Bundle Quality, Safety & Experience Committee 2 March 2021

9.30am Via Zoom

PUBLIC SESSION

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

1.0 09:30 - OPENING BUSINESS AND EFFECTIVE GOVERNANCE

1.1 QS21/34 Chair's Opening Remarks

1.2 QS21/35 Declarations of Interest

1.3 QS21/36 Apologies for Absence

1.4 QS21/37 Minutes of Previous Meeting Held in Public on 15.1.21 for Accuracy, Matters Arising and Review of Summary Action Log

QS21.37a Minutes QSE 15.1.21 Public V0.04.docx

QS21.37b Summary Action Log QSE Public.docx

2.0 FOR DISCUSSION

2.1 09:45 - QS21/38 Covid-19 Vaccination Update - Gill Harris

Recommendation:
The Committee is asked:
1. To note the current vaccination number to date
2. To note the high ranking risks to the programme
3. To recognise the successful completion of gateway 1 the achievement of cohort 1-4 at above 80%

QS21.38a Covid vaccination_reformatted.docx

QS21.38b Covid vaccination appendix 1.pptx

2.2 10:05 - QS21/39 Board Assurance Framework Principal and Corporate Risk Report : Simon Evans-Evans / Louise Brereton

Recommendation:
The QSE 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. Consider whether there is a need for the Board to review the Risk Appetite Statement in the light of some of the existing target risk scores.

QS21.39a BAF and Corporate Risk Report v1.0 amended 23.2.21.docx

QS21.39b BAF and Corporate Risk Report Appendix 1.pdf

QS21.39c BAF and Corporate Risk Report Appendix 2 v2.pdf

2.3 10:20 - QS21/40 Infection Prevention & Control Report : Gill Harris

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

QS21.40a IPC report.docx

QS21.40b IPC Appendix 1 Performance Pack January Data 20210212.ppt

2.4 10:30 - QS21/41 Health & Safety Update Report Covid19 : Sue Green

Recommendation:
The Committee is asked to note the position outlined in the report.

QS21.41 Health and Safety Update Report - COVID19.docx

2.5 10:45 - QS21/42 The Impact of Covid-19 on Child Health Services within BCUHB - Chris Stockport

Bethan Jones and Louise Bell to attend.

Recommendation:
The QSE Committee is asked to endorse this report

QS21.42 Childrens Services Covid Impact Report_reformatted.docx

2.6 11:00 - QS21/43 COMFORT BREAK

2.8 11:10 - QS21/44 Covid-19 Mortality Report : Arpan Guha

Recommendation:
The Committee is asked to review the attached report that documents deaths from COVID 19, findings from reviews undertaken and the associated learning.

QS21.44a Covid mortality report_reformatted.docx

QS21.44b Covid mortality_Appendix 1_updated 18.2.21.pptx

2.9 11:30 - QS21/45 Patient Safety Report Q3 : Gill Harris

Recommendation:
The Quality, Safety and Experience Committee is asked to:
1\. Note the concerns about the introduction of the Once for Wales Concerns Management System incidents module\.
2\. Receive the report and provide feedback on its evolving content and layout\.

QS21.45 Patient Safety Report_reformatted.docx

2.10 11:45 - QS21/46 Update on Planned Care Recovery and Essential Service Delivery Within Planned Care: Gill Harris

Andrew Kent to attend

Recommendation:
The Committee are asked to note the approach that is part of the six-point plan and its link to maintaining patient safety and quality

QS21.46 Planned Care_reformatted.docx

2.11 12:05 - QS21/47 Vascular Task and Finish Group Update : Arpan Guha

Jo Garzoni (Vascular Network Manager) and Sorough Sohrabi (Vascular Consultant) to attend

Recommendation:
The Committee is asked to note the progress made by the Vascular Task and Finish Group

QS21.47a Vascular Update v1.6 JG FINAL 23.2.21.docx

QS21.47b Vascular_RCS Eng IRM Terms of Reference_Appendix 1.docx

QS21.47c Vascular_Task_and_Finish_RAG_Highlight_Report v3 post TF group_Appendix 2.doc

QS21.47d Vascular_Amputation_mortality_review_action_plan v0.4_Appendix 3.docx

QS21.47e Vascular_AAA_mortality_review_action_plan v0.1_Appendix 4.docx

3.0 12:25 - FOR CONSENT

3.1 QS21/48 Sub Group Chairs' Triple A Reports

Note - Patient and Carer Experience Group latest meeting stood down

3.1.1 QS21/48.1 Strategic Occupational Health and Safety Group - Sue Green

QS21.48.1 Chair's Triple A Report SOHS Group 16.02.21_amended.docx

3.1.2 QS21/48.2 Patient Safety Quality Group - Gill Harris

QS21.48.2 Chair's Triple A Report PSQ 17.2.21.docx

3.1.3 QS21/48.3 Clinical Effectiveness Group - Arpan Guha

QS21.48.3 Chair's Triple A Report CEG 19.2.21.docx

4.0 12:35 - FOR INFORMATION

4.1 QS21/49 Quality Improvement Strategy and Patient Safety & Experience Strategy : Gill Harris

Verbal position statement

4.2 QS21/50 Issues Discussed in Previous Private Session

Recommendation:
The Committee is asked to note the report

QS21.50 Issues discussed in previous private session.docx

4.3 QS21/51 Documents Circulated to Members

14.1.21 Q3 and Q4 Operational Plan Monitoring Report as at November 2020
15.1.21 Quality and Performance Report as at November 2020
27.1.21 Limited assurance reports from Audit Wales on 1) Quality Impact Assessment and 2) Continuing Health Care
22.2.21 Dental briefing note

