Bundle Quality, Safety & Experience Committee 15 January 2021

9.30am Virtual via Webex

Public Session

0 Note - Pre Meeting of Independent Members to take place at 09:00

1.0 OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 09:30 - QS21/1 Chair's Opening Remarks

1.2 09:32 - QS21/2 Declarations of Interest

1.3 09:33 - QS21/3 Apologies for Absence

Adrian Thomas, Gavin McDonald, Teresa Owen, Iain Wilkie

1.4 09:34 - QS21/4 Draft Minutes of Previous Meeting Held in Public for Accuracy, Matters Arising and Review of Summary Action Log

++Matter Arising QS20/195 Hospital Acquired Infection++
"The Committee had been provided with two papers – a Covid-19 review of hospital acquired infections and a report from the Covid-19 Delivery Group. A member enquired whether the outbreak had been retrospectively reported to the Health and Safety Executive (HSE) and within Datix".
Response from Peter Bohan "all clusters outbreaks are investigated with 72 hour review and Make it Safe assessment if the outbreak is deemed to be work related all reports are sent to the HSE and is contained in the Q3 report"

QS21.4a Minutes QSE 3.11.20 Public V0.03.docx

QS21.4b Summary Action Log QSE Public.docx

1.5 09:49 - QS21/5 Draft Minutes Joint Audit and Quality, Safety & Experience Committee Held on 24.11.20

QS21.5 Minutes JAQS 24.11.20 V0.03.docx

2.0 FOR DISCUSSION

2.1 09:54 - QS21/6 Board Assurance Framework Principal and Corporate Risk Report: Simon Evans-Evans

Recommendation:
The Committee is asked to:
1. Review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) and Corporate Tier 1 Operational risks presented.
2. Receive assurance on the controls and mitigations in place to manage the risks in line with the Health Board's agreed Risk Appetite Statement.

QS21.6a BAF and Corporate Risk Report - v1-Final.docx

QS21.6b Appendix 1 - BAF 2020-21-QSE Report V2-January 2021.pdf

QS21.6c Appendix 2 - Corporate Risk Register Report.pdf

2.2 10:14 - QS21/7 Infection Prevention & Control Update - Gill Harris

Presentation slides to follow

Recommendation:
The Committee is asked to take assurance from the Infection Prevention presentation

QS21.7a IPC.docx

2.3 10:29 - QS21/8 Health & Safety Q3 Report - Sue Green

Recommendation:
The Committee is asked to note the position outlined in the Quarter 3 Report.

QS21.8 Health and Safety Q3 Report 31.12.20 Final.docx

2.4 10:39 - QS21/9 Holden Recommendations - Matt Joyes

Recommendations:
The Quality, Safety and Experience (QSE) Committee is asked to:
1\. Note the report
2. Approve the two recommendations made arising from this review:
a) All future significant quality-related reports have resultant action plans tracked by the Associate Director of Quality Assurance's Office using the same governance framework and methodology of that used for HIW actions to include progress reporting in the Quality Assurance Report to the Patient Safety and Quality Group (and therefore onto QSE Committee).
b) Any significant quality-related reports, when tracked through the process mentioned in the preceding recommendation, are assured in a timely fashion and have clear close down reports when all actions are complete.

QS21.9a Holden Report.docx

QS21.9b Holden Report Appendix 1.docx

2.5 10:54 - QS21/10 Mental Health and Learning Disabilities Exception Report - Mike Smith

Recommendation:
The Committee is asked to note the report.

QS21.10 MHLD Update FINAL v1.0.doc

2.6 11:09 - **comfort break**

2.7 11:19 - QS21/11 Planned Care Recovery : update - Andrew Kent

Recommendation:
The Committee are asked to note the work to date on the six-point recovery plan

QS21.11 Planned care recovery.docx

2.8 11:34 - QS21/29 Quality Governance Review - Matt Joyes

Recommendation:
The Quality, Safety and Experience Committee is asked to receive this report for assurance.

QS21.29 Quality Governance Review YGC.docx

3.0 11:39 - FOR CONSENT

3.1 QS21/12 Nursing Workforce for Acute Sites, Community Hospitals and Community Nursing Services - Gill Harris/Debra Hickman

Recommendation:
The Committee is asked to acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported.

QS21.12a Nursing workforce.docx

QS21.12b Nursing Workforce Appendix 1 CNO Letter re Critical Care Staffing.pdf

QS21.12c Nursing Workforce Appendix 2 – CNO Letter re Maintaining Staffing Levels.pdf

QS21.12d Nursing Workforce Appendix 3– Nurse Staffing Sitrep reporting criteria.docx

QS21.12e Nursing Workforce Appendix 4i NHS Pressures Local Options Framework Winter 20-21.pdf.docx

QS21.12f Nursing Workforce Appendix 4ii NHS Pressures Local Options Framework Winter 20-21.pdf

3.2 QS21/13 Chair's Report : Patient Safety Quality Group - Debra Hickman

QS21.13 Chair's Report PSQ.doc

3.3 QS21/14 Chair's Report : Strategic Occupational Health & Safety Group - Sue Green

Note - report will be on 'Triple A' format for next meeting

QS21.14 Chair's Report SOSHG.docx

3.4 QS21/15 Chair's Report : Clinical Effectiveness Group - Arpan Guha

QS21.15a Chair's Report CEG Final Version.docx

QS21.15b Chair's Report CEG Appendix 1 - Delivering Effective Clinical Audit.docx

QS21.15c Chair's Report CEG Appendix 2 - Logic Diagram - Effective Clinical Audit.docx

3.5 QS21/16 Chair's Report : Patient Carer Experience Group - Debra Hickman

QS21.16 Chair's Report PCE.doc

3.6 QS21/17 Mental Health & Learning Disabilities Division Resubmission of Written Control Documents - Mike Smith

Recommendation:
The Committee is asked to approve the amended written control documents for implementation.

QS21.17a MHLD Written Control Documents Report template.docx

QS21.17b MHLD Appendix 1 Threats to the person and Environment in Forensic Establishments Policy.docx

QS21.17c MHLD Appendix 2 EqIA Threats to the Person Procedures in Forensic Establishments.doc

QS21.17d MHLD Appendix 3 Major Incident Protocol (6) Amended.doc

QS21.17e MHLD Appendix 4 EQIA Major Incident Plan 2020.docx

QS21.17f MHLD Appendix 5 0041 Forensic Services Handcuff Policy (3).docx

QS21.17g MHLD Appendix 6 EQIA Use of Handcuffs in Ty Llywelyn Medium Secure Unit.docx

4.0 11:49 - FOR INFORMATION

4.1 QS21/18 Serious Incident Report October and November 2020 : Matt Joyes

Recommendation:
The QSE Committee is asked to:
1\. Note the report\.
2\. Note the introduction of the daily Datix review meetings which provides the Health Board with greater oversight and assurance of incidents as they are reported\.

QS21.18 SI Report.docx

4.2 QS21/19 Improvement Group (HASCAS & Ockenden) : Gill Harris

Recommendation:
The Committee is asked to note the progress against the recommendations to date and that the oversight of the remaining open recommendations be provided through existing quality assurance routes.

QS21.19 HASCAS Ockenden update v3.docx

4.3 QS21/20 Safeguarding - Gill Harris

The Committee is asked to note the progress made this year by the Corporate Safeguarding Team

QS21.20a Safeguarding.docx

QS21.20b Safeguarding Appendix 1.docx

4.4 QS21/21 Audit Wales Review of Quality Governance Arrangements - Matt Joyes

Recommendation:
The Committee is asked to note for information the Audit Wales review of the Health Board's Quality Governance arrangements.

QS21.21a Audit Wales Review of Quality Governamce Arrangements.docx

QS21.21b Audit Wales Review of Quality Governance Arrangements_Appendix 1.pdf

4.5 QS21/22 Public Services Ombudsman Public Interest Report - Matt Joyes

Recommendation:
The Committee is asked to receive and note the report formally.

QS21.22a Ombudsman Paper.docx

QS21.22b Ombudsman Appendix 1.pdf

4.6 QS21/23 Healthcare Inspectorate Wales Update Report - Matt Joyes

Recommendation:
The Committee are asked to note the following reports;
1. Healthcare Inspectorate Wales National Review Maternity Services, Phase One Report, Published 19 November 2020
2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), The Stables Medical Practice (Non NHS Managed) on 8 September 2020. Published 17 November 2020
3. Healthcare Inspectorate Wales Quality Check (Planned), Ablett Unit, Glan Clwyd Hospital on 20 November 2020

QS21.23a HIW Paper.docx

QS21.23b HIW_Appendix 3 HIW Quality Check- Ablett.pdf

4.7 QS21/24 Issues Discussed in Previous Private Session

Recommendation:
The Committee is asked to note the report

QS21.24 Issues discussed in previous private session.docx

4.8 QS21/25 Documents Circulated to Members

3.12.20 Briefing note on thrombosis
14.12.20 Quarterly Plan Monitoring Report for November

4.9 QS21/26 Issues of Significance to inform the Chair's Assurance Report

4.10 QS21/27 Date of Next Meeting

2.3.21

4.11 QS21/28 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."

Quality, Safety and Experience (QSE) Committee
Minutes of the Meeting Held in public on 3.11.20 via Webex

Present:

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

In Attendance:

Jackie Allen	Chair of Community Health Council *(part meeting)*
Kate Clark	Secondary Care Medical Director
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum *(part meeting)*
Simon Evans-Evans	Interim Director of Governance *(part meeting)*
Sue Green	Executive Director of Workforce and Organisational Development (OD) (*part meeting)*
Lynne Grundy	Associate Director Research and Innovation (*part meeting)*
Dave Harries	Head of Internal Audit *(part meeting)*
Debra Hickman	Acting Executive Director of Nursing and Midwifery
Ffion Johnstone	Area Director West (*part meeting)*
Matthew Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience
Andrew Kent	Interim Head of Planned Care (*part meeting)*
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead
Teresa Owen	Executive Director of Public Health and Acting Deputy Chief Executive *(part meeting)*
Mike Smith	Interim Director of Nursing Mental Health and Learning Disabilities *(part meeting)*
Chris Stockport	Executive Director of Primary and Community Services *(part meeting)*
Adrian Thomas	Executive Director of Therapies and Health Sciences
Iain Wilkie	Interim Director of Mental Health and Learning Disabilities *(part meeting)*
Mark Wilkinson	Executive Director of Planning and Performance *(part meeting)*

Agenda Item Discussed	Action By
QS20/186 Chair's Opening Remarks **QS20/186.1** The Chair apologised for the late start to the meeting and extended a warm welcome to Jackie Allen and Iain Wilkie at their first QSE Committee meeting. She noted the intention to make full use of the consent section on the agenda and confirmed that members had shared comments with Executives in advance of the meeting. The Prison Health paper would be moved from the consent section to the discussion section.	

QS20/187 Declarations of Interest **QS20/187** Gareth Evans and Adrian Thomas declared an interest in item QS20/205 with regards to their substantive roles relating to speech and language therapy services.	
QS20/188 Apologies for Absence QS20/188.1 Recorded for Arpan Guha and noted that Kate Clark was deputising. A number of officers indicated they would need to leave the meeting for other commitments at some point.	
QS20/189 Minutes of Previous Meeting Held in Public on 28th August 2020 for Accuracy, Matters Arising and Review of Summary Action Log **QS20/189.1** The minutes were approved as an accurate record pending the following amendment: QS20/153.5 to read "planned care group" not "primary care group". **QS20/189.2** Updates were provided to the summary action log. **QS20/189.3** A range of members' briefing notes were noted as having been circulated with specific actions agreed as follows: • The Acting Executive Director of Nursing and Midwifery would follow up and provide detail of training plan trajectories in relation to the Deprivation of Liberty Safeguards briefing note. • The Senior Associate Medical Director/Improvement Cymru Clinical Lead would follow up on the points raised around the level of confidence in the actions set out in the thrombosis briefing note.	DH MM
QS20/190 Patient Story **QS20/190.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience presented the patient story which related to an experience of planned care surgery in the West. The messages and learning around communication had been shared with immediate and wider teams, eg; theatre staff. **QS20/190.2** A discussion ensued. A member sought assurance that staff were given enough opportunity to explain why things had happened in a certain way. Other members were keen to see a more rounded view within patient stories but it was accepted that by their nature they reflected patients' own words and experiences. Pertinent to this particular patient story, a member indicated she would wish to see an improvement in the quality of written information that is provided to patients following surgical procedures and more time awarded to communicating advice to them. Another member enquired whether pre-operative assessments were currently being undertaken and it was confirmed these were taking place virtually with a risk assessment approach to identity those patients that would need to be seen for a full assessment.	

QS20/191 Quarter 2 Plan Monitoring Report **QS20/191.1** A member felt that performance regarding Stroke and Neurodevelopment of children were areas of real concern. The Executive Director of Planning and Performance confirmed that stroke was a priority area and the aim was to finalise a refreshed business case before the end of January 2021 following concerns raised by the Finance and Performance (F&P) Committee on financial aspects previously. He confirmed that he was in communication with the North Wales Community Health Council (CHC) around their concerns also. It was suggested that the Strategy, Partnerships and Population Health (SPPH) Committee consider stroke services at their next meeting. **QS20/191.2 It was resolved** that the Quality, Safety & Experience Committee note the report.	
QS20/192 Quality & Performance Report **QS20/192.1** The Executive Director of Planning and Performance welcomed the queries that had been raised by members prior to the meeting which had been responded to, and he accepted there remained issues with the quality of this report. **QS20/192.2** A discussion ensued. A member referred to the impact of Covid-19 on unscheduled care including a deterioration in ambulance handover times and enquired if there were particular hotspots. It was confirmed that Ysbyty Glan Clwyd (YGC) was a significant outlier and the Executive Team were sighted on improvement actions being put in place by the Managing Director. Another member noted that page 8 of the report indicated that there were less than 20% of children and young people waiting less than 26 weeks for neurodevelopment assessment, however, page 14 said that 80.5% of CAMHS (Child Adolescent Mental Health) assessments were undertaken within 28 days which appeared contradictory. The Executive Director of Planning and Performance undertook to check these figures and respond outside of the meeting. Another member commented that the formatting of data on pages 12 and 13 made it difficult to read; this would be reviewed for future reports. The Committee Chair asked about the numbers of delayed transfers of care for mental health referenced on page 4 did not match the data reported on page 14. The Chair also referred to the narrative for the reasons for some of the delayed transfers as it implied that the delays were due to funding decisions being awaited as it referenced continuing healthcare whereas. The Executive Director of Planning and Performance confirmed the current situation was an improving position in terms of performance and that there was recent intelligence to support this which had not been included in the report. In terms of the reason for the delays he confirmed these were not purely down to funding issues but primarily related to the need to ensure the most appropriate commissioning arrangement could be put in place. The Interim Director of Nursing added that there were often issues of complexity around a safe transfer and safe assessment of need and the overall availability of placements. **QS20/192.2** The Committee Chair was conscious that very often the narrative of the QPR suggested to members there was an issue or concern, when in fact the discussion at the meeting assured them this was not the case. She noted this had been raised previously by the Committee and also the issue of there being inconsistencies in data reported in different	MW MW

papers. The Executive Director of Planning and Performance accepted the comments and hoped that recent personnel changes would go some way to improving matters. **QS20/192.3 It was resolved that** the Quality, Safety & Experience Committee having scrutinised the report, noted the information provided.	
QS20/193 Essential Services and Restart Update *[Mr A Kent joined the meeting]* **QS20/193.1** A member noted that page 5 of the report indicated that a range of improvement initiatives were being rapidly explored and she requested that members receive a short update against each of them outside of the meeting. The CHC Chair raised a point regarding communication with patients and that the CHC were aware of examples where patients were receiving multiple letters about the same appointment and conflicting information. The Committee Chair added that she had a related concern around communication with referrers. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience indicated he had commenced discussions with the Interim Head of Planned Care as to how improvements could be made whilst acknowledging the challenges such as different patient administration systems. One member made reference to the potential use of Waiting List Initiatives (WLIs) and highlighted that this would invariably impact upon staff resilience and wellbeing. The Interim Head of Planned Care agreed that WLIs were not sustainable on a long-term basis and did not engender resilience for patients or staff, and assured the Committee that any such initiative would need to be undertaken whilst observing the need of supporting staff under additional pressure. He added that in terms of a timeline for the longest waiters it was hoped plans would be operative before Christmas, pending their progress through governance processes. In response to a question regarding diagnostics, the Interim Head of Planned Care confirmed that the additional CT scanner was now operational and that the business case for a mobile MRI scanner was proceeding through the Executive approval process. The Executive Director of Therapies and Health Science added that a paper on the development of a Diagnostic and Treatment Centre had been considered by the F&P Committee recently. **QS20/193.2 It was resolved that** the Committee note the content of the paper and the progress being made. *[Mr Mark Wilkinson left the meeting]*	KC AK
QS20/194 Infection Prevention (IP) Report Quarter 2 (July - September 2020/21) **QS20/194.1** A member indicated that upon reading the paper she came away with the view that the Infection Prevention and Control (IPC) team were over-stretched and under-resourced. She also noted that the recommendation within the paper was for the Board to take assurance from the report, however, she felt the paper identified a number of areas of concern. The Acting Executive Director of Nursing and Midwifery agreed that IPC colleagues were fatigued and under pressure, and this was being seen across the UK due to the pandemic. She reported that since writing the paper a business case to increase resource and capacity within the team had received support at Executive Team level, although she anticipated there could be recruitment issues. A member referred to the	

statement in the paper that all patients would have access to hand wipes at mealtimes, and enquired around the practicalities of this in terms of frail patients. The Acting Executive Director of Nursing and Midwifery confirmed that additional support is provided to vulnerable patients through this process which was also encouraged outside of meal times. A member wished to acknowledge previous achievements in IPC and ward accreditation and enquired whether this progress had been lost. It was confirmed that not all aspects had ceased during the pandemic and many areas were now reinitiating activities up to a pre-covid level. **QS20/194.2 It was resolved that** the Committee receive the Infection Prevention report.	
QS20/195 Hospital Acquired Infection *[Lynne Grundy joined the meeting]* **QS20/195.1** The Committee had been provided with two papers – a Covid-19 review of hospital acquired infections and a report from the Covid-19 Delivery Group. A member enquired whether the outbreak had been retrospectively reported to the Health and Safety Executive (HSE) and within Datix. In terms of the next steps and actions, the Associate Director of Research and Innovation confirmed that the recommendations from the Covid Delivery Group would be developed into an action plan. The Acting Executive Director of Nursing and Midwifery added that learning from both the Wrexham and YGC outbreaks would be reflected in the workstreams of the Covid-19 Delivery Group which would all have an Executive sponsor and detailed supporting workplans. She explained that the Delivery Group would be time limited and there would be agreed mechanisms for sustainability of improvement once it was stood down. The importance of being able to 'read across' the range of reports was highlighted. The Committee Chair welcomed the review and the reports, and felt that although the findings were not unexpected it had been a positive exercise which provided staff with an opportunity to raise any concerns. **QS20/195.2 It was resolved that** the Committee receive and note the reports. *[Lynne Grundy left the meeting]*	
QS20/196 Patient Safety Q2 Report **QS20/196.1** The Committee Chair indicated that some questions had been provided in advance and had been responded to. She felt that the format and tone of the paper was of good quality, with context and background well explained. She welcomed the level of analysis within the paper and would wish to see this applied to other reports. She did however feel there was still a need to improve the narrative around never events and to evidence the 'golden thread' of learning and improvement. In addition she would wish to see investigations being completed in a more timely fashion. **QS20/196.2** The Committee Chair referred to the wrong site surgery never event which was reported as having caused major harm, and enquired as to the outcome. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed that whilst this harm category was accurate at the time the report was written, following the completion of the investigation it was likely to be downgraded as	

there was no severe long term harm. He added that the key learning from that particular never event was around surgical safety procedures and that the delivery of this work would also assist in being able to declare compliance with a long-standing open action PSN34. **QS20/196.3** The Committee Chair noted that the QPR stated there was only 1 PSN outstanding however the patient safety report indicated there were 5. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety confirmed that the patient safety report was accurate and there were ongoing conversations with the Executive Director of Planning and Performance and his team regarding the sign off and accuracy of data. **QS20/196.4** The Committee Chair raised a concern around the robustness of the action plan which had been provided at Appendix 3 and reiterated her wish to see more evidence of a 'golden thread' of learning. She also felt that, particularly where harm had occurred, the actions should be more robust and objective rather than relating to discussions, meetings and reminding clinicians of processes. A member referred to the red status action around vascular services and was disappointed to see that confirmation was still awaited from two of the three acute sites. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety indicated that this matter was being addressed on a site basis rather than via the corporate team, however, the member stated she would have expected the outstanding matter could have been resolved with a telephone call before the paper was published. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety acknowledged that the process of actions sitting at a site level were not always the best approach. In terms of the specific point around vascular services not being onsite, the Secondary Care Director assured the Committee that each site did have vascular presence in-hours and there were clear instructions as to how the surgeons could be contacted out of hours, however, there was a continued perception that the whole service had been centralised. The Committee Chair was concerned that this would not be apparent to anyone reading the paper without the benefit of hearing the assurances given at the meeting. The Executive Director of Public Health / Acting Deputy Chief Executive undertook to take this discussion to the Executive Team and to provide an update before the next meeting. **QS20/196.5** A member referred to the section on inquests within the paper. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety confirmed that all inquests were dealt with within the corporate team apart from mental health related ones. The Interim Director of Nursing for Mental Health and Learning Disabilities added that the Division was considering more integration with the corporate process. **QS20/196.56 It was resolved that** the Committee 1. Note and receive the report. 2. Note the focus on improving learning, reducing incidents resulting in avoidable harm and the evolving improvement of assurance in this area recognising significant work remains.	TO

QS20/197 Serious Incident Report August to September 2020 **QS20/197.1 It was resolved that** the Committee receive the report.	
QS20/198 Patient & Carer Experience Report – Q2 2020/21 **QS20/198.1** A member referred to a recent discussion at the SPPH Committee around children's rights and enquired about how children who were carers were being supported and their role recognised. The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety confirmed that this responsibility had recently moved back to the corporate patient experience team and the handover was still being worked through. He accepted that some momentum in this regard had been lost. He also indicated there were challenges in reporting progress at an organisational level. The Executive Director of Primary and Community Services suggested his team could link in with the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety to identify opportunities to reflect this area of work in future reports. **QS20/198.2** A member made reference to the implementation of patient and carer champions and it was confirmed that this would relate to existing staff with recruitment having commenced. A training programme was in place with an ambition that every clinical team and ward would have a champion. The board member asked a further question around a previous focus group for carers and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety acknowledged that this and other local forums were no longer meeting, however, he was aware that carers would appreciate more opportunities to meet and share experiences and the corporate team would work to identify alternative mechanisms for this to happen. **QS20/198.3 It was resolved that** the Committee receive the report.	CS MJ
QS20/211 Prison Health Update - HMP Berwyn Annual Report *[Agenda item taken out of order at Chair's discretion]* **QS20/211.1** A member expressed concern at the length of waiting times for GP and dental appointments. She noted that these would not be acceptable in a community setting and should not be in a prison setting. She also found the reported figures for missed appointments to be of concern. The Executive Director of Primary and Community Services clarified that the reported waiting time of 5 weeks for a routine face to face appointment with a GP did not take into account that there were same day triaged appointments which would allow the men to be seen by a doctor on the same day where required. In terms of dentistry he reported there had been a long-standing issue regarding the fitness of purpose of the dental suite within the prison which had led to long waits prior to the pandemic. Covid-19 restrictions on aerosol generating dental procedures had subsequently exacerbated the situation further and there was an additional challenge as a ventilation unit had failed an inspection. This was now being resolved by the prison service with a contingency plan being developed if the unit could not be replaced. He undertook to let members have a timeframe for this being resolved. In terms of missed appointments the Executive Director of Primary and Community Services noted this has been reported	CS

previously and a key issue relating to logistics of providing prison escorts was being taken forward by the prison. He also reminded members that prisoners could also execute their individual choice of not attending an appointment. **QS20/21.2 It was resolved that** the Committee receive the report for information, noting the ongoing particular areas for attention in the following areas: 1. High level of planned appointments not attended which was highlighted by the Independent Monitoring Board (IMB) report in their annual report which was published in September 2020 – Page 5 2. Increasing waiting list / access to routine dental services at HMP Berwyn – Page 6 3. Upcoming Her Majesty's Inspectorate of Prisons (HMIP) Scrutiny Visit planned for November 2020 – Page 9 4. HMP Berwyn Risk Register – Page 13 5. The Health & Wellbeing Service COVID delivery plan, staged approach in line with Her Majesty's Prison & Probation Service (HMPPS) model – Page 14	
QS20/205 Update report on the investigation of concerns regarding Speech and Language Therapy services in the West Area *[Ffion Johnstone joined the meeting]* **QS20/205.1** The Committee Chair stated that whilst she had seen the redacted report referred to within the papers, other members had not. A member asked whether it was known if actual harm had been caused to staff or patients and she also enquired whether the Royal College of Therapists had been involved and if staff had been offered support from Trade Unions. The Executive Director of Therapies and Health Sciences confirmed there was no evidence of any clinical harm. The Director of Therapy Services / Chair of Healthcare Professionals Forum referred to evidence from stress surveys and sickness data which provided a good insight into how staff were feeling, and that there had been a strong health and well-being element throughout, supported by Workforce colleagues. Listening Leads and Staffside colleagues had made every effort to engage with teams and he felt that generally staff were committed to taking improvements forward. The Executive Director of Therapies and Health Sciences confirmed that at the outset it had been recognised there were some team issues and help had been sought from Workforce colleagues to work through these at an early stage. In terms of the Royal College, the Director of Therapy Services / Chair of Healthcare Professionals Forum confirmed that this matter remained an internal process and although the College assisted in identifying the Independent Clinical Adviser they were not directly involved in the process. They did not act directly as a Trade Union body. **QS20/205.2** The Area Director West added that as part of the action plan the Head of Speech and Language Therapy in the West was linking with service users and patient advocacy groups to get their views. She assured members that evidence was embedded to demonstrate improvement against an action before it was closed down. **QS20/205.3** In response to a question regarding the Organisational Change Policy process the Director of Therapy Services / Chair of Healthcare Professionals Forum confirmed that since writing the report all outstanding historical elements had been completed.	

QS20/205.4 A member stated that as an individual without background knowledge of this matter she found it difficult to appreciate what the original core issue was, and the rationale for redacting certain detail. She also would have liked to have seen more narrative to support the closure of an action plan together with evidence of the outputs from the organisational development (OD) work. The Executive Director of Workforce and OD confirmed that any repercussions from redacted statements had been addressed within the team and reminded members of the balance to be struck in terms of maintaining anonymity when staff had provided information in confidence. In response to a question regarding the management of the investigation it was confirmed the commissioning officer was Mr Gareth Evans on a regional basis and that the Investigating Officer had been externally appointed. Learning and actions had been shared and benchmarked across West, Central and East areas. The Committee Chair welcomed the statement regarding learning but she felt the delay from when the concerns were first raised to the current date was unacceptable and must not be repeated. She also questioned the appropriateness of including detail of awards that had been achieved within this paper as she felt that this was not in itself evidence of progress against the concerns. She was aware that there was a meeting later that week where she could raise further detailed points on the action plan. The Committee Chair acknowledged that the plans to centralise all investigations into the corporate team was a positive move that should ensure that concerns raised by staff are investigated independently, thoroughly and on a more timely basis. She was also aware there had been a substantial review of the raising concerns processes more widely and felt that from an assurance perspective the organisation needed to respond timely and appropriately when staff raised concerns. **QS20/205.5 It was resolved that** the Committee note the internal investigation that had taken place and its findings. *[Chris Stockport and Ffion Johnstone left the meeting]*	
QS20/199 Clinical Audit Update **QS20/199.1** The Committee Chair welcomed early sight of the audit plan and felt that despite there being a number of areas still requiring improvement, significant progress had been made. A member noted that many of the audits did not have a lead clinician identified, and it was reported that some of these would be picked up by newly appointed clinicians – for example respiratory related ones. A member enquired how reliant the audits were on the availability of finances. The Senior Associate Medical Director/Improvement Cymru Clinical Lead responded that a business case was being developed to set out what resources would be needed and which of the audits would need to be delivered within existing resources. In terms of deliverability within the timescales she advised this was very much Covid-19 dependent. The Committee Chair suggested that some objectives could be strengthened as to the purpose of the audit, and she would still like to see a higher prominence of primary care. She also referred to discussions at the Mental Health Act Committee on how audits should feed into that Committee. The Senior Associate Medical Director/Improvement Cymru Clinical Lead noted that an improved cycle needed to be developed and suggested that the mental health audits be picked up in a planned refresh in December/January.	

QS20/199.2 It was resolved that the Committee adopt the interim clinical audit plan 2020/21 as the approved plan.	
QS20/200 Mortality Review Q2 **QS20/200.1** The Senior Associate Medical Director/Improvement Cymru Clinical Lead indicated that the format of the report remained a work in progress as not all data was online yet. The report did contain elements of surveillance data and provided a position statement in terms of the crude death rate which alongside the use of CHKS data could identify any outliers. In-patient deaths were reported for acute and community sites and there were plans to do the same for primary care. It was also reported there was speciality learning across sites and that the situation with clinical coding was much improved. Members welcomed the refreshed format which offered an improvement and supported better triangulation. **QS20/200.2 It was resolved that** the Committee noted the report.	
QS20/201 Vascular Services Update **QS20/201.1** In response to questions from a member, the Secondary Care Medical Director anticipated that casenote reviews and interviews for the external review would commence before the end of November, therefore, any outputs would not be available until towards the end of the financial year. She reported that in terms of patient reported outcome measures (PROMS) conversations were ongoing with vascular surgeons about undertaking some research work. Finally, she responded to a question around the relationship with the CHC in that this continued to be positive and collaborative and she felt that the CHC had a more rounded understanding of the issues facing the vascular service. The Committee Chair queried why both red and green actions were categorised as “in progress”. The Secondary Care Medical Director apologised and indicated that clearer parameters needed to be adopted within action tracking. **QS20/201.2 It was resolved that** the Committee note the progress made by the Vascular Task and Finish Group	
QS20/202 Holden Report Update **QS20/202.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience confirmed that matters were in hand to ensure a full report against the Holden recommendations was provided to the January meeting. He added that weekly meetings were being held to test the evidence and assurances and the report would go through an Executive review in December. **QS20/202.2** A question was raised as to the principle of impartiality if an investigation was undertaken by an individual who worked within the associated specific service area. The Executive Director of Workforce and OD accepted the concern but was confident that people would act professionally and ensure a level of objectivity. The process should also be clarified as part of the new raising concerns procedures and would in all events need to be managed on a case by case basis.	

QS20/202.3 It was resolved that the Quality, Safety and Experience Committee note the report.	
QS20/203 Mental Health & Learning Disabilities (MHLD) Division Exception Report **QS20/203.1** The Interim Director of Nursing felt that the Division was now in an improved position in terms of capacity and was pleased to report that a number of staff had now returned to work from sick leave. He stated however there was still ground to make up which had been exacerbated by the pandemic. He felt that divisional reporting could be further improved to address the 'golden thread' and to align more closely with key risks. He drew members' attention to the summary mortality review within the paper and outlined the complexities associated with benchmarking mortality data. A member enquired as to the timeframe for reviewing the pathway of admission to medical wards and the Interim Director of Nursing undertook to raise this with the Division's Medical Director and feed back outside of the meeting. **QS20/203.2 It was resolved that** the Committee note the content of the report *[Gareth Evans and Mike Smith left the meeting]*	MS
QS20/204 Quality Governance Review (Updated Terms of Reference of the 4 Groups reporting into QSE) **QS20/204.1** The Committee Chair reminded members that the terms of reference for these operational groups were part of a wider piece of work on governance. She suggested to members that the Committee give preliminary approval so that the groups can operate, but with the caveat that they will need further alignment and review as part of subsequent work. **QS20/204.2 It was resolved that** the Committee approve the terms of reference as presented. *[Simon Evans-Evans left the meeting]*	
QS20/206 Healthcare Inspectorate Wales (HIW) Reports **QS20/206.1** The Committee Chair noted that the paper indicated there were 26 overdue actions within the MHLDS Division, and the Executive Director of Public Health undertook to speak to leaders within the Division and report back. It was noted that internal audit colleagues were to start a formal follow-up of all HIW recommendations to confirm that appropriate management action had been taken to implement the actions, and that this would be a regular annual review within the internal audit plan. **QS20/206.2 It was resolved that** the Committee to note the following reports: 1. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Ward 11, Ysbyty Glan Clwyd on 26 August 2020 2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Moelwyn Ward, Ysbyty Gwynedd on 28 August 2020 3. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), of Bonney Cohort Ward,	TO

Wrexham Maelor on 3 September 2020 4. HIW Inspection (Unannounced), Heddfan Psychiatric Unit, Wrexham Maelor Hospital on 7 to 9 July 2020	
QS20/207 Clinical Audit Policy and Procedure (Amended) **QS20/207.1 It was resolved that t**he Committee approve the amendments as noted within the policy	
QS20/208 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards **QS20/208.1 It was resolved that** the Committee note the compliance with the prescribed requirements of the Nurse Staffing Levels (Wales) Act 2016 bi annual calculations for medical and surgical wards which meet 25B requirements and support the report.	
QS20/209 Quality Awards **QS20/209.1** Committee members wished to acknowledge the examples of good practice and achievement as set out in the paper. **QS20/209.2 It was resolved that** the Committee note the report.	
QS20/210 Health & Safety Q2 Update **QS20/210.1** The Committee Chair acknowledged the improvements that were demonstrated within the area of Health and Safety, particularly given the contextual challenges of the pandemic. **QS20/210.2 It was resolved that** the Committee note the position outlined in the Quarter 2 Report and support the actions being taken to delivery against the recommendations agreed by the Strategic Occupational Health and Safety Group	
QS20/212 Patient Safety & Quality Group Chair's Report from 9.10.20 **QS20/212.1** The Committee Chair indicated that some queries from members had been resolved outside of the meeting. She stated that personally she welcomed the 'Triple A' report format. **QS20/212.2 It was resolved that** the report be noted.	
QS20/213 Clinical Effectiveness Group Chair's Report from 15.10.20 **QS20/213.1 It was resolved that** the report be noted.	

QS20/214 Audit Committee Update **QS20/214.1 It was resolved that** the Committee be informed that: 1. In response to the Covid-19 pandemic, this work will take the form of an overview of the whole system governance arrangements for Test, Track and Protect, and of the Local Covid-19 Prevention and Response Plans for each part of Wales. 2. The field work for this review is underway. 3. Work to complete the Review of Unscheduled Care has been postponed and replaced with work on TTP.	
QS20/215 Issues Discussed in Previous Private Session **QS20/215.1 It was resolved that t**he report be noted	
QS20/216 Internal Audit Report Decontamination **QS20/216.1** The Committee Chair reported that actions from the audit report were managed via the Audit Committee. **QS20/216.2 It was resolved that** the report be noted. .	
QS20/217 Documents Circulated to Members **QS20/217.1** It was noted that the following documents had been circulated: 27.8.20 Patient Safety Q1 Report 27.8.20 Patient Experience Report 30.9.20 Q2 annual plan monitoring report 20.10.20 Quality Safety Group September notes	
QS20/218 Issues of Significance to inform the Chair's Assurance Report To be agreed	
QS20/219 Date of Next Meeting Scheduled for 5th January 2021. Conversation took place regarding whether an alternative date would work better in terms of preparation of papers and avoiding the incoming Chief Executive's first week in post.	KD

QS20/220 Exclusion of Press and Public It was resolved that representatives of the press and other members of the public be excluded from the remainder of the 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.'	

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**
5th May 2020				
G Harris A Miskell	**QS20/85.4** Clarify triangulation of urology data with removal of catheters and confirm details of work programme.	July	From the catheter audit carried out across inpatient beds, we learnt that trail without catheters (TWOCs) was not necessarily taking place as frequently as it could be. Daily review of devices was launched in November 2019 as part of safe clean care and a need to reinvigorate device management. A community audit across the continence and district nursing teams was planned for Spring 2020, but this has had to be postponed. Some patients with catheters were awaiting Trans urethral resection of the prostate (TURP), and some patients catheterised in ED for acute retention were reliant on Urology day care services for TWOC as there is no formal TWOC service in the community. IPC would want to commence the community review as soon as able. 03.07.20 further update to be presented to future meeting 9.7.20 no further progress to report 29.7.20 GH confirmed that there was work ongoing but she would need to confirm the timeframe outside of the meeting. 17.08.20 AM has confirmed this has been delayed due to the Covid 19 pandemic and will be picked up again as soon as possible. It is also an agenda item at IPSG.	August

			21.10.10 Due to capacity and prioritisation this action hasn't been completed, however, preparatory work has commenced to establish a task and finish group. 3.11.20 DH reported there was now a designated urology lead working with the IPC team to develop a plan, with an update expected at the next meeting of the IP sub group. 7.1.21 The group held an initial meeting and agreed focus and actions. Further work has been delayed due to the pandemic.	January March
28th August 2020				
~~G Harris~~ M Wilkinson	**QS20/153.5** Share the comments on the eye care services briefing with the Director of Performance and to raise at the planned care group that afternoon.	August	27.10.20 Position statement to be provided at the meeting. GH subsequently confirmed she had fed back to the Planned Care Group. 3.11.20 MW agreed to gather these comments and that the action could be put in his name. 30.12.20 MW confirmed that feedback was provided to the Director of Performance and the issues raised in QSE were reported to the Planned Care Group. An update on eye care: • Alyson Constantine, Acute Care Director at Ysbyty Gwynedd is now leading our work in this area. •The business case is going through our internal review processes. •This specialty is included in our work on diagnostic and treatment centres.	January Closed
D Fearnley (T Owen)	**QS20/155.5** follow up and explain why no improvement was reported for delayed transfers of care within mental health as stated on page 14 of the QPR	September	27.10.20 Position statement to be provided at the meeting 3.11.20 Discussion as part of consideration of mental health paper.	Closed

C Darlington C Stockport	**QS20/168.1** Enquire at the national group whether there were any plans to review priorities in light of covid as part of the development of Quality Improvement Projects through the Quality Assurance Improvement Framework– for example the management of diabetic patients.	November	14.10.209 A new QI project related to planning for urgent care and learning from COVID across clusters has been added to the projects in the QAIF, with strong links to work already begin undertaken at a cluster level. 3.11.20 LR felt the update didn't relate to the action. CS agreed to follow up. 8.12.20 The COVID project reflects increased demand on primary care teams during the pandemic, either through delivery of direct patient care or through direct experience of illness in the teams themselves. It considers the new modes of consultation, infection control precautions and new ways of working with neighbouring practices and community services in the cluster. It recognises that there may be future waves of acute COVID-19 cases and the impact on patients without COVID-19 but who will need access to primary care services delivered in a different way for acute problems or existing long term conditions. There is also likely to be a lasting legacy of patients with physical and mental complications of COVID-19 who will call on primary care for support. This QI project aims to address these multiple issues over the time span of the contract. Practices are asked to implement standardised recording of clinical contacts which will be used to better plan services related to acute conditions and long term care. In terms of reviewing priorities, this has been done in 2 ways – through the WG Recovery plans for all Primary Care Contractors and the identification of essential services on a national basis.	~~Closed~~ ~~January~~ Closed

3rd November 2020				
D Hickman	**QS20/189.3** The Acting Executive Director of Nursing and Midwifery would follow up and provide detail of training plan trajectories in relation to the Deprivation of Liberty Safeguards briefing note.	30.11.20	7.1.21 2019-2020 MCA/DoLS training compliance was 278 2020-2021 MCA/DoLS training trajectory is 840 The overall trajectory for 2020-2021 evidences a downward trend but the data is influenced by issues relating to ESR recording and key departments with low attainment., these areas have targeted actions to improve both compliance, improve trajectory and accurate recording on ESR. It is important to note BCUHB currently does not separate any Level 2 and Level 3 training compliance on ESR.	Closed
M Maxwell	**QS20/189.3** The Senior Associate Medical Director/Improvement Cymru Clinical Lead would follow up on the points raised around the level of confidence in the actions set out in the thrombosis briefing note.	30.11.20	3.12.20 Updated briefing note circulated	Closed
M Wilkinson	**QS20/192.2** The Executive Director of Planning and Performance undertook to check the differing data in the QaPR for neurodevelopment assessment for children and CAMHS assessments and respond outside of the meeting.	30.11.20	6.1.21 Neurodevelopment data is available by the 10th working day post month end. Mental Health Measure data is reported a month in arrears. Therefore, the CAMHS assessment and Intervention data will always be a month behind the latest available Neurodevelopment data. Both data items submitted via the Q&P Report for QSE Committee were correct at the time of reporting.	Closed
M Wilkinson	**QS20/192.2** Review QaPR format following comments that the formatting of data on pages 12 and 13 made it difficult to read.	January 2021	6.1.21 Formatting has been amended	Closed
K Clark A Kent	**QS20/193.1** Provide a short update against each of the improvement initiatives outlined within the Essential Services Restart paper.	December 2020		

T Owen	**QS20/196.4** Ensure discussion at Exec Team around members' comments regarding the reference within the patient safety report around the availability of vascular services on each site and their concern that the paper alone did not provide the full picture. To provide a update before the next meeting.	December 2020		
C Stockport	**QS20/198.1** Link in with the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety to identify opportunities to reflect child carer services and support in future patient and carer experience reports.	January 2021	19.11.20 Meeting held to discuss detail in future Patient and Carer Experience Reports.	Closed
M Joyes	**QS20/198.2** Explore alternative mechanisms for carer forums	January 2021	17.11.20 With current COVID-19 restrictions, the corporate Patient and Carer Experience Team have regular direct conversations with carer organisations to ensure ongoing engagement and the Health Board continues to attend the Regional Carers Group and Regional Young Carers Group. The reformation of in-house carers reference groups or similar will be part of the new Patient and Carer Experience Strategy 2021-2024, reporting into the new Patient and Carer Experience Group, and will be planned to launch post-COVID-19.	CLOSED
C Stockport	**QS20/211.1** Identify timeframe for resolving issue of the failed ventilation unit within HMP Berwyn (dental care)		5.1.21 The remedial work to the dental surgery was competed on 27th November 2020. Both surgeries are now fully operational. There are over 700 patients on the waiting list for routine dental care, with a longest wait of around 18 months. The Head of Healthcare for HMP Berwyn is meeting with the dental division in early January to plan a waiting list initiative for 2021 / 2022. This will address what has	CLOSED

			essentially been an ongoing issue, with the Covid pandemic, and ongoing challenges with heating and ventilation, creating further delay. A dental provider will be commissioned with funding drawn from the financial allocation from HMPPS (Her Majesty's Prison and Probation Service), subject to approval from the Prison Health and Social Care Partnership Board.	
M Smith	**QS20/203.1** Establish timeframe for reviewing pathway of admission to medical wards with the MHLDS Medical Director and feed back outside of the meeting.	30.11.20		
T Owen	**QS20/206.1** Establish position with regards to the 26 overdue mental health division related actions as per HIW paper and feedback outside of meeting.	30.11.20	10.12.20 Briefing note circulated	closed
K Dunn	**QS20/219** Identify alternative January meeting date	30.11.20	Date rescheduled to 15.1.21	closed

8.1.21

Joint Audit and Quality, Safety & Experience (QSE) Committee (JAQS)
Draft minutes of meeting held in public on 24.11.20
via Webex

Present:

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

In Attendance:

Kate Clark	Acting Deputy Medical Director
Andrew Doughton	Audit Lead, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Sue Green	Executive Director of Workforce & Organisational Development (OD) (Part meeting)
Dave Harries	Head of Internal Audit
Debra Hickman	Acting Executive Director of Nursing & Midwifery
Matt Joyes	Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety & Experience
Andrew Kent	Head of Planned Care (part meeting)
Grace Lewis-Parry	Assistant Director Primary Care
Melanie Maxwell	Senior Associate Medical Director / Improvement Cymru Clinical Lead
Rob Nolan	Finance Director – Commissioning (part meeting)
Dawn Sharp	Acting Board Secretary
Adrian Thomas	Executive Director of Therapies & Health Sciences

Agenda Item Discussed	Action By
JAQS20/1 Chairs' Welcome Attendees were welcomed to the meeting.	
JAQS20/2 Declarations of Interest None declared.	
JAQS20/3 Apologies for Absence Recorded for Gareth Evans, Arpan Guha, Sue Hill, Eifion Jones, Teresa Owen and Chris Stockport. Noted that Sue Green would need to leave before the end of the meeting. Deputies were welcomed to the meeting on behalf of Chris Stockport, Arpan Guha and Sue Hill.	

JAQS20/4 Review of Summary Action Log **JAQS20/4.1** The QSE Committee Chair introduced this item by acknowledging the length of time some actions had remained open and reminded members that at the last meeting in 2019 the JAQS Committee did not feel that they had seen sufficient evidence on which to close them down. She confirmed that matters had now moved on and the action log had been reviewed by Executive colleagues and it was accepted that the range of actions relating to clinical audit had been superseded by the refreshed approach to clinical audit across the organisation. The Acting Executive Director of Nursing and Midwifery felt that the revised process set out in the clinical audit paper later on the agenda would address multiple actions which had evolved within the action log. The Senior Associate Medical Director / Improvement Cymru Clinical Lead noted that the assurances around clinical audit would get stronger year on year although she acknowledged there was a remaining gap around primary care. **JAQS20/4.2** A suggestion was made that actions from JAQS should be allocated to either QSE or Audit Committee so they were followed up and reviewed in a more timely manner. The QSE Chair indicated there had been an element of this previously but agreed that progress of actions could be better managed. It was agreed to ask the Interim Director of Governance to review the role and effectiveness of JAQS and to consider the use of a decision log rather than action log. **JAQS20/4.3** Further updates were noted for inclusion within the action log.	SEE
JAQS20/5 Clinical Audit Annual Report 2019-20 **JAQS20/5.1** The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the report which she felt was a much stronger format as a result of lessons having been learned from previous years. She indicated that the report set out a list of mandated audits and identified where there were outliers which would require the development of improvement plans which would need to be 'SMART' and timely. *[Rob Nolan joined the meeting]* The Senior Associate Medical Director / Improvement Cymru Clinical Lead added that the report contained two elements of performance data - one against the national benchmark and the other against the last BCU report. Where data had not been submitted this was RAG rated red and would be addressed. In terms of a baseline report the Senior Associate Medical Director / Improvement Cymru Clinical Lead was comfortable that the Board was in a better position in terms of knowing current performance and where the gaps in assurance were. **JAQS20/5.2** The Senior Associate Medical Director / Improvement Cymru Clinical Lead then drew members' attention to the Priority 2 audits noting that detail around delays were contained within the appendices. She acknowledged there was a substantial amount of work to be done around locally initiated projects but suggested that the chart on page 31 supported that the organisation should now be undertaking some Tier 3 audits and that she would also like to see some speciality audit work too. It was confirmed that the Clinical Audit Policy had been approved in March 2020 but that the roll out of audit work had been stood down with the onset of the Covid-19 pandemic, however, this was now starting to be embedded within the quality governance framework. Clinical Audit leads had been identified against all of the mandated audits which was a positive improvement, and an Interim Head of Clinical Effectiveness had been appointed who had commenced	

conversations around developing a business case for clinical audit and improving support to divisions and sites. Finally it was noted that there was a notable increase in the number of Tier 3 projects being registered, and that an escalation report would be provided for the Clinical Effectiveness Group on a regular basis.

JAQS20/5.3 The Audit Committee Chair felt that the report was clear and easy to understand and provided good examples of strengthening governance. He noted that many of the red rated actions were related to a lack of administrative support and enquired as to progress with the business case for funding. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated it was hoped to complete the business case by the end of January 2021 but that there was also a need to think longer term around ensuring that the right support for teams and specialties could be sustained. The QSE Committee Chair noted that the paper made references to resources required to deliver on some audits and sought assurance that this was being flagged with finance colleagues. The Finance Director (Commissioning) confirmed that business cases underwent a "fit for purpose" review before they were considered at Executive Team, and subsequently would go through a prioritisation process and up to the Finance & Performance (F&P) Committee. It was also highlighted that there were some improvement actions that did not necessarily have a cost implication. The QSE Committee Chair felt it was reassuring that the right sort of conversations around the clinical audit agenda were now being taken forward.

JAQS20/5.4 A member enquired what improvements in terms of behaviours and culture could be made, alongside procedural improvements, to encourage more individuals to want to undertake clinical audit. It was felt that recently audit had not had the required visibility across the organisation and that it was now being linked to pathways to try and address this. There was also a need to ensure that individuals had the capacity to undertake audit as part of normal business and that audit be embedded within service improvements. A member requested that page 30 be amended to refer to a radiology department rather than radiology service, as there had been recent efforts to portray the specialty as a single service. She went on to enquire whether the audits set out within Appendix 3 had an associated date for completion, and it was clarified they only related to Tier 3 audits for which there was a report available at year end. A question was raised regarding the consistency of RAG scoring against the national benchmark and the last BCU report and it was clarified that the green rating in that scenario reflected an improvement on last year's performance.

JAQS20/5.5 The QSE Committee Chair made a general comment that the report was very much improved and gave a more robust source of assurance around the clinical audit function, although she would like to see evidence of learning more clearly set out. She commented that the key on page 26 would be easier to read above the table rather than below it.

JAQS20/5.6 Internal Audit and Audit Wales colleagues were supportive of the progress made with this agenda and that the audit plan was broadly in line with their expectations.

JAQS20/5.7 It was resolved that the Joint Committee approve the Clinical Audit Annual Report 2019/20.

JAQS20/6 Delivering Effective Clinical Audit **JAQS20/6.1** Members felt the paper was clear and logical. **JAQS20/6.2 It was resolved that** the Joint Committee agreed the proposed actions to provide an effective clinical audit function that will support quality improvement leading to safe, high quality care whilst providing the assurance required by the Joint Committee.	
JAQS20/8 Audit Reviews *[Agenda item taken out of order at Chair's discretion. Mr Andrew Kent joined the meeting]* **JAQS20/8.1** The QSE Committee Chair informed members that the Audit Committee had determined that relevant audit reports would be shared with respective committees to provide an opportunity for overall reflection and to consider what had changed as a result of the review. She confirmed that the responsibility for monitoring the associated audit recommendations remained with the Audit Committee. **JAQS20/8.2** The Interim Director of Planned Care gave a verbal update in terms of the review of operating theatres. He explained the booking process which aimed to improve theatre utilisation, highlighting that although the principles were in place, progress had been delayed by the onset of the Covid-19 pandemic and the need to focus on essential services. He confirmed that 5 theatres had been maintained on each acute site for emergency and cancer care but there remained a lack of capacity at the current time to be able to undertake routine activity. This position was monitored on a weekly basis and officers were working closely with clinicians on how capacity could be increased whilst meeting Personal Protective Equipment (PPE) and other Covid-19 requirements such as a the new regime for pre-operative care. He confirmed that the Planned Care Group had developed a 6 point recovery plan which would be discussed by the F&P Committee in December 2020. He concluded by saying officers were disappointed not to have been able to implement the transformational improvements for theatres yet, but they remained committed to this aim. **JAQS20/8.3** A member enquired whether private companies may be contracted with to provide additional capacity at weekends, and expressed concern that this solution was not sustainable. The Interim Director of Planned Care confirmed that a paper was to be discussed by the Executive Team on the 25th November 2020 which included this possibility for high risk patients. In response to a question as to why existing staff could not be utilised if capacity was currently 40% down, the Interim Director of Planned Care reported that this would have an impact on the resilience of the workforce and that staff were already being redeployed to support the Covid-19 response and undertake additional training for example. *[Mrs S Green left the meeting]* He added that waiting list initiatives utilising local staff at an overtime rate were being pursued, together with an insourcing option which would provide a more consistent contractual arrangement. Historically the organisation had outsourced a large amount of activity but this was no longer possible as those providers were having to deal with their own backlog. The QSE Committee Chair sought assurance that the issues originally raised in the review were still on the radar and it was confirmed that they would be incorporated into the 6 point recovery plan utilising a 'once for North Wales' approach to provide consistency. The Audit Committee Chair was content that the recommendations were being addressed, although progress was not at a level he would have wished to have seen. The Audit Lead for Audit Wales reminded	

members that the original review had taken place in 2014 with a follow up in 2019, resulting in a mix of recommendations which were now being combined into a consolidated approach. He felt that there were key positive messages from the 2019 review and that the development of a Diagnostic & Treatment Centre (DTC) approach would over time impact on theatre performance and improvement. *[Mr Andrew Kent left the meeting]* **JAQS20/8.4** The Acting Executive Director of Nursing and Midwifery presented the paper which provided an update against the internal audit review into adult in-patient falls. She highlighted that the direction of travel was focusing on a wider approach to ensure sustainability. **JAQS20/8.5** A member drew attention to reference within the appendix to training being mandatory for nursing staff, and suggested that this was a statement as opposed to an achievement in terms of implementing the falls strategy. The Acting Executive Director of Nursing and Midwifery accepted this point and that there needed to be a more strategic analysis to give a broader overview. In response to a question around ward accreditation she confirmed that this process had continued but through a revised approach due to Covid-19. The Audit Committee Chair noted that the report stated that "due to a number of changes in the senior leadership roles, the overarching Strategic Falls Group referenced within the internal audit review report has not met for some time", and queried whether the implementation of the falls strategy should not be at ward level. The Acting Executive Director of Nursing and Midwifery confirmed that primarily implementation was an operational front-line responsibility and that the Falls Group mentioned was a co-ordinating forum. The Audit Committee Chair felt that if the group was important it should be meeting and wondered if changes in leadership was being given as an excuse. The QSE Committee Chair shared these concerns and asked the Interim Director of Governance to ensure the principle of governance frameworks being robust enough to ensure that changes in leadership did not impact. The Interim Director of Governance indicated he was to present on the governance framework at the Board Workshop on the 3rd December 2020. The Head of Internal Audit noted that he was minded to include falls within the internal audit plan for 2021-22. **JAQS20/8.6 It was resolved that** the Joint Committee receive the update.	SEE
JAQS20/7 Progress Update on Risk Management Strategy **JAQS20/7.1** The Interim Director of Governance presented the paper. He confirmed that the commitment to move to a tier 3 system by the 1st October 2020 had been achieved but did highlight a range of anomalies which were now being quality assured with the corporate risk team. He felt this was a useful process to help staff understand their risk scores and controls. It was noted that the Executive-led Risk Management Group (RMG) oversaw the quality assurance process which had been refreshed alongside the improvement plan and reporting arrangements. The Interim Director of Governance reported there had been good progress on a broader risk discussion with divisions being invited to attend the RMG in turn and aligning risk more closely to accountability meetings. He concluded by confirming that the development of a Board Assurance Framework was on track for the December 2020 Audit Committee. **JAQS20/7.2** The Head of Internal Audit sought clarification around slippage in the implementation plan is and whether there was a risk that the revised strategy would not be	

fully implemented by year end. The Interim Director of Governance reported that he did not feel there was slippage but that some risks had been over scored at Tier 3 level. He confirmed that the strategy was in place and being utilised with the associated quality assurance process scheduled for completion by year end. A member asked whether any of the highly scoring risks were of particular concern and the Interim Director of Governance indicated that the vast majority of entries on the register were real risks to the Board but that the quality assurance process was fundamental to ensuring consistency in scoring and robust management of risks. The QSE Committee Chair was encouraged to read about the self-assessment tool. **JAQS20/7.3 It was resolved that** the Joint Audit and QSE Committee note the progress implementing the Health Board`s new Risk Management Strategy & Policy. *[Mr S Evans-Evans left the meeting]*	
JAQS20/9 Quality Governance Self-Assessment Action Plan **JAQS20/9.1** The Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety & Experience presented the paper and confirmed that all actions were due for completion by the end of March 2021. He confirmed that progress had been made in-year with an update having been provided to the QSE Committee in August 2020. Since that update the most significant progress had been around the Risk Management Strategy and that a further update would be provided to QSE Committee in January 2020. **JAQS20/9.2** The QSE Committee Chair indicated she did not personally feel sighted on progress against the development of a clinical strategy by the end of March 2021. It was noted that the Acting Executive Medical Director had recently given a presentation to the Strategy, Partnerships & Population Health (SPPH) Committee and that at a recent Board meeting the Chair had requested a firm trajectory and timeline. The Acting Deputy Medical Director stated that a clear direction of travel would be prepared by the end of March 2021, aligned with the development of the Digital Strategy. The Joint Chairs expressed concern that since the former Executive Medical Director had presented to the Board on a digitally enabled clinical strategy, the emphasis and approach would appear to have changed and that from a governance perspective the Board needed to be sighted on this and be supportive of the strategic direction. The QSE Committee Chair would raise this with the Health Board Chair. **JAQS20/9.23 It was resolved that t**he Joint Committee note the update of the Quality Governance Self-Assessment Action Plan.	LR
JAQS20/10 Governance Arrangements During Covid-19 **JAQS20/10.1** The QSE Committee Chair noted that Audit Committee members would previously have received this internal audit report but not QSE members, and there was now an opportunity to ask questions and seek assurance as to how governance and meeting structures may be taken forward in a major subsequent Covid-19 wave. The Acting Board Secretary confirmed that the considerations within the paper were being tracked.	

