 progress update - Escalation process is included in the Water Safety Policy, exception reports provided to the Infection Prevention Group</p>	On track

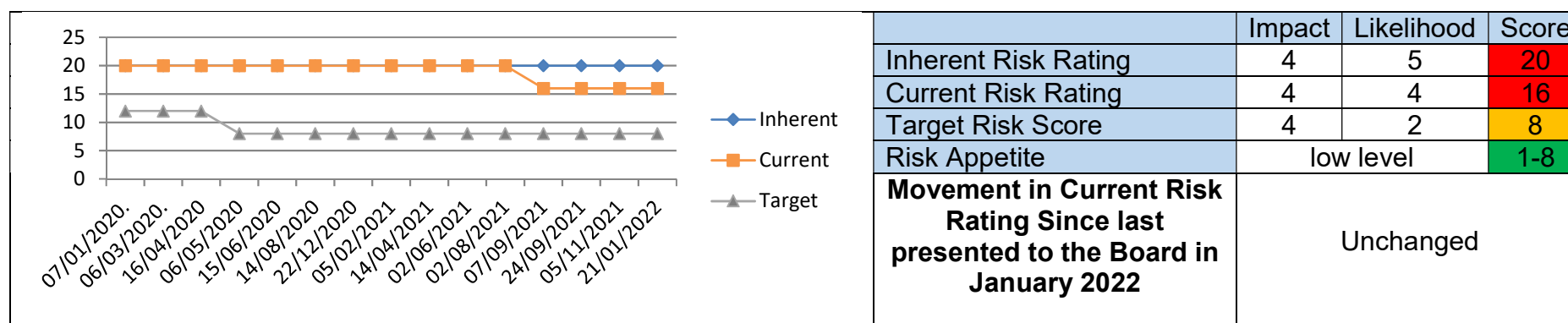
					from the Water Safety Group.	
	12267	Awareness and training programme in place to ensure all staff aware as part of Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	<p>A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.</p> <p>January 2022 progress update – Awareness and Training Programme now in place, proposal to close by 31/03/2022.</p>	On track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for Standard Operating Procedures and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	<p>A policy for Water Safety Management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.</p> <p>As part of the Water Safety Plan infection prevention will need to be integrated within key sections of the plan.</p> <p>January 2022 progress</p>	Delay

					update - BCUHB Water Safety Plan to be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group.	
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the Health & Safety Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	<p>ACTION CLOSED 12/01/2022</p> <p>Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.</p> <p>January 2022 progress update - standardised maintenance strategy adopted and in place by means of single service provider.</p> <p>Proposal to close the action.</p>	Completed
	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on	Delay

					<p>water safety and provide assurance of compliance to the water safety group.</p> <p>January 2022 progress update - Business case to be re-presented to the Executive Team by March 2022.</p>	
	19760	Confirmation that the Health Board has an Appointed Authorising Engineer for water safety, a function that is provided by NHS shared services (specialist estates services).	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	<p>ACTION CLOSED 31/12/2021</p> <p>Provide an independent Water Safety Specialist Engineer to ensure Health Board is compliant in its duties in terms of water safety, which in turn will increase the controls in place and support the reduction in the likelihood of the risk materialising.</p> <p>Appointed Authorising Engineer – appointed December 2021.</p> <p>Proposal to close the action.</p>	Completed
	19761	Improve on the consistent reporting and the identification of little used	Mr Arwel Hughes, Head Of	28/02/2022	Substantiate the adjusted lower risk score that has been signed off at	On track

	outlets in both community and acute settings.	Operational Estates - Interim	committee. January 2022 progress update - picked up as part of the water safety systems programme, subject to any site restrictions due to the pandemic 4th wave.	
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CRR20-04	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 21 January 2022
	Risk: Non-Compliance of Fire Safety Systems	Date of Committee Review: 11 January 2022
		Target Risk Date: 30 September 2022
There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Fire Safety Policy established and implemented. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken. 6. Escape routes identified and evacuation drills undertaken, established and implemented. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

<p>7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff.</p> <p>8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens.</p> <p>9. Appointed Authorising Engineer for fire safety in place through NHS shared services (specialist estates services).</p>	
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Gaps in Controls/mitigations

1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments.
2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals.

Progress since last submission

1. Controls in place have been reviewed and updated to reflect the current strategic position, including the development of the specific Fire Safety Action Plans.
2. Gaps in controls have been reviewed with the identification of appropriate current mitigations.
3. Action ID 12275 - Proposal to close the action as 80% compliance target rate has consistently been achieved over the past 3 years and is monitored via the Fire Safety Group.
4. Action ID 12279 - Proposal to close the action as Albac Mat training is now in place. Estates and Facilities Department provided support to develop the training programme. Manual handling training on Albac Mats is delivered by the manual handling team with refresher training delivered on request. Closure of the action recognises the link on training compliance with the manual handling department.
5. Identification of new Action ID 21491 to develop and implement a Health Board wide Fire Safety Strategy which will bring all procedures, action plans etc., together to improve governance control and oversight of Fire Safety Management.

Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)		BAF21-13 BAF21-17

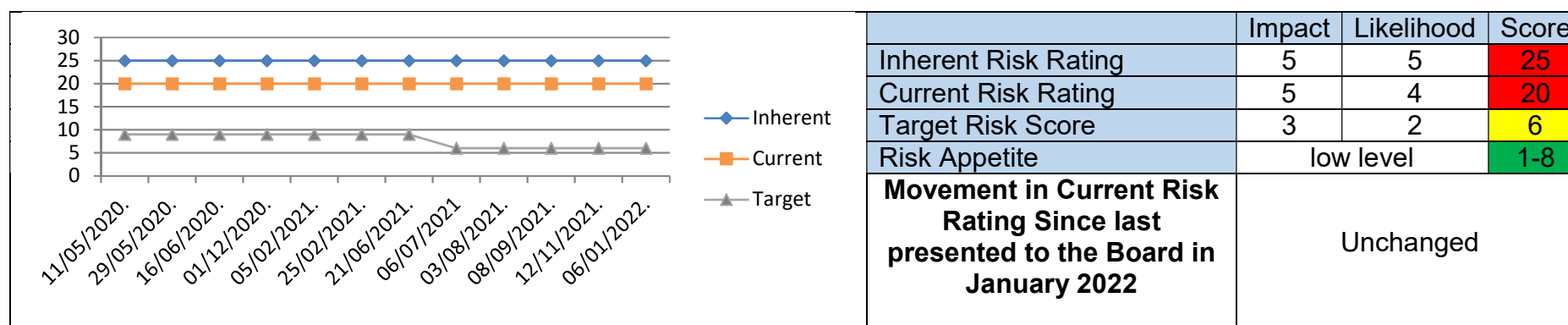
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12274	Identify how actions identified in the site Fire Risk Assessments are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	ACTION CLOSED 21/01/2022 Database located within the fire safety files, managed and updated by the fire safety trainer. January 2022 progress	Completed

					update - Proposal to close the action as 80% compliance target rate has consistently been achieved over the past 3 years and monitored via the fire safety group.	
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	<p>To be included in site specific manual and training developed with Manual Handling Team.</p> <p>January 2022 Progress update – BCUHB will participate in the proposed All Wales Group to look into bariatric evacuation as it's an identified issue across all Health Boards in Wales.</p>	On track
	12279	Albac Mat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>ACTION CLOSED 21/01/2022</p> <p>Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling Team.</p> <p>Extension of the action due date from 30/11/2021 to the</p>	Completed

				<p>31/03/2022 approved at QSE on the 02/11/2021.</p> <p>January 2022 progress update - Support provided by the Estates and Facilities department to develop the training programme. Manual Handling Training on Albac Mats is delivered by the Manual Handling Team with refresher training delivered on request.</p> <p>Proposal to close recognising the link into the Health & Safety Team on Manual Handling Training compliance rates.</p>	
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	<p>30/09/2022</p> <p>Improve safety and compliance with the Order.</p> <p>January 2022 progress update - Following a successful recruiting campaign, a full complement of Fire Safety Advisors is now in place which will assist with delivering the Health Board programme of Fire Risk Assessments in a risk assessed priority.</p>	On track

	21491	Develop and implement a Health Board wide Fire Safety Strategy.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Fire Safety Strategy will bring all procedures, action plans etc. together to improve governance control and oversight of Fire Safety Management.	On track
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CRR20-05	Director Lead: Director of Primary and Community Care	Date Opened: 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 06 January 2022
	Risk: Timely access to care homes	Date of Committee Review: 11 January 2022
		Target Risk Date: 30 June 2022
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Multi-agency care home cell established as part of the emergency planning arrangements with terms of reference for the cell in place along with recorded daily action trackers which enables identification of trigger points where additional mitigation is required. 2. North Wales care homes single action plan is in place, which is reported to the Regional Partnership Board (RPB). 2. Multi-agency pathways agreed and in place with the ability to update and react to new guidance issued. 	<ol style="list-style-type: none"> 1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG.

<p>3. Unified "One contact" data gathering from care homes established with the 6 Local Authorities.</p> <p>4. Remote consulting in place and offered by general practices.</p> <p>5. Home First Bureaus established and embedded across the 3 Area Teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home.</p> <p>6. North Wales Silver Health and Social care Group is in place and reporting into the Strategic Control Group, to identify where joint responses are required and shared learning.</p>	<p>4. Oversight by the Recovery Group.</p>
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Gaps in Controls/mitigations

1. There is a significant shortage in accessing independent provider placements. Bridging Services forms part of the Community Resource Teams and a number of schemes have been put in place to manage these pressures.
2. The capacity of the Health Board and statutory partners to respond to the continuous changes in Government and Public Health Guidance. Prioritisation of Continuing Health Care and the Quality Development Team work programmes are in place.
3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. This has been escalated to the Silver Command Operations Resilience Meeting. Work ongoing with IT department to develop digital system.

Progress since last submission

1. Further development of Primary Care Support to care homes as part of the Single Integrated Clinical Assessment and Triage (SICAT).
2. Controls in place have been reviewed and updated to reflect strategic controls in place aligned with the Multi Agency Care Home Cell establishment and implementation of action plans.
3. Gaps in controls have been reviewed with the identification of appropriate current mitigations also being addressed.
4. Action ID 18646 - Proposal to close the action as this is now embedded into the controls in place identified in relation to the Multi-Agency Cell Action Plan.
5. Action ID 18024 - Proposal to close the action as this is now captured within the current controls in place in relation to the Multi-Agency Cell which undertake the activity.

6. Action ID18025 – Following approval by the Executive Team, this action has been extended to allow sufficient time for requirement for a review by the Regional Partnership Board to mandate the process.

6. Action ID 14949 - Action currently delayed. This is on hold for 4 weeks due to the Quality Development Team required to be re-deployed to support the current high levels of COVID and vaccination programme, it is anticipated this will be completed by 31/03/2022.

7. Action ID 20074 – Action currently delayed. This action remains delayed due to resources within the Health Board and with partners to support COVID vaccination programme and general staffing shortages, it is anticipated this will be completed by 31/03/2022.

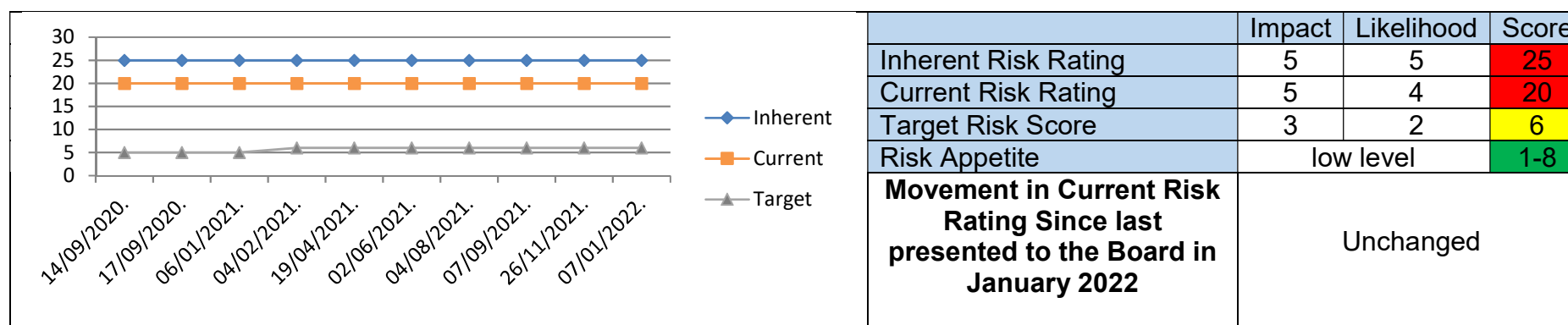
Links to	
Strategic Priorities	Principal Risks
Primary and community care	BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	28/02/2022	<p>This will help eradicate delays in discharge through better co-ordination.</p> <p>Progress to date - Draft framework is in place and we have setup 6 different work streams to implement the various strands of the Quality Assurance Framework. This action is now currently on hold for 4 weeks due to the quality development team required</p>	Delay

					<p>to be re-deployed due to current high levels of COVID and vaccination programmes and the requirement to support care homes with Infection Prevention and Control.</p> <p>It is anticipated that once the staff return, this action can re-commence and be completed by the end of March 2022.</p>	
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	<p>ACTION CLOSED 06/01/2022</p> <p>It will improve patient flow by enabling patients to be discharged to their own homes.</p> <p>Progress to date – This action is now captured within the current Multi-Agency Cell control in place which undertake this activity.</p>	Completed
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/04/2022	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.	On track

	18646	MFD - Work with local authorities and care provides to implement an agreed action plan.	Ms Jane Trowman, Care Home Programme Lead	31/12/2021	<p>ACTION CLOSED 31/12/2021</p> <p>Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients.</p> <p>Progress to date – This action is now captured and embedded into the Multi-Agency Cell Action Plan control in place.</p>	Completed
	20074	Development of an interim relief bank for health and social care.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/01/2022	<p>Allow flexibility in relation to staffing within homes.</p> <p>Progress to date – This action remains delayed due to resources within the Health Board and with partners to support the COVID vaccination programme and general staffing shortages.</p> <p>Anticipated timeframe for completion is 31/3/2022.</p>	Delay

CRR20-08	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 07 January 2022
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Date of Committee Review: 11 January 2022
		Target Risk Date: 30 June 2022
There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.		
This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Outsourcing process and group in place to review progress against the contract. 2. Cataract - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. 'Once for North Wales' process is in place, partially across all sites, patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access. 	<ol style="list-style-type: none"> 1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key

<p>4. Once for North Wales process allows partial flexibility for cross region movement of patients and the ability to allocate further clinic slots.</p> <p>5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites.</p>	<p>Performance Indicators for eye care measure and Key Quality Indicators.</p> <p>4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government.</p> <p>5. Performance reviewed at Secondary Care Accountability Meetings.</p>
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Gaps in Controls/mitigations

1. Further table-top risk stratification is challenging by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case.
2. Surgery has recommenced but the Pan-BCUHB cataract Priority Targeting List (PTL), (to reduce inequality) has yet to be fully operationalised. Outsourcing of the cataract activity is in place along with additional temporary administration support being approved.
3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans.
4. National standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 3.6-4, differences in national standards between number of cataract procedures per list. Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions.

Progress since last submission
<ol style="list-style-type: none"> 1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gaps in controls have been reviewed with the identification of appropriate current mitigations. 3. Monitoring of the target risk date is in place by the service to review if compliance can be met due to current position. 4. Action ID 20392 – Action currently remains delayed. Recruitment has taken place for the West region with partial recruitment only in the East. 5. Action ID 14908 – Proposal to close the action following completion, and the introduction of retinal cameras across all 3 sites. 6. Action ID 15662 – Proposal to close the action following initiation of the pathway pan BCUHB. 7. Action ID 20995 – New action identified for the training of additional non medic Intra Vitreal Therapy (IVT) injectors which will reduce waiting times for new IVT patients and reduce the likelihood of the risk materialising. 8. 693 patients have now been referred to the independent sector provider, against a target of 450. The ongoing target is 100 referrals per week.

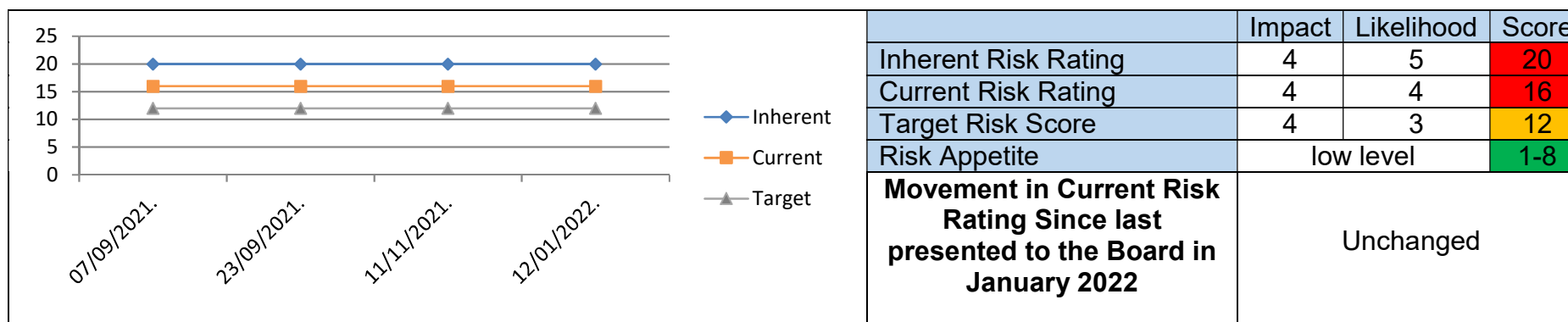
Links to
Strategic Priorities
Recovering access to timely planned care pathways Strengthen our wellbeing focus
Principal Risks
BAF21-02 BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	ACTION CLOSED 07/01/2022 This action will enable the service to effectively mitigate and manage this	Completed

		awaited from internal sources.			<p>risk so as to achieve its target score.</p> <p>January 2022 Progress to date - Action has been completed, equipment now in place across all 3 sites.</p>	
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	<p>ACTION CLOSED 07/01/2022</p> <p>This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.</p> <p>January 2022 Progress to date - Proposal to close the action following completion.</p>	Completed
	20392	Following approval of business case, recruitment of clinical and admin posts for Intra Vitreal Therapy capacity and technical posts for the digital project.	Alyson Constantine, Site Acute Care Director	31/12/2021	<p>Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation.</p> <p>January 2022 progress update - Recruitment has taken place for the West region, partial recruitment in the East region.</p>	Delay

	20995	Training of additional non medic Intra Vitrael Therapy (IVT) injectors.	Mrs Jackie Forsythe, Eye Care Co-ordinator	30/06/2022	Additional non medic injectors will reduce waiting times for new Intra Vitrael Therapy patients which will reduce the likelihood of the risk materialising.	On track
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CRR21-15	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 12 January 2022
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Well-being (Wales) Act 2014.	Date of Committee Review: 11 January 2022
		Target Risk Date: 01 April 2022
<p>There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.</p> <p>This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.</p> <p>This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.</p>		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. All Wales and North Wales Safeguarding procedures approved and in place. 2. BCUHB local work programmes in place and aligned to the national strategies which are regularly reported to Welsh Government. 3. Risk Management has been embedded into the processes of the reporting framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums agendas. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 6. The BCUHB Children's Division are managing the recruitment process for the replacement of the named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor. 	<ol style="list-style-type: none"> 1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place. 2. The inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated. 3. The lack of a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments with alternative platforms in place when they have limited digital patient records.

4. Lack of consistent approach by the 6 local authorities in North Wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible.
5. Named Doctor Safeguarding Children - this post remains vacant. Currently working in conjunction with the Paediatric Team to ensure local arrangements are in place to support the Safeguarding agenda/portfolio.

Progress since last submission

1. Controls have been reviewed and updated to reflect strategic controls in place.
2. Gaps in controls have been reviewed with the identification of appropriate current mitigations.
3. Proposal for an extension to the Target Risk Due date from the 01/04/2022 to the 31/10/2022 to allow time for organisational processes to be followed and to be able to utilise agreed funding for the increased activity within Safeguarding.
4. Action ID 18113 – The action remains delayed due to increased activity and challenged resources, along with a delay in the regional ratification of the Position of Trust Procedure which influences operational activity. It is anticipated that an internal BCUHB Standard Operating Procedure will be in place by the end of March 2022.
5. Action ID 18116 – The action to implement and monitor strengthened governance and reporting pathways for Sexual Assault and Referral Centre (SARC) remains delayed due to re-deployment of SARC staffing to support the COVID Pandemic management. Whilst this has delayed the strengthened governance arrangements, the reporting arrangements are in place and are aligned to the Safeguarding governance and reporting framework. A National Sexual Assault Workstream - Steering Group driven by Welsh Government is in place to support the implementation of the SARC accreditation of which the Police force hold legal entity. Which will require a complete review of the SARC provision throughout Wales which will have a further impact on governance pathways.
6. Action ID 18115 – Proposal to close the action due to the duplication with the Childrens Services Risk, also recognising that whilst the responsibility for the recruitment to the vacant post of Named Doctor Safeguarding, alternative actions are being put in place supported by Corporate Safeguarding to support the mitigation of this risk.
7. Action ID 21216 – Identification of new action to utilise agreed funding to support the increased activity within Safeguarding.
8. Action ID 21217 – Identification of new action to review current and future Paediatrician roles and responsibility to comply with Safeguarding legislation.

Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus		BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	18113	Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].	Michelle Denwood, Director of Safeguarding and Public Protection	20/12/2021	The process and the development of Key Performance Indicators can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	Delay
					January 2022 progress update - Challenged resources due to increased activity, along with a delay in the regional ratification of the Position of Trust Procedure which influences operational activity. Anticipated	

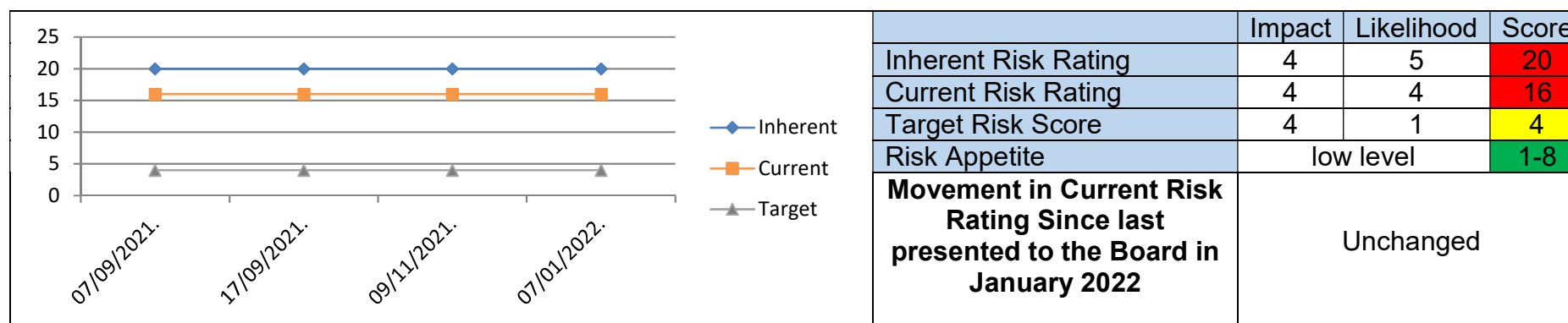
					internal BCUHB Standard Operating Procedure in place by the end of March 2022.	
	18115	Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk.	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business Support Manager	20/12/2021	<p>ACTION CLOSED 31/12/2021, due to duplication with the Childrens Services Risk.</p> <p>Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met.</p> <p>January 2022 progress update - Post has been re-advertised, and still remains vacant. Confirmation has been received from Childrens Services that recruitment to this post is their responsibility and is being managed as part of their ongoing risk management processes. This is therefore a duplicated action.</p> <p>To support the mitigation of the actual risk, the</p>	Close

				<p>Safeguarding Team are working in conjunction with the BCUHB Consultant Community Paediatricians to provide an alternative solution until the vacancy can be filled. Therefore a further action is taking place to review current and future role and responsibilities. See action 21217.</p> <p>Proposal to close the action taking the above duplication and alternative actions / mitigations being put in place.</p>	
	18116	To Implement and monitor strengthened governance and reporting pathways for Sexual Assault Referral Centre.	Michelle Denwood, Director of Safeguarding and Public Protection	<p>10/01/2022</p> <p>Compliance with legislation and early identification of risk and harm.</p> <p>January 2022 progress update - Re-deployment of Sexual Assault Referral Centre staffing for COVID management which has delayed the strengthened governance arrangements, the reporting arrangements are in place and are aligned to the</p>	Delay

					Safeguarding governance and reporting framework. A National Sexual Assault Workstream - Steering Group driven by Welsh Government is in place to support the implementation of the Sexual Assault Referral Centre accreditation of which the Police force hold legal entity. This will require a complete review of the Sexual Assault Referral Centre provision throughout Wales which will have a further impact on governance pathways.	
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	The revised procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks.	On track
	21216	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of	31/10/2022	Enable implementation of the Social Services and Well-being Act to support	On track

			Safeguarding and Public Protection		the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan.	
	21217	Review current and future Paediatrician role and responsibility to comply with Safeguarding legislation.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2022	<p>Ensure roles and responsibilities meet Safeguarding legislation requirements both operationally and strategically.</p> <p>Working in conjunction with the BCUHB Consultant Community Paediatricians.</p>	On track

CRR21-16	Director Lead: Executive Director of Workforce and Organisational Development	Date Opened: 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 07 January 2022
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Date of Committee Review: 11 January 2022
		Target Risk Date: 20 June 2023
There is a risk that insufficient Manual Handling training could lead to staff and patient injury, lost work time, Health and Safety Executive enforcement action (current related Improvement Notice for Patient Falls) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, particularly in the West region, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Health & Safety Strategy has been approved and implemented which includes Manual Handling. 2. Training work programme is in place specifically in relation to Manual Handling. 3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment. 	<ol style="list-style-type: none"> 1. Regular oversight and review by the Occupational Health & Safety Team. 2. Reviewed at the Strategic Occupational Health and Safety Group.

5. Two year training plan in place which will cover delivery of training and current shortfalls in training. 6. Review and implementation of manual handling systems and processes to ensure compliance with the All Wales Manual Handling training passport scheme.	3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.
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Gaps in Controls/mitigations

1. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing.
2. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance.
3. Lack of integrated booking system with the ESR system and ESR is not easy to use. Manual bookings currently in place.
4. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme.
5. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented for two years but this remains a gap in the controls until recruitment has been agreed. Current compliance for Patient Handling refresher is now at 55%.
6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments and portering services. An action plan with specific details of training implementation and systems will be implemented by the 14th March 2022.

Progress since last submission

1. Controls in place have been reviewed and updated to reflect the current strategic position.
2. Gaps in controls have been reviewed with the identification of appropriate current mitigations.
3. Two Health & Safety Executive improvement notices have been received following the recent inspections.
4. Action ID 17978 – Action remains delayed. Accommodation secured for Central region, documents for the West region to be signed by early January for the renting of temporary training rooms.
5. Action ID 17979 – Action remains delayed. This is due being unable to recruit to the additional trainer posts due to the national shortage of manual handling trainers. Re-advertisement of the post has been undertaken and interviews for the manual handling managers due in February 2022.

6. Action ID 17980 – Action remains delayed with confirmation from the Health and Safety Executive that the action has not been achieved and shortfalls identified. Action plans to address these shortfalls will be in place by 14th March 2022.

7. Action ID 18859 – The anticipated action completion date to finalise approve and implement Manual Handling Policy and plan has not been met due to workload and capacity within the team and pressures due to COVID. Following Health and Safety Executive Guidance, the recommendation is that systems and processes need to be in place with the policy to follow, expected completion date will be March 2022.

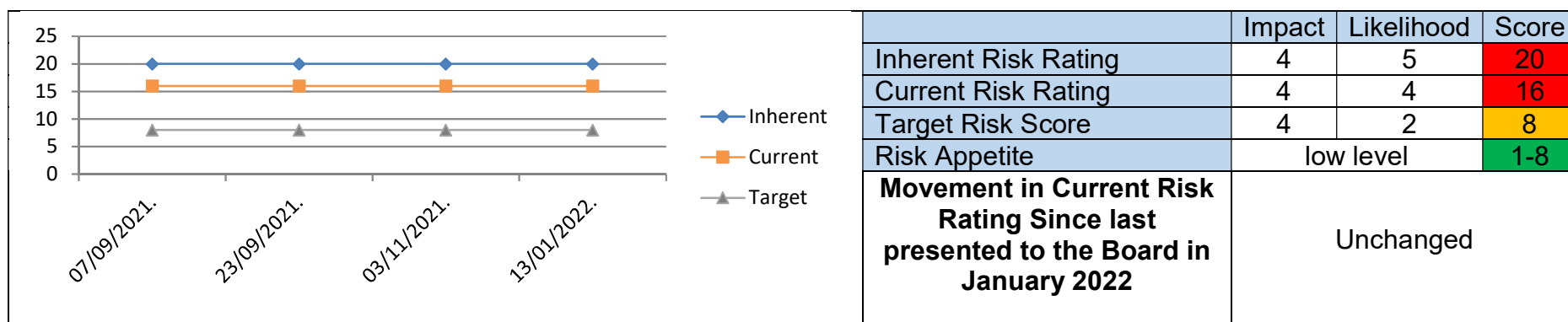
Links to	
Strategic Priorities	Principal Risks
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17978	Renting of temporary training rooms in West, Central & East. Report has been approved for 2 year leases on the premises, awaiting contracts to be finalised.	Mr Peter Bohan, Associate Director Of Occupational Health Safety And Security	30/11/2021	Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing and increasing the number of courses that can be delivered, increase the number of staff trained and increase compliance for BCUHB. January 2022 Progress update - Keys secured for Central region, documents for the West region to be signed by early January.	Delay
	17979	Additional trainers sought, to be clinically	Mr Peter Bohan, Associate	30/11/2021	Additional trainers to provide training to the standard set	Delay

		trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Director Of Occupational Health Safety And Security		<p>within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB.</p> <p>January 2022 progress update - National shortage of manual handling trainers, re-advertisement of the post has been undertaken and interviews for the Manual Handling Managers due in February 2022.</p>	
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Mr Peter Bohan, Associate Director Of Occupational Health Safety And Security	31/12/2021	<p>Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.</p> <p>January 2022 Progress update – Health and Safety Executive have confirmed that this has not been achieved and shortfalls identified and action plans to address will be in place by 14th March 2022.</p>	Delay

	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mr Peter Bohan, Associate Director Of Occupational Health Safety And Security	31/12/2021	<p>Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff.</p> <p>January 2022 Progress update - Delay due to workload and capacity within the team and pressures due to COVID. Following Health and Safety Executive Guidance, the recommendation is that systems and processes need to be in place with the policy to follow, expected completion date will be March 2022.</p>	Delay
	18860	ESR to be reviewed to include manual handling 1A and 1B training courses for inanimate load level 1.	Mr Peter Bohan, Associate Director Of Occupational Health Safety And Security	31/03/2022	Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment.	On track

CRR21-17	Director Lead: Director of Primary and Community Care	Date Opened: 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 13 January 2022
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Date of Committee Review: 11 January 2022
		Target Risk Date: 31 October 2022
<p>There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to Child and Adolescent Mental Health Services (CAMHS) to ensure highest quality patient-centred care.</p> <p>This may be caused by a number of contributory factors, the list below is not exhaustive:</p> <ul style="list-style-type: none">• Current operational hours of CAMHS is 9am-5pm over 7days a week.• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.• crisis presentations to the Emergency Departments with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.• awaiting a CAMHS Tier 4 bed following a mental health assessment. <p>The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.</p> <p>This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.</p>		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Area Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Area Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 9. Safeguarding discharge Standard Operating Procedure for young people in place. 10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS. 	<ol style="list-style-type: none"> 1. A scoping exercise or report of Child and Adolescent Mental Health Services (CAMHS) Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB approach. 3. Risk also regularly discussed at the Area - Quality and Safety Group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with Welsh Government, joined with Mental Health Division on a quarterly basis.

11. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	
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Gaps in Controls/mitigations

1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi-disciplinary team is already in place.
2. Lack of suitable Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all health economy areas and Local Authority partners.
3. Lack of agreed criteria, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission

1. Controls in place have been reviewed and updated to reflect the current strategic position.
2. Gaps in controls have been reviewed with the identification of appropriate current mitigations.
3. Action ID 21236 - Identification of new action for the implementation of recommendations following the Delivery Unit Crisis Care Review.
4. Action ID 17961 – Proposal to close the action due to risk assessments from all 3 regions having now been received.
5. Action ID 17962 - Proposal to close the action with the successful commissioning of the “Just R” recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme.
6. Action ID 17963 – The due date for the action completion has not been met and the action remains delayed due to COVID pressures and re-deployment of staff. A draft policy is currently being finalised and will be presented for consultation by April 2022. A further recommendation that a further review is undertaken once the National Institute for Health and Care Excellence (NICE) guidelines have been published.
7. Action ID 19594 – It is anticipated that the action completion date of the 01/02/2022 to develop a programme of auditing risk assessments will not be met due to COVID pressures and Paediatric Respiratory Surge along with capacity. The programme development has been delayed, but CAMHS and Paediatrics safety meeting monitor are in place and manage any identified risks.

Links to Strategic Priorities		Principal Risks
Improved Unscheduled Care pathways Integration and improvement of Mental Health Services		BAF21-01 BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-Agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	<p>This will enable us to divert young people at the front door and support their needs in different ways.</p> <p>January 2022 progress update - Draft currently being circulated for final comments prior to approval at the Childrens Sub Group of the Regional Partnership Board and Together Mental Health Partnership Board.</p>	On track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing Child and Adolescent Mental Health Services (CAMHS).	Marilyn Wells, Head of Nursing	31/10/2022	<p>This will enable us to meet the needs of young people before crisis occur as most of their needs are psycho-social and not just Mental Health.</p> <p>January 2022 progress</p>	On track

					update - Draft currently being circulated for final comments prior to approval at the Childrens Sub Group of the Regional Partnership Board and Together Mental Health Partnership Board.	
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	29/10/2021	<p>ACTION CLOSED 13/01/2022</p> <p>Ensure a safe environment by identifying all ligature points on the ward.</p> <p>Ligature point assessments received from East, West and Central.</p> <p>Proposal to close as action completed.</p>	Completed
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	<p>ACTION CLOSED 13/01/2022</p> <p>It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will enable us to provide more out-of-hour response.</p> <p>January 2022 progress</p>	Completed

					update - Proposal to close the action with the successful commissioning of the "Just R" recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme.	
	17963	Task and Finish Group to review SCH03 Policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	<p>This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.</p> <p>January 2022 progress update - Due to COVID pressures and re-deployment of staff, a draft is currently being finalised and will be presented for consultation by April 2022. A further recommendation that a further review is undertaken once the National Institute for Health and Care Excellence (NICE) guidelines have been published.</p>	Delay
	17964	Training and awareness raising for relevant professionals in supporting	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On track

		and assisting young people in crisis. For example: Paediatric staff/ Emergency Department, Local Authority and North Wales Police.			January 2022 progress update - Training Needs Analysis Survey has gone out and responses returned with a view to the development of a training programme.	
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	<p>Provision of an age appropriate environment that provides an appropriate alternative to hospital.</p> <p>January 2022 progress update - Safe space pilot to take place from the 31/1/2022 in the East area operating over 3 evenings with access to various specialties. In the process of arranging dates for the West area for conversation on how to take a similar pilot forward.</p>	On track
	19594	Develop a programme of auditing risk assessments as part of the admissions pathways on a quarterly basis.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	01/02/2022	The Risk Assessment and audit process will support the reduction in the risk score whilst recognising that the paediatric wards cannot be a completely ligature free environment.	Delay

					January 2022 progress update - Due to COVID pressures and Paediatric Respiratory Surge along with capacity, the programme development has been delayed, Child and Adolescent Mental Health Services (CAMHS) and Paediatrics safety meeting monitor and manage any identified risks.	
	19595	Further analysis of the incidents reported in order to determine what further actions are required to ensure appropriate reporting of the incidents.	Ms Janw Hughes-Evans, Head of Nursing Children's Services	31/01/2022	<p>Provides a greater understanding of the incidents occurring and the measures required to be put in place to support both staff and patients and supports a safer environment.</p> <p>January 2022 progress update - Due to COVID pressures and re-deployment of staff, it has impacted on the ability to complete this action. Monthly reports to be developed and reviewed by Heads of Nursing with themes being collated on a quarterly basis and presented to both the acute clinical advisory group and</p>	Delay

					the Child and Adolescent Mental Health Services (CAMHS) Clinical Advisory Group, and also to present to the Area Quality and Safety meetings.	
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing	31/10/2022	Provide further assurance following a review by an external body and the implementations of any recommendations to support the development of high quality and safe care.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes	Executive Director of Primary and Community Care	Quality, Safety and Experience	20
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours	Executive Director of Primary and Community Care	Quality, Safety and Experience	16

Appendix 3 – Corporate Risk Register Key Field Guidance

BAF / Risk Template Item	Please refer to the Risk Management Strategy and Policy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Appendix 3 – Corporate Risk Register Key Field Guidance

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	<ul style="list-style-type: none"> - People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	<ul style="list-style-type: none"> - A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Patient Safety Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Sarah Musgrave, Patient Safety Lead Manager Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager						
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality						
Atodiadau Appendices:	1. Patient Safety Report – Dec 2021 – Jan 2022						
Argymhelliad / Recommendation:							
The Quality, Safety and Experience Committee is asked to note the report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The Quality, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient safety. This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.							
Cefndir / Background:							
This report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the Committee. The period under review is primarily December 2021 and January 2022 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.							
Asesiad / Assessment & Analysis							
Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.							

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – This is contained within the report.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report.

Patient Safety Report

December 2021 and January 2022

Produced by the Patient Safety Team, Quality Directorate

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 that involves health care professionals, partner organisations, patients and their carers/families.

The Patient Safety Team, part of the Quality Directorate, is responsible for facilitating and overseeing the incident process, the safety alert process, the collection of patient safety data and reporting, and patient safety culture, learning and improvement (working with clinical leaders and specialists such as Transformation and Improvement Directorate). The Legal Services Team, also part of the Quality Directorate, facilitate and manage claims and inquests.

This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient safety.

Statistical Process Control (SPC) charts or run charts are used where appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:

- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicated by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicated by dotted grey lines.
- A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.
- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)ailing short of the target

There are two sections of this report that may include incidents that affect employees and members of the public, as well as patients; these are nationally reportable incidents and liability claims. As the Quality Directorate manage these matters, they are included in this report to provide an overall view of these areas; however, relevant information is also included in the Occupational Health and Safety Report.

NATIONALLY REPORTABLE INCIDENTS

In October 2020, the NHS Wales Delivery Unit (DU) took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Quality Directorate has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

As of the 14th June 2021, NHS Wales' responsible bodies were required to implement Phase 1 of the Welsh Governments National Incident Reporting Policy. The most obvious change in policy direction is a change in terminology with the removal of the word "serious" from the term serious incident. The intention here in removing the word "serious" is to support a more just and learning culture where reporting incidents does not feel punitive.

From 14th June 2021, the following definition of a nationally reportable patient safety incident applies

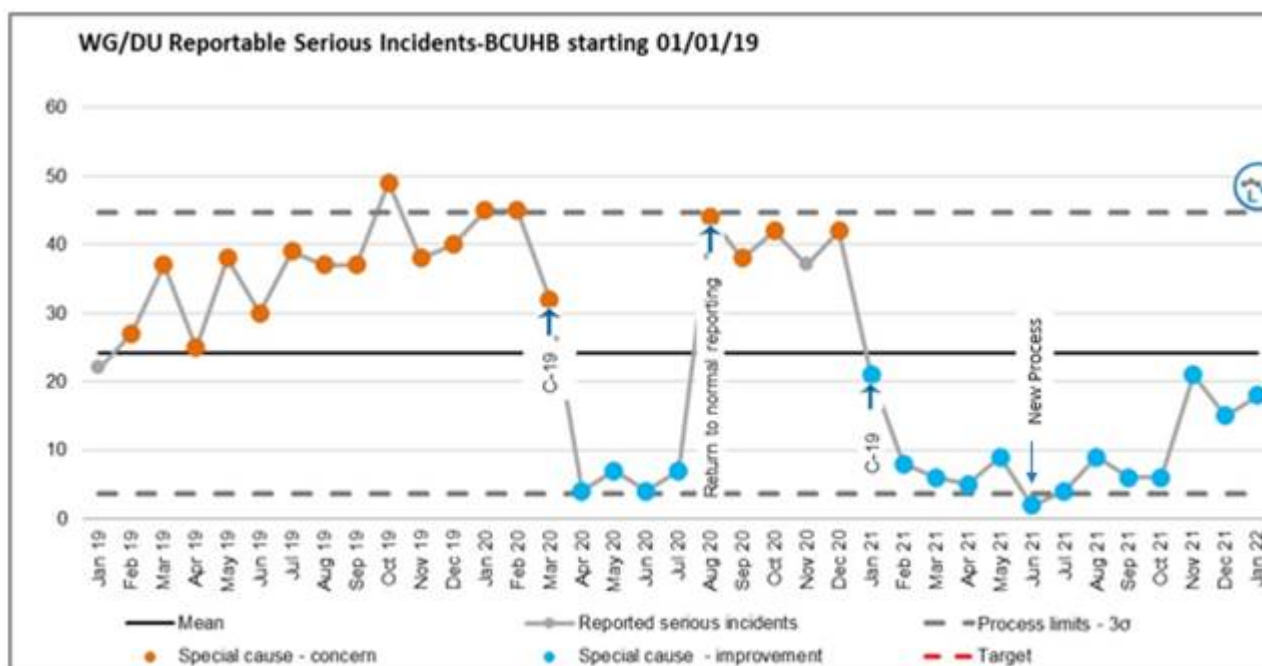
"A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded Healthcare "

The timescale for reporting such incidents has increased from 24 hours to within seven working days.

The Delivery Unit lifted any reporting restrictions that were put in place because of Covid-19 as of the 14th June 2021, and provided a list of Specific National Incident Categories as well as Specific Reporting Arrangements.

Further details around changes to National Incident Reporting in NHS Wales can be found on the Delivery Unit website [Patient Safety Incidents - Delivery Unit \(nhs.wales\)](https://www.nhs.uk/healthcare-quality/patient-safety/patient-safety-incidents/).

Never Events are defined as patient safety incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event. Never Events require full investigation under the National Incident Reporting Policy.



During the time period under review, 34 nationally reportable incidents occurred, one of which was a Never Event incident (see Never Event section below). This is an increase in nationally reportable incidents from the October/November figures of 27. Of the 36 reported, 3 relate to avoidable Health Acquired Pressure Ulcers, 14 related to patient falls. There has been an increase in the number of falls from 3 in the previous time period (October/November 2021). The predominance of falls occurred in Acute West (6), Acute East (3), Acute Central (3), Area West (1), and Cancer Services (1).

The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All Wales position per 100,000 population.

Period	BCUHB Incidents/100,000	All Wales Incidents/100,000
Jun/July 2021	1.0	1.8
Aug/Sept 021	1.8	2.3
Oct/Nov 2021	3.8	3.0
Dec /Jan 2022	4.3	3.2
Average	2.7	2.6

Given the small numbers involved, and the particular reporting requirements for certain incidents, the average should be considered a more useful comparison than an individual quarter.

In addition, there were six Early Warning Notifications (EWN) reported, one of which were Procedural Response to the Unexpected Death In Childhood (PRUDiC) related.

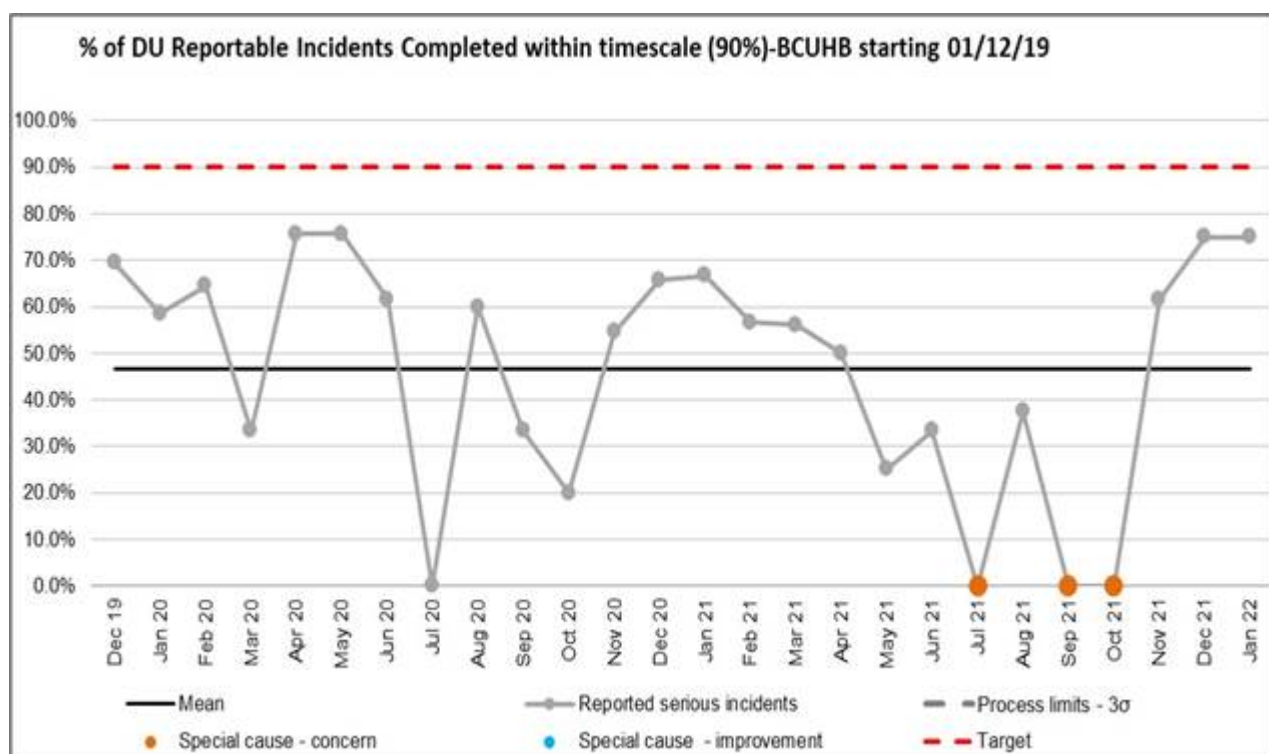
At the time of writing, the total number of national reportable incidents open is 76 of which 36 are overdue. The total number of open incidents has increased from 57 from the previous time period; however, the number that are overdue has increased by only two.