4.4 QS21/52 Issues of Significance to inform the Chair’s Assurance Report

4.5 QS21/53 Date of Next Meeting

4th May 2021

4.6 QS21/54 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 15.1.21 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 (CHC)
Louise Brereton	Board Secretary *(observing)*
Peter Bohan	Associate Director of Health, Safety and Equality
Kate Dunn	Head of Corporate Affairs (*for minutes*)
Gareth Evans	Chair of Healthcare Professional Forum
Simon Evans-Evans	Interim Director of Governance
Arpan Guha	Interim Executive Medical Director
Dave Harries	Head of Internal Audit
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Debra Hickman	Associate Director of Quality Assurance
Matthew Joyes	Assistant Director of Patient Safety and Experience
Andrew Kent	Interim Head of Planned Care Transformation (*part meeting)*
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead
Urvisha Perez	Audit Wales (*observing)*
Mike Smith	Interim Director of Nursing Mental Health and Learning Disabilities

Agenda Item Discussed	Action By
QS21/1 Chair's Opening Remarks The Chair welcomed attendees and confirmed that this month's meeting had a refocused and streamlined agenda to assist officers and the wider organisation in their ability to deal with the ongoing pandemic.	
QS21/2 Declarations of Interest None	
QS21/3 Apologies for Absence Recorded for Adrian Thomas, Chris Stockport, Sue Green and Teresa Owen.	
QS21/4 Draft Minutes of Previous Meeting Held in public on the 3rd November 2030 for Accuracy, Matters Arising and Review of Summary Action Log	

QS21/4.1 The minutes were approved as an accurate record pending amendment to QS20/195.1 to read “In terms of the next steps and actions, the Acting Executive Director of Nursing & Midwifery confirmed that the recommendations from the Covid Delivery Group would be developed into an action plan.” **QS21/4.2** A matter arising relating to QS20/195 Hospital Acquired Infection in terms of whether the outbreak had been retrospectively reported to the Health and Safety Executive (HSE) and within Datix had received a written update from the Director of Health, Safety & Equality as follows "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" **QS21/4.3** Updates were provided to the summary action log.	
QS21/5 Draft Minutes Joint Audit and Quality, Safety & Experience Committee Held on 24.11.20 The minutes were approved as an accurate record.	
QS21/6 Board Assurance Framework (BAF) Principal Risks and Corporate Risk Register (CRR) **QS21/6.1** The Interim Director of Governance confirmed that the reports had been shared with the Audit Committee in December 2020. He reminded members that the BAF was a high level articulation of the risks that may affect the organisation’s ability to deliver on its five strategic priorities. There were 23 principal risks at present and the BAF would be discussed at the Health Board meeting on the 21st January 2021, with the relevant sections of the BAF and CRR then being scrutinized by the respective Committees going forward. He noted that the risks were dynamic and ownership therefore lay with the nominated Executive lead with a supporting ‘check and challenge’ process in place via the Risk Management Group (RMG). **QS21/6.2** Members acknowledged the progress made in terms of risk management and that it was evident that the BAF had further developed and evolved since consideration at the Audit Committee, and would help the Board remain focused on its key risks. The Committee Chair set out some concerns around the mental services sections in the BAF in that she felt there were gaps in evidence of some actions which were shown as complete, and that some of the narrative needed to be reviewed to provide a more accurate reflection of the current situation. She also suggested that some of the descriptions could be better worded and agreed to email her detailed feedback to the Interim Director of Governance and the Executive Director of Nursing and Midwifery in advance of the RMG meeting on Monday 18th January 2021. Other members were invited to send any comments in the same manner. The Executive Director of Nursing and Midwifery would welcome comments to allow for check and challenge by the RMG; she also felt there was a significant gap in terms of a risk around planned care. **QS21/6.3** The Committee Chair raised that a number of the risks appeared to have high risk scores with relatively short “target risk dates” and queried how realistic this was. She queried CRR20-01 (asbestos management and control) as an example, highlighting that some of the actions were not actions but were gaps and that a number of the due dates	IMs IMs