JAQS20/10.2 The Head of Internal Audit extended his thanks for the time and input by officers into the review. He highlighted that a number of actions from the review fell within the remit of finance and that an anonymised report was being developed with All Wales Directors of Finance and Board Secretaries. He drew members' attention to the good practice identified around the work of the Cabinet and the establishment of the financial governance cell. The Audit Lead (Audit Wales) indicated that the Structured Assessment was being shared with the Board at a workshop on the 3rd December 2020 and he recorded that the organisation had been very responsive. He felt there were opportunities to learn from the challenges that were faced during the first wave but that delivery of change had occurred with pace. The QSE Committee Chair noted the reference to maintaining the requirements of General Data Protection Regulation (GDPR) as a priority for consideration, and suggested that the Digital and Information Governance (DIG) Committee may need to pick this up. The Acting Board Secretary would raise this with the DIG Committee Chair and Lead Executive. **JAQS20/10.3 It was resolved that t**he Joint Committee note:- (1) the Internal Audit report and in particular the priority considerations for the future; (2) that these priority considerations are being actively via Team Central and reported to the Audit Committee; (3) the Guidance as issued by Welsh Government in respect of discharging Board Committee responsibilities during COVID-19 response phase.	DS
JAQS20/11 Any Other Business **JAQS20/11.1** The Audit Lead (Audit Wales) flagged that as part of the audit programme there would be some wrap around governance work scheduled. **JAQS20/11.2** The Head of Internal Audit suggested the Board needed to ensure it was sufficiently sighted on the risks pertaining to Brexit. The Acting Board Secretary confirmed this was in hand and there was a meeting scheduled involving the Audit Committee Chair.	

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework (BAF) Principal and Corporate Risk Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Simon Evans-Evans, Interim Director of Governance Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Justine Parry - Assistant Director of Information Governance & Risk
Craffu blaenorol: **Prior Scrutiny:**	Approved by the Interim Director of Governance
Atodiadau **Appendices:**	Appendix 1 – QSE BAF Principal Risk Report Appendix 2 – Corporate Tier 1 Operational Risk Report

Argymhelliad / Recommendation:

The Committee is asked to:

1. Review and note the progress on the Principal Risks as set out in the Board Assurance Framework (BAF) and Corporate Tier 1 Operational risks presented.
2. Receive assurance on the controls and mitigations in place to manage the risks in line with the Health Board's agreed Risk Appetite Statement.

Please tick as appropriate

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

Sefyllfa / Situation:

On the 17th December 2020, the Audit Committee approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements. This new design captures the work undertaken by the Board on the identification of its Priority Areas to support the effective management of the agreed principal risks that could affect the achievement of its agreed Priorities. This has led to streamlining and re-design of the Corporate Risk Register (CRR), which more effectively demonstrates how the Health Board is robustly mitigating and managing extreme risks to the achievement of its operational objectives.

Each Principal Risk has since been reviewed and updated to take effect of any changes or completion of actions to support the mitigation of the risk and to reflect the impact of the next wave of the COVID Pandemic.

Appendix 1 highlights the Board Assurance Framework Principal Risks associated with the QSE Committee, which will be regularly scrutinised by the Executive Team.

Appendix 2 highlights the Corporate Tier 1 Risks associated with the QSE Committee which have been reviewed and agreed at the Risk Management Group (RMG) and will be regularly scrutinised by the Executive Team.

Cefndir / Background:

The implementation of the Board Assurance Framework and the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The design of both the new BAF and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively as well as underlines their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other. This includes the evaluation, monitoring and review of progress, accountability and oversight of the Principal Risks and also the high level operational risks which could affect the achievement of the Health Board's agreed Priorities. These are being monitored as part of an annual improvement plan with oversight by the Risk Management Group, with scrutiny and approval by the Executive Team.

Board Assurance Framework

During November 2020, once the Principal Risks had been agreed by the Executive Team, a series of meetings took place with all Principal Risk Lead Officers to populate each risk template. Support was provided by the Corporate Risk Management Team and each risk was quality assured and required Executive approval prior to inclusion onto the full report.

Whilst the revised Board Assurance Framework arrangements have been presented and agreed at the Audit Committee in December 2020, formal ratification by the Board has not yet taken place and so the regular routine reporting to each individual committee has not yet commenced. It was agreed that this report should be submitted to the QSE for information and discussion rather than approval at this stage.

Once the Board has ratified the implementation of the BAF, the intention is for the Principal Risks to be regularly reviewed the Executive Team with oversight at each Board Committee on a bi-monthly basis and then twice yearly to the Board. Oversight of the system and process will remain with the Audit Committee, who will receive an update twice a year and a copy of the full BAF. The system and process for the management of the BAF will be fully captured within a narrative document, which is currently in development and which will be finalised as part of the governance review work.

In line with the presentation of the Corporate Risks, for all future reports a detailed analysis of any changes to the Principal Risks will be included within the body of this report. As this is the first presentation of the BAF to the QSE Committee, the full risk and assurance report is provided in Appendix 2 with the heat map below.

- **BAF20-02 – Emergency Care Review Recommendations**
  There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.

- **BAF20-08 – Safe and Effective Mental Health Service Delivery**
  There is a risk to the safe and effective delivery of Mental Health & Learning Disability (MHLD) services. This could be due to unwarranted variation and inefficiencies. This could lead to

poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.

- **BAF20-09 – Mental Health Leadership Model**
  There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.

- **BAF20-10 – Mental Health Service Delivery During Pandemic Management**
  There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.

- **BAF20-11 – Infection Prevention and Control**
  There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.

- **BAF20-12 – Listening and Learning**
  There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.

- **BAF20-13 – Staff Engagement**
  There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.

- **BAF20-14 – Security Services**
  There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.

- **BAF20-15 – Health and Safety**
  There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.

- **BAF20-16 – Pandemic Exposure**
  There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.

- **BAF20-24 – Impact of COVID-19**
  There is a risk that Health Board will be overwhelmed and unable carry out its core functions due to the spread and impact of Covid-19 in North Wales, which could lead to reduced staff able to work and increased demand on services (including acute, community, mental health and primary care). This could negatively affect the mass vaccination programme, quality of patient care, outcomes for patients and the Health Board's ability to deliver its plans and corporate priorities.

Corporate Risk Register:
It is important to note that the Health Board`s new CRR has been updated following feedback received on the previous version. Changes have been made to the terminology used for example the "Initial Risk Score" has now changed to Inherent and the continued use of the "Action Plan Module" as a key driver to capture and monitor the completion of actions is proving beneficial for all leads as regular reminders are issued once the completion date has expired. The use of this module is planned to be rolled out across the remaining Tiers, with anticipated completion by March 2021. However, this date is subject to change depending on the future management of the Pandemic and redeployment of staff.

The Corporate Risk Management Team Staff continue to explore engagement, training, capacity building and understanding as drivers for embedding the new CRR and a positive risk-aware culture across the Health Board. For example, an external risk management delivered six bespoke risk management training sessions to senior staff across the Health Board during which 100 staff were trained. Trainees were issued certificates of completion of course and they provided very positive feedback, which have in turn enabled us to improve and tailor the training resources to the needs of our staff and organisation.

Further risk management training commensurate with the roles and responsibilities of staff across the Health Board will be delivered as part of the campaign to achieve 1000 staff trained in risk management in 2021/22. Another strand of this drive will be to deliver risk management training to medical Doctors and Consultants through existing meetings and networks e.g. Junior Doctor`s meetings or Consultant`s meetings.

In summary, a close look at the CRR in Appendix 2 demonstrates that:

- **CRR20-01 - Asbestos Management and Control**
  Key progress: This risk has been transferred to the management of the Estates and Facilities Department within the Planning and Performance Division. The target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. The Executive Team will further scrutinise and advise on action required to actively mitigate and manage the risk.

  The target risk date has been extended to take into account the impact on the Health Board for the management of the second wave of the COVID-19 Pandemic.

- **CRR20-02 - Contractor Management and Control**
  Key progress: This risk has been transferred from the Health and Safety Department within the Workforce and Organisational Development Division to the Estates and Facilities Department within the Planning and Performance Division. The target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. The Executive Team will further scrutinise and advise on action required to actively mitigate and manage the risk.

  The target risk date has been extended to take into account the impact on the Health Board for the management of the second wave of the COVID-19 Pandemic.

- **CRR20-03 – Legionella Management and Control**
  Key progress: This risk has been transferred from the Health and Safety Department within the Workforce and Organisational Development Division to the Estates and Facilities Department within the Planning and Performance Division. The target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. The Executive Team will further scrutinise and advise on action required to actively mitigate and manage the risk.

  Whilst the risk has been reviewed, there have been no further changes incorporated.

- **CRR20-04 - Non-Compliance of Fire Safety Systems**
  Key progress: This risk has been transferred from the Health and Safety Department within the Workforce and Organisational Development Division to the Estates and Facilities Department within the Planning and Performance Division. The target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. The Executive Team will further scrutinise and advise on action required to actively mitigate and manage the risk.

  Individual action completion dates have been extended to take into account the impact on the Health Board for the management of the second wave of the COVID-19 Pandemic.

- **CRR20-05 – Timely access to Care Homes**
  Key progress: A new Lead Officer has been identified to manage this risk. Actions have progressed and completed, with two areas outstanding. The Executive Team will further scrutinise and advise on action required to actively mitigate and manage the risk.

Below is a heat map representation of the QSE Principal and Corporate current risk scores:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				BAF20-02 CRR20-04	
	Likely - 4				BAF20-13	BAF20-08 BAF20-11 BAF20-12 BAF20-15 BAF20-16 BAF20-24 CRR20-01 CRR20-02 CRR20-03 CRR20-05
	Possible - 3			BAF20-10		BAF20-09
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Not applicable.

Financial Implications
Depending on the agreement of reporting arrangements, the management of the BAF is resource intensive and so additional resources may be required once the regularity of reporting has been agreed.

Risk Analysis
See the individual risks for details of the related risk implications.

Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

Impact Assessment
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 the BAF and CRR reports are aligned.

Board Assurance Framework 2020/21

Strategic Priority 1: Safe Unscheduled Care

Risk Reference: BAF20-02		Risk Rating	Impact		Likelihood		Score		Appetite	
Emergency Care Review Recommendations										
There is a risk that the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	4	↓	5	↔	20	↓		
		Target Risk	4	↔	3	↓	12	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Unscheduled Care Improvement Group in place to oversee the improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) Ysbyty Glan Clwyd (YGC) improvement plans in place and approved by Executive Team for ambulance handover and flow including EDQDF. 2) Emergency Department (ED) dashboard established which monitors performance. 3) Established Tactical Control Centres in place. 4) Standardised SITREP / escalation reports submitted 3 x day.	2	1) Roll out of YGC improvement plan to other sites as appropriate. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with WG directive, implement the national EDQDF / Welsh Access Model to identify best practice, agree care standards and implement a uniform model for patient access to and from EDs.	31 March 2021 31 March 2021 31 March 2021 31 January 2021
Q3 and Q4 Plan in place and agreed by the Board, with regular monitoring through Access meeting (weekly) & Unscheduled Care (USC) Improvement Group (monthly).	2	Weekly access meeting chaired by the Executive Director of Planning and Performance, to review assurance against the delivery of the plan.	1	1) USC scoping review to be undertaken to develop strategic blueprint solution for unscheduled care. 2) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care.	31 January 2021 31 March 2021
Interim COO / Interim Director of USC overseeing the Q3/4 plan and variance to the plan with regular reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care.	31 March 2021

Review comments since last report: No change

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-08		Risk Rating	Impact		Likelihood		Score		Appetite	
Safe and Effective Mental Health Service Delivery										
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↔	4	↓	20	↓		
		Target Risk	3	↓	3	↓	9	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20.	2	Agree date for formal reporting and financial transfer of budget finalising the alignment of governance and associated roles to BCUHB corporate.	Complete
Partnership and assurance structures are in place. These are: Together for mental health partnership board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is represented in attendance, all meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a reviewed of the T4MHPB) with a plan to re-establish	2	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have agreed and planned to hold 6 formal stakeholder events for the division reporting back to BCUHB and the division. The Director of Mental Health meets meeting formally with the 6 local authority directors.	2	Local implementation meetings are not currently meeting due to Covid 19 cessation of non urgent work. Refresh the Together for Mental Health Partnership approach.	31 March 2021

The Mental Health Learning Disabilities Divisions Senior Leadership Team report to the Joint Executive Team (JET) of BCUHB. This is a control for the delivery of safe and effective services. Regular reports are presented to the Quality and Safety Executive (QSE) on patient safety and quality issues.	2	The Mental Health Learning Disability Division has an agreed management structure (2019) reporting to the Executive Team and Board, following the agreed governance and management structure of BCUHB. It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental health and Learning Disability service.	2	The divisional triumvirate is in place. The division has 1 of 4 strategic priorities in its Special Measures Improvement framework being to "Review capacity and capability" of the Senior Leadership team. This work is ongoing and interim roles are in place. The division has created 2 additional Deputy Directors reporting to the Director of Mental health to fill operating gaps in partnership and strategy development. There is a role of "Head of Psychology" role vacant through 2020 in the Senior Leadership Team, action is in place to engage with Clinical psychology in the division to replace this role meeting 30.11.20.	31 March 2021

Review comments since last report: Gaps and respective actions to support the mitigation of the risk have been completed, key controls have been strengthened and extensions to action timeframes have been discussed and agreed with the Interim Mental Health Director since the risk was submitted to the Audit Committee on the 17 December 2020.		
Executive Lead: Teresa Owen, Executive Director of Public Health	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** 4 January 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-09		Risk Rating	Impact		Likelihood		Score		Appetite	
Mental Health Leadership Model										
There is a risk that the leadership model is ineffective and unstable. This maybe caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↔	3	↓	15	↓		
		Target Risk	4	↓	2	↓	8	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Interim Senior Leaders in place and working within division. This is alongside other key posts; Interim Director of Nursing and Interim Deputy Directors x2. Each lead specific programmes and will further support and develop leadership, governance and management.	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging it's roles and responsibilities.	2	Stabilise Senior Management with substantive posts.	1 June 2021
Strategy approved and regular updates reported via Special Measures to Welsh Government.	3	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways.	1 June 2021
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	3	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021

		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via Clinical Advisory Group (CAG) and / or Quality and Safety (QSE).	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	1 December 2021
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1		
Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1	Finalise all 4 service areas draft Business Continuity Plans for implementation.	31 January 2021
Quality, Safety and Experience Group restarted and meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	2	Dedicated Governance Structure and Team in place. QSE, Clinical Effectiveness Group, Mortality, Medicine Management all meeting regularly. This will allow regular reviews of performance and safety in service delivery.	2	Re-evaluate the governance structure and arrangements in line with Corporate Governance Review to ensure fit for purpose.	1 December 2021

Review comments since last report: No Change

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 3: Mental Health Services

Risk Reference: BAF20-10		Risk Rating	Impact		Likelihood		Score		Appetite	
Mental Health Service Delivery During Pandemic Management										
There is a risk to the safe and effective delivery of MHLD services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6	
		Current Risk	3	↓	3	↓	9	↓		
		Target Risk	3	↔	2	↓	6	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings.	1	MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG).	2	MH&LD to finalise and fully implement Operational Covid19 Winter Plan. (Final ward transfer 18th January 2021, to enable all areas to return to locality admissions).	Partially Complete
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan.	2	Revisit and assess gaps in recruitment processes to support additional staff requirements.	Complete
Wellness, Work and Us Strategy Launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation.	1	Strengthen timely recruitment of staff to clinical posts.	31 March 2021
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans.	2	Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (Awaiting final version of East Business Continuity plan for Divisional sign off).	Partially Complete

MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group.	2	Develop process to ensure continuous mapping of staff to enable redeployment decisions.	Complete
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1		
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	MH&LD Covid19 Senior Leadership Team briefing meeting in place, currently meeting twice weekly, but flexible and responsive to need, which reports into the Corporate Covid19 meetings.	2		
MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.	1	MH&LD Covid-19 Command Structure SoP developed 21 December 2020.	1	Operationalise the MH&LD Covid-19 Command Structure SOP.	04 January 2021
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	To source and procure additional IT equipment, primarily laptops, to increase the roll out of Attend Anywhere across the MH&LD Division.	31 March 2021

Review comments since last report: Gaps and respective actions to support the mitigation of the risk have been completed since the risk was submitted to the Audit Committee on the 17 December 2020. Extensions to action timeframes have also been agreed by the Executive Director of Public Health.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-11		Risk Rating	Impact		Likelihood		Score		Appetite	
Infection Prevention and Control										
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↔	4	↓	20	↓		
		Target Risk	5	↔	1	↓	5	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements reported via Infection Prevention Sub Group (IPSG).	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group.	2	Finalise recruitment to increase IPC Team resource.	31 March 2021
Infection Prevention Sub Group in place providing regular performance reporting.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3		
Major Outbreak policy currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group, Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2		

Review comments since last report: New Lead Officer to be identified. No further updates provided.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-12		Risk Rating	Impact		Likelihood		Score		Appetite	
Listening and Learning										
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6	
		Current Risk	5	↔	4	↓	20	↓		
		Target Risk	5	↔	1	↓	5	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology.	30 September 2021
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better.	30 June 2021
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning.	31 March 2021

Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned.	30 September 2021
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2			Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy.	31 March 2022
				Implementation of an organisation-wide integrated Quality Dashboard.	31 March 2021

Review comments since last report: No change

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-13		Risk Rating	Impact		Likelihood		Score		Appetite	
Culture - Staff Engagement										
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.		Inherent Risk	4		5		20		Low 1 - 6	
		Current Risk	4	↔	4	🡻	16	🡻		
		Target Risk	4	↔	3	🡻	12	🡻		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Multi Disciplinary Review underway to establish an integrated system for reporting, managing, recording and reporting of concerns and learning/improvement action.	1	Raising Concerns and Safe Haven managed separately with separate process for management, recording, reporting and importantly sharing for learning and improvement. Review recommendations to include: 1. Establishment of 2 Board level "champions" and a role of Speak out Safely Guardian. 2. Introduction of a system to support accessible reporting and engagement with reporters to enable two way conversations (including when reporter anonymous). 3. Establishment of a Multi Disciplinary Speak out Safely Resolution & Improvement Group. 4. Development of a learning and reporting cycle. 5. Review and revision of the existing Policy and guidance. 6. Develop roles for speak out safely leads/aligned with listening/wellbeing leads.	31 March 2021

3. Dignity At Work Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level.	1	1.Dignity at Work Policy under review at All Wales level. 2.Triangulation of themes to be included within the reporting outlined in Raising concerns review. 3. Simplified Guidance to be developed for managers and staff to follow to promote early resolution. 4. Current training to be reviewed to align to revised approach.	31 March 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/ recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2.Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4.Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	31 March 2021

Review comments since last report: No change

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-14		Risk Rating	Impact		Likelihood		Score		Appetite	
Security Services										
There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	5	↔	3	🡻	15	🡻		
		Target Risk	5	↔	2	🡻	10	🡻		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of March 2021 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments.	1	Business Case Developed and to be presented to the Board. Staff Training is in place in certain service areas. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant. Additional Bank staff employed to support Covid vaccination centre work and security review.	2	A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. BCUHB requires copies of SIA licences, enhanced DBS certificates and Security Industry association. CCTV licences from the contractor-which have not been supplied monitoring KPI's stipulated in the contract. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed.	31 March 2021
There is a Security Group established to review workstreams. Specific restraint training is provided in specific areas such as mental health. General V&A training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North West Police.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices. To ensure care and this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping there is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc.	31 March 2021

There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different In many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required.	31 March 2021

Review comments since last report: Controls and Mitigations have been strengthened since the risk was submitted to the Audit Committee on the 17 December 2020. Extensions to action timeframes have also been updated, but these require approval from the Executive Director of Workforce and Organisational Development		
Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	**Board / Committee:** Quality, Safety and Experience Committee	**Review Date:** 4 January 2021
Linked to Operational Corporate Risks:		

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-15		Risk Rating	Impact		Likelihood		Score		Appetite	
Health and Safety										
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	5	↔	4	↔	20	↔		
		Target Risk	5	↔	2	🡻	10	🡻		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety Leadership and Management Training Programme in place across the Health Board, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case to establish robust Safety Competence and leadership training programme including IOSH Managing Safely and Leading Safely Modules for Senior Leadership. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan.	31 March 2021
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for Q3/Q4 planning to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	Clearly identified issues escalated to Board via business case to be reviewed. Gaps in Fire safety for a number of premises including YG working with North Wales Fire and Rescue service on action plans. Close working relationship with HSE to ensure key risks and information required is provided in a timely manner. HSE are scrutinising work activity in many areas, likely to Audit BCUHB for Asbestos and Violence at work shortly.	31 March 2021

Lessons Learnt analysis from COVID reported to Executive Team, Through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews a total of 663 RIDDOR investigations undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200 site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak.	3	HSE have identified gaps in COSHH Regulations specifically fit testing which requires fit2fit training programme to be in place. Improvement Notice from HSE against BCUHB provided on 24th October. Appeal against notice has been adjourned until April 2021. There has been significant investment with fit testing equipment with further plans in place to continue fit testing on new masks. There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas.	31 March 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	31 March 2021

Review comments since last report: The negative impact due to Covid on the delivery of the action plan has been incorporated into the "Gaps and Action" section since the risk was submitted to the Audit Committee on the 17 December 2020. The inclusion of the number of RIDDOR investigations into the mitigation section has also been captured as well as reference to the HSE scrutiny. Extensions to action timeframes have also been updated and are awaiting approval from the Executive Director of Workforce and Organisational Development.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems

Board Assurance Framework 2020/21

Strategic Priority 4: Safe and Secure Environment

Risk Reference: BAF20-16		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Exposure									
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↓	20	↓	
		Target Risk	5	↔	1	↓	5	↓	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group.	1	PPE steering group (PPESG) and Covid Delivery Group reporting into Infection Prevention Sub Group, Patient Safety & Quality Group and Quality & Safety Executive with governance structure in place.	2	Continuous supply is not secure, training availability limited due to staffing resource in PPE and IPC teams. BCUHB to approve second admission screen.	31 December 2020
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Finalisation of ongoing plan and sign off at PPESG.	31 December 2020
Environmental considerations in place to meet new guidance in relation to the built environment and mitigating risks.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates.	31 March 2021

Review comments since last report: New Lead Officer to be identified. No further updates provided.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	4 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority: Operational Risk

Risk Reference: BAF20-24		Risk Rating	Impact		Likelihood		Score		Appetite	
Impact of COVID-19										
There is a risk that Health Board will be overwhelmed and unable carry out its core functions due to the spread and impact of Covid-19 in North Wales, which could lead to reduced staff able to work and increased demand on services (including acute, community, mental health and primary care). This could negatively affect the mass vaccination programme, quality of patient care, outcomes for patients and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	5	↔	4	↔	20	↔		
		Target Risk	3	↓	2	↓	6	↓		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place and meeting regularly. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate.	1	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity.	1	Revised Operational Control Centre arrangements for secondary care to stand up.	04 January 2021
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group.	2	Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making.	2		
Clinical Pathways Group meeting weekly to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT.	2		

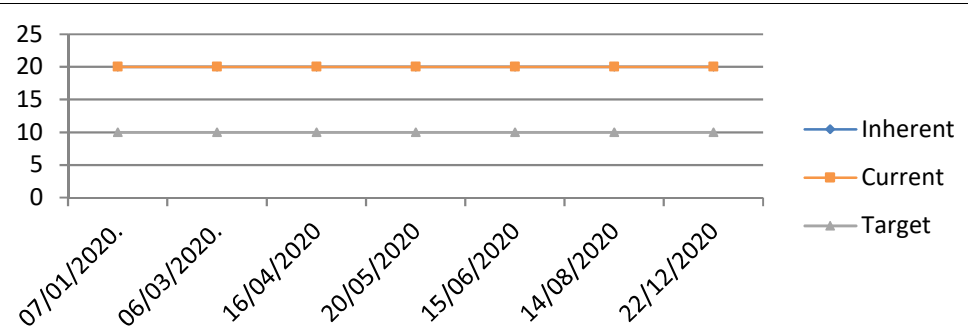
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports.	2		
Executive Incident Management Team has been established and is meeting on a daily basis (weekdays), with formal reporting to Cabinet and Board Briefings.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Cabinet and Board briefings; escalation of matters requiring Board approval.	2		
North Wales LRF Strategic Co-ordinating Group meeting bi-weekly.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis via D20 SitReps.	3		

Review comments since last report: New Risk		
Executive Lead: Chris Stockport, Executive Director of Primary and Community Services	**Board / Committee:** Quality, Safety and Patient Experience Committee	**Review Date:** New Risk
Linked to Operational Corporate Risks:		

Appendix 2 – Corporate Risk Register Report

CRR20-01	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22 December 2020
	Risk: Asbestos Management and Control	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – low level)	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place and partially implemented due to lack of complete asbestos registers on all sites. 2. A number of surveys undertaken, quality not determined. 3. Asbestos management plan in place. 4. Asbestos register available on some sites, generally held centrally. 5. Targeted surveys where capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

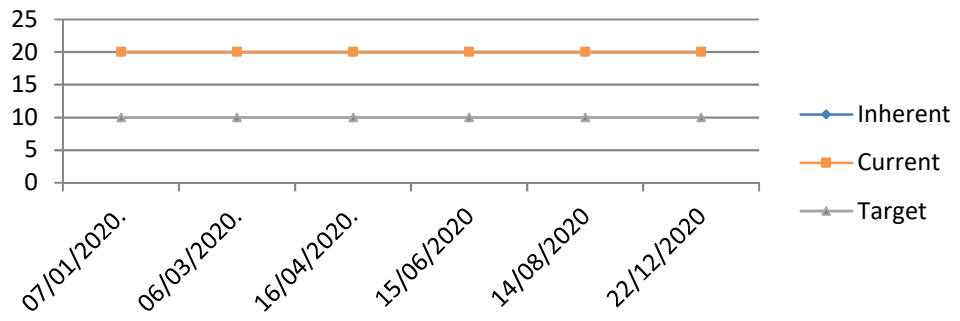
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	30/01/2021		
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	30/01/2021		
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		

	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.	Mr Rod Taylor, Director of Estates & Facilities	30/04/2021		
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/04/2021		

CRR20-02	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22 December 2020
	Risk: Contractor Management and Control	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – low level)	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	unchanged		

Controls in place	**Assurances**
1. Control of contractors procedure in place and partially implemented due to lack of consistency and standardisation. 2. Induction process being delivered to new contractors. 3. There are a number of permit to work paper systems being implemented.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

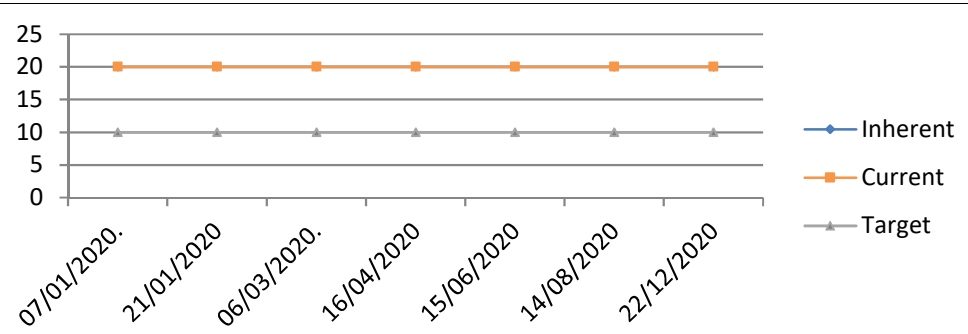
Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF20-15

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12251	Identify current guidance documents and ensure they are fit for purpose.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming to site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of	31/03/2021		

			Estates & Facilities			
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	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	31/01/2021		
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		

CRR20-03	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22 December 2020
	Risk: Legionella Management and Control.	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – low level)	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place and being partially implemented due to lack of consistency and standardisation. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

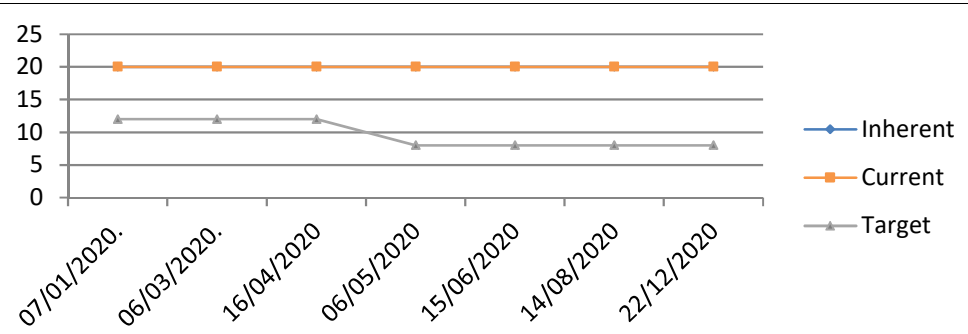
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

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	12261	Update Corporate H&S Review template and H&S Self Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place.	Mrs Susan Morgan, Interim Head of Health and Safety	30/11/2020	Action Closed 1/12/20 - There is an annual review of the Corporate H&S Review and Self Assessment paperwork. This will continue to be included but due to the low return rates at the moment for the self assessment and the reduced number of H&S reviews (due to COVID-19) this is not an effective action to reduce this risk at this time.	
	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	31/03/2021		
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	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	31/01/2021		
	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	31/01/2021		

		dashboard/logging system (Public Health Wales).				
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		

CRR20-04	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 22 December 2020
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 March 2021

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – low level)	4	2	8
Movement in Current Risk Rating Since last presented to the Board in April 2020	unchanged		

Controls in place	**Assurances**
1. Fire risk assessments in place in a number of service areas. 2. Evacuation routes Identified and evaluation drills established and implemented (across a number of areas). 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

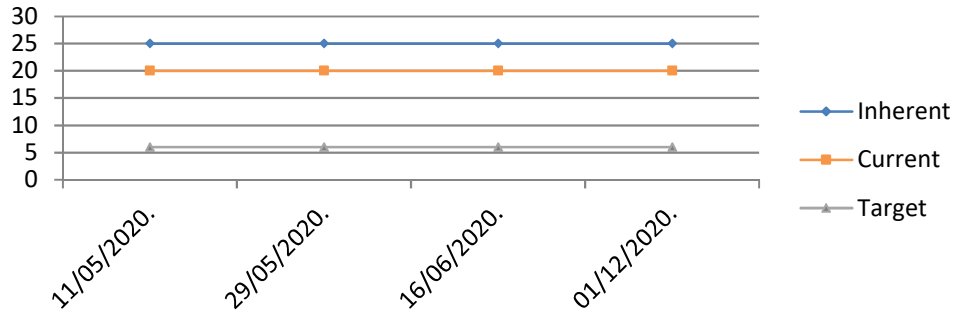
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021		
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021		
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2021	02.11.20 we are currently working with internal Audit reviewing Security and V&A	
	12555	Information from unwanted fire alarms and actual fires is collated and	Mr Rod Taylor, Director of	31/01/2021		

		reviewed as part of the fire risk assessment process.	Estates & Facilities			

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:** 01 December 2020
	Risk: Timely access to care homes	**Date of Committee Review:** 3 July 2020
		Target Risk Date: 31 January 2021

There is a risk that there will be a delay in residents accessing placements in care homes and other communal facilities. 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 wider capacity and patient flow.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – low level)	3	2	6
Movement in Current Risk Rating Since last presented to the Board in April 2020	unchanged		

Controls in place	Assurances
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact a day“ data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular communication with care homes at a local level and across BCU.	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.

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-04

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	12436	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Ms Jane Trowman, Associate Chief of Staff - Operations	31/01/2021	Ongoing weekly reviews	
	12437	Continue to refine and develop communication with care homes at a local level and across North Wales.	Ms Jane Trowman, Associate Chief of Staff - Operations	31/01/2021	Daily calls made. Twice weekly meetings continue with Care Forum Wales, CIW and partners. Weekly national briefings circulated supplemented by local information.	

Cyfarfod a dyddiad: Meeting and date:`	Quality, Safety & Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Infection Prevention & Control Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris – Deputy Chief Executive/Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Sally Batley – Interim Associate Director of Nursing (ADN) – Infection Prevention & Decontamination
Craffu blaenorol: Prior Scrutiny:	Acting Executive Director of Nursing and Midwifery
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to take assurance from the Infection Prevention (IP) presentation

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

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

Sefyllfa / Situation:

The IP presentation will update the Committee on the position of IP performance and the associated risks relating to IP. A summary will be provided on:

1. 2020/21 trajectories, performance, gaps and actions required
2. COVID 19

Cefndir / Background:

Infection Prevention performance and reporting is a mandated requirement for the Health Board. This report will provide a position statement in relation to trajectories, quality improvements, harms and exception reporting.

Asesiad / Assessment & Analysis:

Financial Implications

1. Expand and financially support the significant gaps in the IPCT, including decontamination and antimicrobial stewardship
2. Staff absence for self-isolating, shielding and symptom management.

Risk Analysis

Infection prevention and the ability to deliver the work programme, policy review, preventative and innovation work, and development of the IPCT is currently on the Risk Register. A Delivery Group and Personal Protective Equipment (PPE) risk register has been developed chaired by the Executive Director of Nursing.

Legal and Compliance

Reporting to Incidents for any COVID 19 clusters/ward closures and deaths confirmed on death certificates.

Health Care Acquired Infections (HCAIs) including Covid 19. Reporting to Health & Safety Executive (HSE) via RIDDOR for any dangerous occurrences relating to staff infections.

Bed Spacing and Air exchange monitoring.

Impact Assessment

No impact applicable to this report.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Safety Quarter 3 Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Pete Bohan, Associate Director of Health, Safety and Equality Sue Morgan, Head of Health and Safety
Craffu blaenorol: Prior Scrutiny:	Executive Director of Workforce and Organisational Development
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the position outlined in the Quarter 3 Report.

Please tick as appropriate

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

Sefyllfa / Situation:

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

Cefndir / Background:

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of Occupational Health & Safety (OHS) within BCUHB. The OHS Team developed a comprehensive action plan to identify and mitigate the risks identified. This action plan included key areas of risk such as, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. These actions will still need to be completed to ensure BCUHB compliance with legislation.

Asesiad / Assessment & Analysis

Strategy Implications
BCUHB will be required to implement the OHS 3-year Strategy that focussed on identifying and wherever practicable eliminating or minimising hazards based on the Health & Safety Executive (HSE) Safety Management System HSG65 and principles of Plan, Do, Check, Act. The process described in the Policy will not only help to reduce the likelihood of accidents and ill health. It will also help to improve time for staff to give care to patients, help to reduce financial waste and improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 3-year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to enable change. The changes outlined in this report due to the COVID-19 pandemic will impact on achieving the OHS 3-year Strategy

Options considered
There are limited alternative options than compliance with legislation. These are the minimum criteria and recommendations identified within the gap analysis and business case provided to the Executive Team that require implementation.

Financial implications
There are significant budgetary implications, which are currently not funded. A business case has been produced and shared with the relevant Executive Directors. The major financial implications include staffing for Security and Health and Safety, Training packages include the Institute of Occupational Health (IOSH) Director and Managing Safely programmes. Estates related software includes MiCad for schematic drawings of the estate and Sypol for Control of Substances Hazardous to Health, re-surveys of premises for asbestos, implementation of risk assessment findings for fire and compartmentation particularly in Bangor Hospital and health surveillance systems for staff.

Risk analysis
The significant risks have been escalated to Tier 1 on the risk register and were previously agreed by QSE. These include Leadership of OHS, Security, Contractor Management and Control, Asbestos, Legionella and Fire Safety. These risks were initially added onto the risk register under the Corporate Health and Safety Team and will need to be allocated to the functions who hold the responsibility for the management of these risks.

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

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

1. Health and Safety Gap Analysis Action Plan

The full gap analysis action plan was put on hold at the start of the COVID-19 pandemic. In Q2 a Health and Safety workshop was held to recommence the work required to ensure compliance with H&S legislation. Due to the increased workload at this time for the Corporate H&S team the action plan has been reviewed and priorities reallocated. Those areas that sit with Estates including fire safety, asbestos, control of contractors, working at height, electricity and water management will remain under review by the Estates team. Authorisation has been given to recruit a temporary H&S Advisor specifically to support this work with the Estates Team with a dedicated 15 hours per week.

2. Corporate Health and Safety Team Site Visits

With the onset of the Coronavirus (COVID-19) pandemic in March 2020 and the subsequent government advice to 'stay at home' on the 23rd of March 2020, the Corporate H&S reviews were placed on hold. With changes in restrictions of movement since this date the H&S team primarily focused on supporting the Hospital Management Teams and department managers with site visits to support with the 'social distancing and staying safe' program and later with undertaking risk assessments for staff returning from shielding. In Q1, the H&S team undertook a total of 56 site visits with a further 128 in Q2. In Q3 a further 119 social distancing and staying safe visits were undertaken. The team also reintroduced on a small scale the formal Corporate Health and Safety reviews in Q3 as part of the BCUHB auditing process. To date there have been 33 reviews undertaken and reports have been provided to the managers of these areas to support with ensuring H&S compliance.

3. Reintroduction of Corporate Health and Safety support to Primary Care

During the pandemic the Corporate H&S team advisor for Primary Care has continued to support practices who have individually contacted the team relating to a variety of H&S enquiries. Over the last month the advisor has proactively recommenced on-site and on-line H&S Review planning within all three Primary Care areas. The H&S Advisor has completed preliminary discussions during the Area Quality & Safety Meetings and also one to one virtual meetings with colleagues from the Clinical Governance teams (CGT) to identify which practices should be prioritised. It has been agreed that BCUHB managed practices should be the initial priority but also any 'problematic' practices that are known to both the CGT's and also H&S, with evidence based on previous visits. As GP surgeries will increasingly be required to adapt to the mass vaccination programme H&S will offer and provide support relating to workplace assessments, social distancing requirements, Personal Protective Equipment (PPE) and vehicular and pedestrian routes within car parks and surgeries. Once all managed practices have been visited then further meetings will be held with CGT to agree the visiting programme going forward.

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

A further meeting has been held with the HSE during Q3 to clarify the requirements for reporting staff COVID-19 under RIDDOR. The inspector advised BCUHB to continue to report where there is significant evidence of breaches but to avoid reporting sloppiness or forgetfulness by staff. It was noted that there is a significant rise in the number of staff who are testing positive for COVID-19 but with the numbers in the community increasing it would be difficult to determine that the source is 'probably' work related in many cases. RIDDOR training will recommence in January 2021 via Microsoft Teams and training / support has been available on an ad hoc basis during the pandemic.

Area	COVID-19 RIDDOR's	Non COVID-19 RIDDOR's	Total Q3 2020	Comparison total Q3 2019
Central	44	7	51	8
West	15	11	26	8
East	36	6	42	7
Totals	95	24	119	23

5. Covid-19 Specific Investigations undertaken in Q3

5.1 Wrexham COVID-19 Outbreak

The Corporate H&S team has continued to support the Outbreak Control teams during the COVID-19 outbreaks in Q3 with a further outbreak in Wrexham.

5.2 HSE Improvement Notice

A RIDDOR report of a Dangerous Occurrence was sent to the HSE on the 28th of May 2020 relating to the partial failure of an FFP3 mask. This report has led to an HSE investigation and subsequently BCUHB received an Improvement Notice on the 24th of August 2020.

Work had commenced prior to the issuing of the notice and a Respiratory Protective Equipment (RPE) Task and Finish Group was established reporting directly to the PPE Steering Group. This group was chaired by Corporate H&S and working to recommendations agreed by the Executive Director of Workforce and Organisational Development. To date:

- BCUHB have purchased a total of 18 PortaCount machines and have moved solely to quantitative testing
- 113 fit testers have been trained to use this method
- A program for refitting staff in high risk areas commenced on the Ysbyty Glan Clwyd (YGC) site and up to 18.12.20 92% have been refitted to an appropriate respirator
- The Fit Testing Protocol has been drafted
- A Fit Testing Operational Group meeting has been introduced
- Electronic Staff Record (ESR) competencies have been created for respirator models which is waiting for approval to go on all staff records
- Commencement of recruitment for a dedicated fit testing team

The Improvement Notice was issued to YGC however the Notification of Contravention letter was applicable to BCUHB. Due to the shortages of the 1863 respirator stock and no other viable alternative at that time, this program of refitting all BCUHB staff has not commenced. Two potential options became available with the Meixin 2016V and the 1863+/9330+ (both are the same respirator). An SBAR was taken to the Executives with recommendations on the model of respirator to take forward. There is still consideration that the 8833 stocks may become more widely available and supplies are steadily coming through to the All Wales stock. If this supply chain becomes more stable this may change the recommendations of the SBAR.

The Fit Testing Task and Finish Group has now been stood down as the majority of the recommendations have been completed and those that haven't are in good progress.

5.3 Additional HSE investigations

The HSE have requested information on three staff clusters during Q3. This has required the collation of additional information to provide a report to the HSE. The H&S team now attend all Make It Safe meetings that are taking place to help department managers determine if adequate controls are in place, any further actions required and whether the incidents are reportable under RIDDOR. The team have also been required to collate further information for two patient falls working closely with clinical teams and the Patient Safety and Experience Team.

6. Datix incidents (Personal Injury)

A total of 2,260 incidents were reported in Q3 under the datix category 'Accident that may result in personal injury incidents'. In Q1 and Q2 there was a decline in non-COVID related staff incidents and in Q2 there was a decline in COVID related incidents in comparison to Q1. However both figures have risen in Q3.

	01.01.20- 31.03.20 (Q4)	01.04.20 – 30.06.20 (Q1)	01.07.20 – 30.09.20 (Q2)	01.10.20 – 31.12.20 (Q3)
Total	1,873	2,122	1,867	2,260
Staff	353	770 257 Non C19 513 C19 related	431 301 Non C19 130 C19 related	791 375 Non C19 416 C19 related
Patients	1,484	1,328	1,403	1,432
Other	36	24	33	37

7. Security

7.1 Security related policies and procedures
The V&A, Security, CCTV, lone Working and Lockdown policies are all currently under review

7.2 Datix Incidents (Security)
Security Incidents reported in Quarter 3 on the Datix system are largely comparable to those over the previous 2 years. Changes have been made to the Datix incident reporting system to allow reporters to record if security guard attendance has been requested and the team are monitoring the number of emergency bleeps received. The addition of the Bank Security/V&A advisor has enabled a review of all security and V&A incidents reported on Datix system, those incidents in which staff are harmed and /or police involved contact has been made with departmental managers/BCUHB staff to offer support and advice.

7.3 Security Training
The first draft of the V&A training review has been completed. Initial findings suggest that recommendations from the Health and Social Care Advisory Service (HASCAS) require BCUHB to supply clinical focused training in relation to dementia care to promote lawful and safe interventions in respect to restrictive practice management across all care areas. The focus will be on how to deliver this training going forward. E-Learning V&A training remains available.

7.4 Security Staffing Resources
Security staffing has increased to now consist of 1x 0.8WTE V&A Case Manager/Security Manager and 1x WTE Security/V&A advisor appointed on a "bank" basis, fully supported by the Head of Health & Safety. To effectively manage the security requirements in BCUHB a business case has been submitted to explore the possibility of 3 full time Security Advisors.

7.5 Security Management Provision
A meeting has been held with representatives from the Hospital Management Teams to identify a proposed model going forward. The proposed model would see an increase in the security provision to two guards 24/7 on the 3 District General Hospital sites, which would require additional funding. The security provision required for the Community Hospitals will also need to be agreed and the current suggested proposal is for a mobile security team in each area; this does need to be explored and discussed further.

8. Manual Handling

8.1 Training

During this quarter, the team were able to provide 62 Foundation classes and 107 Refresher classes, offering a total 1,174 places, which is a reduction on Q2, due to a two-week Firewall lockdown, self-isolation and annual leave requirements. This has left a shortfall of 350 places for Level 2 this quarter, these figures do not include the Health Science Students or Temporary Staffing requirements on training and these shortfalls will accumulate and potentially leave BCUHB at further risk of untrained staff.

8.2 Datix (Manual Handling)

28 Datix reports were received this quarter, 64% of these are where training issues can be pointed as the cause for reporting.

8.3 Assessments

During this quarter, 41 assessments were conducted mainly through Skype or Microsoft Teams unless visit needed in Covid risk assessed areas. 85% of assessment carried out are relating to DSE, this has increased due to agile working**.**

8.4 Additional trainers

Authorisation has been given to recruit additional training resource via the Bank whilst awaiting approval of the Business Case which describes the longer term plans to develop effective safety systems for BCUHB. Two full time Bank trainers have been recruited and these are due to commence mid-January.

8.5 Training rooms

When classroom based training was reintroduce in July 2020 access was available to use the three Temporary Hospitals. In Q3 the training access was stopped in both Deeside and Bangor and there are competing demands on the training rooms that were previously utilised by the team. An empty ward has been provided for training in Llandudno hospital and it is planned to reopen the training room in Abergele. The training available for staff based in the East will be limited and there is no current training planned for staff in the West Health Economy. The very limited availability on the Bangor site has been prioritised for Health Science Students. An SBAR has been completed to escalate this to the Executives.

9. Recommendation

The Committee is asked to note the position outlined in the Quarter 3 Report

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Holden Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Matthew Joyes, Assistant Director of Patient Safety and Experience with support of a task and finish group
Craffu blaenorol: Prior Scrutiny:	Review by task and finish group, Responsible Director, Acting Nurse Director for MHLD and Acting Executive Director
Atodiadau Appendices:	Appendix 1 - Assurance Table

Argymhelliad / Recommendation:

The Quality, Safety and Experience (QSE) Committee is asked to:

1. Note the report
2. Approve the two recommendations made arising from this review:
   a) All future significant quality-related reports have resultant action plans tracked by the Associate Director of Quality Assurance's Office using the same governance framework and methodology of that used for HIW actions to include progress reporting in the Quality Assurance Report to the Patient Safety and Quality Group (and therefore onto QSE Committee).
   b) Any significant quality-related reports, when tracked through the process mentioned in the preceding recommendation, are assured in a timely fashion and have clear close down reports when all actions are complete.

Please tick as appropriate

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

Sefyllfa / Situation:

The former Executive Medical Director and Executive Director of Nursing and Midwifery/Deputy CEO commissioned work to validate that the recommendations from the Holden Report (2013) have been implemented and remain sustained. The Acting Associate Director of Quality Assurance oversaw this work ensuring both a corporate objectivity to the work and a degree of independence given they have no prior involvement in the unit, division or report and only joined the Health Board within the last year. The work was also supported by the Acting Divisional Director of Nursing for Mental Health

and Learning Disabilities, who similarly has a degree of independence given they also have no prior involvement in the unit, division or report, having recently started working for the Health Board.

The assurance table attached to this report shows a position statement against all of the Holden Report recommendations. In addition, as previously mentioned, a number of other reviews/reports were undertaken at the same time and position statements have been included against those for completeness of the assurance. The embedded evidence has been removed for this committee paper but remains in the master document.

Cefndir / Background:

In May 2013, the Health Board arranged for the NHS Delivery Unit of Welsh Government to undertake a review of the Hergest Unit and to assess compliance in relation to the Mental Health Measure. A full report from the Delivery Unit was received by the Health Board in June 2013. The actions from the report were prioritised in the Hergest Improvement Plan (HIP) for implementation.

The Health Board commissioned an Invited Review by the Royal College of Psychiatrists (RCP) which took place during October 2013, with a report received by the Health Board in December 2013.

Healthcare Inspectorate Wales (HIW) commenced an unannounced inspection on the 2nd December 2013. Following the 3 day inspection, HIW provided a report to the Health Board on the 17th December 2013 with 21 recommendations.

HIW undertook a follow-up unannounced visit on 12/13/14 May 2014 where the main focus of the visit was to establish progress in addressing the issues highlighted in their visit of December 2013.

Further HIW Inspections took place at the unit in January 2016 and September 2018.

The HIW inspection reports, and the associated improvement plans from the Health Board are available publically on the HIW web site.

On 20 July 2013 the then Executive Director of Nursing and Patient Services visited the Hergest Unit in Bangor and spoke to a number of staff who raised concerns. In a letter, dated 26 July 2013, 42 members of staff concerned confirmed the exact nature of the allegations and confirmed the names of staff who had signed a petition stating that the signatories had "No confidence in the Management of the Mental Health CPG [Clinical Programme Group] in their dealings with the Hergest Unit."

Robin Holden, previously Head of Nursing for the Hergest Unit's predecessor organisation (Gwynedd Community Health Trust), was commissioned to undertake an investigation and produce a report – the Holden Report – under the auspices of the Raising Staff Concern / Whistleblowing Policy (WP4).
A report was finalised and submitted on 08 December 2013.

These collective matters from various reports continued to be monitored by the Health Board's Mental Health Improvement Group established in June 2015 under the leadership of the former Chief Operating Officer with the former Vice Chair of the Health Board in attendance. The work from the group was reported publicly as part of the 100 day plans and continued to be monitored as part of the special measures programme. However, as previously reported, there has not been a specific Holden Report action plan update prepared for the Health Board nor its Committees.

The Holden Report provided the Board with a review and assessment of the issues that were causing staff concern at that time. Under the Health Board's whistleblowing arrangements, staff have the opportunity to raise concerns confidentiality, therefore, to avoid breaching these arrangements and to ensure staff are not discouraged from raising concerns in the future, the Health Board agreed it would not be publishing the full report.

Following a request from the Public Accounts Committee the Health Board took advice and were able to share a report summary and recommendations in a redacted form.

The Information Commissioner's Office (ICO) recently upheld an appeal by a member of the public that the Holden Report (2013) should be published under the Freedom of Information Act, following the Health Board's earlier decision not to disclose the report on the basis that doing so would identify individuals who had expected a right to privacy (i.e. those staff specifically named in the report and those staff who raised concerns through the whistleblowing process who can be identified). The Health Board has appealed this decision and a tribunal hearing is expected in early 2021. A tribunal hearing is expected in mid 2021.

As outlined above, to provide confidence to the Board and our community, the former Executive Medical Director and Executive Director of Nursing and Midwifery/Deputy CEO (at the time Acting CEO) commissioned work to validate that the recommendations from the Holden Report have been implemented and remain sustained.

Asesiad / Assessment & Analysis

The Holden Report made 19 recommendations.

As the assurance table demonstrates, action was taken and remains in place against all recommendations. The actions taken in relation to the other seminal reviews provide further assurance. It is clear the unit is in a very different position to that of 2013 and this is further reinforced by more recent HIW inspections.

However, this review has highlighted that the Holden Report (2013) action plan was not robustly monitored through the Health Board's governance structures at the time. It is therefore not possible to state with confidence that the changes and improvements happened directly as a result of the Holden Report itself. Whilst it is somewhat understandable that the Holden Report was kept confidential as it arose from staff whistleblowing, the absence of a clear tracking mechanism for the actions represents a failure of governance. The review by the Executive Director of Workforce and OD into the raising concerns process will help address some of this key learning, and a further recommendation is that any significant quality-related reports are tracked by the Associate Director of Quality Assurance's Office using the same process and governance framework for HIW action tracking, this ensuring a single and robust database, reporting and escalation process is used. Progress would then be reported to the Patient Safety and Quality Group through the Quality Assurance Report and onward reported to the QSE Committee.

Secondly, it is of note that whilst issues identified in the Holden Report were addressed, due to the significant passage of time (7 years) some issues have reoccurred (such as the current position with a high number of interims in senior divisional leadership positions). A second recommendation is therefore made that any significant quality related reports, when tracked through the process mentioned in the preceding paragraph, are assured in a timely fashion and have clear close down

reports when all actions are complete. This will not only provide the Board with more timely assurance, but it will give greater confident to our community that actions have been take and avoid separate issues being conflated over a long passage of time.

Appendix 1 – Evidence Table (note an index of evidence is detailed at the end of this table)

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
1.	The current arrangements for the Management of the Division are unwieldy. Responsibilities and lines of management are unclear. A triumvirate system of senior management teams has been implemented across the Division based on 3 area teams (east / central / west) and regional services structures. Senior divisional management provides oversight and ownership of divisional governance processes Relationships between significant numbers of Staff and Unit/Senior Managers have broken down. There have been changes in staffing as usual over the period since the Holden Report being written – communication processes are in place: • Daily acute care meeting • Daily safety huddle • Ward meetings • Area PTR • Area QSE • Area operational meetings • Management supervision arrangements in place • Senior management team visible and preset in the area • Be Proud scheme in place • BCU ward accreditation incorporates staff feedback • Inpatient manager walk rounds in place • Head of Nursing regularly undertaking clinical shifts • HIW reports improved staff morale, improved communication between staff and management and a positive working atmosphere.	1) <u>Management</u> 1a) Review of the management structure to develop a locality based senior management team. 1b) Development of the management competencies of ward team managers and ensuring that their budgets allow them to maintain an appropriate complement of staff. Efforts should be made to ensure an early transition from the numerous acting roles to substantive post holders so that they develop solutions themselves in consultation with the multidisciplinary teams. Some day to day management initiatives such as the change of the room configuration and relocation of the medical records have been implemented in a manner that has not taken practicalities into account and indicates that change has been pushed through at an inappropriate level. The ward managers themselves must be supported in this area. 1c) Review of the Hergest Improvement Programme to reduce the number of work streams and consider whether all the work streams have appropriate representation from clinicians. The scope of the work of the Improvement Programme is such that a number of consultants should have time within their job plans to contribute to it and undertake the consultation necessary with colleagues to progress initiatives. Nursing staff of various grades should also participate. Prioritisation within the Improvement Programme should focus on significant service delivery issues. The choice of uniform as a priority given the variety of opinions on this issue in mental health does not seem to be sensitive in the circumstances. The acting Modern Matron does management “walkabouts” which is positive and this could be extended by general managers considering possibilities for more contact. Reciprocal shadowing between	1) An urgent review of the Seclusion room on Taliesin ward is required. The room had a WC and wash basin within it and there was a lack of privacy and dignity as windows in the nurses’ station looked directly onto the WC within the room. The issue was identified in December 2013 and August 2012 and therefore requires more timely action NAPICU attended to review the seclusion suite in 2016 and the suite is now in line with all standards.	**The Measure:** The CPG must take all practical steps to ensure that services delivered in the Hergest Unit are compliant with both the legislation and the Code of Practice relating to the Measure. This includes, but is not limited to, consideration of the processes and controls required to assure compliance with all aspects of parts 2, 3 and 4 of the Measure. MHM compliance monitoring is in place for all parts of the Measure utilising Sharepoint systems. Weekly compliance monitoring is in place between service and ward / team managers. Advocacy is in place. Part 3 is discussed with all patients by Care coordinators.