A piece of work is currently ongoing with the Welsh Government and all Health Boards across Wales, to consider how best to manage the nationally reportable legacy serious incidents which remain open within individual organisations up to 13th June 2021, when the new incident reporting policy became operational. This is work, which had already begun pre-pandemic across all NHS organisations, and much progress had been made. The Welsh

Government are now looking to complete that work pragmatically, taking account of the age of some of the incidents and what learning can be drawn from them. A final decision is awaited.

At the end of January 2022, 26 legacy serious incidents (i.e. those reported prior to June 14th 2021) remain open with the Delivery Unit. Of these, the predominance of overdue incidents relate to Corporate Safeguarding (all PRUDiC) (11), West Acute (6), Cancer Services (3), MHLD (3).

Overall closure rate within timeframe for the year is around 75%, which is a much improved position since June 2021 when the new processes were put in place for the reporting of nationally reportable incidents to the DU by the Patient Safety Team. In addition, the impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment has impacted on the ability of services to respond in a more timely manner to incident investigations.



SPECIFIC NATIONALLY REPORTED INCIDENTS (NRI)

There were 34 NRI's, including one Never Event, for the two-month time period.

As part of the new incident process and in line with the expectation of the Chief Executive, "Rapid Learning Panels" (RLP) take place between the senior service team and clinical executives around 24 hours following a Never Event and/or when an adverse incident where significant harm or death of a patient has occurred. The role of these meetings is to update on immediate learning and actions being taken (including any cross-Health Board immediate learning), identify key risks and provide support where required. This compliments the Make it Safe (MIS) Rapid Review completed within 72 hours.

During December 2021 and January 2022, eight RLP meetings took place into the most serious incidents. The table below illustrates the NRIs reported per division, not including falls. A narrative to identify, themes and trends relating to reportable falls follows the below table.

The immediate learning column reflects the learning at either the 24 hour Rapid Learning Panel and/or the 72 hour Make it Safe Review. It is therefore focused on immediate learning for the clinical teams. In all cases, detailed investigations are underway which will produce improvement plans against the findings.

East Acute - Wrexham Maelor Hospital (1)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Following epidural and bowel operation, patient has suffered L1 spinal damage and double incontinence.	Haematoma on the spinal cord is a known but extremely rare consequence of epidural. However current guidelines do not routinely continue following removal of epidural catheter after day 6.	Discussion with ITU/anaesthetics regarding potential benefits/disadvantages of continuing neurological observations post day 6 following epidural. Also to discuss guidelines with Royal College of Anaesthetists.

East Area (3)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
<p>Delay in treatment due to failure to recognise vascular 'red flags'.</p>	<p>Clear inclusion/exclusion criteria for triage and face to face consultations must be evident.</p> <p>Clinical support for the Advanced Nurse Practitioner (ANP) is required and weekly reviews to identify further learning needs.</p> <p>Documentation must reflect and code consultations, evidencing sources of current guidelines and safety netting/follow up.</p>	<p>Development plan is in place with regular follow up with Area Practice Development Nurse.</p> <p>Broader actions: review of the preceptorship plan and a review of how staff are deployed (including review of level of experience and skill) to cover wider clinical gaps.</p> <p>PADRs are currently underway to ensure all ANPs and Trainee ANPs have a set inclusion/exclusion clinical criteria to ensure they remain within their scope of practice and that areas of future development are identified.</p>
<p>Delay in referral for adjuvant chemotherapy following excision of melanoma. Window of opportunity missed, patient now has metastases.</p>	<p>Importance of tracking progress for a patient's referral to tertiary centres.</p>	<p>Await confirmation of actions from Dermatology Multi Disciplinary Team.</p> <p>Patient Safety Team in discussion with Whiston Hospital.</p>
<p>A code blue was called at 14.36hours. Individual in question was found unresponsive with a ligature tied around his neck and suspended (feet not touching the floor).</p> <p>Ligature was removed and life sustaining treatment was administered.</p>	<p>Existing processes should be fully utilised to support complex patients in prison ensuring appropriate members of the Health & Wellbeing Team are informed of the process.</p> <p>Continuity of Health and Wellbeing support on release and the importance of establishing and</p>	<p>Training to be provided to Health & Wellbeing staff on appropriate and consistent implementation of the COWS assessment.</p> <p>Develop SOP in relation to the communication with acute hospitals re. Information sharing for clinical updates of HMP Berwyn residents.</p>

Patient transferred to ED Wrexham Maelor and subsequently to ITU in Ysbyty Glan Clwyd.	maintaining ongoing support networks, where possible and accepted.	<p>Continuity of Health and Wellbeing support on release and the importance of establishing and maintaining ongoing support networks, where possible and accepted.</p> <p>Review community notes and outcome of referral from HMP Berwyn MHLD Team to East Area CMT in July 2021.</p> <p>Raise awareness / training for staff involved in reception process and documentation of decision making.</p> <p>Discussion required identifying housing / accommodation on release from HMP Berwyn with HMPPS to support successful completion of referrals in relation to Health & Wellbeing.</p>
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West Acute – Ysbyty Gwynedd (2)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Delay in clerking, investigation and treatment of symptoms may have resulted in unavoidable death of patient.	<p>Not to presume that an apparent social admission does not have any underlying health concerns.</p> <p>Importance of obtaining bloods and CG early in admission</p>	<p>Develop an Internal Safety Alert and share across the Health Board. This is also to be shared with clinical staff and cascaded down to junior staff.</p> <p>Review of circumstances on site/pressures at the time of the incident.</p> <p>Also assessment of the skill mix on AMU due to the lack of escalation.</p>

	Importance of escalating difficulties with obtaining bloods or cannulation.	
Patient developed Grade 3 pressure ulcer whilst an inpatient.	The importance of early risk assessment, early implementation of pressure relieving measures.	Also, ED staff will be invited to become pressure ulcer champions in order to facilitate change and care improvements. HAPU lead and senior staff in ED to discuss an action plan to improve pressure area care in ED.

West Area (1)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Immunisation records as far back as 2010 have not been inputted onto the system	Timely inputting of information – awaiting further investigation	Identify all patients and review. . The investigation is going to look at the resourcing and training on the admin staff and the management team have been working above and beyond to contain the issue and put systems in place

Central Acute -Ysbyty Glan Clwyd (6)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Failure to act on adverse symptoms	Improved communication between medical teams; improved escalation routes and procedures to ensure senior support	Consultant to liaise with doctors on call to ensure they are made aware of this case and the plan going forward

		<p>Nursing staff to be made aware of escalating the sickest patient to consultants when ward rounds start.</p> <p>Ensure night staff handing over identify the sickest patient to be seen first.</p>
<p>Delay in patient being seen in IVT clinic. Vision deteriorated significantly when eventually seen.</p>	<p>The patient was on the Follow Up Waiting List and was not discharged from the care of Stanley Eye Unit.</p> <p>Due to issues with capacity and demand, the patient's agreed follow-up was not booked, and it appears that the patient's condition has deteriorated in this time.</p> <p>The importance of reminding patients to contact the Department as soon as there is any sign of vision deterioration.</p>	<p>The patient has been recommenced on intravitreal (IVT) treatment following attendance.</p> <p>To discuss ways to address the backlog, which will include discussion on if 'Do Not Defer' patients can be sub-categorised into an urgent category to prevent reoccurrence of this incident and to complete a SOP.</p> <p>The IVT Service remains on the Risk Register, and subsequent actions to reduce the IVT Waiting Times are being reviewed.</p> <p>Directorate General Manager has advised that Hospital Management Team have recently agreed additional funding to enable the team to recruit to the full resource identified in a previously submitted business case. This investment will support additional nurse injector training as well as administrator and two consultant sessions. A separate business case has also been approved to recruit a Consultant Medical Ophthalmologist who will have sessions supporting IVT. This additional funding will support reduction of the overall waiting times for new and review AMD patients. We hope to have</p>

		recruited and commenced training of nurse staff by April 2022.
Patient with wet age related macular degeneration had appointment for treatment delayed due to capacity issues. Subsequently presented with sub retinal bleed. Now eligible for blind registration.	<p>The issue with this service remains the same and is on the risk register. The service does not have capacity of resources and patients that require 4 week IVT injections.</p> <p>This issue is already on secondary care tier 2 risk register (scoring 20 in spite of mitigation) and has been escalated previously to execs. The harm caused to patient's vision is unavoidable due to lack of capacity.</p> <p>The risk remains on the elective recovery action plan and on the PRM for HMT support. The business plan has now been approved and plans are underway to increase capacity to meet the needs of the service.</p>	Central HMT recently agreed additional funding to enable the team to recruit to the full resource identified in a previously submitted business case. This investment will support additional nurse injector training as well as admin and two consultant sessions. A separate business case has also been approved to recruit a Consultant Medical Ophthalmologist who will have sessions supporting IVT. This additional funding will support reduction of the overall waiting times for new and review wAMD patients. We hope to have recruited and commenced training of nurse staff by April 2022.
Patient with glaucoma (normal tension glaucoma) in his only eye lost vision because he was not seen between in the period between 18.04.2019 and 30.12.2021.	Capacity issues for follow up Glaucoma outpatient appointments can result in significant harm to patients	<p>Risk assessments to be undertaken to increase clinic capacity.</p> <p>Urgent emergency clinics to be arranged – twilight/weekends.</p> <p>Currently on risk register.</p>

<p>Long delay in ambulance for patient with abdominal pathology. Further delays in CT resulted in delay in recognising perforated bowel and subsequent surgery. Patient sadly RIP.</p>	<p>Abdominal CT scans should be requested not abdominal x-rays</p> <p>Quality of documentation to be reviewed and escalated</p> <p>Scans / tests requested - results to be reviewed by the requestor or delegated to a competent person to review and act on accordingly</p> <p>Need to be clear on what is said when specialty referrals are made? For example, in this case advising of a pneumo peritoneal would have triggered a different response</p> <p>There is no dedicated person in ED to review results after 6pm. It is for the MTL to identify people who are available to review results.</p> <p>There is no protocol in ED for the handing over of patients such as this.</p> <p>If ED Consultants conduct a rapid assessment of patients on the ambulance, they must write in the records that it was a rapid assessment so it is understood why a full history etc is not documented at that time.</p>	<p>Patient's referrals are to be made to the Surgical Registrar not SHO.</p> <p>Communication will be going out to all clinicians from Medical Director with a reminder that all specialties must review patients on ambulances if requested to do so by ED. This is to be followed up a week later to all clinicians with clear expectations with regards to specialty referrals that are made.</p> <p>As many junior doctors as possible will be invited to discuss the learning of this case at the Grand Round.</p> <p>Dr. who orders tests should see the test results when back. If you order it you must see it through or pass to someone senior enough to make the decisions. On-call surgical staff to be informed they should go down to ED to review any patients.</p> <p>Share the above with other sites to ensure message consistent across HB.</p> <p>Binding letter to be shared with surgeons to clarify that when required they must review and do the needful for patients that are waiting in back of ambulances outside out Emergency Departments.</p> <p>Discuss the issues around review of patients in ambulance at Grand Round YGC.</p>
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		<p>Clinical Lead for General Surgery to ensure surgical SHO supported. Support for nursing team and MDT involved in case.</p> <p>Referral MUST be at specialty registrar level – not via SHO. BR/AF to produce a letter this evening (16/12) outlining this as an expectation. Applicable to all specialities not just surgery.</p> <p>Review of procedure around observations for patients waiting in ambulances/waiting rooms.</p> <p>Work with the nursing teams involved in the Emergency Department to make sure there is no further learning re news SCORE/Sepsis 6/Antibiotics.</p> <p>Ensure WPAS up to date at all times.</p> <p>Ensure that there is regular, consistent, complete, clear documentation in the CAS Card.</p> <p>Shift co-ordinator to carry out regular rounding to ensure the “sick “ patients are identified, who may be compensating and whose NEWS score does not reflect their deterioration.</p> <p>Review decision to remove the radiology support worker that previous supported radiology overnight.</p> <p>Ensure duty of candour communication carried out and documented accordingly.</p>
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<p>Delay or failure to monitor - FY1 + SHO said no need to transfuse overnight following request by day team to prescribe 2 units of blood as significant drop in HB.</p> <p>Noted that patients cannula was leaking and that the IV fluids were not going through properly. No one was available to cannulate following escalation.</p> <p>Anaesthetist attended ward, unable to get SpO2 on patient therefore NEWS now at MET put out. Patient went into cardiac arrest. Patient sadly died.</p>	<p>The need for patients to be assessed on admission for suitability to admitted to Specialist Ward</p> <p>The need to appropriately escalate for Cannula Treatment and to document info about attempts that have been made.</p> <p>The need for early escalation to Critical Care colleagues when there are signs of patient deterioration.</p> <p>The importance of escalating to Speciality, in this case Cardiology, by an appropriate format given the clinical urgency.</p>	<p>Ward 3 Vascular Doctors to be reminded of the importance to document plan of treatment for patients.</p> <p>Need to determine clear escalation framework around NEWS (National Early Warning Score) across the health board.</p> <p>Establish how many people across all sites are trained to cannulate.</p> <p>Look into the cost of ultrasound/ ultraviolet cannulation machines and determine how appropriate it would be to train nurses to use power ones on wards.</p> <p>Promote to medical teams that they, themselves should be cannulating.</p> <p>Once the framework has been complete around NEWS escalation, decide on a team to articulate and provide relevant training to medical teams. Perform a review of the referrals under the AIT team to understand if there are any patterns emerging.</p> <p>The importance of thorough and timely documentation from the Surgical Team.</p> <p>Review if there are a high number of requests for cannulation coming from areas that do not seem appropriate and provide training and awareness.</p>
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		<p>Ask the site directors to quantify areas where they have shortfalls and training around cannulation.</p> <p>Ensure there is a surgeon/ consultant on the next call in 4 weeks and ensure there is always one when there is a RLP of this nature.</p>
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Central Area (3)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Avoidable Grade 3 pressure ulcer confirm to sacrum.	<p>The importance of checking that all visits are planned and followed up appropriately to avoid harm to patients.</p> <p>Importance of utilising the Malinko scheduling system effectively</p>	<p>RN's who carry out first assessment visit are ensuring next visit is booked.</p> <p>The importance of this has been highlighted to all of the team.</p> <p>Team managers or Case-holders are to audit compliance weekly and ensure all patients have a planned second visit planned on the malinko system.</p>
Tissue viability nurse noted grade 3 pressure ulcer for Nursing Home resident. Deemed avoidable.	<p>The Care Home has not followed process in terms of escalation when there has been decline in health:</p> <p>The Care Home require support with documentation</p>	<p>Ensure referrals to appropriate health professionals when deterioration noted.</p> <p>The CHC Practice development Nurse commenced training with this care home on the 17/08/2021. An annual programme is in place to support this home to address the educational needs of the staff. This training programme will be reviewed on a monthly basis.</p>

Investigations into change in bowel habit not acted upon by GP surgery. Patient subsequently develop Ca bowel	The use of Electronic Patient Record 'tasks' for arranging patient reviews is commonplace in general practice. It is auditable and reliable, with a deputising function to permit tasks to remain actionable when a staff member is on leave or otherwise absent. It remains prone to human error and to time delays in acting upon each task.	Notification to all GPs that significantly abnormal test results should not be actioned by a task being sent for an appointment to be made – but instead that the GP filing the report should directly telephone the patient, or book a telephone appointment directly (rather than relying on an administrator to do so), or set themselves an urgent reminder to act on the abnormal result when next in (e.g. if filing results remotely).

Midwifery and Women's Services (3)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
Stillbirth following review for 3 episodes of DFM (Diminished Fetal Movements)	<p>Importance of performing Symphysis Fundal Height measurement every 2-3 weeks</p> <p>Importance of following national guidance when patients present with DFM.</p>	<p>All community staff to be reminded of need to perform SFH measurement every 2-3 weeks</p> <p>Implementation of new guideline on reduced fetal movements to ensure appropriate management and clear pathways in line with current evidence</p> <p>Case study to be used in local risk management and CTG (cardiotocography) training sessions</p>
Baby two days old was found floppy and unresponsive	<p>Handover between neonatal and postnatal care should be robust and plan of care clearly documented.</p> <p>Interpretation services should be used for all contacts with mothers</p>	Immediate learning to be shared with neonatal unit manager, midwifery ward manager and neonatal to cascade.

Healthy fallopian tube removed prior to visualisation of both fallopian tubes during laparoscopy for ectopic pregnancy.(Never Event)	<p>Visualisation of both tubes prior to removal; progress to laparotomy when haemorrhage; drain all blood prior to visualisation</p> <p>Advice about contraception given by registrar at the time of discharge despite both fallopian tubes of patient being removed.</p>	<p>Lessons Learned document shared across HB</p> <p>Speak to registrar involved regarding importance of appropriate counselling.</p> <p>Presented at Clinical Risk Meeting.</p> <p>Meet with the theatre team and consultant individually and ensure that support is provided.</p> <p>Share learning across the three Women's departments across the sites.</p>
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Mental Health and Learning Disabilities (1)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
BCUHB resident passed away in a fire in his bedroom Nursing home (Out of area)	No immediate learning identified.	<p>BCUHB contact with Provider SLT</p> <p>All air mattresses inspected</p> <p>Fire Service safety checks completed</p> <p>Electrical inspection</p> <p>Welfare checks by LA and Commissioners</p> <p>CQC, HSE & Safeguarding informed</p> <p>BCU in person welfare checks undertaken</p>

Incidents NOT DU Reportable but subject of Rapid Learning Panel (2)

Incident Description	Immediate learning from MIS/RLP	Immediate actions
<p>The response Alarms were activated. When staff attended the designation the patient's bedroom door was locked. Staff looked through the observation window and saw the staff member on the floor with the patient on top. Patient was punching the staff member in his body and face.</p>	<p>From a staff safety perspective, a reminder has been sent and discussed with team manager in regards to staff not entering a patient's bedroom first - consideration should always be given to staff being aware of their escape route - patients should enter their room before staff.</p> <p>Through discussion, consideration was given to the need of PICU earlier in the admission, especially in view of his previous history of admissions to extra care/PICU wards.</p> <p>Master Pass keys for the bedrooms and bathrooms need to be ordered for all substantive staff to have securely on their ID badges so to enable immediate access to the rooms by staff attending incidents. Secure additional keys for Dinas male and Tegid. This should allow for 5 master keys on Dinas Male, female and Tegid.</p> <p>Staff member referred to Occ Health. Incident classed as RIDDOR - H+S aware.</p>	<p>Additional Master Key ordered and awaiting delivery - action to remain open until received.</p> <p>Dinas Male Ward Manager has requested that room pass keys are secured for all substantive staff.</p> <p>Additional Metal detector wands to be ordered for the unit - although not linked specifically to this incident it will be additional safety measure for the unit.</p> <p>Email communication to ward managers from HoN via Learning Bulletin</p> <p>Updated DRAFT on call protocol re Consultant/Junior Doctor arrangements for sickness cover.</p> <p>Discussed with Violence and Aggression caseworker as a more effective way forward. Action to remain open until HoN confirms recommendation relayed to all clinical staff.</p> <p>Estates colleagues have visited the ward to undertake review of the bedroom door locks and to scope alternative - consideration to be given to changing locks to ID badge "swipe" access.</p>

		<p>Email communication ward managers via learning bulletin</p> <p>Progressing through procurement - HoN requesting updates. Action to remain open until item ordered and received.</p> <p>Member of staff declined TRIMM but is being supported via OH.</p> <p>Review by estates completed.</p> <p>HoN shared incident details and MiS actions with other Divisional HoNs.</p> <p>All staff have been instructed, especially when in communal areas or within patient rooms, ensure their personal alarm is set to the highest setting – in that, to ensure that the alarm activates should the staff member fall to the floor.</p> <p>Immediate review of expectation for consultant on call weekends and evening. Ensure that our current policies across all three sites are consistent.</p> <p>Ensure awareness of lone worker policy to all staff.</p> <p>Security management to visit the unit to have a look at the locks and make some immediate recommendations with the staff there.</p>
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		<p>Master Keys are clearly highlighted and kept in an easy to see/ find area of the nursing office.</p> <p>Purchase additional metal detector wands Staff member in question will be referred to OH and TRIMM. Estates colleague to visit the ward to review the bedroom doors and see if there is an alternative locking mechanism available.</p> <p>Share the basic incident details with HON colleagues in Bangor and Wrexham for their awareness and sharing with their staff.</p>
<p>Patient who had attended ED on three occasions, with input from psychiatric liaison team was subsequently retrieved from Menai Straits on Boxing Day having been discharged from ED in the early hours of Christmas day</p>	<p>Consideration of level of risk assessment dependent on presenting problem and risks identified.</p> <p>Psychiatric liaison documentation to be comprehensive and detailed including previous history and particularly elaborating on detail of past and current risks.</p> <p>The issues of alleged abuse must be discussed with safeguarding.</p> <p>Patients to be reviewed in person following any re-presentation regardless of timeframe in between presentations.</p>	<p>Review of Psychiatric Liaison Policy particularly in regards to assessment criteria and documentation and clarity required around the review of patients who are under arrest/in custody.</p> <p>Communication from Director of Nursing to Local SLT's Head of Operations and Head of Nursing.</p> <p>When future assessments takes place ensure this is undertaken properly. If ED teams require support, ensure the support is available.</p> <p>Ensure Psychiatric liaison team see patients referred to them IN PERSON particularly when re-presenting at hospital.</p>

	Access to temporary accommodation needs to be improved.	
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Themes identified from Nationally Reported Incidents

It is acknowledge that a number of the learning points above reflect local learning from the Rapid Learning Panel or Make it Safe Rapid Review. The Patient Safety Team monitor to identify themes and where these need to inform organisation priorities (recognising full investigations are underway). The following section provides a summary of some of these themes and the actions underway.

Falls (n=14)

Within the reporting period there were a total of 14 patient falls that resulted in severe/permanent harm and therefore met the criteria for reporting to the Delivery Unit. East Acute (3), West Acute (6), West Area (1), Central Acute (3), Cancer services (1).

On review of initial learning from these incident, there are several themes that can be identified that contribute to these falls.

- Staff shortage
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Use of call bell

A number of specific actions have been implemented locally.

- New SBAR handover documentation has been instigated to ensure that there is effective communication between nursing staff and also permit the timely and accurate communication with the families of patients
- Safety briefs and team huddles to re-inforce the importance of completion of risk assessments; compliance of which will be monitored via Matron audits and spot-checks.
- Staff are to ensure that all patients are actively encouraged to use the call bells as appropriate and 'at a glance' boards will be visible for staff to instantly recognise those patients whom are considered to be a falls risk.

Delay in treatment for a deteriorating patient (n=3)

There have been three incidents that were reported to the DU during this time period that relate to patients that were escalated due to acknowledgment of a deterioration of a patient, however a delay in response and subsequent treatment that may have resulted in harm (death) of three patients. Two of the incidents occurred in Ysbyty Glan Clwyd and one in Ysbyty Gwynedd. Immediate learning for these incidents was around how nursing staff should further escalate when initial calls for medical input are not responded to. Additionally, through the MIS plus process and Rapid Learning Panel it was identified in two of the incidents that a contributory factor was a delay in cannulation of patient to administer treatment. Immediate action to address are detailed in the table above.

In addition, the Health Board is re-forming an improvement group to look at one aspect of this area. The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR) Group will meet in March 2022. This group has been formed in order to provide Health Board-wide best practice guidance to health care professionals in determine how to trigger, respond, escalate and review the response to the deteriorating patient. The key focus will be on:

- Approving triggers for SEPSIS (e.g. NEWS-2)
- Mapping observations charts to emphasise triggers
- Agreeing the escalation process
 - Care Bundles
 - Outreach
 - Medical Emergency Teams (MET)
- An education program to support outcomes of the group
- Agree how outcomes will be benchmarked and frequency of the auditing process
- The framework of shared learning of outcomes and embedding the escalation process to strive for continued improvement.

Ophthalmology incidents

In the last version of the report, the outcome of a thematic review into ophthalmology incidents was reported where patients have suffered harm (irreversible sight loss) as a result of delays in accessing treatment. A number of additional incidents have been reported since, and have been subject to national reporting. The issue of service capacity is currently a very high scoring risk on the risk register. Work has started to review national registry data to provide further insight into the service compared to other service providers, and to explore a buddy relationship with another tertiary service provider. An improvement project is also being scoped. The individual cases will be subject to investigation including consideration of Redress under PTR Regulations. An updated version of the thematic review has also been commissioned.

Incident subject of review by Health Inspectorate Wales (HIW)

Patient found deceased in vicinity of Ysbyty Glan Clwyd following discharge from Emergency Department

Health Inspectorate Wales (HIW) have undertaken a review into this incident reported early in January 2022. They raised significant concerns around the management of the patient whilst in the Emergency Department as well as issues around documentation within the medical record and have questioned the safety of the discharge of the patient. In addition, concerns were also raised with regards to the Make it Safe plus undertaken at the time of the incident and the fact that it failed to identify issues that HIW review have highlighted.

As a result the Hospital Management Team, in response to this case are working on rapid training for staff, covering values and behaviours, record keeping, and care of intoxicated patients. An internal safety alerts has been shared across the Health Board highlight the incident and the importance of safe discharge processes as detailed in the policy. A full investigation is ongoing into the care and treatment of the patient and the report as a nationally reportable incident. A separate investigation is being undertaken by the Acting Assistant Director of Patient Safety and Clinical Governance.

Independent external investigations ongoing

There is currently one independent external investigations ongoing as commissioned by the Health Board

Location	Incident	Update
CMHT (East) MHL D	Patient known to Community mental health team arrested on suspicion of murder.	Investigation ongoing. The external independent investigation is currently ongoing with staff interviews continuing. Request for estimated date of completion of draft report requested.

LEARNING FROM INCIDENT LEARNING PANELS

Incident Learning Panels (ILP) were introduced as part of the new Incident Management Process. The role of the panel is to moderate and ensure that we are constantly improving the quality of investigations and reports. All investigations into serious incidents that have occurred since April 2021, have been reviewed at ILP. There has been an initial focus on quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted.

Plans are in place to begin extracting and sharing learning from the Incident Learning Panel to include

- Learning on a page to replace the “lessons learned” template re-named **Insight**
- Monthly ILP Bulletin serving as a compendium of all the Insight reports
- A central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Event following each completed investigation

During the months of December 2021 and January 2022, 61 investigation reports were presented to the ILP. 53 reports were approved by the panel, 8 were deferred are required further work for reason such as the quality of the report writing or weak action plans.

In total there are 130 investigations in progress that have been commissioned by the Patient Safety Team. In total, 37% of these are over overdue. West Acute hold the largest proportion of overdue incidents, followed by Central Acute and MHL D. Moving forward, overdue reports for ILP will be highlighted on the weekly bulleting report issued by the Acting Associate Director of Quality in order that these figures are visible to Hospital/Area Management teams

Completed investigations that have been the subject of Rapid Learning Panel

The following includes specific incidents for note by the Committee and any themes:

HMP Berwyn – patient found deceased in cell having been placed in isolation due to symptoms of Covid 19 (August 21)

Gentlemen symptomatic of COVID 19 and currently on isolation unit with HMP Berwyn. COVID 19 swab result observed as positive by Primary Care Manager on 16th August 2021 at 10:30am, swab was taken on 11th August 2021. Code blue called by officers at 11:00am asking for assistance. Healthcare attended and gentlemen was deceased on toilet in his room and appeared to have been so for some time. Ambulance stood down and did not attend.

There were no entries from Health and Wellbeing team to suggest he had been monitored over the weekend. There is no evidence to suggest that further observations would have

prevented the outcome, however observations have since increased by Her Majesty's Prison & Probation Service (HMPPS) prison staff on the isolation community. Health & Wellbeing Peer Mentors (men in prison employed to support Betsi Cadwaladr University Health Board (BCUHB) have also resumed daily welfare checks via telephone to all men on the isolation unit, any concerns are then raised with appropriate clinical staff for follow up.

Ysbyty Gwynedd - failure to escalate deteriorating patient (September 2021)

Patient with vascular dementia, admitted following fall at home sustaining fracture of neck of femur. Patient was deemed fit for surgery and was returned to ward following hemi arthroplasty to left hip. Patient condition deteriorating overnight, however there was no review by doctor when nurse escalated. Patient sadly died following morning.

Patient care and treatment from admission to the Emergency Department was appropriate and timely. However, a conversation with her family regarding her likely outcome would have been appropriate prior to surgery. Baseline observations were recorded appropriately post operatively, but NEWS scoring was incorrect. Patient remained unarousable overnight; however, this was not scored. This may have triggered earlier escalation to the medical team. There is documentation in the nursing record that her low blood pressure was escalated. There was a delay in the Doctor attending the ward following numerous bleeps, and no evidence that the Doctor actually reviewed the patient. This was due to his attendance required with another patient who required emergency support.

It is unclear whether the Nursing staff believed that the patient required urgent review following the call to the on call doctor. It is also unclear that if urgent care was required if the escalation process had been followed. Although the nursing staff requested a medical review, there was no further escalation and a MET call should have been considered earlier. A clear management plan prior to the patient going for surgery would have assisted her plan of care and the escalation process.

Actions

Nursing staff have received update training in regards to managing the deteriorating patient. Ward based NEWS training to be carried out.

Bleep audit to be carried out to monitor response of orthopaedic team.

Improvements to be made in relation to communication with relatives around consent procedure regarding risk of death following neck of femur fractures.

Ysbyty Glan Clwyd – Never Event Retained foreign object (Trocac)

Patient required emergency surgery following injury to eye. Patient was discharged with follow-up but re-presented in the Emergency Department the following day. On examination a trocac (a piece of equipment inserted in the eye during surgery to facilitate the introduction of micro surgical ophthalmic structures) had been retained.

The investigation focused on the patient's perioperative journey and concluded that the swabs, sharps and instruments used had not been checked by the surgical team - which ensures all have been returned at the end of the procedure. The 'Sign Out' section of the Worldwide Health Organisations (WHO) Safety checklist was not completed. This check prompts to confirm if swab, sharps and instruments are correct. These errors were not identified by any of the theatre team prior to the patient leaving the theatre.

The investigating team concluded that the probability of this incident occurring, had a swab, sharp and instrument check been conducted followed by the "Sign Out" at the end of the procedure would have been less likely.

Human factors such as distraction and lack of situational awareness have been highlighted as increasing the potential for the error. Distraction was evident at the end of the procedure with numerous tasks all happening at once, the surgeon leaving theatre prior to safety checks being completed, the scrub nurse talking to the patient who was anxious and the surgical drapes were being removed and the ODP leaving the theatre to look for the notes. Such distractions resulted in lack of communication, support at the end of the procedure and standard practices not being followed.

Actions

A process has now been implemented to cross check swabs and sharps in and out.

Adoption of Integrated Care Pathway (IPC) to capture requirements for patient preparation prior to surgery.

WHO audit to be undertaken on a monthly basis.

Working group to be set up to ensure engagement regards WHO checklist compliance.

Avoidable Grade 3, 4 unstageable pressure ulcers

There were 14 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this time period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when required
- A delay in completing documentation on admission i.e. pressure ulcer management plans and Purpose T documentation
- Lack of communication with the Orthopaedic department regarding management plans/documentation for patients with orthopaedic devices i.e. fixation braces
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

A separate paper has been prepared for the Committee on HAPU.

Falls

There were 12 Investigation reports relating to falls during this time period that were approved following a review at the Incident Learning Panel.

Themes and trends have been identified as:

- Lack of timely and fully completed risk assessments which may have identified a requirement for greater enhanced observation.
- A lack of completed bed rails risk assessments
- Failure to ensure correct non-slip footwear is in place
- Call bell not utilised or not to hand
- Lack of updated risk assessments following a change to a patient's clinical presentation
- Lack of communication during patient handover.

A separate paper has been prepared for the Committee on falls.

Patient Safety Improvement Programme

The Patient Safety Team are currently working closely with the Transformation and Improvement Team to develop a **Patient Safety Improvement Programme**. A workshop has been arranged for 7th February 2022 by the Associate Director of Quality. All medical, therapy and nursing directors have been invited and the aim of the workshop is to work through possible priorities for the projects (approximately 4/5 per year) focused on preventing or reducing harm. The recommendations will then be sent to the Executive Clinical Directors for approval.

Leading for Safety Improvement Programme

Improvement Cymru is commissioning an internationally recognised senior leadership safety improvement programme.

This programme, launching on 17 March, is aimed at Assistant/Deputy Directors of Nursing, Therapies and Assistant/Deputy Medical Directors/clinical leads who have a key role in Health Boards and Trusts for quality.

The programme will be delivered and facilitated by internationally proven safety improvement experts and will enable participants who have responsibility for the safety of care in their organisation to:

- Use the skills they develop to lead and influence improvement work
- Be equipped with the skills, theory, and practical tools critical to developing a successful patient safety strategy for their organisation;
- Be able to create the culture and conditions for improvement to flourish
- Learn how to use diagnostics and measures to determine the safety at system level
- At the conclusion of this programme, participants will be able to develop and implement a plan to improve safety at a systems level.

This programme is a key element of the implementation of the Improvement Cymru strategy: to build the capability of senior clinical leaders in Health Boards and Trusts in Wales.

Two to three funded places are available to BCUHB staff. Applications were opened on 14 February 2022 for Health Board staff to apply.

NEVER EVENTS

During the reporting period, there was one Never Event reported which occurred in an earlier period (October 2022):

- Wrong site surgery – Healthy fallopian tube removed prior to fallopian tube containing ectopic pregnancy.

Learning: Visualisation of both tubes should occur prior to removal; progress to laparotomy when haemorrhage; drain all blood prior to visualisation. Effective review of documentation should occur prior to consultations as advice about contraception was given by a registrar at the time of discharge despite both fallopian tubes of patient being removed.

Actions: Lessons Learned document shared across Health Board. This case was presented at the Clinical Risk Meeting for learning. A full investigation is underway.

In total nine Never Events have been reported so far in 2021/22 (compared to five in 2020/21 and six in the full year of 2019/20).

PATIENT SAFETY ALERTS AND NOTICES

Open Alerts

Reference	Title	Deadline (action underway)	Deadline (action complete)	Applicable To?	Update
PSN057	PSN - Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	27/05/2021	31/12/2021	Area, Secondary Care	Underway - Next meeting arranged 17th Feb2022
PSN060	Reducing the Risk of Inadvertent Administration of Oral Medication by the Wrong Route	07/10/2021		Pharmacy	Pharmacy Leading - Expected completion 05/02/2022
PSN058	Urgent assessment/treatment following ingestion of super strong magnets	13/07/2021	05/10/2021	Area - Central Region, Area - East Region, Area - West Region, Children's Services, Division of Mental Health, Secondary Care, Women's Services	Underway - Child pathway completed awaiting confirmation that Adult and Child pathway are the same
PSN064	Patient Safety Notice PSN064 / January 2022 - Handlebar injuries in the paediatric abdomen	07/01/2022	28/02/2022	MIU / ED	Initial meeting held 01/02/2022 SOP to be developed and shared - update regarding Assessment Scope to be sent to all MIU staff in the interim period. Next meeting to approve SOP 28/02/2022 due to staff availability

Closed Alerts

Reference	Title	Deadline (action underway)	Deadline (action complete)	Status	Closed
CEM/CMO/2022/01 -	Neutralising monoclonal antibodies (nMABs) or antivirals for non- hospitalised patients with COVID-19 - Updated	05/01/2022	05/01/2022	Compliant	06/01/2022
CEM/CMO/2022/02	- Neutralising monoclonal antibody and intravenous antiviral treatments for patients in hospital with COVID-19 infection	06/01/2022		Compliant	06/01/2022
DIN 2021/0036/00	Dangerous Incident Notification NEDeRS®: DIN 2021/0036/00 (NEW) Circuit Breaker - URV12 - Hawker Siddeley	11/01/2022	11/01/2022	Compliant	12/01/2022
NEDER 2021/0975/01 (UPDATE)	Dangerous Incident Notification NEDeRS®: NEDER 2021/0975/01 (UPDATE) Circuit Breaker - NuLec U series - Schneider	11/01/2022	11/01/2022	Compliant	12/01/2022
NEDER 2022/0988/00 (NEW)	Dangerous Incident Notification NEDeRS®: NEDER 2022/0988/00 (NEW) Circuit Breaker - NX Plus-C - Siemens	11/01/2022	11/01/2022	Compliant	12/01/2022
PSA014	Inappropriate anticoagulation of patients with a mechanical heart valve	21/07/2021	28/07/2021	Compliant	12/01/2022
MDSI/2021/009 (Wales)	Hand pieces used in the phacoemulsification technique of cataract removal: need for careful cleaning	21/01/2022	22/01/2022	Distributed for Information only NO ACTION REQUIRED	21/01/2022
DSI/2021/010 (Wales)	Rheovalves disposable needle- free valves: stop using specific lots due to risk of breakage in patient.	21/01/2022	23/01/2022	N/A Nil stock confirmed via Procurement	31/01/2022

PSN059	PSN059 - Eliminating the risk of inadvertent connection to medical air via a flowmeter	10/09/2021	16/12/2021	Compliant	31/01/2022
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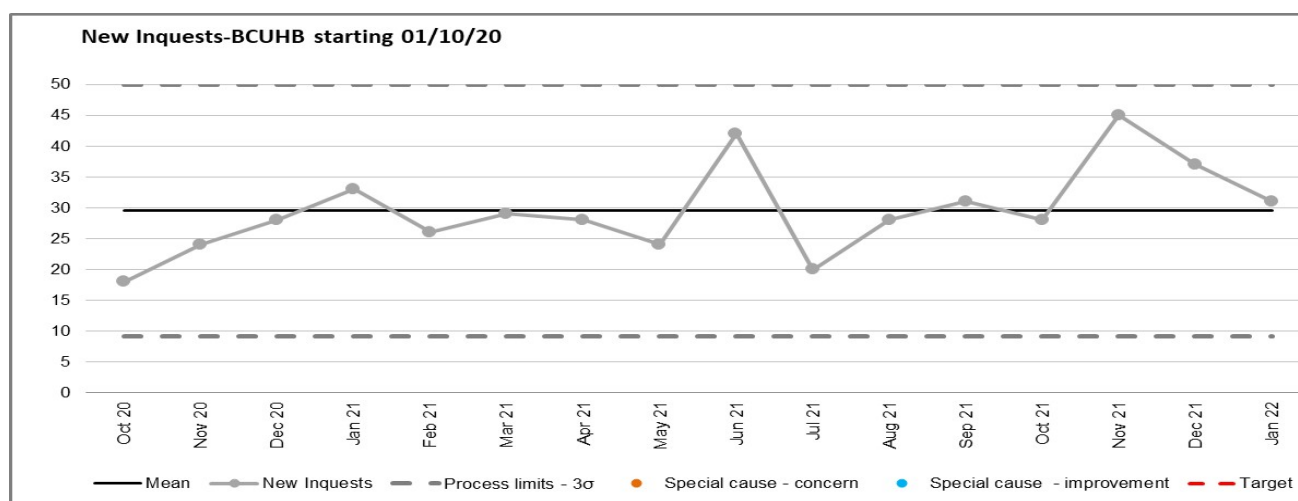
INQUESTS

“An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered. It is not a trial.” (Gov.UK)

Inquests opened:

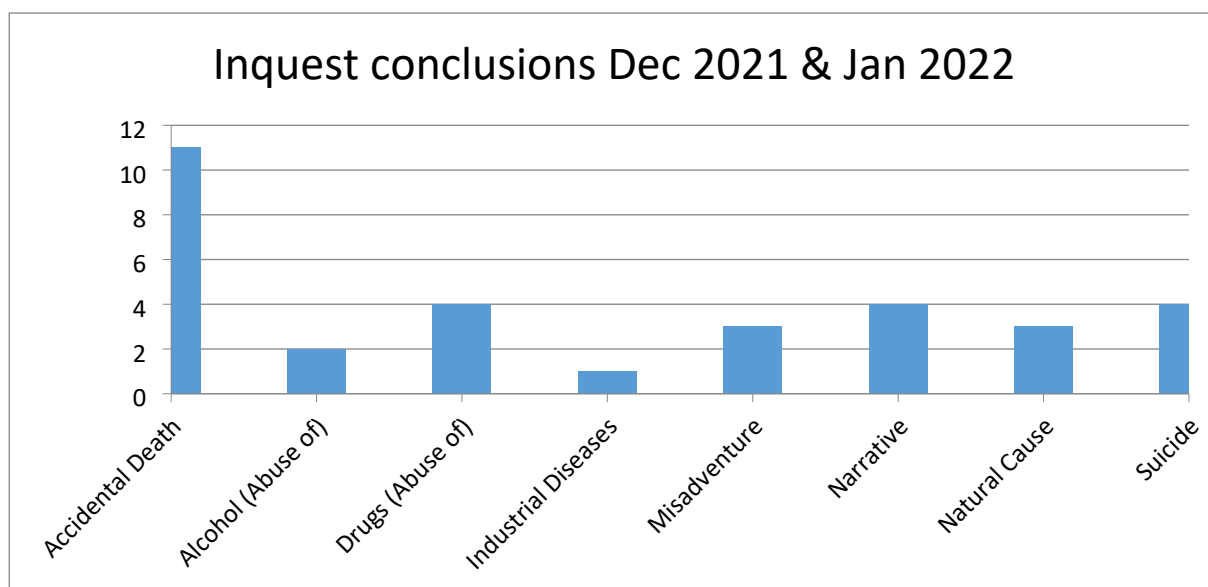
HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board.

During the relevant time period, December 2021 and January 2022, **50** inquests or requests for information from the Coroner were opened. This is lower than the previous number of inquests opened (October and November 2021), but is in line with the usual workload.



Inquests Concluded:

32 inquests were concluded between 1st December 2021 and 31st January 2022, with the inquest conclusions shown below.



The distribution of these inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

Regulation 28 (Prevention of Future Death) Notices

In the period of this report, no new Regulation 28 (PFD) reports were received by the Health Board.

The Health Board responded to the two previously issued Regulation 28 reports within the timescale agreed with the Coroner.

These responses provided reassurance to the Coroner with regard to the concerns raised:

- The implementation of the SNAP procedure – whereby N Acetylcysteine (NAC – the standard paracetamol antidote) may, from 31/01/2022, be safely given over a shorter period of time than previously. Although this has not yet been officially sanctioned by the MHRA, accelerated approval within the Health Board outside of the normal governance procedure has been given.
- Confirmation that the process for escalation of abnormal Pathology results has been approved and implemented across the health Board.
- Details on the new Incident Management Process.

In a separate inquest, the Coroner had requested more information regarding ERCP provision for the patients of North Wales, given the difficulties in recruiting clinicians with the appropriate skills – Mr Ramesh has responded to the Coroner informing them of the agreement with tertiary centre in order to manage demand. A copy of the newly agreed ERCP Referral Protocol has also been forwarded to the Coroner for their information.

REDRESS

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state if at any time during the investigation of a complaint or patient safety incident it is

considered that a qualifying liability exists or may exist, that would attract financial compensation of £25,000 or less, it must be determined whether or not an offer of redress should be made.

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate); and
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

During December 2021 and January 2022, 18 cases were concluded which involved Redress:

- 5 offers of financial compensation as redress were accepted totalling £63750
- 1 written apology was made
- 1 proceeded to become a clinical negligence claim
- 4 were advised to pursue a clinical negligence claim as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.
- 1 was advised that there was no qualifying liability following interim responses being sent
- 6 other responses were sent during the period which had been reviewed for redress but deemed to have no qualifying liability.

Redress offers accepted during this quarter included the following issues:

- There was a failure to act upon a reduced end diastolic flow following a Doppler test resulted in the baby being stillborn.

Learning – Discussion with clinical director and reflection of the case. A new Small for Gestational Age (SGA) policy now in operation

- There was a delay in assessment following the patient's admission to the labour ward. If the baby's heartrate had been monitored sooner, a concern may have been identified and on the balance of probability the baby would have been born earlier and in a less compromised condition and the baby would likely have lived

Learning - Mother was not appropriately managed given her carbon monoxide level. Awareness has been raised with the Community Teams. The SGA Policy has been updated to include growth scans for all women who smoke.

- There was a breakdown in communication between the hospital and the patient's GP and Azathiopurine should have been stopped. If this had happened, it is likely the patient's white blood cells would have improved and therefore avoided the patient's acute illness requiring hospital admission.

Learning - Shared care protocols to be discussed by the partners in the GP practice. Reflection to be performed by the GP who did not stop Azathiopurine as per shared care guidelines. Consultant's practice now is to review the Welsh

Clinical Portal (WCP) for results when reviewing GP letters to ensure he has an up to date picture of the investigations.