were only 2 weeks hence. It was reported that the action plans in place were robust but there were some inconsistencies in understanding amongst officers whether the "target risk date" was the date that the target risk score was expected to be achieved or the date that the risk would be reviewed. The Interim Director of Governance accepted that there was a need to improve consistency of understanding across the organisation. The Director of Health, Safety & Equality updated the Committee on the plans which were in place to increase assurance against CRR20-01 (asbestos management and control). **QS21/6.4** The Committee Chair queried the statement on the report template that the CRR had been agreed by the RMG as she felt there were several examples where the mitigations and controls were inadequately described and she would have expected these to have been addressed by that group before coming to the Committee. The Interim Director of Governance explained that the RMG had met two months previously and so at that time the due dates may have been deemed achievable. The Committee Chair concluded that the Committee could not be assured that the risks were being managed or that adequate scrutiny had been applied by the RMG on the basis of the number of issues identified by members. The Interim Director of Governance welcomed the discussion and challenge and acknowledged that there was still work to be done on the risk register. It was agreed that members would send detailed feedback to the Interim Director of Governance. **QS21/6.5 It was resolved that** the Committee: 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.	
QS21/7 Infection Prevention & Control (IPC) Update **QS21/7.1** The Associate Director of Quality Assurance reported that new interim leadership for infection prevention was now in place which was a positive step. She referred to the detailed slide set which had been provided and highlighted key headlines as follows: • Challenges with delivering a rolling programme of Hydrogen Peroxide Vaporisation (HPV) across site. • Clusters and outbreaks of Covid were providing challenges within staff teams also and the fatigue and emotional impact on the workforce should not be underestimated. • Revised cleaning standards had been received from Welsh Government. • Behaviours were a significant element in terms of transmission. • Progression of the business case for infection prevention was being taken forward. • A pilot around lateral flow testing had been undertaken. • Progress in some areas was inhibited by all Wales factors and were currently beyond local control. **QS21/7.2** A discussion ensued. In response to a question regarding the suspension of HPV deep cleaning, the Associate Director of Quality Assurance assured members that this was being undertaken but on a more reactive than planned basis. Members noted with concern the deterioration in community acquired infections and it was confirmed this had been picked up in a recent accountability review for primary care and that clinical leadership and the work of local infection prevention groups was key to improvements in this regard. The Acting Executive Medical Director wished to highlight the point on the last slide around culture and habit and he felt that changing mindsets continued to be essential to ensuring that IPC was everybody's business. The Executive Director of Nursing and	

Midwifery concurred and added that the interim appointment of Sally Batley would be key to building on a multidisciplinary approach to IPC. In response to a question from a member regarding outbreaks in care homes the Associate Director of Quality Assurance reminded the Committee of the range of support and intervention ongoing with care homes and partners to ensure consistency in standards being applied. The Executive Director of Nursing and Midwifery added that the care homes requiring the most support were identified and targeted as there was evidence that not all were accessing the support available to them. She also reported on the stepping up of the Care Home Cell and that there were daily exception sitreps via the Executive Incident Management Team (EIMT). **QS21/7.3 It was resolved that** the Committee take assurance from the Infection Prevention presentation	
QS21/8 Health & Safety (H&S) Q3 Report **QS21/8.1** The Associate Director of Health, Safety and Equality presented the report and highlighted the following: • There was positive progress around fit testing. • 119 visits from the corporate H&S team had been undertaken in Q3 compared to 128 in Q2. • There had been 33 H&S reviews in service areas. • There had been an increase in the number of RIDDORs in Q3 with 95 being Covid related and 24 non Covid related. In comparison there had been 23 in the same quarter for the previous year. • Themes were being identified from the RIDDORs and in response to some identified issues around non-adherence to social distancing there was work ongoing to address behavioural based aspects. **QS21/8.2** A discussion ensued. In response to a question around the timeframe for compliance with the Improvement Notice regarding failure of a FFP3 mask, the Associate Director of Health, Safety & Equality confirmed this had been adjourned to 19th April 2021 and he was confident that this could be met for Ysbyty Glan Clwyd (YGC). He noted that whilst the Improvement Notice related to YGC specifically, there was an expectation that the organisational response should apply across all sites. He wished to commend the Fit Testers who were working very hard to deliver on the ask. A member enquired as to how fit testing was being recorded and it was reported that advertisements were out for support posts to enable this to be done via the Electronic Staff Record (ESR). Finally, a member enquired as to progress with the development of a business case for additional resources into the corporate team and the Associate Director of Health, Safety and Equality stated that feedback from the review group was now being taking forward in order to finalise the business case. **QS21/8.3 It was resolved that** the Committee note the position outlined in the Quarter 3 Report.	
QS21/9 Holden Recommendations **QS21/9.1** The Assistant Director of Patient Safety and Experience presented the report and highlighted that it incorporated updates against three other key reviews from the Royal College of Psychiatrists, Healthcare Inspectorate Wales (HIW) and the Welsh Government	