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
	• Open door approach to management – staff aware they can approach managers at any time • Reviewing themes and trends from complaints / concerns at PTR shows little evidence of poor working relationships • Reduced activity around WOD ie staff grievance / disciplinary etc • Greatix being submitted by staff about staff • Significantly reduced vacancies – Aneurin and Cemlyn wards fully staffed for the first time in 7 years • Senior team triangulate sickness / vacancies and incidents to monitor emerging themes and are responsive to staff needs. • Staff wellbeing rooms being introduced and in place in some areas • Psychology now present in the unit providing routine debrief and staff support • Listening Leads in place There appears to be a high number of temporary and interim posts. The BCUHB needs to review management arrangements of the Division with a view to strengthening local management of the whole system. The temporary and interim posts need to filled with substantive post holders as soon as possible There are currently a number of posts which are interim as a result of more recent changes and we are working on a solution for this with the substantive post holders and WOD. With regard to the interim posts we have consistent post holders to provide stability in the team and for the delivery of patient care.	managers and clinicians may facilitate future problem solving. Choice of uniform has been discussed with the All Wales Senior Nurse Advisory Group and with Unllais – patients surveyed responded 97% in favour of uniform. Staff are currently in uniform due to Covid.		
2.	The issues surrounding the lack of constructive engagement between the Senior Management Team and the staff of the Hergest Unit needs to be addressed	2. <u>Training and Peer Support</u> Training remains a priority for inpatient teams and Band 6 nurses involved in urgent	2. Whilst it is acknowledged that there has been the creation of a frailty room on two of the wards, a frailty ward would be beneficial for this group of vulnerable adults and would	**Training and induction** The need for all staff, including new and locum staff, to receive training and induction on:

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	urgently. This critical breakdown in communication has created a worrying poverty of leadership in the Unit. See above.	assessments. Participation in structured means of improving the quality of inpatient wards such as "The Productive Ward" or the AIMS accreditation process would be helpful for inpatient teams. Participation in the AIMS liaison service network would be useful. AIMS accreditation previously gained. All wards are now accredited via BCU internal ward accreditation system. Mentoring could be used more often as a clinical management development tool for all disciplines. Staff should be matched to a mentor who has specific skills or experience that they need or wish to develop. Professional development should also be provided in a structured manner for health care assistants. Health Care Assistants now can undertake the HCSW Passport which had targeted learning – HCSW's can now access advanced training and are supported to do so. Level 4 training is available and staff are supported to attend.	enhance the care delivery to this group of patients	○ The role and requirement of the care coordinator. ○ The process for recording assessment of need and risk. ○ The process for developing and recording outcome focussed care plans. ○ The process for monitoring and evaluating care given. ○ The integrated working arrangements with partner agencies and the wider health care system. ○ The application of local information systems. The training guide for the division states: The Mental Health Measure Code of Practice, section 3.39 specifies that: *"Care Coordinators should be supported by effective training to undertake their functions.... in relation to the practical aspects of holistic assessment, addressing communication needs, planning, and liaising, this should include understanding the importance of maximising opportunities for recovery and achieving a better quality of life for the relevant patient"* All staff must attend Level 1 training. All registered professionals will need, additionally, to undertake Level 3 training, as appropriate. The learning outcomes for the Level 1 course are as follows: • Recognise the key features of the Mental Health Measure and how this is applied and supported locally • Understand the key principles on which the Mental Health Measure is founded including the rights of individuals receiving services • Identify clinical pathways that support Mental Health Measure compliance and understand your role in overall delivery of the Mental Health Measure.

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				The learning outcomes for the Level 3 course are as follows: • Recognise the importance of engagement with Service Users & Carers when producing high quality working in Care and Treatment Planning referencing the core values of the Mental Health (Wales) Measure 2010. • Understand the importance of recovery and person centred approaches to Care and Treatment Planning and relate this to current practice in line with the Mental Health Measure. • Demonstrate your role, responsibilities and functions of being a Care Coordinator with an understanding of comprehensive assessment and timely record keeping. Care and treatment plans are written within 12 hours of admission to the unit as per acute inpatient pathway. Care and Treatment plan reviews are held weekly whilst an inpatient with the MDT, patient and any family or carers. Sharepoint is utilised to record compliance with the MHM and carries data on the whole patient caseload and can be easily audited to monitor patient journeys. Audit of CTP is undertaken by the inpatient service manager during senior walkabout on a monthly basis. CTP audit is also reported in the nursing care metrics.
3.	Attention needs to be paid to the status and impact of Mental Health Nursing in the Unit. The recently vacated Programme Manager post, could potentially be redesigned as an Advanced Nurse Practitioner or Nurse Consultant role developing and promulgating excellence in Acute Mental Health Nursing in the Hergest Unit and across the Health Board We currently have: • One ANP being trained for adult community services,	3. <u>Appraisal and Job Planning</u> The Delivery Unit had raised the issue of appraisal and personal development plans for nursing staff and the earlier WP4 investigation addresses nursing professional development. All the consultants were broadly up to date with appraisal but we were given to understand that the arrangements did not lend themselves to feedback on clinical leadership roles. A 360 degree appraisal does link with the system but specific feedback from the clinical managers to the appraisers and appraises linking with job planning is required. Appraisal should also	3. For the Health Board to arrange for an independent review relating to an episode of care Independent review undertaken and all actions completed.	**Care coordination** • The arrangements for the appointment of the care coordinator, within two weeks of acceptance into secondary care services, ensuring all clients have a designated care coordinator to promote continuity of care, particularly those clients admitted from out of area. • The arrangements for community based care coordinator to be actively involved in a client's care planning and review during the inpatient episode.

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	• One fully trained ANP who also has AC status and is currently being processed through job matching for re-banding. There is a potential for this post to be reviewed by the Executive Nurse Director to see if the role should attract Consultant Nurse status (timescale 12 months) • Further ANP course secured and will be allocated locally. Area based nurse training and education group being established to ensure local nurse training budget is appropriately utilised and aligned with NHS Nurse Education Planning Framework.	provide a review as to whether medical staff consider they had had sufficient support to further clinical management responsibilities. Where staff hold an academic appointment it is important for all parties to conduct appraisal and job planning jointly between the clinical service and the University and for all medical staff the job plan should be reviewed annually informed by feedback from appraisal. Mandatory appraisal and revalidation structures are now in place which include 360 reviews as per RPsych regulations. Revalidation of NMC in place and supported.		Care coordinators are allocated for inpatients entering secondary care via SPOAA. Patients who require an inpatient care coordinator area allocated one within 24 if new to service as per acute care pathway. Care coordinators are engaged with inpatient episodes via regular review and MDT meetings on the wards.
4.	Special attention needs to be paid to repairing the relationship between the Modern Matrons and the Ward Managers. The commencement of this work may not be possible until after the grievance procedures that are currently ongoing have been resolved. Very skilled mediation will be necessary and HR advice will need to be sought on how best to facilitate this. This is such a critical area that it may be that expertise will need to be brought in if not available within the Health Board. Grievance procedures were concluded. As in Point 1 systems and processes are in place to strengthen and improve relationships. Current inpatient manager has strong, supportive relationships with ward managers.	4. <u>Mixed Use of the Acute Service</u> Systems must be in place to support ward managers to raise concerns about inpatient mix. The issue of mixed use for older patients who may have high physical dependency needs should be urgently reviewed. The issue of gender mix and whether it would be preferable for the wards to be single sex should also be evaluated. Mixed use also occasionally involves the admission of patients between the ages of 16 and 18 and the service should review whether best practice guidance is adhered to on each occasion. The AIMS inpatient standards (R C Psych) provides such guidance. If a more radical review is not possible for some time staffing should reflect the need for increased support, adjusting in line with specific patient needs. Staffing is always monitored and adjusted for specific patient need – on a daily basis. Admissions of young people aged 16-18 are managed in line with Divisional policy.	4. For the ECT suite to be de-commissioned with immediate effect Completed.	**Care and treatment planning** • The need for all clients to have an outcome focused CTP in the prescribed format. • The need for the client, their carer and, where applicable, the advocate to be involved in developing that plan. • The arrangements needed to ensure the existing community CTP is available, in a timely way, to inpatient staff. All patients subject to CTP have a prescribed format care plan. Care planning is a collaborative process including all relevant parties and the patient. The CTP is incorporated into the integrated case file which is the single case note system following the patient through services.
5.	A structured programme of safety walk rounds and Ward visits should be implemented by the Senior Management	5. <u>ECT</u>	5. Patient information continued to be displayed on whiteboards in the nurses' station and was clearly visible for fellow patients and	**Assessment**

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	Team in order to improve their presence on the wards Inpatient manager walk rounds are on a weekly basis and reported in area QSE minutes. Head of Nursing regularly works clinical shifts. Ward accreditation undertaken. Matron and Ward Manager audits.	The ECT Service is not accredited by ECTAS. There is no dedicated ECT nurse and the number of treatments/year falls well below the number required to meet the ECTAS standards without additional training occurring on a regular basis. In these circumstances the Review Team advises that arrangements for ECT should be made with the accredited service at the Ablett Unit. This advice does not imply any adverse criticism of the nursing and medical staff currently involved but reflects best practice opinion on use of accredited services for ECT. The geographical location of the Hergest Unit does not provide an exceptional reason to deviate from the College position on this issue. Protocols for transport and where appropriate transfer will need to be in place and if this has not already been done the current medical and nursing lead should liaise with their colleagues at the neighbouring Unit to implement this promptly. If this occurs the operational management should expedite use of the space released so that it benefits patient care and supports staff in a tangible manner. ECT is now all delivered via Ablett Unit. All patients being transported for treatment are supported in line with protocol within the ECT policy.	visitors to see (point 17, December 2013) Patient information must be protected. Patient information is now not visible as privacy boards have been installed.	• The completion, on admission, of a holistic assessment including a risk assessment and a physical health assessment. • The appropriate assessment and care coordination processes to meet the needs of people with a multiple morbidity of mental health and substance misuse, people with mental health and a physical problem, and those with a personality disorder. The acute care pathway document is completed upon admission and includes physical health assessment. Co-morbidity is assessed and care planned via the collaborative CTP. Referrals to Occupational Therapy and Physio therapy are completed to allow specialist assessment of physical health needs, social, cognitive function, functional needs, environmental needs etc. Occupational Therapy and Physio therapy input contribute to risk assessment processes.
6.	Arrangements for regular briefing of Staff need to be implemented As in Q1 multiple structures are in place for feedback and communication. Divisional newsletter. CANIAD feedback delivered and minuted at area QSE.	6. <u>Nursing Development Programme</u> A Nursing Development Forum could be considered for the Hergest Unit to harness ideas, and identify gaps in knowledge and identify site visits or e-discussion forums with other areas. NDF is useful for case presentation of difficult to manage patients, reflection on clinical situations and to recognise and celebrate good practice. It would need to be support by some flexibility in staff rota and most forums have a rolling programme to promote best practice, e.g. Nursing patients with co-morbid substance misuse, involving carers.	6. A review of 5 sets of care documentation was undertaken and the following observations were made: a. The assessment of risk was not clear. Standardised MHM documentation now in use. Adult at risk pack now in use for all admissions. b. Section on the Mental Capacity Act 2005 had not been completed. Regular audit in place. c. The CTP for patients was not completed. Regular audit in place.	**Risk assessment/risk management planning** • A consistent approach to risk assessment that reflects best practise and meets the requirements of minimising the potential for: o risk to self, including self-harm, o harm to others, o suicide; and o vulnerability and neglect. • The need for all clients to have a risk assessment that is reviewed regularly. • The need for all clients to have a risk management plan that responds to the

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		d. Information relating to side effect profile was not completed. Medication charts now amended to include allergies and side effects. e. Patient transfer between wards but the CTP had not been completed. Regular audit in place. Transfer of care document in place. f. Numerous observational forms were not dated. Relaunch of Therapeutic Observation and Engagement Policy, forms updated, regular audit in pace, update delivered to all wards. g. Some of the care plans did not define any areas of risk. Standardised MHM document set now in use. h. If core/generic care plans are to be utilised then they must be fully implemented. None in use. i. Risk reducing factors when considering observational levels need to be considered in care plans . MDT decision making in place around observation levels. Ward formulation session in place. PBS plans in use and written in conjunction with patient, family, carer wherever possible. j. BCUHB's procedure on Therapeutic Observations for Inpatients was not being implemented. There were no observational records being used, no entries in notes and no indication that the patients could be safely given some privacy. Relaunch of Therapeutic Observation and Engagement Policy, forms updated, regular audit in pace, update delivered to all wards.	identified needs and is included within the care plan arrangement. • The need for risk management plans to be reviewed to ensure that clients are managed safely, in the least restrictive environment. • The requirement to provide training for care coordinators in risk management in line with the WG Ministerial Letter (7th April 2009) Mandatory Training for Mental Health Staff ensuring the targets are met. All patients have a WARRN formulation on file which takes into account potential areas for harm. The risk formulation is regularly reviewed in the MDT meetings and there are formulation session facilitated by acute care psychologists in place to assist with understanding the formulation and delivering care accordingly. WARRN training is undertaken by registered health and social care professionals as an initial 2 day course. The course incorporates training on content of the clinical interview / process of the clinical interview / techniques to facilitate asking difficult questions / role play exercises and group discussions / formulation / managing risk / risk management planning.

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			k. Seclusion documents did not have a start date when the seclusion continued for a significant period of time. Seclusion Policy in use – regular audit in place – seclusion reviews undertaken by Head of Nursing.	
7.	Steps need to be taken to better engage Staff in the change process. The current implementation plan is clearly in difficulty Staff are involved in QI and have been trained in QI methodology. The use of TODAYICAN within the Division has helped create a culture of permission giving whereby staff are able to influence the care environment directly and implement change. All structures outlined in Q1 facilitate regular discussion and feedback with staff regarding changes at a local level Listening Leads are in place.		7. A review of care relating to the transfer of a patient from a PICU to an open ward. Independent review undertaken and all actions completed.	**Part 3** • Implementation of a standardised process that informs a person of their right to access an assessment for 3 years after discharge from secondary care. This right under Part 3 of the MHM is discussed with the patient by their MDT during discharge planning. A standardised Part 3 letter is also issued.
8.	The Communication Strategy needs to be rethought. It needs to reflect the need for staff to be fully engaged on a personal level Communication has been improved as outlined in Q1. In respect of more recent changes, the Divisional communication strategy is being rewritten currently with engagement being sought from areas.		8. The system for recording staff training was maintained at ward level and each ward had a different system in place. There was no system in place that ensured information was available to the whole of the Hergest Unit. The reality of this system is accessing information, whilst Aneurin ward manager on leave, training records could not be accessed. A comprehensive system for recording and identifying training that is easily accessible must be established. Staff training now all centrally recorded on ESR – all staff can view their own compliance report and managers can view whole team /service compliance.	**Part 4** • Processes to be followed to ensure clients are made aware of, and can access, the IMHA service. The CPG needs to put in place robust monitoring arrangements so that it can assure compliance with the Measure. The IMHA service is available on Hergest Unit and patients are informed of their right to access this service verbally by staff at key points during their admission. Information is also displayed on the patient information boards and is revisited by the MDT during reviews. This is also captured in the Explanation of Rights (appendix A)

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				Weekly local monitoring is in place – informatics distributes details of weekly compliance which is addressed by local managers and teams. The Division is required to report monthly compliance via divisional finance and performance meetings which feed into Board level scrutiny.
9.	Change champions need to be identified throughout the unit, including the more junior and unqualified Staff. Arrangements should be put in place to ensure their time is protected to enable their full participation. This approach would, in part, mirror the successful inclusive approach to change adopted by the current Interim Modern Matron when Ward Manager on Taliesin Change Champions are in place and positively supported to generate ideas for change with colleagues and support implementation of change collaboratively. QSE and Patient Experience meetings are available for feedback and support.		9. There was a number of staff, including new staff who had not received training in Restrictive Physical Intervention (RPI). Furthermore, bank staff do not received RPI training. As a result of this, staff on other wards formed a team to support staff on Taliesin ward because they had insufficient staff trained in RPI. All staff must receive RPI training to ensure staff and patient safety on all three wards Prior to Covid RPI training compliance for the unit was 98% - all bank staff receive RPI training if appropriate to the area in which they are working. PICCS team implementing temporary updating plan during Covid.	**Record keeping and integration of records** All clinical records should comply with The Standards for Health Services in Wales[4] and also relevant Professional guidelines. The CPG needs to ensure that the service user record management system is: • Compliant with relevant legislation and professional standards. • Fit for purpose. • Accessible across the inpatient and community services and between the members of the MDT. The CPG needs to put in place monitoring arrangements to ensure compliance. Case files are integrated – a single case file utilised by all disciplines which follows the patient throughout their treatment journey.
10.	The concurrent implementation of the eight HIP work streams needs to be reconsidered. A glance at the plethora of implementation documents on the HIP notice board is a manifestation of the difficulties being experienced by the current implementation process. A better approach may be to consider the relative urgency of the work streams and prioritise them into smaller steps, in which the staff are engaged. The HIP has been stood down in favour of local supportive governance structures.		10. A review of the use of therapy & activity resources, both equipment and personnel is required. The occupational therapy (OT) craft room and materials were not being shared with the activity coordinator. Support from staff or another activity coordinator would have beneficial results for the wards to maximize the activities on offer. Currently OT substantive and student staff working in the unit. Activity staff employed. One post to be recruited into.	**Referral management** • The CPG needs to develop an operational policy that describes the: ○ service model in place, ○ admission process, ○ management of the service user pathway prior to admission until discharge ○ including the post discharge arrangements, ○ arrangements for ward rounds and ward meetings, ○ involvement of the care coordinator and CMHT in the care planning and discharge arrangements.

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	The T4MH strategy implementation is now the vehicle for major service delivery changes. Local improvements are supported via structures outlined in Q1			Once agreed by the key stakeholders the operational policy needs to be ratified. Staff need to be made aware of its requirements and trained to use it. The policy needs to be reviewed annually. The CPG need to clearly define the arrangements for: ○ consultant medical cover during periods of absence, ○ handover of the responsibilities associated with the Responsible Clinician. ○ The CPG should ensure that staff involved in decisions involving referrals and admissions have access to ongoing supervision and training to support their role. ○ The on-call arrangements should be reviewed to ensure that there are no delays in access to appropriate personnel to support clinical decisions regarding potential risks and admission. ○ The role of the Home Treatment Team in relation to managing crisis admissions should be clarified. There should be consideration of the hours of operation in the context of the wider on call arrangements and junior medical cover. ○ The CPG should ensure that there are adequate numbers of Section 12 Doctors trained and available to meet the needs of the service. The acute care pathway provides a framework for the delivery of acute care service. Medical cover for consultants on leave is managed by each individual consultant providing a plan for cover prior to their leave which is signed off by the clinical director. If cover was to become unavailable the Clinical Director is the default cover. All staff involved in decisions involving referrals and admissions receive monthly management supervision and have an individual training plan agreed at an annual personal development review taking into account contractual / mandatory training, training to enable high level

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
				performance in role and also developmental elements of training / coaching etc. The Division has a mental health specific bronze on call rota in place out of hours to ensure access to a decision maker in a timely manner – this rota links to the organisational silver and gold on call system. The HTT is operational 7 days per week for 12 hours per day – work is ongoing to review service models within the Division. We have a list of Section 12 doctors available for MHA assessments. There have been no incidents reported, where MHA work could not go ahead because of the absence of Section 12 doctors.
11.	Arrangements need to be made for the Ward Staff to have opportunity to engage with external networks of similar organisations. This is particularly important considering the relative isolation, geographically, of the Unit. Otherwise the opportunities for sharing and learning from best practice will be extremely limited Staff are supported and encouraged in their PADR to identify learning opportunities which are developmental rather than aligned to role responsibility. Staff would be positively supported to engage with shadowing/ networking etc wherever possible. We have staff engaged with the National Mental Health Nursing Association. Staff are being trained as coaches. We have nurses identified as development leads on Cynan ward – the outcome of this initiative will be reviewed and rolled out across services. The PICCS team provide annual updating based on best practice and Chair a		11. The recommendations made in the 'Clinical Psychology Adult Acute Mental Health Service Report', dated January 2014, needs to be implemented and actioned to ensure the psychology services are available Full time psychology staff based on the unit now.	**Royal College of Psychiatrists Standards** (2) • The CPG should introduce the Royal College of Psychiatrists Standard (2) across all inpatient Units as a means of benchmarking inpatient care. • The HIP should prioritise the action needed to address those standards that are not fully met (Appendix 5) with particular reference to: o Psychological Therapy o Personalised care o 1:1 therapeutic time o Activities over 7 days The unit has access to acute care psychologists on a full time basis. Clinical Psychology posts were created following the "Clinical Psychology Adult Acute Mental Health Services Report" (2014). As of November 2020, in the West region of BCUHB there are: • One full time band 8a Clinical Psychologist working at the Hergest unit.

HOLDEN REPORT	ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
national forum within Wales on restrictive practice. Systems are in place to alert staff and managers of impending requirement for professional revalidation for nurses. BCUHB is signed up to MARS to monitor medical staffing yearly appraisal			• One full time band 7 Clinical Psychologist working 0.6 FTE at the Hergest unit and 0.4 FTE on Cemlyn Ward, Ysbyty Cefni. • One full time band 4 Assistant Psychologist working at the Hergest unit. These clinicians provide the following: • Psychological assessment and formulation – with a focus on team/MDT formulation work. • Evidence-based short psychological interventions tailored to need during a period of crisis, delivered through a whole team approach. These are delivered at ward level, individually, and through groups. • Case discussion, risk assessment and formulation groups for all levels of staff to attend. These groups also promote psychological safety in group discussions, encouraging more reflective, person-centred working and learning, and increasing inclusivity. • Comprehensive staff training in psychological working, delivered through multiple formats – workshops, self-directed materials, and through bite-size learning sessions that are integrated into case discussion groups. • Psychological consultation for both acute and community services to support continuing care. This includes arranged sessions with community care-coordinators to help support their role in providing care during the period following discharge. • Staff wellbeing and reflective practice sessions, including additional drop-in sessions and support throughout Covid-19. • Significant research and development covering topics such as: demographic factors in the need for admission for people living in North Wales, compassion-focused staff support, the role of social connection in the need for acute inpatient mental health care, person/values based feedback, psychological safety, and many other areas. Projects in progress include studies looking at the impact of covid-19 on staff.

HOLDEN REPORT	ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
			• Developments in progress include improving the screening and follow-up care for individuals where trauma and adverse childhood experiences play a significant role, developing the trauma-informed care throughout the unit, and linking with community colleagues to provide continuity of trauma-informed care post discharge. We are working with Occupational Therapists to develop activity spaces and support, and widening staff support options and training to target and reduce staff burnout and sickness levels. Personalised care is delivered via individual care and treatment plans. 1:1 therapeutic time is provided on as indicated by the care plan but at a minimum of 3 x weekly sessions. Activity workers are available – there are two full time posts one of which is recruited to and one which is currently being recruited to. When fully staffed the model is one of 7 day availability. The activity workers work to provide a consistent programme of activity in line with requests made through service user representation. This is supported and regularly reviewed in partnership with the Therapy team to ensure that the activity provided has been risk assessed and holds therapeutic value. Work is on-going with Occupational Therapy to improve the management support available to the activity workers and ensure that they are offered the best possible clinical supervision. The Occupational Therapy team provide detailed assessment of therapeutic needs following a referral on a 1:1 basis. Following assessment and individual plan for therapy is created to support individuals to improved function and greater wellbeing. The occupational Therapy team work closely with the ward teams and activity coordinators to maximise potential therapeutic contact. The Occupational Therapy team will also handover any therapeutic progress to community

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
				staff on discharge to allow continuity of therapeutic input. Art therapy, Psychology and Physiotherapy is also available within the unit, providing both 1:1 assessments and support as well as contributing to groups and staff training and development.
12.	A training and development programme, including arrangements for Appraisal, Management Supervision and Clinical Supervision, needs to be implemented for all Staff in the Unit. The weekly minuted Ward Managers meetings need to be reinstated without delay. Please see Q1.		12. With the integration of Notes, information had not been carried over in some cases, including risk assessment / outcomes of leave. A plan for the information to be available for the Notes is required. Integrated case files now in use and the notes follow the patient around the service and are multidisciplinary.	**Stakeholder Feedback** **Escalation and Feedback** • The CPG must ensure that staff, service user and carers are able to offer feedback with regards to all aspects of service delivery, including the opportunity to raise formal or informal concerns. • The CPG should support a culture that views complaints, concerns and compliments as a helpful way of measuring satisfaction with the service. • There should be a process of escalation within the CPG that ensures that issues can be raised using a process that does not cause anxiety or fear for those that raise them. Feedback and updates must be provided to those that raise concerns in a timely way. • The CPG needs to put in place a system that collects the views of all stakeholders within Hergest. The views and experience of all stakeholders must underpin an overarching service improvement programme. • The CPG should ensure that there is a process of support and debriefing offered to staff following incidents or concerns raised. All patients, staff, carers anf families are made aware of their right to raise a concern. The Putting Things Right process is available and discussed with all. There are weekly PTR meetings in place in the unit which feed into a weekly Divisional PTR meeting – staff are involved throughout the process. Any person with a concern is actively encouraged to voice that concern – all responses to concerns

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
				are monitored and delivered via the PTR timescales for response – this is in turn monitored by a Quality and Safety lead for the area sat within the Divisional governance structure. Caniad are in attendance at the unit on a frequent basis to scope patient experience and feedback and are present at the monthly QSE meeting on the unit to provide feedback / challenge and to take away information for patients. The report from local QSE feeds into Divisional QSE and also a Divisional patient experience meeting.
13.	A system of recognition would be helpful where the contribution of individual Staff is celebrated BCUHB Awards take place annually and staff can be nominated or nominate. CANIAD Awards take place annually where patients and carers nominate staff for awards. "Cheers 4 Peers" has been implemented in October 2020.		13. The Supervision / appraisal system for medical staff needs to be embedded in their development. The review team did not have the necessary level of assurance that some medical staff had received any performance management reviews. Supervision of junior doctors is undertaken weekly in area and the division utilising identified clinical supervisors.	**Involvement** • The CPG should ensure that there are ongoing opportunities for service users and carers to be involved with the developments of services. • The CPG should ensure that any decisions regarding the Unit or models of care are made with the inclusion of all stakeholders. Caniad are delivering service user and carer involvement for the Division and provide attendees for any meetings, discussion and planning processes related to service provision. Caniad also provide interviewers for staff recruitment processes to undertake value based interviews which are taken into account when appointing staff.
14.	Urgent attention needs to be paid to how the Wards are staffed. The results of the benchmarking exercise recently undertaken, wherein the Unit's staffing establishment is seen as comparable with peers, are in stark contrast to the reported experience of those interviewed. This discrepancy is deserving of detailed scrutiny. The unit has engaged with national nurse staffing reviews on multiple sets of data collection regarding staffing.		14. Some patients had no note on the file as to whether they had been given or understood their rights under S132. All patients detained must be made aware of their rights under S132. Regular audits in place and mental health act admin staff based on site.	**Training** • The CPG must ensure that all staff are compliant with mandatory and statutory training requirements. • Training opportunities that enhance the delivery of care and the skills and knowledge of practitioner need to be provided. Training should be in line with the broader philosophy of the Hergest Unit and reflect the profile of the current service users. Training compliance is reported at a local finance and performance meeting and up into a Divisional

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
	All posts are consolidated and recruitment has been effective – ward managers now have responsibility for their teams and budgets and meet with the finance manager on a monthly basis to ensure they have the required resource for staffing. e-roster indicates safe staffing is reached and e-roster is reviewed regularly by the inpatient manager and the Head of Nursing. All incidents where staffing drops below required safe levels are subject to Datix reporting and immediate review / action. Student streamlining process is in place for recruitment of graduates from the local nursing course at Bangor University and graduates are employed from all courses where possible. The unit is currently fully staffed.			finance and performance meeting on a monthly basis. There is a local training budget which can be accessed by nursing staff to attend training in line with their PADR and broader service delivery plans. The area are currently working on reviewing the nursing workforce and actively campaigning for an educational structure specific to mental health nursing to be developed for post graduate nurses to enable them to develop more specialist skills. The Psychology team are also developing a regular programme of Formulation, working with the full Multi-Disciplinary Team (including Occupational Therapy, Medics, nursing staff etc.) to develop clinical understanding and approaches include a Trauma informed model of care.
15.	Staffing should be planned in such a way that it would be exceptional for Staff working a twelve hour shift to be unable to take a break. All incidents and exceptional circumstances where staffing drops below required safe levels are subject to Datix reporting and immediate review / action All shifts are created in the roster with staff breaks taken into account.		15. For a review of the resources relating to the administration of the Mental Health Act to take place. Mental Health Act administration team in place on site throughout the working week.	**Environment** The CPG needs to consider prioritising improvements to the estate. In particular urgent consideration should be given to: • Bathrooms and toilets to improve privacy and dignity • Ensuring that the ward is a therapeutic space • Improvement in the gardens • The location of the ward office A scheme of improvement has been undertaken in the Hergest Unit which has included: - Renovated bathrooms - Renovated kitchens - Full anti-ligature scheme of works - Garden improvement scheme - Decorating and new furniture and soft furnishings - Improved reception including new front doors to improve disabled access and egress from the unit - New flooring on wards - Improved lighting on wards

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
				There is contract in place for garden maintenance which is managed via estates. Occupational therapy are undertaking garden projects in and around the unit and we have a therapist which undertakes environmental therapy available within the unit also. Occupational therapy are undertaking a scoping piece of work to help us understand the therapeutic value of the whole Hergest environment including looking at how environments can be used to support engagement in therapeutic activity, reduce distress and conflict and improve staff moral and engagement. This work will be reported into the local QSE meeting. It is not possible to move the ward office due to the configuration of the wards however staff only utilise the office when needing to carry out essential clinical administration tasks.
16.	The issues surrounding the Junior Doctors Rota need to resolved urgently. The junior doctor rota is currently oversubscribed with fewer slots than medics available. There are no issues with rota cover, all junior doctors are supportive in managing cover for the rota in exceptional circumstances where there might be a gap. There is an allocated substantive consultant who provides pastoral support to junior doctors in the area.			
17.	The issue of the conflicting models of clinical care that have been adopted by Consultants on the Unit needs to be urgently addressed. The Ward Staff find the current arrangements difficult and it is likely that the current situation will have a			

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
	deleterious effect on recruitment and retention of Senior Medical Staff There are now dedicated acute care consultants (one per ward) working with fidelity to the regional acute care pathway. Team working on the ward has improved as a result and the staff's sense of confidence and trust in the consultant staff has grown leading to a positive working, learning and care environment. This has reduced the demand regarding ward rounds and the abstraction of nursing staff time to attend to administrative processes. Ward rounds are now pre-arranged MDT reviews which take place on a regular basis and are arranged together with the ward team individually to fit the patients journey. Medical staffing recruitment and retention continues to improve.			
18.	The current arrangements for the care of frail elderly Patients needs to be urgently reconsidered. It is clearly unacceptable for the needs of frail vulnerable people to be neglected in the way that has been reported. The wards have now been changed to single sex wards which immediately served to reduce vulnerability regarding some frailty issues. We continue to admit and care for functional older patients on the acute wards. Staff are trained to manage physical health issues and are competent to deliver care to older patients.			

HOLDEN REPORT		ROYAL COLLEGE OF PSYCHIATRISTS	HIW INSPECTION	NHS WALES DELIVERY UNIT
	All patients are assessed prior to admission with an assessment of vulnerability and frailty being taken into account where possible prior to or on admission. There is the facility to allocate single rooms to older patients rather than accommodating them in a bay with other patients. All elements of vulnerability are closely monitored through processes outlined in Q1. Utilising our internal governance systems and processes there has been no identification of neglect or harm as a result of admitting older functional patients to Hergest so therefore this has been removed from the risk register but remains a key focus in the structures outlined in Q1.			
19.	The current arrangements for Ward Rounds need to be addressed as the current arrangements are disruptive to the Nursing care that can be afforded to patients Please see Q16.			

Index of evidence (embedded documents removed for QSE paper but available for inspection)	
QSE TORS AND SAMPLE AGENDA / MINUTES / REPORT	EXAMPLE OF PERFORMANCE REPORT
PTR TORS AND SAMPLE AGENDA / MINUTES	SENIOR WALK ROUND DOCUMENT
ACM TORS AND BLANK MINUTES TEMPLATE	WARD ACCREDITATION DOCUMENTS (Taliesin Ward 19.02.2019)
HUDDLE SAMPLE MINUTES	STAFFING ESTABLISHMENT FIGURES
BAND 7 SAMPLE AGENDA/ MINUTES	NMC REVALIDATION PROCESS
T4MH STRATEGY	OPERATIONAL MEETING TORS AND SAMPLE AGENDA / MINUTES (Now called F&P)
DIVISIONAL MANAGEMENT STRUCTURE	CLINICAL PATHWAY DELIVERY TORS AND SAMPLE AGENDA/ MINUTES
PADR BLANK DOCUMENT	DRAFT AREA NURSING DEVELOPMENT APPROACH
MENTAL HEALTH MEASURE WEEKLY REPORTING EXAMPLE	HTT POLICY
ACUTE CARE PATHWAY	ACUTE OPERATING FRAMEWORK
DIVISIONAL QSE AGENDA AND TORS	MENTAL HEALTH MEASURE UNMET NEEDS FORM AND LOCAL PROCESS
MENTAL HEALTH MEASURE CODE OF PRACTICE & EXPLANATION OF RIGHTS (APPENDIX A)	MHM STANDARD PART 3 LETTER
CTP BLANK PLAN	CTP AUDIT DOCUMENT
WARRN FORMULATION	INPATIENT CONSULTANT LEAVE FORM
ADMISSION / DISCHARGE CHECKLISTS	SAMPLE OF HIP WORKSTREAMS

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health and Learning Disabilities Exception Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director for Public Health (Executive lead for Mental Health and Learning Disabilities)
Awdur yr Adroddiad Report Authors:	Mike Smith, Interim Director of Nursing Mental Health and Learning Disabilities Iain Wilkie, Interim Divisional Director for Mental Health and Learning Disabilities
Craffu blaenorol: Prior Scrutiny:	Divisional Directors Mental Health and Learning Disabilities
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		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	**X**	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

The content of this regular QSE report on Quality, Safety and Experience in the Mental Health and Learning Disability (MHLD) division, is structured around the four divisional priorities of :-

- Stronger and Aligned Management and Governance
- Review of Capacity and Capability
- Delivery of Safe and Effective Services in Partnership
- Engagement with Staff, Users and Stakeholders

These relate to the key risks associated with special measures improvement for the division and the strategic aim of Betsi Cadwaladr University Health Board (BCUHB) for the “Safe integration and improvement of mental health services”. The divisional focus continues to be around these four priorities, despite the recent changes to special measures.

Risks for each of the four areas are described along with the corresponding actions to mitigate or minimise the risk.

The division will refresh and review its risk register in January to better reflect the current situation and accomplishments, and to inform the prioritisation of future work.

The report concludes with an analysis that informs the Senior Leadership Team’s prioritisation of work as we move into Q4.

Cefndir / Background:

This report forms part of regular updates to QSE on the divisional QSE actions and performance

Asesiad / Assessment & Analysis

Strategy Implications
This report outlines the implementation of the next phase plan and compliance with the mental health measure (MHM).

Financial Implications
A financial assessment has not been included within this exception report.

Risk Analysis
The report provides an update to QSE on changes to the corporate risk strategy and register and the consequent divisional reporting of tier 1 risks. Risks are highlighted in each area reported, as are corresponding mitigating actions where appropriate.

Legal and Compliance
This report provides data on compliance with the MHM.

Impact Assessment
There are no proposed service changes within this report and all policies follow due process for EQIA.

Mental Health and Learning Disability (MHLD) Services

1.0 Purpose of report

To provide an update in relation to the quality, safety and experience actions and performance aligned to the four priority areas. We have highlighted the measures in place, key risks in each area and corresponding mitigating actions.

2.0 Mental Health and Learning Disabilities Priorities

1. Stronger and Aligned Management and Governance
2. Review of Capacity and Capability
3. Delivery of Safe and Effective Services in Partnership
4. Engagement with Staff, Users and Stakeholders

2.1 Stronger and Aligned Management and Governance

2.1.1 Divisional Directors and Senior Leadership Arrangements

Measures in place

The substantive Director of MHLD retired from his post at the end of November 2020

The Director of Transformation has returned to work on a phased basis since November 2020

Both interim Deputy Directors have extended their secondments to March 2021. This is supporting the division to progress its work on –

1) Partnerships and engagement
2) Workforce and Covid/winter planning

Identified risks

There has been limited managerial capacity in the division given the significant numbers of post holders on long term absence from the Senior Leadership Team (SLT) This is now significantly mitigated through Q3 and Q4, see actions below. Throughout the reporting period, there has been a limited input from the heads of Psychology services within the division. Engagement with this team is a priority and the focus is on progressing an interim Head of Psychology, and progressing the recommendations from the Psychological Therapies review.

Improvement Actions

The restoration of postholders in all but 1 SLT role has been achieved.
Work is continuing to restore the connection with heads of psychology in the division. An initial meeting was held on 30.11.20 with heads of service and SLT/ED but there was very limited engagement. The division are considering how it can better enable discussions with the divisional psychology heads. .

2.1.2 Outcome of Internal Audit MHLD/Governance

The Division has received the draft Internal Audit Report into its Governance Arrangements for 2020/21. This was received in November 2020. The level of assurance was reported as "limited".

The report highlights a number of areas for improvement. In terms of this section of the QSE report, the following two statements are of particular note:

1) "Limited progress in addressing governance issues most likely compounded by instability and capacity of the Leadership team and Covid stress".
2) "Terms of reference were not complied with or complete and strategy needed to be reviewed".

Actions of stability and restoration of capacity in the leadership team are reported elsewhere (2.1.1), as is aligning and strengthening the governance (2.1.3).

Measures in place

A management response has been prepared to the internal audit report.

2.1.3 Integration of MHLD Head of Governance to Corporate Governance

Measures in place

As per BCUHB arrangements, the divisional governance roles and teams have been re-aligned so that they report managerially and professionally into the BCUHB corporate Associate Director of Quality Assurance from the 1st December 2020.

Identified risks

The division notes that the governance in the division could diverge from corporate processes, or the agreed strategy for alignment, resulting in potential incoherent controls and lack of assurance.

Key actions

Consideration is actively being pursued by the SLT of methods to further align policy, procedures and roles in governance with the corporate governance arrangements (as opportune and timely).

One practical example of this approach is that, the division has developed a specific "Ward Accreditation" quality improvement role in December 2020, (approved by the SLT 8-12-20 that is now at the recruitment stage). The role will be jointly managed and supervised with the corporate nursing Quality Improvement (QI) lead.

2.1.4 Risk Management Strategy

The new Risk Management Strategy (RM01) continues to be implemented

Measures in place

All the divisions across BCUHB are expected to periodically report to the Risk Management Group on how they are identifying, assessing, and mitigating risks.

Divisional Directors and the Divisional QSE members receive the Risk Register report which is reported to the Divisional Quality, Safety Experience (QSE) group.

Identified risks (extreme)
The Division currently has one identified 'extreme' risk (Tier 2, Directorate). Structural and water ingress issues have led to the urgent transfer of patients from Tan y Coed, located on the Bryn y Neuadd (BYN) site to other Units located at BYN.

Improvement Actions

- The Tan Y Coed buildings were evacuated safely and effectively over a one week period. This was undertaken swiftly and carefully, given the urgency and the specific needs of the clients for individualised support (including court of protection) by the Area MHLD team. Remedial work is in place to make the building safe. A target date has been set of the 21.1.21 (for or a bespoke designed facility for very highly complex individuals, who could be most impacted by the change), Tan y Coed buildings 1-3 are still being assessed for a proper impact and design response. Tan y Coed building 4 to be handed back to the division.
- The SLT have set aside a full day early in January 2021 to consider, review, align ownership and refresh mitigating actions now that the divisional register has migrated to the new 3 tier approach.
- A programme of training will be rolled out over the coming months to clarify the new approach to risk management.

2.2 Review of Capacity and Capability

2.2.1 Together for Mental Health (T4MH) Strategy and Operational Plan

The division continues to work to the Q3/Q4 Winter Plan, with agreed profiles against the annex D key government targets and these have been presented to Board. The BCU Planning and Strategic meetings have been suspended for the time being, but efforts continue to be focused on shaping the Divisional Integrated Medium Term Plan (IMTP) for 2021/2024.

Measures in place

Work continues to develop the division's input into IMTP. This plan will be developed with full engagement and collaboration with our workforce and wider partnerships. It will link with key strategies such as "A Healthier Wales", T4MH, and Care Closer to Home etc. The aim is to align plans into one integrated plan. In the meantime, work will continue to deliver the actions identified in Q3/4 and the Together for Mental Health Delivery Plan.

Welsh Government has published their Together for Mental Health Delivery Plan that outlines their strategy for improving mental health across Wales from 2019 to 2022. The plan contains actions and milestones for services, health boards and a range of sectors to work together with the Welsh Government to deliver. The plan looks at four overarching priorities including:

- reducing health inequalities, promoting equity of access and supporting the Welsh language
- strengthening co-production and supporting carers
- workforce
- research, data and outcomes

The division continues to benchmark against the milestones.

Identified risks

The division notes that it could be impaired in its delivery of the Q3/Q4 plan because of the instability of leadership posts and capacity of the Leadership team.

Improvement actions

- The Q3/4 plan actions are mainly on track for delivery as per target. However, following the Gateway Review on the Ablett Business Case, the project team will pause (as suggested) to better describe the strategic fit of the design solution, and also further develop the benefits realisation work.
- The division will prepare its draft plan to support the Health Board's IMTP submission in Q4 20/21.

2.2.2 COVID-19 Divisional Plan

There has been a full review of the MHLD Divisional COVID-19 Plan aligned to the first phase of the COVID-19 Pandemic.

Measures in place
Divisional measures have been put in place to ensure a robust and effective delivery of the winter plan. These include:-

- The MHLD Deputy Director has been identified to co–ordinate COVID-19 related activity.
- A divisional MHLD COVID-19 briefing meeting has been stood up. This meeting exists to ensure there is divisional oversight of Covid-19 activity, flexible and responsive decision making with appropriate governance.
- The MHLD COVID-19 Clinical Pathway, is approved by both the Clinical Advisory Group and the Corporate Clinical Advisory Group.
- The MHLD COVID-19 Clinical Pathway Delivery Group has been set up to manage and monitor the recommendations.
- A number of operational plans/tools are in place, and being implemented across the division (Business Impact Analysis, Business Continuity Plans, MHLD COVID-19 Action Cards and Social Distancing Action Plans) Additional input is provided to support the East team to further review their Business Continuity plan.

- A MHLD area Situational Reports (Sitrep) are completed daily (7 days per week). The information is analysed and populated to enable a Divisional Sitrep summary position. The daily Sitrep call enables monitoring and review/oversight of the Divisional position and informs decision making. The Executive Nurse Director receives the Divisional Sitrep daily and any issues where risks cannot be mitigated locally are escalated to either the appropriate Corporate Personal Protective Equipment (PPE) steering group, Corporate Staff Redeployment meeting, QSE or other appropriate channels/forums.
- A MHLD Divisional PPE Task and Finish Group has been established, reporting into MHLD Divisional daily Sitrep call and MHLD Divisional COVID-19 briefing meeting and the Corporate PPE Task and Finish Steering Group.
- COVID-19 related training is in place with compliance monitored and reviewed through the Workforce workstream.
- The MHLD Divisional Workforce meeting currently meets fortnightly to review the workforce plan. This reports into the MHLD COVID-19 briefing meeting, and other Divisional Governance meetings as required
- "Attend Anywhere" is in the process of being operationalised across the MHLD Division to provide a virtual consultation platform.
- Joint Partnership Group meetings with Staff Side have been established to enhance communication, engagement and collaborative working with partners.
- A MHLD Divisional Silver "on call" has been established to support bronze on call given the increasing pressures, the 7 day Sitrep reporting, and to provide timely additional advice and support with service delivery issues.

Identified risk (1)

The division notes that there is a risk that they will be inadequately prepared for the impact of the COVID-19 pandemic, and that there could be an undesirable impact upon service delivery and staffing resources across the MHLD Division.

Improvement action

A MHLD Divisional Workforce meeting continues to discuss and review the divisional workforce plan, and any workforce related activity. This includes targeted intervention to prioritise recruitment to vacant posts; reviewing of the MHLD Divisional absence reports; agreeing local redeployment and providing staff support. Also the monitoring and review of social distancing action plans. Any issues for escalation are fed into the MHLD COVID-19 Divisional briefing meeting.

Progress continues with the "Wellbeing, Work and Us" Strategy, including the recruitment of a dedicated MHLD Counsellor.

Identified risk (2)

The division notes there is a risk that flexible and responsive communication may be impacted during Covid19. This includes communication between staff, patients and both internal and external stakeholders.

Improvement action

A MHLD Communication and Engagement plan is in place aligned to the MHLD Divisional Covid-19 Winter Plan. The implementation of the plan is monitored and reviewed at the MHLD COVID-19 Briefing meeting.

Identified risk (3)

The division acknowledges the need to provide training for some staff members who may need to be deployed to support COVID-19activity.

Improvement action

Additonal training needs aligned to COVID-19 are monitored and reviewed by the Workforce Workstream group, which reports into MHLD Divisional Workforce meeting. The development of a MHLD Development and Training Group is being established to provide additional focus and oversight.

Identified risk (4)

There is a risk that Information technology and equipment to support operations may not be sufficient due to demand exceeding supply (eg laptops and VPN's/Virtual Private Network).

Improvement action

A COVID-19 funding application has been progressed for the equipment requirements. A priority matrix approach has been implemented to ensure when equipment becomes available it is allocated accordingly. A review of any IT resources that could be shared in the future is being progressed.

Identified risk (5)

There is a risk that "FIT" testing progress will be delayed due to lack of testing resources, and the operational cover requirements across the division.

Improvement action

"FIT" testing numbers are recorded on the daily SITREPs and any barriers to implementation are discussed at area Safety Huddles, and escalated to the Daily SITREP call, and to the PPE Steering Group if required.

An MHLD Divisional action plan is in place to maximise staff who are "FIT" tested. This includes the loan of a "Porta Count" machine, and the recruitment of additional accredited testers. This action plan is monitored and reviewed through local daily safety huddles, and at the MHLD COVID-19 Briefing meeting.

2.2.3 Recruitment & Retention of Staff

The Divisional Workforce meeting is currently meeting fortnightly to review workforce plans. The work stream reports into the MHLD COVID-19 briefing meeting and the Divisional Governance meetings. At these meetings, the team review the Staff Absence report, the BAME (Black, Asian & Minority Ethnic) Risk Assessment Report, the Vacancy and Recruitment report and the Staffing position.

Measure in place
The “Wellness, Work and Us Strategy” was launched in October 2020, to ensure staff are supported. The strategy was approved by the MHLD Divisional Directors in September 2020.

Identified risks

1) The division note the risk that MHLD staff may not be considered a priority for COVID-19 vaccinations.
2) Recruitment and retention could be affected if workforce plans are not given divisional oversight

Improvement Actions
Year one priorities have been developed into a programme plan with key performance indicators and metrics dashboard. These are monitored within the Workforce Work stream reporting into the Divisional workforce meeting.

2.3 Delivery of Safe and Effective Services in Partnership

2.3.1 Heddfan Unit Improvement

The development of the Heddfan Quality Improvement Plan (HQIP) has been previously reported to the QSE. The HQIP pulled together actions from the initial Healthcare Inspectorate Wales (HIW) concerns in June 2020, subsequent actions following their visit, and actions following the learning from other events.

Measures in place
The HQIP Team has continued to meet fortnightly to oversee progress and escalate issues where required. Actions have progressed, and are signed off through the divisional Quality Safety Experience governance process.

Identified Risks
There is a risk that one HIW action will not be achieved. This relates to the successful recruitment to 85% of nurse vacancies.

Further Improvement Actions
The division needs to recruit a substantive Head of Nursing and Matron (for Heddfan).

There are on-going adverts for qualified nurses but these remain difficult to fill especially for Band 5 Registered Nurses. It is known that in April 2021, the Heddfan Unit will welcome 16 newly qualified nurses, who will fill many of the vacancies. The Associate Director of Nursing will be working with the teams to ensure the appropriate support, and allocation is planned and a key focus is on retaining the new recruits.

HQIP meetings are to be replaced (on completion of actions) by a fortnightly Ward Manager meeting led by the Area Head of Nursing. This will hold to account the Ward Managers in the continued delivery of the ongoing audit framework.

Group supervision is to continue on a monthly basis between the Ward Managers and the Area Head of Nursing. Independent individual supervisions commissioned by the Director of Nursing (in response to the HIW report in June 2020) will also continue through until January 2021, allowing staff extra avenues to vocalise concerns and reflect on practice.

2.3.2 Local Primary Mental Health Support Services (LPMHSS) Mental Health Measure (MHM)

MHM performance across the division remains above target, except for East area Part 1a assessments.

Measures in place
Performance is subject to robust area management and is discussed weekly by the Heads of Operations in each area, with remedial action plans put in place where necessary (for example the East improvements. MHM performance is also addressed in monthly supervision with service, county and team managers.

Identified risks

The division notes the ongoing risk that they will not comply with the requirements of part 1a of the MHM

Improvement actions

East area has a recovery plan in place and the trajectory for compliance is the end of December 2020. There was a decrease in compliance in October in Wrexham due to an increase in referrals but the county remains on target for returning to compliance.

There remain some staffing risks where teams have high numbers of staff members on sick leave/isolating due to the current pandemic. East area have the highest incidence of Covid in BCUHB, and the highest staff contact/isolation rates. This is managed via the use of additional clinics, and the recruitment to vacant posts is ongoing.

Action has been taken in Anglesey to trial online interventions groups, which will hopefully reduce the waiting times for intervention during the pandemic. This approach will be maintained for suitable participants in the long term.

2.3.3 Healthcare Inspectorate Wales (HIW)

HIW undertook a Tier 1 Quality check of the Ablett Unit on the 18th November 2020 with the draft report being received into the division on the 2nd December. The draft findings are, on the whole positive, reporting that staff had worked tirelessly and selflessly to meet the new challenges faced at the Unit since the onset of COVID-19. HIW noted within the draft report that they are supportive of the move away from the established model of working initiated during the first phase of the pandemic, supporting a move back to settings providing the traditional mental health service approach.

The Division is currently reviewing the report for factual accuracy have responded to HIW with an action plan. Improvement actions were identified for the Unit focussing on reinforcing the need to ensure that patients are admitted to the appropriate setting, and the need for enhanced deep cleaning during the pandemic.

Identified risks
There are currently 48 open actions for the Division on the Corporate HIW Tracker relating to HIW Quality Checks of Cemlyn Ward, Ty Derbyn, Ty Llywelyn and the Heddfan Unit. Corporate nursing maintain the tracker overview system, and are assertively gathering clear evidence of completion, and sign off before the tracker updates. This can mean some reporting delays, but ensures a robust assurance approach to the CEO and Executive Nurse.

Improvement actions
Progress on open HIW actions is reviewed at local QSE meetings across the division, with the local Senior Leaders responsible for ensuring traction. In terms of divisional oversight, updates on progress are received at the Divisional Directors QSE Group where high-level support and action can be identified.

2.4 Engagement with Staff, Users and Stakeholders

2.4.1 Patient and Carer Experience (PCE) Subgoup

Measures in Place

From the divisional leadership perspective, there is significant focus needed now upon wider engagement with our staff users and stakeholders.

The division has been prioritising since September 2020 “consolidation and restoration” of the senior leadership teams capacity. This will enable better consultation and relationship building, to best achieve assurance and action on the priorities reported herein.

Key risks

The division notes that it can lack presence and engagement with its own staff, partner stakeholders and service users, and this would impact on the ownership of divisional plans and strategy.

Imorovement actions

The Triumvirate have prioritised visbility and presence in services. The divisional Director of MHLD and the team have begun to make links with key partners, meeting heads of local authorities/mental health leads, the Community Health Council (CHC) and the Tawel Fan stakeholders group. The development of the winterplan and covid plan has been finalised and communicated. The longer term work on strategy redesign together with partners is in prepartion.

- The CHC are running 6 stakeholder events. The MHLD have engaged fully with this work. This work commenced on the 11.12.20. The Director of MHLD & the

Director of Nursing have been invited to the annual meeting of the North Wales CHC in January 2021.

- The (PCE) sub group has been re established from October 2020. This is a subgroup of the divisional QSE. The Terms of Reference are agreed and the work plan is in progress.

  The corporate PCE has also been restablished from December 2020. This group receives a Chairman's Assurance report from the divisional MHLD meeting. The assurance report from November has been submitted from the division.

3.0 Analysis

Our strategic aim - **Safe integration and improvement of MHLD Services**

Work is ongoing to consolidate the senior leadership team actions and to target the 4 priority areas of work. With the strong triumvirate established and functioning, and delivering the strategic aim is guiding activity and priorities.

Stronger and Aligned Management and Governance

The division is returning to near full capacity at SLT level with most roles fully restored or adequately mitigated with the interim addition of 2 Deputy Directors. There is a need for BCUHB to consider consolidating this accomplishment, with longer term sustaining action beyond 1st April 2021.

The governance team of the division has been integrated into corporate governance, and handed over formally in December 2020. Further integration discussions and work continues with corporate colleagues as and when appropriate. The division has successfully moved to the new corporate risk approach which is now being embedded, and the Terms of References of meetings have been amended to reflect the corporate approach.

The limited-engagement of psychology as a professional contributor within the MHLD structure due to the absence of a head of psychology and historical issues, may impact upon care model and delivery if not resolved in the near future. This is an ongoing priority area of work.

Review of capacity and capability

The division is continuing to implement the Q3/4 plan, and is developing its IMTP contribution which will be in partnership with our staff and wider partners to achieve the strategic intentions of "Together for Mental Health North Wales", (T4MHNW). This work has been impacted by both MHLD management capacity and the pandemic, but is now progressing.

The division has a COVID-19 plan. The division believes that this is now appropriately robust, and reflects the impact of the wider national and BCUHB approach. Recruitment and retention of all divisional staff is now subject to a detailed project plan.

Delivery of safe and effective services in partnership

The HQiP is due for completion 18th December 2020. The East area will return to a business as normal approach. All actions are complete except one regarding the recruitment to 85% of nurse vacancies.

MHM performance across the Division remains above target - except for East area Part 1a assessments, but there are mitigating actions that are on target for restoration by the end of December.

HIW continue tier 1 (remote) reviews having recently reported on the Ablett Unit with no immediate actions for the division. HIW actions are not updated in the current tracker as timely as they could be, but corporate governance are considering and planning for a HIW module in the review of the Datix system to enable improvements.