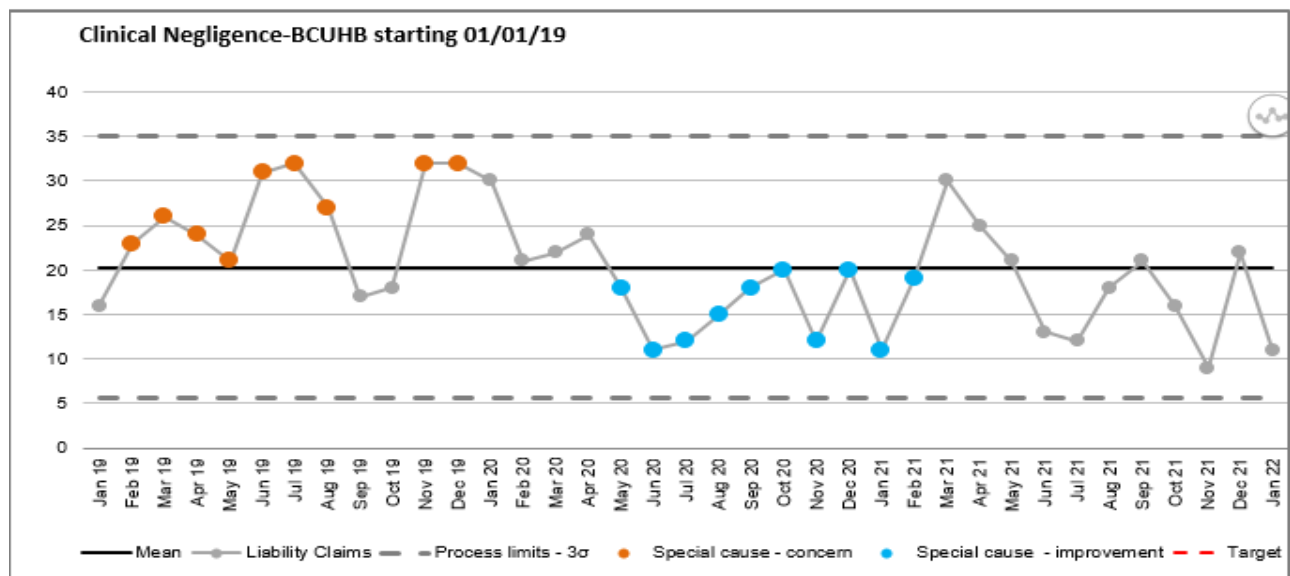
- The fall the patient sustained was avoidable because suboptimal manual handling techniques were used on the ward due to a Sara lifting aid being unavailable.
Learning - Issuing a health board wide alert regarding the different capabilities and specifications of the various standing aids available. Audit and publication of available standing aids to ensure these can be located quickly if one is required

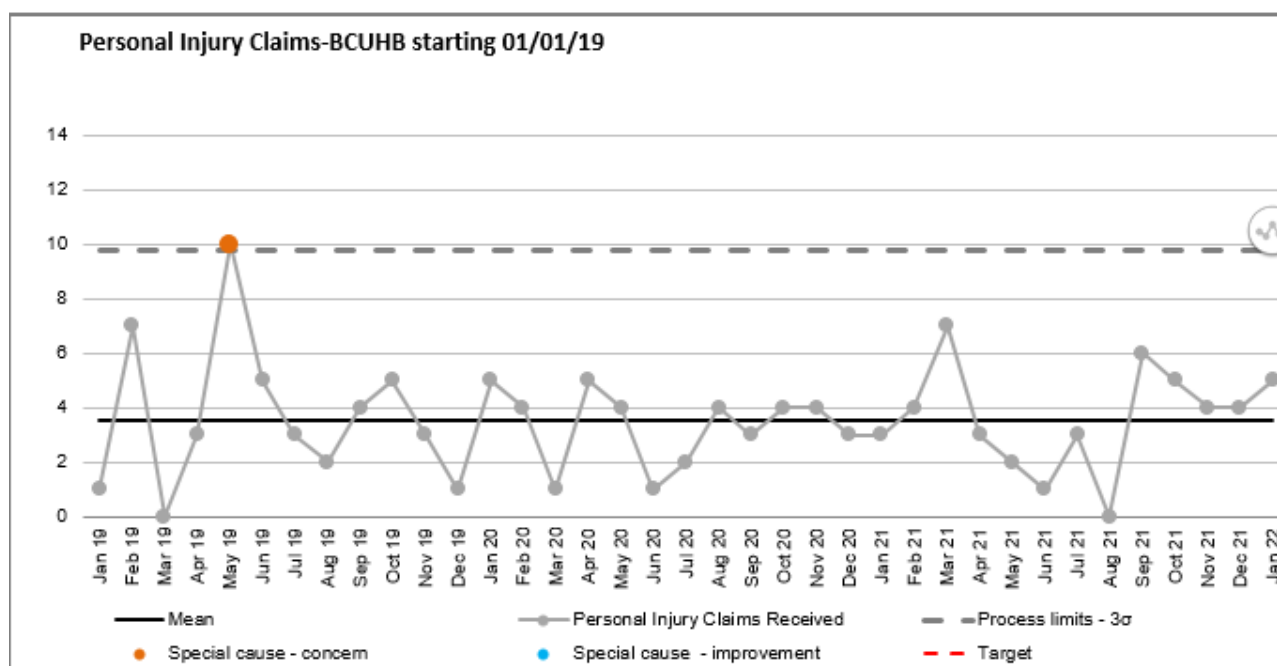
To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool requires the Health Board to submit a Learning from Events Report (LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation – this process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

LITIGATION

During the relevant period, 40 claims or potential claims were received against the Health Board. Of these, 31 related to clinical negligence and 9 related to personal injury.

Whilst this is slightly lower than the previous reporting period, the figures remain steady in comparison. It is anticipated that the Health Board will receive an influx of claims in both PI and Clinical Negligence following a public enquiry regarding the Covid-19 pandemic.





Significant claims and learning

During the relevant period, 24 claims were closed. Of these, 22 related to clinical negligence and 2 related to personal injury.

The total costs for these closed clinical negligence and personal injury claims amounted to £2,835,206.03 before reimbursement from the Welsh Risk Pool. The most significant claims and related learning are detailed below:

- i. *Failure of in-patient Mental Health Team to recognise and reach a consensus in relation to the level of risk of patient; observation level not reviewed or documented on a shift by shift basis; quality of care planning was brief and not patient centred etc. (£1,096,931.83)*

Learning

Admissions policies for acute care and home treatment have now been reviewed, updated embedded. Acute units also now have searching policies and clear guidance on restricted items. The Introduction of a Therapeutic Engagement and Observation Policy has led to a more structured and focussed routine for patients. A Clinical Risk Lead has since been appointed and has focused on the extension of WARNN Risk Training. Acute care meetings also now take place each day.

The learning from this case has been shared widely and the department continue to audit documentation.

- ii. *Delay in diagnosing vaginal tear post delivery of baby and delay in diagnosis of infection postnatally (£91,993.10)*

Learning

Significant drive on training regarding the recognition of vaginal tears. There is now a perineal suturing proforma checklist in place detailing checks to be undertaken. Furthermore, a post-natal handheld notes have been developed to ensure inter-professional working and effective communication in both the community and hospital

settings. A discharge plan and communication sheet is also included. There is an ongoing audit regarding documentation for the Womens Division and lessons learned have been shared widely.

- iii. *Unrecognised ureter damage during hysterectomy procedure following endometrial cancer diagnosis (£221,222.46)*

Learning

The incident was reflected upon by the operating surgeon at the time and the incident has been wider shared for awareness and learning. A contributory factor was the high BMI of the patient. The department has an ongoing business case regarding the treatment for patients with endometriosis which will help in preventing similar outcomes moving forward.

- iv. *Failure to recognise and diagnose chest injury (£224,247.91)*

Learning

The Health Board has conducted a significant amount of training on the careful assessment and imaging of chest injuries. This has included a bespoke Training Course for North Wales based on site in the three Emergency Departments. The Trauma Research and Audit report has been circulated to all ED staff and there has been a development of a local blunt chest trauma tool

- v. *Inadequate treatment of periprosthetic fracture and failure to insert a screw at the top of the nail at the time of the initial surgery (£78,971.11)*

Learning

The main issue was clinical practice. There was a failure to insert a screw at the top of the nail at the time of the initial surgery. A formal presentation regarding the injury and treatment was discussed at a departmental meeting.

Consent and capacity was also discussed with the whole team. There is now a wider discussion between clinicians regarding best course of treatment in complex fractures.

- vi. *Failure to repair an injury to the bladder during a vaginal hysterectomy with appropriate skill care causing/failing to repair second injury to the bladder leading to delay in diagnosis and operation to repair two holes in the bladder. (£91,168.26)*

Learning

The Clinician concerned has reflected on this case with the clinical director. Local training has been delivered regarding the need to undertake imaging prior to the removal of catheters. Lessons learned have also been discussed at the Gynae Forum. A delay in the referral to Urology was also noted in this case and this is now being monitored to ensure patients are seen as timely as possible.

- vii. *Failure to supervise claimant appropriately resulting in falls within hospital (£62,030.00)*

A monthly audit of compliance with the Therapeutic Engagement and Observation policy is now part of the regular Matron walkabouts and the monthly ward quality and safety audit. A monthly audit of compliance with the Prevention and Management of Adult In-Patient Falls policy has also been added to the Matron walkabouts. All falls are overseen by a falls specialist. The Hergest Unit Matron and Interim Head of Nursing will be observing a random sample of nursing handovers during January 2020, to ensure there is senior overview and to identify any improvements which are required. The Health Board's good record keeping guide has been circulated to all ward staff. Matron will be giving feedback on how to improve communication with families. The interim Head of Nursing for West is working with the Health Board's Nursing Bank team to develop an induction programme for HCA bank nurses so that they will be fully familiar with the policies, procedures and expectations of the ward managers before commencing work at the Hergest Unit

- viii. *Failure to perform urodynamic studies prior to TVTO surgery and poor consent process and documentation (£280,327.73)*

Learning

The Health Board conducted an audit of the consent process undertaken in BCHUB in 2018 and will be repeating the audit again in 2020, to ensure the required improvements have been made. The Women's Directorate have commenced local audits of the consent process and associated documentation within Gynae services and the first audit findings will be presented at the Women's December Quality, Safety & Experience sub-group meeting. Following this presentation, audits will be performed on the remaining two sites to ensure recommendations for improvement are actioned and put into practice. Practice now is to perform urodynamics on all patients before any surgery for stress incontinence even if clinically straightforward case. Each patient is discussed at MDT before finalizing the plan to operate.

- ix. *Failure to adequately consent during sterilisation procedure (£113,739.82)*

Learning

Procedure specific consent forms have been developed and implemented.

Consent policy and consent training is undertaken in the directorate.

This incident was shared at the Women's Quality, Safety & Experience sub-group on 16 July 2021.

- x. *Failure to recognise skin cancer as part of a differential diagnosis and perform a punch biopsy (£473,557.47)*

Learning

The concern has been discussed within the MDT team and the need for skin cancer to form part of a differential diagnosis going forward.

This concern is a number of years old and practices have changed, with MDT now having a regular weekly meeting to discuss issues

Keep low threshold for seeing worry lesions- especially when patient is worried and lesion not healing biopsy should be conducted on the USC track

- xi. *The tacks placed too close to the anterior superior iliac spine during a bilateral hernia repair, causing nerve injury (£85,630.67)*

Learning

Discussed at General Surgeons Clinical Governance Meeting on the 5th August 2021

- xii. *Failure to act on clinical findings. Inappropriate assessment of initial heart rate trace and inappropriate follow up care (£64,414.50)*

Learning

Following Local incident Review, there were actions for Midwifery staff as well as the Senior Clinical Teams. The case and the issues highlighted has been discussed with all individual staff concerned as well as shared with the Division members to ensure appropriate dissemination of learning

Themes identified from clinical negligence

Following the introduction of the GMPI Scheme in April 2019, the Health Board is now beginning to see more of these claims coming through. As expected the largest number of open claims continue to relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS.

Themes identified from personal injury claims

The following themes have been identified during the relevant timeframe:

1. Slips/trips
2. Violence & Aggression patients to staff

Personal Injury claims savings due to discontinued or favourable settlements for this period were £37,077.04

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

The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure. Welsh Government have now confirmed that additional contributions will be required. BCUHB's share of the increase will be 17.07% and an additional cost of £2.35m in addition to the contribution already made, creating a significant impact on the overall financial position.

CONCLUSIONS AND RECOMMENDATIONS

This report provides the Quality, Safety and Experience Committee with information and analysis on patient safety including Nationally Reportable incidents and Never Events occurring in the last two months.

The QSE Committee is asked to note the report.

Argymhelliad / Recommendation:

The Committee is asked to note this report.

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol

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

Sefyllfa / Situation:

This paper provides an outline of quality related awards, achievements and recognitions for the period **December 2021 and January 2022**. It is important to note that the COVID-19 pandemic has had a significant impact in this area, with the focus rightly being on service delivery and services changes in response to the pandemic, and many award and recognition schemes were deferred or cancelled.

Cefndir / Background:



Betsi consultant using Artificial Intelligence to improve prostate cancer diagnosis: A consultant, the first in the UK to use an artificial intelligence tool to diagnose prostate cancer, has called himself and his colleagues “pioneers”. Dr Muhammad Aslam, a consultant pathologist and clinical director of North

Wales managed clinical support services at Betsi Cadwaladr UHB, is in the vanguard of improving the quality and speed of prostate cancer diagnosis. He and four consultant colleagues have been using the Galen platform from medical analytics firm Ibex to check digital slides taken from biopsies on

suspected prostate cancer patients. It's the first artificial intelligence application cleared for clinical usage in histopathology in the UK.



Team provide 'life-changing' support to homeless people living with hepatitis C: A rapid treatment programme delivered by NHS staff is having a 'life-changing' impact on homeless people in North East Wales who are living with the hepatitis C virus. Those who have benefitted from Betsi Cadwaladr

University Health Board's pioneering new treatment programme say it's helped them regain access to their children, hug family members again, and re-enter the world of work. Hepatitis C is a blood borne virus which left untreated can cause liver cirrhosis and cancer. However, advancements in medicine have ensured that it can be successfully treated with an 8 to 12-week course of tablets. The virus disproportionately affects the homeless community. Because they often struggle to access and engage with treatment, those who contract hepatitis C can be at risk of long-term complications, including liver cancer. Determined to change this, staff from BCUHB's Pharmacy, Point of Care, Substance Misuse Harm Reduction and Hepatology services have introduced a pioneering new approach to treatment, which is the first of its kind in Wales. By taking their services to homeless people, the team have reduced the time it takes to diagnose and begin treatment from over six months, to just two weeks. The project was established with a grant from Gilead Sciences Europe Ltd in 2019. Since then, 32 people have successfully completed treatment, with life-changing results.



Nursing Support Workers recognised for going above and beyond supporting patients and colleagues: To celebrate this year's Nursing Support Workers' Day staff from Flintshire and Wrexham were invited to nominate colleagues to receive recognition and appreciation for the dedication they bring to their

role. The Practice Development Team, for Flintshire and Wrexham at Betsi Cadwaladr University Health Board, launched the Ward Star Award to thank the support workers, and put the spotlight on the vital contribution they make to patient care across the region. The following winners, who received a Ward Star Award and a gift hamper, were chosen from each directorate within Wrexham Maelor Hospital and community teams covering Flintshire and Wrexham.:

- Surgery - Heather Lloyd, Healthcare Support Worker, from Mason Ward.
- Emergency Quadrant – Mandy Matthias, Healthcare Support Worker.
- Medicine – Freya Williamson, Healthcare Support Worker, from Acute Cardiac Unit.
- Critical Care and Theatres – Gwynra Evans, Health Care Support Worker, Critical Care.
- Paediatrics – Kim Weaver, Housekeeper, from the Children's Ward.
- Community – Lauraine Clayton, Healthcare Support Worker Evening and Overnight District Nurses Team East.
- Mental Health and Learning Disability – Lynda Massey, Healthcare Support Worker from Community Services.
- Maternity and SCBU – Natalie Lancaster, Maternity Support Worker.

Health board and hospice aim to become 'world leader' in children's end of life care: An innovative partnership between a health board and a hospice charity aims to make North Wales a "world leader" in caring for life-limited children. To try and realise this ambition the two organisations Hope House Children's Hospices and Betsi Cadwaladr University Health Board are jointly funding a new lead consultant in paediatric palliative care - a first for North Wales. Covering North and Mid Wales the new post holder will be based with the charity, which has hospices at Ty Gobaith in Conwy and Hope House in Oswestry.

Liverpool and North Wales Network awarded Tessa Jowell Centre of Excellence Status: The Liverpool Network, including The Walton Centre NHS Foundation Trust, The Clatterbridge Cancer Centre NHS Foundation Trust and the North Wales Cancer Treatment Centre, has been awarded Centre of Excellence status after rigorous assessments led by experts from the Tessa Jowell Brain Cancer Mission (TJBCM). With more than 12,000 people diagnosed every year with a primary brain tumour in the UK, the award has been introduced to recognise hospitals for their excellence in patient care. Led by a committee of experts in the field and virtual site visits, the assessments were backed up by patient feedback about the care they received. The TJBCM assessors were impressed by how closely the three members of the Liverpool Network work together to make sure people with brain cancer receive seamless care throughout what can be a very complex treatment journey involving diagnosis, surgery, chemotherapy and/or radiotherapy.

Three nurses receive top nursing accolade : Consultant Nurse in Primary Care Nia Boughton, Karen Bampffield, Community Matron for Dwyfor & Meirionnydd in Gwynedd and Heart Failure Advanced Nurse Practitioner & Echo cardiographer Viki Jenkins were all presented with an award and title of Queen's Nurse at the Queen's Nursing Institute (QNI) Annual Awards Ceremony on 13 December 2021. The title is awarded to nurses who have demonstrated a high level of commitment to patient care and nursing practice.

Great Ormond Street Hospital interested in pioneering work of Betsi physiotherapy lead: A lead physiotherapist who pioneered a policy aimed at understanding bone fractures in children with limited mobility has been asked to speak at Great Ormond Street Hospital. The famous children's medical institution in London is one of many interested in the work of Betsi Cadwaladr University Health Board's Angela Wing. The advanced clinical practitioner in paediatric physiotherapy presented her thesis around childhood fractures in children with low bone density for her Master's degree at Bangor University. Her research led to Betsi Cadwaladr being the first health board in Wales to enact the new policy, making people aware of the dangers of fractures in children with low mobility because of long-term disabilities.



Pharmacy team wins digital innovation award for positive impact on patients: The Pharmacy team at Wrexham Maelor Hospital are celebrating winning a health and care digital innovation award for the positive impact a pilot project has had on the lives of people in North Wales. The team trialled the use of software called Information Reporting Intelligence

System (IRIS) which when working with other healthcare systems, allows pharmacists to generate daily reports to identify and locate Acute Kidney Injury patients for a timelier pharmacist review, within overstretched busy departments. During the 19-day pilot, 50 patients were reviewed by the Wrexham Maelor Emergency Department Pharmacist with 74% of patients requiring Pharmacist intervention to reduce risk of Acute Kidney Injury medication related harm. The Pharmacy team won the Digital Innovation Award at the MediWales annual awards, which recognises and showcases the achievements in the life science sector in Wales.



Wrexham Maelor doctor helps woman, only seven months pregnant, give birth on flight to India: Dr Inshad Ibrahim, from Wrexham Maelor Hospital's Emergency Department found himself helping a woman , only seven-months pregnant, give birth on a plane thousands of feet in the sky. Dr Ibrahim was travelling to South India when two

hours into the flight he heard the crew ask if there was a doctor on board who could help them. The baby, a boy, was delivered during the flight and the aeroplane was diverted to land at a nearby airport where the mother and baby were rushed to the hospital. Dr Ibrahim and his family continued on their way to India.



Phone the family pilot is helping relatives and saving elderly care staff valuable time: A simple idea developed by a nursing sister is keeping families in the loop about relatives' care and saving valuable clinical time for staff. Staff on the elderly care ward at Ysbyty Glan Clwyd (Ward 2) have been conducting the trial, where they make proactive daily

phone calls to a patient's nominated family member. The staff ring one nominated relative for each patient after 2pm every day. They are asked to relay messages about their loved one's condition to other family members and friends.



Ysbyty Gwynedd volunteers providing vital support for patients and families during pandemic: A team of volunteers and healthcare assistants have assisted nearly 4,400 members of the public at Ysbyty Gwynedd during December. Since the start of the pandemic a team of volunteers, which include members of the Royal Voluntary

Service, members of the public who have volunteered their time and Health Care Assistants, have helped patients receive essential supplies from home. Visiting has been restricted at hospitals due to the pandemic and the team at the main entrance have been working hard to ensure patients receive essential items and belongings from home whilst they are in hospital. The volunteers have been manning the desk seven-days-a-week to support members of the public and during the month of December they handled over 1,400 enquiries, helped direct nearly 1,500 patients to their appointment and delivered over 1,100 essential items to inpatients.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Patient and Carer Experience Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Associate Director of Quality Carolyn Owen, Assistant Director of Patient and Carer Experience Sian Youssef, Complaints Lead Rachel Wright, Patient and Carer Experience Lead						
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality						
Atodiadau Appendices:	1. Patient and Carer Experience Report – Aug - Nov 2021						
Argymhelliad / Recommendation:							
The Quality, Safety and Experience Committee is asked to note the report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The Quality, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient and carer experience. This report provides the Committee with information and analysis on significant patient and carer experience issues (including complaints) arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway.							
Cefndir / Background:							
This report is designed to offer improved information and analysis in relation to patient and carer experience, in order to improve the assurance received by the Committee. The period under review is primarily August to November 2021 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.							

Asesiad / Assessment & Analysis
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<p>Assessment and analysis is included within the report including a breakdown of complaints by division/site, details of the most common type of reported complaint and a high-level summary of identified learning.</p>

<p>Goblygiadau Strategol / Strategy Implications – Not applicable.</p>

<p>Opsiynau a ystyriwyd / Options considered - Not applicable.</p>

<p>Goblygiadau Ariannol / Financial Implications – Not applicable.</p>

<p>Dadansoddiad Risk / Risk Analysis – This is contained within the report.</p>
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<p>Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.</p>
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<p>Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report.</p>
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Patient and Carer Experience Report August to November 2021

1. INTRODUCTION

- 1.1 Patient and carer experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe care and clinically effective care.
- 1.2 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient and carer experience issues arising during the period under review, alongside longer-term trend data, and information on the improvements underway. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.
- 1.3 The Health Board has responsibilities for improving patient experience under the following key statutory responsibilities and policy frameworks:
 - NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
 - Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
 - Healthcare Standards for Wales (Welsh Government, 2015)
 - Wellbeing of Future Generations (Wales) Act 2014;
 - Social Services and Wellbeing (Wales) Act 2014;
 - Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)
- 1.4 The Health Board approved its current Patient Experience Strategy in June 2019 and this can be accessed on its web site. The strategy is currently being reviewed to capture learning from implementation and to consider integration of wider issues such as carer engagement, involvement and support.
- 1.5 Statistical process control (SPC) charts or run charts are used where appropriate to show data in a meaningful way, differentiating between variation that is expected (common cause) and unusual (special cause). The NHS Improvement SPC Tool has been used to provide consistency throughout the report. This tool uses the following rules to highlight possible issues:
 - A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicated by dotted grey lines.
 - Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicated by dotted grey lines.
 - A run of seven or more values above or below the average (mean) line represents a shift that should not result from natural variation in the system – this is indicated by coloured dots.

- A run of seven or more values showing continuous increase or decrease is a trend – this is indicated by coloured dots.
- A target (if applicable) is indicated by a red dotted line.

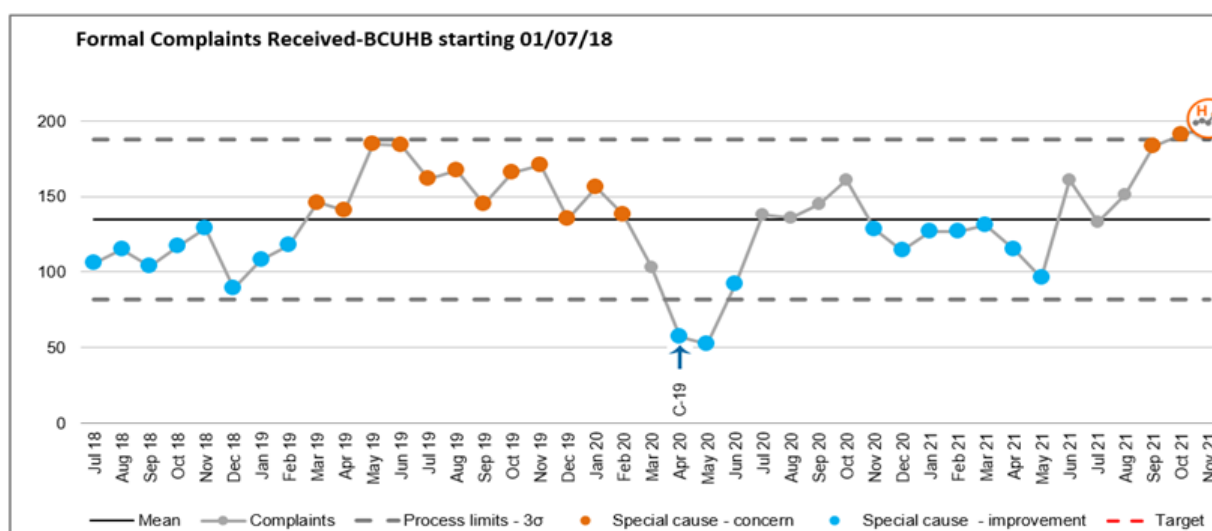
1.6 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

2. COMPLAINTS PERFORMANCE

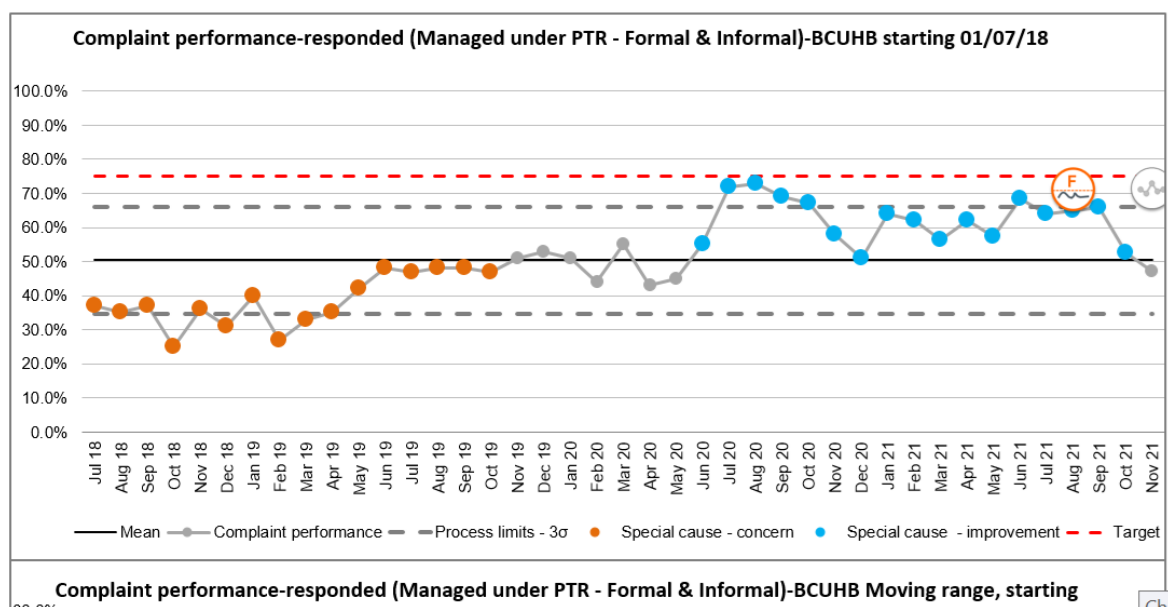
2.1 Complaints are received and responded to in accordance with the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly known as Putting Things Right – PTR) and/or Health Board policy and procedure. Information is also included in this report to enable triangulation of patient safety issues arising from complaints.

2.2 As can be seen in Graph 1, as of the end of November 2021, the Health Board received 721 formal complaints demonstrating a significant increase of 30% on the previous quarter (505 Formal Complaints). The majority of the complaints relate to secondary care services, 22% of formal complaints (158) in relation to clinical treatment and assessments, 13.5% (97) poor communication and 8.2% (59) in relation to appointment waiting times. Other re-occurring themes were in relation to patient discharges from hospitals, prescribing and treatments not providing the expected outcomes.



2.3 At the end of November 2021, performance remained below the all Wales target of 75% for complaints closed within 30 working days. On average, the number of complaints closed within the timeframe was 57.6%. The performance level has

dropped due to the number of complaints received during the quarter (an increase of 30% of formal complaints in comparison to the previous quarter). In addition, the impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment has impacted on the ability of services to respond in a more timely manner.



- 2.4 The 75% target for 30-day response rate was not achieved by the Health Board. This has led to an increase in the number of overdue complaints during this period.

East Secondary Care

East have shown an improvement in 30-day response rates noticeable in September 2021 and October 2021. In August 2021 with a 43.48% response rate, in September 2021 a 55.26% response rate, in October 2021 55.50% and in November 2021 50.00% improving their response rate to response rate with an average of 50.95 % 30-day response rate in this 4-month period which gives them an overall improvement when compared to the response rate in Q2 (46.82%).

Central Secondary Care

Central has seen a further drop in 30-day response rate largely due to the increasing number of complaints received. In August 2021 they had a 31.58% response rate, in September 2021 54.54% response rate, in October 2021 22.73% and in November 2021 25.00% response rate. This provides an average of 33.34%.

West Secondary Care

West have improved slightly in relation to the 30-day response rate in comparison to the previous quarter. In August 2021 they had a 46.43% response rate, in September 2021 72.73%, in October 2021 52.38 % and in November 2021 53.85 % response rate. This gives an average 30-day response rate of 56.35% in Q3.

East Area

East Area have shown a consistent 30-day response rate in this 4-month period. In August 2021 they had an 81.16% response rate, in September 2021 a 77.14% response rate, in October 65.13% and in November 67.44% response, rate which gives them an average of 72.72%.

Central Area

Central Area has seen a significant drop in 30-day response rate in this period. In August 2021, they had a 77.78% response rate, in September 2021 a 69.23% response rate, in October 2021 a 42.11 % and in November 14.29% response rate, which gives, them an average of 50.85% for this period, which is a drop compared to 58.33% in the previous quarter, again due to the increasing number of complaint received. This demonstrates an urgent need for support for the services to investigate their complaints particularly due to the significant drop in performance in November 2021.

West Area

West Area has seen a drop in the in 30-day response rate for the quarter; August 2021 showing as 81.12% which is an improvement on the previous month, however in September 2021 a 59.09% response rate, October 2021 a 63.34% and November falling to 44.44% response rate which gives them an average of 62.25% for this period.

- 2.5 The **Mental Health and Learning Disability Division** continue to have good performance at closure.
- 2.6 The Complaints Team have received 4 formal complaints of note during November 2021 in relation to Anaesthetics: 2 x Grade 3's, 1 x Grade 4 and a Grade 5. 3 of the cases in relation to Women's, with 1 in relation to Secondary Care Surgery. The crux of the complaints are in relation to epidurals and the side effects following the incidents including paralysis and a respiratory arrest. They have been escalated to the Patient Safety Team for a full review.
- 2.7 At the end of November 2021, 272 complaints were overdue, 199 of the complaints are with the services awaiting investigations. The impacts of Covid-19 and the increase in the number of complaints, mean that the services are unable to produce their responses in line with the 40 working day time frame. Twenty complaints have been returned to the services for additional information, 26 complaints are awaiting approval from directors.

Status of Overdue Complaints as at 30/11/2021

Investigation Ongoing	199
Draft With Concerns	13
Draft Sent back to Division for More Work	20
Awaiting Approval	26
Awaiting Signature	14

Rejected by Director	0
All	272

2.8 The number of legacy complaints (prior to the new process) continue to fall week on week and has fallen from 39 overdue in August 2021 to 14 at the end of November 2021. This has involved significant proactive work across all services and dedicated support to secondary services in particular. Attendance at weekly complaints review meetings, providing clarification on complaints which should be referred to the Ombudsman and agreeing complaint responses and closure, have seen a turnaround both in the reduction in number of 'legacy' complaints and increased quality of complaint responses.

2.9 The Complaints Team have received a high volume of investigation reports requiring quality and assurance prior to submission for director signature in the last quarter; this is particularly due to the increased number of complaints thus an increased number of responses. The increased volume has influenced an increasing pressure on the workload, the team have responded positively by working additional hours to mitigate the demand.

2.10 The number of Investigation Reports presented to the team for quality and assurance in the first two weeks of the month of November were as follows:

Date	Number of Investigation Reports received for Quality and Assurance
1/11/21	22
2/11/21	12
3/11/21	18
4/11/21	11
5/11/21	12
8/11/21	16
9/11/21	12
10/11/21	11
11/11/21	15
12/11/21	12
TOTAL	141

2.12 The Complaints Managers and Patient Experience Officers are currently responsible for the quality and assurance of the investigation reports. Due to staff absence (sickness)

and a vacant post, this has meant that the workload has been shared between 3 employees. As part of the Complaints Recovery Plan, the team recruited a temporary staff member from the bank to support the quality and assurance of reports. The team are working within the quality and assurance framework, their role in reviewing the responses within the complaints procedure has demonstrated a significant reduction in the number of second responses required. The quality of the investigation reports has improved with the complainants' questions being addressed from the outset. As noted above, the impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment has impacted on the ability of services to respond to complaints as effectively as possible.

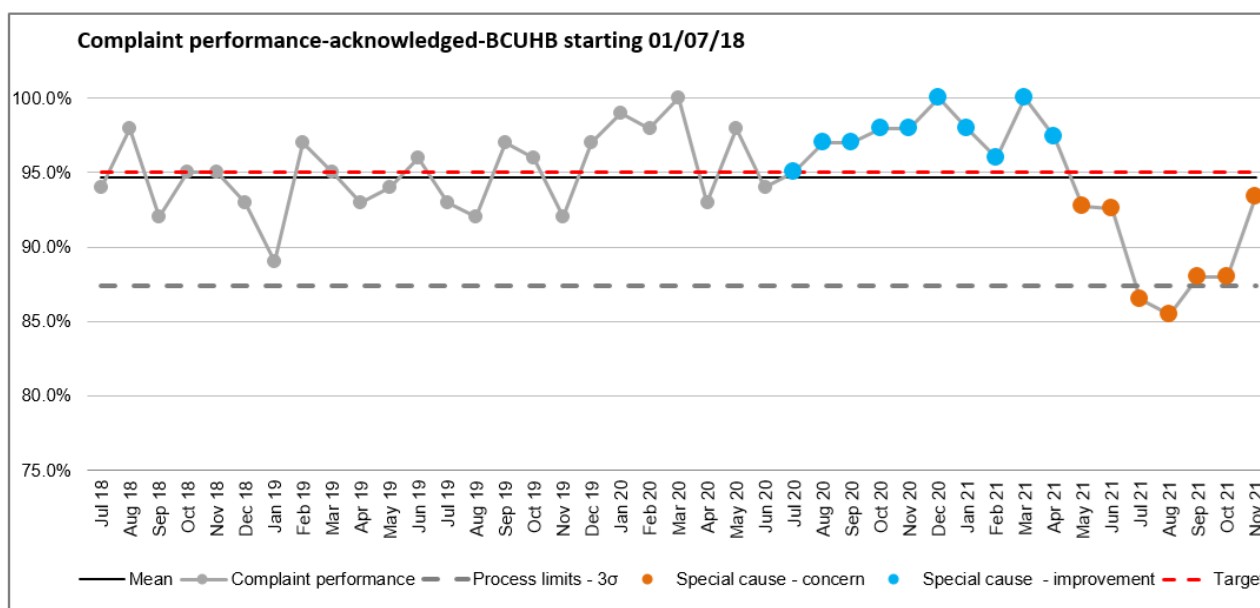
2.13 The Complaints Recovery Plan has been implemented to support services during this difficult period of Covid-19 to improve the Health Boards performance in dealing with Complaints. The main purpose is to improve performance to achieve Welsh Government Complaints Key Performance Indicators and provide support to services with complaint resolution.

- The plan supports the recruitment of a temporary team of complaints investigators to conduct a proportionate investigation into complaints. The team will particularly support the services to identify root cause analysis, source documentation and review medical notes; they will present the investigation reports in line with the current complaints handling procedure on behalf of the services in order to respond to the complaint within reasonable timeframes. We have been successful in attaining approval for 8 wte secondment opportunities to recruit complaints investigators to support the services. We will have 3.04wte joining the team mid-January 2022, by promoting joint working and support for services, our aim is to collaborate with the services to provide a timely resolution to our complainants. It has been difficult to recruit due to pressures on services and no release of staff.
- The plan will identify which services require additional support by way of a review of overdue complaints, this will be actioned weekly. Data will be extrapolated and reviewed. We will use a targeted approach and identify 'hot spots'. Contacts will be made with the site/area leads to discuss the recovery plan and support.
- Complaints Team Training is part of the plan including work to identify the training needs of our own team, providing regular staff training sessions can have huge benefits, investing in skills and knowledge that the training provides, and retaining and developing the team

2.14 The recovery Plan is an on-going action plan where progress will be reviewed at the Quality Directorate Senior Management Meetings.

2.15 At the end of November 2021, an average of 88.7% of complaints were acknowledged within 2 working days against a target of 95%. This rate has fallen from the previous quarter, however during November we are pleased to identify an improved performance with 93.4% of complaints acknowledged within 2 working days. The performance is based on a depleted Complaints Team during the quarter due to staff absence, annual leave and vacant posts. The increase in the workload has had a detrimental effect on meeting deadlines. On average 15 calls per complaints administrator were not complaints related enquiries; however, the team always try to

find resolution for patients. The length of time per telephone call on average was 5 minutes, which in effect affected the employee's capacity by 75 minutes per day, which in turn utilised 16.6% of the employee's time per day.



2.16 The table below demonstrates the significant increase in volume of calls particularly during August and September 2021.

Month	Calls to Main Number – managed by complaints	Calls from main number to PALS Extension	Calls from Main Number to complaints Extensions
August	2297	700	797
September	2296	567	955
October	1846	369	639
November	2620	585	759

2.17 As demonstrated in the table below, during the August to November period 1,129 Early Resolution (ER) cases were recorded, of which 73 (6.5%) were upgraded to formal. This demonstrates a slight decrease in the number of early resolutions received in the previous quarter. (1,144).

Indicator	Team	Aug-21	Sep-21	Oct-21	Nov-21
Early Resolutions					
Number of received	Complaints	315.00	270.00	267.00	277.00
Number of Upgraded to Formal Complaint	Complaints	21.00	33.00	19.00	24.00

2.18 Reasons for failure to manage ER cases include the inability to resolve the matter within 2 working days. This is mainly a result where initial enquiries establish that the issue is more complex than initially thought; this would also trigger conversion to the

formal (PTR) process. Other issues that influence ability to manage ER within the timeframe is highlighted in primary care at present; this is an area usually successful at resolving matters promptly, however they are currently experiencing significant difficulty in discussing with staff and obtaining prompt responses to queries due to amalgamation of practices and phone lines and general pressures on GP practices. Many of these ER are in relation to hospital visitation, phone lines, appointments and access, availability of GP appointments. These take a significant amount of Complaint Team capacity in trying to resolve and manage; we are currently working collaboratively with Primary Care colleagues in East to take a pragmatic approach in attempting to manage these cases.

- 2.20 The team work in partnership with the Patient Advice and Liaison Service to instil a proactive approach to reducing the ER's, thus linking in to their use of virtual aids to facilitate virtual communication with patient families in replacement of hospital visitations.
- 2.21 The team have worked in partnership with services, particularly primary care services and the Clinical Governance/Quality Teams to overcome the barriers to achieving the 2-day time frame for early resolution that the PTR Regulations stipulate. The tight deadline's cause frustrations within services due to the current impacts of the Covid-19 pandemic and staff absence thus being unable to provide a resolution in time. The team have collaborated with services by way of meetings to discuss the barriers and offer solutions for SMART working solutions. On occasions, this has meant that the early resolutions have been formalised to a Grade 1 complaint.
- 2.22 The commencement of the Daily Sitrep Report allows services to attain an overview of the ER and formal complaints logged for their areas and enables services to determine themes and trends, these can be addressed swiftly to avoid further complaints. This is distributed on a daily basis to services via the Daily Quality Alert.
- 2.23 The team have organised a Primary Care Workshop with a view to reviewing the process in handling complaints in relation to Independent Contractors. The process has proven complex particularly in relation to the Health Board being unable to comment on Breach of Duty. Our aim is to implement a clear pathway, seize every opportunity with early resolution, align the front end of the process and explore timely resolution, train the workforce on the regulations and legal implications particularly in relation to primary care contracts to instil knowledge and expertise to improve performance.
- 2.24 Despite the decline in performance with regards to responses submitted within the 30 working days under PTR, we are pleased to report continued partnership working with services has improved the quality of complaint responses to the complainant ensuring that all questions are answered and addressed. The number of early resolutions closed for the quarter was 1,056. The team have worked in partnership with services to provide adequate resolution, the close working relationship with PALS has ensured that we have avoided a high conversion of the complaints to be formalised, via the power of engagement and pro activeness, the conversion has remained low.

3 COMPLAINTS LEARNING

- 3.1 The new complaints process endorses the importance of learning as a key element of complaint investigation and analysis. The complaint investigation process is facilitated by the application of an investigation report template and guidance for the Investigating Officer to follow.
- 3.2 When completed and written up, the allocated adjudicator signs off the investigation report, (the role of adjudicator is at Director of Service level). The adjudicator role also supports the emphasis on learning as a key part of a complaint investigation and assurance and governance arrangements and that identified actions and improvements will be completed.
- 3.3 The new complaints process reinforces the importance of ownership and the need for services to have a detailed awareness of what is happening within their area, why complaints are arising and actions required to address them, preventing similar occurrences. 32% of the complaints within Secondary Care were in relation to the Emergency Department (ED), over 50% of those were in relation to Ysbyty Glan Clwyd's ED. The main theme's being in relation to waiting times in ED, staff not empathetic, poor communication and no access to food or drink whilst in ED.
- 3.4 Learning and development is fundamental to transforming the culture of practice in the Health Board and improving the experience and outcomes for our service users; this can be facilitated through the training of individuals, teams and services.
- 3.5 A core function of the Quality Directorate is to support and train service colleagues in tools, techniques and processes that can improve both patient safety and experience of healthcare. An organisational learning culture will be generated by enabling and empowering staff to provide excellent communication skills, listen and respond effectively to service user feedback and complaints, and to act on patient safety incidents quickly with openness and transparency.
- 3.6 The new training prospectus will be implemented in January 2022 (subject to any winter pressures), which represents a new approach to patient safety and experience incorporating human factors. This will lead to significant gains for both patients and staff as it reaches a critical mass of trained practitioners.
- 3.7 Training will encompass all areas of concerns: complaints, patient safety incidents, claims, inquests and service user experience, and all Health Board staff will have access to training, at the most appropriate level, for both service needs and personal development.
- 3.8 Recognising the demands on each and everyone's time, the department has designed the training curriculum using a modular approach. This approach divides the extensive curriculum into small, discrete modules that are independent and relatively short in duration.
- 3.9 The training will be delivered by way of pre-recorded sessions as well as virtual interactive sessions as soon as Covid-19 restrictions allow. The department is in discussion around linking with ESR.

4 COVID-19

- 4.1 A National Wales Framework Guidance has been implemented to provide a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of Covid-19 in compliance with the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.
- 4.2 The framework has recently been amended to include definitions of harm to ensure a consistent approach to investigating harm in relation to nosocomial transmission of Covid-19 pan BCUHB.
- 4.3 In November 2021, an Operational Impact Assessment was implemented by the Delivery Unit sighting 3 options from the health board to consider in relation to undertaking the investigations in to nosocomial transmission of Covid-19:
- 4.4 The Health Board, following a decision involving Clinical Executives, are currently operating in line with Option 1, which aligns to the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (commonly known as Putting Things Right – PTR) and/or Health Board policy and procedure. However, the Health Board will review the options regularly and are in continuous contact with the NHS Wales Delivery Unit for guidance and support.
- 4.5 The Objectives of the health care acquired Covid-19 reviews is:
- Early identification of potential harm
 - Providing objectivity and being advocates for patients and families
 - Providing accurate and actual information to be communicated to patients and relatives supporting the 'Putting things right process'
 - Follow NHS Wales National Framework Guidance
 - Surveillance and monitoring of Covid-19 HCAI Infections and Minimising risk of further transmission
 - Identify themes/learning of care delivery issues
 - Implement robust and unified Procedures across all areas
 - Review care to provide quality assurance
 - Implement accurate data system interfacing all current data sources
 - Provide data to plan for future waves
 - Ensure accurate reporting
 - Retrospective reporting to the Medical Examiner / Coroner
 - Preparation for an Inquest / Inquiry / Scrutiny
- 4.6 The current number of investigations required in relation to nosocomial transmission of Covid-19 is 1729 (at the end of November 2021).
- 4.7 An increase in correspondence from patients/families affected by health care acquired Covid-19 within the Health Board highlights the need for pro-active engagement. This presents itself following the increase in publications in the media regarding the subject and pressures on the Welsh Government for a Public Enquiry. A pro-active approach

to engage with the public by form of an announcement with information in relation to the intention to review is necessary to maintain public confidence and engagement.

- 4.8 The Health Board are in continuous contact with the DU and neighbouring Health Boards, and similar to the Kings Lynn Trust, the Health Board have adopted a proactive approach to engage with the families of those affected with the nosocomial transmission of Covid-19 to include them as part of the proportionate investigations. The Health Board will encourage meeting families in person to explain, but more so to let them “tell their story”. The feedback to date has highlighted the importance of being able to discuss openly in their language of choice i.e. Welsh/English. The Health Board will also encourage staff involved in the patients care to participate in the conversations with families and support staff to understand what patients and families were going through at the time.
- 4.9 Each investigation takes approximately 6.5 hrs (based on Delivery Unit findings). BCUHB currently adopt the full investigation toolkit by way of a document to support the investigations as well as an SBAR to define the patient’s journey an overall health condition. The investigators are currently concentrating on the deaths connected to the 167 affected by the initial Morris Ward Outbreaks.
- 4.10 The Health Board is implementing an adjudication panel; recruitment is ongoing to the panel to ensure that the appropriate professionals are recruited ensuring that all investigations are proportionate.
- 4.11 In line with Putting Things Right, learning from the investigations are fundamentally important in preparation for future waves, to support this the Patient and Carer Experience Team attend ‘The Wandering Patient Task and Finish Group’. The Wandering Patient Task & Finish Group is one of 5 Task & Finish Groups developed to support and deliver the Safe Clean Care, Harm Free work stream agenda. The aim of the group is to develop a BCUHB algorithm for Wandering Patients in all Inpatient Wards / Units to support a zero tolerance approach to Infections (nosocomial)”. The Group have identified the following:

There is an urgency to review Patient Transfer Procedure in the context of the Covid-19 Environment (NU19) – this impacts beyond the Wandering Patient Task & Finish Group.

- An urgent need for a process for re-commissioning therapeutic space
- Imminent need for data gathering to identify the number of wandering patients within operational services, a snapshot view.

The work has influenced the following:

- A standard operating procedure (SOP)/Risk Assessment is being produced from an Infection Prevention perspective for reinstating group activities.
- Two pieces of work have now been identified, producing a patient algorithm and producing a behavioural quality action plan.