Delivery Unit to provide a more rounded piece of assurance to the Committee. He reminded members that the Holden review had been commissioned back in 2013 via the whistleblowing process and as a result the circulation of the report had been restricted. He stated that this had resulted in a lack of clarity in terms of its reporting route and a lack of clarity in governance terms of the tracking of actions. He drew members' attention to the recommendations within his paper that all future significant quality-related reports had resultant action plans tracked via the same governance framework and methodology of that used for HIW actions, and that there were clear close down reports when all actions were complete. The Assistant Director of Patient Safety and Experience also felt it could be argued that some of the issues raised in 2013 had reoccurred within the Mental Health and Learning Disabilities (MHLDS) division - albeit in different circumstances and with different outcomes. He acknowledged however that this was outside of the scope of this report. Finally, he wished to highlight that there was a directory of evidence against each statement made within the report referenced in the appendix which had not been included in the Committee report but that members could see if they wished. **QS21/9.2** The Executive Director of Nursing and Midwifery welcomed the paper which she acknowledged was the result of comprehensive work. She suggested that consideration be given to further strengthening the sustainability of assurance by revisiting action plans that had been closed down as a cross-check that the quality actions agreed were still in place. **QS21/9.3** A discussion ensued. The Committee Chair recognised the work that had taken place to undertake this review and the challenges of responding to a matter that had occurred seven years ago. She felt that the key issue going forward was to ensure the golden thread of recurring themes from different reviews were triangulated and that they supported organisational learning. Turning to the MHLD division in particular the Committee Chair highlighted that the original report was related to the Hergest Unit and, as referred to by the Assistant Director of Patient Safety and Experience some of the issues originally identified by the various reviews undertaken in 2013 had recurred but in different parts of the service and for different reasons. This indicates the need to focus on the overall governance framework rather than one area. She felt that the Committee needed to be assured that the matters highlighted within the paper would be addressed going forward and that the governance process were appropriate and sustainable. The Executive Director of Nursing and Midwifery observed that the MHLDs division had been subject to several reviews with resultant action plans which had areas of commonality. She felt that the principle of bringing these together would ensure a consistent approach and maximise learning across the wider organisation not just the division. The Associate Director of Quality Assurance suggested that similar findings and observations could probably also be made in other service areas. The Interim Director of Nursing for MHLDs accepted there had been long-standing cultural issues within the division and whilst significant improvements had been made, he suggested that the division was still not where he personally would like it to be in terms of engagement with the workforce and the wider organisation. The Acting Executive Medical Director was supportive of bringing things together where possible and he was aware of examples where the division was working separately – eg; relating to improving clinical effectiveness. The CHC Chair agreed that the underlying cultural issues were significant and that remedial actions needed to be applied on a broader basis across the whole organisation. The Associate Director of Health, Safety and Equality noted that scrutiny and challenge should be viewed as a positive thing and more people needed to accept this mindset. The Interim Director of Nursing for MHLDs confirmed that improvements in terms of organisational development had been	GH

delayed within the division due to Covid but would be picked up again. Finally, a member enquired whether there was a clear communications strategy in place, noting that this was the first time that a detailed narrative against the Holden recommendations had been made available within the public domain. The Executive Director of Nursing and Midwifery undertook to follow this up outside of the meeting with the corporate communications team and the CHC. It was also agreed that officers accept an amendment to the second recommendation regarding broadening this to require an impact assessment at the end of the process to check that closed actions had been embedded. **QS21/9.4 It was resolved that** the QSE Committee note the report and agree that: 1. 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). 2. Any significant quality-related reports, when tracked through the process mentioned in the preceding recommendation, are assured in a timely fashion, have clear close down reports when all actions are complete and proactive periodic follow up to ensure actions have been sustained	GH MJ SEE
QS21/11 Planned Care Recovery : update *[Mr Andrew Kent joined the meeting. Agenda item taken out of order at Chair's discretion]* **QS21/11.1** The Interim Head of Planned Care Transformation presented the paper and highlighted that: • The six point recovery plan stood alone but also was a prerequisite for strategic direction in terms of the organisation's intentions regarding the establishment of a Diagnostic Treatment Centre. • The next report to the Committee would incorporate quality and safety elements of Covid related matters. • An artificial intelligence system was being scoped to allow the validation of patient waiting limit information. Work was also to commence on standardisation within validation and to support those areas that weren't currently validating. • A standard operating procedure would be considered by the Planned Care Transformation Group later in January before discussion by the Executive Team. Any patient who decided not to have their procedure would also have a clinical assessment by their clinician to ensure this was appropriate. • Following a beneficial pilot of Attend Anywhere (a virtual platform for clinics) this would be subject to rapid rollout starting with orthopaedics. • An Escape from Pain programme had commenced and work was being undertaken on an App to provide patients with a digital programme to follow. • Waiting List Initiatives were currently low but it was likely that more use would made of this option. • Outsourcing had been put in place for ophthalmology in terms of cataracts which would allow capacity to be increased through the release of substantive staff to undertake other work such as Age-related Macular Degeneration (AMD) and intravitreal cases. • All specialties now undertook a multidisciplinary review on a weekly basis. • A focus on cancer care had resulted in a significant amount of cancer patients being moved over to receive their care in the West from the next week.	

- All sites would be moving to an essential services only basis from the following week with monitoring of clinical harm being undertaken for those P2 patients whose care had been paused.