The Senior Leadership Team is in the process of considering the effectiveness of the divisional structure to enable the delivery of safe and effective services, and partnership working in local areas as roles have been restored.

Engagement with staff service users and stakeholders

The triumvirate has prioritised both the visibility and managerial presence within service areas during Q3.

The division's priority focus has been, to date, upon service critical issues as reported. However as the division has restored capacity in management roles, it is apparent that there are a number of longer term risks around engagement and partnership to be better addressed as we progress through Q4. Work to date is reported here, but much more emphasis is to be placed by the Senior Leadership Team on building capacity and delivery in this priority area going forward.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Planned Care Recovery – update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gavin McDonald – Interim Chief Operating Officer
Awdur yr Adroddiad **Report Author:**	Andrew Kent- Interim Head of Planned Care Transformation Kate Clark – Acting Deputy Executive Medical Director
Craffu blaenorol: **Prior Scrutiny:**	Interim Chief Operating Officer Acting Deputy Executive Medical Director
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee are asked to note the work to date on the six-point recovery plan

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**

Sefyllfa / Situation:

The Covid situation continues to cause disruption to planned care due to the limitations of activity imposed in the pandemic. Further, the increasing winter pressures continues to threaten planned care activity, resulting in the need to devise a recovery plan that will maintain and improve patient safety and quality, whilst waiting for their procedure.

Cefndir / Background:

Introduction

Planned care activity continues to suffer from the pandemic situation and will continue for the foreseeable future. This paper gives an update on the actions being taken to deliver the recovery plan. The QSE have requested an update of the paper discussed by the Committee in November 2020. The plan has been ratified by the planned care transformation group and is now the framework for improvement. This paper provides an update as of end of December 2020.

Context

The points described in the 3rd of November paper have now been ratified and are now termed as the planned care six-point recovery plan. The recovery will allow us to provide an improved service to our patients, during and after the Covid pandemic but also deliver further activity, which is restricted due to winter pressures and Covid. It has previously being reported to this Committee and to the Finance

and Performance Committee that recovery of elective activity now has to be measured in years rather than quarters. The recovery plan is built on this principle, with the golden thread of improving communication to our patients, improving access and working more as a system being its foundation.

The six-point plan is listed below and an update of each point is described.

Validation

The planned care transformation group are looking at an Artificial Intelligence (AI) approach to validation, this provides an automated approach, improves standardisation of validation across the organisation and provides support to specialties that do not have validation capability. The products available have to be integrated into the current Informatics systems for them to be effective. We are currently in discussions with Informatics on how this can be part of the digital priorities going forward.

We are currently undertaking some pre-requisites to this work such as stakeholder workshops. We are also standardising and consolidating the validation process we currently have with the intention to begin this work in January, subject to staff availability.

We are also working with the primary care clusters to validate referrals to establish if outpatient appointments are still required for patients waiting.

Demand management

A task and finish group has been established, led by clinicians, with an approach to contact all patients at stage 4 who have waited over 52 week (routine long waiters) to establish if they still require their procedure. This piece of work has progressed well and follows other parts of Wales and the UK who have undertaken similar approaches. It is due to go through the appropriate governance process in early January 2021.

Roll out of virtual capacity

The current platform that was subject to a pilot is the “Attend Anywhere” platform. Currently a business case is being discussed with the Executive team regarding the resources required to undertake a full roll out. Further updates will be given when known.

Non-surgical treatment of long waiters

As described earlier in the paper there are a number of patients, who are being continually paused due to the Covid pressures. In particular orthopaedics being one of the biggest groups. This programme of work has allowed rapid deployment of “Escape from pain” programme where selected groups of patients are given therapy treatments to maintain optimisation. Other work such as a digital application approach has also been agreed via the planned care group and will now work at pace to be established.

Extra activity in existing capacity - Waiting List Initiatives (WLIs) and Insourcing

Due to the pressures of this year, the uptake of WLIs is extremely low; we have therefore re-instigated the insourcing model for both Endoscopy and Ophthalmology. The latter has commenced in December 2020 with operating from the first weekend in January 2021; this will be for cataracts,

giving potential extra capacity for other areas of Ophthalmology work to the undertaken by our substantive staff. Endoscopy insourcing is planned from mid-January.

We are now rapidly exploring how this approach can be expanded using our capacity but external staff. We are also extending the 'Once for North Wales' approach as part of the Covid surge plans, ensuring patients in the cancer and P2 categories can be continued to be seen, by moving them from a high Covid site to the lowest, early planning is particularly focused on moving East patients to the West in early January. This is being supported by communications.

Providing ring fenced modular ward and theatres on each site to deliver backlog clearance using WLI or insourcing

From previous planning, it is known that we can utilise a minimum of eight operating theatres across North Wales at weekends. These are being ear marked to support insourcing and P2 activity. However, to help reduce the backlogs, moving towards a diagnostic and treatment centre approach, two sites have identified a desire to provide modular wards, which would allow a ring fenced elective capacity for In-patients.
Current work is ongoing to provide the specification to allow a tender process hopefully from the new financial year.

Conclusion

The six-point recovery plan will provide a framework for the elective transformation for the next 2-3 years, whilst the organisation moves towards a value based health care system. It provides essential re-design of our infrastructure whilst defining new ways of working, alongside more traditional methods of reducing backlogs. Although early days this focus of approach is already developing projects of work that have, or will, be implemented over the next few months. This will improve the quality of the patient's journey. However, the committee will recognise the continuing difficulties in delivering planned activity over the coming months and it is still unknown the cause and effect that will have on patient outcomes.

Asesiad / Assessment & Analysis

Risk Analysis

Long waiters for both stage one and four and the potential to cause clinical harm.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality Governance Review – Ysbyty Glan Clwyd (YGC)
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience
Craffu blaenorol: Prior Scrutiny:	Review by the responsible Director and Executive Director
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to receive this report for assurance.

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

Sefyllfa / Situation:

The Quality Governance Review process is designed to provide the service with an honest and supportive assessment of its arrangements and outcomes in relation to the governance of quality (covering patient safety, patient and carer experience, and clinical effectiveness). The primary aim is to drive improvement and to facilitate the sharing of best practice. A secondary purpose is to provide the Health Board with assurance on quality governance within the service, complementing other internal arrangements (such as clinical audit, ward accreditation) and independent or external arrangements (such as internal audit, Healthcare Inspectorate Wales inspections

Cefndir / Background:

This review is the first of its kind and it is acknowledged the framework and methodology will develop over time. The framework is based around the Welsh Government Health and Care Standards domains with an element of self-assessment adapted from the English Care Quality Commission ratings process. The process consists of data collection, self-assessment by the service, data evaluation by the review panel, further deep-dives where needed, report development and improvement planning.

As a result of the pandemic, a significantly reduced methodology was used. For example, on site visits and discussions did not take place and deadlines were extended to allow the site to focus on front line care delivery.

Ysbyty Glan Clwyd was selected as the service for the first review due to concerns expressed by the Health Board regarding quality governance at the site arising from performance and quality information.

Asesiad / Assessment & Analysis

A copy of the full report is provided for the Committee in private session. In summary: The site is clearly a very busy and active hospital. While the report focuses on areas of concern, there is clearly dedicated staff working hard to deliver high quality care to patients and good practice to be highlighted and shared. This reflected in the overall positive feedback reported by patients, carers and visitors. However, the areas of concern highlighted in this report are significant. These concerns can be grouped into two areas:

1. Management control and governance
2. Sustainable improvements

A number of recommendations have been made to support the site with improvement. Many of these actions require support from the Health Board. In particularly, the most significant recommendations include the development of an improvement plan, engagement plan, workforce plan, alongside a review of governance and risk management arrangements. It is the strong view of the review that piecemeal actions are not appropriate and a long term improvement plan is needed for the site to make the necessary changes in a sustainable way. The success of this plan will require the contribution and support of the wider Health Board.

Due to the limitations referenced in this report two key areas have not been able to be explored sufficiently to provide assurance or recommendations – these include the site's learning culture (covering how lessons are identified, learned and translated into sustainable improvements) and the improvement culture (covering quality improvement capacity, capability and utilisation). There is significant corporate work underway to make improvements in these areas and the site should remain actively involved in those.

It should be noted that the review process encountered numerous difficulties in collecting and collating information - different systems, all coded differently, with data quality concerns and with varying levels of access and responsiveness. There is no doubt that leaders at the site also experience these very same issues in trying to obtain, analyse and triangulate information to inform their current position and improvements. The Health Board's overall information strategy should consider this feedback and work towards making triangulated and accurate information easier to access for local leaders and staff.

Due to the issues identified and the need to provide robust assurance to the Health Board, a re-visit is recommended in 12 months to report on progress.

The Review Panel extends its gratitude and appreciation to the leaders and staff at Ysbyty Glan Clwyd who have engaged with this review, and to the corporate teams who have provided data and analysis in support of the review. This appreciation is even more so due to the unprecedented impact on services from the COVID-19 pandemic and the hard work and dedicated of staff across the service to prepare and respond to the challenges. It is recognised that the pandemic will have impacted upon the service and its staff.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Nursing Workforce for Acute Sites, Community Hospitals and Community Nursing Services
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Debra Hickman, Interim Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Ms Mandy Jones, Interim Secondary Care Nurse Director Ms Naomi Holder, Secondary Care Nurse Director Site Ms Charlotte Hall, Interim Secondary Care Nurse Director Site Ms Lesley Walsh, Interim Secondary Care Nurse Director Site Ms Andrea Hughes, Area Nurse Director Mr Trevor Hubbard, Area Nurse Director Ms Chris Lynes, Area Nurse Director Mr Mike Smith, Interim MHLD Nurse Director Ms Reena Cartmell, Associate Director of Nursing
Craffu blaenorol: **Prior Scrutiny:**	Nurse Deployment Group
Atodiadau **Appendices:**	Appendix 1 – CNO Letter re: Critical Care staffing Appendix 2 – CNO Letter re: Maintaining Staffing Levels Appendix 3 – Nurse Staffing Sitrep reporting criteria Appendix 4 – Ministerial Statement on NHS Pressures and Local Options Framework Winter 20 -21

Argymhelliad / Recommendation:

The Committee is asked to acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported.

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

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

Sefyllfa / Situation:

The Global pandemic of Coronavirus disease (COVID 19) has seen unprecedented affected patient numbers rise in recent weeks and is set to continue, requiring varying levels of treatment, be it invasive or supportive. To provide for this increased need based on analysis of modelling data additional nursing resource has been/will be required in order to:

- Protect Essential Services and Re start Planned Care
- Deliver Safe Unscheduled Care

- Safely staff in patient areas including escalated / surge areas e.g. Ysybty Enfys
- Deliver the Mass Covid19 immunisation programme
- Ensure the safety of our high risk and shielding staff
- Ongoing support for TTP and Vaccination programmes

This paper describes the operational and professional collaboration of all Nurse Directors to maintain staffing levels across the Health Board being cognisant of the impact on the Nurse Staffing Levels (Wales) Act 2016 and maintaining safe staffing in inpatient settings and outpatient care settings to safeguard patients and provide safe care during these unprecedented times. That said there is both a Professional and Legislative requirement for safe, effective, compassionate and dignified care as governed by the NHS Framework and Health Inspectorate Wales.

Cefndir / Background:

In accordance with the Nurse Staffing Levels (Wales) Act 2016, Nurse staffing levels are derived through a rigorous triangulated methodology, which is set out in the Act, which include reviewing patient acuity, service activity & capacity, reported harms and Professional judgment. This encompasses the location, the specialist interventions required and the layout of such clinical areas to ensure that care can be delivered appropriately and safely, as a Health Board we remain committed to this approach. In addition the Health Board is required to comply with the All Wales District Nursing principles which enables a triangulated three-dimensional approach, which captures the complexities of care in the community provided by district nurses in Wales to ensure patients in the community receive safe and appropriate care by a skilled workforce. We know from national data and emerging evidence alongside local intelligence that COVID19 patients are extremely sick requiring significant care and invasive treatment that is protracted in nature. From modelling data published we are also aware that radical plans are required to meet the numbers predicted to be affected by this pandemic, which provides an added tension to existing nurse staffing challenges.

In the space of just a few weeks, we have moved from a position of having a low prevalence of Covid-19 in North Wales to prevalence increasing, with further rises anticipated. Wales has been in a Fire Break lockdown up to the 9th of November 2020, with further restrictions imposed in December 2020. BCUHB, along with its partners, are keeping the situation under very close review. The current modelling suggests acute bed occupancy will peak in early to mid-January 2021 in both acute and community settings as per the Health Board's modelling data.

Asesiad / Assessment & Analysis

Ratios are already being extended in Hospitals UK wide, which include the following areas:

- Critical Care Units
- Emergency Department
- Adult Inpatient surgical / medical wards
- Covid – 19 repurposed wards
- Field Hospitals
- Community Hospitals
- Community services and community resource teams
- Mental Health Services
- Paediatric Services

Critical Care units

The Critical Care Nurse staffing model across the 3 Acute sites is based on a 1:1 Nurse to Patient ratio in line with National Guidance. The escalation plans outline mitigation required to allow restructuring of critical care staffing levels to meet increased capacity. These involve extending critical care nurse ratios to 1:2 patients with support from redeployed registrants who have upskilled in this area. Redeployed registrants will be from areas such as our Clinical Nurse Specialist workforce, whom cover a variety of specialisms and planned care areas such as Theatres.

Emergency Department (ED)
The ED Nurse staffing models having recently been reviewed externally and remain supported by national guidance. The escalation plan outlines proposals for adjusting and restructuring the ED staffing levels in line with the activity demand. Again, redeployed registrants will be from areas such as our Clinical Nurse Specialist workforce, whom cover a variety of specialisms and planned care areas such as Theatres.

Adult Inpatient surgical / medical wards
Although the formal Spring 2020 staffing review was deferred, all of the section 25B wards have been reviewed in the light of potential/actual COVID impact and changes to the ward specialty for surge preparation. As reported in the Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards presented to QSE in November 2020.

Covid – 19 repurposed wards
A review of the modelling data provided a baseline calculation of Nurse staffing levels as described for the Adult Inpatient Medical and Surgical wards Acute, Community and Mental Health & Learning Disabilities (MHLD) by the designated officer and subsequently approved by the Executive Nurse Director. The staffing levels were based the triangulated approach and at a point in time as per the Nurse Staffing Act (Wales) 2016. As data emerges regarding the current levels of demand and acuity presenting, these will continue to be reviewed dynamically, also considering other evidence and intelligence from around the world. The staffing assurance reports continue to be monitored through the existing governance routes as previously reported.

Ysbyty Enfys
Additional capacity has been provided in Deeside Enfys Temporary Hospital. The Nursing workforce establishments have been calculated based on potential demand and the agreed Clinical Model for the Health Board. This has required a degree of fluidity due to the ongoing modelling discussions and resource available to support the specific pathways and clinical competence required. Redeployment from all areas of the Health Board has been undertaken with additional recruitment as available.

Community services
A review of all community services has been completed, including District Nursing caseloads, which has supported the redeployment of certain staff groups and reengineering delivery of previous services/pathways. Some of the changes include:

- Suspension of non-essential contacts & visits across a variety of primary and community services for children and adults
- Discharge hubs developed in each Health Community
- Review of community hospital function in line with the clinical model
- Collaboration with Care homes to support seamless pathway and transition and to avoid potential admission where not clinically indicated

Mental Health Services
A review of Mental Health services and pathways has identified opportunities for new ways of working; there has been a COVID/ Non Covid approach to service provision. Redeployment opportunities are dynamic in line with these changes and in line with National guidance.

Paediatric Services
A review of Paediatric and Health Visiting services and pathways has identified opportunities for new ways of working; there has been a COVID/Non Covid approach to service provision. Temporary cessation of services such as School Nurses has provided redeployment opportunities in line with National guidance and Regional opportunities.

All of the above staffing levels will be determined in line with the levels of care determined in the Health Boards clinical model.

Maintaining the Nurse Staffing levels
The Health Board has an overarching duty under section 25A of the Nurse Staffing Levels Act (Wales) 2016 to provide sufficient Nurses within its services and commissioned services to allow time to care for patients sensitively. However, in these unprecedented times it is acknowledged in the Chief Nursing Officer's (CNO) letter (see appendix 2) that maintaining Nurse staffing levels will be a challenge and it is the responsibility of the Executive Nurse Director to minimise risks to Patient Safety. Professional judgment remains the responsibility within the Nursing leadership to mitigate risk, taking reasonable steps in maintaining the Nurse staffing levels as directed for the wards within section 25B. It is important to note that varying from calculated Nurse staffing levels alone does not constitute non-compliance with the Act.

In line with the recommendations of the CNO's letter, consistency of record keeping and rationale/mitigating actions taken are paramount, to ensure any variation is escalated as per the Health Board's Nurse Staffing Policy.

Actions supported by Executive Team to maximise use and deployment of the workforce include:

- Support for in sourcing arrangements of Registrants where applicable to support redeployment of existing staff to areas within the HB e.g. planned care activity etc.
- Deployment of Senior leads into clinical activities to further support clinical activity/ workforce shortages
- General target fill rate for bank 80%, by exception for 80%+ on a risk assessed informed basis
- Agency HCSW sign off at tactical level in and out of hours
- Agree overtime payments of substantive full and part time staff above their normal contracted hours.
- Risk assessment of meetings regards standing down until end of January 2021
- Communication to staff regards Audits/Review process in January 2021
- Communication to Managers and staff regards the approval of study leave in January / February 2021
- Communications regards the approval of Annual Leave in January/February 2021
- Nurse patient ratios to be enacted in line with agreed nurse staffing plans and all necessary actions taken prior and agreed by the Senior Nurse staffing deployment group

Escalation plans
The Pandemic modelling data that has been assimilated to North Wales demographics consideration

has been given to the Nurse staffing requirements and it is recognised that to meet the predicted demands significant variation from that of previously planned Nurse staffing levels that the Board would have been informed of current requirements.

We have observed Nurse staffing levels in Hospitals UK wide vary significantly from those supported and previously experienced. Effective transition through the Patient pathway is critical to maintain access to both our Emergency Departments and our Critical Care units. Ensuring we maximize on our acute and intermediate capacity is essential to ensure that our highest acuity patients are cared for in the safest of environments.

Nurse staffing levels of this nature would be implemented when key triggers have been reached as defined in the Nurse staffing Mitigation plans for both Area and Acute sites as approved by the Executive Nurse Director with the support of the Executive Incident Management Team in hours and Gold on call out of hours.

Acute sites triggers would include:

- Usual funded critical care capacity full – overflow into quasi-critical care areas (theatre recovery, other acute care areas). High level of non-clinical transfers (Covid 19 Pandemic Critcon level 2 or 3)
- Usual funded non invasive respiratory beds full (Covid/Covid Suspected/Non covid) and overflow to surge capacity required
- Staffing below recommended numbers or ratios for case-mix (incl. lack of dedicated supervisory nurse), and/ or inadequate numbers of support staff.

Health Board wide triggers would include:

- capacity / occupancy demand outweighing that available across all areas of the HB
- sickness / absence

Reporting Nurse staffing levels:
As previously reported Nurse Staffing levels are presented Annually to the Board with Bi-Annual calculations, due to COVID impact, as previously reported it is recognised that:

- Acuity audits undertaken in July will not provide comparative data due to the novel nature of the wards
- Repurposed COVID wards due to the Pandemic were subject to the prescribed triangulated approach but harm data will be based on novel data set
- Professional judgment as designated persons is a key determinant in ensuring nurse staffing in all areas is managed as appropriately as possible during an extraordinarily difficult time
- January All Wales Acuity audit has been deferred by the CNO for Wales until further notice; this may affect the triennial report to Welsh Government.

Strategy Implications

Safe Nurse staffing levels and District Nursing principles impacts all elements of the Health Board Strategy aims

Financial Implications

COIVID – 19 plan

Risk Analysis

Risks associated with

- Extending Nurse ratios in a time of crisis due to the pandemic surge.
- Impact of planned care cessation to support redeployment into critical areas across the HB.
- Impact of increasing sickness absence due to increasing community COVID prevalence.
- Increased staff anxiety associated with increasing transmission and shielding impact
- Staff resilience

Legal and Compliance

Quality and Safety will be monitored using existing Metrics via existing Governance and reporting mechanisms which will be reported by exception to the Health Board via the Executive Board Nurse and Executive Board Medical Director

Impact Assessment

As above

Health and Social Services Group
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

Our ref:

Date: 23 November 2020

Executives Directors of Nursing – Health Boards

Via email

Dear all,

RE: Critical Care Nurse Staffing ratios

At the start of the Covid-19 pandemic, on 25 March 2020, I wrote to you regarding the professional guidance developed at a UK level regarding the approach that could be taken for staff ratios in critical care settings during the pandemic. This guidance was endorsed by the UK Chief Nursing Officers in association with a wide number of nursing professional associations and covered appropriate staffing levels for critical care throughout the various surge levels.

In July 2020, I issued a joint letter with Dr Chris Jones, DCMO, stating that lessons learnt across the UK, both in terms of the practicality and safety of operating at the higher the surge levels/ratios as well as the reality that staffing in most cases has not proved to be the limiting factor for critical care capacity, had led to a review of this guidance. It has been agreed that the Critical Care Nursing Exceptional Surge Guidance referred to in my letter of 25 March would be withdrawn in Wales. In future, Health Boards should seek to meet the requirements set out on page 8 in the Faculty of Intensive Care Medicine's bridging guidance:
https://www.ficm.ac.uk/sites/default/files/ficm_bridging_guidance_for_critical_care_during_the_restoration_of_nhs_services_-_22_may_2020.pdf

On 9 November, the Intensive Care Society and the UK Critical Care Nursing Alliance have issued the attached statements on nurse staffing for COVID wave two, which I would like to draw to your attention. Both statements state:

'nurse: patient ratios are maintained at a minimum of one trained critical care nurse* and one registered healthcare professional** for two level 3 beds (compared with the normal 1:1 ratio), and one trained critical care nurse with one registered healthcare professional for four level 2 beds (compared to the normal 1:2 ratio). This should be achieved through the redeployment of staff from outside of critical care, who should have received surge training.'

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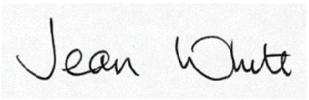
I would be grateful if you could support critical care units to ensure the above staffing ratios are adhered to in order to secure patient safety and staff well-being in the second wave and possibly subsequent waves of the pandemic.

I would also like to draw your attention to feedback given to me by the Critical Care Network Service Improvement Group during a meeting I attended recently. One of the issues raised with me was that staff from outside of critical care, who were released and had received training in critical care competencies for the first wave, are not necessarily being supported/released where they are willing to do an occasional shift within critical care to help maintain those skills, should they be redeployed again in the future. This may be something you would wish to look in to locally to ensure you have the staff trained/refreshed to support your plans for surge in critical care cases.

Finally, I appreciate the many competing pressures on nurse staffing and the strains across the system, but I would ask that you look to protect critical care nurses from being redeployed to other areas, including to high care respiratory wards providing CPAP. There is training available to support developing CPAP competencies for nursing staff if required.

Yours sincerely



Professor Jean White CBE
Chief Nursing Officer
Nurse Director NHS Wales

CC: Judith Paget, Aneurin Bevan UHB
Gill Harris, Betsi Cadwaladr UHB
Len Richards, Cardiff and Vale UHB
Paul Mears, Cwm Taf Morgannwg UHB
Steve Moore, Hywel Dda UHB
Tracy Myhill, Swansea Bay UHB

Health and Social Services Group
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Prif Swyddog Nyrsio – Cyfarwyddwr Nyrs GIG Cymru
Chief Nursing Officer – Nurse Director NHS Wales

Llywodraeth Cymru
Welsh Government

To: NHS Executive Nurse Directors

15 October 2020

Dear Colleagues,

Update on COVID19 disruption to Nurse Staffing Levels (Wales) Act 2016

You will recall that I wrote to you in March of this year as the NHS prepared for the predicted disruption of the Covid19 pandemic. In that letter I set out my expectations of how the pandemic might impact the various duties of the Nurse Staffing Levels (Wales) Act 2016, and stressed the importance of a unified approach across the country.

This included a rationale that wards *repurposed as novel Covid19 wards* would fall outside of the 25B ward definition, and therefore not be subject to the prescribed triangulated methodology. This was of course written early in the spread of the virus, where reasonable worst case scenario projections were describing a near-future where our NHS wards would be predominantly occupied by critically unwell Covid patients, and where field hospital care would be prevalent. Thankfully, those grim projections were not fully realised.

Following a meeting with the Chairs of the All-Wales Nurse Staffing Group and its Adult sub group, it is clear to me that the reality of how wards have been managed in the intervening months has been more nuanced and complex than we initially might have expected.

Understandably, different quarantining protocols and the repurposing of inpatient bed areas have been applied across NHS Wales. These range from: entirely Covid-free wards; wards with Covid-positive patients who are asymptomatic and being treated for other medical or surgical conditions; Covid-positive patients who are symptomatic but not acutely ill from the disease and being treated for other medical or surgical conditions; and wards where all patients are critically unwell with Covid requiring intensive care primarily for that reason.

With the benefit of hindsight of how the first phase of the Covid19 pandemic evolved, I feel that it would be timely to clarify how the lived experiences of the last six months relate to the dispensations outlined in my letter of 24 March. Questions have been raised from an operational perspective whether – for example – a ward with asymptomatic Covid-positive patients not being treated for Covid-related illness would be exempt from the 25B definition. The most concise way to answer this is to refer back to the Statutory Guidance of the Act where the definitions of adult acute medical and surgical wards apply "*according to the primary purpose of the ward*".

If the primary purpose of a ward remains the treatment of patients for medical or surgical conditions, and the Welsh Levels of Care tool is still applicable to that setting, then in my view those wards would remain under the auspices of 25B of the Act.
Conversely, if a ward was legitimately repurposed to treat those critically unwell Covid19 patients - as we expected in March to be a more common occurrence – my view would

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remain that those wards would be considered exclusions with an expectation you would follow national advice on staffing critical care areas.

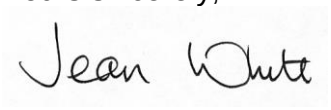
On 1 July 2020, an updated version of the Healthcare Monitoring System (HCMS) went live for use. Informed by the All-Wales Adult work-stream, the enhancements were designed to support health boards in recording data that the Act lists as being necessary under section 25E (reporting). With this in mind, I would expect to see the beginnings of a more detailed reporting picture from 1 July 2020 than had previously been possible. I do appreciate that the disruption caused by Covid19 will not have created the optimum conditions for the roll-out of this updated system, but I hope that you have instructed your senior staff on the importance of ensuring that the data are being captured as accurately as possible as this will inform the first public 3-year report due in May next year.

Finally I want to thank you for your focus and hard work over the last six months. With the winter approaching and a second peak of Covid infections coming with it, you will be required to display the same resolute character and professionalism in the face of potentially greater adversity than the NHS has endured so far this year. I hope this letter provides the clarity and support you will need to be able to capture the nurse staffing story in a consistent way to inform next year's reports. I would also like to remind you of the portions of my 24 March letter that highlighted the various areas of work where the Act gives health boards the discretion to make decisions on whether or not to undertake certain processes. As we approach another period that may well bring unprecedented pressures, I want to be clear that those discretionary provisions are still relevant. All I would ask – once again – is that you make those decisions together as a peer group, and take a unified approach where possible and appropriate.

A hoffech gael yr wybodaeth hon yn Gymraeg, byddwch cystal â rhoi gwybod.

If you would like to receive this information in Welsh, please let me know.

Yours sincerely,



Professor Jean White CBE
Chief Nursing Officer
Nurse Director NHS Wales

COVID-19 Pandemic Staffing Levels RAG Rating Definitions

	Triggers /Descriptor	Mitigation
Green	**Fully operational, business as normal.** • Community capacity available across system. • Patterns of service and acceptable levels of capacity are for local determination. • There is capacity available for the expected emergency and elective demand. • No staffing issues identified. • Use of specialist units/beds/wards have capacity • Good patient flow through ED and other access points. • Pressure on maintaining ED 4 hour target. • Infection control issues monitored and deemed within acceptable parameters. • GP attendances within expected levels with appointment availability sufficient to meet demand.	Nursing and therapies workforce mitigated from within existing staffing / bank / agency
AMBER	**Significant issues or risks that can be mitigated, but still operational.** • Opening of escalation beds (in addition to those already in use) • Infection control issues emerging • Lower levels of staff available, but are sufficient to maintain services (with mitigation) • Increasing levels of sickness absence. • Lack of medical cover for community beds. • Patients in acute and community settings unable to be discharged due to outbreaks in care homes / unavailability of dom care • Community caseloads reviewed and visits to priority patients only to be provided • Clinic activity reviewed and prioritised in line with staffing availability	As above and additionally CNS workforce will be deployed within their native specialty wards **OR** where skills / competence / additional upskilling allows. Corporate Nursing & Therapies staff deployed to patient facing care. Risk assessment completed to request authorisation to move to agreed reduced staff to patient ratios ratio's capacity / caseload / clinics
Red	**Critical issues that may reduce operational effectiveness.** • All available escalation beds within a defined area are full, staffing capacity severely compromised. • Unable to maintain Amber level staff to Patient ratio or caseload / clinic cover either due to number of patients or due to high levels of sickness absence.	As above risk assessment completed to request authorisation for cessation /suspension of agreed services to executives to facilitate redeployment of staff and to move to fully extended staffing ratio's as outlined in each divisional mitigation plan (see appendices)

Llywodraeth Cymru
Welsh Government

WRITTEN STATEMENT
BY
THE WELSH GOVERNMENT

TITLE **NHS Pressures**

DATE **10 December 2020**

BY **Vaughan Gething, Minister for Health and Social Services**

When I issued the Winter Protection Plan in September, I made it very clear that I expected this winter to be one of the most challenging that we will have seen across the health and care system. Health and social care organisations have plans in place and have been taking urgent action to ensure they are ready to respond to the demands of COVID-19, to continue to provide essential services and to prepare for winter pressures.

Despite those best efforts, the rate of COVID-19 transmission continues to rise across communities in Wales at an alarming rate. As transmission rises, it becomes increasingly difficult to maintain the fragile balance between providing care to those who require hospitalisation because of COVID-19 and the delivery of essential, non-COVID services. There are now more patients being treated with, or recovering from COVID-19 in our hospitals than ever before.

Difficult choices will have to be made as services and our workforce start to be stretched beyond the levels that we would normally see at this time of year. NHS organisations will need to take action to ensure they stand ready to face increasing levels of COVID-19 in the coming weeks and in the run up to Christmas. My priority remains to save lives and to minimise harm.

We are starting to see significant pressure on our unscheduled care services. NHS Wales is still here for you if and when you need it, but it is beginning to feel the weight of the demands upon it at this difficult time.

As we move further towards winter, it is vital that our health and social care system in Wales is prepared. I am firm in my commitment to support NHS organisations to take local decisions and action to continue to provide care and support to the most vulnerable people in our communities. I am choosing to act now before we see sustained surges in demand over Christmas and into the New Year. A larger number of people requiring high levels of care is anticipated over the coming weeks as we see higher levels of Covid-19 in our

communities alongside visible system pressures which arise in this most challenging period for the NHS.

I have taken advice from professional colleagues, including NHS Chief Executives and Medical Directors to inform my decision to act now to ensure our preparations can be made in a planned and measured way. I have therefore approved a framework of actions, within which local NHS organisations can make decisions. Please see attached annex.

We are collectively growing increasingly concerned about the potential risk of harm to patients who require access to essential healthcare services. The framework of actions for local consideration by NHS organisations is intended to mitigate the potential risk of harm in the system by:

- maximising use and deployment of the workforce;
- ensuring people only access 999 or hospital care if essential;
- reducing long delays in crucial parts of the system;
- improving patient flow; and
- enabling people to leave hospital when ready, reducing the risk of readmission.

These actions will ease the pressures on the NHS by allowing for services and beds to be reallocated and for staff to be redeployed to priority areas.

As well as taking individual actions set within a local context, I also expect NHS organisations to work together to ensure the resilience of the emergency response beyond their own boundaries.

Our NHS Direct Wales online service and the 111 telephone number are still available and protect our vital primary care and emergency department services from undue demand.

The key principle is to keep people safe and to keep patients out of clinical settings if there is no urgent need to attend.

The COVID-19 vaccination programme, which commenced this week gives us great hope about returning to some sort of normality. But we are not there yet. It will take a number of months for the vaccination programme to be rolled out fully. In the meantime, NHS organisations are having to redeploy staff from other areas to support that effort.

The health and care workforce is doing a fantastic job in extremely difficult circumstances, as we enter a busy winter period following what has already been the most challenging of years. I thank them for their hard work, commitment and perseverance.

It is not surprising that we are starting to see an increase in NHS staff absences due to sickness, including COVID-19 and self-isolation. The welfare and well-being of the workforce, as well as the wider population of Wales, in the face of this pandemic is critical at this testing time in order to support and deliver services to the people of Wales.

To be clear, if rates of COVID-19 transmission in communities continue to rise, and pressures on the health and care system continue to increase, Welsh Ministers may need to consider what further urgent actions and restrictions are necessary.

In the meantime, Welsh Government, and the health and care system will do everything it can to keep you safe. Help us help you - I am asking every one of us to do everything we can to protect ourselves and to protect the NHS. Together we will keep Wales safe.

Service Suspension	Potential Redeployment	Risks	HB Assessed Risk
Cancel outpatient clinics (F2F and Virtual)	Medical staff to support wards/ED OP Nursing staff to wards	Increased waiting times Potential missed cancer diagnosis	
Cancel specialist nurse clinics	Redeploy specialist nurses to wards/field hospital	Increased waiting times Patient deterioration Failure to review medication	
Cancel non-urgent elective operating	Surgeons redeployed to wards Anaesthetists/ODPs to ITU Theatre nurses to ITU/Wards	Increased waiting time Further deterioration and potential harm Further disability/pain Increased anxiety	
Cancel non-critical community clinics e.g. community therapies, primary care clinics in Community Hospitals, day services	Staff redeployed to wards/Field Hospital	Increased waiting time Isolation of vulnerable patients Increased pain/disability Deterioration and risk of hospital admission	
Cancel non-urgent diagnostic services (e.g. radiology/endoscopy)	Redeploy radiographers to support as HCSWs Redeploy endoscopy nurses to wards	Increased waiting time Potential missed diagnosis Risk of harm	
Cancel non-critical home-based services e.g. district nursing, community therapies, OPMH etc	Staff redeployed to wards/Field Hospital	Deterioration of patient Isolation/MH issues Pain/harm	
Close community dental services	Staff to support field hospitals/vaccination	Dental issues unresolved Waiting time increase Pain/harm	
Cease school nursing	Staff to support vaccination/field hospitals	No provision for schools MH issues unresolved Increased CAMHS referrals Fall behind in childhood immunisations	
Cease health visiting services	Staff to support vaccination/field hospitals	No support to families Potential safeguarding issues missed Child development issues missed	
Clinical staff in non-clinical roles	All clinical trained staff with current registration are redeployed to clinical areas in DGHs/Field Hospital e.g. CHC staff/safeguarding/training	Routine work not progressed Core HB services impacted e.g. complaints/safeguarding/clinical governance/CHC Training unavailable for new staff	
Cancel cancer elective operating	Surgeons redeployed to wards Anaesthetists/ODPs to ITU Theatre nurses to ITU/Wards	Significant risk of harm Worsening prognosis for patient	
Cancel urgent elective operating	Surgeons redeployed to wards Anaesthetists/ODPs to ITU Theatre nurses to ITU/Wards	Significant risk of harm Increased waiting times	

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	**Patient Safety and Quality Group (PSQG)**
Chair of meeting or lead for report	**Debra Hickman** **Acting Executive Director of Nursing and Midwifery**
Date of meeting	**11 December 2020**
Version number	**V1.0**
Appendices	**N/A**

Reporting To	
Name of meeting	**Quality, Safety and Experience Committee**
Date of meeting	**15 January 2021**
Presented by	**Debra Hickman** **Acting Executive Director of Nursing and Midwifery**

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

- The group has been stood down in January 2021 to allow services to focus on the COVID response. Matters of risk, escalation and action monitoring will be progressed by Directors and Executives directly to ensure governance arrangements are adhered to by exception.
- A Further East COVID outbreak was reported by the Infection Prevention Control (IPC) Sub Group, the Operational Control Group meets daily to review and action from Post Incident Review (PIR) findings. Epidemiology data confirms growing community transmission, which is influencing. Decision to amend the Operational Control Team (OCT) reporting has been supported by Public Health Wales (PHW) and Welsh Government (WG) given the increasing community rates, however focus remains on ceasing Nosocomial transmission.

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

- A report was received from the IPC Sub Group noting the Covid 19 “toolkit” was approved at IPSG 08.12.20 and for ratification at PSQG 11.12.20, this replaces previous guidance and incorporates learning from Health Board outbreaks, National and International evidence. Additional IP resource is actively being recruited to following approval of the IP business case. The catheter audit is currently on hold due to the demands of COVID on resource. All IP policies have now been reviewed.

- The Personal Protective Equipment (PPE) Group reported on stock position and the challenges of a wide range of masks. The dedicated PPE staff intranet microsite continues to be updated so that all advice and guidance is current and easily accessible. This includes input from Corporate Communications, Infection Prevention and Control Teams, Health and Safety team and Office of the Medical Director team, who are responsible for the Clinical Pathways information. We have received confirmation regards receipt of delivery of the 3M 8833 masks into Wales, the Health Board have received an allocation of this stock with further delivery expected.

- An update was received from the Medication Safety Group. Omissions continue to account for the highest number (24%) of administration errors reported across BCUHB. A focus on sliding scale insulin prescribing and administration is taking place at Ysbyty Glan Clwyd (YGC) following a themed analysis of the incidents. An in depth Medicines management review is taking place with the medicines management Nurses, safety Pharmacist and Lead Nurse in the Mental Health * Learning Disability (MHLD) Division with a view to replicate across specialities. A review of the discharge process & the production of TTOs (to take outs) at each community hospital site is being undertaken due to a concern that there is deviation from the Medicine Policy. Pharmacists are transcribing discharge medication for all wards in the community hospitals, but there are no GP's/medical staff to write/authorise TTO's, this poses an increased risk of medication errors on discharge prescriptions. Discussions are underway to seek a resolution. Dr Berwyn Owen received the formal report for the independent Controlled Drugs review completed in October 2020 from the Accountable officer of NHS England/NHS Improvement. Procurement have identified a need to check on BCUHB ring-fenced ranitidine IV supplies and alternatives. There are no dates for supplies of ranitidine to become available. Stock reserved for Obstetrics and Gynaecology and for cancers services is now running low. There are discussions as to whether alternatives e.g. oral/IV PPI may be considered.

- The Concerns and Quality System Group reported on key priorities – 1. Finalisation of the revenue business case for procurement of the new Once for Wales (patient, carer and visitor) Feedback System 2. Submission of an updated services and locations directory for the Once for Wales Concerns Management System and Once for Wales Feedback System 3. Submission of a combo-linking map for services and locations for the Once for Wales Concerns Management System and Once for Wales Feedback System 4. Submission of a user account mapping exercise for the Once for Wales Concerns Management System and Once for Wales Feedback System. The group has approved a data migration strategy for the new Concerns Management System (from the old BCU Datix system).

- With regards to HASCAS & Ockenden during the first wave of the Covid-19 pandemic / lockdown the stakeholder meeting schedules for both the Improvement Group and Stakeholder Group were paused. The Stakeholder Group reconvened on 5th November supported by the Community Health Council (CHC). MHLD advised the Group of the future ambition for MH&LD services following a review and refresh within the Division which included actions arising

from the HASCAS & Ockenden recommendations, the work done to date in response to these, alongside other reports including Healthcare Inspectorate Wales (HIW) and the Holden Report. The CHC agreed to support the Health Board in reaching out to wider group of stakeholders to enable a focused conversation to help move forward in the development of MH&LD services. This would be facilitated through a schedule of six 'safe space' events covering key areas within the MH&LD division, which will be run utilising the 7Cs approach.

- Divisional updates were received and scrutinised.

    - Secondary care – Falls and Hospital Acquired Pressure Ulcer (HAPU) strategic groups reformed with Senior Nursing Leadership in place to drive forward improvement work. Ysbyty Gwynedd (YG) are undertaking a detailed review regarding ambulance diverts and will share the outcome and learning. The risk is being mitigated by an Ambulance Divert Policy which is subject to Clinical Advisory Group (CAG) approval. There is a risk to the East Primary Care Phlebotomy service with the re location from Enfys Deeside site. Options to extend the working day and weekend working are being considered, alongside seeking alternative venues.

    - West Area - GPs not attending community sites regularly to re-write prescription charts. Reduced medical cover in the community hospitals to sign off discharges. Pharmacists are transcribing discharge medication. No GP/medical cover to write/authorise TTOs. Pharmacists are undertaking the transcribing and clinical authorisation checks. There is an increased risk of medication errors on discharge prescriptions. Area Medical Directors (MD) and pharmacy and all GP leads have been reminded of their roles and responsibility, a follow on meeting to review is scheduled.

    - Central Area - There are currently two nursing care homes in escalation at present in Denbighshire - one in Ruthin and one in Llangollen. Twice weekly escalation meetings are being held to support investigation, improvements and mitigate against identified issues for both homes. All professionals across Health and Local Authority jointly participate to ensure requirements are being met. Current issues with staffing in Child Adolescent Mental Health Services (CAMHS), they are operating at 66% substantive staffing, rising to 70% utilising agency to mitigate gaps where possible. Risks across a variety of services due to the non-availability of laptops for staff, with a significant number of staff outstanding receipt. Occupational Therapy has the largest gap, with 24 orders still open. This is affecting service delivery.

    - East Area – Significant risk highlighted due to the inability to deliver and maintain dental service waiting times at HMP Berwyn. This is due to a reduction in staffing (this risk is held by Central Area although the impact affects Area East).

    - Women's and Midwifery - HIW National Maternity Performance Report released in November 2020. A National meeting took place on the 2nd December which was a learning event from the HIW findings, and local actions to take place as a result. HIW Self-assessment review tool has

been developed locally to undertake spot checks across all three units in preparation for HIW's return.

- MHLD - The development of the Heddfan Quality Improvement Plan (HQIP) included corporate colleagues from Safeguarding and Quality Improvement, Ward Managers and staff at the Heddfan Unit and Senior Leaders in the Division. The HQIP pulled together actions from the initial HIW concerns, subsequent actions following their visit and actions from learning from other events. A safeguarding quality action plan has been developed following the Safeguarding peer review so was not integrated into the HQIP but was overseen as part of the HQIP meetings. The HQIP Team has continued to meet fortnightly to oversee progress and escalate where required. Actions have progressed and signed off through the divisional Quality Safety Experience governance process. However, one HIW action will not be achieved relating to the 'successful recruitment to 85% of nurse vacancies'. There are ongoing adverts for qualified nurses but these remain difficult to fill especially for Band 5 Registered Nurses. The Division has been working towards an improved position for overdue Datix during November 2020, the reduced position has been maintained and there continues to be drive for further improvement. There have been two outbreaks of Covid 19 within inpatient settings for the Division during November 2020 with one expected death reported alongside an increase in the number of staff testing positive. Work began on the Learning Project in October 2019. The overarching goal of the project is to improve the way the Division learn and improve practice through the process of investigating incidents.

- The Tier 1 Risk Report was noted as showing only 1 risk aligned to quality. The Risk Team will be asked to ensure alignment is correct for future reports.

- A new rolling, thematic process was presented and approved for reviewing Level 4 Site Escalations to ensure individual and collective learning is captured and taken forward across the system. The system will not move forward with implementation.

- The updated Ward Accreditation Process and Framework was presented and approved.

- A North Wales Safeguarding Board Extended Adult Practice Review was received and noted. Two actions were applicable for BCU - As best practice GP surgeries to identify a Safeguarding Lead, and Care Inspectorate Wales (CIW) to share information with commissioners of non-compliance, which may affect safety and well-being of residents. A recommendation to measure timeliness of Safeguarding and Establishment Control (EC) process and to ensure that there is no need to wait for strategy to start EC process and no delay in reviewing other patients in the care home. The Safeguarding Sub Group will maintain oversight of the action plan delivery.

- The Group approved a number of procedures:

- MHLD Children Visiting Mental Health Wards
- MHLD Procedure for the exceptional admission of Children under the age of 18 years to an acute psychiatric inpatient unit
- Claims Procedure

3. Achievement – include any significant achievements and outcomes

- Complaints have made a significant performance improvement, resulting in the best performance the Health Board has ever achieved.

Quality. Safety & Experience Committee 15th January 2021	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board To improve health and provide excellent care

Chair's Report Strategic Occupational Health and Safety Group

Meeting date:	21.10.20
Name of Chair:	Sue Green, Executive Director of Workforce and Organisational Development
Author:	Peter Bohan Associate Director Health, Safety and Equality
Summary of business discussed:	• Reports from Sub Groups • Updates from Occupational Health including Flu Vaccinations, COVID antigen testing/ vaccinations, team resources, RIDDOR reports. • Update from the Corporate H&S Team Q2 report.
Key assurances provided at this meeting:	• Social Distancing visits being undertaken by the Corporate Health and Safety team • Estates undertaking responsibility for the risk registers for Asbestos, Legionella, Contractor Control, Fire and Electricity
Key risks including mitigating actions and milestones	The gap analysis of 31 pieces of legislation, 117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP. Identified significant areas of none compliance. Clearly identified objectives for Q3/Q4 planning to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed.
Issues to be referred to another Committee	N/A
Matters requiring escalation:	• Legionella: noted that Legionella risk assessments are overdue with 75% not being completed within the specified timeframe. • Fire Safety: A fire safety notice may be issued in regards to the compartmentation in YG. • Security: a full review of security provision across BCUHB is required as significant risks to staff and property identified. • HSE Improvement Notice: although refitting of masks has almost been completed on the YGC site this has not been carried out across BCUHB due to the limitations on FFP3 masks. • Manual Handling: increasing non-compliance for practical manual handling courses, which is also impacting with delays in recruitment of bank nursing staff.

Well-being of Future Generations Act Sustainable Development Principle	Policies and site specific developments have specific EQiA reviews. Work of the Group works with Trade Union partners and service Leads on changes to guidance and policies considering staff, visitors, contractors, volunteers and patient wellbeing at all times.
Planned business for the next meeting:	Range of regular reports from Sub Committees, HSE guidance and interpretation of legislation. Covid management and RA process in service areas.
Date of next meeting:	2.2.21

CEG Chair's Report to QSE

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	**Clinical Effectiveness Group**
Responsible Director	**Prof Arpan Guha, Acting Executive Medical Director**
Date of meetings	**10th December 2020**
Version number	**1**
Appendices	**Appendix 1 - Delivering Effective Clinical Audit** **Appendix 2 -Logic Diagram - Effective Clinical Audit**

Reporting To	
Name of meeting	**Quality, Safety and Experience Committee**
Date of meeting	**15th January 2021**
Presented by	**Prof Arpan Guha, Acting Executive Medical Director**

The Clinical Effectiveness Group (CEG) became effective 15th October 2020 with new Terms of Reference (TOR) and Cycle of Business (COB) being developed. The Clinical Effectiveness Group meets bi monthly and the first meeting was in October, *(Chair's report was submitted to QSE meeting on 3rd November 2020).*

The purpose of the Group is to provide advice and assurance to QSE in discharging its functions and meeting its responsibilities with regard to the Clinical Effectiveness of health services CEG has 15 reporting groups within its functions Clinical Audit, NICE assurance and clinical outcomes.

The list of reporting groups are as follows:

- Clinical Improvement & Audit Group Sub-group Chair or Representative
- North Wales Managed Clinical Services Quality Committee Chair or Representative
- Mental Health & Learning Disabilities Clinical Effectiveness Sub-group Chair or Representative
- New Technologies Oversight Committee Chair or Representative
- Reducing Mortality Sub-group Chair or Representative
- Strategic Delivery Group for Palliative & End of Life Care Chair or Representative
- NICE Assurance Sub-group Chair or Representative
- Radiation Protection Committee Chair or Representative
- Pathology (including Blood Transfusion Committee and Point of Care Chair or Representative)
- Resuscitation Committee Chair or Representative
- Drugs and Therapeutics Sub-group Chair or Representative
- Trauma Sub-group Chair or Representative
- Clinical Law and Ethics Sub-group Chair or Representative
- Medical Education Sub-Group Chair or Representative
- Research & Innovation Strategic Partnership Chair or Representative

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

There are no matters for formal escalation. A number of high-risk issues are identified in the assurance section for the QSE Committee's awareness.

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

A number of Chair's Reports were received from sub-groups, which are summarised below:

Reporting group: - Clinical Improvement & Audit Group Ysbyty Gwynedd

Issue: Tier 1 and Tier 2 Clinical Audit

- A risk was noted that there was poor compliance within some Tier 1 and 2 audits

Explanation:

- Need for further development within directorate

Action undertaken to date:

- Leads and data collectors to be identified and have accountability
- Meetings commenced in November so triumvirates are held accountable on monthly basis to ensure progression

Date of Completion:

- End of January 2021

Issue: M & M reviews

- A risk was raised with regard to the backlog of stage 2 M & M reviews and slow progression to Datix mortality review system
- Lack of access to reviews means limited sharing of raw data to inform learning, increasing backlog will become unmanageable

Explanation:

- Need for further training to support the process of documenting mortality reviews

Action:

- Training has commenced for Stage 2 Datix and SJR training across directorates
- Stage 1 training to be rolled out

Date of Completion:

- Early 2021

Reporting group: Pathology (including Blood Transfusion Committee and Point of Care)

Issue: Identification of unknown patients

- This risk was raised at the Hospital Transfusion Committee with the distribution of the Identification Policy, that BCUHB procedures differ across all sites

Explanation:

- Procedures differ across BCU, which makes it impossible for BCU Blood Transfusion to standardise their policies and procedures.

Action:
To provide assurance, further discussions have taken place and escalated to the following groups:

- ❖ NWIS Quality and standards
- ❖ Blood Health group
- ❖ All Wales Pathology quality and regulatory compliance group
- ❖ Feedback into the BCU patient identification SOP

Date of Completion:

- Update to be brought back to next CEG meeting once reply/advice is received from the above.

Reporting group: Drug and Therapeutics Sub-group

Issue: National Prescribing Indicators 2020-21 update

- GP practice level performance from April to June 2020 has demonstrating no improvement or a slight deterioration.

Explanation:

- The impact of COVID has limited the ability of the GPs to undertake reviews on patients during the initial surge. .
- Primary care prescribing support teams are working remotely due to social distancing.

Action:

- Issue has been highlighted to Primary Care via the Area MDs and will be kept monitored by DTG and escalated to CEG.

3. Achievement – include any significant achievements and outcomes

Clinical Effectiveness Group

- The new format for this group, which commenced on 15th October, was received overall very positively. Some improvement areas have been identified, about order of agenda items, and the divisional reports, as it was felt there was duplication to several meetings, and review of the membership of the Terms of Reference, all these will be addressed by the next meeting scheduled for 11th February 2021.
- ***Appendix 1 and Appendix 2*** papers were previously presented at the JAQs meeting on delivering effective clinical audit and the logic diagram, and have been included for reference.

Pathology (including Blood Transfusion Committee and Point of Care)

Maintaining the service during Covid 19 pandemic

- The BCU Blood Transfusion laboratory teams liaised with the Welsh Blood Service to maintain minimum levels of bloodstocks while continuing to be able to provide blood on demand. This was only possible by working as a team pan BCU and closely managing bloodstocks locally, using the latest blood tracking and remote issue technology to maintain service delivery.
- Whilst shortages were and are occurring, the close management of the local bloodstocks has meant that supply and demand remain in balance without jeopardising patient safety.

Convalescent plasma for treating Covid 19 patients

- BCU Blood transfusion laboratories are supporting the use of convalescent plasma to treat Covid 19 supplied by Welsh Blood Service.

Major haemorrhage protocol

- Achieved accreditation to ISO 15189 – Medical laboratories requirements for quality and competence. All three BCU Blood Transfusion laboratories are accredited to ISO 15189 under the same accreditation scope.
- BSQR compliance –continual compliance monitored and achieved.
- Maintaining the service during Covid 19 pandemic - the BCU Blood Transfusion laboratory teams liaised with the Welsh Blood Service to maintain minimum levels of bloodstocks while continuing to be able to provide blood on demand. This was only possible by working as a team pan BCU and closely managing bloodstocks locally, using the latest blood tracking and remote issue technology to maintain service delivery.

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Appendix 1

Cyfarfod a dyddiad: Meeting and date:	**Joint Audit and Quality, Safety and Experience Committee November 2020**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	Delivering Effective Clinical Audit
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha – Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell – Senior Associate Medical Director/ Clinical Lead Improvement Cymru
Craffu blaenorol: Prior Scrutiny:	Prof Arpan Guha – Acting Executive Medical Director
Atodiadau Appendices:	***Appendix 2**: Logic Model for Clinical Effectiveness*

Argymhelliad / Recommendation:

"The committee is asked discuss whether they agree the proposed actions will provide an effective clinical audit function that will support quality improvement leading to safe, high quality care whilst providing the assurance required by the committee.

Please tick as appropriate

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

Sefyllfa / Situation:

The clinical audit function in BCUHB has been an area of concern for some time, providing limited assurance that services recognise and value the role of clinical audit in delivering the clinical effectiveness agenda through adherence to evidence based practices and supporting better patient outcomes.
This paper reviews the progress made against the model previously presented (2019) recognising that this has been hampered by the Covid19 pandemic (see appendix 1). It reviews the outstanding actions and any additional changes required. The committee is asked to discuss this document and provide support in principle for the planned improvements and activity.

Cefndir / Background:

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness".[1]

Clinical audit is integral to improving quality, safety and delivery for patient care in Wales. Audit provides an invaluable insight into the quality of care being provided and monitors how well improvements are being taken forward. All organisations should have annual clinical audit programmes in place which include both national, and local audits that address their priorities.[2] To support an effective clinical audit function a logic model was presented to QSE and Audit Committee in 2018/19 (see appendix 1). There were 3 main themes:

- An appropriate plan that supported key quality and safety issues and aligned with the quality improvement strategy
- Sufficient resources to support delivery of the plan
- Ownership & leadership so staff understand the need for audit and are participating in the delivery of the plan.