- 4.12 The re-occurring themes from the investigations to date:

- Missed screening opportunities
- Low-level description of positive results – resulted in patients being transferred to Covid ward and then in contact with positive patients.
- Delays in isolating and transferring confirmed positive cases to a Covid ward, exposing contacts longer than necessary, increasing the risk of conversion.
- Inappropriate use of PPE – staff and patients
- Wondering/vulnerable patients – need for enhanced staffing with the right skill mix
- Environment – cluttered areas on ward, limited storage facilities in some areas, bay doors restricting visibility for at risk patients
- Staff movements to be appropriately managed
- Outbreak Control Team to meet within 24 hours of an outbreak.
- Proactive testing of staff when an outbreak has been declared – clear procedure required.
- Closure checklist for ward
- Standardisation of processes for closing a ward
- Develop and circulate a Standard Operating Procedure detailing the processes for managing positive and negative patients to prevent the spread of infectious diseases.
- Social distancing measures re beds 2 metres apart and staff socially distanced during break times etc.

4.13 Timely learning extracted from investigations and information presented as an action/improvement plan in preparation for any future waves, currently by way of an infographic. However, the Covid-19 Review team have a robust archiving system to ensure that all documents and learning are captured on the SharePoint Drive.

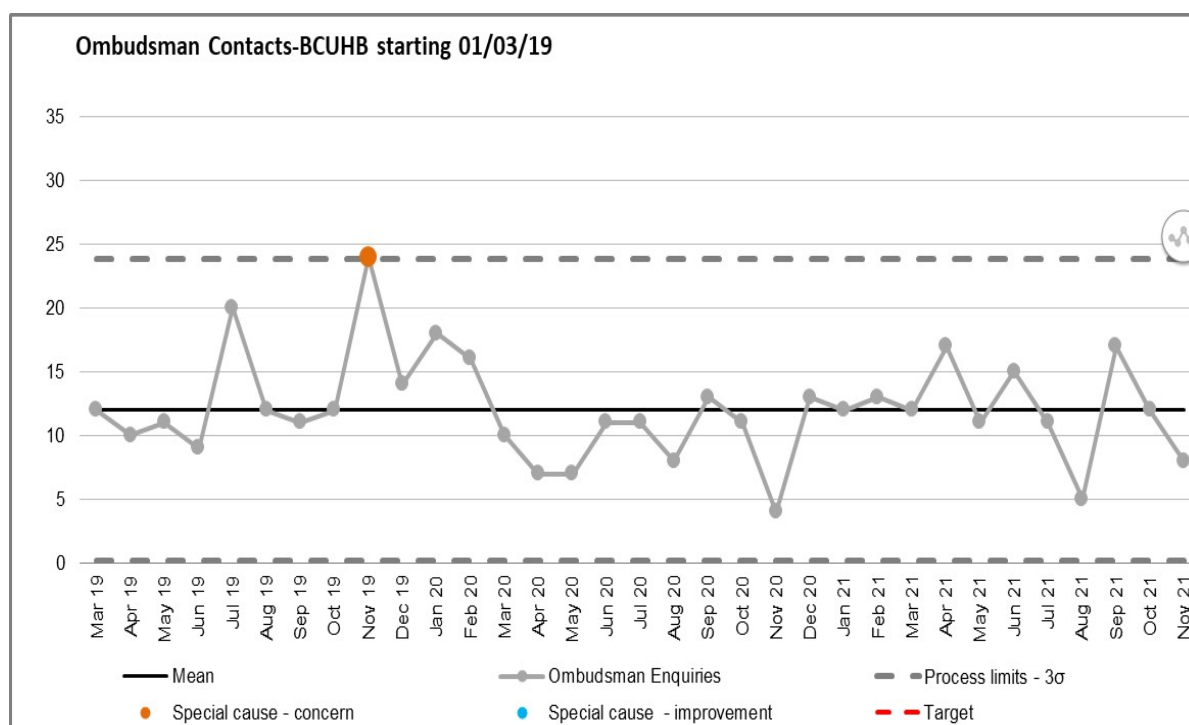
4.14 The Patient and Carer Experience Team has worked collaboratively to support the development of a Long Covid-19 Recovery Pathway to Treatment and Rehabilitation. This has meant pro-actively engaging with patients who are experts by experience as well as relevant professionals to develop the pathway. The group have been successful in identifying an inter-disciplinary approach to access services whilst securing funding for an interim project & clinical resources to support.

4.15 The team have collated a number of patient stories recorded via audio and transcript from patients living with Long Covid-19 syndrome, the contributions will support the Health Board to raise awareness of the Long Covid-19 Syndrome whilst extracting the learning to ensure that the health board improves services to rehabilitate and treat our patients.

5 OMBUDSMAN

5.1 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales.

5.2 During the months under review, the Ombudsman contacted the Health Board regarding 42 new concerns (compared to 54 in the previous comparable period).



5.3 During the period under review the Health Board have received notification that a further 12 new complaints will be fully investigated by the Ombudsman, (compared to 20 in the prior comparable period).

5.4 The Health Board currently has 65 Ombudsman Investigations ongoing across the Health Board, of which 15 are within the West, 31 within Central and 19 within East.

5.5 Quarterly calendar dates have been scheduled with the Ombudsman's Improvement Officer to promote partnership working with the Ombudsman's office. The Health Board met the Ombudsman's Improvement Officer on 22nd April 2021 and 12th August 2021. Further regular meetings will be timetabled throughout next year.

5.6 **Ombudsman Public Interest Report.**

During an investigation into concerns raised by Mr Y, the Ombudsman received evidence from the Health Board which indicated that, at the time Mr Y was placed on an urgent list for prostate cancer treatment in August 2019, there were a total of 16 other patients with the same urgent clinical priority awaiting the same procedure (prostatectomy - surgery to remove the prostate).

The Ombudsman had a reasonable suspicion there were other possible incidents of service failure and maladministration in relation to the other patients on the waiting list. He commenced an investigation using his own initiative power of investigation to consider whether the Health Board exceeded the Referral to Treatment Time ("RTT" – the waiting time management rules) target for cancer waiting times for treatment of prostate cancer in respect of the 16 patients who were awaiting prostatectomies.

The Ombudsman's investigation found that, in August 2019, the Welsh policy position in accordance with Welsh Government guidance was that, only patients treated in Wales were reported against the Welsh cancer waiting time targets. The Health Board therefore only produced "breach reports" and undertook harm reviews for the patients it treated. This did not apply to patients referred by the Health Board for treatment in

England. Of the 16 patients on the waiting list in August 2019, 8 were referred to England for treatment. If they had been treated in Wales, the breaches of the target timescales would have been reported for all 8 patients because the amount of time they waited for treatment exceeded the 62 and 31-day target for cancer RTT (the target times relate to whether a patient had been designated as urgent suspected cancer or non-urgent suspected cancer). Four of the patients on the waiting list who were treated by the Health Board had exceeded the cancer waiting time target and these breaches of the target timescales were reported and harm reviews were completed.

While the Welsh policy position at the time meant there was no requirement to produce breach reports to the Welsh Government or to carry out harm reviews for Health Board patients treated in England, the geographical location of treatment should not have left these 8 patients in the position where they were denied the harm review process because they were treated outside Wales. Regardless of the Welsh policy position at the time, the Health Board was obliged to undertake appropriate monitoring of the care and treatment of its patients under its commissioning and contracting arrangements. It should also have considered the impact of the delay in treatment. These failures amounted to maladministration.

The new Single Cancer Pathway ("SCP") which has replaced all previous cancer targets, has addressed the anomaly of the previous approach and all patients now referred from secondary care for treatment outside Wales for their cancer treatment must be included in cancer waiting times monitoring arrangements and all patients not treated within the target should have an internal breach report completed. However, to remedy the injustice to the 8 patients, in line with my approach to remedy, the Ombudsman recommended that the Health Board should return these patients to the position they would have been in had they been treated in Wales and carry out a harm review for each patient. He also recommended that the Health Board reviewed its harm review process to ensure it was in line with the requirements of the SCP.

The Ombudsman has reported on the Health Board's urology service several times and is concerned that issues relating to capacity and succession planning within the urology department seems to be longstanding. He therefore recommended that the Health Board referred the report to its Board to consider capacity and succession planning for the urology department.

The Health Board accepted the recommendations and presented a 'Review of Urology services and patient experience' paper at the Board Meeting 18 November 2021. The first meeting of the Urology Improvement Group was also held on 23 November 2021.

5.7 Emerging Themes

One emerging theme continues to be the increased number of cases being returned to the Health Board by the Ombudsman with instruction that they are to be re-investigated under the Putting Things Right Regulations in order to consider Redress. This is due to the poor quality and inadequate initial investigation held by the Health Board where qualifying liability has not been considered. There are currently 9 cases which the Ombudsman has recommended they be considered for Redress.

5.8 Own Initiative Powers of Investigation under the PSOW Act 2019

There are currently 2 investigations ongoing which are being carried out under the Ombudsman's own initiative powers of investigation under the PSOW Act 2019.

- i. One investigation has been extended to consider whether failings may have occurred in the prescription/administration of lorazepam and the recordings of the patients' observations following this and action taken as a result. The Ombudsman's Clinical Adviser has also expressed concern about the causes of death listed in the post mortem report.
- ii. One investigation has considered the care and treatment the late patient received from the Health Board when she attended the Emergency Department of Ysbyty Gwynedd and failed to provide Ms M with appropriate care and treatment, failed to undertake appropriate tests and investigations, including specifically, a brain scan, and inappropriately discharged Ms M. The Ombudsman has now completed his investigation and the Health Board has accepted the report and is currently in the process of implementing the recommendations.

6 COMMUNITY HEALTH COUNCIL

- 6.1 The North Wales Community Health Council (NWCHC) has undertaken a limited number of inspections. The reduction in inspections undertaken remains because of restrictions arising from COVID-19, also reflecting the fact that hospital visiting in general has not been fully established due to ongoing arrangements and restrictions because of the COVID-19 pandemic.
- 6.2 The CHC continues to focus on engagement activities and providing advocacy service for complainants

7 Putting Things Right - Redress

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

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate); and
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

- 7.2 During October and November 2021, 39 cases were concluded which involved Redress:

- 7 offers of financial compensation as redress were accepted totalling £66,850
- 2 written apologies were made
- 6 proceeded to become a clinical negligence claim

- 9 were advised to pursue a clinical negligence claim, as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.
- 1 was advised to pursue a personal injury claim
- 3 were advised that there was no qualifying liability following interim responses being sent
- 11 other responses were sent during the period, which had been reviewed for redress but deemed to have no qualifying liability.

7.3 Redress offers accepted during this quarter included the following issues:

- Failure to complete the necessary falls documentation and no evidence that a falls care plan was completed to reduce the risk of patient falling and sustaining an injury.
Learning - learning event-training days were held for the district nursing team to demonstrate the required standard of documentation required.
- Poor personal care contributed to patient's scalp infection, which meant shunt had to be removed and this materially contributed to the infection, which ultimately led to patient's death.
Learning – an action plan addressing each of the failures identified has been completed.
- Failure to ensure call bell was within patient's reach and steps not taken to check ability to mobilise safely following surgery, resulted in patient fall and injury.
Learning - Email sent to whole team highlighting the importance of ensuring all patients are assisted correctly post operatively to walk in the first instance.
- Cannula not inserted in accordance with clinical guidelines caused patient to suffer extravasation injury and cellulitis.
Learning - Review of Critical Care documentation relating to PVCs undertaken to evaluate whether redesign is required to enhance compliance with VIP monitoring/ core PVC documentation requirements
- Failure to refer patient to the Early Pregnancy Assessment Unit caused unnecessary pain and suffering for seven days.
Learning - Community Midwifery Matron has reminded team they should ensure that where condition indicates, any woman who contacts the community base for advice with vaginal bleeding/pain should be referred into the EGU for assessment
- Failure to check for retained placenta resulted in-patient having to undergo two additional theatre procedures to address bleeding.
Learning – Clinician has reflected on his practice and has discussed this at a Clinical Governance meeting to raise awareness amongst other colleagues.
- Delay in transferring patient promptly into the Emergency Department and the failure to then assess and treat patient appropriately, materially contributed to her death.
Learning - Improvement of patient flow through the hospital as part of its 'Building Better Care' programme, which in turn should reduce the pressures that ED face is ongoing.

7.4 To ensure that learning and improvements are actioned at the earliest possible stage, the Welsh Risk Pool requires the Health Board to submit a Learning from Events Report (LFER) within 60 working days of a qualifying liability being determined within a complaint or incident investigation – this process includes the actions that the Health

Board have put in place. The LFER will be considered by the WRP Committee who will approve reimbursement to the Health Board for the costs entailed in each redress case, once satisfied with the evidence of learning provided.

8. PATIENT FEEDBACK

- 8.1 Patient feedback and listening to the voices of patients, carers and service users, is key to ensure effective service improvement. It is paramount that the Health Board fully takes into account the feelings, views and experiences of patients, carers, and service users, and how such feedback can positively influence service change and development.
- 8.2 Despite the challenges presented by Covid, the Patient and Carer Experience Team have continued to support services in the process of capturing feedback, and to provide evidence that all services are working towards the stated aim of capturing 20% of patient/care/service user experience, which is key performance target inherent in the patient safety and experience strategy (BCUHB, 2019). The Patient and Carer Experience Team continue to collect service user feedback through various in house methods including; paper questionnaires, analysis of social media, increased media visibility and via the PALS service.
- 8.3 CIVICA™ patient feedback system for Wales is currently being embedded across the Health Board and is a mechanism to support real time patient and service user feedback. The online patient feedback system supports the development and deployment of multiple surveys across multiple channels, along with standard reporting, alerting and enhanced text analytics. It signals an important milestone in providing every patient and service user with an opportunity to have their voices heard and acted upon.
- 8.4 As part of implementing the CIVICA patient feedback system, we have introduced internet based service user experience questionnaires supported by the use of QR codes across all service points. Throughout Q3, the following actions were undertaken to support the roll out of CIVICA patient feedback system:
- Throughout the week leading up to World Patient Safety Day in September 2021 the CIVICA, system was launched to staff and the public using a series of videos and staff interviews shared on social media and on the intranet.
 - CIVICA staff user accounts were established for all key users including Patient Safety and Experience Staff, Heads of Nursing, Matrons and Ward/Department Managers.
 - Service point mapping has been extended/amended to include BCUHB Dental Service, Heart Failure Service, Radiology and community hospital locations.
 - Recorded video instructions and training has been produced to assist staff in creating patient feedback reports. The training is now available on SharePoint to support to the migration from local push reports to utilising the reporting functionality within CIVICA.
 - Sixty new iPads have been purchased, configured and deployed across the health board to support digital feedback. The iPads have the CIVICA App installed on

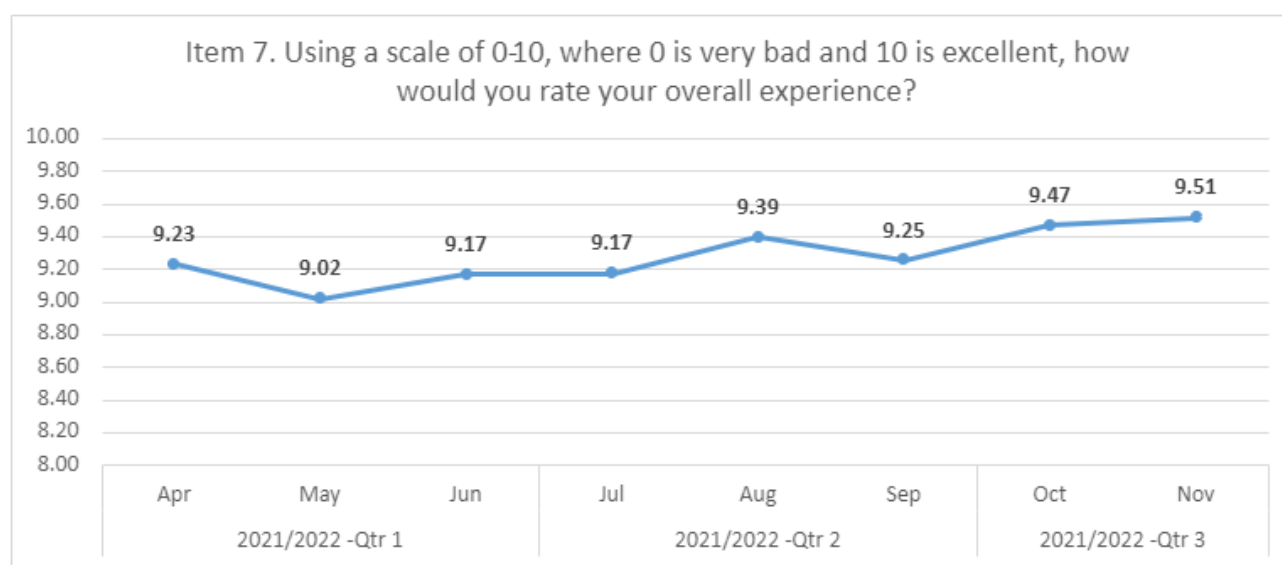
them in order to provide a direct link to the on-line patient experience survey whilst also supporting virtual visiting.

- QR Code posters directing patients to the online patient feedback survey have been created and put up around hospital sites, including areas such as ED waiting rooms, to encourage patients and carers to share their feedback.

8.5 In September, there was a slight decrease in the number of returns from the real time patient/service user feedback compared to previous months. Since October, returns have been gradually increasing and are back up to on average 900 per month. Please see table below for more detail:

No of Returns				
	Central	East	West	Tot
Qtr 1	1550	1053	675	3278
Apr	300	326	228	854
May	383	313	193	889
Jun	867	414	254	1535
Qtr 2	1519	860	654	3033
Jul	596	376	163	1135
Aug	558	212	238	1008
Sep	365	272	253	890
Qtr 3	1135	447	267	1849
Oct	538	254	117	909
Nov	597	193	150	940
Total	4204	2360	1596	8160

8.6 Overall satisfaction in patients' experience in accessing health board services has increased from Q2. See table below:



8.7 Positive feedback not only shares good practice, but also raises staff morale and job satisfaction. The Patient and Carer Experience Team continues to select a 'Feel good Friday comment of the Week'. This is presented to the relevant ward/department along

with a certificate and the comment publicised on the Health Board's social media pages.

8.8 Below are examples of Feel Good Friday comments received in Quarter 3:

"The staff went above and beyond their call of care and duty. I feel like ANGELS have looked after me. Nothing was too much trouble for any of them."

"I would like to thank all of the Acute Medical Unit staff who looked after my mother-in law; sadly, unbeknown to us, she was too poorly for you save. Thank you for allowing us to spend precious time with her, it will help us cope with our loss. Thank you again and please pass this on to your wonderful nurses who looked after her."

8.9 There are always aspects of care where feedback suggests that improvements should be implemented. Key themes associated with a negative patient experience for Q3 remain the same as previous reporting periods. The following negative key themes were identified:

- **Communication**, key examples include; families and carers being unable to access information regarding the care of their relatives and loved ones, which in many cases was exacerbated by visiting restrictions, patients unsure of 'what is happening next', as well as patients reporting that communication between the care team appeared confused resulting for example in patient histories being repeated.
- **Co-ordination of Care** this theme includes ineffective communication regarding the care, treatment, plans, care pathways and the location of relatives within hospital sites.

8.10 In response to the issues around communication, the Patient and Carer Experience Team delivered training to Matrons across BCUHB to raise awareness of the service they offer. The training highlighted the need for positive communication with relatives and families, giving staff the tools to support communication such as the use of iPads for virtual visiting.

8.11 Due to an increased number of negative PALS enquiries, PALS Officers at Ysbyty Wrexham Maelor met with staff from the Emergency Department at a Patient Group Feedback meeting to see how patient experience could be improved. Both teams are now working together on shared actions.

8.12 At Ysbyty Gwynedd, the Patient and Carer Experience Team are supporting three wards (Conwy, Gogarth and Glaslyn) as part of a 90-day project to improve patient feedback in particular around improving communication with patients and carers. As part of the 90-day project, staff have visited the wards and undertaken care2share discovery interviews with patients to capture real time feedback. PALS Officers have spoken to staff on the wards to see what improvements can be made. After the 90-day project has been completed we will look to roll this out across the health board.

- 8.13 In Ysbyty Glan Clwyd each PALS Officer has been assigned directorates to work intensively with to help improve patient experience, improve staff relationships and to support direct service improvements.
- 8.14 From August to November, staff undertook 21 Care 2 Share discovery interviews with patients across Ysbyty Glan Clwyd, Ysbyty Llandudno and Ysbyty Gwynedd to collect real time feedback to help support service improvement across the wards.
- 8.15 There have been positive efforts within service areas to address feedback around poor communication, such as the distribution of 60 additional iPads to wards and departments to support virtual visiting and Letters to Loved ones.
- 8.16 The Patient and Carer Experience Team are currently improving their Intranet pages to help support staff with signposting patients to services that support carers and bereavement support. As the use of iPads to support virtual visiting has increased, we have been exploring options of how we can support services with the digital inclusion agenda to help improve patient experience.

9 PATIENT STORIES

- 9.1 Stories told by individuals from their own perspective regarding a health care setting, or the care they have received, has been identified as a powerful tool to understand their lived experience. This is acknowledged as an influential and compelling method of collecting patient feedback and can identify specific opportunities for future service improvement as they come directly from the patient themselves.
- 9.2 In the period, PALS Officers captured 14 patient stories. The service has received an increase in the number of requests from departments to capture patient stories relating to their service area with a particular focus on:
- Vascular stories – presented at monthly Vascular Steering Group meeting
 - Mental Health – presented at monthly Mental Health Act meetings and bi-monthly Mental Health PCE meeting
 - Urology – presented at the Urology Improvement Group.
 - To create a more sustainable model of capturing patient stories across the health board and to keep up with the demand, the Patient and Carer Experience Team are offering patient story training to staff. Providing the appropriate resources and digital equipment to capture patient stories. This model is currently being followed with the Safeguarding Service to train staff to capture patient stories.
- 9.3 Following a patient story captured the patient felt that a 6-day transport service from WAST to support the Renal Service would improve patient experience, The Patient and Carer Experience Lead was invited to present this patient story at WAST Quality Patient Experience and Safety committee. This was an excellent example of collaborative patient led improvements in North Wales with our WAST colleagues.
- 9.4 In November 2021, 7 members of staff from the Patient and Carer Experience Team, Concerns Team, Communication and Engagement Team completed a 6-week patient stories video training course so they can help assist in capturing patient stories through

film. Video and audio equipment is now available in each area for staff to use to help capture patient stories.

10 PATIENT EXPERIENCE BEREAVEMENT AND LIAISON SUPPORT

- 10.1 Ensuring carer and family feedback is collected to improve bereavement experiences is a priority for the health board. The Patient and Carer Experience Team have a focused work stream to improve bereavement services for both families and BCUHB staff. In collaboration with the wider Quality Directorate, Pathology Department and Bereavement Officers the Patient and Carer Experience Team has led on enhance bereavement support services including providing internet based advice leaflets, specific in-box for related enquiries, and protocols for returning the property of deceased patients to the next of kin.
- 10.2 In the period, the Patient and Carer Experience Team responded to 23 PALS Bereavement related enquiries.
- 10.3 The Health Board Patient and Carer Experience Lead is chair of a task and finish group to help improve family and staff experience of bereavement across the health board. The task and finish group has been working on the following actions:
- To learn from bereavement experiences by developing a collection of family/carers stories called 'Our Stories' to support service improvement. In November, we captured a parent's story around their experience of losing their baby and the impact restricted visiting had on the parent's ability to spend time with their baby.
 - We have consulted with spiritual groups, BAME communities, Patient and Carer Champions and volunteers to review the bereavement booklet we give out to families to ensure it meets the needs of all communities we serve. Two bereavement booklets (bereavement booklet and pandemic bereavement booklet) have been reviewed. It was suggested that a one page easy read document outlining the steps needed to be taken when a family member/loved one passes away should be produced and be used in addition to the bereavement booklet.
 - Feedback identified the need to develop quality signposting information/support on our internet and intranet to support staff and families.
 - The task and finish group felt it was important that we hear the voices of our staff in relation to their experiences with bereavement.
- 10.4 The Patient and Carer Experience Team have commissioned three pieces of bereavement artwork to be displayed across three hospital sites and we have commissioned a publication of Covid 19 patient stories, which include bereavement experiences.

11 LETTERS TO LOVED ONES

- 11.1 As previously acknowledged, during the COVID-19 pandemic, visitation to all to hospital sites throughout BCUHB has been restricted. Letters to Loved Ones was an initiative developed by the Patient and Carer Experience Team as a response of the

restricted visiting measure to help maintain communication between loved ones and patient. It continues to be a successful service, with a good uptake of messages sent on a weekly basis. A message to a loved one who is an inpatient in hospital is sent in via email or telephone, and that message is then hand delivered to the patient on the ward. This remains a popular service, whilst the restrictions in visiting remaining in place.

11.2 The Patient and Carer Experience Team received one hundred and eighty-nine Letters to Loved Ones requests in the period. Below is the breakdown per locality:

Central	75
East	35
West	79

11.3 We continue to offer this service as it is an effective way for families to pass on messages to loved ones in hospital whilst restricted visiting is still in place.

12 IMPROVING CARERS EXPERIENCE

12.1 In October 2021, the new role of Carer Experience Manager joined the Patient and Carer Experience Team. Their role for the next 12 months is to develop a 3-year operational plan to improve carer experience across the health board.

12.2 Whilst BCUHB are committed to providing advice and support to help meet carer needs, efforts to engage and communicate with carers appear to be inconsistent. Furthermore, there does not appear to be a central point to record who is engaging with carers to improve services. Evidence from feedback gathered by the Patient and Carer Experience Team points to three main areas where BCUHB fails to engage with carers - communication, consent and collaboration.

12.3 The Health and Social Care (Quality & Engagement (Wales) Act 2020 is expected to come into force in spring 2023 and sets out the goal of ensuring carers are placed at the heart of a whole-system approach to health and social care services and stresses the importance of listening to all voices through continual engagement.

12.4 The impact of having carers supporting at home secures early patient discharge thus reducing the strain on hospitals in acute and community settings. Carers are also in a position to be able to identify patient needs sooner, rather than later, at a time when medical intervention could be sufficient at primary or community level reducing the pressure on acute setting.

12.5 Since starting in post the Carer Experience Manager has achieved the following:

- Asset mapping of stakeholders with the aim to provide signposting resources on the intranet for staff to access.
- On national Carers Rights Day in November, a campaign was launched to recruit lived experience carer representatives.
- Discussions have taken place with Hywel Dda University Health Board to adopt their Investors in Carers accreditation scheme.

- Exploring the set up a staff focused working group including clinicians, nurses, management, volunteers and the support of Betsi Cadwaladr UHB Independent Members to start the process of changing the culture.
- Preparing for a 12-week formal engagement exercise to commence in January 2022 to support the outline of the carers engagement process and operational plan setting out our ambitions to listen to the views and engaging with carers across the Health Board population. This will determine new service models that meet both service demand and carer needs of the future to understand what we do well and what to do more of and establish what is not working well.

12.6 The Carer Experience engagement will co-design the future for the health board, patients, carers, service users, staff, the public, key stakeholders and partners so that we move beyond the traditional way of including carers to truly address the needs through continuous engagement.

13. PATIENT & CARER CHAMPIONS

13.1 The Patient and Carer Champion is a Health Board initiative developed by the Patient and Carer Experience Team. There are currently 103 staff Patient and Carer Champions across North Wales. The Patient Champion award scheme has been developed with the Patient and Carer Champions having three levels of awards to achieve should they wish Bronze, Silver and Gold. They can also achieve certificates of attainments. Through this scheme, we can help standardise the approach of public facing information such as ward noticeboards.

13.2 In September 2021, Diane Sweeny an Activity Co-ordinator from Mold Community hospital was the first member of staff to be awarded a gold certificate for her work as a Champion.

13.3 From August to November, 8 members of staff completed training to become Patient and Carer Champions. The Patient and Carer Champions continue to meet as a group monthly. In the period, 5 guest speakers attending these meetings to deliver signposting and awareness training representing the following organisations:

- Carers Wales
- Alzheimer's Society
- Carers Wales
- Conwy Mind
- NEWCIS/Carers Outreach.

13.4 As well as external organisations providing signposting training to the champions, staff have asked if they could deliver service specific training to the group to help raise awareness of health board priorities.

13.5 We have continued to promote the benefits of champions in areas where there is little or no patient and carer champion representation. The Patient and Carer Champions have been a great asset in promote the use of CIVICA online patient feedback surveys and virtual visiting.

14. ACCESSIBLE HEALTH CARE

14.1 The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Patient and Carer Experience Team are working towards the aim of ensuring increased organisational awareness and compliance with the accessible healthcare standards.

14.2 Since August, the team have been focusing on the following key areas:

- In collaboration with BCUHB managers and staff, we have been working to review the content of the Sensory Loss Toolkit to ensure it continues to meet the needs of patients with sensory loss. As part of the review, it has been agreed that the toolkit will be stored on SharePoint and shortcut links downloaded onto health board owned iPads. This will help us to keep the toolkit up to date easily and accessible to all. Paper copies of the toolkit will also be available to wards/services on request.
- The Patient and Carer Experience Team continue to work jointly and successfully with mental health services, to explore accessibility to mental health services, for those with hearing loss. As part of the Toolkit review training going to be including a sensory loss mental health section that will include signposting to specialist support services. The patient and Carer Experience Service are also going to be amending their accessible health care training programme to include sensory loss mental health.
- Capturing patient stories with the focus on patients with sensory loss and their experiences of accessing health board services is a key priority. Discussions have taken place with services about how best to deliver training, share skills and resources to enable services to capture patient experiences.
- Following a High Court judgement, it has been requested that the Health Board should consider the use/greater use of easy read leaflets and photos or videos when providing care and treatment for patients with comprehension problems. To support this request the Patient and Carer Experience Team are going to develop an easy read guide for staff to follow when producing written information. The easy read guide will form part of the Patient Information Policy appendix. To help identify what easy read documents would best support patient's staff and services have been consulted. Once the easy read documents have been produced, these documents will be stored in a central library on the intranet for staff to access. This work will be completed over the next quarter.

CONCLUSIONS AND RECOMMENDATIONS

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

The QSE Committee is asked to note the report.



Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group
Chair of meeting or lead for report	Gill Harris, Executive Director of Nursing and Midwifery
Date of meeting	10 December 2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	01 March 2022
Presented by	Gill Harris, Executive Director of Nursing and Midwifery

1. Alert – include all critical issues and issues for escalation

- Patient story (Cheryl's story) – The Group reflected on this powerful story and requested a communications plan around chemotherapy card alerts to ambulance service and Health Board staff
- The Group noted staff pressures across the Health Board including the significant pressures arising from the expected winter pressures.

2. Assurance – include a summary of all activity of the group for assurance

- **Personal Protective Equipment (PPE) Group:** The Group noted differences in the Central hub from East and West, and asked for a review and agreement on a way forward to ensure Centre is in harmony with the other 2 sites.
- **Infection Prevention and control:**
 - The Group noted significant pressure created on isolation single rooms.
 - The group noted ventilation remains an issue due to estate – which is critical to reduce Covid spread.
- **Safer Medications Group:**
 - A defined audit timetable is lacking, and it is expected Divisions undertake own audits.
 - The Group are working with Medicines Management nurses to improve the policy and provide more assurance.
 - The group is reviewing safer storage of medicines to prevent waste, looking into including elements in Ward Accreditation.

- **Medical Devices Oversight Group:**
 - The group is to review policy on evidence based maintenance regarding medical devices, the service is working well and the annual review assured working safely.
- **Medical Gases Group**
 - Policy issues exist with progress made but a number are now due for review, the group are working with the Policy Manager, and there is a need for the policies to join up to make it easier for users to find what they are looking for.
 - Oxygen incidents – cylinder design was highlighted as a significant concern after an incident, the lead thanked GH for the letter to the supplier which triggered a meeting to discuss concerns.
 - Clarity around Porters changing medical gas cylinders was provided, and the group are developing a Standing Operating Procedure (SoP) that is in the final stages of approval.
- **Quality System Management:** Implementation is moving forward with the new systems (Datix and CIVICA).
- **All divisions provided a report to the group:**
 - **Secondary Care: Delay in Critical Care** refurbishment at Wrexham links with the ventilation issues. **HAPU'S** (Hospital Acquired Pressure Ulcers) – the Group requested more information if they are hospital/area or avoidable/unavoidable. **Never event** (Ophthalmology) at Abergele – no harm to patient. Rapid review identified staff had not followed the surgical site safety checklist properly.
 - **West Area: Lease agreement** - issue with one of the managed practice has been going on for 12 months and is affecting Estates ability to go in and undertake compliance issues. **Medication errors** – an increase around prescribing in Community pharmacies, and lack of locum cover, was noted.
 - **Central Area:** Limited capacity for level 3 PICU across England, currently the only bed available last night was in Sheffield, considerable distance to travel from North Wales. **Flu planning** in schools (nasal flu) has considerable challenges but progressing well.
 - **East Area:** Managed Practices - three serious incidents relating to managed practices, and Governance teams are supporting and working with them.
 - **Womens: CoCH** - Continuing concerns regarding quality assurance with the Countess of Chester, a meeting was arranged recently, unfortunately the data and quality outcomes information is still unavailable. **Anaesthetics department** – Epidural Catheter, action plan for learning included in Appendix 3, has been shared widely.
 - **Mental Health:** No representatives present
- **Death in Custody:** Prison and probation ombudsman is required to undertake an investigation of any death that occurs in a prison setting, HIW contribute a Clinical Review to the investigations. HB received a number of these reports from HIW, all actions were assured as completed. The Quality Assurance Team will be receiving all

of the reports in future and actions uploaded to Datix and monitored through to completion.

- **Resuscitation Team:** Looking to lease sites to address a venue issue in Central but in the meantime only able to offer intermediate life support level courses for Central, all advanced courses will run in the East and West. Linking with Estates and reviewing risk.
- **COVID-19 update:** An update was provided on the progress of the healthcare acquired COVID review work.
- **BCUHB Mortuary / Body storage unit initial security audit: November 2021:** Initial audits completed on the Acute sites. Issues identified under review, there is justification for a further piece of work to compile a more detailed action plan around systems and process.
- **Review of Ophthalmology Incidents:** A review has been undertaken of incidents where harm had been caused (permanent harm) and found 2 incidents had not been reported although they had been dealt with appropriately within the HB. Retrospectively reported monitored and tracked and DU happy with response.
- **Phlebotomy service:** The service is under pressure and there is a need to increase productivity.
- **7 procedural documents** were submitted for approval – all approved :
 - PRUDIC SoP document
 - SM003 Pregnancy Testing in the Substance Misuse Service
 - Creutzfeldt-Jakob (CJD) or variant Creutzfeldt-Jakob
 - IPC06 Infection Prevention Hand Hygiene Policy and Procedure
 - MM30 Procedure for the preparation, observation, assessment and supervision of non-registered practitioners (HCSW) to undertake the administration of insulin for clinically stable named adults in community nursing
 - Hypophosphataemia Management for Adults inpatients
 - NU03 Nurse Staffing Levels Policy

3. Achievement – include any significant achievements and outcomes

- **Infection Control :** success was noted regarding lateral flow for visitors being rolled out across the Health Board



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University Health Board

CEG Chair's Report to QSE

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	Clinical Effectiveness Group
Responsible Director	Dr Nick Lyons (report submitted by Chair of February 2022 CEG, Dr Conrad Wareham, as Deputy Medical Director)
Date of meetings	10 February 2022
Version number	1
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience (QSE) Committee
Date of meeting	1 st March 2022
Presented by	Dr Nick Lyons/Dr Conrad Wareham

1. Alert – include all critical issues and issues for escalation

It is acknowledged that some Clinical Effectiveness activity has been displaced by the high operational pressures related to the current Pandemic. The impact on Tier 1 Audit was reported within the Q3 Audit report and the completion of processes / finalised policies, which when complete will strengthen the Clinical Effectiveness delivery across BCUHB, has been slowed due to reduced staff availability, redeployment, and standing down / or scaling down of overseeing groups.

The February CEG meeting was not quorate, however discussion on agenda points did proceed, with no decisions made in the meeting. Items for decision will be circulated to members out of session with outline of in meeting discussion. This was important to start to restore business. Recognising that the meeting was not quorate post meeting business is being managed in line with advice from the Board secretariat.

NICE Implementation / Assurance

Issue:

Divisional, locality and corporate capacity to chase, assure and report NICE compliance remains a risk. While the outcome of Oct 2022 business case is awaited, the interim Head of Clinical Effectiveness is working with the Associate Director of

Patient safety to explore future joint working to deliver assurance at locality / operational level. However, the risk remains until extra capacity is available.

Explanation:

- There is insufficient Divisional, locality and corporate capacity to chase, assure and report NICE compliance. The NICE process is additionally not consistently owned / understood.
- Roll out of Audit Management and Tracking (AMaT) pilot to hospital sites originally planned for Q3 had to be stepped down due to operational pressures of COVID.
- Actions taken to date include:
 - NICE process mapped and SOPs developed to strengthen internal management and consistency.
 - Clinical oversight of the NICE process / dissemination has been increased
 - NICE policy has been redrafted to respond to learning and strengthen governance, it is subject to final consultation before ratification.
 - The Business case for additional staff resource to deliver NICE assurance at Locality and Corporate level was submitted in October, outcome awaited.
 - Reporting has been reviewed and strengthened to increase the visibility of compliance rates / to support targeted action by the accountable leads.
 - NICE is included within New Health Check meetings instigated Q3 by the Interim Head Clinical effectiveness to promote visibility and understanding of NICE requirements, in advance of holding to account.

The Terms of reference for the NICE Assurance Group have been reviewed / updated to include a broader group of MDT stakeholders (to provide essential link with senior nursing, risk management, contracting, and performance). These will be approved under the advice of the Board secretariat due to non quoracy.

Action:

Meeting not quorate. Meeting attendees therefore noted:

- Outcome of business case awaited
- NICE policy to be ratified as planned.
- Need to ensure progression of AMaT pilot and required staff resource to deliver this.
- Refreshed reporting approach which has increased the visibility of NICE compliance. Continued focus required.

Date of completion:

- Agreed under (acting) Chairs action - update to next CEG meeting, with formal review in 3 months.

2. Assurance – include a summary of all activity of the group for assurance

The agenda items are summarised below:

The following Chairs reports were received and included in the meeting papers sent to all members prior to the meeting.

- Strategic Delivery Group for Palliative and End of Life Care
- Pathology
- Reducing Avoidable Mortality Steering Group ·
- Medical Education · Mental Health & Learning Disability ·
- Drugs & Therapeutics Group ·
- NICE Assurance Group

The policies circulated in advance of the meeting for approval by consent will be managed under the advice of the Board secretariat due to non quoracy.

Standard Agenda Items

- Q2 Clinical Effectiveness Report (b/f December – for noting) & Q3 Clinical Effectiveness Report – for discussion
- Draft Clinical Audit Annual Plan 2022/2023
- Research & Development Update (verbal update)
- Quarterly Mortality Report (verbal update)

Feedback suggested further work on the following areas:


- NICE actions as above.
- Draft 2022/23 clinical audit plan was reviewed at the CEG, where it was agreed that it requires finalising and cross checking to ensure responds to key organisational priorities / risks. The plan will submitted to the QSE May meeting for ratification.

3. Achievement – include any significant achievements and outcomes

Clinical effectiveness resources have been developed and launched by the Clinical Effectiveness team to support Clinical Effectiveness capability / activity 2022/23.

These include a new Clinical Effectiveness Intranet page; launch of Lunch and Learn sessions targeted at key enabling skills (including action planning, understanding mortality indicators). Bespoke training sessions on Audit skills, NICE Guideline understanding; and AmAT training provide a timely response to identified learning needs. Weekly Clinical Effectiveness clinics and the establishment of (Clinical Effectiveness) Health Check meetings provide an additional layer of support at Divisional level.

Good progress has been made in relation to the Mortality review process in line with the All Wales model and progress will be addressed in a separate paper.

QSE 1 March 2022	<div style="text-align: right;">  <div> Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board </div> </div> <p style="text-align: center;"><i>To improve health and provide excellent care</i></p>
Advisory Group Chair's Report	
Name of Advisory Group:	Strategic Occupational Health and Safety Group
Meeting date:	1st February 2022
Name of Chair:	Peter Bohan Associate Director of Occupational Health Safety and Security
Responsible Director:	Sue Green Executive Director of Workforce and Organisational Development
Summary of key items discussed:	<p>Reporting of injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)</p> <p>A total of 22 RIDDOR reports were made to the HSE in Q3. These break down into the following:</p> <ul style="list-style-type: none"> • 14 incidents involving staff: 1 Needle-stick injuries reported as Dangerous Occurrences, 1 exposure via eye splash reported as a Dangerous Occurrence, 1 scald, 3 violence and aggression incidents, 5 musculoskeletal injuries and 3 slip, trip and fall incidents. • 7 patient related falls with Specified Injury • 1 visitor related fall with Specified Injury <p>HSE Update</p> <p>The HSE provided details of the planned inspections including the two material breaches in relation to manual handling requiring improvement notices. Prior to the COVID-19 pandemic the HSE announced their planned 'Inspections of Violence and Aggression and Musculoskeletal Disorders in Healthcare' programme. This is a national programme planned to examine management arrangements for violence and aggression (V&A) and musculoskeletal disorders (MSD's) at care providers in the public sector. Evidence available to the HSE indicates that assaults on staff and MSD's continue to be prevalent in this sector. The HSE inspection of BCUHB took place on 16th – 18th November 2021 and consisted of two inspectors, separately based in Ysbyty Gwynedd (YG) and Wrexham Maelor Hospital (WMH). The inspector on the</p>

	<p>WMH site was an Occupational Health specialist inspector and in addition to looking at MSK's and V&A she reviewed the COVID arrangements for the site. The inspector on the YG site had previously served an Improvement Notice on BCUHB in July 2021 for adult in-patient falls and she spent one of the three days reviewing the HB's progress on the YGC site. The HB were issued a Notification of Contravention letter after this inspection which gave eight areas of required improvements.</p> <p>Estates risk register</p> <p>Asbestos Management, Fire Safety and Water Safety remain on the Corporate Risk Register with a current score of 16. Waste Management requires reviewing as 80% of waste has been treated as clinical waste, this is costly and not efficient use of resources. This became an issue due to COVID management. Work is being undertaken to reduce clinical waste and re-establish the use of clear bags to increase the opportunity for recycling.</p> <p>Manual Handling Training</p> <p>The updated compliance report for 2021 has identified that Patient Handling refresher continues to decline with the Health Board now sitting at 50% compliant. Along with the current Improvement Notice, the Health Board is at significant risk of further enforcement action and this remains on the risk register as 16 extreme. Training facilities have now been procured for manual handling training and trainers recruited to ensure MH risk is reduced from the current level.</p>
<p>Key advice / feedback for the Board:</p>	<p>Wellbeing Cell Sub-group</p> <p>A report was circulated and described the pro-active work being undertaken to support staff including:-</p> <ul style="list-style-type: none"> • A tender process is taking place to seek external psychological counselling due to tendering regulations. They went out on 17th January and must be open for 30 days, until 21st February. • A business case is being submitted to seek recurrent funding for additional posts within the Wellbeing Support Services. • A communication strategy is being reviewed regarding the BetsiNet page for staff wellbeing, as this requires promotion across the organisation. Other ways of communication are being considered and developed. <p>Estates and facilities</p>

Estates and Facilities subgroups will now meet quarterly instead of bi-monthly as a return to business as usual. Risk registers have been reviewed and updates will be taken to Risk Management Group for ratification.

Occupational Health Report

An update was given on the Health Surveillance 12 month programme. Final flu results will be provided at the next meeting work continues on key areas of risk including immunisation, sickness absence reviews and pre-employment screening.

Health and Safety Reviews

Corporate Health and Safety reviews are required under the BCUHB Health and Safety Policy as part of the mandatory requirement to monitor H&S compliance. In Q1 of 2021/22 49 reviews were completed, 31 in Q2 and 28 in Q3. A review report is provided to managers to support with ensuring H&S compliance.

Health and Safety Training

Training via Microsoft Teams remained in place for Q3 including COSHH, risk assessment and RIDDOR along with a Manager's H&S Toolbox talk on a rolling four week programme. In Q3, 10 training courses took place with a total of 101 attendees.

IOSH Managing Safely courses have been booked to commence in Q4 and will be delivered by an external provider. IOSH Leading Safely courses will commence in Q1 2022/23. During this quarter, the team offered 101 orientation classes, 56 patient handling refresher classes and 13 inanimate load-handling refresher courses. Bespoke refresher training has been developed and trialled in Mortuary, Theatres, Estates and Facilities, Midwifery and the Emergency Departments. This training is now in line with the timings and content of the All Wales Passport and Information Scheme (Passport Scheme).

Security / Violence and Aggression incidents

In Q3, 911 incidents were recorded on Datix in comparison with 982 in Q3 2020 and 1068 in Q3 2019. All reports have been reviewed by the team and interventions provided in 572 of these incidents.

Fit Testing

Across BCUHB in Q3, the Health and Safety Fit Testing Team undertook 1,097 fit tests. Fit2Fit accreditation-The first member of the team has now achieved Fit2Fit accreditation enabling the team to deliver fit testing training to staff. In house training is being

	<p>developed to commence delivery in Q4. Following a further HSE Notification of Contravention, there was a requirement to ensure information and monitoring of correct use of respirators. A trial of respirator identification cards was successfully carried out and during Q3 printers for these cards were installed. A programme for issuing cards for all staff in high-risk areas who already have a current fit test will commence in Q4.</p> <p>CCTV Policy and EQiA</p> <p>The CCTV Policy and EQiA was ratified subject to minor amendments and required final sign off at QSE.</p>
Targeted Intervention Improvement Framework Domain addressed	Leadership (including governance, transformation and culture)
Planned business for the next meeting:	<ul style="list-style-type: none"> • A Project Security Lead has been appointed on a six-month contract to focus upon the security redesign project. A review of key areas of risks to be provided to the next SOSH Group and business case. • Review significant risks escalated from Estates Safety Groups ensuring adequate controls are in place. • Review Occupational Health and Wellbeing plan to provide additional support for the staff well-being agenda. • Review Union Partners and areas H&S Reports to provide assurance of progress against OHS objectives.
Date of next meeting:	

Disclosure:

Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board



Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Mandy Jones, Deputy Director of Nursing - Chair (on behalf of Gill Harris, Executive Director of Nursing and Midwifery)
Date of meeting	03.11.2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	01 March 2022
Presented by	Gill Harris, Executive Director of Nursing and Midwifery

1. Alert – include all critical issues and issues for escalation

- **Triple A reports from Divisions:**

- The overdue complaint investigation position was noted. Work is underway to recruit temporary additional complaint capacity who will be supporting services with the most need.