QS21/11.2 A discussion ensued. Members acknowledged the seriousness of the situation that was set out within the paper and welcomed the accompanying verbal presentation which provided a personalised overview of the mitigating actions being put in place to reduce harm. The Interim Head of Planned Care Transformation stated that he and his colleagues genuinely wanted to be able to deliver for patients and that the challenges facing them were very real with the knowledge there would be a national post-Covid legacy of harm for patients who have had procedures delayed. He stated that the team believed passionately that every single patient that they could arrange to be operated on during the pandemic would be one less who suffered harm and had to wait even longer. Members acknowledged the importance of ensuring the Board, Committees and the wider public were aware of the emotional and physical impact upon staff who continued to work so hard to provide the best quality care, and remained dedicated in their resolve to help patients even during the most challenging times. The Acting Executive Medical Director added that he commended those clinicians who were travelling with their patients to enable them to receive their care on other sites, whilst continuing to balance the Covid risk. The Executive Director of Nursing and Midwifery confirmed that the latest planned care position had been shared at EIMT and she assured members that a clinical risk approach was in place with clinical reviews being undertaken. She made a comment around the differing role of the Finance and Performance Committee in terms of planned care but that the QSE Committee needed to be appraised of quality and safety aspects. The Committee Chair thanked the Interim Head of Planned Care Transformation for his very personalised presentation adding that it provided the Committee with a more informed understanding of the review taking place on patients on whether their treatment could or should go ahead safely at this point. She highlighted however that this detail was not in the written report and therefore would not be as visible to the public. She acknowledged that reports to the Finance and Performance Committee should be focussed on the performance of planned care including waiting times and numbers. However, she agreed with the Executive Director of Nursing and Midwifery that reports to the QSE Committee should be person focussed, providing assurance on how the clinical risk to patients was being managed. The Interim Head of Planned Care Transformation agreed to look at the focus of his report for the next meeting.

QS21/11.3 It was resolved that the Committee note the work to date on the six-point recovery plan
[Mr Kent left the meeting]

QS21/10 Mental Health and Learning Disabilities Exception Report

QS21/10.1 The Interim Director of Nursing (MHLDs) presented the report which was focused around the four priorities to work towards this –

- 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

He indicated that risks and mitigating actions against each of the priorities were being identified and he was confident there was a far more cohesive approach. Members' attention was drawn to section 3 of the report which provided an analysis of key areas of

improvement which were noted as restoration of capacity and improvements to capability; stronger and aligned management and governance; and improved effectiveness in partnership working. **QS21/10.2** Members welcomed the progress that had been shared and felt that there was a more positive energy across the division. The extension of the secondments within the senior leadership team were also welcomed. A request was made that the next report to the Committee provide a higher focus on the engagement with stakeholders and partners. **QS21/10.3 It was resolved that** the Committee note the report.	MS
QS21/29 Quality Governance Review YGC **QS21/29.1** The Committee Chair stated that the Committee had received a detailed report to discuss in private session but she had asked for a summary statement to be provided in public session. The Executive Director of Nursing and Midwifery confirmed that the quality governance review process had been established in order to provide opportunities for assurances through deep dives and that YGC had been identified as the first site to be assessed through this process. She confirmed that many elements of the report related to the ability to provide sustainable improvements and that relevant teams within the hospital had now been asked to develop detailed improvement plans to support the high level actions. The Associate Director of Quality Assurance welcomed the review process and felt it supported the principle of the organisation knowing its sites and services and where the risks were. The Assistant Director Patient Safety and Experience confirmed further reviews would be undertaken via a rolling programme but this had been delayed by the pandemic. **QS21/29.2 It was resolved that** the Committee receive the update.	
QS21/12 Nursing Workforce for Acute Sites, Community Hospitals and Community Nursing Services **QS21/12.1** The Chair reminded members that the paper had been submitted within the consent section however she was aware that a member wished to raise a point. This related to Appendix 4ii regarding redeployment and the member suggested that in terms of radiography for example there could be a cohort of other staff, including administrative staff, who could assist. She also made the point that if there was consistency in services it would be easier to redeploy, giving an example that in health visiting not all teams were providing face to face care currently. Finally she wished to acknowledge on behalf of Trade Union partners that they have felt very involved in redeployment discussions. The Associate Director of Quality Assurance reported that staffing was reviewed in totality and risk assessments considered by the EIMT. For nurse staffing in particular the situation was very dynamic. **QS21/12.2 It was resolved that** the Committee 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.	
QS21/13 Chair's Report : Patient Safety Quality Group	

QS21/13.1 The report was received as a consent item.	
QS21/14 Chair's Report : Strategic Occupational Health & Safety Group **QS21/14.1** The report was received as a consent item.	
QS21/15 Chair's Report : Clinical Effectiveness Group **QS21/15.1** The report was received as a consent item.	
QS21/16 Chair's Report : Patient Carer Experience Group **QS21/16.1** The report was received as a consent item.	
QS21/17 Mental Health & Learning Disabilities Division Resubmission of Written Control Documents **QS21/17.1** The Chair reminded members that the paper had been submitted within the consent section however she was aware that a member wished to raise a general point that written control documents needed to be more cognisant of gender neutral language. **QS21/17.2 It was resolved that** the Committee approve the amended written control documents for implementation.	
QS21/18 Serious Incident Report October and November 2020 **QS21/18.1 It was resolved that** the QSE Committee: 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.	
QS21/19 Improvement Group (HASCAS & Ockenden) **QS21/19.1** The Committee Chair wished to highlight that the evidence against the recommendations was subject to review by internal audit colleagues. The Executive Director of Nursing and Midwifery wished to acknowledge the CHC's support to a recent related engagement event. It was also confirmed that as the improvement group's work had concluded, updates would be stood down from the Committee's regular cycle of business, whilst acknowledging that separate but related pieces of work would be embedded within wider governance structures. **QS21/19.2 It was resolved that** the Committee note the progress against the recommendations to date and that the oversight of the remaining open recommendations be provided through existing quality assurance routes.	
QS21/20 Safeguarding **QS21/20.1** The Committee Chair indicated there had been recent conversations around the reporting lines for safeguarding and she felt there was a lack of clarity across the	