Progress against this model and outstanding actions are highlighted below:

Asesiad / Assessment & Analysis

PLAN

PROGRESS:

1. 2020/21 plan agreed at QSE but delayed
2. Draft quarterly update report to CEG (Nov 2020)
3. Monthly escalation report to CEG for overdue action plans (Nov 2020)
4. Annual Audit report 2019/20 drafted (Nov JAQS)

NEXT STEPS:

1. Plan requires more information about audit objectives to enable robust scrutiny
2. Ensure tier 2 audits reflect all priorities including claims (financial risk)
3. Ensure work to expected business cycle for 2021/22
4. Capture tier 2 primary care activity

RESOURCES

PROGRESS:

1. Clinical Audit policy and procedure agreed to focus resources effectively.
2. Introduced electronic registration for Tier 3 audits linked to access to case records
3. Linked audit activity to the Quality Improvement hub - shared resources

NEXT STEPS:

1. Business case for developing audit capacity, both corporately and within the divisions. (Interim Head of Clincial Effectiveness appointed)
2. identify software to enable action plan monitoring.
3. Work with new governance structures to ensure changes are fit for purpose

LEADERSHIP

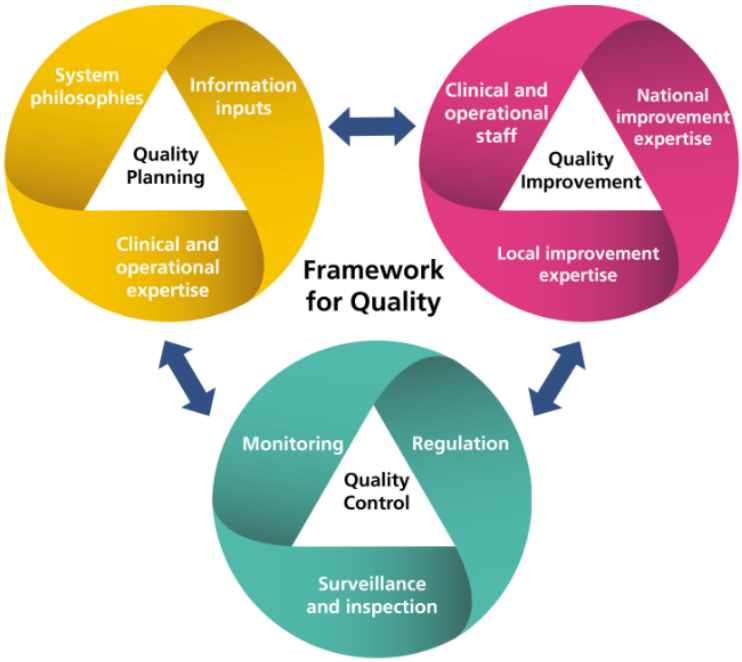
PROGRESS:

1. Escalation process developed to promote timely review and action planning.
2. Sign off process re-developed to ensure action plans are appropriate and deliverable. (from September 2020)
3. 4. E alerts to ensure divisions are aware of registered tier 3 audits; enabling tighter control on audit activity

NEXT STEPS:

1. Ensure all tier 1 audits have an idenfied site and or BCU wide lead (as required).
2. Implement the developed polices, procedures and processes
3. Ensure Divisions are sighted on the audit programme through the quarlerly review process
4. Work with management teams to ensure Clinical Leads and auditors have adequate time to particpate fully.

Strategy Implications:



Clinical Audit is an integral part of a quality framework:

Control – audit describes whether there is reliable care delivering to the standards required. It can also provide the assurance that service changes have been embedded in practice.

Planning – audit identifies gaps in service quality that need attention; these can be aligned with the quality strategy to support prioritisation.

Improvement – audit can provide the measurement needed to monitor change. It can tell you when the change is embedded enabling you to move the focus of improvement elsewhere.

Within BCU, a group are meeting to re-develop the quality strategy. This will align to the new quality governance structures and will encompass a safety strategy, a clinical effectiveness strategy and a patient experience strategy. Clinical audit will be one of the key drivers in the clinical effectiveness strategy.

Options considered

Not applicable to this paper

Financial Implications

This paper does not include financial costs.

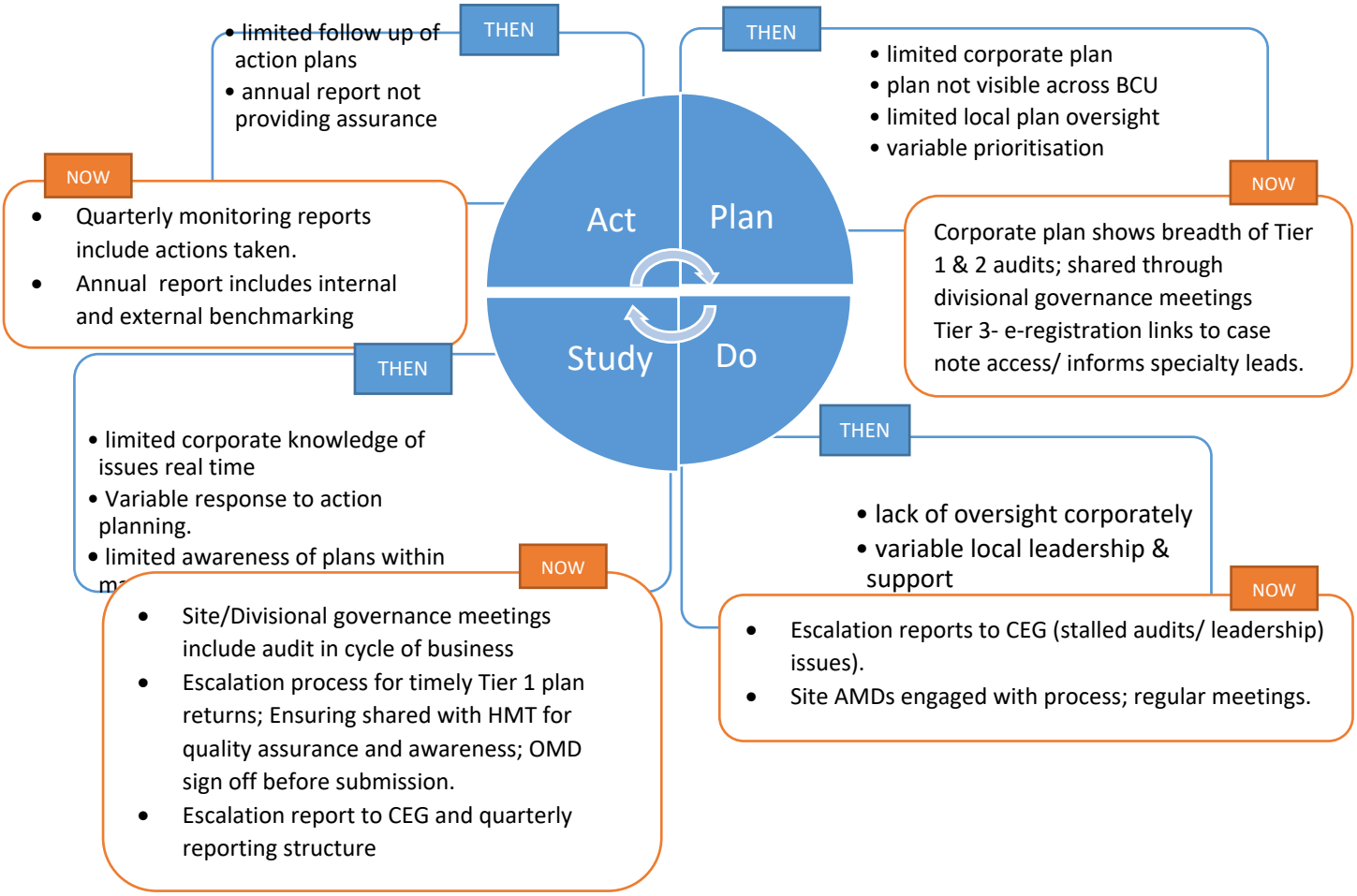
Clinical audit needs to be included in the digital strategy, so that data requirements are captured as part of clinical care wherever possible. This will enable real-time monitoring for clinical pathways and also support better understanding of key outcomes; this is the long term ambition.
In the interim, a business plan is in development that will support delivery of the audit policy, with the focus being additional resources within the divisions rather than the corporate team. There is work in progress to identify suitable software to support audit tracking and action plan monitoring. In addition, we need to ensure clinical staff have enough time to complete audit including driving any changes identified within their work timetables. For secondary care doctors, there is an expectation that SPA time will be identified to support this; however for those leading audit, third SPA time may be required. However, GPs and other clinical professionals need agreed time within their role to enable them to participate.

Risk Analysis

The Tier 1 element of the Clinical Audit Plan relates to mandatory projects within the national programme as prioritised by Welsh Government. Tier 2 includes some projects which are required for accreditation, regulation and licensing; along with management of risk, quality, safety and patient experience. Resourcing to support activity corporately is currently under review and is recorded within the Risk Register (reference: 2961) with a current tier 2 risk rating of 12. This has been mitigated by reducing the scope of activity of the corporate team for example introducing a digital solution to register tier 3 audits. There is work in progress to articulate the additional resources required to support a fully functional audit programme.

There is a risk of a lack of assurance for services where there is patchy or non-compliance with the plan. When these are Tier 1 audits, it is usually due to lack of resources i.e. clinical time to capture the complex and /or continuous data, and delivering any associated improvements; mitigation might be more localised audits and other sources of assurance.

There has been progress in the last 12-18 months:



There is work predominantly with the secondary care HMT to embed audit reporting within the governance structures from speciality to Board; quarterly reporting and escalation reports to Clinical Effectiveness Group will identify issues earlier for action. Going forward the clinical strategy includes the development of pathways that explicitly links to relevant national audits.

The logic diagram still remains fit for purpose and over the coming months the focus will be on improving the leadership element:

At a system level, the quality strategy will encompass the clinical effectiveness strategy and so reaffirm the role of audit. The change in governance structures provides a thread in the performance management of audit through the site and divisional clinical effectiveness meeting, to the Clinical Effectiveness Group; this group should then be able to provide robust assurance to the Quality, Safety and Experience Committee.

This will be achieved through enhanced monitoring reports that will provide more timely information on improvement with the internal and external benchmarking and service improvements; whilst giving audit and related improvement more visibility, holding people to account when there are unresolved issues highlighted through the escalation/exception reports.

This will need to be underpinned by additional resources; an interim Head of Service has been employed to who will be writing the business case as a priority within the next 10 weeks.

Legal and Compliance

NHS organisations in Wales are expected to participate in clinical audit as part of the requirements of Standard 3.3 of the Health and Care Standards 2015, which requires healthcare organisations to have a cycle of continuous quality improvement that includes clinical audit.

Compliance with participation in the National clinical audit programme is documented within the Annual report for the committee and through exception reporting and quarterly clinical audit update reports to Clinical Effectiveness Group (from October 2020).

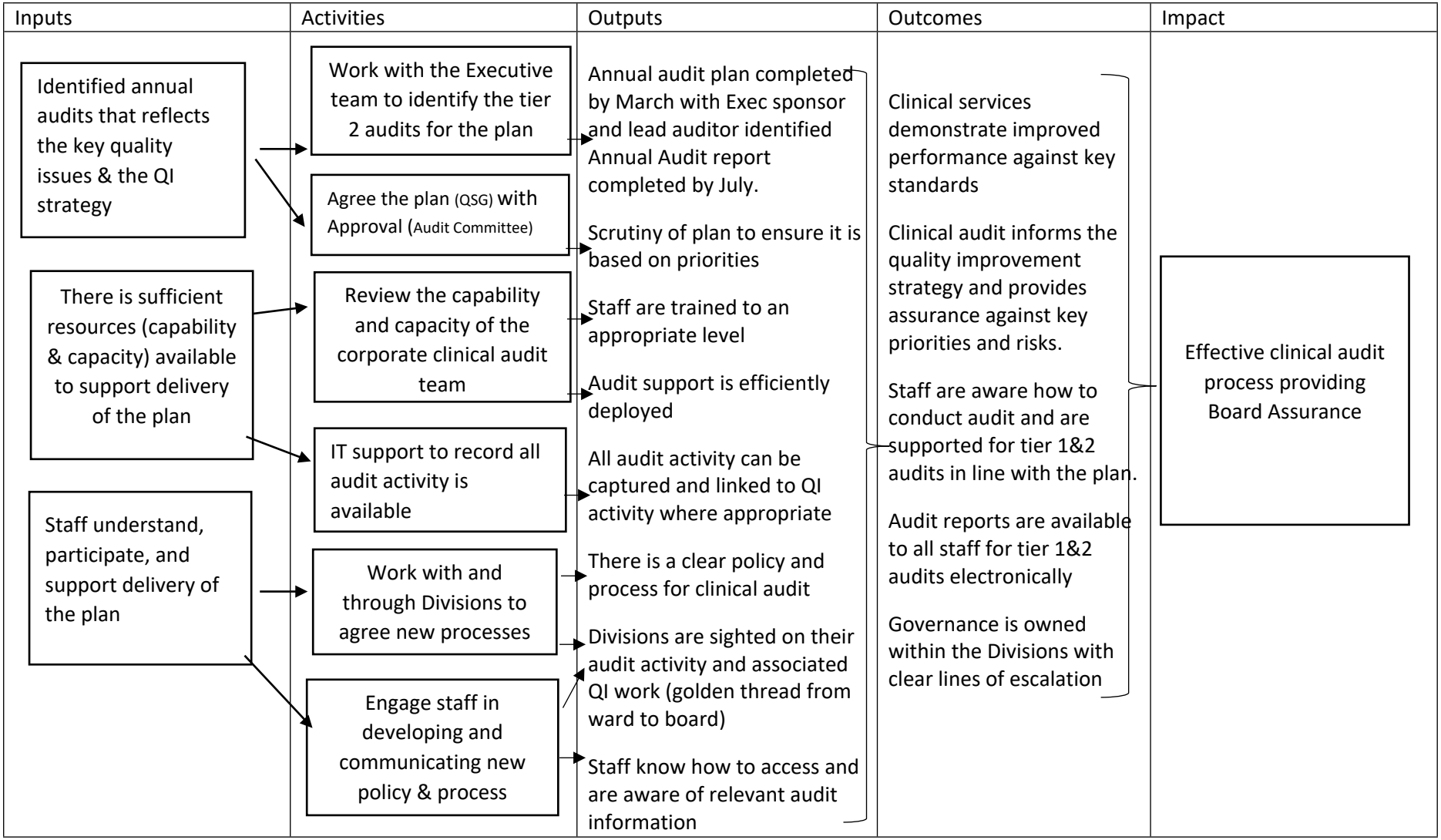
Impact Assessment

An equality impact assessment was undertaken in developing the clinical audit policy. Improving the effectiveness of clinical audit highlights no additional equality issues.

References

1. Dickens P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales
2. Welsh Government governance e – manual http://www.wales.nhs.uk/governance-emanual/clinical-governance
3. Delivering Best Practice in Clinical Audit https://www.hqip.org.uk/resource/best-practice-in-clinical-audit/

Appendix 2: Logic Diagram: Effective Clinical Audit (2019)



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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	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience On behalf of Debra Hickman, Acting Executive Director of Nursing and Midwifery
Date of meeting	15 December 2020
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	15 January 2021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance and Assistant Director of Patient Safety and Experience

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

- **Realtime feedback**: All Wales System is being progressed; the Corporate Patient and Carer Experience Team is developing a business case to provide access to the platform. A bespoke, interim solution (COVID secure) is in place providing some limited feedback to services via dashboard and monthly reports. Formal process due to be in place by April 2021.

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

- **Dementia pathways** – new pathways developed that outline the need for clear an effective coordination of care and essential communication. **Pathways Approved.**

- **Bereavement sub Group**: Developing a Bereavement Quality Improvement Plan, supporting partnership working with Stakeholders and Patient Advice and Liaison Service (PALS). Linking with All Wales Compassionate Cymru Group, which helps communities support each other.

- **Patient Communication and Readers Panels Sub-group**: The process is being refined following each meeting with a new template designed to feedback to the authors; collaborating closely with the Equality Team.

- **Triple A reports from Divisions:** Following feedback at the last PCE Group, a meeting was held with Divisional representatives to review the template. Positive feedback received on the new template. Updates were received from Divisions on their patient and carer experience activity, key themes and learning. In particular it was noted the significant reduction in early resolutions being upgraded to formal complaints at Wrexham Maelor Hospital (due to active daily monitoring and progression by the Site Governance Team) and a significant reduction in falls (40%) and medication incidents (50%) in Ysbyty Gwynedd (linked to the roll out of harm prevention workshops and the expanded and enhanced use of the new Make it Safe rapid reviews).

- **Strategic Equality Plan 2020/2024:** The Strategic Equality Plan is being developed in collaboration with stakeholders. Embedding the equality duty and supporting the organisation to operate from an equality perspective is a key strategic priority. The Equality Team and Patient and Carer Experience Team are working closely together on an ongoing basis through the operational and strategic equality forms.

- **New Complaints Handling Procedure:** An update was provided on the new procedure and process development and it was noted further engagement is underway with governance leads and senior nurse leaders. Implementation will begin during Q4 using a quality improvement approach.

- **Patient and Carer Experience Strategy 2021/2024:** There will be an overarching Quality Strategy in place with a Patient and Carer Experience Strategic Plan focussing on actions and 'so what'. Development is underway with the new strategies in place from April 2021.

- **Engagement Team:** Positive engagement activities undertaken at corporate and a more localised area level, working with communities and stakeholders to foster confidence, to help develop and improve services. This has been focused on key areas of strategy development, service improvements, strengthening partnerships and networks, and COVID -19 awareness and health advice. Other key campaigns that the Engagement Team are currently supporting include the restarting of key screening tests and the Test Trace Protect (TTP) programme. The Engagement Team has been working with the TTP programme leads in ensuring information and key messages are shared with as wide an audience as possible.

- **Healthcare Inspectorate Wales:** Significant activity over recent weeks – follow up visit took place in Emergency Department (ED) at Ysbyty Glan Clwyd (YGC), Tier 1 Quality Checks in ED at Ysbyty Gwynedd (YG), Quality Checks in Ablett Unit at YGC and follow up visit in Hergest. There will be reduced activity from Healthcare Inspectorate Wales (HIW) going into January recognising COVID pressures. HIW hold regular monthly meetings with the Associate Director of Quality Assurance and Executive Director of Nursing and Midwifery that support a valued working relationship

- **Bi monthly Patient and Carer Experience Report Oct-Nov 2020:** The report provides the group with assurance on the Health Board's work to improve patient

and carer experience. Excellent progress made on complaint performance, acknowledgement rates above national target and response rate now around 70% and nearly at the national target. The Letters to Loved Ones and PALS Bereavement Support Services were noted. An update was also provided on work to engage and support young carers.

- **Ombudsman Lessons Learned Report:** One report was presented which outlined the distress caused to families when given a delayed diagnosis. Representatives will take learning back to their services.

3. Achievement – include any significant achievements and outcomes

- Complaints have made a significant performance improvement, resulting in the best performance the Health Board has ever achieved.
- A patient and volunteer representative are now a member of the group, strengthening the external representation that has already been put in place over the year from the Community Health Council, HIW and CANIAD. A carer representative is in the process of being identified and a number of carers have an expressed an interest in becoming a member of the group.

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 15th January 2020
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health and Learning Disabilities (MHLDS) Division - Resubmission of Written Control Documents
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Iain Wilkie, Interim Director of MHLDS
Awdur yr Adroddiad Report Author:	Mrs Wendy Lappin, Mental Health Act Legislation Manager
Craffu blaenorol: Prior Scrutiny:	In accordance with the Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents (WCD), authors are responsible for ensuring that appropriate consultation has taken place with the relevant individuals and groups. Each WCD was considered by the Quality Safety Group (QSG) at the meeting held on 11th September 2019 with detail of prior scrutiny being set out on the respective title pages. The QSG was supportive of recommending each of the written control documents to the QSE Committee for approval. QSE Committee considered the WCDs on 24th September 2019 and requested further work be undertaken ahead of resubmission.
Atodiadau Appendices:	1. Written control document relating to Threats to Persons in Forensic Establishments 2. EQIA relating to Threats to Persons in Forensic Establishments 3. Written control document relating to Major Incidents (Ty Llewelyn) 4. EQIA relating to Major Incidents (Ty Llewelyn) 5. Written control document relating to Handcuffs 6. EQIA relating to use of Handcuffs

Argymhelliad / Recommendation:

The Committee is asked to:
1. Approve the amended written control documents for implementation.

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

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

Sefyllfa / Situation:

BCUHB has a statutory duty to ensure that appropriate written control documents are in place to comply with legislation, enabling staff to fulfil their roles safely and competently. The Committee, within the remit of its terms of reference, may consider and approve policies concerning Quality, Safety and Patient Experience matters.

Cefndir / Background:

Following generic feedback from the QSE Committee, the attached WCDs have been reviewed within the Mental Health & Learning Disabilities Division and formatting and typographical errors duly amended. In addition advice was sought from the Associate Director of Health and Safety, the Head of Security, the Violence and Aggression Case Manager and North Wales Police on the content of the WCDs and their views and comments are reflected in the attached versions.

Specific comments on each WCD have been incorporated as follows:

Handcuffs Policy

- The terminology used within the document is required to be in accordance with that used by allied agencies and training providers.

- In respect of clarification of scenarios and options the policy identifies when and why the use of handcuffs would be implemented.

- The use of handcuffs to facilitate escorted leave is on all occasions a pre planned action which involves the patient and staff members who have been identified to facilitate the leave. Identified staff will have undertaken approved handcuff training and the leave will be care planned and risk assessed accordingly to ensure the most appropriate escorts are identified taking into account any staff concerns.

Threats to the Person in Forensic Establishments Policy

- EQIA amended in regards to consistent reference to firearms act.

- The policy is not felt to require further review by the Occupational Health and Safety group as liaison and review have taken place and been have agreed with allied agency: North Wales Police. This is an existing policy which takes into account the potential risks associated with mentally disordered offenders.

Major Incident Protocol – Ty Llywelyn Medium Secure Unit

- With regards to referencing medium secure units, the policy refers to Ty Llywelyn in its title and within its body. The only other medium secure facility to be mentioned is that of the Spinney Unit which is the identified placement contained within the associated mutual Aid plan.

- In relation to contacting the matron ahead of contacting the police there is no mention of this within the document, however, implementation and escalation processes are clearly defined.

- With regards to security Ty Llywelyn is a registered Hospital run by Health Care professionals operating within a medium secure care environment, Security is the responsibility of all staff working within its parameters and this is reflected in unit policies and procedures. Whilst we liaise closely BCUHB security leads, North Wales police and the Ministry of Justice it is not felt that

links with alternative security providers are indicated in line with national medium secure standards.

- The policy is not felt to require further review by Health and Safety group as liaison and review have taken place and been have agreed with allied agency: North Wales Police. This is an existing policy which takes into account the potential risks associated with mentally disordered offenders.

Asesiad / Assessment & Analysis

Strategy Implications
WCDs support good governance.

Financial Implications
Authors have a responsibility to consider any training and resource implications that are identified as a result of implementation of the policy and to set out who is responsible for the training programme as documented within the Health Board's Policy on Policies.

Risk Analysis
Up to date and easy to follow policies and written control documents minimise risk to patients, visitors, employees and the Health Board

Legal and Compliance
WCDs help to ensure that statutory requirements, standards and regulations are understood, and provide a framework to monitor compliance.

Impact Assessment
Each of the WCDs have been subject to EQIA screening – copies of which are appended.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Version 4

MHLD 0008

Threats to the Person and Environment within Forensic Establishments Policy (Ty Llywelyn Medium Secure Unit)

Author & Title	Ian Jones, Security Lead Simon Allen, Clinical Operational Manager – Forensic and Rehab Services				
Responsible Dept / director:	Mental Health/Learning Disability Division				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval				
Date approved:					
Date activated (live):	April 2019				
Documents to be read alongside this document:	Ty Llywelyn Security Policy Ty Llywelyn Major Incident Protocol Fire Safety Policy Postal Packets Policy				
Date of next review:	January 2023				
Date EqIA completed:	April 2019				
First operational:	June 2016				
Previously reviewed:	Jan 2019				
Changes made yes/no:	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.

CONTENTS

1. Introduction/Overview

Ty Llywelyn is a medium secure unit which accommodating male patients between the ages of 18-65, usually detained under the Mental Health Act (1983). Patients in Ty Llywelyn are deemed to require secure conditions in order to manage the risk that they pose to themselves and the wider public and to manage the potential for absconding.

The nature and function of the service requires the Health Board to have a policy in place to ensure that staff are aware of the processes in place to enable them to deal effectively and safely with a number of high risk, threat situations.

2. Policy Statement

The policy exists to provide a framework for the management of specific high risk scenarios which would trigger the implementation of the Ty Llywelyn Major Incident Protocol (MIP). Although these are not the only circumstances in which the MIP would be activated they are the high risk scenarios which would give concern for immediate threat to life and limb within the unit.

3. Aims/Purpose

The policy will provide a framework to enable staff to deal effectively and safely with these scenarios.

4. Objectives

The policy will enable staff to recognise and respond to incidents which would trigger the implementation of the Ty Llywelyn Major Incident Protocol.

5. Scope

- All staff employed within Ty Llywelyn Medium Secure Unit.
- Forensic Psychiatric Service Management.
- BCUHB Senior Management

6. Roles and Responsibilities

The enactment and escalation of the policy remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit, Forensic Service Management and BCUHB Management group.

7. Main Body

a) VIOLENT DISORDER / RIOT SITUATION

Violent Disorder/riots are exceedingly rare occurrences. They can be spontaneous or pre-planned outbreaks of determined disruption to the service by persons(s) using violence and/or acts of destruction and can be dangerous to public, patients, staff, visitors and others. There may also be a financial implication when damage occurs to buildings and internal fixtures and fittings

Riot as defined by the Public order Act is defined as follows : Section 1 of the Public Order Act 1986 creates the offence of riot.

1(1) Where 12 or more persons who are present together use or threaten unlawful violence for a common purpose and the conduct of them (taken together) is such as would cause a person of reasonable firmness present at the scene to fear for his personal safety, each of the persons using unlawful violence for the common purpose is guilty of riot.

1(2) It is immaterial whether or not the 12 or more use or threaten unlawful violence simultaneously.

1(3) The common purpose may be inferred from conduct.

1(4) No person of reasonable firmness need actually be, or likely to be, present at the scene.

1(5) Riot may be committed in private as well as in public places.

As can be seen there is no requirement for a person of reasonable firmness to be present at the scene

Violent disorder is defined as : Section 2 of the Public Order Act 1986 creates the offence of violent disorder.
2(1) Where 3 or more persons who are present together use or threaten.

Violent Disorder/riots can be unpredictable and so it can be difficult to plan specific responses in advance. This protocol is concerned with the prevention and management of riot / serious disturbance and returning the unit to normal operation as soon and safely as possible should the situation occur.

Prevention

All threats and/ or intelligence in relation to patient disorder must be taken seriously and reported immediately to the most senior member of staff on duty. Such a situation requires full assessment and patients may need to be isolated and moved around the unit as required to minimise the potential of riot or serious disturbance.

Occasionally, individual patients may resist planned interventions, or may become disturbed in their behaviour and be thought to be at increased risk of violence due to mental state. This policy is not intended to provide guidance for managing inpatient violence or aggression that would normally be considered in the patients risk management plan.
Please refer to ‘Proactive Reduction and Therapeutic Management of behaviours which challenge’ Policy (MHLD 0049) for this guidance.

Management of Incident

In reporting any major incident which would necessitate the involvement of other Emergency services there is requirement to work in line with the JESIP Doctrine (Appendix 2)

Violent Disorder/riot is deemed to have occurred if:

- Individuals make a determined attempt to disrupt operation of the service, using violence and/or damage to property, to a level that puts the safety and well being of the public, themselves and/or others within the unit in jeopardy, or;
- Individuals threaten to breach security within or beyond the perimeter of the unit, and
- If It is beyond the resources of staff to restore safety and therapeutic milieu

Priority is to preserve the safety of as many people as possible by withdrawing from the immediate vicinity and directing non participating patients, staff and others to a safe area.

Staff must not engage if perpetrators are brandishing / purporting to or are suspected of possessing weapons.

The most senior member of staff within Ty Llywelyn (Incident Officer) must determine whether the incident requires the instigation of the Ty Llywelyn Major Incident Protocol and activate the Protocol accordingly.

Local intervention may be implemented to restore order when:

i. The incident is contained.
ii. There is no further risk of serious injuries.
iii. Non-participants are not trapped within the vicinity.
iv. Damage to the environment is not extensive and poses no public safety risk.

If the situation does not meet any of these criteria, and there is little prospect of local resolution the Ty Llywelyn Major Incident Protocol must be activated.

Post Incident Management

Account for all patients and staff and determine their wellbeing and whether medical or other assistance is required, provide clean area for patients to reside whilst staff carry out post incident procedures and are able to resume normal patient supervision, which may involve transfer to other areas.

Assess riot participants and determine care, treatment and placement needs (this may include police custody).

If the Ty Llywelyn Major Incident Protocol has not been initiated, staff may need to preserve evidence and photograph any damage. The area of the incident should only be cleared when given clearance from senior staff and following liaison with police and fire service.

Contact Estates to secure, remove or repair any unsafe items after damage has been recorded.

Arrange for senior staff to provide debrief sessions for staff and patients.

Ensure that all relevant documentation is completed and details of individuals involved in the incident are noted and made available to police. These will be collated by Senior Practitioner on the Unit. Statement taking when investigating a crime is the preserve of police given the possible gravity of the situations described. Any notes made by the staff group at the time must be declared to police.

Once police have relevant statements that they require then the Health Board can request statements for the internal investigation.

b) HOSTAGE SITUATION

Definitions

This document will adopt the following definition for hostage situations :'A person seized or held as security for the fulfillment of a condition'(Oxford English Dictionary): 'an incident in which a person is unlawfully held against his/her will, usually through the use of threats or when actual physical force is used'(Cambridge English Dictionary).Hostage Taking. A person ,whatever his nationality who in the United Kingdom or elsewhere a) Detains any other person ("The Hostage") and b) in order to compel a State international or governmental organisation or person to do or abstain from doing any act, threaten to kill, injure, or continue to detain the hostage.(Taking of Hostages Act 1982). The perpetrator of the act will be referred to as the 'hostage-taker' and the victim as the 'hostage'. It is also worth remembering that there could, in situations of this nature, be more than one hostage-taker or hostage.

General Principles

Should a hostage situation develop anywhere within Ty Llywelyn, it must be regarded as serious by all staff members and lead to initiation of the Ty Llywelyn Major Incident Plan.

First-on-Scene

This term refers to the person discovering a hostage situation and is a crucial stage in determining a successful outcome.

Resist the temptation to intervene verbally or physically as this may inflame the situation and endanger any hostages.

Upon being made aware of a hostage situation staff must notify the Senior Nurse on the unit immediately, await instructions, and not return to the incident unless instructed to do so.

The most senior member of staff must initiate the Ty Llywelyn Major Incident Protocol and identify an Incident Manager

Incident Management

Evacuate the immediate area quickly and quietly and ensure that all staff, service users and visitors are safe and accounted for.

The incident area and immediate surroundings should be designated a secure area.

For the course of the hostage situation, only key personnel should be allowed access into this area i.e. those who have a specific role or involvement in managing the incident. Staff must maintain safe distance from the hostage situation.

Non-essential staff, service users and visitors are not allowed in secure areas.

Once notified, the parameters of the secure area will be reviewed by the Incident Manager.

Observation
It is important to gather as much information as possible regarding the incident as this may help the police and Incident Manager in their overall strategies. Make a note of the following:

- What has happened?
- Who is involved; how many hostages or hostage takers are there involved. (Gender of all involved).
- Where they are.
- Any weapons or barricades involved.
- Any injuries, including the hostage-taker.
- The mental state and mood of the hostage-taker and hostage.
- Any evidence that drugs or alcohol are involved.
- Any relevant environmental factors such as damage to the building, wet floors etc.
- Any relevant physical medical conditions history (angina, pregnancy etc)
- Have the hostage takers issued any demands /reasons.

Other Staff
The following are important points for other staff to note:

- Do not attend the scene unless specifically told to do so.
- Respond to all delegated tasks quickly and calmly.
- Keep phone-lines clear – make only essential calls and keep them brief.

Post-Incident Process
Post incident process should be followed as per Ty Llywelyn Major Incident Plan and in line with the "Obligatory Response to violence in Health Care Documentation" (Appendix 3). This is the agreement between NHS Wales, Welsh Government, the Police and Crown Prosecution Service and other stakeholders.

c) DETECTION OF A FIREARM
Ty Llywelyn maintains a restricted items list (Ty Llywelyn Security Policy) in order to prevent contraband items from entering the premises. Firearms, naturally, are contained within the list of contraband items and it remains incumbent upon all staff to apply procedures rigorously to deter attempts to introduce a firearm via any route. This procedure and the secure structures at the perimeter of the unit constitute one aspect of the clinic's preventative measures.

For other preventative measures please view Ty Llywelyn Security Policy.

However unlikely a firearm incident may appear, staff must remain conversant with this policy and retain a working knowledge of the following procedures.

(i) **Action to be taken upon discovering a firearm within the unit.**

If it is safe to leave the firearm undisturbed, whilst preventing access to it by others, then the area should be preserved as a scene-of-crime for police investigation. During regular office hours The Clinical Operations Manger / Forensic Service Site Manager, On-Call Consultant should be contacted by the most senior staff member (Incident Officer) at the

scene for advice. Do not touch the firearm. In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational on-call guidelines.

If it is not safe to leave the firearm in situ, preserve the scene as best you can, remove the firearm to the Incident Officer who should ensure that the firearm is removed to a non-clinical area. Make no attempt to unload or “make safe” the weapon. Treat the firearm as if it is loaded and ready to fire. Do not carry it by the trigger or with fingers inside the trigger guard. If you can avoid touching the firearm you should, to preserve forensic evidence, e.g. by carrying it inside a plastic bag. Staff should be aware that ‘home-made’ firearms do not always present as conventional weapons and caution should be adopted around the discovery of suspicious devices.

If you cannot avoid touching the firearm, carry it by the barrel with the barrel pointed at the floor. Wherever possible, obscure the firearm from view e.g. wrapped in paper/material. Never insert objects i.e. pens, into the barrel/trigger guard to carry the firearm.

The Incident Officer or delegated other will contact the police, advise them a firearm is being held and their attendance at scene is required.

Discovery of ammunition should be managed in the same cautious manner.

(ii) **Action to be taken should a person be known / suspected of being in possession of a Firearm within the Unit.**

Contact the police by ringing 3333 and advise them that we have activated the Major Incident Protocol as a firearm has been detected or an individual is known or suspected of being in possession of a firearm.

Whenever the Major Incident Protocol is activated in the suspicion of firearm possession, Reception staff must be informed in order that they can facilitate Police access and limit unnecessary access to the unit.

Under no circumstances should the person be challenged nor any attempt made to encourage surrender of the firearm, nor to disarm them forcibly.

All other patients, visitors and staff should be removed from the vicinity of the individual suspected of being in possession of a firearm. Once the area has been evacuated, staff should leave the area, locking access doors behind them, creating a contained zone. The area should be vacated as calmly and covertly as possible.

Upon Police attendance at the Unit, the Incident Officer will appraise them as to events in the designated Incident Management Room.

Police should be advised of pertinent patient health issues that may have a bearing on their deployment and operation.

Unit staff will co-operate fully both during the incident, whilst re-establishing order and in related post incident investigations/criminal proceedings.

(ii) **Roles and Responsibilities**

For an outline of roles and responsibilities refer to core roles and responsibilities in Section 10 of the Major Incident Protocol.

d) EXPLOSIVE DEVICE THREAT/SUSPICIOUS PACKAGES

Explosive device threats whether genuine or 'false alarms' are regrettable hazards of modern living. The nature of Ty Llywelyn as a Medium Secure Unit renders it more likely to be the subject of an explosive device threat. It is Ty Llywelyn policy that all notifications of an explosive device are treated as genuine until such time they are demonstrated to be hoax/malicious.

Hoax/malicious phone calls reporting explosive devices are a criminal offence and as such must be reported to the police.

Calls reporting explosive devices fall in to two categories:

- Threats where no device has actually been planted:

Such hoaxes may not be merely malicious and consideration must be given to them being an attempt to test security, disrupt or create diversion.

- Threats warning of a genuine device:

These may be attempts to avoid casualties but they also enable individuals to blame others in the event of injury.

Genuine threats are frequently inaccurate with regard to where and when a device may explode and staff receiving a telephone threat may not be trained in respect of such calls. While staff may be unable to assess a threat, accuracy or origin their recall and impressions of the caller could be important.

It is acknowledged that receiving such a threat may have an adverse affect on staff members who may require counseling /additional support following the incident.

Explosive device threats must be taken seriously taking in to account the service provided and security/safety implications for patients, visitors and staff.

(i) **Primary Aims and Objectives**

- To ensure the safety of patients, visitors, staff and general public
- Inform Emergency Services
- To maintain Unit security
- To identify/discount the threat at the earliest opportunity
- To return the Unit to normal operation as soon as is safely practical

(ii) **On receipt of a Telephoned Threat**

During regular office hours The Clinical Operations Manager/Forensic Service Site Manager, On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward. In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.

It is important to gain as much information from the caller as possible. Do not interrupt the caller; try to keep him / her talking. Staff should complete **EXPLOSIVE DEVICE THREAT-TELEPHONE CALL INFORMATION SHEET** (Appendix 1)

a) Sex and approximate age of the caller
b) The tone of voice (deep, soft, slurred, intoxicated, angry, happy, nervous, confident)
c) Any specific characteristics (accent, speech impediment, unusual pronunciation)
d) Background noises (traffic, machinery, music)
e) Nature of call / coin box whether caller number displayed (phone 1471 for caller ID)
f) Did the voice sound familiar?

(iii) **Try to engage the caller in conversation by asking the following questions:**

a) Where has the device been placed?
b) When will it explode?
c) What does it look like?
d) What type of explosive is it?
e) Why has the device been placed here?
f) Attempt to get the caller/ organisation name

(iv) **Follow on actions**

a) Note the time of the call
b) Telephone Police using 3333 giving details of the call/ Activate Ty Llywelyn Major Incident Protocol
c) Ring 1471 (If the telephone has that facility) or contact switchboard to attempt to trace caller number
d) During regular office hours The Clinical Operations Manager, Forensic Service Site Manager On Call Consultant should be contacted by the most senior staff member (Incident Officer) in Reception/on the Ward .In the event of the incident taking place outside of regular office hours the Incident Officer will contact the Bronze on-call as per organisational guidelines.
e) Evacuate the area by activating fire alarm system and carry out the evacuation procedures as for fire

(v) **Letter Bombs / Parcels**

Such devices could be delivered through normal postal services (Royal Mail, Courier) or by hand.

(vi) **Staff suspicions may be aroused by:**

a) Weight - If excessive for size and apparent contents
b) Grease marks on the wrapping exterior i.e. Seeping from inside the package

(vii) **If suspicions cannot be alleviated:**

a) Do not attempt to open or tamper with the package/letter.
b) Inform the police immediately/Activate Ty Llywelyn Major Incident Protocol
c) Evacuate the area using fire alarm procedure.
d) Do not use Unit Radios/Pagers/Mobile phones within 30 metres as this could lead to device detonation.

8. Training

The importance of training cannot be over emphasised in terms of amelioration of the risk of threats to individuals within Forensic settings. It is recognised that the nature of risk can be fluid and therefore training and update of all staff is essential. This will be achieved through initial induction training and annual unit staff update as a facet of the in house Ty Llywelyn training plan.

9. Audit

Annual audit will be undertaken through review of unit training records and DATIX incidents relating to threats towards the person in Forensic Establishments i.e. Ty Llywelyn.

10. Review

Every three years.

11. Appendices

APPENDIX 1

EXPLOSIVE DEVICE THREAT TELEPHONE CALL INFORMATION SHEET

(Please retain in Reception/Ward Offices)

Date……..

Time Call Received…….hrs

Time caller hung up…….hrs

Exact words used by caller:
……
……
……
……
……
…….....

Questions to ask:

Where has the device been placed?

……

…….....

When will it detonate?.....(date/time)

What does it look like?

.....

What kind of explosive is it?

.....

Why did you place the device here?

.....

Name of caller/ Organisation involved

.....

DESCRIPTION OF CALLERS VOICE

Male/Female (Please circle)

Approximate age:

Young……. Middle Aged…… Elderly……

Tone of voice (deep, soft, slurred, intoxicated, angry, laughing, nervous, confident)

.....

.....

.....

Any special characteristics (accent, speech impediment or unusual pronunciation)

.....

.....

Background Noises (traffic, machinery, music)

.....

.....

.....

Call from a call/coin box and telephone number if shown on your telephone display screen:

.....

.....

.....

Did the voice sound familiar?

.....

If so who did it sound like?

.....

.....

.....

Give a summary of anything peculiar that you may have sensed or thought of during the call. Although it may not seem significant it could be of great value when associated with past or future calls of this nature.

Remarks:

.....

.....

.....

.....

.....

.....

Senior Staff Informed (Clinical Operations Manager, Forensic Service Site Manager, Consultant on Call, Bronze on call)

Details:

.....

.....

.....

Time Informed……..hrs

Person receiving threat phone call:

.....

(If necessary please use other side for additional info)

APPENDIX 2

There is requirement for Emergency services to work in line with the JESIP Doctrine, as this is the manner in which all the Emergency services report and respond to major incidents. For example the METHANE format should be utilised in reporting an initial incident so as to give clarity of the type and nature of the incident

Appendix 3

Obligatory Response to violence:

http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/3127212%20-%20Abridged%20version%20of%20AVC%20with%20updated%20signature%20page%20%28HEIW%29.pdf

www.nwssp.wales.nhs.uk/sitesplus/documents/1178/Part%20Two%20and%20Part%20Three%20of%20Final%20AVC%20Doc%20.pdf

- **References**

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice 2008
The Mental Health Act Reference Guide 2008

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	Title
Simon Allen	Clinical Operational Manager – Forensic and Rehab Services
Lisa Jones	Clinical Site Manager - Forensic
Ian Jones	Practice Development Nurse/Security Lead
Greg Yates	Ward Manager
Steve Roscoe	Health and Safety
David Baker	Violence and Aggression

Engagement has taken place with:

Name	Title	Date Consulted
North Wales Police		January 2019
Ty Llywelyn Staff		January 2019
BCUHB Fire Officer		January 2019

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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.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

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Part A

Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Threats to the Person Procedures in Forensic Establishments	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.	
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?	Forensic Mental Health Service Management Team	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	Name	Title/Role
		Simon Allen	Clinical Operations Manager - Forensic and Rehab
		Ian Jones	Practice Development Nurse
		Lisa Jones	Modern Matron
5.	Is the Policy related to, or influenced by, other Policies/areas of work?	'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013) National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RPsych 2010) Firearms Act 1968(The Firearms Actmakes it an offence for any individual to have unlawful posession of a firearm).	

6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

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 (3) any other information that has informed your assessment of Potential Impact.
	Positive (**+**) Negative (**-**) Neutral (**N**) No Impact/Not applicable (**N/a**)	Scale (see Table A on next page)	
Age	(N)	Neutral (N)	Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy.
Disability	(N)	Neutral (N)	Disability will be taken account of for patients, staff and others by way of regular risk assessment if an indivudal in the environment to which the policy applies has a disability which requires adjustments to be made.
Gender Reassignment	(N/a)	Neutral (N)	N/A
Pregnancy & Maternity	(N/a)	No impact/Not applicable (N/a)	Any pregnant women working in the environment to which the policy applies will have an up to date risk assessment in place.
Race / Ethnicity	(N)	Neutral (N)	An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy this policy. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account as far as is safe and practical to do so.

Religion or Belief	(N)	Neutral (N)	There is a risk that implementation of this policy might result in triggering of the Ty Llywelyn Major Incident Plan. This might in turn might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which this policy caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident. Any disruption to the environment which has an impact upon any individals ability to adhere to the customs of their faith will be managed accordingly to allow for worship as soon as is safe. The ability to adhere to principles of faith during an incident where security is acutely compromised cannot be guaranteed.
Sex	(N)	Neutral (N)	The in patient unit currently has single sex facilities only but during implementation of this policy we cannot guarantee that any change in the environment in which the individual is temporarily cared for will be single sex.
Sexual Orientation	(N/a)	No impact/Not applicable (N/a)	Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the policy.
Welsh Language	(-)	Low positive (+)	The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of this policy we cannot guarantee that a change in the environment in which the individual is temporarily cared for may not comply with the Welsh Language Act.
Human Rights	(N)	Neutral (N)	Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice.

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 the table below 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.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

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	The policy is designed to protect vulnerable individuals from incidents which present immediate risk of harm to life and limb. The Firearms Act 1968 makes it an offence for any indivdual to have unlawful possession of a firearm. Regardless of age, gender, religon, disability, sexual orentation, race and ethinicty no individual is exempt under UK Law.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	N/A

3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	It provides an approach that strengthens the concept of co-working and collaboration between different partner organisations to ensure achieving a common aim of patient and public safety and security.

Part B:

Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Threats to the Person Procedures in Forensic Establishments

2. Brief Aims and Objectives:	A policy which ensures that incidents related to Violent Disorder/Riot Situations, Hostage Situations, Detection of Firearms, Explosive Device Threats/ Suspicious Packages within Ty Llywelyn Medium Secure Unit are safely and efficiently addressed.

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes ☒	No ☐
3b. Could any of the protected groups be negatively affected?	Yes ☒	No ☐
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes ☐	No ☒

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
	Record Reasons for Decision i.e. what did the assessment of scale on Form 2 indicate in terms of positive and negative impact for each characteristic? There may be an impact upon the ability to care for people through the Welsh language as the Mutual Aid acute dispersal plan which could be activated if the Major Incident Plan is triggered indicates that patients will be moved to a hospital in England whilst Ty Llywelyn in out of use. BCUHB will endeavour to send Welsh speaking staff with these patients wherever it is possible to do so and will prioritise this issue.	

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes ☐	No ☒	Not applicable ☐
	Record Details:		

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?	Robust multi agency debriefing process post incident
	Who is responsible?	
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	December 2021

7. Where will your decision or policy be forwarded for approval?	BCUHB Board Level

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	Distribution of policy for comment to MH/LD Division BCUHB / North Wales Police / BCUHB Fire Officer

	Name	Title/Role

9. Name/role of person responsible for this Impact Assessment	Simon Allen Ian Jones	IService Manager Practice Development Nurse
10. Name/role of person approving this Impact Assessment	Statutory compliance committee	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

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:			
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?			
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?			
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.			

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

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Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

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Betsi Cadwaladr
University Health Board

Version 6

MHLD 0009

MAJOR INCIDENT PROTOCOL
TY LLYWELYN MEDIUM SECURE UNIT

Author & Title	Ian Jones, Forensic Security Lead Simon Allen, Clinical Operational Manager – Forensic and Rehab Services
Responsible dept / director:	Director of Mental Health & Learning Disability Division
Approved by:	MHLD Policy/Procedure Group – 27 August 2020 MHLD Divisional Senior Leadership Team Quality Safety and Experience Group – 17 September 2020 QSG – QSE -
Date approved:	August 2020 as draft whilst progressing through Health Board processes
Date activated (live):	May 2019
Documents to be read alongside this document:	• Ty Llywelyn Mutual Aid Agreement • Forensic Service Business Continuity Plan • Ty Llywelyn Operational Policy • Ty Llywelyn Security Policy • Fire Procedure • Threats to the Person in Forensic Establishments Policy
Date of next review:	August 21
Date EqIA completed:	January 2019

First operational:	2014				
Previously reviewed:	May 2019				
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.

CONTENTS

1. Introduction/Overview

Clinical services for mentally disordered offenders in North Wales are provided by the Forensic Mental Health Services.

Ty Llywelyn is a 25 bedded purpose-built Medium Secure Unit on the Bryn y Neuadd Hospital site, Llanfairfechan.

The Unit provides assessment, treatment and rehabilitation for patients who, with the appropriate balance of care, are considered likely to recover and ultimately return to their own communities.

Referrals are taken from a variety of sources including the generic Mental Health Services, Criminal Justice System, Prison Services, Special Hospitals and Social Services.

The care and treatment of every patient is planned and regularly reviewed by a team which includes Consultant Psychiatrists, Nurses, Social Workers, Therapists and Psychologists.

The standards for Medium Secure Units (MSU)'s specify that all Units should have contingency / major incident protocol, and that this must be agreed with the Police and other Emergency Services covering as a minimum Hostage Taking, Serious Disorder, Riot and Escape (NICE 25, Ty Llywelyn Threats to the Person in Forensic Establishments Policy). The purpose of such a protocol is to ensure the safety of patients, visitors, staff and others in addition to:

- Maintaining security
- Discovering or discounting the threat at the earliest opportunity
- Returning the unit to normal routine as soon as safely possible
- Assisting the Police in establishing the origin of the threat

2. Protocol Statement

The Major Incident Protocol provides BCUHB with the framework for the most effective response to significant incidents and adverse circumstances which have the potential to occur within the secure in-patient environment of Ty Llywelyn Medium Secure Unit. It also guides the organisation through the crisis response phase of a major incident and towards the implementation of a Business Continuity and Service Recovery Plan.

3. Aims/Purpose

The Major Incident Protocol (MIP) is aligned to a series of procedures as cited in Threats to the Person and Environment in Forensic Establishments Policy. These are specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn that have the potential to occur. These scenarios could include, amongst others:

1. Fire
2. Hostage
3. Bomb threat
4. Firearms
5. Violent Disorder / Riot
6. High risk absconsion

These scenarios have their own specific procedures to confirm and direct action appropriate / specific to the nature of the scenario. These all dovetail the Major Incident Protocol (MIP), which acts as the overarching protocol for the co-ordination and management of any Major Incident Scenario. The MIP provides a framework for the most effective response to the above scenarios plus any additional scenarios that would render the entire MSU or part thereof uninhabitable to inpatients and unsuitable for staff occupation. The management of any scenario or type of major incident with the MIP will be in accordance with available resources and aim to ensure the most prompt return to normal operational status and practice. In order to ensure a response appropriate to the nature of the Major Incident and in acknowledgement of the variance between the above scenarios, the various agencies and departments with a role and function sign up to 'Memorandums of Intent' and in doing so they commit to the details within the Protocol ensuring the safety of both MSU patients and members of the public, thereby maintaining an effective and fast response to the major Incident situation.

The MIP advises partner agencies and organisations of the MHLD Divisions responsibilities, protocols and specific procedures for co-coordinating a response to a Major Incident. These partner agencies include Welsh Government, Health Care Inspectorate Wales (HIW), Welsh Health Secure Services Commission (WHSSC), neighboring general hospitals and mental health units, Local Authorities and Emergency Services.

4. Objectives

The document provides the framework for a safe, effective coordinated response to a major incident occurring within Ty Llywelyn Medium Secure Unit and where the transfer of patients to appropriate alternative accommodation indicated

5. Scope

The document relates to all staff employed within Ty Llywelyn Medium Secure Unit, the Forensic Service Management team and BCUHB senior management.

6. Roles and Responsibilities

The enactment and escalation of the protocol remains the responsibility of staff employed within Ty Llywelyn Medium Secure Unit, Forensic Service Management and the wider BCUHB management group.

7. Major Incident Plan

7.1 Prevention

The above events are extremely rare occurrences within MSU's. Ty Llywelyn operates as a secure environment in line with Royal College of Psychiatry Minimum Standards for Medium Secure Units which include:

- A physical environment incorporating security features such as perimeter fencing, locked areas and external/internal CCTV.
- A high level of security awareness and relational security training amongst staff.
- Detailed pre-admission assessments highlighting prior risk of offending behaviour.
- Comprehensive multi-disciplinary individual patients risk assessments.
- Appropriate levels of observation whilst patients are both within the MSU and the community.
- Provision of high quality patient care in line with the Mental Health Measure (Wales).
- Fostering a positive culture between staff and patients in which patients can feel influential over their care and the environment.
- Adequate staffing levels.
- Adherence to local and organisational policies and procedures.

7.2 Categorisation of Incident

An incident within the secure perimeter of the MSU resulting in the entire loss of the clinical environment and requiring the immediate safe transfer of all patients is categorised as a **CLASS A INCIDENT.**

An incident within the secure perimeter of the MSU, that results in only a partial loss of the clinical environment and may require the safe transfer of some of the patients to alternative temporary accommodation is categorised as a **CLASS B INCIDENT**.

7.3 Categorisation of Patient

MSU patients present various levels of risk, which, in association with the legal requirements for safe custody of all patients will necessitate the need for a clear classification system to denote the risk profile for each patient. This specific risk profile will exist only for the purposes of the MIP and will not be used to assist day to day clinical management of the patient population.

It is the responsibility of the Responsible Clinician / Multi-Disciplinary Team to establish each patient's risk profile which will be recorded in the patient's notes and in the Unit Major Incident Plan Folders, which are held with the unit Coordinator file and in Ty Llywelyn reception. Catagorisation will take place prior to admission to Ty Llywelyn and be reviewed and recorded in clinical notes fortnightly at the Clinical Team Meeting.

Category 1 Patients
This group of patients would be those most likely to abscond, be detained under a restriction order, have no leave outside the unit or whose mental state would be seen as currently having deteriorated to such a degree as to pose a high risk. Included in this category would be patients on trial leave from high secure hospital and prisoners transferred to hospital for assessment also patients where there has been a high level of media attention or issues of sensitivity relating to their offence. This group will require a highest level of security in transfer to any temporary placement alternative appropriate custody.

Category 2 Patients
This group of patients would be those who would require close monitoring, may be subject to restriction orders and have some degree of escorted leave outside the unit. Some of these patients could be accommodated temporarily in alternative appropriate accommodation. This may include a Psychiatric Intensive Care (PICU) placement or alternative medium or low secure placement.

Category 3 Patients
This patient group would be at a stage where they already have unescorted grounds / community leaves and, as such, are deemed a lower risk. These patients would be able to be grouped together to enable their movement to temporary accommodation with a much reduced escorting resource and might typically be placed within an open acute ward within the Division or a psychiatric rehabilitation unit. Some of these patients may have commenced their graduated discharge plans to areas of lesser security and, with MOJ permission; these patients could be temporarily advanced to the appropriate placement.

7.4 Transfer and Conveyance

The MOJ must be contacted and provided with details of detained patients under Court Section, together with the location where these patients are to be temporarily detained. The MOJ will then give verbal authorisation and if necessary confirmation via email to the effect that a Warrant has been issued for the transfer of such patients to the alternative appropriate environment. The MOJ has a 24 hour telephone number (0300 303 2079).

Patients should be grouped according to their categorisation status with the first consideration being to move Category 1 patients securely and safely off the premises to their temporary accommodation.

These patients will be given priority by MSU Staff, Police and additional Emergency Services in attendance and, wherever practicable, will be placed in health vehicles for safe transfer.

Category 2 and 3 Patients can then follow supported by remaining MSU staff and Emergency Services until all Patients have been safely evacuated from the Unit.

Should a decision be made to transfer a patient by emergency service vehicles, MSU staff will remain in attendance as a health escort unless otherwise indicated by emergency services risk assessment.

Patients being transferred out of Ty Llywelyn MSU to temporary alternative appropriate environments will be supervised by Ty Llywelyn staff wherever necessary. Observation levels need to be maintained in line with individual Patient's Care and Treatment Plans / MHM documentation.

The care of transferred detained Patients from the MSU remains the responsibility of the MHLD Division / BCU, even if in temporary Police custody or an alternative public sector or private secure environment. (See Mutual Aid Agreement)

Staff will ensure that appropriate vehicles will be used dependent on level of risk; the division has agreed all available vehicles will be handed over. Ty Llywelyn Community Team pool car keys are held in the upstairs team office in Ty Llywelyn.

7.5 Activating Major Incident Protocol

In reporting any major incident which would necessitate the involvement of other Emergency services there is requirement to work in line with the JESIP Doctrine (Appendix 7).

The MIP will be activated by telephoning the Emergency Services via 3333 stating that the 'Major Incident Protocol' needs to be activated for the Ty Llywelyn MSU because of:

- Fire
- Hostage
- Bomb threat
- Firearms
- Violent Disorder / Riot
- High Risk Absconsion

The caller should identify themselves providing their name & role, contact details of the Major Incident Officer and Communications Officer on site at that time. They should then request that the Force Incident Manager (FIM) initiate a response in line with the agreed MIP and JESIP Principles. This will enable the emergency services to recognise the call as:

- Genuine
- Of Serious Nature
- Requiring a pre-agreed response
- Necessary to ensure public protection

The emergency services will set into motion appropriate responses according to the incident type which may result in the deployment of police officers and other emergency services as necessary, to the MSU in response to the incident.

The strategies required of the Police / emergency services and Ty Llywelyn staff will be different for each specific type of Incident and are described under the separate procedures for each incident. These should be read and followed in conjunction with the MIP once the Major Incident Protocol has been activated. MSU staff should cross reference between documents as applicable.