2. Assurance – include a summary of all activity of the group for assurance

- **Patient Story:** Vascular services - This story captured the process from initial screening to diagnosis and the delivery of aftercare. It was a positive reflection on the care provided by the ward staff and clinicians but also identified areas for improvement.
- **Bereavement Quality sub Group:** The Group have developed proposal for adoption of the Swan Bereavement Model. Further discussions are underway around identifying funding streams prior to submitting to Executives
- **Patient Communication and Readers Panels Sub-group:** a key priority of the Group is to ensure all Health Board leaflets have been through the correct process, to provide high quality accessible information and to develop the central library in the new Intranet.
- **CANIAD:** Patient feedback is positive and they feel they are listened to and treated with dignity and respect in partnership with the Health Board and also around decisions with their care.

- **Community Health Council:** Report submitted – the CHC requested assurance from the Health Board that the issues identified have been actioned around prepared food and allergens. The Assistant Director of Patient and Carer Experience is exploring a task and finish group which also links to recent feedback.
- **Healthcare Inspectorate Wales:** On-site inspections identified some issues being addressed, and some positives highlighted including staff interacting and treating patients with dignity and respect, patients felt safe and could speak to members of staff if needed to.
- **Ombudsman Complaints Lessons Learned Report:** This report was shared for learning and is related to a patient's poor experience. Clinicians were misdirected because they did not accept the patients statement that she was not self medicating. The Report will be shared for learning.
- **NHS Delivery Framework for Patient Experience:** submitted to Welsh Government, which provides evidence on how BCUHB is responding to service users experience feedback to help improve and redesign its services.

3. Achievement – include any significant achievements and outcomes

- The opening of new Dementia and Adult MH Centre Unit at Bryn Beryl was noted.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	NU06: The Prevention and Management of Adult In-patient Falls						
Cyfarwyddwr Cyfrifol: Responsible Director:	Mandy Jones, Interim Secondary Care Nurse Director						
Awdur yr Adroddiad Report Author:	Diane Read, Head of Quality Improvement (Corporate Nursing)						
Craffu blaenorol: Prior Scrutiny:	Clinical Policies & Procedures Group – August 2021 Document consultation portal – August 2021. Targeted MDT consultation to ensure MDT engagement – August 2021. Patient & Safety Quality Group – September 2021. QSE (by Chair exception) - September & December 2021.						
Atodiadau Appendices:	1. NU06 Policy 2. EQIA						
Argymhelliad / Recommendation:							
The Committee is asked to review the attached policy and ratify (for launch pan BCUHB March 2022).							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input checked="" type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						Y/N	
EQIA attached as appendices.							
Sefyllfa / Situation:							
BCUHB received an HSE Notice of contravention following an Inpatient fall. HSE highlighted failings that included non-adherence to the existing policy in terms of staff training (in particular completion and action taken following risk assessment completion), sharing of information of inpatient falls risk when clinical environments change. These areas were not within the existing policy to support staff with their delivery of care.							
Cefndir / Background:							
Following receipt of the HSE Notice a Multidisciplinary Working Group was formed to review / update the Policy. This amended policy has been shared for consultation as follows:							
<ul style="list-style-type: none"> • Pan BCUHB via communication channels and local networks; • Uploaded onto the "Draft Policies and Written Control Documents for Comment" Intranet page; • Presented to the Clinical Policies and Procedures Group on the 23rd August 2021; 							

- Presented to the Patient Quality & Safety Group for ratification on the 14th September 2021;
- Submitted to QSE Chair (via Chairs exception in September & December 2021).

Feedback (following above consultation) was then collated (to provide an audit trail should HSE require this), reviewed amended to reflect applicable feedback.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Please see appendix 2 (EQIA).

Opsiynau a ystyriwyd / Options considered

No further options considered as older version of policy unfit for purpose following receipt of HSE notice.

Goblygiadau Ariannol / Financial Implications

N/A

Dadansoddiad Risk / Risk Analysis

N/A

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Policy updated in line with HSE Notice.

Asesiad Effaith / Impact Assessment

Please see appendix 2 (EQIA).

The Prevention and Management of Adult In-patient Falls

Author & Title	<p>Diane Read, Quality Improvement Corporate Nursing Lead</p> <p>Steven Grayston, Assistant Area Director Of Therapy Services (Central)</p> <p>Mat Phillips, Regional Safeguarding Specialist For Adults/adults Living With Dementia</p> <p>Frances Millar, Head of Safeguarding Adults</p> <p>Erin Humphreys, Head of Nursing</p> <p>Susan Morgan, Head of Health & Safety</p> <p>Debra Hickman, Secondary Care Nurse Director</p> <p>Ceri Anne Jones, Lead Medical Pharmacist</p>
Responsible Dept / director:	Secondary Care Nurse Director
Approved by:	
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	<ul style="list-style-type: none"> • BCUHB Policy for Using Bed Rails Safely and Effectively MD07; • BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings MM17 • BCUHB Concerns Policy PTR01a • BCUHB Guidelines for Adult Patients Requiring Enhanced Observation and Engagement within Acute and Community Hospitals • BCUHB Levels of Enhanced Care for Adult Inpatients Policy NU21 • Dementia Care pathway • NICE National Institute for Health & Care Excellence Falls in Older People Quality Standard Published 25 March 2015 • Safeguarding Policy • Concerns Policy PTR01a <p>http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17</p>
Date of next review:	September 2022

Date EqIA completed:	August 2021				
First operational:	March 2022				
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. Introduction/Overview

Falls are the most frequently reported adult in-patient clinical incident and are a significant patient safety challenge for the NHS in Wales. There are more than 240,000 reported falls in acute hospitals and mental health trusts in England and Wales every year (that is over 600 a day) [*Royal College of Physicians. National audit of inpatient falls Audit report 2015. London: RCP, 2015.*](#) The effects of falls can range from no harm to serious injury and death. However, even those falls that do not result in serious physical harm can cause a great deal of distress, resulting in consequences that can threaten an individual's independence, confidence and general wellbeing. Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimise, not just the number of falls but also the associated complications and distress for the individual across all the health board wards.

2. Policy Statement

To ensure BCUHB incorporates the All Wales Falls and Bone Health Multifactorial Assessments (FBHMA) ([Appendix 1](#)) as part of the Nationally Standardised Adult Inpatient Assessment and Core Risk Assessments. This will be embedded through collaborative working and aligned to the All Wales Safeguarding Procedures to ensure the risk of all categories of harm (to all adult in-patients) caused by falls is minimised.

This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment and appendices are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care by care planning/ prevention interventions and management of Risk Assessment findings.

Definition of a fall

For the purpose of this policy, Falls are commonly defined as

“An event which causes a person to, unintentionally, rest on the ground or lower level, and is not a result of a major intrinsic event such as a stroke) or overwhelming hazard” NICE guidance Falls: applying All Our Health August 2017 and RCN www.rcn.org.uk/clinical-topics/older-people/falls.

3. Purpose

Health care professionals have a duty of care to minimise risks to their patients. BCUHB aims to take all reasonable steps to ensure the safety and independence of its patients, and respects the rights of patients to make their own decisions about their care following an appropriate framework to support this (where the person lacks capacity to do so independently the Mental Capacity Act 2005 would apply).

Inpatient falls are one of the most frequently reported incidents within BCUHB. The consequence of a fall can be more than a physical injury alone and can have a significant bearing on the individual's wellbeing and future options. Falls can be both a cause and a consequence of delayed transfer of care. Falls can impact someone's confidence not just in mobilising but in all independent tasks. There is a strong correlation between falls and age and as BCUHB's patient population increases in age and complex multi-morbidity, the challenge to reduce the number of falls (and the experience of harm from falls) is significant.

Adult inpatients on hospital wards may be at risk of falling for many reasons including:

- a history of falls;
- medically unwell;
- hypoxia (reduced oxygen levels);
- altered cognition including dementia or delirium;
- the effects of their treatment or medication;
- impaired mobility;
- visual and other sensory impairments along with their mental health and general wellbeing;
- Environmental disorientation.

Although most falls result in no physical harm or ongoing distress, falls do sometimes result in catastrophic injury, be that emotional or physical, including death. Some falls are a potential consequence of promoting patients autonomy and encouraging recovery of mobility after acute illness or surgery with positive measured risk management continuing to be encouraged.

The purpose of this policy is to ensure all preventative measures are known and in place where applicable, all falls are reviewed and information scrutinised with lessons learned shared across BCUHB for shared learning.

4. Aims and Objectives

The aim of this policy is to demonstrate our commitment to ensuring that our staff manage the optimal prevention of falls in the inpatient setting when caring for adult inpatients who may be at risk of falls and management of patients immediately post fall.

Many falls are preventable and therefore the objectives of this policy are to:

- Support person centered care planning (including advanced care decisions where applicable).
- Ensure that effective processes are in place for assessing patients (and therefore recognising those at risk of falls).
- Ensure the completion of the All Wales Falls and Bone Health Multifactorial Assessment ([FBHMA – Appendix 1](#)) on admission for all adult inpatients.
- Implement effective, timely, multi-factorial intervention which reduces the number of patient falls and subsequent injury to those who have fallen.
- Ensure a safe environment using effective assessment and intervention.

- Ensure effective assessment, management and rehabilitation for those who have fallen or those who are at risk of falling.
- Establish a multi-disciplinary approach to FBHMA and management.
- Support patients to remain independent, empowered and safe.
- Support the implementation of the All Wales Safeguarding procedures in relation to falls.
- Ensure a mental capacity assessment is undertaken upon admission, in order to understand the patients self-perception with regards to their mobility and ability to understand the risk of falls and consequences.
- Where there is a cognitive impairment of the mind or brain that is impacting on the patients ability to make a specific decision, a mental capacity assessment must be undertaken. For the patient to make a capacitous decision they must be able to understand, retain, use and weigh up the relevant information to make that decision. Any decision made on behalf of the patient should be done in their best interests and the interventions/restrictions that are identified as necessary to prevent harm must be achieved in a way that is less restrictive of the patient's rights and freedoms. The mental capacity assessment must be completed at the earliest opportunity (upon admission) and must be re-assessed throughout the hospital admission.

5. Scope

This policy applies to all staff involved in the direct or indirect care of adult inpatients regardless of grade or profession and includes bank, locum and agency. The policy provides all health care practitioners with a clear framework for safe and effective practice relating to the prevention and management of the risks of inpatient falls and sets out the standards and competencies expected when performing this role.

6. Roles and Responsibilities

6.1 Chief Executive

The Chief Executive has overall responsibility for strategic direction and operational management, including ensuring that BCUHB policies comply with the legal, statutory and good practice guidance requirements.

6.2. The Health Board

The Health Board has responsibility for setting the strategic context in which this policy will be implemented and the resources required for effective training.

6.3. Patient Safety and Quality Group (PSQG)

This Group has responsibility for monitoring the assurance framework and assuring the Health Board's compliance this policy.

6.4. Strategic Falls Group (SFG)

The SFG will monitor the delivery of the FBHMA ([Appendix 1](#)) and provide assurance to the Executive Management Group (EMG) via the Executive Director of Nursing and PSQG as a routine cycle of business regarding effective progress with implementation.

6.5. Local Senior Managers e.g. Directors of Nursing and Divisional Directors

Local Senior Managers are responsible for ensuring that:

- This policy is implemented and adhered to (across their services).
- Training or education needs are identified and met.
- Requirements for implementation of the policy are built into the delivery planning process.
- Staff have received, are aware of and comply with all relevant policies and supporting documentation.

6.6. Senior clinical leads, Heads of Nursing, Matrons and Ward managers:

Senior clinical leads, Heads of Nursing, Matrons and Ward managers are responsible for ensuring that:

- Processes and arrangements are in place to support the implementation of the policy via their operational structures across all clinical areas in the divisions.
- Related investigations are completed in the applicable timeframe stated within Concerns Policy PTR01a and themes and learning from serious incidents and that Root Cause Analysis investigations are disseminated.
- Staff within their area are aware of their role and responsibilities in relation to the FBHMA ([Appendix 1](#)).
- Staff are giving adequate time to complete mandatory Adult Inpatient Falls Training ([see section 13](#)).

6.7. Corporate Health and Safety Team

The Corporate Health and Safety Team are responsible for ensuring that:

- Accessible training is provided for employees.
- Training is compliant with Module E in the All Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme).
- Escalation if training resources are inadequate to meet the demands of the organisation.

6.8. All Staff

All staff, including bank, locum and agency staff, are responsible for:

- Compliance with the policy.
- Identifying a training need in respect of policies and procedures and bringing it to the attention of their line manager.
- All clinical staff whose role requires assessing all adult inpatients by completing the FBHMA ([Appendix 1](#)) and undertake interventions and signposting within their scope of practice.
- Working collaboratively with multi-disciplinary team members to manage individual FBHMA ([Appendix 1](#)) risk factors in accordance with the NHS Wales Governance e-Manual/Supporting Guidance Standard 2.3
<http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17>
- All clinical staff are required to escalate through Ward Manager / Matron / Head of Nursing any resource implications, which affect completion of the FBHMA ([Appendix 1](#)) in the clinical area.

- Ensuring that the local risk register is accurate and reflects risk, controls and assurances that are in place, to minimise the risk of harm from inpatient falls.
- Ensuring escalation of FBHMA ([Appendix 1](#)) and bone health related incidents and / or trends are reported, investigated and escalated in line with BCUHB Concerns Policy ([PTR01a](#)).

7.1 Falls Assessment Process

All adult inpatients must be risk assessed using the National standardised risk assessment tool FBHMA ([Appendix 1](#)) in the following circumstances:

- Within 6 hours of admission and on transfer to other clinical areas (for example, from the Emergency Department to Acute Medical Unit, Surgical Assessment unit or any other wards).
 - Following change of location within the ward (for example, adult inpatient moved / changed bed location from a shared bay area to side room).
 - Adult inpatient physical or cognitive condition has changed (for example, patient undergone anaesthetic; patient has developed an infection leading to delirium, changed mobility, changed mobility aid etc.).
- Weekly reassessment of all Adult in-patients using the FBHMA is mandatory (if no conditional change or ward location change or transfer between wards has required a reassessment previously).

An additional training (E learning module level 1b) to support completion of the Falls and Bone Health Multifactorial Assessment must be completed by Clinical staff responsible for risk assessing adult in-patients using the FBHMA ([Appendix 1](#)).

7.2 Falls Prevention

Once risk assessed, all adult inpatients **MUST** have the appropriate actions and interventions documented on the FBHMA tool ([Appendix 1](#)).

Mobility aids used by patients to support mobility / transfer must be within easy reach of the patient if able to mobilise independently.

Appropriate chair and bed heights should be used for adult inpatients according to their height and needs.

Bariatric adult inpatients will require specialist equipment (chairs/beds) and will require assessment for Manual handling equipment.

Call bells **MUST** be within easy reach of patient at all times. Orientation to the ward and surrounding environment **MUST** include a demonstration of how to use the call bell and patient observed using the call bell.

All patients at risk of falls **MUST** have a bed rail risk assessment completed within 4 hours admission to the ward. The bed rail assessment (Policy for Using Bed Rails Safely and Effectively: [MD07](#)) is contained within the BCUHB Adult Inpatient Risk Assessment booklet / documentation. This risk assessment informs the nurse when bed rails should be appropriately used or avoided (dependant on patient risk).

Lying and standing blood pressure must be performed on admission (if not contraindicated) to identify possible postural hypotension for all patients over 65yrs, for all patients following a fall and all patients presenting with Acute Kidney Injury (AKI). Refer to Royal College of Physicians Guidelines ([Appendix 2](#)) for taking a lying and standing blood pressure.

An underlying cause for postural hypotension should be investigated and discussed with the MDT and all actions documented in the patient medical records. The patient must be educated in steps to reduce the risk of falling as a consequence (e.g. sitting for a few minutes longer before standing).

At risk patients (where possible) should be nursed in the safest available location of the ward depending on clinical need and risk.

For at risk patients, staff are responsible for ensuring the patient has safe footwear when mobilising ([Appendix 3](#)). Patient's own well-fitting footwear is always the first choice in falls prevention. For patients who do not have access to safe footwear, double tread anti-slip socks must be provided by the area as a last resort for a short period **ONLY** (if family or carers cannot help with providing safe footwear).

All adult inpatients with a sensory deficit **MUST** have the details documented on the FBHMA ([Appendix 1](#)) and where able document discussion with patient and family / carers to ensure correct communication aids are available (such as correct glasses, hearing aids etc.). All communication aids **MUST** be within easy reach and cleaned appropriately. Visual checks can be undertaken at the bedside for patients who are uncertain of their visual acuity using the Royal College of Physicians instructions for bedside vision checks (see [Appendix 4](#)).

Wards with several at risk patients **MUST** consider cohorting these patients, to allow for optimum visibility of that group whilst avoiding any mixed sex accommodation breaches.

The member of staff appointed to a cohort area on the ward cannot leave the area until he or she has another staff member to take over. If the staff member responsible for observing a cohort patients is required to perform a duty which would prevent them from maintaining eye contact with their patients (e.g. to go behind curtains to attend to another patient, or assist a patient to the bathroom) wherever possible, they must inform another member of staff to ensure continuous observation is maintained.

If a member of staff needs to hand over the responsibility for observing to another member of staff the handover **MUST** be clearly communicated between the two members of staff.

The Enhanced Care Risk Assessment and scoring tool ([Appendix 5](#)) should be used, along with the clinical judgement of staff to aid decision making.

For those patients who do require enhanced observation who are able to mobilise to a bathroom/ toilet enhanced observation **MUST** continue to be adhered to throughout all aspects of care delivery.

For those patients with mental capacity (who refuse enhanced observation) risks **MUST** be discussed with the patient and family (if applicable) and documented in patient records.

BCUHB Intentional Rounding / SKIN Bundle supports regular patient reviews for assistance with care and environmental checks in terms of clutter, mobility, and call

bell access to the patient.

Nursing staff **MUST** provide patients with falls prevention educational information, and where appropriate then ask patients to teach back the key points. The provision of falls prevention education should be documented in the patient records. This process is repeated until the patient demonstrates comprehension and again if they have a fall.

For adult inpatient with a diagnosed Cognitive Condition the BCUHB Dementia Pathway ([Appendix 6](#)) **MUST** be adhered to.

At the earliest opportunity (following admission) in discussion with the Patient and / or family / carers the 'This is me' document ([Appendix 7](#)) **MUST** be completed or reviewed/updated.

An alert symbol **MUST** be placed on the board above the bed, communicated on handover and ward safety brief ensuring all those involved in the patient's care are aware of their risk of falling. Alert symbols are contained within the [Ward Accreditation E handbook to support MDT Communication](#).

Medical Staff are responsible for checking if patients have received a medication review by GP annually, and ensuring a timely medication review by pharmacy colleagues is completed (following inpatient admission) to ensure analysis and review of medications that may contribute to patients risk of falling. This can be evidenced in the patient medical records (preferably at clerking or at the first opportunity to clarify patient's medications with carer or GP).

Medical staff are responsible for ensuring a cardiovascular review is conducted. The outcome of the reviews and actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patients medical record.

Medical staff are responsible for ensuring undiagnosed or acute confusion is investigated, treated and documented within the patient records. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical record. The BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings ([MM17](#)) should be considered.

Medical staff are responsible for ensuring an eyesight or hearing assessment. If more comprehensive or sophisticated assessment is required, referral to Ophthalmology or Audiology must be considered. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical records.

In line with assessment actions (once a referral is received by Therapy Services) the physiotherapist is responsible for ensuring a mobility review is undertaken. Any actions required **MUST** be discussed with the multidisciplinary team and clearly documented in the patient's medical records.

The Registered Nurse is responsible for ensuring the All Wales Continence/Toileting Risk Assessment is completed within 4 hours of admission to the Ward.

All staff are responsible for ensuring the environment, including bed spaces and main patient walkways remain clutter free at all times.

All staff are responsible for ensuring that drinks, call bells, mobility aids and personal belongings, including spectacles and/or hearing aids if required, are left within in easy reach of the patient on completion of care. Consideration **MUST** be given to patient's

normal home routines for example bedside table on the left hand side of bed at home positioning of bedside table on left hand side as an inpatient.

On transfer of care from one clinical area (ward or department) to another (including the Emergency Department and Critical Care) a transfer / handover document (SBAR form) **MUST** be completed in adherence to Patient Transfer Policy NU19. Any Adult inpatient with an identified falls risk **MUST** be clearly communicated to the receiving clinical area/department. The FBHMA ([appendix 1](#)) **MUST** then be reassessed and updated by the receiving ward for all Adult inpatients.

All Staff to promote activity (where possible) to prevent deconditioning of the patient by encouraging participation and independence with activities of living such as washing, dressing, walking, standing and maintaining hydration and nutrition ([PJ Paralysis Campaign](#)).

If a patient has a potential or confirmed infection risk requiring isolation precautions in a side room (and has in addition been identified at an increased risk of falls), a multidisciplinary team (MDT) discussion of all risks should take place using clinical judgement to determine the risk for closure of the side room door. Advice can be sought from Infection Prevention Team. Prevention strategies **MUST** be put in place to mitigate any risk for the patient and the clinical area. The Registered Nurse **MUST** document rationale for side door to be open in patient records.

Falls medication review to be completed by ward pharmacist (dated and signed). This should include a review of the patient's social history, anticholinergic burden score, antipsychotic use etc. The review and actions **MUST** to be documented in the patient medical records.

For Patients who have history of fractures and possible Osteoporosis an MDT review and further investigation/screening maybe required, the review and actions **MUST** be documented in the patient medical records.

For Women within our Maternity inpatient areas (following an epidural for a planned or emergency Caesarean Section) the Registered Midwife **MUST** adhere to the guidance outlined within the BCUHB Integrated Care Pathways (ICP) for BCUHB Planned Caesarean Section ICP or BCUHB Emergency Caesarean Section ICP.

7.3 Post Falls Management

A registered practitioner **MUST** undertake appropriate action in the event of a patient fall. The post fall procedure **MUST** be followed immediately following a fall ([Appendix 8](#)) the post fall procedure should be available on view for all staff to access easily.

The correct Manual Handling Equipment **MUST** be accessed and used once the patient is safe to move from the floor to a place of safety.

Once the patient is safe and clinically stable the BCUHB Post Falls Checklist ([Appendix 9](#)) will support further on going actions to reduce the risk of another fall.

All staff on duty at the time of the inpatient fall (including members of the MDT), **MUST** complete the Hot Debrief to identify opportunities for learning and making it safe in

preparation for ward handover and safety briefs, once the patient is safe and comfortable.

In the event of an inpatient fall, a full review of FBHMA ([Appendix 1](#)) and updated interventions **MUST** be documented and actioned.

All inpatients post fall **MUST** be referred to the ward pharmacist for a further medication review. The Pharmacist **MUST** document all action points within the patient medical records.

All patient falls **MUST** be reported through the Health Boards' incident reporting system: [Datix](#).

All falls should be identified on the local measles map ([Appendix 10](#)) of the ward if applicable to that in patient area to support local Quality Improvement.

All falls of moderate harm and above are reviewed by a daily panel led by the Corporate Patient Safety Team which will identify those falls that meet the threshold for a serious incident investigation (i.e. severe, permanent harm or death). All serious incident investigations are scrutinised at a Corporate Incident Learning Panel. This panel provides senior, objective scrutiny and again provides a forum for themes or hot spots to be identified. These forums are in addition to divisional level harms panels which review harm on a weekly basis led by senior clinical staff.

Patient falls identified as a 'work-related accident' and result in a specified injury for example a bone fracture (excluding digits), or unconsciousness, are reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). A full list of specified injuries can be found on the HSE website: <https://www.hse.gov.uk/riddor/specified-injuries.htm>

For a patient fall to be identified as work-related, one of the following must have played a significant role: either the way the work activity was carried out; or if any failure of equipment or the condition of the site or premises was contributable. The statutory timescale for reporting this category under RIDDOR is up to ten days from the date of the fall. The patient's name, date of birth, address and postcode should be detailed on the Datix at the time of completion. All RIDDOR reports are made to the HSE via the HSE Website by the Corporate Health and Safety (H&S) Team. Therefore, if a patient fall results in a fracture (excluding digits) or unconsciousness, the RIDDOR box on Datix should be ticked so that the Corporate H&S Team is alerted and the initial investigation report should be uploaded onto the Datix report within three days of the date of the fall. The initial investigation report should include information in relation to the falls risk of the patient, whether the assessment of this risk had identified a requirement for mitigation and if so, whether this mitigation was in place at the time of the fall. It should also include details regarding the environment where the fall occurred and of any equipment involved. It is important that this three day timescale is met, to ensure enough time to for the Corporate H&S Team to review this information, make further enquiries if necessary and to report appropriately within the ten day statutory timescale. Any death that may be attributable at least in part to a fall should be referred to the Coroner ([Coroners and Justice Act 2009](#)).

7.4 Monitoring & Compliance

Falls incident data will be analysed and any trends, patterns or lessons learned will be shared across the organisation via the Fall's Steering group, local Falls prevention groups, Quality and Safety groups and Local Professional Forums.

Monitoring for compliance with completion of the FBHMA and required falls prevention interventions will be undertaken on a monthly basis using the Ward Manager and Matrons metrics.

Monitoring of compliance for the post fall procedure and handover process of patients deemed at risk of an inpatient fall will be undertaken on a monthly basis using the Ward Manager and Matrons metrics.

All data will be available for public view on the patient safety notice boards on entering or within inpatient wards.

7.5 Patient Transfer

Prior to any transfer (internally or externally) it is the responsibility of the Registered Nurse looking after the patient to ensure that transfer is safe, comfortable and dignified for patients. The Safe Transfer Guidance NU19 supports the transfer of patients. The Registered Nurse **MUST** complete the SBAR handover document with the receiving Clinical area/ward ensuring clear communication of the Falls risk of the patient before transfer.

For all transfers to a ward to continue the patients management of care the receiving ward **MUST** update the FBHMA ([Appendix 1](#)) within 4 hours of the patient being received.

7.6 Patient Discharge

For patients who have had a fall whilst an inpatient (or deemed at risk of further falls on discharge) the Allied Health Professional / Registered Nurse / Medical Staff are responsible for working towards agreed interventions to help safe discharge to prevent further falls. From this agreed holistic discussion, include any safety advice / environmental improvements / lifestyle / specific written advice / leaflets or any follow up required by the relevant primary care / domiciliary members (where appropriate). This should involve notification to GP practice of the risks and interventions, including clear recommendations or actions for onward monitoring, support, or input from additional community MDT services (where appropriate).

All discussions and outcomes **MUST** be documented in the patient record and discharge letter as appropriate prior to discharge.

8.1 Safeguarding

The [Social Services and Well-being \(Wales\) Act \(2014\)](#) has 11 parts. Part 7 relates to safeguarding. The provision in part 7 requires Local Authorities to investigate where they suspect that an adult or child is at risk of abuse or neglect.

Section 126 (1) of the Act defines an “Adult at Risk” as an adult who:

- a) Is experiencing or is at risk of abuse or neglect;
- b) Has needs for care and support whether or not the authority is meeting any of those needs;
- c) As a result of those needs is unable to protect him or herself against the abuse or neglect or the risk of it.

Definition of neglect:

“Neglect’ means a failure to meet a person’s basic physical, emotional, social or psychological needs, which is likely to result in an impairment of a person’s well-being (for example: impairment of the person’s health or, in the case of a child, an impairment of the child’s development).”

The Act imposes a duty on relevant partners, (which will include Health Boards and Trusts) to report to a Local Authority if there is reasonable cause to suspect that an adult or child is at risk.

The Wales Safeguarding Procedures 2019 provide guidance for anyone working with children and adults in Wales, whether in a paid or unpaid role, in the statutory, third (voluntary) or private sector, in health, social care, education, police, justice or other services. The Wales Safeguarding Procedures 2019 builds on statutory guidance in the Social Services and Well-being (Wales) Act 2014, Part 7 Safeguarding and specifically Working Together to Safeguard People: Volumes: 5 and 6. They ensure that safeguarding practice accurately reflects statutory guidance and is standardised across agencies in Wales. They replace the All Wales Child Protection Procedures 2008 and Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse 2010 (updated 2013)

8.2 Safeguarding: What to consider for In-Patient Falls

A fall can be reportable under the adult at risk process when there are concerns there is abuse or neglect linked to it. There could be concerns that the fall occurred because of abuse or neglect (including self-neglect) or that care and treatment following a fall was abusive or neglectful. You will need to decide whether any of the following categories of abuse apply:

- Neglect: Person(s) responsible for the care and support needs (whether paid/unpaid) did not carry out their responsibilities as expected before or after the fall. This would include unwitnessed falls when patient is on observation, multiple falls of same patient when no clear review has taken place.
- Organisational abuse: The fall occurred because of wider systemic failures within an organisation.
- Physical abuse: Someone pushed/tripped/struck the adult which resulted in the fall.
- Self-neglect: The fall occurred because of a lack of self-care, care of one’s environment or a refusal of services. Mental capacity will be a key consideration in these cases and MUST to be clearly documented in the patients records.

- Psychological / emotional: Person(s) responsible for the care and support needs (whether paid/unpaid) and or other individuals not involved in the provision of care removing mobility or communication aids or intentionally leaving someone unattended when they need assistance. Also intimidation, coercion, harassment, use of threats, humiliation, bullying, pre or post fall.

It is required that you contact your designated safeguarding person (Safeguarding Specialist) for all adult at risk concerns. The need to seek advice should never delay any emergency action needed to protect an individual or group. Contact details can be found here: [Betsi Cadwaladr University Health Board | Contact the Safeguarding Team \(wales.nhs.uk\)](https://www.betsi-cadwaladr.nhs.uk/contact-the-safeguarding-team)

9. Equality Impact Assessment including Welsh Language

This document is subject to an Equality Impact Assessment (EqIA) completed alongside the development of the document, reviewed by an expert group of multidisciplinary team members and submitted at time of document approval as part of the organisation's governance framework.

10. Training & Implementation

All BCU Health Board staff **MUST** complete the Mandatory Level 1a Adult Falls Prevention Awareness training on ESR. This training **MUST** be completed every 2 Years.

Additional training for all Clinical staff (whose role requires assessment of Adult In-patients using the FBHMA) **MUST** complete level1b on ESR this includes instruction on how to complete the FBHMA and additionally the care and management of an Adult patient following an in-patient fall.

In addition all Clinical staff **MUST** complete face to face (classroom based) training for Manual Handling every 2 years, This training is referred to as Module E, this will contain an overview/recap of the FBHMA completion, care of the patient who maybe falling / fallen / collapsed this training is in line with the All Wales NHS Manual Handling Training Passport and Information Scheme (Passport Scheme) which incorporates training on the prevention of falls along with the organisation's Post Falls Procedures.

This training **MUST** be completed before a new employee commences in post where they may be moving / handling a patient and then every two years as part of their Patient Handling refresher training.

Both level 1 and level 2 will be recorded on the Electronic Staff Record in line with the mandatory training policy ([WP30](#)) with a competency attached for Organisational and management review of compliance.

The Person Specification to ensure competent trainers can be found in the All Wales NHS Manual Handling Passport Scheme.

All Clinical staff MUST complete mandatory Level 2 Adult Safeguarding training; an element of the training will include post Falls management.

11. Implementation

This policy will be cascaded via all electronic communication channels across BCUHB for all staff, verbally via the quality and safety groups Board to ward level. Specific launch events for Falls Prevention. The policy will also be accessible to the public via the BCUHB internet site.

12. Further Information - Clinical Documents

This Policy has been developed by an expert Multidisciplinary Team who reviewed current evidence and Organisational policies that are required to be reviewed in line with this policy. The evidence base provided for this policy. Includes:

- [NICE Quality Standard Falls in older people](#)
[State of the nation – Wales report Royal College of Physicians](#)

This policy has been developed with the specific needs of the older adult in mind in addition to all Adult inpatients with specific consideration for inpatients with confirmed diagnosis of Dementia.

13. Audit

Adherence to this policy will be subject to Audit and routine monitoring of key sections such as completion of the FBMHA, interventions and post fall management through the established weekly and monthly Health Board wide Ward Manager and Matrons metrics. These metrics are a Health Board requirement for all Adult inpatient wards. Data will be shared monthly with the Strategic Inpatient Falls steering group and as a routine cycle of business for PSQG.

14. Review

This document will be reviewed following a period of 3 years (or sooner if national evidence / research available).

15. References

- SA01 Adult at Risk Safeguarding Procedures;
- Wales Safeguarding Procedures 2019;
- NICE Quality Standard Falls in Older People March 2015;
- <http://www.wales.nhs.uk/governance-emanual/health-and-care-standards-supporting-gui-17>
- Cochran review

16. Appendices

<u>Appendix 1</u>	<u>Fall and Bone Health Multifactorial Assessment</u>
<u>Appendix 2</u>	<u>Measurement of lying & standing Blood Pressure (RCP)</u>
<u>Appendix 3</u>	<u>Falls Prevention and Footwear</u>
<u>Appendix 4</u>	<u>Bedside Vision Check for Falls Prevention (RCP)</u>
<u>Appendix 5</u>	<u>Enhanced Care Risk Assessment & Risk Scoring / Plan of Care: Appendix 1: Levels of Enhanced Care for Adult Inpatients Policy: NU21 (page 15, 16 +17)</u>
<u>Appendix 6</u>	<u>Care Pathway for Patients with a diagnosis of Dementia on General Wards (Acute & Community Hospitals)</u>
<u>Appendix 7</u>	<u>This is Me (Alzheimer's Society)</u>
<u>Appendix 8</u>	<u>Immediate Post Fall Protocol</u>
<u>Appendix 9</u>	<u>Post Fall Checklist updated version</u>
<u>Appendix 10</u>	<u>Falls Measles Map (example only)</u>



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University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

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

<u>For:</u>	<i>NU 06 The prevention and management of Adult In patient falls</i>
<u>Date form completed:</u>	<i>9th August 2021</i>



PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Updated NU 06 The prevention and management of Adult In patient Falls
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimize, not just the number of falls but also the associated complications and distress for the individual across BCUHB. This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment, identified risks and the evidence based interventions and care planning that are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care. The policy and the appendices contained within it have been assessed in terms of the potential negative impact the policy and the appendices may have on equality of our Adult In patients.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	As per the Policies' on policies approval guidance, final approval will be via the Quality and Safety Executive Committee
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<p>The existing policy (NU06) will have been subject to Equality Impact Assessment. This was not able to be located and as the current NU06 has been reviewed and updated a new Equality Impact Assessment has been completed.</p> <p>Other policies that are related to (and influenced by) NU06 The Prevention and management of Adult Inpatient falls are as follows:</p> <ul style="list-style-type: none"> • BCUHB Policy for Using Bed Rails Safely and Effectively MD07;

Part A

Form 1: Preparation

Please answer all questions

		<ul style="list-style-type: none"> • BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings MM17; • BCUHB Concerns Policy PTR01a; • BCUHB Guidelines for Adult Patients Requiring Enhanced Observation and Engagement within Acute and Community Hospitals; • Dementia Care pathway; • NICE National Institute for Health & Care Excellence Falls in Older People Quality Standard Published 25 March 2015; • Safeguarding Policy.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	<p>The policy key stake holders are all BCUHB staff with specific reference to clinical staff.</p> <p>Communication strategy for the Policy includes launch events, local groups BCUHB bulletin, social media, local and BCUHB forums.</p>
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	<p>Lack of engagement from staff with the training.</p> <p>Lack of time for staff to access level 1 training on ESR and level 2 for clinical staff face to face training 2 yearly as part of manual handling update.</p>
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	<p>The policy covers all aspects from assessment to evidence based interventions for all Adult inpatients and provides clear instructions that must be followed by BCUHB staff who are responsible for assessment of Adult In patients.</p> <p>The policy also provides clear instructions to follow post fall of an Adult inpatient. The policy provides clear patient safety instructions to ensure all Adult in patients receive the same evidence based care promoting equality of care for everyone.</p>

Part A

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

Please answer all questions

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

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

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

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

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

Part A

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

Please answer all questions

Protected characteristic or group	<p>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"</p> <p>You can also visit their website here</p>	<p>How will you reduce or remove any negative Impacts that you have identified?</p>
<p><i>Guidance for Completion</i></p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

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

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age	Yes		Yes		<p>NU06 The Prevention and Management of Adult Inpatients Falls is specific to all Adult inpatients and will have a positive impact on their experience as it is evidence based interventions and assessment to maintain patient safety.</p> <p>This reviewed policy is more comprehensive and user friendly with clear interventions for HB staff to adhere too. The policy includes the requirements for training and this will have a positive impact on our older adults.</p> <p>Evidence base includes NICE Quality Standards.</p>	Not applicable
Disability	Yes		Yes		<p>NU06 will have no negative impact on inpatients with a disability however; the policy outlines the clear completion of the risk assessment tool that MUST be completed on admission for all adult in patients. This has specific consideration for assessment and intervention for Adult in patients with sensory deficit, mobility and cognitive related conditions whilst promoting the individuals level of independence. Evidence demonstrates that people with</p>	Not applicable.

Part A

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

Please answer all questions

				<p>physical impairment and sensory impairment are more likely to fall, therefore thorough assessment and interventions and actions taken and outlined within the policy will have positive impact.</p> <p>In addition there is a positive impact in the mental health and wellbeing of both older and disabled people through reassurance that the risk of falls is being positively addressed by the Health Board as evidence indicates falls can lead to loss of confidence, fear of falling loss of independence and increased risk of isolation.</p>	
Gender Reassignment		NO		<p>There is no negative impact identified for staff or patients in terms of Gender reassignment. The policy has been updated using gender neutral language. The policy references only once gender specific term as women on the maternity unit following Caesarean Section.</p>	Not applicable
Pregnancy and maternity		NO		<p>No negative impact on pregnancy or maternity, NU06 references the care and safety of women following an epidural following emergency and planned Caesarean section in terms of preventing falls.</p>	. Not applicable
Race		NO		<p>There is no negative impact on race, language used in the policy is neutral.</p>	Not applicable

Part A

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

Please answer all questions

Religion, belief and non-belief		NO			This policy has no negative impact on staff or patients from any faith community, non-belief background. The policy does not impact any rituals or philosophical beliefs. Staff are able to maintain their staff uniform in line with BCUHB uniform guidance when complying with this policy.	Not applicable
Sex		NO			The assessment is that there is insufficient evidence to determine that this policy has a negative impact upon staff or patients in terms of being male or female. The evidence used for this policy development references Older people as opposed to male or female: NICE Quality Standard Falls in older people highlights Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year. State of the nation Wales report 2020 states there are approximately 12,500 inpatient falls in Wales each year in total highlighting the magnitude of the need to prevent falls regardless of male or female.	Not applicable
Sexual orientation		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to patient sexual orientation.	Not applicable
Marriage and civil		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to a patient's marital status.	Not applicable

Part A

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

Please answer all questions

Partnership (Marital status)						
Socio Economic Disadvantage		NO			This policy will not negatively impact individuals following assessment using the Socio Economic Duty criteria/guidance.	. Not applicable

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

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
Yes		Yes		Article 8 UN convention on the rights of people with disabilities	The policy applies equally to all patients with an emphasis on assessment and planning discharge in accordance with article 8 of the Human Rights Act 1998. The policy also considers in more detail the rights of people (Adults) with disabilities for preventing and managing their risk of falls whilst as an in-patient within BCUHB.	Not Applicable

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

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	Yes		Yes		Once approved, this policy will be submitted for translation, all posters or checklists for staff will be translated. All public / patients information leaflets are available in the welsh language.	No negative impact identified
Treating the Welsh language no less favourably than the English language		No			Once approved this policy will be submitted for translation.	No negative impact identified

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>A full consultation was done with the MDT Steering group.</p> <p>Policy review and development group was full MDT including H & S colleagues.</p> <p>First draft of the policy shared via the consultation portal between 28.06.21 to 28.07.21.</p> <p>Feedback to be received on both the policy and the EqIA as the documents progresses through the approval groups with multi-disciplinary representation.</p>
<p>Have any themes emerged? Describe them here.</p>	<p>Consideration for Women on maternity following epidural to be included.</p> <p>Review and access to staff training.</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>Additional narrative referencing the BCUHB Integrated Care Pathway (ICP) For women requiring an Emergency Caesarean section and women requiring a Planed Caesarean section.</p> <p>Development of robust training package clearly outlined for all BCUHB staff, levels of training reflect the level of clinical responsibility for Adult in patients.</p>

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1)
for further direction on how to complete this section please click [here training vid p13-18](#)

Copy from Form 1

Updated NU 06 The prevention and management of Adult In patient Falls

2. Brief Aims and Objectives:
(Copy from Form 1)

Betsi Cadwaladr University Health Board (BCUHB) has reported an increasing picture of falls and falls with harm and as such it is timely to ensure the necessary safeguards are in place and being carried out to minimize, not just the number of falls but also the associated complications and distress for the individual across all health board. This policy describes the risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment, identified risks and the evidence based interventions and care planning that are to be used to deliver safe and effective care by maintaining a safe environment and effective management of risks of patients falling whilst in our care. The policy and the appendices contained within it have been assessed in terms of the potential negative impact the policy and the appendices may have on equality of our Adult In patients.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**

Yes



No



Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	<p>The assessment of the policy and the appendices has not identified any negative impacts in terms of equality.</p> <p>The policy has a positive impact on care of our patients in terms of prevention and management of falls with Adult in patients with a sensory deficit, mobility or cognitive conditions.</p>		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes <input type="checkbox"/>	<input type="checkbox"/>	
	<p>The assessment process has not identified any minor negative impacts.</p>		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
	How is it being monitored?	<p><i>Monitoring of the risk assessment compliance and quality of completion, staff training, compliance with post fall management and incidence of Adult In patient falls will take place weekly and monthly as part of the suite of Ward Accreditation metrics which are</i></p>	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

implement your policy or proposal?		<p><i>captured via the IRIS electronic system which is well established within the In patients areas for the past 2 years.</i></p> <p><i>The metrics to monitor the policy in greater detail will be additional metrics within this system.</i></p>
	Who is responsible?	Ward Managers for data collection via Ward Accreditation metrics
	What information is being used?	Data will be on display within In patient areas (wards) to support quality improvements, data will be shared at local Quality and Safety groups, Strategic Falls Steering group and Patient Safety and Quality Group. Existing reports will be strengthened with the additional metrics. In addition Data will be used as part of the In patients Falls learning panels.
	When will the EqIA be reviewed?	The EqIA will be reviewed at the same time as the policy requires a review.

7. Where will your policy or proposal be forwarded for approval?	Patient Safety and Quality group and Quality and Safety Executive Committee.
--	--

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity Senior sign off prior to committee approval:	Name	Title/Role
	Diane Read	Quality Improvement Team Lead Corporate Nursing
	Steven Grayston	Assistant Area Director Of Therapy Services (Central)
	Debra Hickman	Secondary Care Nurse Director
	Debra Hickman	Secondary Care Nurse Director
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No negative impacts identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None ,		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Not Applicable.		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	<i>Not Applicable.</i>		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	None		



IPC06

INFECTION PREVENTION HAND HYGIENE POLICY AND PROCEDURE (An Element of Standard Infection Control Precautions)

Author & Title	Samantha Walker Clinical Service Lead Infection Prevention and Control East				
Responsible Dept / director:	Ms Gill Harris Executive Director of Nursing & Midwifery Betsi Cadwaladr University Health Board				
Approved by:					
Date approved:					
Date activated (live):					
Documents to be read alongside this document:	IPC03 Standard Precautions Procedure IPC31 Aseptic non-touch technique procedures COVID-19 Toolkit				
Date of next review:	April 2024				
Date EqlA completed:	April 2021				
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Changes made yes/no:	Yes	Yes			



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1. Hand Hygiene Policy – At a Glance

Hand hygiene is the most important activity to prevent the spread of infection.

The point of care is the crucial moment for hand hygiene.

Hands must be cleaned immediately before any patient care activity.

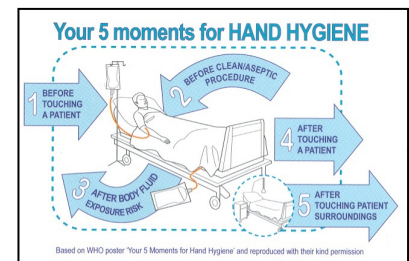
Wearing gloves does not replace hand hygiene.

Hands must be cleaned before patient care even if gloves are worn, and immediately after gloves are removed.

All staff must ensure that that they perform correct hand hygiene when required and encourage others to do so.

How and When?

- Routine hand hygiene must be performed:
 - Before and after patient contact
 - After removal of gloves/Personal Protective Equipment (PPE)
 - Between tasks on the same patient
 - Before a clean or aseptic task
 - After contact with the patient environment
- The highest likelihood of transmission of microorganisms from the hands of healthcare workers to service users is at the point of care.
- Alcohol hand rub is convenient, suitable and effective in almost all situations; **however**
- **HAND WASHING** with liquid soap and water must be carried out:
 - When hands are visibly contaminated or dirty
 - When patients have diarrhoea and/or vomiting
 - When patients are known or suspected to be infected with a spore forming organism (e.g. *Clostridium difficile*) or norovirus
 - As indicated, when donning/doffing personal protective equipment for specific infections e.g. COVID-19 infection
- Hand hygiene with both soap and water and alcohol hand rub should be carried out using the accepted six stage technique.



Bare Below the Elbow

- All staff are expected to be suitably dressed for clinical practice and be Bare Below the Elbow (BBE). Long sleeves and hand/wrist jewellery obstruct correct hand hygiene technique and increase the risk of cross-infection.
- This includes in areas where long sleeved gowns (Level 2 PPE) are required to be worn sessionally e.g. in critical care areas, high risk respiratory areas.



Skin Concerns

- Any member of staff with skin problems associated with hand hygiene must notify their line manager and discuss treatment and prevention with the Occupational Health Department and their General Practitioner.

2. Introduction

Hands are the most common way in which microorganisms, particularly bacteria, are transmitted to, and cause infection in, patients. Effective hand hygiene prevents the spread of microorganisms, reduces the risk of infection to patients and helps to protect staff. It is considered to be the **single most important practice** in reducing the transmission of infectious agents and preventing subsequent development of HealthCare-Associated Infection (HCAI).