Committee structure which had the potential to cause duplication or create gaps in assurance. The Board Secretary indicated she would pick this up to review how respective cycles of business complemented each other. **QS21/20.2 It was resolved that** the Committee note the progress made this year by the Corporate Safeguarding Team	LB
QS21/21 Audit Wales Review of Quality Governance Arrangements **QS21/21.1** It was resolved that the Committee note for information the Audit Wales review of the Health Board's Quality Governance arrangements.	
QS21/22 Public Services Ombudsman Public Interest Report **QS21/22.1** The Committee Chair noted that the report related to urology services which had been an area of concern previously. The Assistant Director Patient Safety and Experience added that the start date for the review by Audit Wales had been delayed due to the pandemic. **QS21/22.2 It was resolved that** the Committee receive and note the report formally.	
QS21/23 Healthcare Inspectorate Wales Update Report **QS21/23.1 It was resolved that** the Committee 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	
QS21/24 Issues Discussed in Previous Private Session **QS21/24.1 It was resolved that** the Committee note the report	
QS21/25 Documents Circulated to Members 3.12.20 Briefing note on thrombosis 14.12.20 Quarterly Plan Monitoring Report for November	
QS21/26 Issues of Significance to inform the Chair's Assurance Report To be agreed outside of the meeting	
QS21/27 Date of Next Meeting 2nd March 2021. The Committee Chair suggested this would also need to be a focused agenda.	

QS21/28 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 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.'	

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. 15.1.21 Committee Chair was content the matter was covered within main IPC report.	January March Closed
3rd November 2020				
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	15.1.21 Suggested that this action be revisited once the paper had been presented later on the agenda however this was overlooked. 17.2.21 Kate Clark confirmed initiatives were covered off in paper submitted to QSE on 15.1.21	Closed
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	15.1.21 The IM who had raised the point stated it had been resolved outside of the meeting	closed
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	15.1.21 The Interim Director of Nursing MHLDS confirmed this had been resolved.	Closed
15th January 2021				

Independent Members	**QS21/6.2** Email Simon Evans-Evans with any comments on the BAF and CRR ahead of the Risk Management Group meeting.	18.1.21	Completed	Closed
G Harris	**QS21/9.3** Follow up the matter of a communications plan for the Holden report recommendations, involving the CHC	31.1.21	19.1.21 Meeting arranged between CHC and Matthew Joyes on 25/01/2021.	Closed
G Harris M Joyes S Evans-Evans	**QS21/9.3** Agree amended wording to second recommendation regarding close down of quality related reports.	31.1.21	19.1.21 Revised wording developed and incorporated into minutes.	Closed
M Smith	**QS21/10.2** Ensure that next routine report from the MHLDS division provided a higher focus on engagement with stakeholders and partners	4.5.21	Mike Smith confirmed in hand for May meeting.	
L Brereton	**QS21/20.1** Pickup concerns around reporting lines for safeguarding matters as part of a wider review of CoBs	2.3.21	17.2.21 Louise Brereton confirmed matter will be addressed through the ongoing review of the Board and Committee business cycles linked into the governance review work.	

22.2.21

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Covid-19 Vaccination update
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing & Midwifery / Deputy Chief Executive
Awdur yr Adroddiad Report Author:	Mr Andrew Kent, Interim Head of Planned Care Transformation
Craffu blaenorol: Prior Scrutiny:	Mrs Gill Harris, Executive Director of Nursing & Midwifery / Deputy Chief Executive
Atodiadau Appendices:	slide 1- update position of vaccination programme

Argymhelliad / Recommendation:

The Committee is asked:

1. To note the current vaccination number to date
2. To note the high ranking risks to the programme
3. To recognise the successful completion of gateway 1 the achievement of cohort 1-4 at above 80%

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 pandemic has led to the largest vaccination programme the country has seen in the post war era.

Cefndir / Background:

The programme is being delivered at pace in multiple locations with systems and processes that are new or are being made resilient as we undertake the work. The safety and quality of the vaccine from administration to the injection is under constant review and refinement. The goal is to provide a vaccination programme that can be handed over as a business as usual model.

Asesiad / Assessment & Analysis

The North Wales vaccination programme continues at pace with at the time of writing with 190,000 citizens vaccinated and the first milestone achieved of over 80% vaccinated in the cohorts 1-4. The programme however wants to ensure that all of the cohort 1-4 that is left have been reached and given an offer. It is estimated that this is 17,000 citizens throughout North Wales and will be people who may have been covid positive or are hard to reach individuals. Currently a validation process is ongoing and they will all be written to and given an appointment and text message to attend. It is

important for the Committee to note that the vaccine programme will do everything possible to contact this group and an offer of vaccine will remain open going forward to ensure health equality.