Awareness of the content of the MIP is not sufficient in preparation to deal with each of the six types of incident listed above. All MSU staff needs to maintain a high level of awareness of the content of each of these separate procedures in addition to the Major Incident Protocol.

7.6 Stakeholder Responses

In the event that Police intervention is required, the authority to act will be determined by the North Wales Police Command and Control Structure.

In all cases of a major incident, the relevant emergency service (in accordance with incident type) may deploy to Ty Llywelyn MSU, but will not automatically take charge of the incident or Unit. There are many areas where the emergency services can assist in restoring control of an incident without taking direct action or being the lead responsible agency.

Upon an emergency service undertaking the role of lead agency, they must first be granted permission to intervene by the MHLD Division / BCUHB. Control of the unit will be signed over to emergency services by the most senior member of staff at the scene. This document is to be retained by the relevant emergency service which 'signs over' the unit to them allowing emergency services to enter and take the required action (Appendix 2). Prior to signing over the unit, the MHLD Division retains responsibility for events within the unit. A similar process and document needs to be signed upon conclusion of a major incident to confirm that control and responsibility has reverted back to the MHLD Division.

7.7 Major Incident Room

A Major Incident room should be established as soon as the MIP is activated. The location of the room will depend upon the extent of any damage to the MSU, risk to staff or need to locate the room elsewhere, e.g. on the Bryn y Neuadd Site or another location The location of the room will be determined by the Incident Manager.

In the event of a Category A Major Incident affecting the whole of the MSU, the switchboard function, which operates from the Unit for the Bryn Y Neuadd site, would be transferred to another District General Hospital. The telephone number for the unit would be 01248 682101.Once the Major Incident Room is established, the main phone contact number must be communicated to all agencies. If mobile phones are required the ward mobiles can be collected from reception and used.

7.8 Roles and Responsibilities

There are two Major incident files which are held in the Unit Coordinator Folder and Ty Llywelyn Reception. These files contain information essential to the management and coordination of incidents.

The roles and responsibilities of specific individuals within the MIP are contained within Role Cards (Appendix 1). These will be held within the Major incident files.

First on Scene
The role and responsibility of the first on scene is:

- Preservation of life, safety and security.
- Activation of internal alarm systems.
- To advise the person in charge of the unit and take instruction.

These main roles are:

Major Incident Officer
Take charge of the incident and establish a structured management plan in relation to the incident.

Staffing Coordinator
Support and deploy staff as directed by the Major Incident Officer.

Communications Officer
Ensure effective communication links across all agencies; carry out briefings as directed by the Major Incident Officer. Communications Officer must liaise with the BCUHB Press Officer Communications Lead for Mental / Learning Disability division. Brief and update staff of the requirement to maintain confidentiality as per BCUHB policy due to potential press / media interest.

7.9 Post Incident & During

Once the major incident has been brought under control arrangements will be made to ensure the MSU can return to its normal operational function at the earliest opportunity. Staff will be briefed as to timescales, any interim arrangements and adjustments specific to MSU patients temporarily located elsewhere and the impact on their roles, shifts and base.

Staff may be required, on a temporary basis, to work at another location within or outside BCUHB and will be supported by line managers to facilitate this. Staff will be expected to engage with any associated investigation indicated in the aftermath of a Major Incident. Staff will be supported by line managers and appropriate BCUHB Workforce and Organisational Development Department (WODD) who will give advice, guidance and support as necessary.

Anyone involved in a major incident may suffer the impact of trauma and stress, including professionals and patients. De-briefing allows for an assessment of the potential impact to be considered and following this Initial Impact Assessment the MHLD Division in association with Partner Divisions, WOD and the BCUHB Health at Work Department will develop and provide a programme of counseling and support in response to identified need.

7.10 Staff Awareness

It is the responsibility of all staff working within the North Wales Forensic Service to evidence appropriate knowledge and awareness of the MIP and associated specific procedures for various incidents

7.11 Mutual Aid Plan

Any activation of the MIP might require the instigation of the Mutual Aid Plan. The Clinical Operations Manager / Forensic Service Site Manager or senior clinician will confirm activation of the Mutual Aid Plan.

8. Equality including Welsh Language

An EQIA has been completed.

There is a risk that the implementation of the plan might result in an individual being temporarily cared for in an environment which might not address their immediate religious/faith needs. The nature of major incidents to which the plan refers means a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.

The organisational commitment to supporting the Welsh Language Act and service user language preferences are identified through assessment and care and treatment planning. However during implementation of the Major Incident Protocol it cannot be guaranteed that a change in the environment in which the individual is temporarily cared for may comply with the Welsh Language Act.

Application of this pathway will take in to account:

- Mental Health Measure(Wales 2010)
- Revised Adult Mental Health Services National Frame work
- Guidance for the Commissioners of Forensic Mental Health Services (2013)
- National Policing Improvement Agency Guidance on Command and Control
- Minimum Standards for Medium Secure Units (RPsych 2010)
- Mental Health Act 1983
- Code of Practice for Wales 2016
- Human Rights Act 1998
- Mental Capacity Act 2005-Code of Practice
- Deprivation of Liberty Safeguards-Code of Practice

9. Resources

- Mutual aid agreement between BCUHB and The Spinney
- Ongoing in house staff security training.
- Ongoing liaison with Emergency services/partner agencies

10. Training

Ongoing in house staff security training takes place during staff induction and annually as part of security update training.

Training is coordinated by Forensic Service Site Manager/Unit Security Lead.

11. Implementation

The Major Incident Protocol (MIP) is aligned to a series of in house procedures/protocols specific to the various serious and high risk scenarios with the specific patient population managed at Ty Llywelyn.

The document will be implemented when a high risk scenario occurs within Ty Llywelyn Medium Secure Unit, namely:

- Fire
- Hostage situation
- Explosive Device/Suspicious package
- Detection of a firearm
- Violent Disorder / Riot
- High Risk Absconsion

12. Further Information - Clinical Documents

- Ty Llywelyn Operational Policy
- Ty Llywelyn Security Policy
- Fire Procedure
- Threats to the Person in Forensic Establishments Policy -
  (Hostage situation)
  (Explosive Device /Suspicious package Detection of firearms)
  (Violent Disorder / Riot)
  (High Risk Absconsion)

13. Audit

An audit will take place annually as a facet of the training review.

Ward Managers and Forensic Service Site Manager retain the responsibility to ensure staff receive training and update in respect of the situations and processes pertaining to the implementation of the Major Incident Protocol within Ty Llywelyn
It is envisaged that in the implementation of the Major Incident Protocol formal review of the processes would take place.

14. Review

Review will take place on a 3 year basis.

15. References

The Mental Health Act 1983 as amended by the Mental Health Act 2007
The Code of Practice for Wales 2016
The Mental Health Act Reference Guide 2008

16. Appendices

Appendix 1 – Role Cards

MAJOR INCIDENT OFFICER	MAJOR INCIDENT ACTION CARD 1
Normal Role	Will always be the most senior member of staff at the location when an incident occurs. The role of Major Incident Officer may be handed over to a more senior member of staff at any time during the incident.
Major Incident Role	Establish the incident control room
	To lead the major incident control team
	Coordinate strategic response to an incident until such time that the On-call Command and Control procedures are in place at the scene
The Major Incident Officer will take charge of the incident and establish a structured manner in which to manage the incident in conjunction with emergency services	

Essential Actions

- Establish a major incident room as soon as the MIP is activated.
- Collect major incident File of which there are two which are held in the Unit Coordinator Folder and Ty Llywelyn Reception. These files contain information essential to the management and coordination of incidents.
- Clarify with first on scene that contact with police has been made with Police by telephoning the Emergency Services via 3333 / 999 emergency number and that the Force Incident Manager has been instructed that the 'major incident protocol' needs to be activated.
- Appoint staff to the required roles of Staffing Co-ordinator and Communications Officer.
- Implement and adhere to the procedures specific to the nature of the major incident as each requires a variable response.
- Brief Police and other emergency services on their arrival and ensure that the Staffing Co-ordinator facilitates the establishment of respective emergency services 'Mobile Control Posts' and any casualty clearing stations and ambulance loading areas if necessary.
- If required, adhere to Division agreements for the authorisation of immediate expenditure as required.
- Following the conclusion of a major incident the Major Incident Officer should seize and secure any documentation generated by Health Board staff during the course of the incident.
- The Major Incident Officer should complete a Datix report outlining the course of the events and indicating where all evidential / seized documentation are located to assist with further investigations.
- Brief emergency services on issues relating to the layout of the building, patient / staff locations and assist in the creation of a dynamic operation risk assessment.
- Collate all relevant clinical documentation which will inform stakeholders in relation to clinical presentation, risk and legal status of the patient population.
- Ensure that Communications Officer has established links with the Ministry of Justice.

STAFFING CO-ORDINATOR	MAJOR INCIDENT ACTION CARD 2
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	To deploy staff to appropriate areas as directed by Major Incident Officer / Incident Control Room
	To ensure that the whereabouts of all responding BCUHB staff are known at all times
The Staffing Co-ordinator will ensure that the responding staff carry out all directions with unified approach, and act in accordance with guidance given by emergency services.	

Essential Actions

- Support and deploy staff in association with Major Incident Officer to ensure appropriate levels of clinical supervision are provided for patients being transferred or re-located.
- Assess staff in relation to skill mix, their location during initial incident response and the co-ordination of staff both entering and leaving the incident area.
- Assess the need for additional staff including relief staff, staff re-deployment or central nursing agency staff.
- Consider issues relating to staff welfare including; breaks, meals and if required transportation and accommodation.
- Arrange any necessary patient transfers in association with the Major Incident Officer.
- Ensure staffing deployment is in-line with the procedures specific to the nature of the major incident as each requires a variable response.

COMMUNICATIONS OFFICER	MAJOR INCIDENT ACTION CARD 3
Normal Role	Always allocated by the Major Incident Officer
Reports To	Major Incident Officer / BCU Command & Control
Major Incident Role	Ensure good communications across a wide range of agencies
	Maintain a comprehensive, contemporaneous chronology of events.
Communication in the event of a major incident should be expected to be extremely difficult. It is important that the communications officer is able to identify, prioritize and maintain essential lines of communication.	

Essential Actions

- Contact the Ministry of Justice at the earliest opportunity and inform them of the potential need to re-locate patients due to a major incident.
- Brief senior staff as required; including BCUHB Command and Control staff (Bronze, Silver and Gold On-Call)
- Assist Major Incident Officer to brief emergency services.
- Prepare responses to internal queries from partner agencies.
- Liaise with commissioners as applicable.
- Arrange for immediate supply needs to be met.
- Divert Press & Media enquiries to Senior Management Team. Liaise with BCUHB Press Officer Communications Lead for Mental / Learning Disability division.
- Maintain a comprehensive, contemporaneous chronology of events to include:

    - All telephone communications, incoming and out-going.
    - Verbal and non-Verbal communications.

These are critical roles in the event of a major incident and require knowledge and understanding of the Major Incident Protocol, the different areas of Ty Llywelyn the Health Board and of individual staff responsibilities. The roles must be established early in the event of a Major Incident being declared and handed over to an appropriate senior staff member when available.

Appendix 2 – Operational Handover Document

HANDOVER PROCEDURE TO BE USED IN THE EVENT THAT FULL OPERATIONAL CONTROL OF THE UNIT NEEDS TO BE HANDED OVER THE A REPRESENTATIVE FROM THE EMERGENCY SERVICES	
BCUHB ROLE :	
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
HANDED OVER TO :	(e.g. North Wales Police)
NAME :	
TITLE :	
DATE :	
TIME :	
SIGNATURE :	
REASON FOR HANDOVER :	
UNIT SIGNED BACK TO BCUHB VIA: (STATE PERSONS NAME / TITLE)	
SIGNATURE:	
DATE:	
TIME:	

Appendix 3 –Ty Llywelyn Major Incident Communications Log

DATE	TIME	COMMUNICATION TYPE (email etc)	MADE BY	MADE TO	DESCRIPTION
EXAMPLE 12/4/2019	18:00	Telephone	J. Smith (Incident Officer)	North Wales Police	Report Major Incident and detail discussion

THIS DOCUMENT MUST BE RETAINED AS EVIDENCE UPON THE CONCLUSION OF THE INCIDENT AND HANDED TO THE MAJOR INCIDENT OFFICER AND POLICE

Appendix 4 – Conveyance Matrix

MAJOR INCIDENT PROTOCOL – EVACUATION & MOVEMENT MATRIX

EVACUATION LOCATION CODE →	RED	AMBER	GREEN
DETAILS OF PREFERRED / COMPULSORY EVACUATION DETAILS AND ESSENTIALS ACTIONS	WHENEVER POSSIBLE THE PATIENT SHOULD REMAIN IN TY LLYWELYN MEDIUM SECURE UNIT THE PATIENT MUST ONLY BE MOVED IN SECURE TRANSPORT. THE PATIENT MUST NOT BE TRANSPORTED IN THE COMPANY OF OTHER PATIENTS. THE PATIENT WILL BE MOVED NON-STOP TO AN ALTERNATIVE SECURE ENVIRONMENT WHICH MAY INCLUDE:- ALTERNATIVE MEDIUM SECURE UNIT. IF APPROPRIATE RETURN TO HIGH SECURITY OR PRISON NO PATIENT ASSESSED BELOW CATERGORY 1 WILL BE EVACUATED TO A RED LOCATION OTHER THAN A MEDIUM SECURE UNIT CONSIDERATION MUST BE GIVEN TO POTENTIAL USE OF HANDCUFFS DURING TRANSFER	CONSIDERATION TO BE GIVEN TO THE PATIENT REMAINING IN TY LLYWELYN MEDIUM SECURE UNIT. THE PATIENT CAN BE MOVED IN BOTH SECURE AND NON-SECURE TRANSPORT (WITH CONSIDERATION GIVEN TO ESCORTS). WHEN APPROPRIATE THE PATIENT CAN SHARE TRANSPORT, DEPENDENT ON CLINICAL RISK ETC. THE PATIENT CAN BE MOVED TO THE FOLLOWING:- A LOCALITY ACUTE MENTAL HEALTH PICU. LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM SECURE UNIT / PROVIDER. (ASSESS NEED FOR HEIGHTENED OBSERVATION ON ARRIVAL AND ESCORT PROVISION)	TO BE RE-LOCATED WHENEVER THE NEED ARISES. THE PATIENT CAN BE MOVED IN A STANDARD VEHICLE, AND CAN BE MOVED AS PART OF A GROUP. THE PATIENT CAN BE MOVED TO THE FOLLOWING LOCATIONS: A LOCALITY ACUTE MENTAL HEALTH PICU. LOCALITY ACUTE MENTAL HEALTH WARD (WITH ESCORTS) LOCAL LOCKED / LOCKABLE REHABILITATION UNIT. ALTERNATIVE MEDIUM / LOW SECURE UNIT PROVIDER.
PATIENT CAT. CHECK →	CATEGORY 1	CATEGORY 2	CATEGORY 3

THIS MATRIX ACTS AS A REFERENCE GUIDE TO STAFF AND THERE MAY BE OCCASIONS WHEN INCIDENT MANAGERS AND STAFF MAY NEED TO ACT OUTSIDE OF THIS GUIDANCE FRAMEWORK. HOWEVER, IN ALL INSTANCES IT IS ESSENTIAL THAT THE MOVEMENT OF PATIENTS BETWEEN LOCATIONS IS CARRIED OUT IN-LINE WITH ANY RESTRICTIONS

Appendix 5 – Mutual Aid Plan

Contingency Plan
Emergency bed contingency

Introduction
As part of the provision for secure in-patient facilities there is the need to ensure that probity around this is maintained when major incidents occur, which render part, or all, of the facilities as unusable.

The contingency plan allows for the transfer of patients to temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

The following procedure has been established to maintain communication between services and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.
The following document represents the agreements in place with these providers, in situations of this nature and considers the major aspects of these operations in terms of:

- Communication
- Decision making
- Clinical risk
- Transportation
- In-house/local operational provision
- Future planning
- Staffing
- Funding

The purpose of the document is to consider these factors in a systematic way to provide clear guidance and support in dealing with these emergency situations.

The scenarios will be subject to desktop exercises with the providers included, and the procedures agreed within, will be developed following these.

These plans will also be reviewed and ratified on an annual basis which will capture any changes in functions, or, to buildings that may impact on this agreement.

The agreement has been reached with providers to satisfy the contingency needs of these individual units involved, as well as supporting the wider contingency plans of the specialised commissioning team. Crucially, the commissioners contingent needs can only be met by provider units agreeing to support each other in these circumstances, so this agreement also has their support in place.

Key components of the shared agreement are:

- The plans for each unit in their decision making around the movement of the service users, were agreed around them being non-prescriptive at this stage, it was felt that decisions would be best made on the day and that functioning in the capacity of

each unit in providing support was the most appropriate way forward.

- It is understood, that the agreement is only for the first 72 hours of any such situation and that any agreed plans would be appropriate to these circumstances/timescales.

- Buy-in around transport arrangements was crucial, in that any services that are affected by these types of situations, should expect that partners involved in the agreement will prioritise this need and respond accordingly with its support. This was agreed by partners.

- Each unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

Plans for decant:
The unit would need to carry out a risk assessment on their patient group prior to any decant and establish where it would be most appropriate to move which patient to. They could then be clear about which area would be the most appropriate to provide the support depending on the risks identified. Included in this risk assessment would also be consideration of how long the service will remain out of commission.

The Spinney
Related policies include:
- Serious Untoward Incident
- Business continuity.

Introduction
The contingency plan allows an option for the transfer of male patients to The Spinney for temporary accommodation for between 12–72 hours following a major incident requiring full evacuation of the unit.

There may also be some service users whose risk profile can be catered for in conditions of lesser security, i.e. LSU, so we would use the document Appendix A to quantify the individual need and utilise the provision there if appropriate, and other LSU beds where appropriate.

The following procedure has been established to maintain communication between services involved and to enable senior staff to make appropriate arrangements for the service users and accompanying staff.

The Procedure
The Spinney providing assistance
In the event that the building or part thereof of one of the partner Hospital is declared unfit and full or partial evacuation is required to The Spinney; there will be contact with

the Site Co-ordinator/Senior Nurse On Call via 01942 885300. ROCG on call will then be contacted to oversee the contingency.

Senior Nurse on Call/ROCG on call (The Spinney) will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which The Spinney may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at The Spinney.

The Spinney Senior Nurse on Call will contact the Site Co-ordinator to notify and appraise them of the situation and give them the details obtained from Emergency Coordinator.

The Senior Nurse on Call will activate the response contingency plans i.e. transportation of mattresses to the social room/main gym (as appropriate), make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The Spinney Maintenance will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

The Spinney will arrange for the receipt of any high risk service users expected and make arrangements for their clinical care for the duration. The visiting hospital will identify the individual needs of each high risk service user, including their staffing requirements. They will be responsible for providing care/medical staff for these service users. Any high risk service user, who cannot be safely accommodated in the main gym and social room area, should be transferred to a ward/s if beds can be found for them. Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

Senior Nurse on Call at The Spinney will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. Senior Nurse on call will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to The Spinney, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Specific Considerations for the Spinney
The outline plan is for wards to be used as temporary, emergency accommodation. If there are no beds available, mattresses will be used in the gym/social room as appropriate.

Mattresses and some bedding are stored in the housekeeping department and arrangements will need to be made to bring these to the designated place at The Spinney

The gymnasium/social room if to be used will need to be prepared; some tables and chairs can remain (enough to accommodate the people coming), the remainder will be removed and secured by the maintenance department.

Check any vacancies/spare beds on the wards to accommodate the high risk patients.

Arrange for a quick key and security induction for the staff shortly after arrival at the unit, to facilitate movement around The Spinney

Ensure that appropriate staff is informed as soon as possible so that all meetings/functions booked for the social room/main gym is cancelled with immediate effect and until further notice.

The visiting hospital Manager to ensure they make contact with the nurse in charge of the patients and further ensure that this contact is maintained through shift changes throughout their stay.

As soon as possible after arrival, the site coordinator should engage the nurse in charge of the service users to ascertain any special pharmacy requirements; special needs requirements (e.g. diet) and assist in meeting their needs. (Partnerships in Care will recharge any NHS Trust for any out of pocket expenses incurred during the emergency).

- The gymnasium/social room will provide the following accommodation: Floor space which can accommodate approximately up to 12 mattresses
- Floor space can also accommodate some chairs and tables; there is a television aerial and electrical socket.
- There is access to gent's toilet – there are no bathroom/shower facilities. These are to be shared with The Spinney service users and staff.
- The dining room has refreshment facilities.

Within the first 8 hours of the transfer, it is imperative that the visiting hospitals Directorate Senior Managers and Elysium corporate senior managers/Incident Management Team meet together to review the transfer and look to further planning and resource implications etc.

It is imperative that high quality communications are maintained between senior managers and duty managers to ensure the smooth running of, what will be a difficult and ever changing situation.

Ty Llywelyn

It should be noted that Ty Llywelyn is a male only facility.

Ty Llywelyn has 25 beds and will only be able to accommodate utilizing the gymnasium environment. It would be unsuitable for Ty Llywelyn to accept high risk transfers from the affected hospital during the period of mutual aid.

Ty Llywelyn providing assistance

In the event that the building or part thereof of The Spinney is declared unfit and full or partial evacuation is required to Ty Llywelyn; there will be contact with the Forensic Service Site Manager/ Senior Nurse On Duty or Unit Coordinator via 01248 682682. The senior member of staff on duty will then oversee the contingency. Ty Llywelyn is able to offer assistance with the temporary transfer of up to 10 service users between 12 and 72 hours.

The senior member of staff will note the request and require the following information: (see Appendix A):

- Briefing about the incident and status of the building.
- Briefing about the number of service users involved and their current location (e.g. temporary shelter).
- Risk Status of the patient group to be transferred, paying attention to any individuals who are disturbed/disruptive/traumatised and may require to be accommodated in a suitable ward environment, rather than the temporary accommodation in the conference suite.
- The number of staff who will accompany the patients and any needs in terms of staffing resources.
- Any other resource requirements which Ty Llywelyn may be able to assist with e.g. catering / pharmacy requirements.
- Transport arrangements and desired time of arrival at Ty Llywelyn.

The senior nurse at Ty Llywelyn will notify and apprise the Forensic Service Senior Management Team of the situation and give them the details obtained from Emergency Coordinator.

The senior nurse will activate the response contingency plans i.e. transportation of mattresses to the gym, make catering/pharmacy arrangements for the visiting service users and staff; arrange for on call personnel (in hours) to assist with making ready the temporary accommodation.

The senior nurse will arrange for available staff to assist with preparations i.e. receive mattresses/catering supplies, clear the main gym area and social room area and make ready for receiving service users and staff.

Beds on available wards will be made available for as many of the transferred service users as possible. Use of temporary sleeping accommodation in the main gym/social room area will be a “last resort”.

The senior nurse at Ty Llywelyn will then liaise to confirm and discuss the arrangements made and agree transfer arrangements. The senior nurse will maintain communication to ensure all information is up to date with a changing situation.

Once the visiting service users have been transferred to Ty Llywelyn, the visiting hospitals Senior Manager will be able to make further arrangements for their transfer to other NHS Trust facilities or other external facilities, as a more permanent arrangement; this will be expected to occur within 12–72 hours from the incident.

Out of Hours
If the Mutual Aid agreement should be required to be activated outside of normal working hours the following process should be used:

Ty Llywelyn offering assistance:

- Spinney Hospital to contact the Unit Coordinator at Ty Llywelyn.
- Unit Coordinator to inform Bronze on Call Manager for Mental Health/Learning Disabilities Division that the Mutual Aid Agreement is being activated.
- The Bronze on Call Manager will then assist the Unit Coordinator in following the actions as outlined above (Ty Llywelyn Providing Assistance) and report to the Forensic Service Senior Management Team when appropriate.
- The Bronze on Call Manager will make the decision to call in extra staff if required to assist with carrying out the Mutual Aid Agreement safely.

Contact details - The Spinney
The Spinney Hospital,
Everest Rd,
Atherton,
M469NT.

Tel-01942 885300
Fax-01942 885301

Interim Hospital Director	07393 460802
Regional Operations Director	07771 767404

Contact details Ty Llywelyn
Ty Llywelyn MSU,
Bryn Y Neuadd Hospital,
Llanfairfechan,
LL33 0HH.

Tel: 03000 852933
Fax: 682146

Operations Manager:	03000 852961
Forensic Service Site Manager:	03000 852732

Approval Confirmation - Major Incident Mutual Aid Plan			
Ty Llywelyn, Medium Secure Unit, BCUHB and The Spinney Hospital, Elysium Health Care			
Review Date		24th April 2019	
Next proposed Review		20th April 2020	
Simon Allen Service Manager North Wales Forensic Service BCUHB T:01248 682135 E: Simon.Allen@wales.nhs.uk A: Ty Llywelyn, Medium Secure Unit, Bryn Y Neuadd, Llanfairfechan. LL33 0HH		Sandy Adams Interim Hospital Director Northern Region Elysium Healthcare T: 07525731719 E: sandy.adams-thompson@elysiumhealthcare.co.uk A: The Spinney Hospital, Everest Road, Atherton, M46 9NT	
Signature		Signature	

<table>
<tr><td colspan="4">The Procedure for Each Transfer</td></tr>
<tr><td>Date</td><td>Number of Staff Required</td><td>Description of Incident/status of building</td><td>How many Service Users at current location</td></tr>
<tr><td></td><td></td><td rowspan="4"></td><td></td></tr>
<tr><td>Time</td><td>Call received from</td><td rowspan="3"></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Description of Patient being transferred</td><td>Any other Requirements (catering/pharmacy)</td><td>Transport and Time of Arrival</td></tr>
<tr><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Signed</td><td colspan="2"></td><td>Date:</td></tr>
</table>

Appendix 6 – AWOL Form

Date of Admission		Section			
Date Form Completed					
Details Updated		Current Named Nurse			
Updated By					
Patient's Title		Date Of Birth			
Surname					
Previous Surname		Sex			
First Name					
Other Names		Marital Status		Ethnicity	
Aliases					
Index Offence		Date Of Offence			
Categorisation under Major Incident Procedure (1,2,3)					
Home Address		Telephone Numbers			
Description/Distinguishing Features		Height		Weight (if known)	
		Hair Colour		Eyes Colour	
Front View Full		Head Picture			
Side View Left		Side View Right			

Date Pictures Taken		
Next Of Kin	Next Of Kin Address	
Relationship to Patient		
Family Address if different to Next Of Kin	Telephone Numbers including Mobile Phone	
Significant Other/Person/s at Risk	Address	
Relationship To Patient		
Psychiatric Condition/ History/ Physical Issues		
Current Psychiatric Medication	Current Other Medication	
	Haloperidol, Lorazepam, Procyclidine	
Allergies		
Specific Risk Factors		
Previous Absconding	Date	
	Outcome	
Any Other Information		

DETAILS OF INCIDENT

Date Of Incident	
Time Reported Missing	
Place Last Seen	
Time Last Seen	
Current Mental State	
Current Description (including Clothing if known)	
Any Other Relevant Information	
Specific Information; i.e. Passport Number, Bank Book Number etc	
Name Of Incident Officer/N.I.C.	Grade
Time Unit Coordinator Informed	
Time Senior Nurse Informed	
Details Faxed/E-mailed to Police	Time Sent
Faxed / E-Mailed	
North Wales Police Fax Number	
North Wales E-Mail Address	

Appendix 7 – METHANE format

There is requirement for Emergency services to work in line with the JESIP Doctrine, as this is the manner in which all the Emergency services report and respond to major incidents. For example the METHANE format should be utilised in reporting an initial incident so as to give clarity of the type and nature of the incident

Members of the Working Group:

Name	Title
Simon Allen	Clinical Operational Manager – Forensic and Rehab Services
Ian Jones	Security Lead
Lisa Jones	Forensic Service Site Manager
Dr Caroline Mulligan	Clinical Director – Forensic Services
Louise Llewelyn	OT Service Manager
Dr Julia Wane	Consultant Clinical Psychologist
Dr Katie Elliott	Consultant Clinical Psychologist
Paul Grimshaw	Reception Supervisor
Julie D Jones	Administration Manager
Greg Yates	Ward Manager
Bethan Young	Ward Manager
Nicky Jones	Ward Manager
Gareth Griffiths	BCUHB Fire Officer
David Baker	Violence and Aggression Lead
Steve Roscoe	Health and Safety - Security

Engagement has taken place with:

Name	Date Consulted
North Wales Fire Service	January 2019
Welsh Ambulance Service	January 2019
North Wales Police	January 2019
MH & LDS Division	

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	Forensic Service Major Incident Plan
Date form completed:	03/11/2020

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or 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?	Forensic Service Major Incident Plan
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This is an assessment of the impact of the implementation of an major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB. The major incident plan is designed to outline process and procedures to be followed in the event of a major incident within services as defined by the plan. A major incident is categorised as: Fire, Bomb, Hostage, Firearm, Large Scale Disorder, Multiple Escape.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Forensic Mental Health Service Management Team
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Measure (Wales 2010) 'Revised Adult Mental Health Services National Service Framework' (2005) Guidance for Commissioners of Forensic Mental Health Services (Joint Commissioning Panel for Mental Health, May 2013)

Part A Form 1: Preparation

		National Policing Improvement Agency Guidance on Command and Control Minimum Standards for Medium Secure Units (RCPsych 2010)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	BCUHB North Wales Police North Wales Fire and Rescue Welsh Ambulance Trust Welsh Health Specialised Services Committee Secure Services Contract Team Ministry of Justice
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Circulation and communication of the document Staff training and awareness Inter-agency development of process Key stakeholders communicating the plan effectively within their own organisations. Preparatory walk through of plans Ongoing robust maintenance of the plan

Part A

Form 1: Preparation

7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? 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
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)		X			Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the plan.	
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)				X	There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.	

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		X			Gender reassignment would be taken into account for the patient on admission and for staff following pre leave planning stage, risk assessment.	
Pregnancy and maternity		X			No impact to patient group – All male. Escorting staff will require risk assessment to ensure high risk escort is appropriate in line with BCUHB policy.	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.		X			An individual's race / ethnicity will be fully taken into account during care and treatment planning and by proxy the major incident plan. Any change in the environment in which an individual might be cared for will be planned taking their race and ethnicity into account.	
Religion, belief and non-belief				X	There is a risk that implementation of the plan might result in an individual being temporarily cared for in an environment which might not be the conducive to their immediate needs.	

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

					There may be situations whereby the environment in which the individual is temporarily cared for might not have access to facilities required for an individual to practice their faith. The nature of the major incidents which the plan caters to means that a pragmatic approach to immediate care and management might need to be adopted in order to ensure the safety of all affected by the incident.	
Sex (men and women)		x			The in patient unit currently has single sex facilities only but during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will be single sex.	
Sexual orientation (Lesbian, Gay and Bisexual)		x			Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation. These factors would be taken into account during the implementation of any part of the plan.	
Marriage and civil Partnership (Marital status)		x			Policy has no impact	
Low-income households		x			Policy has no impact	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	X				Application of this pathway would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		X			Service user language preferences is identified through assessment and care and treatment planning	
Treating the Welsh language no less favourably than the English language				X	The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning. However during implementation of the Major Incident Plan we cannot guarantee that a change in the environment in which the individual is temporarily cared for will comply with the Welsh Language Act.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Policy development has taken place in consultation with partner agencies/emergency services. Consultation has additionally taken place with Service users and carers through user group representative.
Have any themes emerged? Describe them here.	No
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

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)	Forensic Service Major Incident Plan

2. Brief Aims and Objectives: (Copy from Form 1)	To assess the impact of the implementation of major incident plan for forensic mental health services within the Mental Health and Learning Disability Division, BCUHB.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes x	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance?	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	Implementation of the Major Incident Plan might result in the temporary inability to cater for the needs of the characteristics above but these would be considered as a matter of urgency for each individual affected by the incident. The needs of the patient population will be reviewed on a regular basis and the detail of the management of a major incident adapted to meet their needs whenever possible within the caveat that there may potentially be an overriding responsibility to safety and security for a limited period of time.		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x	
	Record Details:		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes x	No	
	How is it being monitored?	Robust multi agency debriefing process post incident.	

Part B Form 5: Summary of Key Findings and Actions

implement your policy or proposal?	Who is responsible?	Forensic Mental Health Services Management Group
	What information is being used?	Factual information post incident. Key stakeholder feedback on the implementation of methodologies contained within the plan.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	February 2022

7. Where will your policy or proposal be forwarded for approval?	MH & LD Divisional Policy Meeting

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be**	Name	Title/Role
	Ian Jones	Ty Llywelyn Unit Security Lead
	Simon Allen	Clinical Operational Manager Forensic Psychiatric Services/Rehabilitation

Part B Form 5: Summary of Key Findings and Actions

undertaken as a group activity	Paul Hanna	Head of Nursing Regional Specialist Services
Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
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?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Version 4

MHLD 0041

Mental Health & Learning Disabilities Division
POLICY FOR THE USE OF HANDCUFFS
(Specific to Ty Llywelyn Medium Secure Unit)

Author & Title	Paul Hanna, Head of Nursing, Regional Specialist Services, Mental Health and Learning Disability Division Simon Allen, Clinical Operational Manager for Forensic and Rehab Services				
Responsible Dept / Director:	Director of Mental Health and Learning Disabilities Division				
Type of Document	Policy				
Approved by:	MHLD Policy Implementation Group 07.05.19 MHLD Q-SEEL – 16.05.19 PAG – 12.08.19 Chairs Approval QSG 11.09.19				
Date approved:	QSE				
Date activated (live):	June 2019				
Documents to be read alongside this document:	• Health Offender Partnerships 2007 Best Practice Guidance: Specification for Adult Medium Secure Services • Crown Prosecution Service: Handcuffing of Defendants 2008 • Association Chief Police Officers England, Wales and Northern Ireland 2006: Guidance on the Use of Handcuffs • Mentally Disordered Offenders: the restricted patient system • Handcuffing Course Guidance Booklet – Jan 2019				
Date of next review:	May 2022				
Date EqIA completed / reviewed:	April 2018				
First operational:	September 2018				
Previously reviewed:					
Changes made yes/no:					
Details of changes since last review					

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

CONTENTS

1. INTRODUCTION

1.1 The aims of this policy are to provide information and guidance for staff concerning:

- The reasons for the use of handcuffs;
- The requirement for appropriate assessment and justification before their use; and
- Their roles and responsibilities in relation to the use of handcuffs.

1.2 Handcuffs will be required for the maintenance of security and / or safety in certain circumstances, as directed by the Ministry of Justice, when patients are being escorted outside a secure perimeter or transferred to another unit or establishment. The most common example is when there is a significant risk that a patient may attempt to abscond whilst escorted to an external appointment. Another is when there is a significant risk that a patient will attempt to cause harm while being escorted outside or being transferred.

1.3 At the pre-admission meeting before a service user is admitted the issue of emergency leave and whether the use of handcuffs needs to be considered will be agreed and documented by the Multi-Disciplinary Team and a lead from the Positive Interventions Clinical Support Service (PICSS).

1.4 Despite the above points, it is important to note, the guiding principle is that patients will not have handcuffs applied routinely while being escorted or transferred. In order to adhere to this principle and to comply with relevant guidance and legislation, an individual risk assessment should take place before any use of handcuffs. These assessments should take into account the following points.

- The patient's circumstances and background;
- Their current and recent presentations;
- The circumstances and environment of the proposed trip outside a secure perimeter;
- risks to the safety of the patient;
- risks to the safety of the escorting staff;
- risks to the safety of other professionals;
- risks to the safety of the public

1.5 Ordinarily, those who undertake this assessment will be members of the patient's multi-disciplinary team (MDT), including where possible, the person who will be the Lead Nurse for the secure escort and the person who will apply the handcuffs. The assessing members of staff should be satisfied that, acting in good faith,

they have considered matters objectively and come to a decision that they believe to be defensible should it be questioned or challenged.

1.6 For planned occasions when a patient will be escorted to a non-secure environment and there will be (or may be) a requirement to remove the handcuffs, there should be a management plan that addresses this in detail.

1.7 Mental Health Act Code of Practice for Wales (revised 2016) states that in some exceptional circumstances where the patient's behaviour leads to the identification of the need for some form of mechanical restraint, such restraint may, in certain circumstances, be agreed by the hospital managers.

1.8 As outlined above, the use of handcuffs is not the first line method of managing disturbed or violent behaviour within Betsi Cadwaladr University Health Board. As the use of handcuffs undoubtedly constitutes a form of mechanical restraint, this policy is intended to satisfy the *Code of Practice* requirement for a policy to be in place governing handcuff use.

1.9 The application of handcuffs will be considered a use of force. This means that each application of handcuffs to a patient must be reasonable, necessary and proportionate intervention for each individual occasion. Intentional application of force to a person will constitute an assault if it is not justifiable.

1.10 The principal legal authority that is relevant to such instances stems from Section 3(1) Criminal Law Act 1967 and from Common Law (re: self defence and preventing a breach of the peace). The members of staff who escort a patient may use force in order to prevent crime and to stop a patient from becoming unlawfully at large. When secure transfers are undertaken, section 137 MHA 1983, `Provisions as to custody, conveyance and detention`, is also relevant. The members of staff who undertake a secure transfer may use reasonable force in order to stop a patient from escaping from legal custody.

1.11 Written confirmation of use of handcuffs must be completed on the relevant form, `Record of Use of Handcuffs'. This confirmation will be undertaken jointly by the Lead Nurse for the escort and the member of staff who applies the handcuffs. However, it is important that both understand their contributions to this.

1.12 As the application of handcuffs will be considered a use of force, the following points apply to the person who applies the handcuffs:

- She or he must be aware of all relevant facts, including the risk assessment,
- She or he must believe the use of handcuffs to be appropriate and reasonable on that occasion.

These matters are essential because she or he is responsible for her/his actions.

1.13 The Lead Nurse for the escort / transfer has overall responsibility and accountability for the escort so:

- She or he must be a registered practitioner, Band 5 or above who has been involved in the leave planning, risk assessment and will also have awareness of the patients individualised care plan.

1.14 The person whom the patient will be handcuffed to should be appropriately trained and assessed as a suitable escort and amenable to undertake this role,

- She or he will be involved in the planning and have an awareness of any identified risk factors.

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2. SCOPE

This policy applies to all staff working clinically with patients, or involved in authorisation for/ application of handcuffs in the Ty Llywelyn Forensic Service.

3. DUTIES

3.1 Chief Executive

The Chief Executive is responsible for ensuring the Health Board has appropriate policies in place and complies with its legal and regulatory obligations.

3.2 Accountable Director

The Executive Director for Mental Health Services is the responsible Director for this policy and has overall responsibility for ensuring that the security policy and practice within the Ty Llywelyn Forensic Service to legislative requirements and the Clinical Security Framework.

3.3 Multi Disciplinary Teams

As far as practicable, multi-disciplinary teams are responsible for discussing and planning leave (including secure escorts/transfers), and completing a risk assessment prior to the leave commencing. In relevant cases, the risk assessment will include consideration of whether or not use of handcuffs is appropriate.

3.4 The Positive Interventions Clinical Support Service

The Positive Interventions Clinical Support Service will be a standing member of the MDT when the use of handcuffs is being considered. They will support the Handcuff Monitoring group that will meet on a quarterly basis to review the use of handcuffs in the period.

3.5. The escorting team of staff

3.5.1 When handcuffs are used to escort or transfer a patient, the escorting team of staff will have at least 3 members. On almost all occasions, a vehicle will be used, and when this is the case, the team of 3 will not include the driver in its number.

3.5.2 All members of staff who make up the secure escort team must attend a briefing prior to escorting a patient in handcuffs. As far as practicable, the briefing should involve the Clinical team managing the service user's care. This can be done by contacting the relevant Security Department in advance and it is to ensure consistency in the undertaking of secure escorts and transfers. Where it is not practicable to have someone from the Clinical team involved, a briefing should still take place and include all members of staff who will form the escorting team. Even in the event of an unplanned/ emergency escort, the members of staff involved in escorting the patient should be made aware of the plan for the occasion and their roles and responsibilities. They must also know about basic safety procedures, in the event that the service user becomes difficult to manage while attached to a member of staff.

3.5.3 As mentioned in point 1.5 above, if there will be or may be a requirement to remove the handcuffs during the episode of leave, there should be a management plan that addresses that in detail. When handcuffs are used (or might be used) for a prolonged period – such as an inpatient stay in a general hospital – the management plan must include regular reviews of the use of the handcuffs. The reviews will include reviewing use of escort chains if these have been used (e.g. for a patient admitted to a general hospital. The Lead Nurse for the escort will be responsible and accountable for ensuring reviews are undertaken and recorded clearly. As a guide, reviews should be undertaken at least every day and when circumstances alter.

3.6 Staff at the secure reception

Staff at the secure reception will be responsible for issuing and receiving returned handcuffs, escort chains and keys. They will also be responsible for maintaining inventories of these.

4. JUSTIFICATION OF THE USE OF HANDCUFFS

4.1 As mentioned in Section 1 above, patients who are being escorted outside secure buildings will not have handcuffs applied routinely. An individual risk assessment should be undertaken in each case and this should lead to a professional, defensible decision being made. Any use of handcuffs must be justifiable.

4.2 As a guide for staff, the situations listed below may lead to decisions to use handcuffs.

4.2.1 Where it is assessed that the application of handcuffs is necessary to prevent the patient from trying to escape from our custody whilst outside a secure perimeter.

4.2.2 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to others (e.g. escorting staff, members of the public) while being escorted or transferred.

4.2.3 Where it is assessed that the application of handcuffs is necessary to prevent the patient from causing harm to herself / himself while being escorted or transferred.

5. USE OF HANDCUFFS FOR PLANNED LEAVE

5.1 Relatively few episodes of leave within Ty Llywelyn require *secure* escort / transfer arrangements and the use of handcuffs, but of those that do, a distinction can be made between “planned” and “unplanned / emergency” occasions.

5.2 Episodes of planned leave that require secure escorting arrangements will be subject to thorough and documented risk assessment before they go ahead. This includes attending medical treatment that is not considered to be “urgent” or an “emergency”.

5.3 Generally, transfers that require secure arrangements will always be planned and not be emergencies so they too will be subject to thorough and documented risk assessment before they go ahead.

5.4 Both the decision to use handcuffs and the rationale for this should be documented clearly in the patient’s electronic record (Paragon).

5.5 All relevant authorisation must be complete and available to the escorting team of staff before the planned secure leave or secure transfer occurs. E.g. Section 17 form when applicable.

5.6 Patients who are subject to restriction orders also require suitable authorisation from the Ministry of Justice (MoJ) for leave.

5.6.1 If such leave has been granted in the past it must be checked whether or not the leave granted covers this particular episode. If it does not, or if the leave has since been revoked, further permission will be required.

5.6.2 For episodes of leave for medical treatment for restricted patients, MoJ document Annex B – *Medical leave application for restricted patients* – should be completed and submitted in advance.

5.6.3 If there is any doubt concerning MoJ authorisation, the MoJ should be contacted before the leave takes place in order to clarify matters.

5.7 In cases of transfer of patients subject to restriction orders, a warrant for transfer will be required from the MoJ.

5.8 The escorting team of staff should address and check all relevant paperwork as part of their briefing and prior to taking the patient out of the secure perimeter. They should not escort a handcuffed patient outside the secure perimeter unless they are satisfied that all is in order and all arrangements are clear to them.

5.9 The use of handcuffs should be explained to the patient prior to the leave or transfer. Wherever possible, s/he should be involved in the plan.

5.10 If there are any concerns that discussing the plan with the patient will increase the risk of her / him attempting to abscond or cause harm during the leave, or that it might cause her / him distress, staff should agree to limit the information that they provide. Matters discussed with the patient should be recorded in electronic records (Paragon) and the escorting team of staff must be made aware of what has and what has not been discussed with the patient.

5.11 The member of staff to whom the patient will be handcuffed will on all occasions be of the same gender. The lead nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The lead nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

5.12 During a planned secure escort in which handcuffs have been applied, they should only be removed if:

- their removal is stipulated for these circumstances on the management plan, or,
- in extreme circumstances, if there are clear grounds to justify this (e.g. if handcuffs are impeding essential examination or treatment).

The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

5.13 If neither of the above apply, but there appears to be a reason to remove the handcuffs, authorisation for their removal should be sought via telephone contact with a senior nurse (Modern Matron, Service manager or Bronze Manager on-Call) or someone in a more senior position than this.

5.14 Generally, handcuffs will not be removed during secure transfers. On arrival at the destination they should be removed only when in a secure part of the receiving unit / facility and following agreement with the receiving staff. In the event of extreme circumstances en route, if there were clear grounds to justify removal (e.g. if handcuffs were impeding essential examination or treatment) they could be removed. The Lead Nurse for the escort would be responsible and accountable for the decisions and actions undertaken.

5.15 If handcuffs have been removed during a secure escort or transfer, whether because this formed part of the management plan, following authorisation via the telephone or because of extreme circumstances, they should remain off only for as long as is necessary. The Lead Nurse for the escort will be responsible and accountable for the decisions and actions undertaken.

6. USE OF HANDCUFFS FOR UNPLANNED / EMERGENCY LEAVE

6.1 Unplanned secure *transfers* of patients to other units / facilities should not take place.

6.2 As a guide, unplanned *leave* that requires secure escorting arrangements and the use of handcuffs should not take place. However, in emergencies, such as when a patient who has no leave appears to require urgent or emergency medical treatment and this cannot be provided inside the relevant unit, secure escort should be facilitated.

6.3 As far as is practicable, an immediate risk assessment will be required prior to this unplanned / emergency leave so that suitable risk management arrangements can be put in place. E.g. use of handcuffs if indicated by the risk assessment, a suitable number of escorts, a secure vehicle if available.

6.4 As far as is practicable, the immediate risk assessment will be undertaken by the Nurse in Charge, the members of staff who will form the escort team and the Unit Co-ordinator. Wherever possible it should also be discussed with the Service Manager or the Bronze Manager on Call. The outcome of this assessment, including the rationale, plus details of those involved must then be documented by the Unit Co-ordinator in her / his report and by the Nurse in Charge (or a delegated Registered Nurse) in the patient's electronic record (Paragon). The Duty Senior Nurse of the unit and the Bronze on Call should also make a record of his/her involvement.

6.5 The risk assessment must balance the apparent risk to the patient with the heightened risk posed by such unplanned leave e.g. risk of absconding, risk to the public, risk to the escorting member of staff.

6.6 In extreme cases, such as when a patient is unconscious or immobile, in may be inappropriate to use handcuffs but appropriate to take them. This is in case the circumstances alter and the patient regains full consciousness or mobility.

6.7 Staff should be aware that a minority of patients might feign ill health or harm themselves intentionally in order to be taken out of a secure environment.

6.8 The Lead Nurse for the escort must satisfy themselves that the use of handcuffs will not impede the patient's or staff's (i.e. the person whom the patient will be handcuffed to) safety or wellbeing. The Lead Nurse will check the patient's wrists for any visible injuries and determine whether the application of handcuffs is appropriate. Any changes to skin integrity in this area prior to the application of handcuffs should be noted and recorded on a body map. Similarly, a check should be carried out on the person whom the patient will be handcuffed to, and any marks noted and recorded in the relevant paperwork.

6.9 During an unplanned secure escort/ in which handcuffs have been applied, they should only be removed if there are clear grounds to justify this (e.g. if they are impending essential medical examination or treatment). They should remain off only for as long as is necessary.

6.10 Relevant members of staff should be precise in recording the times and details of Contact and events: i.e. contents of discussions and subsequent decisions, times of handcuff removal and handcuff re-application etc.

6.11 If unplanned / emergency leave is required for a patient who is subject to a restriction order, MoJ authority should be obtained beforehand wherever possible. Where this is not practicable, the MoJ should be informed as soon as it is practicable. The MoJ should also be informed as soon as it is practicable. The MoJ should also be updated on the risk management arrangements and, when it takes place, the return of the patient within the secure perimeter.

7. RECORDS OF THE USE OF HANDCUFFS

7.1 It is important that the exact times of events are recorded clearly and sequentially:

The exact time at which the handcuffs were applied;

The exact time the patient (with escorting staff) left the secure building;

The exact time and place at which they were removed; and

Any other applications and removals that take place during the episode of secure level or transfer.

7.2 The names of staff involved and the patient must be documented clearly as per requirements on the relevant paperwork.

7.3 When the secure escort/transfer has been completed the Lead Nurse for the escort is responsible and accountable for overseeing the completion and then the distribution of copies of the forms.

8. ISSUE AND RETURN OF HANDCUFFS

8.1 Staff at the relevant secure reception will issue the handcuffs and keys to a member of the escorting team, and maintain a record of this. They will also record the return of the items when the escorting team return them.

9. TRAINING

9.1 Training in the use of handcuffs will be provided by Ty Llywelyn in house trainers who have undertaken Ashworth Hospital accredited 'Train the Trainers' course. This will be funded by Regional services and will be through BCUHB procurement processes.

9.2 All staff whose role may involve the use of handcuffs will be required to attend and complete approved in house training. Updates / refreshers should be completed (by meeting the set training criteria) every 2 years.

9.3 If more than 2 years has lapsed for a member of staff, she/he will not be 'live' in relation to handcuff training. As far as practicable, members of staff who are no longer on the 'live' register should not apply handcuffs to a patient nor be handcuffed to a patient.

9.4 Ty Llywelyn Handcuff trainers are required to maintain their skills via attendance and completion of trainers' training updates via:

Security Training Department
Merseyside NHS Foundation Trust
Indigo Building
Ashworth Hospital
Maghull
Merseyside
L31 1HW

10. MONITORING AND REVIEW

10.1 Ty Llywelyn will produce a *Use of Handcuffs* report quarterly which provides details of when handcuffs have been used in the service. Reports are distributed to Service Directors and Senior Managers and to the County Wide Services Senior Management meeting at its monthly meeting. The report will be reviewed by the leadership team with the support of the Centre Positive Interventions Clinical Support Service team.

10.2 In the instances of emergency handcuff use consideration will be given to completion of DATIX.

10.3 This policy will be reviewed every 3 years, or sooner where a need is identified. The Service Manager is responsible for ensuring the reviews are carried out

11. SUPPORTING DOCUMENTS/BIBLIOGRAPHY

Criminal Law Act 1967

Department of Health (2008) *Code of Practice, Mental Health Act 1983*: TSO

Department of Health (2008) *Reference Guide to the Mental Health Act 1983* London: TSO

Human Rights Act 1998

Mental Health Act 1983 (amended 2007)

Mental Health Act Code of Practice for Wales (2016)

MOJ form (Annex B), *Medical Leave application for restricted patients R (on the application of Graham) v Secretary of State for Justice [2007]*

[This provides interesting insight into a ruling on whether or not the handcuffs of a prisoner who was escorted for hospital treatment could constitute and infringement of his rights under Article 3 of the European Convention on Human Rights. Article 3 forbids torture and inhuman or degrading treatment.]

Appendix 1

Use of Handcuffs – Application for Authorisation Record Sheet

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Reason for request for use:

Risk Assessment:	
Current Leave Status:	**Destination:**
Nature of Escort:	**Need for Escort:** **Low** **Medium** **High**
Index Offence:	

Past/recent history of absconding:	**Risk to public, staff or self:**
Current Mental State:	
Patients current physical state, (particularly conditions relevant to handcuff use, e.g. muscular-skeletal injuries):	
Risk assessment of destination/ Things to consider:	
Circumstances in which handcuffs may be removed & reapplied while outside of secure services:	
Staff escort number:	**Ratio and gender of staff to patient:**
Risk assessment related to risk of escape from the secure perimeter:	
Date:	**Completed by Print & sign:**

Authorisation 09:00 – 17:00 hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**

Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Authorisation Out of Hours		
Authorised by: (Name)	**Signature:**	**Date:**
Authorised by: (Name)	**Signature:**	**Date:**
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		
Declined by: (Name)	**Signature:**	**Date:**
Reason for refusal:		

Appendix 2

Use of handcuffs – Use form

Patients name:	**Date of Birth:**
Sex: **Male / Female**	**Hospital Number:**
Ward:	**Legal Status:**
Consultant (RC):	

Handcuffs applied by (Name):	**Signature**	**Date:**
Secure Transport used: **YES** ☐ **NO** ☐ **Handcuff use directs the use of secure transportation.**		
DETAILS OF EVENT / INCIDENT & GENERAL SAFETY PROCEDURES CARRIED OUT:		
Handcuffs removed by (Name):	**Signature:**	**Date:**

ANY INJURIES SUSTAINED:	**YES** ☐ **NO** ☐
IF YES, PLEASE GIVE DETAILS INCLUDING CAUSE OF INJURY:	
SEEN BY DOCTOR:	**YES** ☐ **NO** ☐
DATIX COMPLETED:	**YES** ☐ **NO** ☐

COPY AND SEND TO:	
Locality Manager Forensics	☐
Modern Matron Forensics	☐
Ward Manager	☐

Appendix 3

Handcuff use -Handcuff Condition Log Daily Check

Date:	Time:	Checked by: (print name)	Condition of Handcuffs/ Action Taken:	Signature:

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	Use of Handcuffs in Ty Llywelyn Medium Secure Unit
Date form completed:	03/11/2020

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or 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?	Use of Handcuffs in Ty Llywelyn Medium Secure Unit
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This is an assessment of the impact of the implementation the Use of Handcuffs in Ty Llywelyn Medium Secure Unit Policy for Forensic Mental Health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when utilising high risk escorted leave that require planned use of Handcuffs.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Forensic Mental Health Service Management team
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Therapeutic Engagement and Observation Policy Ty Llywelyn Security Policy Ty Llywelyn Escort Policy Ty Llywelyn Section 17 Therapeutic Leave Policy Code of Practice for Wales 2016
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	BCUHB MSU Patient Group

Part A Form 1: Preparation

		Families and Carers Ministry of Justice
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Circulation and communication of the document Staff training and awareness Patient awareness sessions
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? 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
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)		x			Clinical assessments and treatment planning allow due consideration for any age related factors. These factors would be taken into account during the implementation of any part of the policy for both staff and patients.	
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health,		x			Disability will be taken account for patients, staff and others by way of regular risk assessment of any individuals residing or working in Ty Llywelyn who has a recognised disability which requires adjustments to be made.	

sensory loss, Cancer, HIV)						
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		x			Gender reassignment would be taken into account for the patient on admission and for staff following pre leave planning stage, risk assessment.	
Pregnancy and maternity		x			No impact to patient group – All male. Escorting staff will require risk assessment to ensure high risk escort and application of handcuffs is appropriate in line with BCUHB policy.	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.		x			An individual's race / ethnicity will be fully taken into account during care and treatment planning and leave risk assessment.	

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Religion, belief and non-belief		x			Religion and belief would be taken into account on admission and included in the care and treatment plan. Consideration given to escorting staff beliefs and religious ideation when planning leaves, although no impact when using handcuffs.	
Sex (men and women)		x			The gender of any escorting staff will be taken into account and included in any risk assessment carried out prior to leave out of the unit being authorised however the use of handcuffs should not have an impact on gender.	
Sexual orientation (Lesbian, Gay and Bisexual)		x			Clinical assessments and treatment planning allow due consideration for any issues related to sexual orientation although this will not impact on any individual staff member or patient.	
Marriage and civil Partnership (Marital status)		x			Policy has no impact	Patient is detained under Mental Health Act 1983 in an Inpatient setting
Low-income households		x			Policy has no impact	As above

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	x				Application of this policy would take into account the Mental health Act 1983 – Code of Practice, Human Rights Act 1998, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		x			Service user language preferences are identified through initial assessment and care and treatment planning	
Treating the Welsh language no less favourably than the English language		x			The organisational commitment to supporting the Welsh Language Act and service user language preferences is identified through assessment and care and treatment planning Welsh language will be taken into account when planning all leaves and explanations of policy use can be provided in the medium of welsh if required.	