Every human being carries large numbers of microorganisms. Most are harmless but many have the potential to cause infections in vulnerable people. It must always be assumed that every person encountered could be carrying potentially harmful microorganisms that might be transmitted to others. Hand hygiene to help prevent this is one of the eleven elements of Standard Precautions; undertaking it is an essential element of ensuring everyone's safety.

All of the steps detailed in this policy/procedure assist in ensuring hands are as free from contamination as reasonably practicable and therefore carry a minimal risk of causing infection.

The term hand hygiene used in this document refers to processes carried out to reduce the bioburden of microorganisms on the hands. These include hand washing and hand decontamination achieved using other products such as alcohol-based hand rub. Supporting evidence and literature is listed in the reference section of this policy; this includes documents and guidance issued by the National Institute of Clinical Excellence, World Health Organisation, National Infection Prevention and Control Manual for Wales and Scotland, and Evidence-based Practice in Infection Control Guidelines.

Microorganisms on the hands can be classed as 'transitory' or 'resident'. Transitory microorganisms are easily acquired and transmitted, and are most likely to cause healthcare-associated infection; routine hand hygiene is intended to remove these organisms to prevent this transmission and routine hand hygiene at the times specified in this policy is the minimum required.

More rigorous hand hygiene procedures are required when carrying out more invasive procedures in order to also reduce the number of resident organisms and further reduce the risk of infection. Different hand hygiene procedures may therefore be required depending on the procedure to be carried out and known or suspected hazards and risks to the member of staff and the person being cared for.



3. Purpose

This policy is to ensure that all staff perform hand hygiene optimally and effectively to reduce infection risk to patients. The policy will be used in conjunction with other Health Board policies that contribute to the prevention and management of infection and its spread.

4. Scope

This policy applies to all services directly provided by the Health Board and all staff should familiarise themselves with the requirements contained within it.

Please note that this policy can be made available in different formats should this be required.

5. Responsibilities

5.1 Managers/Clinical Directors Must:

- Set a good example by complying with the policy themselves and supportively challenging poor practice in others.
- Ensure that all staff receive instruction/education on the principles of hand hygiene.
- Ensure that an up-to-date, evidence-based hand hygiene policy is easily available to all staff.
- Ensure that adequate resources are in place to allow for the recommended infection prevention measures, such as hand hygiene, to be implemented. This includes liaison with the estates/maintenance staff, General Practitioner (GP) partners, Dentists, Care Home owners, etc in relation to hand hygiene facilities such as sinks and safe access to hand sanitiser.
- Ensure that community-based staff are signposted to locations of hand hygiene products and disposable single use paper towels to support staff to carry appropriate supplies.
- Ensure participation in surveillance and audit programmes at a national or local level and provide active support for presentation and improvement of hand hygiene compliance results.
- Undertake a risk assessment to optimise patient/client/residents and staff safety, consulting expert infection prevention guidance if/as required.
- Support staff in any corrective action or interventions if an incident occurs that may have resulted in transmission of infection.
- Ensure any staff with health concerns, including any skin irritation related to occupational hand hygiene, or those who have become ill due to occupational exposure are appropriately referred e.g. General Practitioner or Occupational Health.
- Ensure that patients, clients, residents, visitors and/or carers have access to hand hygiene facilities and are supported to use these.

5.2 All Staff Must:

- Apply the principles of standard precautions, including hand hygiene. All staff have a responsibility to ensure that they undertake effective hand hygiene and encourage others who have patient contact, contact with the patient environment, or with items used with, for or on



patients, to do so and supportively challenge non-compliance.

- Liaise with their managers/colleagues to ensure hand hygiene products and disposable single use paper towels are available in the community.
- Ensure all other staff/agencies perform hand hygiene.
- Explain to patients, clients, residents, carers and visitors infection prevention requirements such as hand hygiene and how they can be supported to undertake hand hygiene.
- Encourage patients, clients, residents, carers and visitors to question any lack of hand hygiene by staff if this is observed.
- Ensure supplies of hand hygiene products and other materials, such as paper towels are readily available for all to use, including for patients, clients, residents, carers and visitors.
- Ensure standardised hand hygiene posters, featuring when and how to perform hand hygiene, are displayed in relevant, prominent areas.
- Report to line managers any deficits in knowledge or other factors in relation to hand hygiene, including facilities/equipment or incidents that may have resulted in cross contamination.
- Attend mandatory or update infection prevention education sessions.
- Consider hand hygiene as an objective within staff continuing professional development ensuring continuous updating of knowledge and skills.
- Be aware of and participate in hand hygiene campaigns.

5.3 Staff With Infection Prevention and Control/Health Protection Responsibilities Must:

- Provide education for staff and management.
- Act as a resource for guidance and support when advice on hand hygiene is required.
- Provide advice on individual risk assessments for performing hand hygiene.
- Support the monitoring of compliance.
- Use multi-faceted approaches to improve hand hygiene compliance; including reminders, education and feedback strategies.
- Provide patient information and support staff to actively involve patients in hand hygiene improvement programmes.

5.4 Patient and Visitor Hand Hygiene

- Patients, clients, residents, carers and visitors should have access to and be provided with suitable information and facilities for hand hygiene in all areas.
- Staff should actively encourage and support patients, clients, residents, carers and visitors to maintain good hand hygiene when visiting the organisation to ensure that we continue to reduce the risks associated with the transmission of infection.
- Patients must be encouraged to wash their hands after visiting the toilet or using a commode/urinal and before eating. Patients can be assisted to do this if unable to perform the task themselves. Either a bowl of soap and water with a clean hand towel, or an individually packaged hand hygiene wipe must be offered to patients.
- Carers and visitors must also be encouraged to undertake hand hygiene when accessing care settings, particularly if assisting with care activities.



5.5 Incident Reporting:

- Any incidents where failures in hand hygiene have occurred or where there are product/facilities issues that affect effective hand hygiene and in turn Health and Safety should be reported as per local incident reporting procedures, and to the Infection Prevention Team.

5.6 General Good Practice:

- Health and safety issues, related to staff, patients/clients and visitors should also be considered in relation to products used for hand hygiene, e.g. drips or spillages from hand hygiene products and any risks of slips, falls or ingestion of products. Risk assessments should be carried out locally to highlight/manage relevant issues.
- Control of Substances Hazardous to Health (COSHH) and product data sheets should be referred to in order to ensure safe use of/exposure to products being used for hand hygiene.

6.0 When to Perform Hand Hygiene

Each member of staff should consider what level of hand hygiene is required in any given situation.

Four key factors need to be considered:

1. the level of the anticipated contact with patients or objects
2. the extent of the contamination that may occur with the contact
3. the patient care activities being performed
4. the susceptibility of the patient

As a minimum, hands must be decontaminated immediately before and after each and every episode of direct patient contact or care and after any activity that may result in the hands being contaminated, even if gloves are worn. Hands must always be decontaminated after removing gloves and other items of personal protective equipment.

The point of care is the crucial moment for hand hygiene. The point of care represents the time and place at which there is the highest likelihood of transmission of microorganisms from the hands of healthcare workers to patients/clients/residents. The most important times for hand hygiene during care delivery are described by the World Health Organisation (WHO) as '**Your 5 Moments for Hand Hygiene**'. The diagram and description below give an example for a patient in bed but note that **the "5 Moments for Hand Hygiene" can be applied to all care settings.**

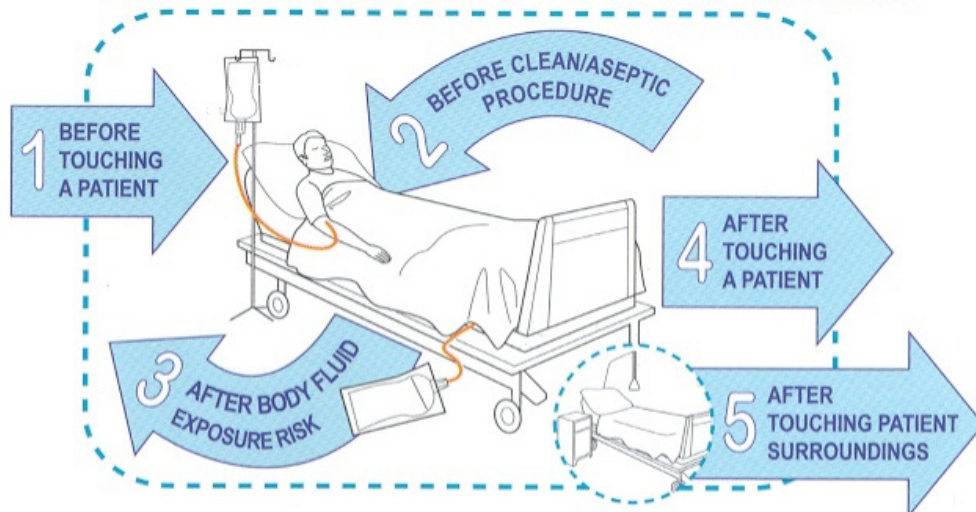
Important COVID-19 note: when personal protective equipment is worn as per COVID-19 guidelines, hand hygiene must be undertaken:

1. Before putting on personal protective equipment.
2. During removal of personal protective equipment, following the correct doffing procedure and always after the removal of gloves (first step when doffing the personal protective



equipment worn for COVID-19), prior to removal of any additional items of personal protective equipment that are worn.

Your 5 moments for HAND HYGIENE



Based on WHO poster 'Your 5 Moments for Hand Hygiene' and reproduced with their kind permission

Before patient contact	When? Clean your hands before touching a patient when approaching him/her. Why? To protect the patient against harmful germs carried on your hands.
Before a clean/aseptic task	When? Clean your hands immediately before any clean/aseptic task. Why? To protect the patient against harmful germs, including the patient's own, from entering his/her body.
After body fluid exposure risk	When? Clean your hands immediately after an exposure risk to body fluids (and after glove removal). Why? To protect yourself and the healthcare environment from harmful patient germs.
After patient contact	When? Clean your hands after touching a patient and his/her immediate surroundings when leaving the patient's side. Why? To protect yourself and the healthcare environment from harmful patient germs.
After contact with patient surroundings	When? Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched. Why? To protect yourself and the healthcare environment from harmful patient germs.

Examples for other settings are given in Appendix 1.

If gloves have been worn, hand hygiene **must** be performed after their removal. Hands can still become contaminated whilst wearing or on removal of gloves, and so must be cleaned effectively. It should also be noted that hand hygiene must be performed **between tasks on the same patient**; for example after assisting with personal hygiene, and before assisting with feeding.



7.0 Levels of Hand Hygiene

7.1 Social (Routine) Hand Hygiene

Social hand hygiene will remove transient organisms. Liquid soap and water and alcohol-based hand rub (if hands are visibly clean) are both adequate and appropriate for this.

Examples of when routine hand hygiene is required are as follows:

- Before patient contact
- Before carrying out a different task for the same patient
- Before handling, preparing or eating food
- Before any aseptic procedure
- Before starting work
- When entering and leaving any ward/department/healthcare setting
- After patient contact
- After contact with patient surroundings or equipment
- After removing gloves and other items of personal protective equipment
- After using the toilet
- After completing a procedure
- After making a bed
- After any cleaning/decontamination activity
- After personal contamination e.g. blowing your nose.
- Handling surfaces likely to be contaminated e.g. specimen pots, suction bottles, waste or used linen

Note that wearing gloves does not remove the need to decontaminate hands: Gloves are a supplement to hand hygiene, **NOT** a replacement for it.

Always use the correct process for hand hygiene – EVERY TIME.

The following is a link to a video demonstrating hand washing with soap and water:

<https://youtu.be/-boVsHgDDOc>



Best Practice: How to hand wash step by step images

Steps 3-8 should take at least 15 seconds.

 <p>1</p> <p>Wet hands with water.</p>	 <p>2</p> <p>Apply enough soap to cover all hand surfaces.</p>	 <p>3</p> <p>Rub hands palm to palm.</p>
 <p>4</p> <p>Right palm over the back of the other hand with interlaced fingers and vice versa.</p>	 <p>5</p> <p>Palm to palm with fingers interlaced.</p>	 <p>6</p> <p>Backs of fingers to opposing palms with fingers interlocked.</p>
 <p>7</p> <p>Rotational rubbing of left thumb clasped in right palm and vice versa.</p>	 <p>8</p> <p>Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.</p>	 <p>9</p> <p>Rinse hands with water.</p>
 <p>10</p> <p>Dry thoroughly with towel.</p>	 <p>11</p> <p>Use elbow to turn off tap.</p>	 <p>12</p> <p>Steps 3-8 should take at least 15 seconds.</p> <p>... and your hands are safe*.</p>

Adapted from the World Health Organization/Health Protection Scotland
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*Any skin complaints should be referred to local occupational health or GP.



7.2 Procedure for Routine Hand Washing

- Ensure that you are 'Bare below the elbow' i.e. long-sleeved items are removed or sleeves are rolled up to expose wrists and forearms and no jewellery, wrist watches or other items are worn on the hands or wrists. Fingernails should be short and free from nail polish. (False nails must not be worn.)
- Cover any cuts and abrasions with a waterproof dressing.
- Ensure that everything which is needed to perform hand hygiene is present i.e. liquid soap, paper towels, and waste bin for used paper towels.
- Ensure that the sink area is free from extraneous items, e.g. medicine cups, and utensils (note that hand wash basins should not be used for anything other than hand washing so the presence of these types of item may indicate that people need to be reminded of this).
- Turn on the tap and check the temperature of the water. Water should be comfortably warm. Note that hand washing with cold water is slightly less effective than washing with warm water but much better than not washing hands at all.
- Wet hands all over.
- Apply liquid soap. One squirt (about 3mls) should be sufficient but apply more if required to get a good lather.
- Rub hands together to generate a good lather then clean your hands using the following steps to ensure all surfaces are cleaned:
 1. Rub hands palm to palm with the fingers interlaced.
 2. Rub the back of the left hand with the right palm with fingers interlaced, i.e. making sure that the fingers of the right hand go into the spaces between the fingers on the left hand, then swap your hands over to clean the back of the right hand with the left palm.
 3. Interlock your fingers so that the fingers of each hand are tucked into the opposite palm and rub from side to side.
 4. Grasp each thumb in turn with the opposite hand and clean it by rotating the thumb within the grasping hand.
 5. Rub the tips of the fingers of each hand in the opposite palm in a circular motion.
 6. Rub each wrist with the opposite hand, taking care to clean each wrist all the way round.
- Rinse your hands well under the water, taking care to rinse off all the soap.
- Turn off the taps using a 'hands-free' technique, e.g. elbows. Where taps are not 'hands-free', use a paper towel to protect your hand while turning the taps off.
- Dry your hands thoroughly with disposable paper towels.
- Dispose of the paper towels without re-contaminating your hands, i.e. if the bin has a lid use the foot pedal; do not touch the bin lid with your hands.



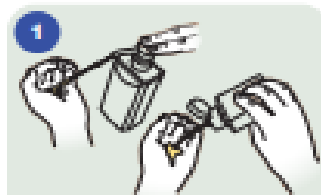
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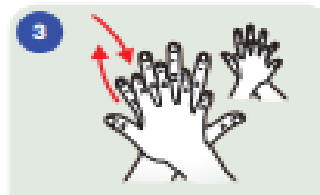
Best Practice: How to handrub step by step images



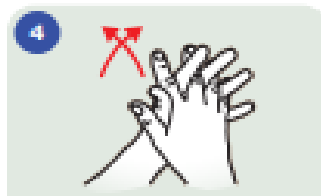
1
Apply a palmful of the product in a cupped hand and cover all surfaces.



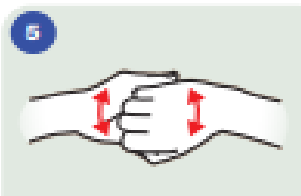
2
Rub hands palm to palm.



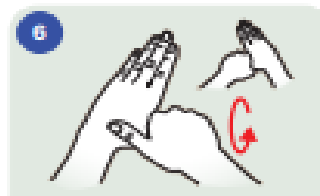
3
Right palm over the back of the other hand with interlaced fingers and vice versa.



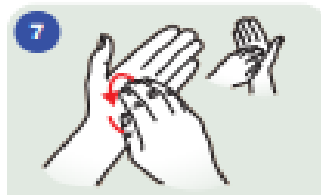
4
Palm to palm with fingers interlaced.



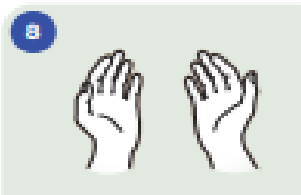
5
Backs of fingers to opposing palms with fingers interlocked.



6
Rotational rubbing of left thumb clasped in right palm and vice versa.



7
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.



8
Once dry, your hands are safe.

Adapted from the World Health Organization/Health Protection Scotland
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7.3 Procedure for Routine Hand Hygiene with Alcohol-based Hand Rub (ABHR)

Alcohol hand rub is appropriate and effective for most routine hand hygiene. If your hands are dirty or contaminated, or you have been dealing with a patient with diarrhoea or vomiting you must wash your hands with soap and water (see above).

- Ensure that you are 'Bare below the elbow' i.e. long-sleeved items are removed or sleeves are rolled up to expose wrists and forearms and no jewellery, wrist watches or other items are worn on the hands or wrists. Fingernails should be short and free from nail polish. (False nails must not be worn.)
- Cover any cuts and abrasions with a waterproof dressing.
- Dispense enough hand rub into the palm of one hand to cover both hands all over (about 3-5mls).
- Rub your hands together to spread the hand rub all over your hands using the following steps to ensure all surfaces are covered:
 1. Rub hands palm to palm with the fingers interlaced.
 2. Rub the back of the left hand with the right palm with fingers interlaced, i.e. making sure that the fingers of the right hand go into the spaces between the fingers on the left hand, then swap your hands over to clean the back of the right hand with the left palm.
 3. Interlock your fingers so that the fingers of each hand are tucked into the opposite palm and rub from side to side.
 4. Grasp each thumb in turn with the opposite hand and cover it with hand rub by rotating the thumb within the grasping hand.
 5. Rub the tips of the fingers of each hand in the opposite palm in a circular motion.
 6. Rub each wrist with the opposite hand, taking care to clean each wrist all the way round.

Wait for the hand rub to dry (about 10-20 seconds). This ensures that the alcohol has the maximum disinfectant effect.

Please note: Where there is no running water available or hand hygiene facilities are lacking, staff may use individually packaged hand hygiene wipes, followed by ABHR and should wash their hands at the first available opportunity.

7.4 Forearms

If forearms are contaminated at any time, they must be included within the hand hygiene that is subsequently undertaken, using either soap or water and/or alcohol based hand rub. This is most important to note in consideration of COVID-19, when staff are bare below the elbows wearing Level 1 or Level 2 personal protective equipment.



7.5 Hygienic (Aseptic) Hand Hygiene

Hygienic hand washing removes transient and some resident microorganisms and involves the use of a disinfectant to kill microorganisms and provide a residual antimicrobial effect. This may be in a combined product such as an antimicrobial soap (e.g. Hibiscrub) or a standalone disinfectant such as alcohol-based hand rub for use on hands that are already visibly clean.

Alcohols are effective and fast acting against a wide spectrum of bacteria and fungi (but not bacterial spores) as well as many viruses. Because of the convenience of alcohol hand rubs, they are made widely available and may be used for routine hand hygiene when hands are visibly clean. Hand rubs do not remove dirt and organic material, which may inactivate alcohol and render it ineffective as well as physically preventing it from reaching the target microorganisms. Hands that are not visibly clean must be washed with soap and water before using hand rub.

Hygienic (aseptic) hand hygiene is required:

- Prior to an aseptic procedure (excluding surgery).



- When there is a high probability of microbial contamination, e.g. after contact with a patient in isolation.

Alcohol-based hand rubs alone should not be used if a patient has diarrhoea or vomiting, or is known or suspected to have an infection caused by a spore-forming organism. These include *Clostridium difficile* and gas gangrene caused by *Clostridium perfringens*.

7.6 Surgical Hand Antisepsis

The objective of surgical hand antisepsis is to reduce the release of microorganisms from the skin during surgery by reducing the number of microorganisms (both transient and resident) on the hands and forearms to the minimum that is reasonably practicable. Surgical hand antisepsis (often referred to as 'surgical scrubbing') must be carried out before carrying out surgery or other invasive procedures such as insertion of a central line. Methods for this involve physical cleaning and chemical disinfection, usually involving extended washing with a combined soap and disinfectant solution (often referred to as a 'surgical scrub solution'); disinfection of already-cleaned hands with an alcohol-based hand rub; or a combination of both.

Perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times e.g. prior to insertion of central vascular access devices.

- Remove all hand/wrist jewellery.
- Nail brushes should not be used for surgical hand antisepsis.
- Nail picks (single-use) can be used if nails are visibly dirty.
- Soft, non-abrasive, sterile (single-use) sponges may be used to apply antimicrobial liquid soap to the skin if licensed for this purpose.
- Use an antimicrobial liquid soap licensed for surgical scrubbing or an alcohol based hand rub licensed for surgical rubbing (as specified on the product label).
- Alcohol based hand rub can be used between surgical procedures if licensed for this use or between glove changes if hands are not visibly soiled.

Aqueous antiseptic solutions (surgical scrubs) are aqueous solutions containing soap and an antibacterial agent such as chlorhexidine gluconate, povidone-iodine, or Triclosan. Solutions containing these agents act by lifting transient micro-organisms from the skin, and destroying both transient and some resident micro-organisms. Chlorhexidine also has a residual effect that slows re-growth of bacteria.

The operating team should always wash their hands prior to the first operation on the list using an aqueous antiseptic surgical solution and the method described below. Note that almost all studies into pre-surgical hand hygiene discourage the use of scrubbing brushes; scrubbing brushes may damage the skin and increase shedding of skin cells and bacteria.



Procedure for Surgical Hand Antisepsis with an Aqueous Antiseptic Solution




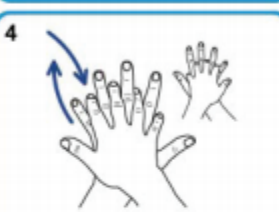

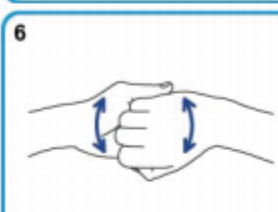




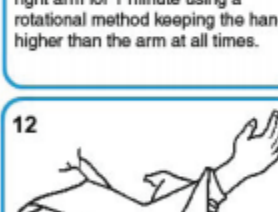
1. Remove debris from underneath fingernails, using a sterile nail cleaner and liquid soap under running water.
2. Wet hands under running water.
3. Dispense aqueous antiseptic solution.
4. Hand wash vigorously for 3-5 minutes. Use the six steps described for hand washing to ensure that all surfaces of the hands are covered. Extend the wrist-cleaning step to include the whole forearm up to the elbow. Ensure that all surfaces of hands, wrists, and forearms are thoroughly cleaned. Throughout the procedure keep the hands higher than the elbows to ensure that the flow of water is away from the hands
5. Rinse hands and forearms thoroughly under running water, still holding the hands at a higher level than the elbows
6. Dry hands with disposable sterile paper towels, starting from the fingertips and working down to the elbow. Ensure hands and forearms are completely dry before donning sterile gown and gloves as residual moisture will encourage the re-growth of bacteria.

Before subsequent operations, hands and forearms may either be cleaned using either an antiseptic surgical solution as described above or, if they are visibly clean, disinfected using an alcohol- based hand rub.

If hands are soiled then they must be washed again with an antiseptic surgical solution.



Surgical Scrubbing – surgical hand preparation technique using antimicrobial soap – step by step

<p>1</p>  <p>Wet hands and forearms*</p>	<p>2</p>  <p>Put antimicrobial liquid soap onto the palm of each hand/arm using the elbow of your other arm to operate the dispenser</p>	<p>3</p>  <p>Rub hands palm to palm. Steps 3 - 8 should take a minimum of 2 minutes</p>
<p>4</p>  <p>Right palm over the back of the other hand with interlaced fingers and vice versa.</p>	<p>5</p>  <p>Palm to palm with fingers interlaced.</p>	<p>6</p>  <p>Bends of fingers to opposing palms with fingers interlocked.</p>
<p>7</p>  <p>Rotational rubbing of left thumb clasped in right palm and vice versa.</p>	<p>8</p>  <p>Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa. Rinse hands between steps 8 - 9, passing them through the water in one direction only.</p>	<p>9</p>  <p>Put antimicrobial liquid soap onto the palm of your left hand using the elbow of your other arm to operate the dispenser. Use this to scrub the right arm for 1 minute using a rotational method keeping the hand higher than the arm at all times.</p>
<p>10</p> <p>Repeat the process for the other hand and arm keeping hands above elbows at all times.</p> <p>If the hand touches anything at any time, the scrub must be lengthened by 1 minute for the area that has been contaminated.</p>	<p>11</p>  <p>Rinse hands and arms by passing them through the water in one direction only, from fingertips to elbow. Do not move the arm back and forth through the water.</p>	<p>12</p>  <p>Hold hands above the elbow. Use one sterile, disposable towel per hand and arm. Blot the skin of the hand, then use a corkscrew movement to dry from the hand to the elbow. The towel must not be returned to the hand once the arm has been dried and must be discarded immediately.</p>

*Nails should be cleaned using a soft, single-use disposable nail brush or nail pick before the first scrub of the day or if visible dirty. Any skin complaints should be referred to local occupational health or GP.



Procedure for Surgical Hand Antisepsis With an Alcohol Based Hand Rub

If hands and forearms are visibly clean and have already been 'scrubbed' using an antiseptic solution then disinfection with an alcohol-based hand rub is acceptable before further cases on the operating list. Note that this must be with a product designed and licensed for pre-operative use; conventional alcohol hand rub as used for routine hand decontamination is not sufficient. Suitable products will include additional, long-acting compounds (e.g. chlorhexidine gluconate or quaternary ammonium compounds) limiting re-growth of bacteria on the gloved hand. These products should be used as described below.

1. Visually inspect the hands and forearms for contamination. If there is any visible contamination on the hands or forearms or under the nails, scrub with an aqueous antiseptic solution as described above.
2. Dispense sufficient solution into the palm of the hand to cover the hands and forearms completely (about 15ml).
3. Rub the solution into all surfaces of the hands and forearms following step by step Surgical Rubbing technique to ensure that all surfaces are covered. Extend the wrist-cleaning step to include the whole forearm up to the elbow. If using a liquid solution, keep the hands higher than the elbows to ensure that any flow of solution is away from the hands. Apply more solution if required to cover all surfaces. Continue rubbing the solution into the skin until it has dried.
4. Repeat step 3, covering the hands and forearms, then repeat again covering just the hands
5. When hands and forearms are completely dry, don sterile gown and gloves.



Surgical Rubbing – surgical hand preparation technique using alcohol based hand rub – step by step

- The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands.
- On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.
- After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).
- Surgical procedures may be carried out one after the other without the need for hand washing, provided that the hand rubbing technique for surgical hand preparation is followed (images 1 to 15).



Adapted from the World Health Organization



Germs. Wash your hands of them.



Part of the National Infection Prevention and Control Manual (NIPCM), available at: <http://www.nipcm.hps.scot.nhs.uk/>.
Produced by: Health Protection Scotland, July 2018.



Glove Puncture During a Procedure

If gloves are punctured or torn during surgery, they must be removed. Hands must be decontaminated using the most appropriate method as described above before donning fresh gloves.

8. Hand Hygiene Facilities

Senior managers should ensure that all staff involved in healthcare have access to appropriate hand hygiene facilities and materials.

Healthcare facilities should have:

- Alcohol based hand rub at the point of care (either installed or issued to staff for personal use).
- Hand wash basins specifically for hand hygiene only.
- Adequate supplies of suitable liquid soap and paper towels at each hand wash basin.
- A hands-free waste bin close to each hand wash basin.

The type and number of facilities, and their situation in relation to where work/care is carried out should be in accordance with the relevant guidance. Current guidance suggests a minimum of one sink per single room/small ward areas; one sink between four patients in acute, elderly and long term care settings; one sink between six patients in low-dependency settings; and one hand washbasin at each bed space in critical care and isolation facilities. Equipment sinks alone are not suitable for hand washing; dedicated hand washing facilities should be provided. Dedicated hand washbasins should also be provided where food/drinks are prepared.

Hand washbasins should not have plugs or overflows. They must not be used for any other purpose.

Taps on hand wash basins should be mixer units to allow an appropriate temperature to be set and sited so that water strikes the basin bowl and does not go directly into the plughole. They must be of a type that can be turned off without using the hands, to avoid re-contamination. Wrist, elbow or foot operated taps are acceptable.

Motion sensor controlled taps (i.e. turn on and off when hands are waved in front of a sensor light area allowing touch-free operation of the tap) may be useful in some areas but are complex and associated with an increased risk of contamination of the water supply. They must not be installed without prior consultation with the Estates and Infection Prevention Teams. Any such systems must respond promptly so that users are not put off by any delay in water delivery and provide users with adequate time to wet their hands prior to performing hand hygiene and. They must be mains operated to avoid battery failure.



Poorly maintained or damaged hand hygiene facilities, e.g. basins with chipped/cracked enamel, should be reported to Estates and repaired as soon as possible as uneven or damaged surfaces may harbour microorganisms.

8.1 Hand Hygiene Supplies

The availability of supplies for hand hygiene is essential.

- Hand hygiene products (e.g. liquid soap, antiseptic hand wash solution and alcohol based hand rub), should be provided in wall mounted, easy to use, easy to clean, holder systems containing single use, disposable cartridge sets, particularly in clinical or communal care areas. In some non-acute care settings, freestanding bottles of liquid soap are acceptable.
- Community-based staff should be supplied with appropriate liquid soap; single use paper towels; and alcohol based hand rub for personal use in settings where suitable facilities are not conveniently available.
- Where there is no running water available or hand hygiene facilities are lacking, staff may use individually packaged hand hygiene wipes, followed by ABHR and should wash their hands at the first available opportunity.
- Nozzles of solution bottles/containers must be kept clean and free of any congealed product. Bottles should not be reused or 'topped up'. The inside of these bottles, even those containing antiseptic solutions, can become a breeding ground for bacteria over time.
- Soft, user-friendly disposable paper towels for hand drying must be available at hand washbasins. They should be stored in wall-mounted dispensers that are easy to use and clean.
- Supplies of paper towels and other hand hygiene supplies should always be stored in a clean dry area prior to use.
- Estates/maintenance staff are important partners in ensuring that hand hygiene facilities are adequate and that supplies are mounted appropriately.
- Patient, clients, residents, carers and visitors must have access to hand hygiene supplies and be supported to use these if required.



9. Care of Hands and Fingernails

Clinical staff must be aware of the potentially damaging effects of hand decontamination products if they are used incorrectly. Skin damage is often associated with the detergent base of the preparation and/or poor hand washing technique. Note that alcohol based hand rubs are, for use, generally less damaging than soap. The irritant and drying effects of hand hygiene preparations (both actual and perceived) are often identified as a reason for failure to adhere to hand hygiene guidelines. Hands and fingernails need to be kept in the best possible condition. Dermatitis is painful and damaged or broken skin on the hands harbours more microorganisms than intact skin and is more difficult to clean effectively. The following points are essential for staff with patient contact and highly recommended for all staff:

- Always wet hands before applying soap. Soap is more likely to cause skin damage if applied directly to dry skin.
- Staff must use moisturising hand cream as required to maintain the skin on the hands in good condition. At the start and end of each shift and when on a break is recommended as a minimum. Wall mounted dispensers or individual tubes of hand cream should be used. Communal tubs of hand cream must not be used. Creams used should not affect the action of hand hygiene products or the integrity of gloves.
- Cover all cuts and abrasions with a waterproof dressing.
- Always dry hands thoroughly, including the backs of hands and in between fingers. Leaving hands to air dry, even partially, can cause skin drying and irritation.
- Notify your line manager of any skin problems associated with hand hygiene and discuss treatment and prevention with the Occupational Health Department and your General Practitioner.
- Keep nails short and clean.
- Do not wear nail polish if working in a clinical area. The pitted surface of nail polish harbours microorganisms.
- Do not wear artificial fingernails or nail extensions if working in a clinical area. They are frequently colonised with harmful microorganisms and have caused outbreaks of infection.
- Do not use nailbrushes for routine hand hygiene as they may abrade and damage the skin. They may be used during the surgical scrub procedure if required but are not recommended.
- The six-stage hand hygiene process must be followed in order to ensure nail areas are cleaned properly.

10. Hand Hygiene and Jewellery

- Any jewellery or other items on the hands or wrists will harbour and protect microorganisms and make hand hygiene less effective. Jewellery/items will become contaminated and are unlikely to be effectively cleaned through routine hand hygiene, particularly jewellery or items with an intricate design and/or inset stones. Items, including jewellery can also be a potential



hazard to patients or the wearer during any moving and handling task.

- All jewellery, or other items must be removed from the hands and wrists when working in clinical care settings or providing patient care.
- ALL staff providing care must remove all jewellery, or other items from the hands and wrists at the start of the working day.
- Plain wedding/partnership bands and mandatory plain metal religious symbols (see below) may be worn. However, these must be moved or removed when hand hygiene is being performed in order to decontaminate the skin beneath them.
- Please note that this policy only addresses jewellery, or other items with respect to hand hygiene. Other jewellery, or other items may also present a hazard to the wearer or to patients and may only be worn if permitted by the relevant health and safety and uniform/dress code policies.

10.1 Religious/Cultural Dress and Jewellery

Some jewellery is mandated by particular cultures and religions. An example is the kara, an iron or steel bracelet worn by Sikhs. Such items may be worn in everyday practice as long as their cleanliness is maintained alongside regular hand hygiene. Guidelines on aseptic procedures when a plain metal band is worn on the finger also apply to the kara and any similar items.

Please note: Managers must explore with individual members of staff where there may be issues of religious/cultural significance and negotiate a suitable arrangement to ensure that no risks are posed to the member of staff, patients, clients, residents, visitors and the public or to their colleagues. Any issues that cannot be resolved locally should be referred to the appropriate senior manager. Advice may be sought from the Infection Prevention Team if required. This aspect of the hand hygiene policy is kept under regular review.

11. Hand Hygiene and Bare Below the Elbow

The 'Bare below the Elbow' (BBE) code aims to reduce the transmission of healthcare associated infections and promote patient and staff safety by facilitating effective hand decontamination. Service users have come to expect healthcare staff to be bare below the elbow and observing staff to be compliant is likely to contribute to patients' confidence in their care. The Board of BCUHB fully endorses BBE in line with this National code. **All staff in clinical areas* must comply with the BBE policy. This includes staff not in direct contact with the patient.**

The only exceptions to this rule are where a specialist role is being undertaken which demands that personal protective clothing be worn for health and safety purposes e.g. an Estates Officer working on a ward, servicing a clinical waste macerator; catering staff who wear long jackets in the kitchen.

Clinical staff in BCUHB uniform must not wear wristwatches or other hand/wrist jewellery while on Health Board premises or while providing patient care in any circumstances, other than as stated in this policy.



To ensure hands can be decontaminated easily and effectively it is essential to wear work clothing that does not go past the elbow. Jackets and coats should be removed and long sleeves rolled up to expose the wrists and forearms. Wristwatches and other hand and wrist jewellery must be removed. Failure to do this will reduce the effectiveness of hand hygiene. Long sleeves that are not rolled up will become contaminated during patient care and that contamination is likely to be passed to other patients. They will also become wet when hands are washed.

* Clinical area means the door that provides direct access to a ward or department where patients are seen or treated or in any facility where personal care is being provided. The requirement applies to all staff entering the area.

Summary of BBE Policy

- Nails must be short and clean – no nail polish or extensions.
- Wristwatches must not be worn in clinical areas.
- No other jewellery, or other items should be worn around the wrist.
- No rings should be worn other than the permitted single plain wedding/partnership band.
- Sleeves must be short or rolled securely up to the elbow – this includes in areas where long sleeved gowns (Level 2 PPE) are being worn sessionally e.g. in critical care and high risk respiratory areas.
- Ties (if worn) should be securely tucked in – lanyards are not to be worn.
- Any cuts or abrasions must be covered with a clean waterproof dressing.

11.1 Religious/Cultural Dress and BBE

Any cultural or health issues that may affect a member of staff's compliance with BBE should be brought to the attention of the line manager, Infection Prevention Team and Occupational Health Department (if appropriate) for advice.

Advice has been sought nationally on the specific issue of 'Bare Below the Elbow' as some interpretations of religious teaching require that long sleeves be worn. It has been established that all major religions endorse the principle that an individual should do no harm to others. The wearing of long sleeves prevents effective hand hygiene as it is not possible to clean the wrists fully, and hand hygiene is essential for safe patient care. Therefore staff who have agreed with their manager that they may wear long sleeves in order to comply with their religious beliefs must still roll up their sleeves to ensure the wrist and forearm are exposed in the following circumstances:

1. When undertaking direct patient care
2. As part of standard, contact, respiratory or protective isolation and infection prevention precautions
3. When performing hand hygiene, whether using soap and water or alcohol hand rub



11.2 Non-Clinical Areas

Staff working in other areas must adhere to the same standards for hand hygiene as clinical areas if, as part of their work in these areas, they are required to wear gloves/aprons and wash their hands to remove potential contamination. Hand hygiene **MUST** be performed after removal and disposal of gloves and other items of personal protective equipment.

For example: staff cleaning corridors and public toilets, and staff working in non-patient areas handling specimens and/or contaminated items of equipment; staff collecting and transporting waste and soiled linen.

12. Monitoring and Audit of Hand Hygiene

Regular monitoring and audit of compliance with this policy is essential. This includes observation of hand hygiene practice and bare below the elbow together with timely feedback to healthcare workers to ensure standards of hand hygiene are achieved and sustained.

- Hand hygiene compliance monitoring is undertaken through direct observation of practice at ward/department/healthcare facility level (See Appendix 3).
- There is a requirement for each area to undertake 10 hand hygiene observations on a weekly basis. Areas are encouraged to co-ordinate peer review audits e.g. audits undertaken by Matrons, neighbouring Ward/Department Managers or other visiting staff to provide assurance of compliance data.
- Supportive challenge of any non-compliance that is observed is encouraged as part of this audit process.
- The hand hygiene observational audit tool that is used is built within 'IRIS' and provides compliance data in real time, to support rapid feedback and the development of improvement plans if required.
- Hand hygiene compliance data must be clearly and appropriately displayed within the clinical setting and reported regularly through local governance arrangements; this includes via the local Infection Prevention Groups and the wider Health Board.
- Patient hand hygiene audits are also undertaken to provide assurance that patients, are supported with their individual hand hygiene needs and support the development of improvement plans within identified areas, if required.
- The Infection Prevention Team also support this process by undertaking random quality control hand hygiene observational audits.



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All Wales NHS Dress Code, Free to Lead, Free to Care. Welsh Assembly Government. Crown Copyright, 2010.

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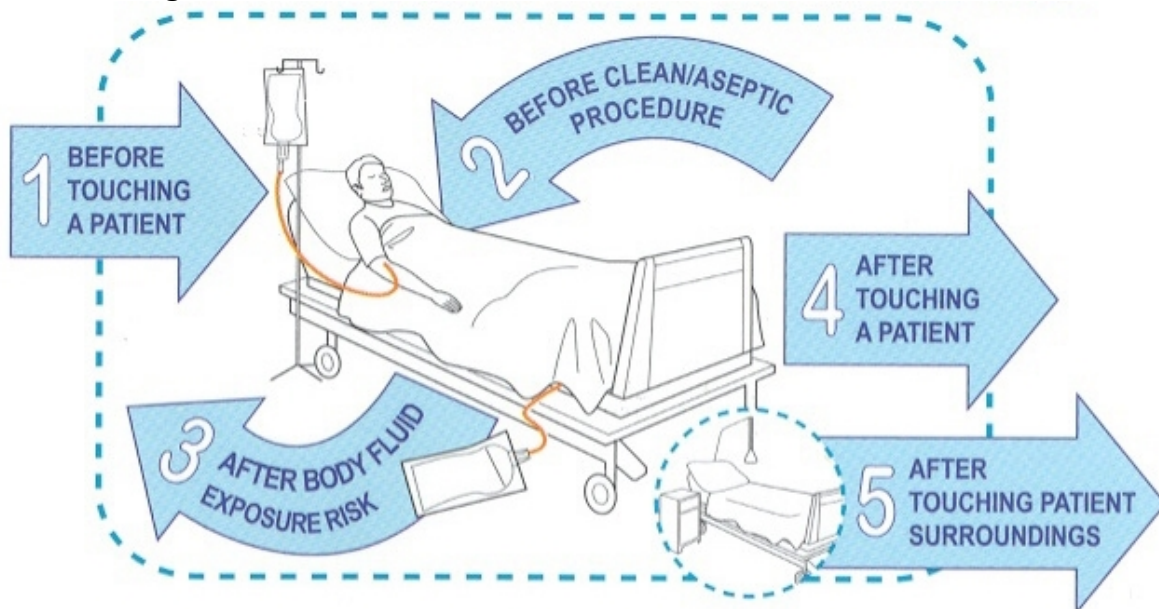
Appendix 1

5 Moments for Hand Hygiene

1. Non-Acute Care, Out Patients and Ambulatory Care Settings

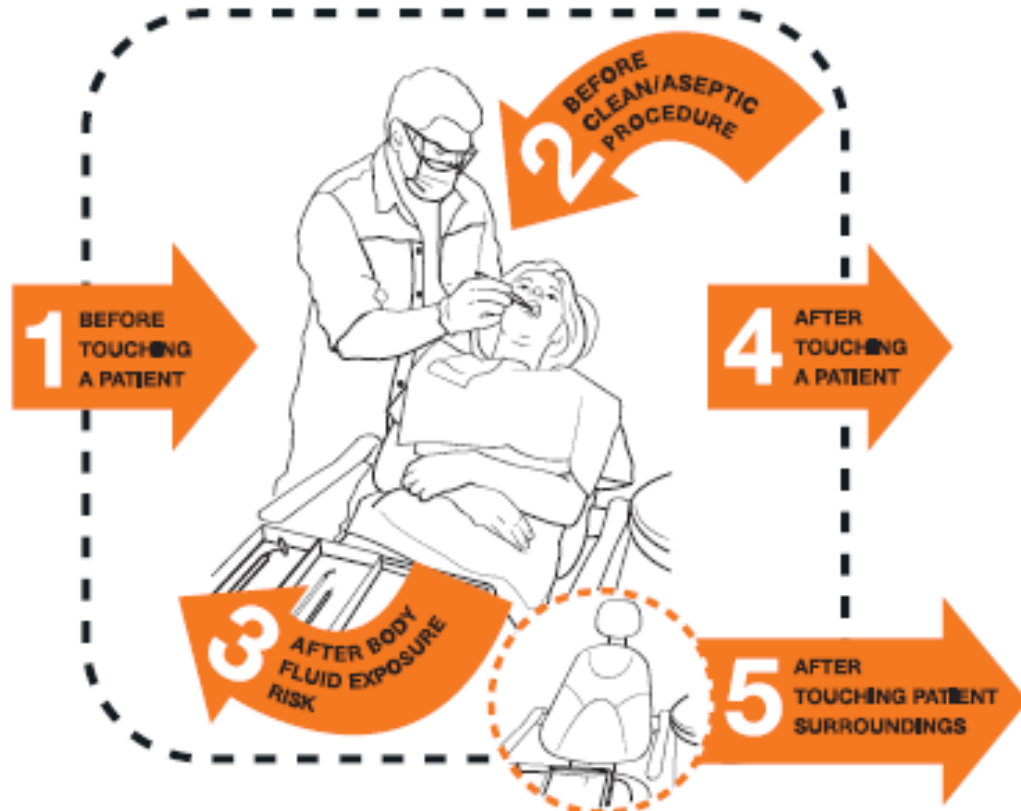


2. Acute or Longer Term Care With Bedbound Patients





3. Dental Care





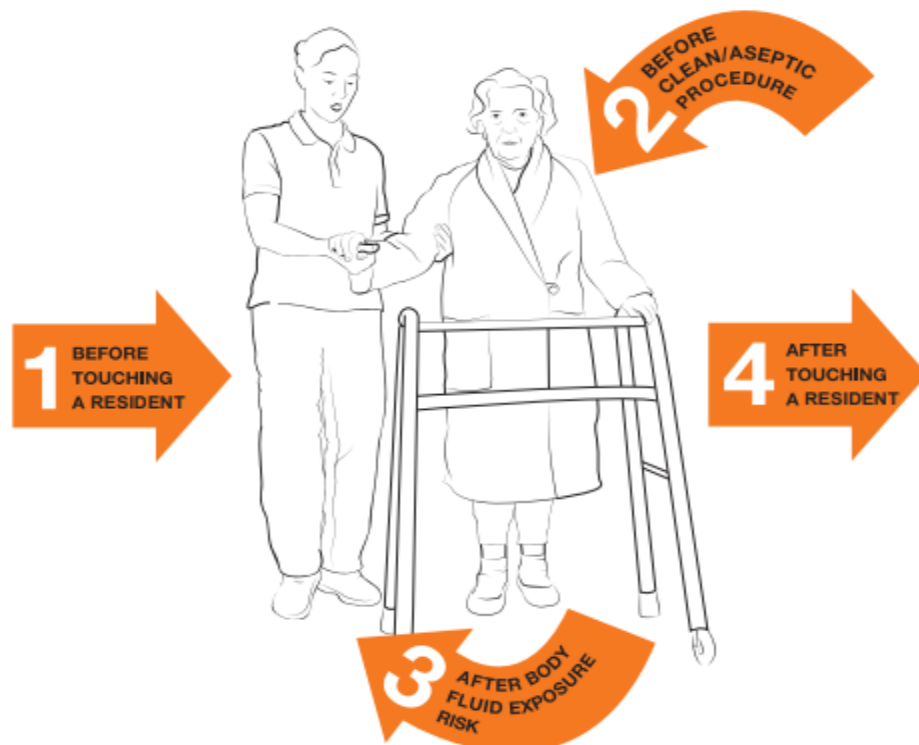
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4. Residential Care Settings

Your Moments for Hand Hygiene

Health care in a residential home



1	BEFORE TOUCHING A RESIDENT	WHEN?	Clean your hands before touching a resident.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the resident's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after a procedure involving exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the environment from harmful patient germs.
4	AFTER TOUCHING A RESIDENT	WHEN?	Clean your hands after touching the resident at the end of the encounter or when the encounter is interrupted.
		WHY?	To protect yourself and the environment from harmful patient germs.