In the week commencing the 15/02/2021 the organisation has commenced 2nd dose vaccinations at both the Hospital and Mass Vaccination Centres, whilst continuing smaller clinics to vaccinate the "hard to reach numbers."

Plans for delivery are being reviewed for the next cohort 5-6 and vaccine distribution chains are being finalised.

The call centre function is being reviewed as it is recognised it was not giving the support to the public, daily monitoring with mystery callers continues and measures put in place. A call centre manager from the local authorities has been seconded to support the transformation, finally the executives have agreed to fund the upgrading of the telephony system to improve call handling for staff and the overall call experience for the public.

We are also reviewing the full booking process as we move to the wider cohort with the use of a two-way text communication to improve the citizen's experience, followed by a letter.

The overall programme now has a new senior manager, supported by the planned care team, who are offering their expertise in system and process thinking.

The strategic direction of the programme and how this will be delivered as business as usual is being discussed with stakeholders, primary care, GPs and cluster leads and is ongoing.

QSE update: Vaccination Programme (Gill Harris)

Update dated: 17/02/2021

Update Summary

The vaccination programme achieved the first national milestone of cohorts 1-4 on the 15/02/2021 with a successful vaccination rate of 88%

There are still approximately 17,000 citizens that are “hard to reach” that we are contacting so that no one is left behind in this programme

As February 17th 190,000 vaccinations have been given

As of the 16th February 2nd doses vaccinations have begun at the mass vaccination centres

A number of quality issues regarding the welsh immunisation system (WIS) are being worked on to makes the system more resilient.

Vaccination distribution chain is now more stable and moving to 3-4 week distribution cycle, allowing booking system to be more stable.

Actions required:

- Cohort 1-4 achieved
- Call centre being improved with workforce and technological improvements
- Process of booking is being improved
- Systems being made more resilient in preparation for next cohorts

Risks and Issues

Description	Controls in place	Further action to achieve target risk score	Risk Rating (current)	Change since last
There is a risk that, in the event of an unforeseen clinical incident the lines of responsibility may not be clear. This may be caused by oversight due to the speed of the programme and stepping up to Business as Usual. The potential impact might result in a delay in decision-making/action and people may not be sure of compliance with procedures, training and other requirement.	1. Clinical issues have been directed to the clinical workstream with limited capacity to provide day to day oversight	1. Production of a clinical governance diagram to clarity lines of oversight and responsibility	15	NEW RISK
There is a risk of unsustainable pressure on services with knock-on effects caused by rising COVID-19 infections leading to local lockdown, system pressures, workforce pressures etc. Surge / super-surge situation. The impact may be to suspend the vaccination programme due to strain on staffing causing dis-benefits elsewhere in system.	1. Intelligence Cell early warning tracking and modelling feeds into Vaccination Planning 2. Alert Level 4 measures in place to reduce transmission 3. Full LRF and SCG structure in place to work to combat the spread of C19 in the community, reduce hospitalisations and subsequent pressures including working with Health & Social Care on hospital discharges 4. Ability to escalate and influence WG via SCG or directly where additional measures may be required 5. Dedicated Silver group owning managing and mitigating risks	1. 1. Monitor information from Intelligence Cell	15	1

Interdependencies / Support needed

Version 2 plan in development.

- Plan will include updated baseline plan, booking systems / arrangements, outline workforce plan.
- Plan being updated through established planning work stream to take into account remainder of the vaccination programme.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Board Assurance Framework 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:	Dawn Sharp, Assistant Director: Deputy Board Secretary Justine Parry - Assistant Director of Information Governance & Risk
Craffu blaenorol: Prior Scrutiny:	Executive Team meeting on the 11th February 2021
Atodiadau Appendices:	Appendix 1 – QSE BAF Principal Risk Report Appendix 2 – Corporate Tier 1 Operational Risk Report

Argymhelliad / Recommendation:

The QSE 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. Consider whether there is a need for the Board to review the Risk Appetite Statement in the light of some of the existing target risk scores.

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:

Following on from the previous work undertaken nationally between the All Wales Audit Committee Chairs and the Board Secretaries Network, it is essential that the Health Board has an effective system in place in which identifying and managing risk is a continuous process.

The revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised 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 has been reviewed 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 Executive Team.

This paper will endeavour to provide assurance that risks which could compromise the achievement of the Health Board`s Priority Areas are being robustly, efficiently and effectively mitigated and managed to expected standards and in line with best practice.

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 underlining 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.

The BAF was presented and approved by the Board on the 21st January 2021, 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.

The future management of the BAF has transferred back to the Office of the Board Secretary from the Corporate Risk Management Team, with the risk management system and process continuing to be managed by the Corporate Risk Team.

In line with the presentation of the Corporate Risks, all reports will include a detailed analysis of any changes to the Principal Risks within the body of this report, with the full QSE Principal Risks included within Appendix 1.