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	The policy development group was inclusive of colleagues from partner agencies. In addition to this CANIAD (our third sector partner) were involved in consultation
Have any themes emerged? Describe them here.	No
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

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)	Use of Handcuffs in Ty Llywelyn Medium Secure Unit

2. Brief Aims and Objectives: (Copy from Form 1)	This is an assessment of the impact of the implementation of Use of Handcuff in Ty Llywelyn Medium Secure Unit Policy for forensic mental health services, within the Mental Health and Learning Disability Division, BCUHB. The Policy is designed to outline process and procedures to be followed when planning, applying for and implementing safe use of Handcuffs within Ty Llywelyn, Medium Secure Unit.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance?	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x	
	Record Details:		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes x	No	
	How is it being monitored?	All incidents of Handcuff use will be reviewed by Ty Llywelyn clinical team and datix completed for review by Mental Health division governance / Putting things right team	
	Who is responsible?	Ty Llywelyn Clinical team	

Part B Form 5: Summary of Key Findings and Actions

implement your policy or proposal?	What information is being used?	Existing record keeping process within the medium secure unit including risk assessments, use of handcuff documentation to be reviewed by modern matron.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	May 2022

7. Where will your policy or proposal be forwarded for approval?	MH/LD Divisional Policy Meeting

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
	Paul Hanna	Head of Nursing Regional Specialist Services
	Simon Allen	Clinical Operational Manager Forensic Psychiatric Services/Rehabilitation
	Ian Jones	Ty Llywelyn Unit Security Lead

Part B Form 5: Summary of Key Findings and Actions

Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
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?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Serious Incident Report –October and November 2020
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience Sarah Musgrave, Lead Manager for Incidents Kath Clarke, Head of Patient Safety
Craffu blaenorol: **Prior Scrutiny:**	Review by the responsible Director and Executive Director
Atodiadau **Appendices:**	Serious Incident Report – October and November 2020

Argymhelliad / Recommendation:

The QSE Committee is asked to:
1. Note the report.
2. Note the introduction of the daily Datix review meetings which provides the Health Board with greater oversight and assurance of incidents as they are reported.

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

Sefyllfa / Situation:

This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although several months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

Cefndir / Background:

A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in: the unexpected or avoidable death of one or more patients, staff, visitors or members of the public, another serious occurrence from a specified list or one of the specified Never Events.

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.

Serious Incident Report
October and November 2020

Produced by the Patient Safety and Experience Department,
Office of the Executive Director of Nursing and Midwifery

1. INTRODUCTION

1.1 A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
- a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
- a person suffering from abuse;
- adverse media coverage or public concern for the organisation or the wider NHS;
- the core set of 'Never Events' as updated on an annual basis.

1.2 Never Events are defined as Serious 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 serious 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 Serious Incident Framework.

1.3 Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be done within 24 hours of the incident. Welsh Government respond within 24 hours and set-out a grade of the incident.

- Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, Welsh Government will automatically close the incident after 3 days and no further correspondence with them is required.
- Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board organisation within 2 calendar months. In order to close this incident Welsh Government require confirmation that an appropriate investigation has been undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.
- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure.

Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

1.4 In October 2020, the NHS Wales Delivery Unit took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Corporate Patient Safety and Experience Department has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

1.5 This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in October and November 2020 although 14 months of trend data is included to allow for period on period comparison in the last year.

1.6 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:

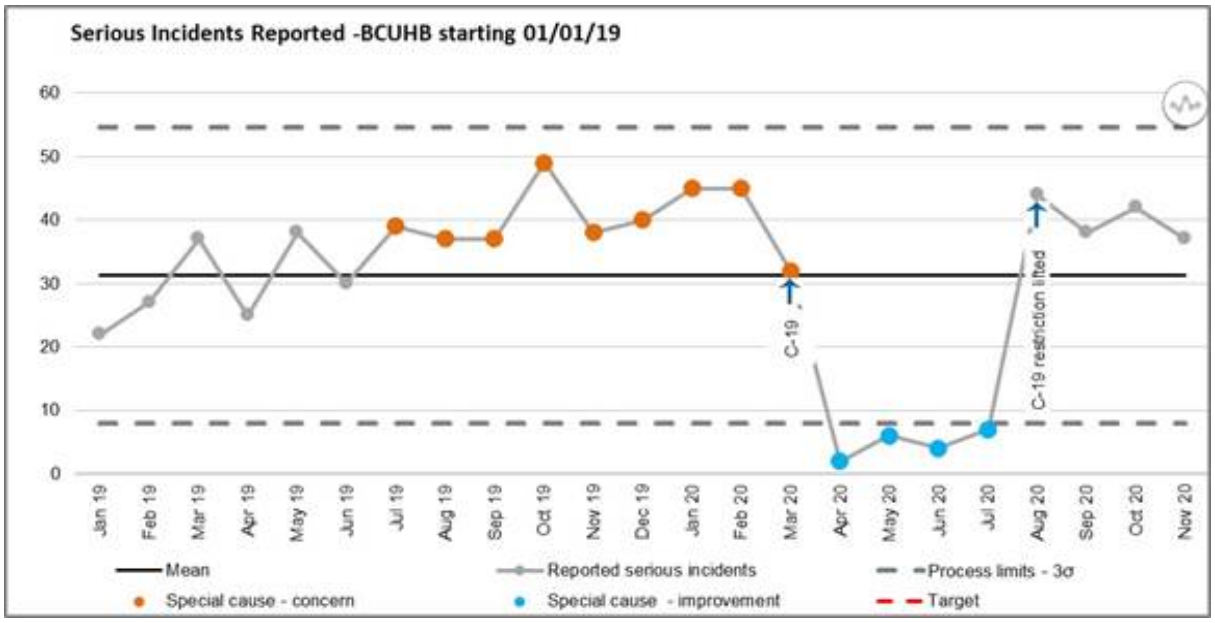
- A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
- Two out of three data points falling near a process limit (upper or lower) represents a possible change that should not result from natural variation in the system – the process limits are indicted 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.

1.7 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is capable of 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. OVERALL SERIOUS INCIDENTS

2.1 During the time period under review, 86 serious incidents were reported and 6 sensitive issue notifications were submitted. This is an increase in serious incident reporting from the Aug/Sept figures of 68. This can be explained, as incident reporting did not resume its pre-COVID reporting requirements until 20 August 2020 (as mentioned in previous reports the national reporting requirements were amended during the first wave rom March 2020 to August 2020).



2.2 At the time of writing, 73 serious incidents remain open with Welsh Government of which 21 are overdue (down from 23 in the last report). Of these, the predominance of overdue incidents relate to Central Area (5), MHLD (4) and East Area (3). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (3) and these relate to matters subject to police investigation. A number (9) are overdue by 6-12 months and (4) are overdue by 3-6 months.

2.3 Overall closure rate within timeframe for the year is around 54%, which has dropped from previously high levels of compliance.

3. SPECIFIC SERIOUS INCIDENTS

3.1 The following serious incidents or sensitive issue notifications were reported during the reporting period are being specifically highlighted for the attention of the Committee:

<u>Mental Health and Learning Disability Division</u>

- A member of Health Board staff was sadly killed outside Wrexham Maelor Hospital following collision with car.
- Death by suicide of a patient open to CMHT (n=3).

- Unexpected deaths of patients open to community services including substance misuse services (cause unknown) (n= 18, which is an increase from 11 in the previous reporting period).

Of the 18 unexpected deaths, 12 occurred in the East, 4 in Central and 2 in West. A total of 5 patients were found dead at home. Investigations or mortality reviews are ongoing – a number are already confirmed as natural causes. It is important to note, in-line with the national Serious Incident Policy, all unexpected mental health deaths are reported as a serious incident within 24 hours of being made aware of the death regardless of circumstances.

Secondary Care Division

- COVID-19 outbreak at YGC.
- Avoidable pressure ulcers (n=9).
- Falls resulting in severe harm (n=18).
- Patient died in Wrexham Emergency Department Wrexham.

Whilst an increasing number of falls and HAPUs are noted, due to the impact of COVID-19 on reporting and activity, it is difficult to draw any immediate conclusions at this time although an increase from 6 falls (August/September) to 18 falls is a threefold increase. The Incident Team are currently reviewing the Datix submitted to see if any themes can be identified or any other reason for the increase in numbers.

In relation to the incident regarding a patient who sadly died in the Emergency Department waiting room at Wrexham Maelor Hospital, a first Serious Incident Review meeting has been undertaken and an interim report has been submitted to the Hospital Director of Nursing.

Immediate recommendations are as follows:

1. Assurance provided that streaming/triage are discreet functions and not completed at the same time at front entrance.

2. Assurance that there is a robust audited policy in place to ensure all locums employed in the ED have the appropriate training in resuscitation.

3. Clarification is sought from the locum agency that the locum who examined Mr WP has the appropriate level of resuscitation competence

4. Assurance that patients waiting in the waiting area for longer than they have been triaged to be seen are assessed properly for signs of deterioration are re triaged as necessary.

5. Review the process for initiating diagnostic investigations (bloods/ECGs) prior to medical examination within the out of hours period

6. Review the arrangements in place for children waiting to be seen in the Emergency Department and assurance of adherence to safeguarding recommendations

7. Evidence that all members of the public who witnessed the event in the waiting room have been contacted, offered support and in particular with respect of the safeguarding responsibilities for the child who visibly distressed after the event

8. Assurance that patients waiting in the waiting area are offered food and drink during extended stays

9. Clarification that members of the public who attend the ED and have impairments such as hard of hearing, cognitive difficulties can be accompanied by their relative

10. Confirmation of the process including the roles, responsibilities and process for completion and approval of Make it Safe and reporting of Serious Incidents to corporate team for sign off and submission to Delivery Unit.

The Interim Secondary Care Nurse Director has requested the development of an action plan to provide assurance that ongoing risks identified from the SIR have been mitigated.

Area Divisions

- One avoidable pressure ulcer across community and community hospital services.
- Six falls resulting in harm

In the previous period (August/September there were 0 falls reported).

4. NEVER EVENTS

4.1 During the reporting period, there were zero Never Events reported.

4.2 All internal investigations into Never Events are complete. An external expert review into a Never Event in urology remains underway and we await the final report; the incident therefore remains open. The report from the independent expert undertaking this review has not yet been received due to COVID pressures. Enquiries are being made to determine what the expected date is to receive the report.

4.3 In total, four Never Events have been reported so far in 2020/21 (compared to six in the full year of 2019/20).

5. LEARNING FROM SI REVIEWS

5.1 A number of recurring issues have been identified in relation to surgical incidents and Never Events as outlined above. The failure to have or use a Local Safety Standards for Invasive Procedures (LocSSIPs) is a theme. The Quality and Safety Group prior to its transition into the new Patient Safety and Quality Group requested a detailed assurance plan from the Secondary Care Division to address these concerns. There has been good progress in the development of an accessible LocSSIPS via the intranet through collaboration with the Informatics Department, the Patient Safety and Experience Department and Hospital Medical Directors. This is still work in process but completion is hoped for early in the New Year.

5.2 In response to the increasing number of falls and Hospital Acquired Pressure Ulcers (HAPUs), the Acting Executive Director of Nursing and Midwifery has re-commenced the strategic falls and HAPU groups. Additionally, the Associate Director of Quality Assurance has requested progress updates on the work and outcomes of both quality improvement collaborative projects.

5.3 Since the start of the financial year, seven Never Events have been closed within the Health Board with the following key learning/themes identified:

- Lack of Local Safety Standards for Invasive Procedures;
- Failure to follow correct procedure or check;
- Gaps in the availability of effective human factors training.

As mentioned above, an improvement plan is underway the first two points. Work has also been underway in Secondary Care to improve peripherally inserted central catheter (PICC) line safety and there are plans to take this forward regarding mid line safety. A working group is also now underway to take forward human factors training and two cohorts of clinical staff have recently been trained.

5.4 The Corporate Patient Safety and Experience Department is undertaking a comprehensive review of the incident process and this is being conducted in co-production with divisions and other stakeholders. This work was due to commence in March 2020 but due to the COVID 19 pandemic was put on hold. A revised plan has now been developed and a new process is planned for launch in 2021. A “soft” implementation of the new process is currently underway with the introduction of daily Datix review meetings in November 2020. These daily meetings are chaired by members of the Patient Safety and Experience Department and attended by the Governance leads. The focus is currently on all major and catastrophic incidents reported in the previous 24 hours. The immediate Make it Safe response is reviewed and a decision is taken on the level of investigation (concise or comprehensive) required. Actions from these meeting are tracked, using Datix, through to conclusion. In addition, a trial of newly developed templates for concise and comprehensive investigations has commenced. Feedback thus far has been positive from services.

6. CONCLUSION AND RECOMMENDATIONS

6.1 This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although longer term trend data is included to allow for period on period comparison in the last year. Thematic analysis is included in the quarterly Patient Safety Report.

6.2 The QSE Committee is asked to note the report.

6.3 The QSE Committee is asked to note the introduction of the daily Datix review meetings which provides the Health Board with greater oversight and assurance of incidents as they are reported.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Improvement Group (HASCAS & Ockenden)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Claire Brennan, Head of Office, Executive Director of Nursing
Craffu blaenorol: **Prior Scrutiny:**	Review by Executive Director of Nursing & Midwifery
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the progress against the recommendations to date and that the oversight of the remaining open recommendations be provided through existing quality assurance routes.

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

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

Sefyllfa / Situation:

The paper provides an update following recent meeting held with the Stakeholder Group and wider stakeholder engagement for Mental Health & Learning Disability (MHLD) services as well as an overview of the current progress of the recommendations arising from both the HASCAS independent investigation and the Ockenden governance review.

Cefndir / Background:

During the first phase of Covid-19 pandemic, the regular reporting arrangements through the Improvement Group and Stakeholder Group for the HASCAS & Ockenden recommendations were formally stood down to enable the organisation to prioritise on the immediate, urgent and emerging requirements in response to the pandemic.

The Improvement Group meeting, which oversees the progress of the recommendations, reconvened on 28th July 2020, and the Chief Officer and Deputy Chief Officer of the North Wales Community Health Council (CHC) were invited to attend for overview and commentary on achievement of the recommendations. Subsequent feedback from the CHC proposed that wider extensive engagement with patients, families, carers and public be conducted before approving the recommendations as being fully implemented.

A meeting of the Stakeholder Group was reconvened on 5th November, which was chaired by the Acting Chief Executive, supported by the CHC and attended by the senior management team of the Mental Health & Learning Disability (MHLD). The senior management team assured the Group that whilst there had been an urgent need to reprioritise the focus during the first wave of the pandemic, work had continued where possible to drive improvements within the division and continue to progress the work of the recommendations. The future ambition for MHLD services was also set out to the members following a review and refresh of the MHLD division, taking account of the actions arising from the HASCAS & Ockenden recommendations and the work done to date in response to these, alongside other reports including HIW Inspections and the Holden Report.

The Stakeholder group were also informed of the Health Board's intention to move forward with a wider group of stakeholders, within an effective and meaningful engagement process, that reflects and builds on the existing stakeholder involvement to date, which was recognised as a valuable and constructive input. It is now proposed that stakeholder engagement be extended to also include a wider group of patients and families / carers to capture more recent experiences of the MH&LD service.

The CHC agreed to support the Health Board in reaching out to a wider group of stakeholders to enable a focused conversation to help move forward in the development of wider MHLD services. The CHC confirmed this will be facilitated through a series of six 'safe space' events covering key areas within the MHLD division which will be run utilising the 7Cs approach (compliments, concerns & complaints, care planning, care provision and communications). The events will provide an opportunity to listen to and hear about individual's experiences, including where needs have not been met and positive stories, and to hear what they want from services. The first event was held on 10th December which focused on Community Mental Health Services. The following is the list of the key areas that have been identified for the forthcoming events;

- Community Mental Health Services (10th December)
- Older Persons Mental Health Care
- Substance Misuse Services
- Learning Disabilities
- Adults with Functional Mental Health Problems / Adult Psychiatric Services
- CAMHS & the Transition to Adult Services

Asesiad / Assessment & Analysis

Significant work has progressed over the two years since the establishment of the Improvement Group and Stakeholder Group and for those recommendations that have been signed off as fully implemented, these continue to be monitored through various forums within the relevant divisions that are leading on the recommendations, this includes for example, the Strategic Palliative & End of Life Care Group and Workforce Improvement Group.

Work also continues to progress the remaining open recommendations that are not yet fully implemented, acknowledging there are some longer term objectives. It is proposed that this work which is ongoing to address these recommendations becomes business as usual and is overseen and monitored through existing governance processes, for example; i) Safeguarding Structures and Deprivation of Liberties identified actions report through the Safeguarding Governance & Performance Group and are also reported within the bi-annual report into QSE; ii) Health Records performance against the identified actions is reported to the Patient Records Group then onto the Information Governance Group via Chair's Assurance Report, and to the Digital Information Governance Committee in the quarterly update report from Informatics. Existing internal governance arrangements will provide robust governance and assurance arrangements and existing Terms of Reference will be updated to reflect these monitoring arrangements and it is therefore proposed that the HASCAS & Ockenden Improvement Group be stood down.

The Health Board's Internal auditors are currently reviewing evidence for all recommendations which are noted as fully implemented for additional assurance and it is also proposed that Internal Audit also review the governance processes for the open recommendations for further assurance.

The MHLD division are also reviewing all actions identified within the Holden and HIW reports which reflect a number of similar themes, to ascertain status of actions undertaken and encompass into one single plan going forward to define the highest priorities to concentrate on in the first instance.

The current status of the 35 recommendations for both HASCAS & Ockenden are detailed below and illustrated in figure 1 below;

- 13 are reporting green, as on track to achieve delivery;
- 1 is reporting amber, where work is progressing but some additional focus or support is required to address some challenges that is impacting on timely progress;
- 21 recommendations have now been agreed as fully implemented (and continue to be monitored through local reporting arrangements within the relevant division).

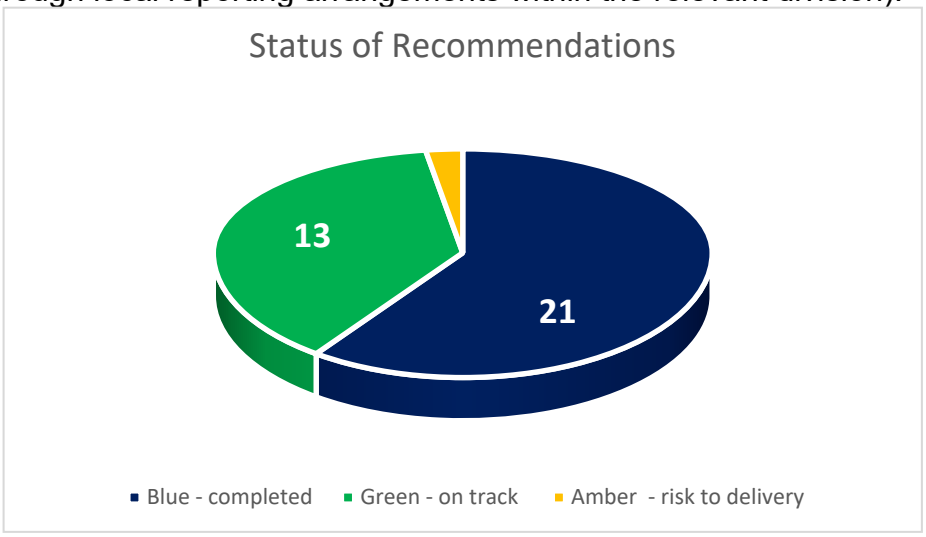


Fig.1 status of recommendations

The Committee are asked to note that the Ockenden recommendation 2d to appoint a second Dementia Consultant Nurse was completed in July 2019. However due to retirement of the postholders, one of which has returned on a part time basis, this has created vacancies to this post and recruitment processes are underway to appoint to the posts with interviews scheduled for 5th January 2021 which also includes stakeholder participation on the panel.

Further to the work undertaken to date it is also acknowledged that Stakeholder engagement has been instrumental in a number of areas.

The participation and engagement of the members of the Stakeholder Group, whom have worked with the operational leads for some of the recommendations and supported the progress made, was recognised and acknowledged, and formally noted that their contribution has been invaluable in progressing the work of the recommendations. The following highlights some of the engagement work with stakeholders to progress the recommendations;

- Safeguarding activity – stakeholder members were invited to engage with a Level 3 MHLD training event and asked to engage with the process, attend, and provide constructive comments and feedback in relation to the event and package content. A feedback report was subsequently drafted by Stakeholder member Mr J Gallanders, setting out some key issues with regards to safeguarding training for both BCUHB staff and agency / bank staff that was presented to the stakeholder group.
- Engagement with the revision of the Deprivation of Liberty Safeguards (DoLS) structure, consultation and review.
- Participation as interview panel members – this was agreed to be a positive step forward and will continue for future recruitment processes where Stakeholder's are able to support this.
- Visits to Mental Health units and End of Life care facilities on Bryn Hesketh, Colwyn Bay and Ysbyty Cefni, Ynys Môn. Two stakeholders commended improvements made to the end of life suite at Bryn Hesketh and in particular the photo wall within on the unit, which stakeholders felt had transformed the unit.
- Attendance at the first day of a 5-day aggression training course with the Positive Intervention and Clinical Support Services team.
- Another member has agreed to be actively involved in the Ablett Redevelopment programme.

Strategy Implications
The report is for administrative purposes in response to the findings of both the HASCAS Independent Investigation and the Ockenden Governance Review. In terms of impact the recommendations align to the overall improvement work that the Health Board is driving.

Financial Implications
The Executive Team previously agreed funding for additional posts identified initially to support progress of the relevant recommendations where this need was identified.

Risk Analysis
Additional resources required were identified to support 3 of recommendations in order to progress the work further to deliver improvements and fully address the recommendations

Legal and Compliance
There are no legal implications

Impact Assessment
Operational leads will undertake any necessary equality / quality impact assessments where applicable within the remit of the work for their respective recommendations

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	BCUHB Corporate Safeguarding 6 Monthly Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Michelle Denwood, Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Corporate Safeguarding Team
Atodiadau **Appendices:**	1. Chair's Report from Safeguarding Governance & Performance Group

Argymhelliad / Recommendation:

The Committee is asked to note the progress made this year by the Corporate Safeguarding Team

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

Sefyllfa / Situation:

The purpose of this report is to present an overview of the activity driven by the Corporate Safeguarding Team during 2019-20. The key issues are highlighted within the attached report from the Safeguarding Governance & Performance Group.

Cefndir / Background:

The purpose of this report is to provide a six-month (April – October 2020) overview of strategic activities and highlight significant achievements and provide assurance in relation to safeguarding adult and children and young people at risk of harm, Violence against Women, Domestic Abuse & Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS) and overarching safeguarding activities.

The report includes the time period of the current COVID-19 pandemic which has influenced some of the data findings and safeguarding activities. To evidence this, data and activities have also been captured up to the 1st November 2020 to include the second lockdown period.

There are currently three main organisational drivers, which have an influence upon the strategic priorities for 2020-2021. These will be used to identify the alert, assurance and achievement for this report.

Asesiad / Assessment & Analysis

As detailed in the attached report.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	Safeguarding Governance and Performance Group
Chair of meeting	Michelle Denwood Associate Director of Safeguarding
Date of meeting	14th October 2020
Version number	V1.0
Appendices	No

Reporting To	
Name of meeting	Quality, Safety and Experience (QSE)
Date of meeting	
Presented by	Michelle Denwood, Associate Director of Safeguarding

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

The Health and Social Care Advisory Service (HASCAS – Rec:12) and the Donna Ockenden (Rec:9)

The review acknowledged DoLS as a high risk area and identified key recommendations. The implementation of these recommendations was monitored by the HASCAS Implementation Group.

The only outstanding recommendation is the service review, the appointment of additional Best Interest Assessors (BIAs) were appointed in the revised Safeguarding Structure in 2018. A more comprehensive review of the service has taken place due to the increase in clinical demand, lack of out of hours' service provision and new legislation.

The new Code of Practice for the Mental Capacity Act and Liberty Protection Safeguards is expected during 2021. Work has commenced to prepare the organisation and key stakeholders of the intended challenges as an outcome of the new legislation. It is proposed BCUHB will have an additional 1700 applications based upon the current data.

Deprivation of Liberty Safeguards (DoLS) Internal Audit

The DoLS Internal Audit provided positive feedback regarding the improvements and the strategic direction of the service since 2018. However, the outcome was reported as Limited Assurance which was directed to areas of improvement required by the Managing Authority

(Wards). All recommendations have been implemented but additional resource is required to ensure implementation and ongoing assurance.

The Safeguarding Business Case has been developed with consideration given to both the audit findings, HASCAS/DO report recommendations and the current and future service demands and will be considered by the Executive Team during January 2021.

Child Practice Review (CPR), Adult Practice review (APR) and Domestic Homicide Review (DHR)

There are currently 6 reviews taking place across North Wales, all are at different stages and all require the engagement of BCUHB. All Adult Practice Reviews (APR), Child Practice Reviews (CPR's) and Domestic Homicide Reviews (DHR's) comply with National Safeguarding Procedures.

Key themes from recent CPR's include disguised compliance and the lack of professional curiosity from all professionals and the lack of consideration for the completion of a Health Pre Birth Assessment (HPBA) by midwives and health visitors.

As best practice, it was recommended that each GP surgery should identify a Safeguarding Lead, engagement is taking place but remains outstanding.

Key findings from recent DHR's is the lack of routine enquiry domestic abuse (REDA) being carried out by BCUHB staff in high-risk areas, such as Emergency Departments. This lack of opportunity for a victim to disclose is increasing the potential risk of continued abuse and/or death.

The VAWDASV lead role is currently incorporated within the Head of Safeguarding Children's Job Description due to the removal of the Domestic Abuse lead from the revised safeguarding structure in 2017/2018. The reinstating of this post has been included in the business case for consideration by the Executive Team to support the mitigation of risk.

Learning from Local and National CPR's

Cardiff and Vale Safeguarding Board published an extended CPR in 2016, which highlighted a number of health contacts that could have provided an opportunity to safeguard the deceased child.

The review recommended that Emergency Departments (ED's) must hold weekly safeguarding meetings, to consider head injuries and burns in children aged under one and fractures in children aged under two years.

From the 1st January to 30th June 2020, 190 sets of clinical case notes have been audited to gain assurance relating to the outcomes for Children.

The Key findings are:

- 132 (70%) of the cases were children presenting with head injury
- 42 (22%) of the cases were children presenting following a fracture
- 16 (8%) of the cases were children presenting with a burn

Table 1 Breakdown of Cases with No Safeguarding Consideration by Hospital with Presenting Complaint

Hospital	Head Injury	Fracture	Burn	Total
YG	10	4	0	14
YGC	7	1	1	9
WMH	40	11	4	55
Total	57	16	5	78

From a safeguarding perspective 41% (n=78) of the cases had no documented evidence that safeguarding was considered, with 31 of the 78 cases having no Safeguarding Injury Flowchart completed (Table 1). Eight (8) of these were in Ysbyty Glan Clwyd and 23 were in Wrexham Maelor Hospital. This may have resulted in further harm to a child.

Corporate Safeguarding will engage with the Emergency Departments to review, support pathways and reporting to strengthen safeguarding assessments of children.

As a result of this learning this activity is now embedded within the three (3) ED's and commenced in January 2020.

Trauma Risk Management (TRiM)

BCUHB is the first Health Board in Wales to undertake this activity.

Following the introduction of TRiM in May 2020 to October 2020 there have been 15 incidents that meet the criteria. Fifty-three (53) staff have attended a Trauma Incident Briefing (TIB) with a further ten (10) staff requiring an individual TRiM assessment.

In recent months' capacity has been an area of concern due to the recent demand. This will require ongoing review in Q3 and Q4.

Practice Development, Learning and Training Q1 & Q2

An informed and competent workforce reduces the potential risk of harm, and the accountability of compliance management is by the divisional managers.

Child at Risk Training

Table 2 – Training Data for Safeguarding Children Level 1 and 2

Safeguarding Module	May-20	Oct-20	Trajectory
Safeguarding Children – Level 1	79.4%	78.9%	↓
Safeguarding Children – Level 2	77.5%	77.5%	↔

Table 3 – Compliance by Divisions

Division (Oct-20)	Staff	Children L1	Children L2
Area Teams Central	2696	85.8%	84.1%
Area Teams East	2574	85.2%	84.9%
Area Teams West	1813	85.4%	83.8%
Corporate Services	7924	67.0%	60.4%
Estates and Facilities	1948	41.8%	30.0%
MHLD Services	2094	85.4%	82.9%
NW Managed Clinical Services	1453	82.0%	80.7%
Women's	841	89.8%	92.6%
Ysbyty Glan Clwyd	2130	78.5%	74.1%
Ysbyty Gwynedd	1906	79.6%	77.3%
Ysbyty Wrexham	1874	78.5%	72.5%
Average Compliance	27253	78.1%	74.9%

The Women's Division is fully compliant with Level 1 and 2 Child at Risk training whilst Corporate Services and Estates/Facilities are the lowest performing Divisions.

Across the three Emergency Departments, compliance with Level 1 and 2 Child at Risk training by medical staff is low and has required the development of urgent implementation plans.

Table 4 illustrates compliance across the three BCUHB Emergency Departments that includes medical staff up to Q2 (October 2020).

ED Medical Staff Oct-20	Staff	Children's L1	Children's L2
YG Medical Staff	52	59.6%	58.8%
YGC Medical Staff	43	65.1%	65.1%
WMH Medical Staff	40	52.5%	47.5%

Adult Safeguarding Training

Improving safeguarding training compliance is a key activity for Corporate Safeguarding. A reduction in compliance is reported during Q1 and Q2 of 2020-2021, see Table 5 below.

Table 5.

Safeguarding Module	May 2020	October 2020	Trajectory
MCA – Level 1	85.3%	75.3%	↓
MCA – Level 2	86.0%	76.6%	↓
Safeguarding Adults – Level 1	78.9%	78.5%	↓
Safeguarding Adults – Level 2	76.7%	77.4%	↑

In comparison to pre COVID-19 figures we have seen a reduction in compliance across the four training programmes highlighted above.

Deprivation of Liberty (DoL) 16/17 year old

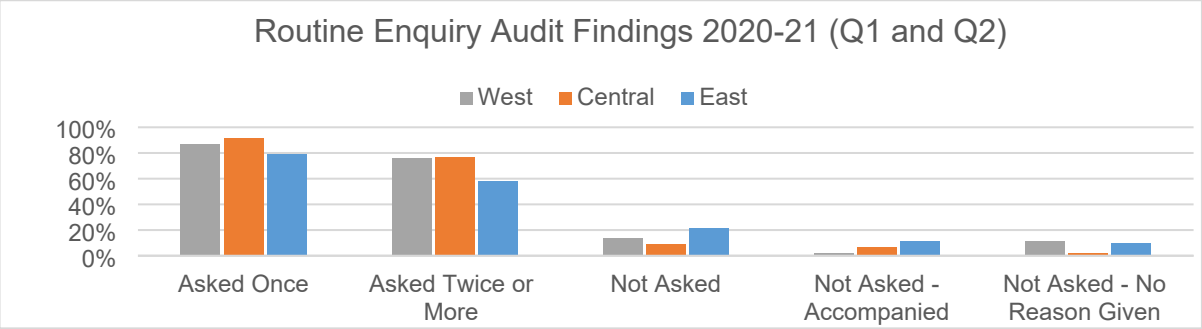
In 2019, new case law was introduced. This new legislation has had an impact upon the number of cases reported to the Court of Protection (CoP), resulting in increased legal costs and the potential for the unlawful detention of a young person.

Audit Activity

Routine Enquiry Domestic Abuse (REDA) during Pregnancy

This audit was the result of recommendations from a number of Domestic Homicide Reviews. The methodology for this audit was a retrospective case note audit. The bar chart demonstrates the findings and comparison against each of the 3 area teams across BCUHB.

Table 6



The audit evidenced;

- The proportion of women being asked the routine enquiry questions at least once at their antenatal appointment has shown improvement; 80% in Q1 and 91% in Q2
- The proportion of women being asked twice or more is also improving; 67% in Q1 and 73% in Q2, which is the highest it has been to date.
- In Q1 20% of women had not been asked about REDA but this compliance significantly improved to 9% in Q2 with 1% mitigation (accompanied) given with 7% no reason given.

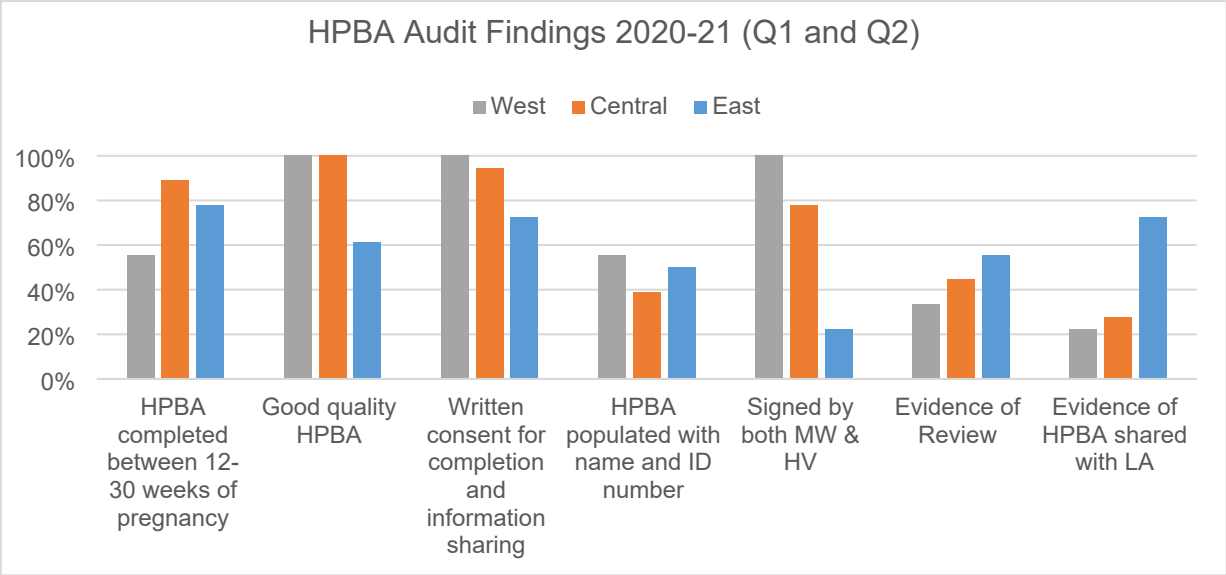
The overall improvements could be attributed to the intensive support given by Corporate Safeguarding but could be also be a result of the restrictions in visiting/accompanied within the Women's Division during the COVID-19 pandemic, which has allowed midwives an increased opportunity to see women alone.

Further improvements need to be recorded, this audit will continue during 2020-2021 with quarterly reporting of findings.

Health Pre-Birth Assessment Audit [HPBA] 2020-21 (Q1 and Q2)

Following recommendations from a number of Child Practice Review BCUHB will complete an annual audit to identify any disparities in the HPBA process, in line with BCUHB Guidance for the Completion of Health Pre-birth Assessment by the Midwife/Health Visitor.

Table 7



The audit found;

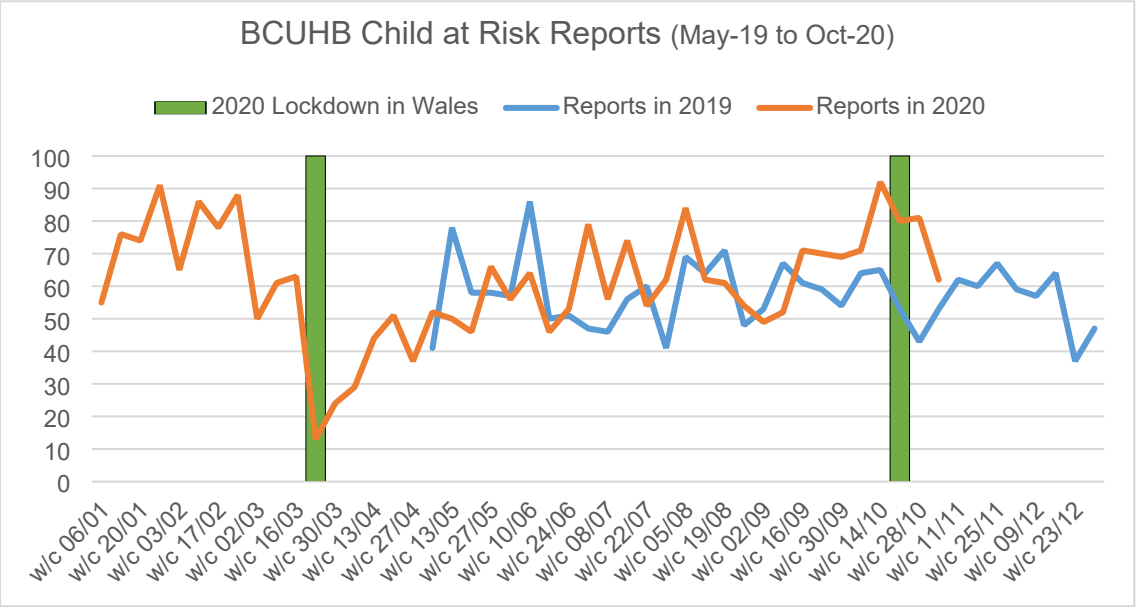
- The proportion of HPBA's completed between 12-30 weeks of pregnancy has increased in 2020-21; 70% in Q1 and 78% in Q2.
- Written consent for the completion of the assessment and information sharing is improving in 2020-21 compared with the findings in 2019-20.
- All three areas have poor compliance in evidencing a review has taken place and that HPBA has been shared with the Local Authority.

Compliance remains low in areas and a further regional evaluation audit of safeguarding group supervision has been commenced for Q3 and Q4 and will be reported in the Annual Report 2020-2021.

Child at Risk Performance and Activity

A total of 1516 child at risk reports were received through this period by health professionals, which averages to 253 reports a month. Figure 1 identifies the number of child at risk reports by month from May 2019 to the end of Q2 2020-21. The graph reports a lower and upper control limits and median line to provide an overview of any trends and highlights the period of Wales's lockdowns.

Figure 1 - Number of Child at Risk Reports (January – November 2020) with Wales's lockdowns highlighted.



Following the first lockdown on the 23rd of March 2020, there has been a reduction in the number of child at risk reports in the West and Central Area. The East area has seen an overall increase in child at risk reports. The decrease in child at risk reports could be attributed to a reduction in the number of children accessing the Emergency Departments, a reduction of face-to-face working arrangements and the closure of schools.

The local findings follow the national picture, with many agencies voicing the impact of COVID-19 and social distancing measures. The activity also highlights the potential risks for children during lockdown.

The highest reports to children's safeguarding up to Q2 of 2020-21 were:

- Emergency Department (ED) – 475 reports – 31%
- Midwives – 282 reports – 19%
- Health Visitors – 208 reports – 14%
- CAMHS – 111 reports – 7%

The highest report-makers so far in 2020-21 have been ED (31%). In comparison to last year, there have been less reports received from Health Visitors and Child and Adolescent Mental Health Service (CAMHS) up to Q2 2020-21

Adult at Risk Performance and Activity

Table 8.

Adult at Risk Reports	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov		Reporting Trend
2019	75	91	92	107	103	97	106	85	86	110	92		⇧
2020	99	118	117	72	106	135	150	119	107	107	100	-	

A decline in Adult at Risk Reporting was highlighted at the beginning of the COVID-19 pandemic. This was recorded as a national trend in Adult Health and Social care and was a trend reported from partner agencies.

The general reporting of Adult at Risk cases has been higher than in 2019 and this may be due to the initial reduction in face to face contact but may also be an indication of the work undertaken by Corporate Safeguarding to promote the Adult at Risk and the Adult Safeguarding agenda during this period. This continues to place additional strain upon the service.

MHLD Heddfan Unit

The change in function of the unit may have contributed to an increase in incidents and subsequently the number of Adult at Risk Reports submitted. Health Inspectorate Wales (HIW) reported the receipt of concerns raised by BCUHB members of staff based within the Heddfan Unit. As a result of this Corporate Safeguarding engaged with the division to identify key themes. These themes highlighted the number of the Adult at Risk Reports received which included an increase in alleged patient on patient reported assaults. There was also an increase in the number of professional allegations (in relation to staff within the unit) reported.

A further concern recorded was specific to the quality of the Adult at Risk Reports received and the actions taken to make safe the situation.

A continued demand is the enhanced support required by the division due to the patient/client group and recognised risks. The single point of contact by Corporate Safeguarding was recognised as good practice but is not a sustainable due to the demands across the organisation.

Multi Agency Risk Assessment Conferences (MARAC) for Domestic Abuse Victims

Table 9. Number of MARAC Referrals Annual data 2018-2019- 2020-21(Q1&2)

Year	West	Central	East	Total
2018-19	46	57	68	171
2019-20	66	53	61	180
2020-21 (Apr - Nov)	34	44	37	115

There have been 115 MARAC referrals from health, in Q1&2 of 2020-2021. This is an increase in referrals in comparison to the same time period as last year (n=88). This could be related to patients being seen alone due to restrictions in visiting during COVID-19 pandemic giving staff opportunities to ask routine enquiry questions. Equally, it could be due to an increase in domestic abuse due to the challenges of the COVID-19 pandemic and lockdown periods, which is reported and in line with the National picture.

Deprivation of Liberty Safeguards (DoLS) – Performance and Activity

In 2019-20, the DoLS team received a total of 1014 applications, see Table 13 below. There have been a further 667 DoLS applications between April 2020 and the end of October 2020

which gives a trajectory in excess of 1100 applications for the year ending 2020-2021. This is the largest number of applications received since the DoLS framework was implemented and causes challenges for the team due to a lack of resource.

Table 10.

Year	West	Central	East	England	Other	Applications
2018-19	89	257	343	55	0	743
2019-20	177	282	483	72	0	1014
2020-21 (Apr – Oct)	106	212	307	40	2	667

Out of the 667 DoLS applications that have been submitted so far in 2020-2021, 325 (49%) of them contained some issues or concerns that resulted in them having to be returned to the Managing Authority (Ward). Table 14 below illustrates the non-compliance with forms by area.

Table 11.

April to Oct 2020-2021	West	Central	East	England	Other	Total
Applications Received	106	212	307	40	2	667
Major Issues with Forms	71	111	133	10	0	325
% of Forms with Issues	67%	52%	43%	25%	0%	49%

Corporate Safeguarding (Supervisory Body) conducted a number of documentation audits, which included the MHLD Division, this activity scrutinised completed DoLS documentation by the wards (Managing Authority).

The identified themes are;

- No mental capacity form to evidence the assessment has taken place
- No patient care and treatment plan
- No evidence of MHA Section details, reported or evidenced
- No named consultant recorded

Poor quality documentation results in delay, duplication of activity, challenge in the Court of Protection (CoP) and ultimately it can cause the unlawful detention of patients resulting in harm and resulting in financial and reputational damage.

Safeguarding Children Supervision Sessions

Individual safeguarding supervision has continued virtually with an average compliance of 83-100% across all Health Visitors and School Nurses during the pandemic.

100% compliance was not achieved during Q1 and Q2 due to staff being redeployed to other service areas and due to those who were shielding due to COVID-19.

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

Adult and Child at Risk Procedures

The development of these revised procedures explains to all BCUHB staff how to safeguard Adults and children at risk of abuse, neglect and/or harm by outlining the process clearly in line with the Social Services and Well-being (Wales) Act 2014 and the Wales Safeguarding Procedures 2019. This improves compliance and reduces risk.

Child at Risk Reports

During this period, good multi-agency working was adopted between BCUHB Children's Services, Local Authority Children's/Education Services and Corporate Safeguarding to ensure a co-ordinated approach was implemented to continue to safeguard children. Weekly multi-agency meetings are held to provide additional assurance.

Ward Accreditation

The development and ratification of a Safeguarding Assessment Tool and working collaboratively with the BCUHB Quality Improvement Corporate Nursing Team, Ward Accreditation Programme created a platform for continuous improvement in patient safety, patient experience and encourages staff engagement to recognise good safeguarding practice

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix provides assurance and drives improvements, this is evident in the year on year improvements demonstrated in the data. In 2018 BCUHB Corporate Safeguarding scored 14 out of a possible 25, 2019 saw an improvement with a score of 23 out of 25 and this year scored 25 out of 25, demonstrating consistent progress.

CPR/Learning from Reviews

All engagement, actions and any recommendations relating to BCUHB are monitored following the Safeguarding Governance and Reporting Framework.

To support the key findings from CPR's the North Wales Safeguarding Board has developed a Multi-Agency Protocol, "Working with Families Who Display Disguised Compliance"

To support staff and improve assurance BCUHB has revised the, "Guidance on the Completion of Health Pre-Birth Assessment (HPBA)" and supporting documentation.

An annual audit of the completion of HPBA is being carried out and all findings are shared in safeguarding group supervision sessions, via the Safeguarding Bulletin and in Safeguarding Forums and relevant groups.

This activity provides BCUHB with full assurance that learning is reviewed and implementation plans/audits are conducted. All findings are used to influence training and improve clinical practice.

Trauma Risk Management TRiM

Informal feedback has reported a positive response from staff engaged in this process.

An evaluation will take place by the end of Q4 2020-21. This will provide invaluable information to assist the review of the TRiM process and support the review of staff well-being.

Multi Agency Risk Assessment Conferences (MARAC)

The collation of the number of health MARAC referrals also gives Corporate Safeguarding an opportunity to monitor any themes/trends and to review the quality of the referral highlighting any future training needs. This provides additional assurance minimising potential risks to the victim.

Safeguarding Practice Development, Learning and Training

The six monthly training report highlighted key areas across BCUHB where safeguarding training compliance is below the Health Board Key Performance Indicator of 85%. A targeted approach to improve compliance has been shared in Divisional Forums and Safeguarding Forums.

Safeguarding training compliance is scrutinised by the Practice Development, Learning & Training Task Group which is chaired by Head of Safeguarding Adults, and reports into the Corporate Safeguarding Governance & Performance Group and Area/Divisional Safeguarding Forums.

Routine Enquiry Domestic Abuse (REDA) during Pregnancy

This audit demonstrates BCUHB are continually improving in their compliance to ask women the routine questions at least once during pregnancy. It also highlights areas of improvements to be made in Q3&Q4.

It provides assurance and evidences compliance of Standard 2 Routine Enquiry, All Wales Minimum Standards.

Health Pre-birth Assessment:

The Health Pre-birth Assessment audit informed BCUHB Women's and Children's Division of the progress made over Q1 & Q2 and where improvements could be made.

MHLD Heddfan Unit (Wrexham)

In response to the increased activity at the unit an agreed Heddfan Quality and Improvement Plan (HQIP) and Safeguarding Action Plan (SAP) was produced.

This was to ensure that the Unit was supported, had a safeguarding single point of contact and safeguarding assurance was obtained by supporting learning and the implementation of best practice by reviewing clinical cases.

Corporate Safeguarding provided an out of hours, 7 days a week services when required to support to the MHLD Division to mitigate risk. This is not included within the current service and is included within the Business case as an important service provision.

Deprivation of Liberty Safeguards (DoLS)

The Corporate Safeguarding Team (Supervisory Body) have implemented all of the internal audit recommendations to provide assurance; this includes the development of a Standard Operating Procedure, which reduces error and strengthens compliance for front line staff (Managing Authority). There has been targeted activity and training relating to Safeguarding Ambassadors and DoLS Authorisers.

3. **Achievement** – include any significant achievements and outcomes

CPR - Concise Child Practice Review – NWSCB 2018 Wrexham 1

Corporate Safeguarding have contributed to the development of the Multi-Agency Protocol – Working with Families Who Display Disguised Compliance. This will support staff in their practice in caring for those families who are difficult to engage.

Ward Accreditation

Joint working with the Ward Accreditation Programme has enabled the Safeguarding Activity Report to be developed and incorporated into the Ward Accreditation activity with a robust evidence based approach. The enables consistency, appropriate challenge and the identification of both commendable practice and improvements across the organisation.

Safeguarding Practice Development, Learning and Training

Key areas have seen an improved compliance and a targeted approach is in place for departments which have reported a compliance of less than 85%.

Implementation of Wales Safeguarding Procedures

A review of all BCUHB Safeguarding Policies, Procedures and Guidance has taken place, which ensures BCUHB is fully compliant with the revised legislation.

Deprivation of Liberty (DoL) 16/17 year old

To ensure staff have full understanding of this case law, a training package has been developed and sessions delivered within the Children's Division.

A workshop event was delivered to 68 staff, with a focus on discussing complex cases. This enabled staff to embed the new case law into clinical practice by discussing real life cases.

Safeguarding Maturity Matrix

To be the only NHS organisation in Wales to achieve full compliance demonstrates how BCUHB Corporate Safeguarding continually evidence improvement and provide assurance against National Safeguarding Quality Indicators.

Trauma Risk Management TRiM

The Corporate Safeguarding Team have sixteen trained practitioners who have successfully responded to traumatic incidents experienced by BCUHB staff. Early identification of staff exposed to trauma aids to promote a healthy workforce by supporting the welfare needs of staff.

Audit Activity

- **Routine Enquiry Domestic Abuse Audit**

  The audit highlighted the proportion of women who were asked the Routine Enquiry questions at least once at their antenatal appointment is improving; 80% in Q1 and 91% in Q2.

- **Health Pre-birth Assessment Audit (HPBA)**

  There is clear evidence of improvement with further activities in place to further improve compliance. In Q1 70% completed the HPBA between 12-30 weeks of pregnancy which improved to 78% in Q2.

- **Deprivation of Liberty Safeguards Documentation Audit**

  The audit findings have resulted in a targeted approach within key areas and Divisions. This has resulted in improved procedural compliance and a reduction in the potential unlawful detention of patients.

Routine Enquiry Domestic Abuse (REDA)

Corporate Safeguarding have engaged with both Primary Care Services and Emergency Departments across all localities to support the promotion of the REDA. The REDA is an assessment tool to identify those who are at risk of violence or domestic abuse

Adult Safeguarding Supervision

Corporate Safeguarding have now established a robust Group Supervision Plan to promote the adult safeguarding agenda and support staff to engage in the Adult at Risk process. The Group Supervision allows for staff to discuss cases, and reflect and learn in a safe and supportive environment.

Safeguarding Ambassadors

There are currently ninety-nine (99) trained safeguarding ambassadors across BCUHB.

There is evidence of the improved quality of Adult at Risk Reports and a reduction in inappropriate reporting as a direct result of ambassador intervention and partnership working with the Safeguarding Team.

Safeguarding Bulletin

Corporate Safeguarding have continued to produce the monthly safeguarding bulletin throughout the COVID-19 Pandemic. The bulletin has been capturing and sharing relevant, topical and current issues, as well as themes and trends specific to all aspects of the safeguarding agenda. Items within the bulletin are directly linked to current practices and include live updates and communications to inform staff across BCUHB. The continual reinforcement of key messages strengthens compliance and reduces risk.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Audit Wales Review of Quality Governance Arrangements
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Mathew Joyes, Acting Associate Director of Quality Assurance Anne Hall, Head of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	Review by responsible director
Atodiadau Appendices:	Appendix 1 - Audit Wales Review of Betsi Cadwaladr Health Board Quality Governance Arrangements Project Brief

Argymhelliad / Recommendation:

The Committee is asked to note for information the Audit Wales review of the Health Board's Quality Governance arrangements.

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

Sefyllfa / Situation:

Audit Wales are undertaking a review of the Health Board's Quality Governance Arrangements with a proposal that set up work will commence in December 2020. The review fieldwork will take place January 2021 to March 2021 with a draft report in April 2012 and final report in May 2021. The Audit methodology includes, document reviews, interviews with staff and board members, data collection, staff survey and observations.

The Audit will seek to address the following question:

"Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?"

Key Lines of Enquiry include:

- Does quality drive the organisational strategy
- Does the organisation promote a quality and patient-safety-focused culture
- Do organisational structures and processes support delivery of high-quality, safe and effective services
- Do corporate and operational arrangements for performance monitoring and reporting provide an adequate focus on quality and patient safety

A self-assessment against the Key Lines of Enquiry is in the process of being completed and will be shared with relevant executives and Board members.

Cefndir / Background:

The Auditor General has included an examination of quality governance arrangements in their programme of performance audit work at relevant NHS bodies. The review forms part of the programme of work that will be undertaken to satisfy the Auditor General that NHS bodies have proper arrangements to secure the efficient, effective and economical use of resources, as required by Section 61 of the Public Audit Wales Act 2004. The Auditor General's powers under section 145A of the Government of Wales Act 1998 are also relevant to this review.

Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste and variation. The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act will strengthen the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

The review is being conducted across all Health Boards. The review will examine both the operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting. It will draw on the methodology that was used in the 2019 joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board. It will form part of a wider programme of work aimed at getting a better understanding of quality governance arrangements across NHS Wales.

Asesiad / Assessment & Analysis

Strategy Implications - The Health Board Quality Strategy 2021-2024 is currently in development and will reflect the Health Board's Quality Governance Arrangements and the expectations included in the Wales Audit office Review.

Options considered – As outlined, a self-assessment is underway in preparation.

Financial Implications - No implications from this paper.

Risk Analysis - No implications from this paper.

Legal and Compliance - No implications from this paper.

Impact Assessment - No implications from this paper.

Archwilio Cymru
Audit Wales

Project brief

Reference: November 2020

Date issued: 1794A2019-20

Review of Quality Governance Arrangements

Background

1 The Auditor General has included an examination of quality governance arrangements in his programme of performance audit work at relevant NHS bodies. The review forms part of the programme of work that he will undertake to satisfy himself that NHS bodies have proper arrangements to secure the efficient, effective and economical use of resources, as required by Section 61 of the Public Audit Wales Act 2004. The Auditor General's powers under section 145A of the Government of Wales Act 1998 are also relevant to this review.

2 We had originally planned to begin our reviews of quality governance during the early part of 2020, but the onset of the pandemic meant that we needed to pause the planned work. That pause has allowed us to adjust both our scope and approach to fit within the context of COVID-19. This briefing note sets out our intended approach to the review.

3 Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulation. Further information is set out in our fair processing notice attached at Appendix 1. We ask that you share this project brief with officers, independent members/non-executive directors and any other staff that we will be interviewing or meeting with as part of this work. This will help to ensure they understand the purpose of our review and how we will use the information we collect.

Why are we doing this work

4 Quality should be at the 'heart' of all aspects of healthcare and 'putting quality and safety' above all else is one of the core values underpinning the NHS in Wales. Poor quality care can be costly in terms of harm, waste and variation.

5 The drive to improve quality has been reinforced in successive health and social care strategies and policies over the last two decades. In June 2020, the Health and Social Care (Quality and Engagement) (Wales) Act became law. The Act will strengthen the duty to secure system-wide quality improvements, as well as placing a duty of candour on NHS bodies, requiring them to be open and honest when things go wrong to enable learning. The Act indicates that quality includes but is not limited to the effectiveness and safety of health services and the experience of service users.

6 Quality and safety must run through all aspects of service planning and provision and be explicit within NHS bodies' integrated medium-term plans. NHS bodies are expected to monitor quality and safety at board level and throughout the entirety of services, partnerships and care settings but our annual Structured Assessment work across Wales has pointed to various challenges. These challenges include the need to improve the flows of assurance around quality and safety, the oversight of clinical audit and the tracking of regulation and inspection findings and recommendations.