World Health
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March 2012



Appendix 2

Hand Hygiene Observation Tool

Ward	Date	Auditor	Staff name	Staff Designation	Hand hygiene performed Y/N	Was the most appropriate agent used Y/N/NA	All areas of hands decontaminated Y/N/NA	Bare below Elbows Y/N	Comments e.g. What moment of hand hygiene failed? If not bare below why?

|



Appendix 3

Hand Hygiene Observational Tool

Instructions

- Clinical areas are required to perform 10 observational audits of Hand Hygiene per week for their area of accountability
- The observations will be based on Opportunities for Hand Hygiene in line with the WHO '5 moments for Hand Hygiene'.
 1. Before a patient contact
 2. Before clean/aseptic technique
 3. After contact with blood or other bodily fluids/removing gloves
 4. After patient contact
 5. After contact with the patient's surroundings
- The auditor should assess the hand hygiene opportunity to determine if the solution used was appropriate (i.e. if the member of staff observed had contact with a patient with diarrhoea – soap and water should have been used)
- The auditor should assess whether all areas of the hands were appropriately decontaminated.
- During the audit the auditor should observe if the member of staff in question was Bare Below the Elbow i.e.
 - Fingers are free from any rings, with the exception of one plain wedding ring), nail varnish (including clear), false nails or nail extensions.
 - Wrists are free from watches, bracelets/bangles etc.
 - Sleeves are worn short or rolled up **above** the elbow.



Members of the Working Group (Revision V5):

Name	Title
Samantha Walker	Clinical Service Lead – Infection Prevention (East)
Andrea Ledgerton	Advanced Lead Nurse Specialist Infection Prevention

Engagement has taken place with:

Name	Title	Date Consulted
Infection Prevention and Control Team		June 2021
Infection Prevention Sub Group members		22 nd June 2021



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IT FORMS

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

<u>For:</u>	Infection Prevention Hand Hygiene Policy and Procedure
<u>Date form completed:</u>	11/08/2021



KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Infection Prevention Hand Hygiene Policy and Procedure.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy is to ensure that all staff perform hand hygiene optimally and effectively to reduce infection risk to patients. The policy will be used in conjunction with other Health Board policies that contribute to the prevention and management of infection and its spread.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Gill Harris Executive Director of Nursing and Midwifery Betsi Cadwaladr University Health Board
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	This policy is related to all infection prevention policies, procedures or guidance including (but not exclusive to): Infection Prevention and Control Guidance for Maintaining Services within Healthcare Settings. IPC31 Aseptic non-touch technique procedures. COVID-19 Toolkit. EqIA have been completed on previous versions of the Infection Prevention Hand Hygiene Policy and Procedure.

Part A

Form 1: Preparation

Please answer all questions

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	<p>This policy applies to all staff employed by the Health Board, plus service users, visitors, contractors and carers.</p> <p>Engagement forms part of a continuous rolling programme of infection prevention improvement through staff training and promotional materials.</p>
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	<p>The success of this policy is dependent upon good communication, training, physical resources to support hand hygiene, promotional materials, inclusive processes to monitor compliance with hand hygiene and provide supportive feedback as required.</p>
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	<p>Assessment has identified no inequality or disadvantage to implementing this policy, as the policy is promoted equally to all.</p>

Part A

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

Please answer all questions

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

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

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

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

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

Part A

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

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?"	How will you reduce or remove any negative Impacts that you have identified?
<p><i>for further direction on how to complete this section please click here training vid p13-18</i></p> <p>Guidance for Completion</p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p>			

Part A

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

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age		X			The policy is inclusive of all ages and people of all ages will be supported to follow this policy without exclusion.	
Disability		X			<p>The policy is inclusive of all, including those people with different types of impairment and health conditions and people will be supported to follow this policy without exclusion.</p> <p>There is a possibility that wheelchair users or people with other physical impairments may not be able to access existing facilities. In this case, reasonable adjustments would be made to support.</p>	
Gender Reassignment		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	
Pregnancy and maternity		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	

Part A

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

Please answer all questions

Race		X			The policy is inclusive of all and people from all backgrounds will be supported to follow this policy without exclusion.	
Religion, belief and non-belief		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	Hand washing with soap and water is a hand hygiene method available to any individual not wanting to use an alcohol-based hand sanitiser
Sex		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	
Sexual orientation		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	
Marriage and civil Partnership (Marital status)		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	
Socio Economic Disadvantage		X			The policy is inclusive of all and people will be supported to follow this policy without exclusion.	

Part A

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

Please answer all questions

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

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

[UN Convention on the Rights of the Child](#)

[UN Convention on the rights of people with disabilities.](#)

[UN Convention on the Elimination of All Forms of Discrimination against Women](#)

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	X			No human rights are potentially affected by this policy.	This policy is inclusive of all, however patients, visitors and carers maintain the freedom to choose in relation to their hand hygiene needs – the policy provides guidance on what is recommend, to support individuals to have an informed choice.	

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

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		X			This policy is not currently translated into the Welsh language, although this can be facilitated if required.	Arrange for a Welsh translation of this policy on request
Treating the Welsh language no less favourably than the English language		X			All infection prevention policies are currently available in the English language.	Arrange for a Welsh translation of this policy on request

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. <i>for further direction on how to complete this section please click here training vid p13-18</i>	This policy has been shared with the Infection Prevention Team for initial consultation and will be shared with the Clinical Procedures Group for wider consultation.
Have any themes emerged? Describe them here.	No themes have emerged.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	No changes to recommendation have been identified following initial consultation.

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	Infection Prevention Hand Hygiene Policy and Procedure.
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2. Brief Aims and Objectives: (Copy from Form 1)	This policy is to ensure that all staff perform hand hygiene optimally and effectively to reduce infection risk to patients. The policy will be used in conjunction with other Health Board policies that contribute to the prevention and management of infection and its spread.
---	--

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</p> <p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
--	--	------------------------------------

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p><i>Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?</i></p>		
<p>5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</p>	<p>Yes <input type="checkbox"/></p>	<p>No <input checked="" type="checkbox"/></p>
<p><i>Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.</i></p>		
<p>6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</p>	<p>Yes <input checked="" type="checkbox"/></p>	<p>No <input type="checkbox"/></p>
	<p>How is it being monitored?</p>	<p>A process is in place to monitor compliance with hand hygiene practices across the Health Board.</p> <p>Details of this process are included within the policy.</p>
	<p>Who is responsible?</p>	<p>Responsibility is defined within the policy.</p>
	<p>What information is being used?</p>	<p>Hand hygiene compliance monitoring is an observational process and utilises a standardised audit tool that is readily available – details are included within the policy.</p>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	When will the EqIA be reviewed?	To be determined – three years following policy approval in conjunction with the policy review.

7. Where will your policy or proposal be forwarded for approval?	Clinical Procedures Group/Strategic Infection Prevention Group
--	--

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity	Name	Title/Role
	Samantha Walker	Clinical Service Lead – Infection Prevention (East)
	Stephen Doore	Equality and Inclusion Manager
Senior sign off prior to committee approval:	Andrea Ledgerton	Advanced Lead Nurse Specialist – Infection Prevention
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Action Plan

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

	Proposed Actions	Who is responsible for this action?	When will this be done by?
	Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.		
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No actions identified.		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	No changes proposed.		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No negative impacts identified.		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	No negative impacts identified.		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	No actions taken or planned as part of this assessment.		



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**Version &
Reference
Number**

Author & Title	Closed Circuit Television (CCTV) and Body Worn Video (BWV) Policy				
Responsible Dept / director:	Health & Safety Department Sue Green Exec Director of Workforce &OD				
Approved by:	Strategic Health & Safety Group				
Date approved:	TBC				
Date activated (live):	TBC				
Documents to be read alongside this document:	CCTV Procedure All Wales Information Governance Policy All Wales Information Security Policy IG01 Records Management Policy IG04 Access to Information Policy IG13 Confidentiality Code of Conduct IG24 Notification of Information Security Breach Procedure IG14 IM&T Security Procedure In the picture: A data protection code of practice for surveillance cameras and personal information				
Date of next review:	3 years from approval date				
Date EqIA completed:	20 October 2021				
First operational:					
Previously reviewed:					
Changes made yes/no:					

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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Definitions used in this document,

BCUHB= Betsi Cadwaladr University Health Board

CCCTV= Closed Circuit Television

BWV=Body Worn Video

1. INTRODUCTION/OVERVIEW

This document sets out the appropriate procedures and authorised responsibilities, in respect of the use and installation of CCTV surveillance systems and Body Worn Video (BWV) operated by or on behalf of Betsi Cadwaladr University Health Board (BCUHB).

2. POLICY STATEMENT

BCUHB is committed to providing a safe and secure environment for all staff, patients, and visitors to its premises and services. To assist with this BCUHB has CCTV and BWV on many of its sites/locations.

The purpose of CCTV and BWV operated by or on behalf of BCUHB is for:

1. The prevention or detection of crime and / or disorder;
2. The apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings);
3. In the interest of public and employee health and safety;
4. The protection of public health;
5. The protection of BCUHB property and assets.

Images and recordings, hereon referred to as “data”, captured by CCTV and BWV are considered personal data under Data Protection legislation.

This document takes account of the following:

- The Data Protection Act 2018
- “In the picture: A data protection code of practice for surveillance cameras and personal information”, issued by the Information Commissioners Office, version 1.2
- The Human Rights Act 1998
- UK General Data Protection Regulation (UK GDPR)
- Police and Criminal Evidence Act 1984
- IG policies and procedures <http://howis.wales.nhs.uk/sitesplus/861/page/42035>

3. AIMS / PURPOSE

The aim of this document is to articulate consistent working practices, and provide guidance in relation to the use of CCTV and BWV operated by, or on behalf of, BCUHB. These practices will protect data held by the Health Board whilst allowing the appropriate level of access to material when requested by individuals or other agencies such as the Police, subject to there being a justified legal basis as defined in section 2.

4. OBJECTIVES

This policy covers all data recorded by CCTV and BWV controlled by BCUHB. This will include the viewing, copying, and disclosure of the data in accordance with legislation.

Responsibility for the data held on each CCTV system (or multiple systems) will be managed by the hospital director for the 3 acute sites, community hospital administrators for community sites, and a nominated individual with managerial responsibility for all other sites, hereon referred to as "leads".

These leads will ensure that a Standard Operating Procedure; a template of which is available within the CCTV Procedure, is implemented for those CCTV system/s, and will identify all authorised persons / roles who are permitted to view / access the CCTV footage. A BCUHB Standard Operating Procedure for CCTV has been developed to operate alongside this policy and can found on the BCUHB intranet (link will be added)

5. SCOPE

This policy applies to all staff, patients, members of the public, service users, students, contractors, volunteers, those on honorary contracts, and any other individuals working for other employers / organisations on behalf of BCUHB, such as security guards.

It covers all CCTV systems and BWV operated by or on behalf of BCUHB.

Any staff member who misuses any CCTV system or BWV operated by or on behalf of BCUHB may be subject to disciplinary proceedings. Any individuals working for or on behalf of BCUHB may also be reported to the police for possible criminal investigation.

CCTV systems will not be used to routinely monitor the workforce to ensure they comply with organisational policies or procedures. However, images of staff may be used if it is identified that staff are possibly involved in criminal activity, gross misconduct or behaviour which puts others at risk. All such matters are to be investigated in accordance with Workforce and Organisational Development policies & procedures.

The document does not cover the use of images used as part of an individual's treatment plan, for example, patients who are in seclusion, or are the subject of enhanced monitoring requirements.

6. ROLES AND RESPONSIBILITIES

Chief Executive

The Chief Executive has overall responsibility for Data Protection and Information Security within BCUHB. As accountable officer, they are responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support the safe and secure handling of information.

Executive Director of Workforce and Organisational Development

The Executive Director for Workforce and Organisational Development assumes the lead responsibility for Security of the Health Board which includes all CCTV & BWV systems owned or operated on behalf of BCUHB.

The Executive Director for Workforce and Organisational Development delegates Strategic and Operational aspects of CCTV to the Associate Director for Health Safety & Security and the Head of Health and Safety.

Corporate Health and Safety Team

In addition to the delegated strategic and operational aspects of CCTV, the Corporate Health and Safety Team have responsibility for providing specialist security advice to BCUHB. This will include the use and location of CCTV and BWV and the implementation of this policy and the associated Standard Operating Procedure for CCTV.

Data Protection Officer

The Data Protection Officer has delegated responsibilities from the Chief Executive specifically with regards to compliance with Data Protection legislation and the rights of data subjects.

Director of Estates and Facilities

The Director of Estates and Facilities is responsible for the overall management of the CCTV systems in regards to the installation, maintenance and repair (including contracts), as well as CCTV signage. They must ensure that this policy is complied with for all sites.

They will ensure that any external organisation providing installation / maintenance and processing services related to CCTV is subject to a written contract with clearly defined responsibilities, ensuring that information is only processed in accordance with BCUHB instruction, and includes guarantees related to security, storage and appropriately trained staff in accordance with legislation.

They will ensure that where users identify defects or failures to any CCTV systems, there are processes in place for prompt assessment and repair within acceptable timelines.

Information Governance

Information Governance will be responsible for Subject Access Requests under Data Protection legislation, the approval of Police requests via SA3 forms, and Information Commissioner Office registration, which will include the use of CCTV and BWV.

Leads

All leads as identified in Section 4 of this document, will ensure that a Standard Operating Procedure, based on the template contained within the CCTV Procedure, is in place for their site, and reviewed at least annually, or before, if required.

All CCTV & BWV users

All identified authorised users of CCTV systems and BWV as identified in the Standard Operating Procedure completed by all Leads will be responsible for complying with this policy and associated procedures, and relevant legislation.

They will ensure that all data is handled securely, breaches may result in internal and/or criminal investigations.

It will be the responsibility of all authorised users of CCTV and BWV to report any defects, risks or concerns to their line manager who will liaise with the BCUHB Estates or BCUHB Head of Health and Safety as required.

All users must be up to date with their mandatory Information Governance training. Any users working on behalf of the Health Board must attend appropriate training, which will include training on the use of CCTV and BWV systems, and their wider information governance responsibilities.

All users are personally responsible for ensuring that no actual or potential security breaches occur as a result of their actions. Failure to comply with this and associated procedures may lead to disciplinary action, and could also result in criminal investigation.

BCUHB Health & Safety members are classed as authorised persons for all BCUHB CCTV & BWV systems.

7. INSTALLATION

Any new or replacement CCTV systems operated by or on behalf of BCUHB must be jointly authorised by the Director of Estates and Facilities and the Associate Director of Health, Safety and Security or the Head of Health and Safety.

New or replacement systems must include an appropriate training package from the system installers for all authorised users to confidently operate the CCTV system.

8. CAMERAS, IMAGES & SYSTEM CAPABILITIES

It is essential that the location of the equipment be carefully considered, so as not to invade the privacy of persons outside the perimeter of BCUHB premises. Prior to installation a site survey will need to be conducted with a Corporate Health and Safety (Security) advisor and the contractor to ensure that any equipment installed is fit for purpose and complies with legislative requirements.

A pre requisite of any installation will be that:

- Cameras must be appropriately sited to provide clear images
- All cameras are located in prominent positions within public and staff view and do not infringe on clinical / treatment areas unless authorised and appropriately risk assessed
- Signage meets requirements of Section 9 of this policy.

It is essential that the data produced by the equipment is as clear as possible in order to be effective for the intended purpose(s).

Upon installation, all equipment is tested to ensure that only the designated areas are monitored and high quality images are available in live and play back mode with accurate time and date stamps. All CCTV equipment and BWV should be serviced and maintained on a regular basis, and managed through Estates or Health & Safety, as appropriate.

Existing CCTV systems can be updated or replaced through the purchase and installation of improved cameras, providing there is no impact on the areas of coverage. This process should be continuous as legislation and technology changes.

New systems installed following the date this policy is ratified must be capable of retaining images for 31 days.

9. SIGNAGE

Signs are to be erected on all entrance points to sites where CCTV is operated by or on behalf of BCUHB, as well as throughout the sites to ensure that staff, patients, and visitors are aware that they are entering an area covered by CCTV surveillance equipment. Example of signage is contained within the CCTV Procedure (Add Hyperlink).

Signs must be clearly visible with contact details of the Corporate Health and Safety Team displayed. They need to identify the details of the organisation operating the system and the purpose of its use, all signage must be bilingual (Welsh/English).

Where users are wearing BWV, this must be obvious to the individual(s) they are recording, ideally by the use of signage or verbal declaration.

10. VIEWING AND ACCESS TO IMAGES

Monitors displaying live images are required to be placed in a restricted area where only authorised users can view them. Monitors currently displaying images to non-

authorised users must be repositioned or switched off until they can be repositioned appropriately.

The authorised user will be required to complete a CCTV Log which can be found in the associated CCTV procedure (link will be added), which records all times, dates etc. when the system has been accessed, and this must be made available to the Corporate Health and Safety (Security) team upon request.

Devices used to record / store CCTV and BWV data must be placed in a restricted access area secured against unauthorised removal or tampering.

Access to data

Data Protection legislation provides an individual the right of access to information held on them and this can include CCTV / BWV footage. Requests for access to this data must be made via a Subject Access Request (SAR) to the Information Governance department: [Subject Access Request \(SAR\) - Betsi Cadwaladr University Health Board \(nhs.wales\)](#).

In the event that captured images of individuals not subject to the subject access data request cannot be redacted on a system, it will be a decision for the Data Protection Officer as to whether BCUHB can lawfully comply with the request.

11. EQUALITY INCLUDING WELSH LANGUAGE

An equality impact assessment has been conducted in relation to this document and no adverse impact has been identified. The Welsh Language is treated no less favorably than the English language. All information developed specifically for the public is available bilingually such as CCTV signage. All correspondence received from the public such as subject access requests will be forwarded to the Information Governance department in the language it was received.

12. WELL-BEING OF FUTURE GENERATIONS

The five ways of working have been interwoven within this Policy, those being:

- Long term – balancing short-term needs with long-term needs.
- Prevention – stopping problems happening or getting worse.
- Integration – thinking about how this strategy works with other plans.
- Collaboration – working together with other services to meet our goals.
- Involvement – involving people so they have a say in decisions.

13. ENVIRONMENTAL IMPACT

This document has considered the impact it has upon the Environment, through frequent review of its content any environmental impacts can be considered. It is envisaged that any new CCTV systems will be of sufficient quality to have as low an impact on the environment as is reasonably practicable.

14. RESOURCES

There are resource implications to implementing this document as there will need to be appropriate professional experience and skills available in order for CCTV systems

to be reviewed prior to installation of new systems, for the viewing, retrieval and distribution of images. These will be impactful for the Associate Director of Health, Safety & Security.

15. TRAINING

All staff users must be up to date with their mandatory Information Governance training, which must be completed every 2 years. Any users working on behalf of the Health Board must attend appropriate training, which will include training on the CCTV and BWV systems, and their wider information governance responsibilities.

Leads must arrange appropriate training for all authorised users of CCTV from CCTV installers in respect to its operation.

16. IMPLEMENTATION

This document will be reviewed and endorsed by the BCUHB Strategic Health & Safety Group and the Information Governance Group prior to being activated. This will allow for a wide-ranging consultation.

This policy will be published in line with the corporate policy on policies, and awareness is raised via communication channels such as the weekly corporate bulletin, Information Governance bulletin, email alerts and Information Governance training.

17. AUDIT& REVIEW

This document will be reviewed by the document owner every 3 years. However, a review earlier than this may be prompted by factors including:

- Legislative or regulatory changes.
- Structural or role changes.
- Operational or technological changes.
- Changes in the rationale for CCTV and BWV deployment /use.
- Organisational learning.
- Audits and reviews of the effectiveness of the policy.



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EQUALITY IMPACT ASSESSMENT FORMS

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

<u>For:</u>	CCTV Policy
<u>Date form completed:</u>	20 th September 2021



PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Betsi Cadwaladr University Health Board (BCUHB), CCTV Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The overall aim of the policy is to promote a positive culture for CCTV use and it's management and to encourage ownership at every level as well as the development and sustainability of high quality support services and systems.</p> <p>BCUHB is committed to providing a safe and secure environment for all staff, users and visitors to its premises and services including use of CCTV. The purpose of CCTV controlled by BCUHB is for:</p> <ul style="list-style-type: none"> a) The Prevention or detection of crime or disorder; b) The Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings); c) In the Interest of public and employee Health and Safety; d) The Protection of public health; e) The Protection of BCUHB property and assets.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	<p>The Chief Executive has the authority to agree and approve any changes necessary to all Policy. The Executive Director of Workforce and Organisational Development has been appointed as the Executive for Security – CCTV is an associated function. The Policy will be formally reviewed and approved by;</p> <ul style="list-style-type: none"> • Strategic OHS Group • Quality, Safety and Experience Committee. • Board
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>The CCTV Policy is informed by relevant legislation and acknowledges and supports,</p> <ul style="list-style-type: none"> • Security Management Framework- Welsh Government July 2005 • Betsi Cadwaladr University Health Board's policies including.

Part A

Form 1: Preparation

		<ul style="list-style-type: none"> • HS02 Policy & Guidance –Protecting Employees from Violence & Aggression. • IG14 IM&T Security Procedure <p>The Policy relate to work activities within all BCUHB, Divisions, Departments and Specialities. The standard procedures in operation will require cross referencing with the Policy to ensure work is carried out in a safe manner. The procedures in place will require modifying to ensure they are compliant with the Policy.</p>
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The policy will apply to all premises and undertakings of BCUHB. Stakeholders will include all staff, contractors, visitors, Trade Union Partners and volunteers. This will be accompanied by a message to all users in the Corporate Bulletin advising of the review. The draft policy has been shared with BCUHB Information Governance representatives prior to presentation to the Strategic Occupational Health and Safety Group SOH&S group. Following this, the draft policy will be uploaded to the staff intranet for review/consultation. As a result of this consultation any required changes will be communicated to SOH&S group to enable the document's ratification.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	The capacity to deliver the changes will be challenging due to Security staffing resources. An action plan has been developed (in form of business case to increase staffing resources which is awaiting approval) to support the Policy implementation plan. Culture and some entrenched working practices may hinder the drive for change. However we have senior level commitment to the changes from the Board and this will make a significant difference to the program plans.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	CCTV systems will not be monitored or operated during "live" situations –except emergency events e.g. missing patients, therefore there should be no overtly negative impact on any group of persons. Footage cannot be accessed without senior management approval following submission of the relevant formal request form, and accessed only by appropriately qualified staff. The Policy will have a positive effect identifying areas of concern such as all crime including violence/aggression and abuse directed all persons, and it is believed it will assist in deterring incidents of harm.

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

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

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

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

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

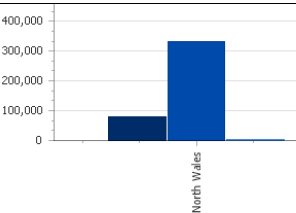
- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission,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

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

- participant (you and your colleagues) knowledge

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	✓		✓		North Wales has an ageing population. Between 1998 and 2018, the proportion of the population aged 65 and over has increased from 18.5 per cent to 23.0 per cent, while the proportion of the population aged 15 and under has fallen from 19.8 per cent to 17.8 per cent.(gov.wales) As such more older persons may have images captured on CCTV systems.	Footage cannot be accessed without senior management approval following submission of the relevant formal request form, and accessed only by appropriately qualified staff.
Disability (think about different types of impairment and health conditions:- i.e. physical,	✓		✓		Although CCTV is not installed in all BCUHB mental health sites, due to there being more Datix incidents reports of violence & aggression in those areas this could have an impact not seen at other locations.	Footage cannot be accessed without senior management approval following submission of the relevant formal request form, and accessed only by appropriately qualified staff.

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

mental health, sensory loss, Cancer, HIV)					 <p>79000 people identify as having a disability in North Wales with 330000 people classed as not disabled.(Stats Wales/Welsh Government 2020) as those people may require medical assistance they may have their images capture on CCTV-this would include those with temporary disability due to short term illness/injury.</p>	
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)	✓		✓		No evidence to suggest CCTV will impact this group negatively.	
Pregnancy and maternity	✓		✓		No evidence to suggest CCTV will impact this group negatively	
Race (include different ethnic minorities,	✓		✓		No evidence to suggest CCTV will impact this group negatively. Historical issues of prejudice and oppression may lead to suspicion and unease.	We ensure that clear signage is installed to ensure that all site users are aware

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

Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.						of CCTV usage is in place for security and safety.
Religion, belief and non-belief	✓		✓		No evidence to suggest CCTV will impact this group negatively	
Sex (men and women)	✓		✓		No evidence to suggest CCTV will impact this group negatively. Note; women make up 80% of BCUHB staff (BCUHB Annual Equality Employment Report 2020-21	
Sexual orientation (Lesbian, Gay and Bisexual)	✓		✓		No evidence to suggest CCTV will impact this group negatively	
Marriage and civil Partnership (Marital status)	✓		✓		No evidence to suggest CCTV will impact this group negatively	

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

Low-income households	✓		✓		No evidence to suggest CCTV will impact this group negatively	
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Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166>

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
x		x			Human rights will not be adversely affected. The Policy's aim is to have a positive impact on	

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

					maintaining health and wellbeing as well as mitigating the occurrence of incidents that may cause harm. The policy does not cover CCTV as part of an individuals treatment plan.	None identified
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Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

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

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

Part A Form 4: Record of Engagement and Consultation

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

We have a legal duty to engage with people with protected characteristics under the

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	We engaged with all staff groups who attend the Strategic OHS Group including leaders in Celtic Pride, Equality Leads, meetings with key stakeholders such as Trade Union Partners.	
Have any themes emerged? Describe them here.	We have identified that further work is necessary related policies such as Security and Violence & Aggression.	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	The Policy places clear responsibilities on Assistant Directors and Line managers to undertake suitable and sufficient risk assessments which need to be specific about the work activities and risks identified. The Policy is guided by the gaps identified throughout the safety management system a 12 month action plan including developing Policy, procedure and guidance is being implemented.	

Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	BCUHB CCTV Policy
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The overall aim of the policy is to promote a continual positive culture and to encourage ownership at every level as w BCUHB is committed to providing a safe and secure environment for all staff, users and visitors to its premises and services including use of CCTV.</p> <p>The purpose of CCTV controlled by BCUHB is for:</p> <ul style="list-style-type: none">a) The Prevention or detection of crime or disorder;b) The Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings);c) In the Interest of public and employee Health and Safety;d) The Protection of public health;e) The Protection of BCUHB property and assets. <p>ell as the development and sustainability of high quality support services and systems.</p>
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From your assessment findings (Forms 2 and 3):

Part B Form 5: Summary of Key Findings and Actions

3a. Could any of the protected groups be negatively affected by your policy or proposal?		Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?		Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?		Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The CCTV policy will have a positive impact on wellbeing. This includes risk assessments in all areas of BCUHB. The purpose of the policy is to protect staff, others equipment and services from adverse incidents affects to allow the core function of healthcare delivery/promotion of positive health related outcomes. The overall assessment is considered to be positive.		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	The document will be translated into Welsh.		

Part B Form 5: Summary of Key Findings and Actions

identified minor negative impact?		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	Strategic OHS meetings, audits, reviews Quarterly reports on activity and escalated to QSE as required.
	Who is responsible?	Associate Director of Health, Safety and Equality
	What information is being used?	<p>E.g. will you be using existing reports/data or do you need to gather your own information?</p> <p>The information will be generated by H&S Leads, H&S Advisors, Head of Occupational Health and Wellbeing, Manual Handling Manager, Head of H&S, Security Manager, risk registers and reported incidents etc.</p>
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	When the Policies is reviewed in line with Policies on Policies.

Part B Form 5: Summary of Key Findings and Actions

7. Where will your policy or proposal be forwarded for approval?	The Strategic Occupational Health and Safety Group Quality, Safety & Experience Committee Board
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8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity Senior sign off prior to committee approval:	Name	Title/Role
	Susan Morgan	Head of Health and Safety
	David Baker	Violence ,Aggression Case Manager
	Peter Bohan	Associate Director Health Safety and Equality
	Sue Green	Executive Director Human Resources and Organisational Development
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	None identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None identified		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	None identified		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	None applicable		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Regular review of policy which will be informed from relevant group's feedback as well as comments from the consultation.		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1st March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Complaints Policy and Procedure						
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality						
Awdur yr Adroddiad Report Author:	Carolyn Owen, Assistant Director of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead						
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery Matthew Joyes, Associate Director of Quality						
Atodiadau Appendices:	Complaints Policy and Procedure						
Argymhelliad / Recommendation:							
The committee is asked to approve the attached policy and procedure which has been developed followed wide engagement, review of national standards and an external expert review.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	Y	Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	



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University Health Board

**Version &
Reference
Number**

Complaints Policy and Procedure

Author & Title	Head of Patient and Carer Experience Assistant Director of Patient Safety and Experience				
Responsible Dept / director:	Associate Director of Quality				
Approved by:	Quality and Safety Experience				
Date approved:	March 2022				
Date activated (live):	March 2022				
Documents to be read alongside this document:	<ul style="list-style-type: none"> • Ombudsman Procedure • Complex Complaints Procedure • PALS Procedure • Incident Policy and Procedure • Redress Policy and Procedure • Claims Policy and Procedure • National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 • Putting Things Right: Guidance on dealing with concerns about the NHS • Public Services Ombudsman for Wales - Complaints Standards Authority - Complaint Handling Processes – Statement of Principles 				
Date of next review:	March 2023				
Date EqlA completed:	November 2010				
First operational:	March 2023 (fully replaces PTR01 and PTR01A)				
Previously reviewed:					
Changes made yes/no:					

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Complaints Handling Principles

Betsi Cadwaladr University Health Board is committed to engaging with the community it serves and to listening and learning as we make continuous improvements in everything we do.

There is a standard framework to handling complaints across NHS Wales, which complies with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 – known as ‘Putting Things Right’ (‘PTR’).

Within Betsi Cadwaladr University Health Board, our approach is enhanced around the following key principles which have been developed in co-design with people involved in the complaints process:

1. **Person-centred:** The patient, carer and family will be at the centre of the complaint. The focus will be on what matters to them. Time will be taken to understand their needs.
2. **Fair:** Patients, carers, families and staff will be treated fairly and with dignity and respect throughout the complaint. No person shall suffer for having raised a complaint.
3. **Open and honest:** Investigations and responses will be open and honest. Where issues are identified these will be clearly stated, meaningful apologies given and information provided on what will be done to put things right and improve for the future.
4. **Timely, effective and proportionate:** Complaints will be resolved promptly, or where more detailed investigation is needed this will be clearly communicated. People will be kept informed throughout the complaint. Investigations will be thorough, proportionate and of a high standard.
5. **Outcome and improvement focused:** The primary aim of the complaint is to put things right based on what matters to the patient, carer and family. Complaints will be used to drive improvement in the quality of services.

This policy and procedure sets out the practical arrangements for our complaints handling to achieve complaint responses within the PTR requirements and our own complaints handling principles.

Complaints Policy

1. Introduction

Our complaints handling policy and procedure reflects Betsi Cadwaladr University Health Board's ('the Health Board') commitment to welcoming all forms of feedback, including complaints, and using them to resolve concerns, improve services, address complaints in a person-centred way and to respect the rights of everyone involved.

It will support our staff to resolve complaints as close as possible to the point of service delivery and to respond thoroughly, impartially, and fairly by providing evidence-based decisions based on the facts of the case.

2. Scope

The document explains the Health Board's strategic vision for the handling of complaints, the principles that have informed the Board's approach, and the detailed procedure for the management of all complaints.

The policy and procedure applies to all Health Board services and staff. Specific arrangements are in place for independent primary care practitioners and complaints involving other organisations, which are detailed later in this document.

3. Policy Statement

The Health Board is committed to a culture of handling all complaints in accordance with our complaints principles – this means that we will handle all complaints to ensure they are:

- Person-centred
- Fair
- Open and honest
- Timely, effective and proportionate
- Outcome and improvement focused.

4. Aims/Purpose

This policy and procedure provides our staff, our community and our stakeholders with a single point of reference for understanding our approach to the management of complaints. The policy and procedure is designed in such a way as to enable the reader to familiarise themselves comprehensively with its content, or to navigate to those elements of immediate importance.

An effective and efficient complaints process that provides for both resolution of concerns and organisational learning is integral to the policy. Information from complaints can help improve the services we provide to our community and provides invaluable feedback to the Health Board. Investigating and responding to complaints must be viewed as part of our daily practice of continuously listening, learning and improving patient and carer experience and not as something exceptional.

Our complaints handling procedure places the person making the complaint, their families and carers, at the heart of the process. We will address complaints effectively, resolve them as early as we can, and learn from them so that we can improve our services for everyone.

The policy and procedure also promotes the benefit of resolving general concerns and early resolution. Not every complaint requires an investigation, and these

alternatives to a detailed enquiry can provide many complainants with a speedier outcome to their concerns.

This procedure explains the processes to follow when responding to complaints. It contains references and links to support staff when following the steps outlined, and explains how to process, manage, and reach decisions on several types of complaints.

Finally, this policy and procedure sets out how the Health Board will comply with the relevant statutory and regulatory frameworks including the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, Putting Things Right (PTR) Guidance, and Public Services Ombudsman for Wales (PSOW) Complaints Standards.

5. Roles and Responsibilities

5.1 Responsible Officer

The Executive Director of Nursing and Midwifery is executive lead for quality and the designated Responsible Officer for the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

They are charged with and have authority for overseeing the management of the complaints process ensuring that complaints are dealt with under a single governance arrangement. They hold to account all clinical services and individuals for the effective application of the policy and procedure.

The Associate Director of Quality is the designated Deputy Responsible Officer who will act on behalf of the Responsible Officer.

5.2 Senior Investigations Officer

The Associate Director of Quality is the designated Senior Investigations Officer for the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

The post holder will have responsibility and accountability through the Responsible Officer to the Board for the strategic development and management of the Health Board's arrangements for responding to complaints in line with the requirements set out by the Welsh Government. The post holder will be responsible for developing and implementing a long term strategic approach for the introduction and maintenance of systems which recognise the need to learn from concerns as well as seeking effective remedies for patients, including where appropriate the provision of redress.

5.3 Patient and Carer Experience/PALS/Complaints Team

The Patient and Carer Experience/Complaints Team (which includes the Patient Advice and Liaison Service-PALS) reports to Associate Director of Quality, and via the Complaints Team provides the central point of contact and coordination for the handling of complaints across the organisation. The team coordinates the process for the management of complaints, provides support to clinical services and monitors progress in line with the standards set out in this policy and procedure and the PTR and PSOW standards.

5.4 Local Quality Teams

The Local Quality Teams report to Associate Director of Quality, and provide local support to services to implement this policy and procedure and monitor the implementation of action and improvement plans including Learning From Events Reports and Ombudsman action plans. They working in partnership with services to ensure learning and action is to reduce the number of complaints and improve patient and carer experience.

5.5 Health Community/Network Directors

Clinical services and their senior teams are accountable and responsible for the resolution of general concerns and investigation of complaints as outlined in this policy and procedure. They are responsible and accountable for ensuring the effective implementation of this policy and procedure throughout their services. They will ensure Investigating Officers are supported in their roles which includes providing sufficient time to attend training and to perform the role.

5.6 Complaint Investigating Officer (IO)

The Complaint Investigating Officer will:

- Complete the IO training pathway before undertaking the role, and therefore be skilled in investigation techniques
- Undertake investigations in a manner consistent with the requirements set out in this policy and procedure
- Produce investigation reports and action plans of an acceptable quality in a format that complies with this policy and procedure
- Develop and maintain regular contact with the person making the complaint, ensuring they are contacted and involved at the start of the investigation, kept updated throughout and be prepared to meet on conclusion to discuss the findings
- Maintain in real-time their progress via the electronic complaints concerns management system (Datix progress notes).

5.7 Complaint Adjudicator

The adjudicator role is the responsibility of a senior member (at director level) of the service in which the complaint sits e.g., Director of Nursing, Medical Director. The adjudicator reviews the investigation report, its recommendations, and actions, and takes or allocates responsibility for those actions and directs how they will be monitored. The adjudicator must approve the investigation report for disclosure to the person making the complaint and then forwards it to the Complaints Team once approved.

If the Complaints Team have any comments to make in relation to the investigation report prior to disclosure, they will return it to the adjudicator to manage.

The adjudicator must be prepared to meet with the complainant to discuss the investigation and actions taken.

5.8 All staff

All members of staff within the Health Board are expected to follow this policy and procedure particularly the responsibilities regarding first contact detailed below. All members of staff are expected to engage with and support complaint investigations and resultant improvement actions.

6. Training

The Quality Training Prospectus supports staff to lead and resolve concerns, early resolutions and complaints.

A record of those members of staff who attend training will be recorded on ESR.

The training will be regularly updated in line with any Welsh Government changes or amendments to the Putting Things Right Guidance or best practice.

Complaints will be investigated by appropriately trained staff who have completed an appropriate level of training.

7. Audit

A rolling audit programme will be developed by the Associate Director of Quality to ensure compliance with this policy and procedure.

8. Review

This policy will be reviewed every 2 years, or sooner in the light of legislative or organisation change.

9. References

A mixture of legislation, regulations, national policy and guidance govern the handling of complaints. This includes Welsh Government directives regarding patient and carer experience models, and regulations governing the operation of complaints processes and the provision of remedy and redress.

The Health Board has a mandatory responsibility to listen and learn from patient and carer experience and the key policy frameworks include:

- The Health and Social Care (Quality and Engagement) (Wales) Act 2020
- Complaints Standards Authority-Wales Guidance for Public Service Providers on Implementing the Concerns and Complaints Policy 2020
- NHS Delivery Framework 2018/2019 (NHS Wales, 2018)
- Parliamentary Review of Health & Social Care in Wales (2018)
- Listening and Learning from Feedback: A Framework for Assuring Service User Experience (WG 2015a)
- Health & Care Standards for Wales (WG 2015b)
- Wellbeing of Future Generations (Wales) Act 2015
- Social Services and Wellbeing (Wales) Act 2014

The following legislation, regulations, guidance and reviews govern and inform the Board's model for handling patient and carer concerns:

- Health and Social Care (Community Health & Standards) Act 2003
- NHS Redress (Wales) Measure 2008
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

- Model Complaints Policy and Guidance for Public Services In Wales (2011)
- Putting Things Right: Guidance on dealing with concerns about the NHS (2013)
- Using The Gift of Complaints review commissioned by the Welsh Government and authored by Keith Evans (2014)

The Policy is additionally informed by the 2013 Francis Inquiry into Mid-Staffs and the recommendations of the associated Clwyd Hart review of NHS hospital complaints systems. In developing this Policy, the Health Board have also given consideration to other relevant UK wide initiatives in respect of best practice in NHS complaint handling.

Complaints Procedure

1. Raising a complaint

Definition of a complaint

The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 define a complaint as “any expression of dissatisfaction”. A complaint may relate to:

- Care and/or treatment
- Delays
- Failure to provide a service.
- Inadequate standard of service
- Dissatisfaction with the organisation’s policy
- Treatment by, or attitude of, a member of staff
- The organisation’s failure to follow the appropriate process including issues affecting the rights and freedoms of a data subject under the Data Protection Act 2018
- Lack of information and clarity about treatment, appointments, and
- Access or contact difficulties with departments/services.

This list does not cover everything.

Not all issues brought to the attention of staff are necessarily complaints. These may be:

- General or specific enquiries
- Information requests
- Comments, and
- Suggestions

An example of this may be where someone has been referred to a consultant and is unsure what this means. Concerns of this nature fall short of a complaint as the person is not expressing dissatisfaction but is seeking information.

Not everything is a complaint because it is described or presented in that way. It is the substance of a person’s concern that should inform decisions about how best to respond to them.

It is necessary for staff to be able to distinguish between these ‘general concerns’ and what constitutes a complaint. Staff must then use the appropriate channels e.g., Patient Advice and Liaison Service (PALS), to handle them, continuing to ensure that a response is provided to the person raising the issue.

Exclusions

A number of matters are explicitly excluded from consideration under this policy and procedure as set-out in the PTR Regulations. These include:

- Concerns notified by a primary care provider relating to a primary care provider’s contract or arrangements under which they provide primary care services - these issues are dealt with through different mechanisms relating to the Regulations covering primary care;
- Concerns where a member of staff has an issue with their employment contract – these matters would be dealt with under the Health Board’s workforce policies and procedures;

- Where the concern is being or has been investigated by the Public Services Ombudsman for Wales;
- Where the Health Board has not complied with the Freedom of Information (FOI) Act 2000 – such concerns would be dealt with by the Information Commissioner's Office
- Disciplinary proceedings – these would be looked at under the Health Board's workforce policies and procedures;
- Where someone tries to re-open the same concern that they have already agreed was dealt with satisfactorily as an Early Resolution – unless the Complaints team consider the Health Board needs to look into the issue again and then it must follow the Investigation under PTR process (see below);
- Where the concern has already been investigated under the previous complaints procedure, that is, complaints that were reported pre 1 April 2011 and concerns that have already been considered under the Regulations;
- Complaints in respect of which court proceedings have already been issued. If court proceedings are issued when a concern is already under investigation in accordance with the Regulations, all further investigation of the concern must stop
- Where a concern relates to an individual patient funding treatment request, that is, requests for funding of services not usually provided on the NHS in Wales – these concerns will be dealt with under a separate all-Wales process for decision and review.

Who can raise a complaint

Almost anyone can raise a complaint and the Health Board will then be under a duty to consider whether it can be investigated. However, it might not always be possible to share the full details of the investigation with the person raising the concern, for instance, if they are not the patient or not their next of kin (this is detailed in the section on consent. Complaints can therefore be raised by:

- people who are receiving or who have received services from the Health Board
- people affected or likely to be affected by the actions, errors or decisions of the Health Board
- staff members
- a third party acting on behalf of a person who is unable to raise a concern e.g. a young child or someone who lacks capacity to act on their own behalf because that person wants someone else to represent them
- a third party on behalf of a person who has died.

Time limits for raising a complaint

A concern can be notified no later than 12 months from the date on which the concern occurred, or if later, 12 months from the date the person raising the concern realised they had a concern.

To investigate a concern after the 12 month deadline, the Health Board must consider whether the person raising the concern had good reason not to notify the concern earlier and whether, given the time lapse, is it still possible to investigate the concern thoroughly and fairly.

The discretion to consider a concern that has been notified outside the 12 month period referred to in paragraph 5.16 above is subject to the provisions of Regulation 15(3) which provides that a concern cannot be notified 3 or more years from the date

the concern occurred or 3 or more years from the date the person became aware of the matter, which the concern is about. Or if the person who raised the concern is a child at the time of the injury the three-year period does not begin to run until the individual reaches the age of 18. In these cases, the period will expire on the eve of the person's 21st birthday; if the person who raised the concern lacks capacity under the Mental Capacity Act 2005, the three-year period may never begin to run, or it can start at the date of recovery.

How a complaint can be raised

The Health Board has a single route for anyone to raise a complaint, by contacting the Complaints Team:

The Complaints Team
Ysbyty Gwynedd
Penrhosgarnedd
Bangor
Gwynedd LL57 2PW

Telephone: 03000 851234

Email: BCU.ComplaintsTeam@wales.nhs.uk

Online: <https://bcuhb.nhs.wales/contact-us/contact-us/make-a-complaint/>

However, a complaint can be raised with any member of staff – it is therefore important that staff can differentiate between a general concern that can be resolved locally, a complaint that can be resolved locally through Early Resolution and a complaint that needs Investigation under PTR. The following sections provide a clear process.

Withdrawing a complaint

A concern may be withdrawn at any time by the person who notified the concern. The withdrawal of the concern can be made in writing; electronically; or verbally in person or by telephone. If a concern is withdrawn verbally, the Health Board should write to the person as soon as possible to confirm their decision. However, even if the concern has been withdrawn, if it is felt that the investigation of the concern is still appropriate, the Health Board can continue to investigate.

2. Complaints Handling Framework

General concerns should not be handled through the complaints framework. Details on how to handle these are detailed below.

Our complaints handling process provides two opportunities to resolve complaints internally:

1. Early resolution (see section 4);
2. Investigation under 'Putting Things Right (PTR) (see section 5).

3. Complaint Handling: First Contact

First Contact describes the point at which a patient, carer, family member or member of the public initially brings an issue to the attention of a member of staff, PALS, or the Complaints Team, and seeks help in resolving the matter.

All members of staff have the potential to be a point of First Contact.

When this occurs, consideration should be given as to whether the issue is one of a general concern or a complaint.

General concerns

Examples of the type of issues that may fall within the broader category of general concerns are as follows:

- Comments concerning service delivery and patient experience
- Subjective personal opinions on policy or service delivery
- The sharing of information about matters of general concern
- Anxiety or worries regarding personal care and treatment
- Requests for information related to personal care and treatment
- Questions about personal care and treatment

Where such issues are raised, the appropriate course of action is to take ownership of the matter and identify how best to source the required information, guidance, advice, help, assistance, answer or response.

The temptation to default into 'complaints mode' and direct patients to the complaints process without considering the substance of the concern must be avoided.

It is the responsibility of all staff to listen, understand and act on any general concern, and to carefully consider the issues raised and the best course of action for resolution.

At the end of these exchanges, the person may indeed wish to pursue one or more matters as a complaint. This is perfectly fine, and if the process of answering their questions has resolved the majority of the concern, then what is left is a more manageable and focused set of issues that are readily susceptible to consideration through the complaints process.

Time spent with a patient or carer addressing their concerns is time saved responding to an investigation at a later point.

Where questions about personal care and treatment are concerned, First Contact requires staff to proactively communicate with the patient to address their concerns. This can be done in a number of ways, but the expectation is that wherever possible a meeting with the patient or carer should be convened. Relevant practitioners, supported by local PALS if helpful, should attend and be fully prepared.

The purpose of the meeting is to provide sufficient and adequate explanations and the objective is to facilitate closure for the patient or carer. This reflects an approach in which such proactive engagement is seen as 'business as usual' and part of the daily work of healthcare professionals rather than a stand-alone activity inextricably linked to complaint handling.

Complaints

As outlined above, a complaint may relate to:

- Care and/or treatment
- Delays
- Failure to provide a service.
- Inadequate standard of service
- Dissatisfaction with the organisation's policy

- Treatment by, or attitude of, a member of staff
- The organisation's failure to follow the appropriate process including issues affecting the rights and freedoms of a data subject under the Data Protection Act 2018
- Lack of information and clarity about treatment, appointments, and
- Access or contact difficulties with departments/services.
- This list does not cover everything.

Not all complaints allege harm or are complex in nature and they may be able to be responded to within 2 working days. This is known as *Early Resolution* (see section 4).

Some complaints will need to have a more comprehensive investigation before a suitable response can be provided: these may be because of the degree of harm alleged, the complexity involved e.g., multiple services, or the number of questions included in the complaint itself. If the complaint is not suitable for Early Resolution, the it will be *Investigated under PTR* (see section 5) and must be forwarded to the Complaints Team immediately for further management.

4. Complaint Handling: Early Resolution

In practice, Early Resolution of complaints means resolving the complaint, at the first point of contact with the person making the complaint, and within 2 working days of receipt (day 1 = the day received).

Following First Contact, if Early Resolution seems appropriate, the staff member involved should seek the advice and support of a manager to achieve Early Resolution locally. The PALS Team can also assist.

For early resolution to be successful, there should be clarity on:

- What exactly is the person's complaint (or complaints)?
- What do they want to achieve by complaining (establish the expectations of the person making the complaint)?
- Can this be achieved, and if not, explain why not, and signpost to PALS or the Complaints Team as appropriate as this may mean an Investigation under PTR is more appropriate.

You may resolve the complaint by:

- Putting right the issues being raised
- Offering an apology
- Explaining why the issue occurred
- Explain what will be done to stop this happening again.

All Early Resolutions must be documented; all staff must complete the First Contact Form (available on the intranet). This enables ongoing reference, issue capture and, on resolution, actions, and learning.

For service staff completing the First Contact form please send it through to the Complaints Team so that it can be electronically captured. This can be via internal post or scanned and emailed to BCU.Complaints@wales.nhs.uk.

The complainant must be kept informed of how their complaint is progressing. The type (e.g., phone, email) and frequency of communication will be agreed with the complainant at first contact.

Resolution must be agreed to the satisfaction of the complainant. If they are unhappy with the response or it is unresolved after 2 working days, then refer the complaint to the Complaints Team for Investigation under PTR.

Where a person complains direct to the Complaints Team or PALS Team then they will also undertake the decision on whether Early Resolution is appropriate and will work with the appropriate service to resolve as outlined above.

5. Complaint Handling: Investigation under PTR

Not all complaints are suitable for early resolution and not all complaints will be satisfactorily resolved within 2 days.

Complaints handled at the 'Investigation under PTR' stage of the complaints handling process are typically serious or complex and require a more detailed investigation before an appropriate response can be provided.

An investigation aims to establish all the facts relevant to the points made in the complaint and to give the person making the complaint a full, objective, and proportionate response that represents the Health Board's final position.

Initial assessment and grading

Following first contact and determination that it is a complaint to be Investigated under PTR, or escalation of an unresolved Early Resolution complaint, an assessment of the complaint will be carried out by the Complaints Team to determine the depth and scope of the investigation required.

If it has been alleged within the initial complaint that harm has or may have been caused, then the Health Board has a duty to consider whether a qualifying liability exists and whether the Redress arrangements apply (see section 8). However, if it is considered that the amount of financial compensation awarded would exceed £25,000 qualifying liability should not be considered.

The complaint is assessed for the degree of harm alleged and/or the complexity of the issues involved, potential risk for patient safety and likelihood for financial compensation.

Following assessment, a grade will be applied. This grading will be kept under review and may be amended as the investigation progresses.

If the assessment identifies a potential patient safety incident that requires investigation then the Incident Policy and Procedure will be followed and the complaint should be considered at the Daily Incident Review Panel. Should the panel determine a patient safety investigation is required then that process takes precedence.

There is no automatic right to a formal investigation, and whilst regard should be given to the complainant's wishes, it is ultimately the substance of the complaint that informs the Health Board's decision.

Acknowledgement

All complaints Investigated under PTR must be acknowledged no later than 2 working days after the day on which it is received. This is done by the Complaints Team. The acknowledgement can be in writing or via email depending on how the complaint has been received.

The acknowledgement also provides an opportunity to:

- clarify the issues of concern with the person making the complaint.
- seek consent.
- outline the timescale in which the response is likely to be provided, and
- offer information on the availability of advocacy and support service.

Consent and data protection

All Investigations under PTR need to comply with the Data Protection Act 2018 (DPA).

Consent is the lawful basis that allows the Health Board to access and use a patient's personal data; within PTR this is to aid the investigation of a complaint.

Whilst it is good practice to seek consent at the acknowledgement stage of the complaint handling process, delay, or failure to provide written consent does not mean that the Health Board is unable to investigate the complaint. This is especially important in situations where issues of patient safety and/or public interest are evident.

There is a distinction to be made between the ability of the Health Board to gather evidence and investigate a complaint, and whether the investigation findings can be lawfully disclosed or shared.

Disclosure or sharing of information must be carefully considered if consent is not obtained. The Health Board is under no obligation to provide a detailed response if it is felt that it is inappropriate to do so.

"PTR: processing and disclosing personal information under GDPR" (2020) provides guidance in relation to both consent and disclosure. This document is available on the intranet. Any additional questions regarding the right to investigate complaints and disclose findings should be signposted to the Information Governance Department or the Complaints Team.

All decisions must be clearly documented on the complaint file within Datix.

Investigation

An investigation aims to establish all the facts relevant to the points raised in the complaint and to give the person making the complaint a full, proportionate, and balanced report that communicates its findings, both openly and honestly.

The Complaints Team will send a complaint to the relevant service for investigation. The service is responsible for appointing an Investigating Officer (IO) to complete the investigation. The service must avoid any actual or perceived conflicts of interest in the appointment of an Investigating Officer.

If the complaint spans several services, a lead service will be identified by the Complaints Team. The lead service will then identify the Investigating Officer who will coordinate the investigation and responses. All other services are expected to promptly and efficiently support in the investigation.

In some cases, the Associate Director of Quality Assurance or Executive Director of Nursing and Midwifery may provide direction on the appointment of an Investigating Officer, such as require one to be appointed from a difference clinical service, or external to the Health Board.

The Investigating Officer must speak with the complainant to clarify the matters of complaint, the scope of the investigation, to establish lines of communication (including how regular updates will be provided) and to involve them in the investigation itself as appropriate. This must happen at the start of the investigation.

It is the responsibility of the service in which the complaint arises to provide an investigation report that outlines the:

- **Issues under investigation** – these must have been clarified with the person making the complaint at the acknowledgement phase and again when the Investigating Officer first speaks with the complainant.
- **Facts found during the investigation** – clearly stating where these have been evidenced from e.g., clinical records.
- **Conclusion** – a decision whereby the investigator comes to a view on the merits of the complaint considering the findings established.
- **Improvement plan** – a proposed course of action agreed by the service that will remedy any substantive failings identified by the investigation and make future service and quality improvements.

A key principle for the Health Board is that personal resolution for the patient or carer has equitable standing to that of organisational learning. Correcting the detriment experienced by the individual affected must be central to the process for handling complaints.

The following provides some examples of remedies that may provide for appropriate redress:

- The acknowledgement of failures and omissions
- The provision of apologies
- Explanations for failures and omissions
- Corrective action to remedy identified failings in service delivery
- Mediation to facilitate conflict resolution between parties
- Reviews of policy where injustices in its application are identified
- Referrals for a reassessment of healthcare needs
- Referrals to counselling services
- Patient stories shared with the Board or services
- Financial compensation for loss (please refer to the Redress section).

The organisational learning that comes from complaints is a parallel driver for the Health Board and therefore recognises the importance of both.

For most complaints, the investigation will be straightforward; for those more complex complaints, especially those that allege harm, such as Grade 3, 4 and 5, a more comprehensive investigation is needed that will require in-depth exploration of the issues identified.

The assessment of the complaint by the service, following grading by the Complaints Team, is key to directing that a proportionate level of investigation is undertaken.

The quality of the investigation report is important, and in terms of best practice should:

- Be clear and easy to follow and understand, written in a way that is person-centred, open and honest and non-confrontational,

- Avoid technical terms, but where these must be used to describe a situation, events, condition, etc., an explanation of the term should be provided,
- Address all the issues raised and demonstrate that each element has been fully and fairly investigated.

The investigating officer must maintain contact with the complainant throughout the investigation to ensure they are updated and involved. The exact nature and frequency will be case specific and should be agreed with the complainant but as a minimum must include the initial conversation described above and an update on conclusion of the investigation that it has been sent for adjudication.

6. Complaint Handling:

Response

The provision of clear and unequivocal responses to patients about the outcome of any investigation forms an essential part of the complaints process.

As a general principle under PTR, anyone raising a complaint must receive an appropriate written response, which sets out what was investigated and what the investigation found.

Timescale

The Health Board must take all reasonable steps to send a response to the person making the complaint within 30 working days beginning on the day upon which it received notification of the complaint.

If a response is unable to be provided within thirty working days, the Health Board must ensure that the person making the complaint is informed of the reason by way of a letter. The delay must be escalated to the Head of Patient and Carer Experience in advance by the Investigating Officer of service, who will grant any extensions beyond 30 working days.

It is the responsibility of the Investigating Officer to ensure that investigation progress is updated on Datix so that the Complaints Team can correspond with the person making the complaint i.e. send a holding letter.

If a delay means a response is being sent after the 30 working days then the response must then be sent as soon as reasonably practical and within six months of it being received. It is only within exceptional circumstances that responses can exceed six months and the reasons for delay must be agreed with the Associate Director of Quality Assurance in advance by a director of the service.

Adjudication

This final stage is known as adjudication and is the end stage in the complaints process at which point a senior manager of the Health Board reaches a decision on a complaint. That decision will be communicated to the complainant in a letter that will accompany the investigation report.

Whilst the investigating officer is an impartial and objective finder of fact, it is the adjudicator's responsibility to consider the investigator's findings, conclusions and recommendations, and reach a decision on the complaint itself.

The adjudicator acts as the arbiter, thereby conveying organisational ownership and responsibility for the complaint. This arrangement also avoids conflicts of interest.

The adjudicator can accept an investigator's findings, conclusions and recommendations without reservation, or may reject them either whole or in part.

Where the latter is the case, an adjudicator must give good reasons for their decision including the rationale for their judgment. However, it is anticipated that adjudicatory challenges to investigatory outcomes will be the exception as a consequence of the Board's investment in and commitment to conducting quality investigations.

Adjudication has two stages:

1. A person of a director-level position within the clinical service makes the adjudication decision of an investigation report. Once approved, the report is sent to the Complaints Team.

Following this, the Complaints Team will perform a quality check on the investigation report and will draft the accompanying response letter. This letter shall be written with brevity (ideally no more than a couple of pages in length) and set out in headline terms the Board's decision, any action to be taken, and the complainant's further rights. The letter will refer the complainant to the investigation report for the relevant detail that has informed the adjudicator's decision on their complaint. The correspondence will be written in a personal and empathic style, whilst the accompanying investigation reports will be exclusively concerned with matters of evidence and fact. The letter will include an apology where appropriate. The letter will also include an offer for the complainant to meet the investigating officer or adjudicator. Once complete, the letter and investigation report is passed to the second stage of adjudication:

2. The Responsible Officer or their deputy (which may include other corporate director-level staff acting on their behalf) will make a final adjudication decision of the investigation report and the accompanying letter.

Actions following adjudication

When final approval is given, the Complaints Team will progress issue of the investigation report and the accompanying letter to the complainant. The Complaints Team will ensure the Datix record is updated, actions are added to the action module and the complaint files closed.

The final investigation report and the accompanying letter will be issued to the service by the Complaints Team who will be responsible for:

- Ensuring staff are aware of the investigation findings – this includes supporting staff who may be affected and supporting any learning;
- Implementing the actions on the improvement plan and ensuring evidence is uploaded to the action tracking module of Datix.

The accompanying letter will include a leaflet outlining information about the complaints process, the redress process, the means of providing feedback on the complaints process, details of the Community Health Council and details of the Ombudsman. The letter itself must include reference to the right of the complainant to approach the Ombudsman.

The local quality teams will be responsible for tracking actions and monitoring progress.

Unresolved Complaints

If the complainant is dissatisfied with the outcome of the investigation into their complaint, the matters raised should not be investigated again. Only if there are issues which have not been addressed initially, should a further response be provided. Arrangements can be made for the complainant to speak to the Investigator for them to discuss the contents of the investigation report and explain anything that is not clear.

If the complainant approaches the Public Service Ombudsman for Wales, the Health Board may be asked to provide a further complaint response letter in order to address any outstanding concerns which were not resolved during the initial investigation.

7. Ombudsman

If the complainant is unhappy with how the Health Board has dealt with their complaint, complainants have the right to contact the Public Service Ombudsman for Wales who will review the matter and will determine on a case by case basis whether to consider the matter.

The Ombudsman is concerned with maladministration causing injustice and this will inform its decisions about accepting a complaint for further consideration. The Health Board cooperates openly and transparently with any enquiries or investigations undertaken by the Ombudsman. The Ombudsman can be contacted as follows:

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ
phone: 0300 790 0203
fax: 01656 641199
email: ask@ombudsman-wales.org.uk
website: www.ombudsman-wales.org.uk

The Health Board has a specific Ombudsman Procedure in place which details how any cases taken forward by the Ombudsman will be managed.

8. Redress

This section of the procedure provides strategic level information on the Health Board's approach to meeting its obligations under the Regulations, and the legal principles that inform decisions concerning the payment of financial compensation.

When harm is found during a complaint investigation, and it is determined that this has been caused by a breach of duty then the Health Board has a duty to consider redress.

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

The provisions for financial compensation contained in the Regulations are intended to provide patients with a speedier and more accessible alternative to pursuing court

based actions for settlement. The procedure provides for financial compensation for patients as one specific form of redress, subject to relevant eligibility criteria and conditions being met.

Most complaints do not allege harm, or find any harm has been caused on investigation, and so most response letters will not refer to an offer of redress (known as a 'Regulation 24' response letter).

If it is thought that harm has been caused following a breach of duty, then the response letter must provide the person raising the complaint with information in relation to the potential for redress. This may be an interim response (known as a 'Regulation 26' response letter) which indicates the need for further investigation to confirm that harm has been caused by the breach of duty, or a response offering financial compensation (known as a 'Regulation 33' response letter).

If the qualifying liability would attract financial compensation of greater than £25,000 then this would result in a 'Regulation 24' response which states that an offer of redress would not be made under PTR but will provide information to take this forward under civil law.

Financial compensation can only be considered if there is a proven qualifying liability in the law of Tort. Investigations will therefore need to establish that the Health Board failed both in its duty of care to a patient, and that the breach of that duty has been causative of the harm that the patient experienced. Only when both of these tests are satisfied will the Health Board consider the payment of financial compensation. In reaching judgments concerning eligibility for financial compensation, the Health Board will also give due regard to the legal principles informing payments for clinical and medical negligence and the developing case law.

The general rule is that if the harm to the patient would not have occurred 'but for' the negligence, then the negligence is the cause of the damage (causation established). If the harm would have occurred in any event, the negligence is not the cause of the damage.

If an investigation identifies possible redress, then please refer to the Redress Policy and Procedure. Advice can be sought through the Complaints Team.

When an investigation identifies that redress is applicable then a 'learning from events' report should be commenced by the service as soon as the investigation is concluded. This will be done by the lead service of the complaint. This report is required by the Welsh Risk Pool within 60 working days to demonstrate that the Health Board has learnt from the issues raised. The Corporate Complaints Team can be contacted if you have any queries in relation to this.

9. Dealing with unreasonable demands and/or behaviour

People may act out of character in times of trouble and distress, with the circumstances leading to a complaint resulting in the person acting in an unacceptable way. People who also have a history of challenging or inappropriate behaviour, or have difficulty expressing themselves, may still have a legitimate complaint.

Behaviour should not be viewed as unacceptable just because the person making the complaint is forceful or determined. However, the actions of people who are angry, demanding, or persistent, may result in unreasonable demands on time and resources or unacceptable behaviour towards staff.

The Health Board seeks to protect its staff and there is procedural guidance available that provides information on what to do when confronted by this behaviour; the Health Board will apply this guidance to guard their staff from unacceptable behaviour such as unreasonable persistence, threats, offensive or aggressive behaviour.

It is vital that staff ensure that there is a complete factual record of events that have taken place and what steps have been taken to de-escalate or manage the situation. Notification to your line manager should also be made as well as reporting any abuse via the incident reporting process.

10. Complex complaints

When a complaint is first received, or at any stage during an investigation, the Health Board must consider whether further actions are required, for example referral to Workforce Department regarding staff conduct or capability issues; the Safeguarding Team regarding relevant concerns; the Patient Safety Team if the matter is serious enough to be referred to the Welsh Government as a serious incident.

The matter may also require referral to other external bodies such as:

- Professional bodies eg General Medical Council; Nursing & Midwifery Council
- Healthcare Inspectorate Wales
- Legal & Risk Services – Complex Patient Team
- Information Commissioner

In such circumstances, the complaint should be referred in the first instance to the Complaints Lead who will arrange to make the necessary referrals, and communicate with the complainant as appropriate.

The Complaints Lead may also establish multi-disciplinary teams or processes to manage complex complaints. Services are expected to support and engage with such processes.

11. Record-keeping

Documentation and record keeping in relation to complaint handling is vital to ensuring that we comply with statutory regulations as well as being good practice to record all communication, decision making and progress.

First Contact must be fully documented and recorded in the current complaints module: this is done via the First Contact form (by the member of staff who is notified of the complaint), which is then inputted into the electronic complaints module (Datix®) by the Corporate Complaints Team.

For all staff, the progress notes within the electronic complaints module are a key function to enable shared and contemporaneous information between services i.e., the investigating officer and the Corporate Complaints Team. Therefore, the person making the complaint will be able to be updated in a timely and comprehensive manner.

The Patient and Carer Experience Team will also aim to gather feedback on the experience of complainants following their journey through this complaints process. This feedback will be used to improve and develop the complaints procedure.

12. Special considerations

Primary Care

If a primary care provider is a managed practice under the Health Board then any complaint is managed as per this procedure.

If the Health Board receives a complaint about a primary care provider, it must be determined whether it is more appropriate for the Health Board or the primary care provider to consider the complaint.

Before making the decision, the Health Board must determine from the complainant whether the complaint has been considered by the primary care provider and if a response has already been provided. If this is the case the Health Board will not be able to consider the complaint.

The complainant must also be asked whether they consent to the complaint being sent to the primary care provider.

If it is decided that it is more appropriate for the Health Board to investigate the complaint, the complainant and the primary care provider must be informed, and the matter dealt with in accordance with this procedure. However, Redress does not apply to primary care providers and only a factual response should be provided without any consideration of any qualifying liability.

If it is decided that it is more appropriate for the primary care provider to investigate the complaint, the complainant and the primary care provider must be informed, and the primary care provider must deal with the complaint in accordance with the PTR Regulations. The complainant must also be advised of their right to notify the Public Services Ombudsman for Wales about the Health Board's decision.

HMP Berwyn

As with all complaints, those relating to healthcare services within HMP Berwyn are responded to within the same regulatory framework as NHS Wales. This means this policy and procedure applies. When a prisoner expresses dissatisfaction about the healthcare service they have or have not received, or about the standard or quality of service, the healthcare staff at HMP Berwyn, through Health and Wellbeing Peer Mentors and/or Service User Engagement Officers, will attempt early resolution if appropriate or possible. If early resolution is not possible then the prisoners will access 'Investigation under PTR' via the Complaints Team.

The peer mentors can be found via the communities or via the health and wellbeing helpline. The peer mentors do their best to answer the concerns immediately, if they are unable to do so, they will speak to a service user engagement officer and a response will be made available within two working days. If the response has not provided an appropriate resolution, the peer mentors are informed and contact is made by the service user engagement officer.

Complaints involving other organisations.

Most complaints are likely to be about services provided by the Health Board. However, there will be situations where services provided by other organisations e.g., another Health Board and/or Trust, are included within the concern. Where a complaint is raised which may involve more than one organisation then the Health Board must, within 2 working days of receipt of the complaint, acknowledge the

involvement of another organisation to the complainant and seek consent to share information with all those involved.

Once consent has been received, other organisations (single or multiple) involved must be informed of the complaint and through the Health Board designated Investigating Officer (IO) agree:

- Which of the organisations will act as lead in coordinating and investigating the complaint?
- Who will directly communicate with the person raising the complaint and keep them updated?
- To provide a joint response, issued by the lead organisation.
- The sharing of information relevant to the complaint, subject to consent obtained at the outset.
- Representation at any relevant meetings.

Complaints raised through an elected representative

Complaints raised through an elected representative are received into the Chief Executive's or Chairman's Office and are coordinated by the Public Affairs Team.

Complaints are then forwarded to the Complaints Team for progression under this procedure with responses reviewed and sent by the Chief Executive following normal approval and sign off.

Some matters raised with elected representatives are not complaints and are referred to as "enquiries." This could include general concerns as outlined above. These matters will be addressed by the Public Affairs Team directly with the respective clinical service.

Data Protection and Information Governance

Complaints relating to data protection and information governance issues will be notified by the Datix system, once reported, to members of the Information Governance Department. Each complaint will benefit from a review by a member of the Information Governance Department who will assess the risk and grade the complaint according to the severity levels outlined in the appendix. This will determine whether the complaint needs to be reported to the Information Commissioner and/or Welsh Government. The investigation of the complaint will then follow the same investigation process until adjudication whereby a member of the Information Governance Department will review the final response alongside the clinical service adjudicator.

13. Advocacy

The Health Board supports and encourages the use of advocates within all services and all staff are required to actively promote this. Details of advocacy services are provided in the Complaints and PALS leaflets available from the Health Board web site or directly from the Patient and Carer Experience Department. All services are required to display the publicity materials on accessing PALS and the complaints process.

The North Wales Community Health Council is the statutory complaints advocacy service covering the Health Board area. By law, people who wish to complain about the care and/or treatment they receive from the NHS are entitled to free, independent and confidential advocacy services to help them make their complaint.

The CHC can be contacted as follows:

Wrexham Office
Units 1B&1C Wilkinson Business Park
Clywedog Road South
Wrexham LL13 9AE
Tel: 01978 356178

Bangor Office
11 Chestnut Court
Parc Menai
Bangor, Gwynedd LL57 4FH
Tel: 01248 679284

Email: complaints@waleschc.org.uk

14. Equality, diversity and accessibility

When written communication is requested and required, every letter/email will be answered in the language in which it was received (Welsh or English) and all personal correspondence will be written in the language used by the person receiving the letter/email if this is known.

For telephone communication, any person contacting the Health Board by telephone is able and welcome to do so through the medium of Welsh or English. If no bilingual member of staff is available to deal with a person who wishes to speak Welsh, the offer will be made to transfer the call to a Welsh speaker, or a Welsh speaker will phone back as soon as he or she is available. If this is not possible, the caller may be offered the option of a translator, or continuing the call in English, or to write to the organisation in Welsh.

Other language resources, including British Sign Language (BSL), can also be accessed via interpretation services. These services are available using telephone, face-to-face, BSL, Deafblind, Braille and translation services. Please refer to the Health Board website/intranet where details of the interpreting services are listed. All written communication and documentation are available in a range of languages and accessible formats, including Easy Read, plain language and large font. Please contact the Patient and Carer Experience Team if you require further information.

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:

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

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

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqlA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Part A

Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Review of Patient and Carer Experience – Complaints Handling Procedure December 2020 – (Ver 0.1).
2.	Provide a brief description, including the aims and objectives of what you are assessing.	BCUHB is committed to the promotion of a positive, inclusive and open culture for the handling of patient and carer concerns as an integral component of wider engagement process, which aims to listen, learn and act on the experience of patients, carers and other service users as the basis for continued quality improvement. This Procedure provides our staff, the public and other key stakeholders with a single point of reference for understanding our particular approach to the management of the complaints process, and wider engagement processes within which this sits.
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Carolyn Owen (Head of Complaints & Carer Experience)
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>The Board has a mandatory responsibility to listen and learn from patient and carer experience and the key policy frameworks include:</p> <ul style="list-style-type: none">• The Health and Social Care (Quality and Engagement (Wales) Act, 2020)• Complaints Standards Authority-Wales Guidance for Public Service Providers on Implementing the Concerns and Complaints Policy 2020• NHS Delivery Framework 2020/2021 (NHS Wales, 2020)• Parliamentary Review of Health & Social Care in Wales (2018)

		<ul style="list-style-type: none"> • Listening and Learning from Feedback: A Framework for Assuring Service User Experience (WG 2015a) • Health & Care Standards for Wales (WG 2015b) • Wellbeing of Future Generations (Wales) Act 2015 • Social Services and Wellbeing (Wales) Act 2014 • Health and Social Care (Community Health & Standards) Act 2003 • NHS Redress (Wales) Measure 2008 • National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 • Model Complaints Policy and Guidance for Public Services In Wales (2011) • Putting Things Right: Guidance on dealing with concerns about the NHS (2013) • Using The Gift of Complaints review commissioned by the Welsh Government and authored by Keith Evans (2014) • Accessible Information and Communication Standards for people with Sensory Loss (WG, 2013)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	<p>Patients, Carers, Relatives and Other Service Users</p> <p>Chairperson, Vice Chairperson, Chief Executive Office, Other Board Members, Associate Director of Quality Assurance, Senior Investigations Officer, Divisional Leads, Managers and ALL Operational Staff Groups.</p> <p>Voluntary and Charity Groups representing patients, carers and other service users such as Community Health Council/Citizen Voice Body, Centre for Sign Sight & Sound, Vision Support, etc.,</p>
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	<p>This procedure aims to develop an open and engaging culture in which patient, carers and other service users are able to share their experiences, in an open, risk free manner, which promotes dignity and organisational learning in line with our mandatory and statutory responsibility outlined at 3. Engagement with patients, carers and other service users at all stages from “first contact” through to ‘resolution’ is critical to the success of the procedure. This review ensures that there are a sufficient range of mechanisms to enable <i>ALL</i> patients, carers and other service (regardless of their protected characteristics), are proactively provided with the opportunity, within the scope of this procedure, to enable a satisfactory, complete, timely and where possible early resolution to the issues raised. Thus sharing their experiences so that BCUHB is able to listen, learn and act on these, in line with its mandatory responsibilities.</p>

The Patient Care Safety & Experience Team, are currently implementing a number of project managed work streams which operationally provide a number of controls cited in section 2., namely;

1. Provision of a Patient Advice Support and Liaison (PALS) service across BCUHB facilitated by 9.0 wte PALS officers.
2. Provision of real/near time patient, carer and other service user feedback – including real/near time, and retrospective feedback such as patient stories. These feedback mechanisms enable segmentation of feedback by protected characteristic and support service improvement e.g. You Said We Did, Ward Accreditation and Organisational Quality Assurance (see 6 below).
3. Provision of written information for patients, carers and other service users, commensurate with the requirements of ISUE02 – BCUHB Guidelines on Written Information for Patient, Carers and Service Users. The guidelines reinforce BCUHB's statutory duty to provide information in accessible formats commensurate with identified communication needs arising from sensory loss and/or protected characteristics.
4. Compliance with the all Wales Accessible Information and Communication Standards for People with Sensory Loss (WG, 2013) including, in collaboration with the Centre for Sign Sight and Sound provision of the Accessible Health Care Scheme.
5. Development of the Patient & Carers Champions role to support the above work streams and key elements of the Carers Strategy.
6. Board level accountability for the achievement of the outcomes of this strategy and the wider Patient & Carer Safety and Experience agenda, via agreed QA framework reporting; Bi monthly Patient and Carer Experience Report – destination Executive Patient and Carer Experience Group (PCE), Bi monthly Patient Safety Report – destination Executive Patient Safety and Quality Group (PSQ) and Quarterly Reporting, and Quarterly to the Board Quality Safety and Effectiveness Group (QSE). Operationally the above is supported via Quality Assurance and Local Dash boarding of Data.

Other Generic Controls

7. The Implementation of the All Wales WPAS platform across all operating regions by the end of Q4-2020/2021 under the auspices of the WIS project will provide; an enhanced ability to record protected characteristics and associated communication needs, increased flexibility over appointment templates, enable the standardisation of the coding and

		<p>recording of communication needs, and the production of exception reports eg clinic preparation lists which flag in advance the need to book a WITS interpreter.</p> <p>8. In line with other HBs in Wales BCUHB is migrating its current internet site to MURA content management system, which along with the latest browser technology will provide improved compliance with Web Accessibility Guidelines (QCAG) 2.1 AA and include an ability to change font size and support for a variety accessibility add-ins such as Adobe™ – Read Out Loud. The redesign of the Complaints (Putting Things Right) page and associated links has been given a high priority, has now been complete, and includes a digital user interface for those patients, carers and other service users who wish to raise a concern using the internet and signed BSL guidance is provided in relation to this.</p> <p>9. Each complaint once resolved is evaluated using a feedback survey in order to determine the effectiveness of the service and as the basis for service development.</p> <p>10. 'Treat Me Fairly' equality training is mandated component of BCUHBs Mandatory Training Policy (WP33).</p> <p>11. The Complaints Datix™ enables the user to set a (Yes/No) flag if the Concern related to Equality or Discrimination, this enables broad monitoring of the complaints in relation to those where equality or discrimination is alleged as a contributing factor.</p>
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Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:-		Please detail here, <u>for each characteristic listed on the left</u> : - (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+) Negative (-) Neutral (N) No Impact/Not applicable (N/a)	High Medium or Low	
Age	N	Low	2.1 The complaints public facing interface uses a multi-media, multi-channel approach in order to enhance inclusion. The service is resourced with staff who possess a wide range of experiences who are specifically trained in complaints handling and in relation to positively responding to the needs across the age spectrum. Real/Near Time feedback from patient, carers and other service

			users highlights the importance of the provision of timely, accurate, empathetic, and in-person response to concerns and along with alternative communication channels, this remains a prime feature of the 'First Contact' phase of the complaints handling model, proposed within this procedure. (See also sections 1.1-1.6 above).
Disability	-ve	Low	<p>2.2. Disabilities resulting in sensory loss or impairment are reported by our patients, carers and other service users as a key barrier to access to our service and progression within these on the same basis as other patients, carers and other service users. Accessing and using the complaints process is no exception, and it is important that regardless of disability (or any other protected characteristic) patients, carers and other service users are not in any way disadvantaged in accessing and using the complaints procedure. The ability to sign post patients, carers and other service users to the accessible health care scheme, run collaboratively with the Centre for Sign Sight and Sound under the auspices of a rolling SLA is along with PALS a key control.</p> <p>2.3 Compliance with the all Wales Accessible Information and Communication Standards for People with Sensory Loss (WG, 2013) including, in collaboration with the Centre for Sign Sight and Sound provision of the Accessible Health Care Scheme, enables patients, carers and other service users to access additional, independent support in accessing and using the Complaints Process. This is augmented by access to the PALS service during working hours Mon-Friday. (See also sections 1.1 & 1.4 above)</p> <p>2.4 Additionally, access to internet based information, in an accessible format, is critical for patients, carers and other service users with a sensory loss, and recent developments in the provision of BSL signed guidelines on making a complaint, coupled with developments in migrating BCUHB Web Site to the MURA platform which is compliant with Web Accessibility Guidelines (QCAG) 2.1 AA and includes an ability to change font size and support for a variety of accessibility add-ins such as Adobe™ – Read Out Loud and MS-Office – Read Out. Ensures increased accessibility in relation to communication needs arising from sensory loss. (See also sections 1.7-1.8 above)</p> <p>2.5 Physical Accessibility to our estate can be problematic; however, the Concerns and PALS teams can ensure meeting space appropriate to the needs of the patient, carer and other service user and/or appropriate virtual access if this is required. (See also section 1.1 above)</p>

Gender Reassignment	-ve	Low	<p>2.6 Treat Me Fairly equalities training provides a firm basis to ensure the provision of an inclusive culture and staff are generally self-aware and are able to avoid negative stereotypes relating to gender reassignment. Within the concerns and wider Patient Safety and Experience team this is reinforced via departmental induction, managerial supervision, group supervision and debriefing & review sessions where appropriate. (See also section 1.10 above).</p> <p>2.7 The Patient Carer and Experience (PCE) executive sub-group enables general representation from patients, carers and other service users relating to this and other protected characteristics and the PCE is responsible for reviewing this procedure and the associated EQIA. Additionally, the impact of the procedure on this and other protected characteristics may be evaluated (i) via complaints questionnaire and (ii) indirectly via existing frameworks for listening, learning and acting on patient, care, and other service user feedback – see sections 1.2, 1.6, 1.9 & 1.11 above.</p>
Marriage & Civil Partnership	-ve	Low	(See 1.1-1.11 and 2.1-2.7 above, and 2.9 below)
Pregnancy & Maternity	-ve	Low	(See 1.1-1.11 and 2.1-2.7 above, and 2.9 below)
Race / Ethnicity	-ve	Low	(See 1.1-1.11 and 2.1-2.7 above, and 2.9 below)
Religion or Belief	-ve	Low	<p>(See 1.1-1.11 and 2.1-2.7 above, and 2.9 below)</p> <p>2.8 BCUHB has a highly developed Chaplaincy Team, and the PALS and Concerns Team are able to draw on their advice and guidance as required. Additionally, the Chaplaincy Team as integral members of the Patient Carer and Experience group will review this procedure prior to board approval.</p>
Sex	-ve	Low	<p>(See 1.1-1.11 and 2.1-2.7 above, and 2.9 below)</p> <p>2.9 Although not explicitly stated within the procedure, in line with BCUHBs approach to Dignity and the overarching aims of the Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019), via flexible deployment of Concerns Team, PALS officers, and Service Experience Managers, the Patient Carer Experience and Safety Department will make every practical effort to</p>

			ensure that patients, carers and other service users are given the opportunity to choose to discuss their concerns with a male or female team member (and/or by a team member identifies as male of female).
Sexual Orientation	-ve	Low	(See 1.1-1.11 and 2.1-2.9 above)
Welsh Language	N	Low	<p>(See 1.1-1.11 and 2.1-2.9 above)</p> <p>2.10 Compliance with the Welsh Language Wales Measure (WG, 2011) is integral to this procedure, the wider Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019). This procedure explicitly recognises that patients, carers and other service users have a statutory right for services to be provided through the medium of Welsh. To facilitate this, (i) the Datix™ Complaints Data table enables the complaints handler/PALS officer to record that the patient, carer and other service users wishes to communicate with the HB in Welsh, (ii) recruitment strategy is such that there are sufficient members of the complaints and PALS team to provide a bilingual service and (iii) such provision is monitored via BCUHB's strategic Welsh Language Group.</p>
Human Rights	N	Low	<p>(See 1.1-1.11 and 2.1-2.10 above)</p> <p>2.11 In developing this procedure and the wider Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019) it has been implicitly assumed that the development of the patient, carer and other service user experience and in particularly the ability of BCUHB to Listen, Learn and Act on this, also promotes a human rights agenda as set out by the Human Rights Act (UK, 1998) in particular, Right to Life (Article 2), Freedom of Expression (Article 10), Right to marry and start a family (Article 12) and to live free from Discrimination (Article 14). BCUHB's Equality & Diversity Policy (WP8) clearly establishes these links and is explicitly referenced within framework ISUE01. However, in order to further the Human Rights agenda as set out by the HRA (UK, 1998) – the training programme accompanying this procedure will make this link explicit with reference to the supporting materials BCUHB intranet.</p>

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Form 3: Assessing Impact against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity; and
- Foster good relations between different groups

1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise

This EqIA itself has identified that there are sufficient controls in place (see 1.1-1.11 and 2.1-2.11) either as a result of existing organisational frameworks which promote equality and diversity, as well as those specific to this procedure and the wider Patient Carer & Safety (Complaints) and Experience team as defined by the Patient & Service User Experience Strategy, 2019-2022 (BCUHB, 2019) and the wider engagement agenda which underpins BCUHBs statutory responsibility to listen, learn and act on feedback (WG, 2015, 2020).

The Patient & Carer Safety & Experience team who will have prime responsibility for operationalising this procedure, have the skills, knowledge, attitudes and awareness of the Equality and Human Rights agenda to respond empathetically to the needs of our patient, carers and other service users in a way which promotes dignity and enables them to share

	<p>their experiences with us. The Patient & Carer Safety & Experience team have developed a project managed work stream which builds on the competencies engendered via 'Treat Me Fairly' to develop the skills and knowledge base required to effectively implement this procedure, both within the department and the wider organisation.</p>
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	<p>This procedure is one part of a much wider engagement strategy. It sets out how the board [and thus the organisation] expects its staff to engage with patients, carers and others when they raise concerns about care, treatment and other matters of general importance. It emphasises the crucial need to understand the exact nature of any concern that is shared, and of choosing the best course of action by way of response.</p> <p>This EqIA and the development of this framework alongside the Patient & Service User Strategy 2019-2022 (BCUHB) will enable BCUHB to build on existing best practice to ensure that process of listening and learning from patients, carers and other service users, is firmly integrated within the Equalities and Diversity agenda. The developed nature and broad approach to the complaints resolution process proposed by this procedure will ensure that (i) the needs of patients, carers and other service users are at the forefront of decision making, (ii) roles and responsibilities are clearly defined, and (iii) these are the focus scoped "training and development programmes including;</p> <ul style="list-style-type: none"> • Patient and Carers Care • Communication • Putting Things Right Complaints Training • Legal Awareness • Records Management • Safeguarding Children and Vulnerable Adults • Sensory [loss] Awareness • Equality and Diversity Awareness <p>Implementation of this procedure coupled with the experience already gained in listening, learning and acting on the feedback of patients, carers and other service users, including those with protected characteristics will significantly contribute to a culture of inclusivity and wider equality awareness within the Patient & Carer Safety and Experience Team and the wider organisation. Along with the reporting and accountability (QA) frameworks outlined in section 1.6 above, it provides the infrastructure necessary to create the organisational learning required to ensure that where services fall below the expected standards required of</p>

	<p>us, that we are able to identify contributory factors relating to equality and human rights, amongst others and act on these to improve services. Thus ensuring that the Patient & Carer Experience – General Concerns & Complaints Procedure not only becomes a central tenet of culture which promotes patient safety through providing the infrastructure to listen, learn and act on patient, carer and other service user experience but also for proactively promoting equality and diversity in the work place.</p>
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	<p>In line with the general approach to the delivery of the Patient & Carer Experience and Safety agenda, the development of this procedure has been based on co-productive collaboration between a number of key internal and external stakeholders. Providing a voice for patients, carers and other service users with protective characteristics and in particular sensory loss has been a prime consideration. Understanding the views of these stakeholders has been made possible via the highly developed mechanisms for listening and learning developed as an integral component of the wider engagement agenda, which is an integral component of managed work streams (see sections 1.2 & 1.6 above), such that these are central to what we do, and how we do it.</p> <p>The existing infrastructure for engagement has made it possible to in addition to understanding the views of patients/carers/services, to work collaboratively with a number of key partners in the development and review of this procedure, some key examples include;</p> <ul style="list-style-type: none"> • BCUHB Equalities Department, Patient Safety and Experience Department Managers & Staff, Service Managers, Chaplaincy Service etc., • Community Health Council, (soon to become Citizen Voice Bodies) • 3rd sector organisations such as Centre for Sign Sight & Sound, Vision Support, WITs, Help the Aged etc. <p>amongst others.</p> <p>The process of collaboratively developing this procedure has enabled BCUHB to create a parallel learning structure which has engendered the organisational creativity and innovation to ensure that patients, carers and other service users and those who represent them are able to share their experiences with us, in a manner which promotes a culture of inclusivity commensurate with BCUHB's stated values. This provides an extremely firm context in which to operationalise this procedure. In reviewing this process through the lens of this EqIA; it is interesting to note how as an organisation we set out to improve our ability to</p>

	listen to and resolve the concerns of our patients, carers and other service users but in so doing have also developed a framework for promoting equality and human rights.
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Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD		
1. What is being assessed? (Copy from Form 1)	Review of the Complaints Handling Procedure December 2020; aligned to the Patient and Carer Experience – General Concerns & Complaints Policy – October 2020 – (Ver 0.1)		
2. Brief Aims and Objectives: (Copy from Form 1)	BCUHB is committed to the promotion of a positive, inclusive and open culture for the handling of patient and carer concerns as an integral component of wider engagement process, which aims to listen, learn and act on the experience of patients, carers and other service users as the basis for continued quality improvement. This procedure provides our staff, the public and other key stakeholders with a single point of reference for understanding our particular approach to the management of the complaints process, and wider engagement processes within which this sits.		
3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No	<input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input checked="" type="checkbox"/>	No	<input type="checkbox"/>
3c. Is your decision or policy of high significance?	Yes <input checked="" type="checkbox"/>	No	<input type="checkbox"/>
4. Did the decision scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic?		
	The review of the Patient and Carer Experience – General Concerns & Complaints Procedure is highly significant both to the successful implementation of the Patient & Carer Service User Strategy 2019-2022 (BCUHB, April 2019), accountable work streams within the wider Patient & Carer Safety and Experience Team and to BCUHB's statutory		

	and mandatory obligations including the development of a patient safety culture which promotes equalities and human rights. Having reviewed the procedure in terms of their impact on each of the cited protected characteristics including human rights, the procedure and/or compliance with related policies and/or the cited resources and/or the cited training and development provide sufficient controls in relation to any identified risk such that a full impact assessment is not required in this case.	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ✓	No
	<p>Record Details:</p> <ol style="list-style-type: none"> 1. Monitoring, resourcing and implementation of the agreed action plan for improved compliance with the Accessible Information and Communication Standards for people with sensory loss as documented within the WG narrative Performance Report and endorsed by the PCE (September 2020) 2. Continued project management of work streams identified in section 1.1-1.6 above. 3. Development of Training Materials and Intranet to support the development of skills and knowledge in relation to this procedure (see section 2.1), which in turn underpin the skilful performance of roles identified within the procedure. 4. Continue to develop the infrastructure to listen learn and act from patient, carer and other service user experience including from the complaints/resolution process inherent in this procedure. 5. Continue to improve the ability to report patients, carers and other service user experience by protected characteristics, including experiences captured as an integral component of the complaints process and of the wider experience of making a complaint in order to develop services which are inclusive and free from discrimination. 	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes ✓	No
	How is it being monitored?	Via internal project managed work streams within the Patient & Carer Safety and Experience Team, reporting to organisational Quality Safety and Effectiveness, Patient and Carer Experience Group, Patient Safety & Quality and Equalities groups.
	Who is responsible?	Head of Patient & Carer Experience and Complaints, delegated responsibility to Patient & Carer Safety and Experience Team Managers.
	What information is being used?	Data sets are available as an integral component of existing reporting arrangements for Complaints Monitoring (DATIX™) and for Recording Patient, Carer and other Service User

		Experience. These arrangements will be enhanced by the utilisation of local dashboards to segment data by Protected Characteristics as an integral component of the Transformation and Learning Workstream.
	When will the EqIA be reviewed?	May 2024

7. Where will your decision or procedure be forwarded for approval?	Patient and Carer Experience Group December 2020
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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	<p>In line with the general approach to the delivery of the Patient & Carer Experience and Safety agenda, the development of this procedure has been based on co-productive collaboration between a number of key internal and external stakeholders. Providing a voice for patients, carers and other service users with protective characteristics and in particular sensory loss has been a prime consideration. Understanding the views of these stakeholders has been made possible via the highly developed mechanisms for listening and learning developed as an integral component of the wider engagement agenda, which is an integral component of managed work streams (see sections 1.2 & 1.6 above), such that these are central to what we do, and how we do it.</p> <p>The existing infrastructure for engagement has made it possible to in addition to understanding the views of patients/carers/services, to work collaboratively with a number of key partners in the development and review of this procedure, some key examples include;</p> <ul style="list-style-type: none"> • BCUHB Equalities Department, Patient Safety and Experience Department Managers & Staff, Service Managers, Chaplaincy Service etc., • Community Health Council, (soon to become Citizen Voice Bodies) • 3rd sector organisations such as Centre for Sign Sight & Sound, Vision Support, WITs, Help the Aged etc. <p>amongst others.</p>
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9. Names of all parties	Name	Title/Role
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involved in undertaking this Equality Impact Assessment:		
	Carolyn Owen	Head of Patient & Carer Experience

Form 4 (ii): Action Plan

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

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	<p>The controls in sections 1.1-1.6 are those which broadly fall within the scope of Managed Work Streams within the Patient & Carer Experience and Safety Tem, are the prime mechanisms for mitigating the minor risks identified in section 2.</p> <p>The General Concerns and Complaints Procedure 2021 supports controls which largely relate to all Wales initiatives and the wider systems infrastructure which defines the context of this procedure.</p> <p>It also outlines in relation to the following protected characteristics; Disability, Gender Reassignment, Marriage & Civil Partnership Pregnancy & Maternity, Race / Ethnicity, Religion or Belief, Sex.</p>	<p>Head of Patient and Carer Experience.</p> <p>Head of Patient and Carer Experience. Head of Information Quality Concerns Quality Management Systems Group</p> <p>Head of Patient and Carer Experience. Strategic Equalities Group</p>	Quarterly beginning Q4-2020/2021
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	##To Be Discussed ##		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	See actions outlined above; especially in relation to the following protected characteristics; Disability, Gender Reassignment, Marriage & Civil Partnership Pregnancy & Maternity, Race / Ethnicity, Religion or Belief, Sex.	Head of Patient and Carer Experience. Strategic Equalities Group	Quarterly beginning Q4-2020/2021
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	Controls have been identified for all potential negative impacts see actions outlined in section 1 (1.1-1.11) and section 2 (2.1-2.11) above.	Head of Patient and Carer Experience. Strategic Equalities Group	Quarterly beginning Q4-2020/2021
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	## To be Discussed ###		Quarterly beginning Q4-2020/2021



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 1 March 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Summary of business considered in private session to be reported in public						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery						
Awdur yr Adroddiad Report Author:	Philippa Peake-Jones, Head of Corporate Affairs						
Craffu blaenorol: Prior Scrutiny:	None						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Committee is asked to note the report							
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input type="checkbox"/>	Er gwybodaeth For Information	<input checked="" type="checkbox"/>
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
To report in public session on matters previously considered in private session							
Cefndir / Background:							
Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.							
Asesiad / Assessment							
The Quality, Safety and Experience Committee considered the following matters in private session on 11.1.22 Hergest Serous Incident Review.							