7 Given this context, it is important that NHS boards, the public and key stakeholders are assured that quality governance arrangements are effective and that NHS bodies are maintaining an adequate focus on quality in responding to the pandemic. The current NHS Wales planning framework reflects the need to consider the direct and indirect harm associated with COVID-19. It is important that NHS bodies ensure their quality governance arrangements support good organisational oversight of these harms as part of their wider approach to ensuring safe and effective services.

8 Our review will examine both the operational and corporate approach to quality governance, looking at issues such as organisational culture and behaviours, strategy, structures and processes, information flows and reporting. It will draw on the methodology that was used in the 2019 joint review of quality governance arrangements at Cwm Taf Morgannwg University Health Board. It will form part of a wider programme of work aimed at getting a better understanding of quality governance arrangements across NHS Wales.

Audit approach

9 The review will seek to address the following question: **Do the organisation's governance arrangements support delivery of high-quality, safe and effective services**? **Exhibit 1** sets out the key lines of enquiry we will consider.

Exhibit 1: key lines of enquiry

Do the organisation's governance arrangements support delivery of high-quality, safe and effective services?

1. Does quality drive the organisational strategy?
    a. Are quality and patient safety priorities clearly defined, documented and periodically reviewed?
    b. Are COVID and non-COVID risks to quality and patient safety identified and documented along with mitigation to eliminate or reduce their impact?

2. Does the organisation promote a quality and patient-safety-focused culture?
    a. Is the organisation actively participating in quality improvement initiatives?
    b. Do organisational values and behaviours support a quality and patient-safety-focused culture?
    c. Does the organisation take steps to listen to patients and staff and involve them in monitoring service change/improvement?
    d. Is there a strong culture of learning lessons from patient and staff feedback or concerns?
    e. Is quality and patient safety an integral part of workforce management processes?

3. Do organisational structures and processes support delivery of high-quality, safe and effective services?
    a. Are there clear lines of accountability for quality and patient safety across the organisational structure ie 'floor to Board'?
    b. Are there effective corporate and operational controls to support delivery of high-quality and safe services?
    c. Is there enough resource and expertise to support and improve quality governance arrangements?

4. Do corporate and operational arrangements for performance monitoring and reporting provide an adequate focus on quality and patient safety?
    a. Does the organisation have comprehensive and timely information for monitoring and reporting on quality and patient safety?
    b. Is the organisation examining the direct and indirect harms known to result from COVID?
    c. Does quality and patient safety receive effective coverage at both corporate and operational management meetings?
    d. Does the Board and its committees receive information about quality and patient safety to support effective scrutiny and assurance?

10 In addition to reviewing corporate level arrangements for quality governance, we plan to review the arrangements for general surgical services (the tracer) to test the 'floor to board' perspective in the Health Board. We will discuss the details and practical arrangements for testing these arrangements, along with our proposed methodology (**Exhibit 2**), with the Health Board at a set-up meeting prior to commencing audit work.

Exhibit 2: proposed methodology

Methodology	Activity
Document review	Our review will include, but is not limited to, relevant organisational strategies for quality and safety, board, committee and sub-committee papers, executive and operational management team papers related to quality and safety, relevant policies/procedures, risk registers, performance reports or quality dashboards and patient experience reports. Where documents are not publicly available, we will request these from the Health Board to provide evidence against our lines of enquiry. We may use evidence from other agencies, such as the NHS Internal Audit and Assurance Service and Healthcare Inspectorate Wales.
Interviews with staff and board members	We will arrange virtual interviews with relevant individuals, including board members, executive directors and corporate and operational staff. The interviews will cover broad themes, such as quality and safety priorities, organisational culture, roles and responsibilities, monitoring and reporting performance, quality improvement activity and sharing learning and lessons.
Acute Division data collection form	We will ask the three Acute Divisions to complete a data collection form that seeks information on aspects of the Division's quality governance arrangements.
General Surgery data collection form	We will ask the General Surgery leads across the 3 acute sites to complete a data collection form.

Methodology	Activity
	This form seeks information on aspects of the quality governance arrangements for general surgery.
Corporate data collection form	We will ask the Health Board to complete a data collection form that seeks information about the level and type of corporate resource available to support and improve quality governance arrangements.
Staff survey	We will invite operational staff working in the tracer speciality to take part in our online attitude survey about quality and patient safety arrangements within the organisation or their area of work.
Observations	We will draw on observations at the Quality and Safety Experience Committee and Corporate Quality and Safety meetings within the review period as appropriate. We also aim to observe at least one relevant meeting of the Operational Quality and Safety Groups within the Health Board. We will discuss how best to focus our observations, at the set-up meeting.

11 Auditors will work remotely to carry out the audit given our on-site work remains suspended in accordance with COVID legislative requirements and our desire to ensure our work does not impede the Health Board's continuing response to the pandemic. We will work with the lead executive director for the audit to agree the timing and focus of interviews with operational staff and board members, and the information required to support our work. Interviews will be undertaken virtually via telephone, MS Teams or Skype.

12 We have engaged with Healthcare Inspectorate Wales (HIW) to inform the scope and audit approach for this work, building on the learning from our 2019 joint review of quality governance at Cwm Taf Morgannwg University Health Board. While the work described in this document is not being conducted as a formal joint review, we will continue to work closely with HIW to ensure relevant information is shared and to prevent any duplication of activity. HIW relationship managers may join us at interviews and attend our internal meetings to discuss audit findings.

Timing of the work

13 The indicative timescales for the key stages of the audit work are shown in **Exhibit 3**. Where appropriate, we will give interim feedback if issues of concern arise during our work.

14 We will keep our delivery arrangements and the timescales under close review and adjust them to avoid unnecessary burden on the Health Board at a time when coronavirus infections and associated admissions are rising within Wales. We accept that these factors may impair the ability of Health Board to respond in a timely way to requests for information and interviews.

Exhibit 3: indicative timescales for the work

Key stage	Timing
Set up	December2020 to January 2021
Fieldwork	January to March 2021
Draft report	April 2021
Final report	May 2021

Reporting our findings

15 We will prepare a report for the Health Board setting out local findings and any recommendations arising from the work. In line with the Audit Wales arrangements for public reporting, we will publish the report on our website once it has been formally considered by the relevant Board committee.

16 We may summarise the findings from our local work at NHS bodies in a national publication which may then be laid before the Senedd in line with the Auditor General's powers set out in Section 145A of the Government of Wales Act 1998.

Audit Wales Contacts

17 The project team and their contact details are set out in **Exhibit 4**.

Exhibit 4: project team

Name	Contact details
Urvisha Perez Senior Auditor	Urvisha.Perez@audit.wales 07866 797712
Gabrielle Smith Audit Lead	Gabrielle.Smith@audit.wales 02920 320608
Carol Moseley Audit Manager	Carol.Moseley@audit.wales 07771 943265
David Thomas Audit Director	Dave.Thomas@audit.wales 07798 503064

Appendix 1 – Fair processing notice

This privacy notice tells you about how the Auditor General for Wales (and the Wales Audit Office on his behalf) processes personal data provided by you in connection with our quality governance review of NHS Trusts and Health Boards in Wales.

Who we are: The Auditor General for Wales' work includes examining how public bodies manage and spend public money, and the Wales Audit Office provides the staff and resources to enable him to carry out his work.

Data Protection Officer (DPO): Our DPO is Martin Peters, who can be contacted by telephone on 029 2032 0500 or by email at: infoofficer@audit.wales.

The relevant laws: We process your personal data in accordance with data protection legislation, including the Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR). Our lawful basis for processing is powers and duties under legislation, including the Public Audit (Wales) Acts 2004 and 2013, Government of Wales Acts 1998 and 2006, Local Government (Wales) Measure 2009 and Well-being of Future Generations (Wales) Act 2015.

Purposes for processing: We are collecting opinions and information to help us carry out our quality governance review at health bodies. Some of this information may be about identifiable individuals, which would make it personal information, even though the purpose of our work is not in itself to collect information about identifiable individuals. The information collected (including anonymised quotes) will be used for this review and may also be used in our wider statutory audit work.

Who will see this data? The Auditor General and the WAO audit team will have access to the information you provide. We may share some information with senior management at the audited bodies involved, and our published report may include some information. We may share some data with other public service review bodies, such as HIW, where the law permits this. The Auditor General may present a report to the Senedd.

How long we keep the data? We will keep your data for six years (or 25 years if it is included in a published report).

Our rights: The Auditor General has rights to information, explanation and assistance under paragraph 17 of schedule 8 Government of Wales Act 2006 and/or section 52 Public Audit (Wales) Act 2004 and/or section 26 of the Local Government (Wales) Measure 2009. It may be a criminal offence, punishable by a fine, for a person to fail to provide information.

Your rights: You have rights to ask for a copy of the current personal information held about you and to object to data processing that causes unwarranted and substantial damage and distress.

To obtain a copy of the personal information we hold about you or discuss any objections or concerns, please write to: The Information Officer, Wales Audit Office, 24 Cathedral Road, Cardiff, CF11 9LJ or email infoofficer@audit.wales. You can also contact our Data Protection Officer at this address.

The ICO: To obtain further information about data protection law or to complain about how we are handling your personal data, you may contact the Information Commissioner at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF, or by email at casework@ico.gsi.gov.uk or by telephone 01625 545745.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 15th January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Public Services Ombudsman Public Interest Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director Of Quality Assurance And Assistant Director Of Patient Safety And Experience, Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Public Services Ombudsman for Wales
Craffu blaenorol: Prior Scrutiny:	The Hospital Management Team at Ysbyty Glan Clwyd together with the Acting Deputy Executive Medical Director and Acting Associate Director Of Quality Assurance have considered and accept the findings within the Report
Atodiadau Appendices:	Appendix 1 - Ombudsman Public Interest Report

Argymhelliad / Recommendation:

The Committee is asked to receive and note the report formally.

Please tick as appropriate

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

Sefyllfa / Situation:

The Public Services Ombudsman for Wales (PSOW) issued the Health Board with a public interest report relating to a complainant who remained dissatisfied with their response received from the Health Board. The report was made under s23 of the Public Services Ombudsman (Wales) Act 2019 ("the Act"). The Health Board has a duty under s24 of the Act to publicise the report and make it available to the public at its offices and via the Health Boards website.

Cefndir / Background:

The complainant Mr Y, escalated that Betsi Cadwaladr University Health Board exceeded the referral-to-treatment target for cancer waiting times for the treatment of their prostate cancer. He was concerned that following a biopsy which confirmed a diagnosis of prostate cancer, there was a delay in providing them with an appointment for treatment. As Mr Y was concerned about the impact of the delay, he sought private treatment.

The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules") at the time of the events complained about stated that: "Newly diagnosed cancer patients that have been referred as urgent suspected cancer, and confirmed as urgent by the specialist to start definitive treatment within 62 days from receipt of referral …"

Asesiad / Assessment & Analysis

The Ombudsman found that the Health Board would have missed the RTT Rules timescale in Mr Y's case by at least 106 days taking into account the estimated waiting times at the time of Mr Y's diagnosis (3 months).

Considering the Ombudsman's professional advisers advice that early radical treatment was essential in high-risk disease, a 3 month wait for definitive treatment was deemed unacceptable regardless of the RTT Rules. This was reported as a service failure. In Mr Y's case, the delay for treatment, and concern about the potential impact on his clinical condition from any delay, led to his decision to seek private treatment. The delay, well in excess of the 62-day target in Mr Y's case, caused him significant distress and anxiety, and his decision to seek private treatment sooner (rather than wait for the Health Board to provide treatment) did not lessen the impact of the Health Board's service failure on Mr Y at a very worrying time. At the time Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. This was deemed to be an injustice to Mr Y. The Ombudsman therefore upheld this complaint.

The Health Board agreed to the Ombudsman's recommendations that before 14th January 2021, the Health Board should:

a) Provide Mr Y with a fulsome written apology for the failing identified in this report.
b) Make a redress payment of £8,171 to Mr Y to represent the cost of his private treatment.

To confirm, an apology letter was posted together with a cheque on 17 December 2020.

The Health Board also agreed to the Ombudsman's recommendation that, before 3 April 2021 the Health Board should:

c) Refer the report to the Board and ask it to set up a Task and Finish group to review the Urology service to identify where it can improve service delivery, in particular in relation to cancer treatment targets, to ensure that patients' (particularly high-risk patients) care and treatment is not compromised.

The following information has been provided by the Acting Deputy Executive Medical Director and shared with the Ombudsman:

A urology reconfiguration group was set up in January 2019 to review the challenges within Urology and develop a plan to improve service delivery, this was paused as a result of COVID. During COVID the Health Board have worked through the planned care improvement group to pilot a 'Once for Wales' principle to improve access to Urology. As a result of the work of both of these groups the Health Board has made substantive consultant appointments, re-introduced a cystectomy service

back to North Wales and have secured approval to lease a robot which will reduce risk relating to this particular issue.

Ombwdsmon
Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

The investigation of a complaint against Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201905373

Contents	Page

Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr Y.

Summary

Mr Y complained that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer and that due to the delay in providing him with treatment, and the potential impact of any delay, he sought private treatment.

The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules") at the time of the events complained about stated that: "Newly diagnosed cancer patients that have been referred as urgent suspected cancer, and confirmed as urgent by the specialist to start definitive treatment within 62 days from receipt of referral …"

The Ombudsman found that the Health Board would have missed the RTT Rules timescale in Mr Y's case by at least 106 days taking into account the estimated waiting times at the time of Mr Y's diagnosis (3 months). Considering the professional advice that early radical treatment was essential in high-risk disease, a 3 month wait for definitive treatment was unacceptable regardless of the RTT Rules. This was a service failure.

In Mr Y's case, the delay for treatment, and concern about the potential impact on his clinical condition from any delay, led to his decision to seek private treatment. The delay, well in excess of the 62-day target in Mr Y's case, caused him significant distress and anxiety, and his decision to seek private treatment sooner (rather than wait for the Health Board to provide treatment) did not lessen the impact of the Health Board's service failure on Mr Y at a very worrying time. At the time Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. This was an injustice to Mr Y. The complaint was **upheld**.

The Health Board agreed to the Ombudsman's recommendations that, within **6 weeks** of the date of the final report, the Health Board should:

a) Provide Mr Y with a fulsome written apology for the failing identified in this report.

b) Make a redress payment of £8,171 to Mr Y to represent the cost of his private treatment.

The Health Board agreed to the Ombudsman's recommendation that, within **4 months** of the date of the final report, the Health Board should:

c) Refer the report to the Board and ask it to set up a Task and Finish group to review the Urology service to identify where it can improve service delivery, in particular in relation to cancer treatment targets, to ensure that patients' (particularly high-risk patients) care and treatment is not compromised.

The Complaint

1. Mr Y complained that Betsi Cadwaladr University Health Board ("the Health Board") exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer. He was concerned that following a biopsy which confirmed a diagnosis of prostate cancer, there was a delay in providing him with an appointment for treatment. As Mr Y was concerned about the impact of the delay, he sought private treatment.

Investigation

2. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mr Y. Professional advice was obtained from Mr David Almond, a Consultant Urologist ("the Adviser") with extensive experience. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about.

3. The Ombudsman determines whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report, but I am satisfied that nothing of significance has been overlooked.

4. Both Mr Y and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant guidance

5. The Welsh Government's "Rules for Managing Referral to Treatment Waiting Times" ("the RTT Rules") at the time of the events complained about stated that:

> "Newly diagnosed cancer patients that have been referred as urgent suspected cancer ("USC"), and confirmed as urgent by the specialist to start definitive treatment within 62 days from receipt of referral ..."

"... the 62 days commence from the date the hospital receive the referral, not when the specialist reviewed the referral."

6. The National Institute for Health and Care Excellence ("NICE") Guidance (NG131) – Prostate cancer: diagnosis and management (May 2019) ("the NICE Guidance"). The NICE Guidance amongst other things, outlines various treatments that should be offered for medium and high-risk localised prostate cancer.

7. The Health Board's Prostate Protocol (June 2019) ("the Protocol") divides patients with prostate cancer into risk groups based on clinical stage, PSA level (prostate specific antigen – a PSA test is not a specific test for cancer but a marker of cancer risk) and Gleason score (used to grade cancer).

8. One of my predecessors issued guidance, "Principles for Remedy", which recognised that remedying injustice and hardship is a key aspect of the Ombudsman's work. It also set out how bodies should put things right when they have gone wrong. The underlying principle to remedy is to ensure that the listed authority restores the complainant to the position they would have been in if the maladministration or poor service had not occurred, when this is possible.

The background events

9. On 29 May **2019** Mr Y's GP made an urgent suspected cancer ("USC") referral to the Health Board's Urology department. Mr Y's PSA was raised (at 20μg/l).[1] The referral was received by the Health Board on 30 May and confirmed as USC due to raised PSA.

10. Mr Y was seen by a locum consultant urologist on 18 June and he was listed for a prostate biopsy. He underwent the biopsy on 28 June.

[1] μg/l stands for micrograms per litre. The higher the PSA level, the more likely it is that the patient has prostate cancer.

11. Mr Y was seen by a consultant urologist ("the Consultant") on 11 July who confirmed a diagnosis of prostate cancer (the prostate biopsy results confirmed a Gleason score of 3 + 4;[2] left lobe of prostate). Mr Y's management was listed for discussion at the next Urology Multi-Disciplinary Meeting ("the MDT").

12. A bone scan on 26 July was reported as clear. An MRI (Magnetic resonance imaging is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) on 3 August (to stage prostate cancer on the left side) concluded that the disease was organ confined (i.e. had not spread). On 7 August the MDT recommended surgery as part of multimodal treatment.

13. On 13 August the Consultant requested that Mr Y be placed on the pathway for a prostatectomy (surgery to remove the prostate). The Consultant also wrote to a colleague asking him to see Mr Y as a private patient as Mr Y felt that the 3-month wait on the NHS pathway was too long and he was considering private treatment.

14. Mr Y arranged to see a private provider on 15 August where different treatment options and risks of surgery were explained. Mr Y opted for surgery and underwent a prostatectomy procedure privately on 27 August.

Mr Y's evidence

15. Mr Y said the Health Board failed to meet the guidelines for cancer diagnosis and treatment as it exceeded the 62-day referral to treatment pathway.

16. Mr Y said that in August **2019** he anticipated, based on information given to him by the Health Board, that the pathway would take in excess of 7 months. Mr Y therefore arranged to receive treatment from a private provider. He said he suffered financially as a result. Before arranging the private treatment, Mr Y submitted a complaint to the Health Board on 16 August, asking for a resolution to his complaint (i.e. to provide him with treatment) so that he did not have to seek private treatment. He also asked

[2] The Gleason score is a system used to grade prostate cancer using samples from a biopsy of the prostate. It helps predict prognosis. The higher the score, the more aggressive the cancer.

the Health Board to explain whether his cancer would spread beyond his prostate if he waited for NHS treatment (the response was provided on 25 November, after Mr Y had his private treatment).

17. Mr Y said the biopsy, scan and MRI in July / early August reported no cancer in the right side of his prostate. However, after he underwent a prostatectomy with the private provider, he was told that cancer was present in both sides of the prostate. As the information in early August was very different from that reported in the biopsy at the end of August, Mr Y said it seemed his cancer was spreading. Mr Y said if the cancer had been treated quickly it may not have spread. He said this was a distressing thought.

The Health Board's evidence

18. The Health Board formally responded to Mr Y's complaint on 25 November **2019**. The Health Board said that Mr Y was not treated within the 62-day referral to treatment pathway, and it apologised for this. It said the length of wait for prostate treatment was reflective of demand and capacity constraints which the Health Board was striving to address. Whilst additional capacity had been secured at other hospitals, it said the demand for treatment continued to outweigh capacity.

19. In correspondence with my office, the Health Board confirmed it was undertaking work with clinicians and other urology specialist teams to deliver a sustainable service model for the future and improved management of its cancer pathways. This was with a view to improving patient flow and waiting times. It said that it was looking to secure a contract for up to 24 months to create additional capacity for prostatectomies. It confirmed that it already had a contract with another hospital outside the Health Board area for 8 prostatectomies per month but it had no other external provider and no further additional capacity had been identified (it said it obtained a one-off capacity for 16 prostatectomies from a health provider in England). It confirmed that a weekly meeting took place to discuss capacity for complex urology cancer surgery.

20. The Health Board said the cancer tracking system showed that Mr Y was added to the waiting list on 13 August 2019 and that all patients on this list had the same urgent clinical priority. It said that at the time of placing Mr Y on the waiting list, there were a total of 17 patients awaiting the same procedure. It said all patients were listed as urgent and remained on the USC pathway until treated. It said the average wait time for a prostatectomy procedure at the time Mr Y was placed on the list, was 2 to 3 months.

21. The Health Board confirmed that it was, and still is clinical practice, to offer radical radiotherapy (with androgen deprivation therapy)[3] and radical prostatectomy for treatment of organ confined prostate cancer. It said that evidence suggested that radiotherapy alone has inferior results compared to the combination (radical radiotherapy and androgen deprivation therapy) and it has been standard practice at the Health Board to offer both together for about 10 years.

22. The Health Board said that whilst it was difficult to comment on the conversation that took place with Mr Y, the clinical letters stated that Mr Y opted for radical prostatectomy which it said suggested that other treatments were discussed. It said Mr Y had a fairly high PSA test, making the possibility that the cancer was outside the prostate, higher. Surgery was therefore offered as part of multimodal therapy, meaning that if the cancer was not completely removed, Mr Y may well have needed to have radiotherapy in addition to surgery, therefore increasing the complications of treatment. It said that it is the Health Board's normal practice to give information on both surgery and radiotherapy / androgen deprivation therapy to a patient where both can be offered, and let the patient decide which one they prefer.

23. Finally, it said that a variety of treatments can be offered for intermediate and high-risk localised cancer and can include, amongst others, either radiotherapy / androgen deprivation therapy or surgery. It said this was the practice when Mr Y was seen and is still the case.

[3] A treatment for prostate cancer to reduce the level of male hormones (androgens) or stopping them from getting into prostate cancer cells. This can cause the prostate cancer to shrink or grow more slowly.

Professional Advice

24. The Adviser said that suspicion of prostate cancer was first raised in May 2019 when Mr Y's PSA was raised (20μg/l). He said with this level of PSA, the probability of prostate cancer exceeded 67%. On 11 July he said the histology of prostate biopsies confirmed the diagnosis of Gleason 3+4 prostate cancer (with a maximum core length of 13mm). He said that although subsequent imaging showed the cancer to be organ confined, the Urology MDT recommended multimodal therapy (radical prostatectomy followed by external beam radiotherapy to the pelvis),[4] this was because they assessed that this was high-risk disease. The Adviser said low risk prostate cancer is often managed non-operatively and simply observed and monitored, but in high-risk disease early radical treatment is essential.

25. The Adviser said that using Mr Y's cancer staging (T2b N0 M0),[5] grading (Gleason 3+4) and PSA level of 20μg/l, Partin tables[6] predicted a high-risk (46%) of extra prostatic extension of the disease (the spreading of the cancer out of the prostate gland) and regional lymph node involvement (18% - presence of cancer cells in the lymph nodes, small structures that work as filters for harmful substances).

26. The Adviser said the Protocol stratified risk according to PSA, T stage on imaging and Gleason grade. According to the Protocol, Mr Y's Gleason grade and T stage defined his disease as intermediate risk. That said, the Protocol also stated that if any one of the 3 parameters was above the threshold for that level of risk stratification, the risk was increased to the next level. He said that for a PSA of 10-20μg/l the risk was defined as intermediate and 20μg/l was high risk. Mr Y's PSA of 20 placed him on the threshold of high-risk disease.

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[4] External beam radiotherapy is high-energy X-ray beams targeted at the prostate to damage the cancer cells and stop them from growing and spreading to other parts of the body.

[5] The TNM system is a way of staging prostate cancer. It stands for Tumour, Node, Metastasis. T describes the size of the tumour. There are 4 main stages of cancer size in prostate cancer (T1-T4). T2b means the cancer is only half of one side of the prostate gland. N describes if the cancer has spread to the lymph nodes. N0 means that the nearby lymph nodes do not contain cancer cells. M describes whether the cancer has spread to a different part of the body. M0 means the cancer has not spread to other parts of the body (information taken from https://www.cancerresearchuk.org/about-cancer/prostate-cancer/stages/tnm-staging).

[6] The Partin tables use pre-operative clinical features of prostate cancer (Gleason score, serum PSA and clinical stage) to predict whether the tumour will be confined to the prostate.

27. The Adviser said the RTT Rules stated that the target time for treatment of patients with cancer was 62 days, which he said would have been 30 July. From the information available to the Adviser his understanding was that, when surgery was suggested on 13 August 2019, there was a waiting time of up to 3 months for radical prostatectomy. Based on this information, he said the earliest time that Mr Y could have been offered radical prostatectomy through the NHS would have been 13 November, which was around 168 days after the referral was received. The Adviser said that with or without the cancer waiting time targets, the delay to the start of treatment was completely unacceptable.

28. The Adviser said that Mr Y underwent radical prostatectomy as a private patient on 27 August (4 weeks after the RTT target treatment date). He said that this short delay was unlikely to have affected Mr Y's future outcome significantly; post-operatively his PSA was unrecordable, which suggested that no viable cancer cells had been left behind. He said that, although histology of the operative specimen revealed extra prostatic extension of the disease and lymph node involvement, this was always likely because of the defining features of high-risk disease at presentation.

29. The Adviser said it was difficult to estimate how much 3 months further delay would have affected Mr Y's outcome. While there was no difference in outcome for a patient with low risk disease undergoing immediate or delayed prostatectomy, the effect of delayed treatment on patients with high risk disease was harder to predict. In addition, he said the psychological distress caused by waiting for treatment of a potentially life-threatening cancer would need to be factored in.

30. In terms of Mr Y's assertion that if his cancer had been treated quickly it may not have spread, the Adviser said that although there may be some truth in Mr Y's assertion that the delay to treatment caused local spread of disease to the opposite lobe of the prostate, he said this was very hard to quantify. He said it was more likely that the disease was always present on both sides of the prostate because the disease on the right side had not been detected pre-operatively for technical reasons. Histology of the surgical specimen revealed unexpected disease in the apical region (the end of an organ) of the prostate on the right side. He said this area of the prostate was notoriously difficult to image.

31. The Adviser said that, based on the records of Mr Y's consultations, it was unclear if all available treatment options were explained / offered to Mr Y.

32. In terms of the Health Board's actions in outsourcing treatment and its capacity to provide treatment, the Adviser said that an offer of 8 additional prostatectomies per month would be sufficient to clear the backlog within 2 months and would provide sufficient capacity to meet ongoing requirements.

Analysis and conclusions

33. In reaching my conclusions I have been assisted by the advice and explanations of the Adviser, which I accept in full. The conclusions, however, are my own.

34. Mr Y complained that the Health Board exceeded the referral-to-treatment target for cancer waiting times for treatment of prostate cancer and that due to the delay in providing him with treatment and the potential impact of any delay, he sought private treatment.

35. In accordance with the RTT Rules, Mr Y should have received definitive treatment for his cancer within 62 days of the receipt of the USC referral on 30 May 2019. Considering that Mr Y was told on 13 August that the waiting times for treatment were at that time, 3 months, Mr Y would not have realistically received treatment until 13 November, 168 days after receipt of the USC referral. The Health Board would have missed the 62-day target by 106 days. The Health Board has already acknowledged and apologised to Mr Y that it breached the RTT Rules in Mr Y's case. Taking into account the advice, that early radical treatment was essential in high-risk disease, a 3 month wait for definitive treatment was unacceptable regardless of the RTT Rules. This was a service failure. In addition, I am not satisfied that the records clearly demonstrate that all available treatment options were explained / offered to Mr Y, and I concur with the Adviser in this regard. That said, the private Surgeon explained all available treatment options to Mr Y before he opted for surgery and therefore, he was not ultimately disadvantaged. I **invite** the Health Board to reflect on this point, and the importance of clearly documenting discussions with patients when treatment options are offered / discussed.

36. To uphold a complaint, I must be satisfied that a service failure has caused harm or injustice. Whilst I have noted the advice about the difficulty in estimating the impact of a 3 month delay on clinical outcome, as Mr Y sought private treatment, the actual impact (as opposed to the potential impact of a 3 month delay) was mitigated. Mr Y's treatment was therefore not delayed to the extent it would have been had Mr Y continued to wait for treatment from the Health Board. I am also guided by the advice that a short delay between the definitive date that Mr Y should have received treatment by the Health Board and the actual date he received treatment privately was unlikely to have significantly affected Mr Y's future outcome. I also accept the advice that on the balance of probabilities (the standard of proof I apply when investigating complaints), it was more likely that the disease was present on both sides of Mr Y's prostate rather than any delay causing a spread to the right lobe of his prostate.

37. However, the diminished impact on Mr Y's clinical outcome as a result of his action in seeking and paying for earlier private treatment should not, and does not, exonerate the Health Board of its responsibility to provide necessary treatment within the timescale set out in the RTT Rules for cancer treatment, especially for a high-risk patient.

38. In Mr Y's case, the delay for treatment, and concern about the potential impact on his clinical condition from any delay, led to his decision to seek private treatment. The delay well in excess of the 62-day target in Mr Y's case, caused him significant distress and anxiety, and his decision to seek private treatment sooner, rather than wait for the Health Board to provide treatment, does not lessen the impact of the Health Board's service failure on Mr Y at a very worrying time. At the time Mr Y sought private treatment, he was concerned that the cancer would spread if he waited for NHS treatment. This was an injustice to Mr Y. I **uphold** the complaint.

39. This is not the first time my office has had cause for concern about the Health Board's delivery of treatment / investigations for prostate cancer. Last year I received 2 complaints that multiparametric magnetic resonance imagining (mp-MRI) scans (a special type of scan that creates more detailed pictures of the prostate than a standard MRI) were not made available to 2 patients in accordance with recommendations in the

NICE Guidance.[7] As a result, both patients paid for private scans. As the Health Board agreed to reimburse the costs of the private scans and set out arrangements it had put in place to provide mp-MRI scans at 3 main hospitals in North Wales to comply with the updated NICE Guidance published in May 2019, I was satisfied that the actions taken, in both these cases, resolved these individual complaints. I was also assured that appropriate arrangements had been put in place by the Health Board so that other patients were not impacted in future.

40. In addition, I issued a public interest report in October **2016**,[8] which found that, not only were there delays in diagnostic testing (including template biopsy) to determine if the patient had cancer, but when tests confirmed an aggressive form of prostate cancer, the patient had to wait a total of 132 days (from diagnosis) to receive his first definitive treatment for prostate cancer (a radical prostatectomy). The failure in diagnostic testing, specifically, a delay in undertaking a prostate template biopsy, was reported again in August **2018**.[9]

41. The Health Board said the length of wait for prostate treatment was reflective of demand and capacity constraints. While the Health Board has taken steps to address capacity issues which, based on the advice I have received, appears reasonable, it is concerning that Mr Y and 16 other urgent patients were (potentially) waiting in excess of the 62-day target for treatment in August **2019**.

42. As I am concerned that there were 16 other patients on the waiting list for a prostatectomy at the time Mr Y was placed on the list and that they were all deemed to have urgent priority, I cannot ignore the possibility that these other 16 patients may well have waited beyond the 62-day wait for treatment. Given their urgent status (and confirmation as USC), this may have had serious consequences for their prognosis / treatment. This is clearly a matter that is in the public interest and this is further supported by the related concerns about prostate treatment received by other patients

[7] Cases 201804421 & 201803742.
[8] 201503554.
[9] 201702873.

which my office has previously investigated. I have therefore commenced an Own Initiative Investigation[10] to consider these 16 cases as I am satisfied that the criteria have been met.

43. In Mr Y's case I am satisfied that he suffered an injustice for the reasons set out in paragraph 38. Had the RTT Rules not been breached, Mr Y, a high-risk patient, would not have been in a position where he had to consider and, ultimately, opt for private treatment. The distress caused by the Health Board's inability to offer treatment, well in excess of the timescales set out by the Welsh Government for treatment of cancer, understandably left Mr Y with a stark choice; wait for treatment not knowing what impact this would have on his prognosis and future treatment, or pay for private treatment to mitigate the uncertainty. In line with "the Principles of Remedy", I consider that reimbursement of the cost of that treatment will restore Mr Y to the position he would have been in had the service failure not occurred.

Recommendations

44. I **recommend** that, within **6 weeks** of the date of this report, the Health Board should:

a) Provide Mr Y with a fulsome written apology for the failing identified in this report.

b) Make a redress payment of £8,171 to Mr Y to represent the cost of his private treatment.

45. I **recommend** that, within **4 months** of the date of this report, the Health Board should:

c) Refer the report to the Board and ask it to set up a Task and Finish group to review the Urology service to identify where it can improve service delivery, in particular in relation to cancer treatment targets, to ensure that patients' (particularly high-risk patients) care and treatment is not compromised.

[10] Under section 4 of the Public Services Ombudsman (Wales) Act 2019.

46. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Nick Bennett
Ombudsman

3 December 2020

Public Services Ombudsman for Wales
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Cyfarfod a dyddiad: Meeting and date:	15 January 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) – Update Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes Acting Associate Director of Quality Assurance/Assistant Director of Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Erika Dennis Senior Quality Assurance and Regulation Manager
Craffu blaenorol: Prior Scrutiny:	Bi-monthly reports submitted to the Patient Safety and Quality Group (PSQ).
Atodiadau Appendices:	1. Link to Healthcare Inspectorate Wales National Review Maternity Services, Phase One Report, Published 19 November 2020 2. Link to Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), The Stables Medical Practice (Non NHS Managed) on 8 September 2020. Published 17 November 2020 3. Healthcare Inspectorate Wales Quality Check (Planned), Ablett Unit, Glan Clwyd Hospital on 20 November 2020 **-** included as an Appendix as the report has not yet been published by Healthcare Inspectorate Wales at the time of writing

Argymhelliad / Recommendation:

The Committee are asked to note the following reports;

1. Healthcare Inspectorate Wales National Review Maternity Services, Phase One Report, Published 19 November 2020
2. Healthcare Inspectorate Wales Tier 1 Quality Check (Planned), The Stables Medical Practice (Non NHS Managed) on 8 September 2020. Published 17 November 2020
3. Healthcare Inspectorate Wales Quality Check (Planned), Ablett Unit, Glan Clwyd Hospital on 20 November 2020

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

Sefyllfa / Situation:

The purpose of this paper is to inform the Committee of the HIW reports noted in 'Recommendation', and to provide assurance to members that these matters are being progressed.

HIW National Review Maternity Services, **Phase One Report (Appendix 1)**
Publication date: 19 November 2020

https://hiw.org.uk/sites/default/files/2020-11/20201118HIWNationalReviewofMaternityServicesEN_0.pdf

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

Phase One

HIW launched the national review of Maternity services across Wales in June 2019. Phase one of the review ran from June 2019 to summer 2020. The review explored the experiences of women, their partners and families, and the extent to which health boards across Wales:

- Provided safe and effective Maternity services
- Understood the strengths and areas for improvement within their maternity services.

From June 2019 to January 2020 HIW carried out a programme of unannounced inspections of maternity services across Wales. Following this, they carried out a further programme of announced inspections within free standing birthing units. Each inspection resulted in its own inspection report.

All maternity inspection reports and the terms of reference for Phase One have previously been reported to QSE and can be found on HIW's website https://hiw.org.uk/.

Summary of Phase One Findings

- The quality of care being provided across Wales is generally good, and the majority of women and families who use maternity services report positive experiences, delivered by a hugely committed and dedicated group of professionals.

- Maternity services are, in general, delivered in a safe and effective way, and this is supported by almost 3,500 responses to HIW's public survey. The overwhelming majority of respondents were satisfied and positive with the standard of care and support they received along each stage of the maternity pathway, however, HIW identified some areas requiring improvement.

- HIW found that: the level of support, advice and guidance for women and families was positive, and that women receive enough information to make informed decisions about their care. However, some women did not feel they were able to express opinions and concerns about their birth choices, felt ignored, or they did not receive consistent care due to the number of professionals they saw on their pregnancy journey.

- The 25 maternity unit inspections (with each report published on HIW's website), were generally satisfactory. However, HIW consistently found improvements were required around the checking of neonatal resuscitaire and emergency equipment, medical emergency arrangements, security of new-born babies and management of medicines. These issues were addressed immediately following each inspection through HIW's Immediate Assurance process, with the relevant health board providing us with assurance regarding actions taken to address these concerns.

- Staff were committed and dedicated, doing their utmost to provide high quality care. However, it was clear from HIW inspections and survey results that staff were working under pressure, and they felt that there are not enough staff to enable them to do their job properly.

- HIW did not find any significant concerns regarding the oversight of services within each health board, and found clear organisational structures in place throughout Wales, with clear lines of reporting and accountability.

- HIW saw clear and robust processes for reporting and investigating clinical incidents and concerns. In general, risk assessments and risk registers were completed and maintained, and were updated regularly. However, HIW did find room for improvement in ensuring that trends, themes and learning arising from incidents are effectively shared with staff. As such, health boards need to ensure that a positive, clear and transparent reporting culture is present within their maternity services, so that quality of care can be maintained and improved.

Next Steps

HIW expect all Health Boards across Wales to carefully consider the findings from the phase one review and the recommendations set out in Appendix C of their phase 1 report (page 65). This information will then be used to further improve services being provided to women, and to inform further work across Wales, as highlighted within the report. Welsh Government recommendations are also detailed within Appendix D (page 76).

Three months after the publication of the report (February 2021), each Health Board and Welsh Government, are required to submit an improvement plan in response to the recommendations. This is to ensure that the matters raised by the review are being addressed. The findings within the review so far have enabled HIW to review the scope and direction of phase two.

There are agreed national actions and timelines for the next steps. Fiona Giraud, Director Of Midwifery & Women's Services has confirmed that discussions with Welsh Government and HIW took place at a briefing event in November 2020, and it has been specifically agreed that health boards have a three months response and return time scale as we have agreed to some national actions to support our overall responses on this occasion, and to ensure quality and consistency in our submissions.

As such, in response to the report the Women's Directorate has taken the following steps:

Locally

1) Formally reviewed the phase one report and discussed the findings and learning at the Women's Service Board on 27th November 2020.
2) Considered all 32 recommendation for Health Boards and the 5 recommendations for Welsh Government's consideration.
3) The full report has been circulated by e-mail to all staff within the Women's Directorate.
4) The slides from the WG/HIW Learning Event have been circulated to Leads / Managers to inform local discussions as part of the Women's governance structure.
5) An update on the findings of the Report and the Service's response was presented to executives colleagues at an Executive Accountability meeting on 26/11/20 and a formal update was provided to the Corporate Patient Safety and Quality Group on 11/12/20.
6) The Service is currently working with stakeholders to complete the response template as requested by HIW.

Nationally

1) A multidisciplinary team representing local services attended a National Learning Event on the 2 December 2020, hosted by Welsh Government and HIW, in response to the publication of the report.
2) The team representing the health board presented their top 3 priorities having reflected on the findings and learning from the report
3) The Director of Midwifery and Women's Services will be attending a meeting of the Heads of Midwifery Advisory Group to consider the recommendations made in the report and looking at national solutions going forward. The HIW Lead Investigator for this review will be present at the meeting.
4) The Director of Midwifery and Women's Services also sits on the HIW Maternity Review Stakeholder Group and attended a meeting on 8 December 2020 where; the findings of the phase one review were shared, an update from the National Learning Event was provided, a comprehensive discussion was held regarding the scope of phase two of the review and timing of this phase due to COVID was considered.

The Health Board's response to the recommendations (Appendix C) will receive review and sign off by both the Executive Director of Nursing and Midwifery and the Patient Safety and Quality Group prior to submission to HIW in February 2021. Subsequently, the completed improvement plan, along with updates in relation to the above actions, will be reported to QSE in March 2021, for assurance.

Phase Two

HIW are now working on phase two of the review and it is their intention to conduct phase two of the national review between November 2020 and March 2021, with a view to reporting their findings by summer 2021. HIW are aware that these timescales may be contingent upon the impact of the COVID-19 pandemic, and winter pressures.

Phase two will conclude with an overall national review report, which will incorporate phase two findings and will reflect on phase one, and the overall review conclusions. It seeks to report in more detail on antenatal and postnatal care, and follow-up on some inspections undertaken phase one.

The Stables Medical Practice
HIW Tier 1 Quality Check (Planned), The Stables Medical Practice (Appendix 2)

Inspection Date: 8 September 2020
Publication Date: 17 November 2020
https://hiw.org.uk/sites/default/files/2020-11/20201117TheStablesEN_0.pdf

On 8 September 2020, an announced Tier 1 Quality Check (off site inspection) was undertaken at the Stables Medical Centre, Hawarden. Subsequently, an immediate assurance notice was issued to the practice. Both the immediate improvement plan and improvement plan can be found at the back of the report (pages 8 to 11).

Whilst this is not a Health Board Managed Practice, due to the issues raised by HIW following this inspection, along with outcomes from three previous HIW inspections since 2017 which had highlighted a number of ongoing improvements required, HIW invited the practice and the Health Board to a provider meeting which took place on 19 October 2020.

On 21 October 2020, HIW wrote both to the practice and Health Board to advise that as a consequence of the meeting, HIW remain concerned over the ability of the practice to address the issues from their inspection, and sustain improvements that have been made. HIW noted that they are also concerned about the role of the Health Board in providing support to the practice; *"It was unclear what the plans of the health board in response to our concerns, and in particular, what intervention or support is planned in response of the health board's significant ongoing concerns regarding The Stable Medical Centre".*

Chris Stockport, Executive Director Primary & Community Care has oversight of this issue. Following the recent letter received from HIW, the Health Board responded to confirm what steps it has and will take in relation to this matter. An assessment document with an action plan pending, has been formulated by the service.

This was reported to the Patient Safety and Quality Group (PSQG) on 13 November 2020 and will continue to be reported to PSQG to ensure oversight and monitoring moving forward.

Ablett Unit, Glan Clwyd Hospital
HIW Quality Check (Planned), Ablett Unit, Glan Clwyd Hospital Report (Appendix 3)

Inspection Date: 20 November 2020
Publication Date: to be confirmed

It is very pleasing to report that there were no immediate issue raised, and overall, the inspection was positive. HIW did however make some recommendations for improvement. The Health Board completed an Improvement Plan providing SMART actions and timescales, against the three recommendations made by HIW.

On 11 December 2020, HIW confirmed that they have evaluated the Health Board's response and concluded that it provides them with sufficient assurance. This is because the improvements HIW identified have either been addressed and/or progress is being made to ensure that patient safety is protected.

The Mental Health and Learning Disabilities Directorate have responsibility for the Improvement Plan and will continue to report on the progress of actions through the internal governance meeting

reporting structure. In addition, Corporate Quality Assurance will liaise with the service and ensure oversight and monitoring of the Improvement Plan by using the HIW Corporate Tracker and will report on progress to the Patient Safety and Quality Group (PSQG).

Cefndir / Background:

HIW inspect the NHS in Wales, from General Practices to Hospitals. HIW assess compliance based on the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation.

As previously reported to QSE, there is an agreed internal Standard Operating Procedure (SOP) for HIW along with a timeline which confirms the HIW timescales for issuing the Health Board with any immediate concerns and/or improvement plans for completion, based on the findings from the inspections.

The Corporate Quality Assurance Team is responsible for coordinating and overseeing all HIW activity. This is done historically through a tracking spreadsheet with services also owning local trackers; as reported previously a central database is being developed and implemented to create a “Once for North Wales” approach, improve assurance from evidence availability and reduce delays and duplication.

Asesiad / Assesent & Anaysis

Strategy Implication

The provision of quality care in a safe environment is paramount to the Health Board’s Quality Strategy (QIS) and Living Healthier Staying Well.

Financial Implications

None identified

Risk Analysis

Compliance with the Health and Care Standards is a requirement for all NHS Wales organisations.

Legal and Compliance

Compliance with the Health and Care Standards is a requirement for all NHS Wales organisations.

Impact Assessment

This report is purely administrative, there are no associated impacts or specific assessments required.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name: Ablett Unit (Glan Clwyd Hospital)

Activity date: **20 November 2020**

Publication date:

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
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Digital ISBN XX

WG41024

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Ablett Unit at Glan Clwyd Hospital as part of its programme of assurance work. The Ablett Unit provides NHS mental health services and is managed by Betsi Cadwaladr University Health Board.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Interim Acute Care Clinical Site Manager on 20 November 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The Ablett Unit has traditionally been an acute care admissions unit for adults and functional older persons. However, in April 2020, the Ablett Unit was temporarily recommissioned to be the Acute Care Admissions Unit for all adult patients across North Wales. These new regional arrangements were implemented by the health board in an attempt to safely manage acute patients during the pandemic. Non-acute patients at the unit were relocated to other sites to accommodate this change.

The following positive evidence was received:

We were told that patients are generally very unwell when being admitted into the unit and therefore the new care pathways for patients through the temporary regional model in North Wales are communicated to the families and advocates of patients wherever possible.

We were provided with documentation that outlined the significant changes undertaken to ensure the unit could safely provide care to acute adult patients. Wards were designated as 'red', 'amber' and 'green' to help separate and manage patients according to their COVID-19 status. This has meant that for short periods the 'amber' ward will become a mixed ward. We were told that this had been risk assessed, and that bedrooms and bathrooms are segregated as much as possible to maintain the privacy and dignity of patients, and that staff monitor any shared spaces at all times.

We were told that the long stay rehabilitation ward was closed to allow for anti-ligature risk assessments to be undertaken. We saw evidence of the existing and additional control measures and modifications put in place to ensure the ward environment was appropriate and safe for acute patients. The other wards are subject to anti-ligature risk assessments annually.

We were told that visiting arrangements during COVID-19 shifted to virtual communication due to the national restrictions on visitors in healthcare settings. Patients have been able to stay in contact with their families, friends and/or carers using their own mobile phones or using an iPad made available to patients by the hospital.

We were told that all patients have risk management plans that include an assessment on

whether patients are eligible for Section 17 leave[1]. The Interim Acute Care Clinical Site Manager described how changes to granting patients' leave had been managed during COVID-19. Patients were typically not granted leave from hospital during periods of lockdown and staff undertook shopping on behalf of patients. When patient leave was granted after lockdowns had been lifted, we were informed that appropriate PPE was worn by staff and patients and social distancing was adhered to.

We reviewed data on the amount of incidents involving challenging behaviour and restraint at the unit and discussed this information with the Interim Acute Care Clinical Site Manager. We were told that the majority of such incidents that have occurred over the last three months involved a small number of patients with demanding acute needs. We saw that reviews of incidents had taken place and that learning opportunities and training needs had been identified and actioned where necessary.

The following areas for improvement were identified:

The Interim Acute Care Clinical Site Manager told us about a serious incident that occurred at the unit a few months ago, whereby a patient was admitted to the unit's Section 136 suite[2] instead of being admitted to a more appropriate setting. HIW understands the difficulties involved with identifying an appropriate placement for this patient, but the health board must ensure that patients are not inappropriately admitted to the unit to help protect staff and ensure patients receive the right care and treatment when needed.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We spoke to the Interim Acute Care Clinical Site Manager about the arrangements in place to help stop the transmission of COVID-19 throughout the unit. Patients are triaged in the community by the Home Treatment Team to check for symptoms of COVID-19. All patients are then tested for COVID-19 upon admission to the unit and initially placed on the 'amber' ward. Patients are then either moved to the 'green' or 'red' ward depending on the result of their COVID-19 status. We were informed that appropriate Personal Protective Equipment

[1] Section 17 of the Mental Health Act allows detained patients to be granted leave of absence from the hospital for a defined purpose and duration to help patients in their recovery for discharge back into the community.
[2] A Section 136 suite is a facility for people who are detained by the Police under Section 136 of the Mental Health Act.

(PPE) is available for staff to barrier nurse patients on the 'amber' and 'red' wards in line with national guidance. Encouragingly, the unit has only reported two positive cases of coronavirus for patients.

We were told that all staff have been made aware of how to safely don and doff PPE and on which PPE to wear during different situations, for example, when undertaking a planned necessary restraint. The Interim Acute Care Clinical Site Manager confirmed that regular PPE refresher training is available for staff and that daily audits are undertaken to check their competency and understanding of their responsibilities in relation to PPE. Daily stock checks of PPE are undertaken by staff to ensure there are no incidents of shortages at the unit.

We saw that a COVID-19 social distancing action plan had been completed for the unit to ensure it could adhere to social distancing guidelines. The Interim Acute Care Clinical Site Manager confirmed that patients were being encouraged to socially distance wherever possible. Mealtimes have been split into two separate sittings to help facilitate extra space amongst patients and staff.

We saw evidence of a recent Infection Prevention (IP) Review Visit undertaken by the Clinical Service Lead for Infection Prevention at the health board, to check the infection prevention and control (IPC) arrangements in place at the unit. We noted that the review was positive.

We were provided with mandatory training statistics for staff and saw that compliance with IPC training was high across all staff members within each ward at the unit.

The following areas for improvement were identified:

We were told that there were no specific health board policies available in relation to infection prevention and control or in response to the COVID-19 pandemic. However, HIW are aware from previous quality checks undertaken recently within Betsi Cadwaladr University Health Board, that such policies are available. We were previously informed that relevant policies were being reviewed and were pending approval at the Infection Prevention Sub Group scheduled for 13 October 2020. The health board must ensure that all staff are aware of such policies and that findings from quality checks undertaken by HIW are recognised and shared across all health board settings.

The Interim Acute Care Clinical Site Manager told us that cleaning rotas have been altered to reflect the enhanced programme of cleaning undertaken at the unit since the onset of COVID-19. However, recent COVID-19 daily audit checklists show that domestic enhanced cleans are not being performed (e.g. additional cleans of high touch points) across the unit. The service must ensure that surfaces are regularly wiped down to help stop the transmission of COVID-19 throughout the unit.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed. We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

During the undertaking of the quality check it was apparent that staff have worked tirelessly and selflessly to meet the new challenges faced at the unit since the onset of COVID-19. This has included staff working overtime or working bank shifts to help ensure the unit can deal with the high volume of admissions of acute adult patients. HIW understands that plans are being implemented across the health board to move away from the regional model and move back to settings providing their traditional mental health services. We would support this move to help protect the health and wellbeing of staff working within mental health services across the health board. HIW will continue to seek assurance around the impact of the regional model, including the pressures faced by mental health services across North Wales through its Relationship Manager[3] role.

The following positive evidence was received:

We discussed the arrangements in place to help ensure that there is the right skill mix and number of staff on the unit during each shift. Rotas are normally reviewed on a monthly basis and we saw evidence of Staffing Escalation Procedures developed by the health board to help staff understand the steps required to ensure there are adequate numbers of staff working on each shift to meet the needs of patients. However, staffing requirements are now subject to daily scrutiny since the unit became the Acute Care Admissions Unit for all adult patients across North Wales.

We were informed that staffing levels are monitored constantly and any risks are escalated through either the acute care meetings held daily or the local safety huddles held three times a day. Staff are typically allocated to specific wards for an extended period of time to allow an element of consistency to the care provided to patients throughout their short stay on the unit. However, we were told that staff are redeployed based on need to areas identified as having the highest levels of risk at any given time when required.

The Interim Acute Care Clinical Site Manager described the support provided to staff in their roles. This included regular clinical supervision opportunities and the completion of annual Performance Appraisal and Development Reviews (PADR), to discuss objectives and to help identify any learning requirements. We were told that 83% of staff had received their annual PADR and that plans were in place to ensure those outstanding would be completed within the

[3] HIW Relationship Managers work closely with each health board and trust across Wales to understand the risks and issues faced by each organisation to help provide HIW with assurance on their performance.

next month. We saw evidence that compliance with mandatory and statutory training was high amongst staff working at the unit. Initiatives such as relaxation sessions have also been offered to help support staff with their wellbeing.

We were told that the needs of patients have continued to be met by involving patients and their families in the development and review, of their care and treatment plans. This has had to take place virtually during COVID-19, but has still involved relevant clinicians and multidisciplinary team members. We were informed that there were issues initially working remotely with Community Mental Health Teams (CMHTs) across North Wales. This was because patients were often admitted to the unit a long way away from their local area and support teams. Encouragingly, we understand communication has since improved and the required documentation is being provided by CHMTs to allow the unit to plan for the timely and appropriate discharge of patients.

The Interim Acute Care Clinical Site Manager told us that support is available to help the unit discharge its duties to patients with regards to the Mental Health Act (MHA). The MHA administration team at the health board provide guidance to staff when necessary to help ensure patients are aware of their rights. Patients have continued to have their cases reviewed by the Mental Health Review Tribunal for Wales and access to wider health professionals such as advocacy has been made available to patients remotely.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

Improvement plan

Setting: Ablett Unit, Glan Clwyd Hospital

Date of activity: 20 November 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must ensure that patients are admitted to mental health units across North Wales where they can receive the appropriate care and treatment for their needs.	Health and Care Standards Wales Standard 3.1 Safe and Clinically Effective Care	The MHLD Division has plan in operation to transition patient admissions within the Local Authority areas as per process pre pandemic. Each locality has submitted plans in liaison with Infection Prevention Team for their units regarding segregation and isolation of patients in relation to Covid. They are now progressing with any works required to complete the transition.	Heads of Operations	31st January 2021
2	The health board must ensure that findings from quality checks undertaken by HIW are recognised	Health and Care Standards Wales Standard 6.3	There is a governance process for communication regarding feedback such as findings from HIW reviews.	Director of Nursing	31st December 2020

	and shared across other health board settings.	Listening and Learning from Feedback	Communication through local and Divisional Quality Safety Experience Meetings and subsequently shared with equivalent meetings across the rest of the Health Board. Whilst each individual service/area take responsibility for their Improvement Plans and report via the internal governance reporting structure to ensure learning and communication, the Health Board also have a Corporate HIW Action Tracker which is overseen by Corporate Nursing. Bi-monthly reporting on progress against all actions, including matters for escalation, go to the Patient Safety and Quality Group which is chaired by the Executive Director of Nursing and up to the Corporate Quality and Safety Committee, when required. Collectively, these raise staff awareness to HIW Inspections and aid learning across the Health Board. To strengthen learning further, we are working to ensure the triangulation of data from intelligence such as Datix. Datix is an information system, which captures Risk, Complaints, Incidents, and Patient Experience. A HIW 'Test' Module has been built into Datix. Moving forward, this should allow us to triangulate and strengthen our learning from HIW and across other intelligence		

			as listed above.		
3	The service must ensure that domestic enhanced cleans are being undertaken to help stop the transmission of COVID-19 throughout the unit.	Health and Care Standards Wales Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The Acute Care Manager already escalated this prior to the quality check with Facilities Manager which is aligned to ensuring domestic staff are cleaning the unit as per expectation. The Acute Care Manager is monitoring this on a daily basis during their walk around and escalates any ongoing issues with Facilities Manager. Additionally, the Infection Team also carry out walk rounds on the unit and provide feedback regarding any issues and assist with any escalation. Locality Infection Prevention Group (LIPG) meetings are scheduled on a monthly basis are also in situ with MHLD included. Exceptions regarding any issues with audits such as Credits 4 Cleaning are received at this forum for assurance and any assistance, reporting any matters of significance into the Environmental Group.	Ablett Acute Care Manager.	Complete.

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: Tom Regan, Head of Nursing, Mental Health & Learning Disabilities

Date: 10 December 2020

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 15th January 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Kate Dunn, 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**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	✓

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Quality, Safety and Experience Committee considered the following matters in private session on 3.11.20:

- Presentation on quality governance review at Ysbyty Glan Clwyd