The Executive Team reviewed the BAF risks for SPPH at their meeting on 11th February. The Board Secretary reported that she intends to condense the suite of papers going forward. The Executive Team noted that there had been good engagement with risk leads. The work will be finessed as part of its evolution, noting that the number of risks should reduce once the strategic BAF risks are clearly defined and the development of the Health Board's overarching strategy will aid this. It was

considered that some risks are too operational currently. It is intended to include an overview of all BAF risks within future iterations of this paper.

It is recognised that in a number of risks the target risk score is above the current risk appetite. Taking account of the current environment given the pandemic. Risk Leads have been very clear on what they believe can realistically be achieved in relation to the target risk. Whilst the leads recognised the need to bring the target risk score in line with the appetite, there view was that this would not be achievable under the current conditions.

Taking this into account the Board may wish to re-examine its risk appetite with regard to certain risks or consider what additional actions, funding or resources will need to be assigned to bring the target risk score within its existing appetite. Key progress on the specific QSE BAF risks is detailed below:-

- **BAF20-02 – Emergency Care Review Recommendations**
  Key progress since last submission to the Board: Key controls, gaps and mitigations updated to reflect the current Covid position. Extension to the action timeframes have been agreed and the current reviewed but remains extant.

- **BAF20-06 – Pandemic Management**
  This risk has been closed due to the duplication and similarities with the risk BAF20-24. A new risk has been created CRR20-25 which will have oversight at the Quality, Safety and Experience Committee.

- **BAF20-08 – Safe and Effective Mental Health Service Delivery**
  Key progress since last submission to the Board: Actions and target dates reviewed and updated.

- **BAF20-09 – Mental Health Leadership Model**
  Key progress since last submission to the Board: Actions reviewed and expanded. Reference to Special Measures removed and replaced with Targeted Intervention.

- **BAF20-10 – Mental Health Service Delivery During Pandemic Management**
  Key progress since last submission to the Board: Key controls, mitigations and actions reviewed and updated together with target dates. Note some actions reported previously have been completed and are now incorporated within controls and mitigations.

- **BAF20-11 – Infection Prevention and Control**
  Key progress since last submission to the Board: New Lead Officer appointed. Controls updated and additional actions identified. Target risk score revised. Note this is now above current risk appetite level in view of operating currently within the pandemic environment.

- **BAF20-12 – Listening and Learning**
  Key progress since last submission to the Board: Target risk score - likelihood changed from 1 to 2 thereby giving an overall score of 10 (previously 5) - this is due to taking into account culture change required. The systems and processes will support the reduction of the score, however the embedding to change the culture will take longer. Lead is confident of achievement of those actions due for delivery by March 2021.

- **BAF20-13 – Culture / Staff Engagement**
  Key progress since last submission to the Board: Extensions to last two action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

- **BAF20-14 – Security Services**
  Key progress since last submission to the Board: Extensions to last two action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

- **BAF20-15 – Health and Safety**
  Key progress since last submission to the Board: Extensions to all action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

- **BAF20-16 – Pandemic Exposure**
  Key progress since last submission to the Board: New Lead Officer appointed. Controls and actions updated (including realistic delivery dates). Target risk score increased. Note this is above the current risk appetite level due to the current pandemic environment within which staff are operating.

- **BAF20-24 – Impact of COVID-19**
  This risk has been closed due to the duplication and similarities with the risk BAF20-06. A new risk has been created CRR20-25 which will have oversight at the Quality, Safety and Experience Committee.

- **BAF20-25 – Impact of COVID-19**
  New Risk: There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.

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 in September 2020 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. Building on from these initial sessions, in house training sessions are now being delivered commensurate with the roles and responsibilities of staff across the Health Board 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, and this will commence from April 2021.

The delivery of this training has been incorporated in the RM03 – Risk Management Training Plan which supports the delivery of the updated Risk Management Strategy and Policy.

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

- **CRR20-01 - Asbestos Management and Control**
  Key progress since last submission to the Board: Following the Corporate Health and Safety Audit in 2019 for Asbestos Management a number of areas were assessed as non-compliant. A detailed action plan has been implemented to address and correct the non-conformances raised. Whilst some of the actions can be completed, the majority are subject to a business case being agreed for completion of the works. The actions and target risk date have been reviewed and where appropriate 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.

  This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-02 - Contractor Management and Control**
  Key progress since last submission to the Board: Following the Corporate Health and Safety Audit in 2019 for Contractor Management a number of areas were assessed as non-compliant. A detailed action plan has been implemented to address and correct the non-conformances raised. The actions and target risk date have been reviewed and where appropriate 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.

  This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-03 – Legionella Management and Control**
  Key progress since last submission to the Board: Following the Corporate Health and Safety Audit in 2019 for Legionella Management a number of areas were assessed as non-compliant. A detailed action plan has been implemented to address and correct the non-conformances raised. The actions and target risk date have been reviewed and will continue to be reviewed and where appropriate 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.

  This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team.

- **CRR20-04 - Non-Compliance of Fire Safety Systems**
  Key progress since last submission to the Board: Following the Corporate Health and Safety Audit in 2019 for Fire Safety Management and Systems a number of areas of fire safety were

assessed as non-compliant. A detailed action plan has been implemented to address and correct the management non-conformances raised. The actions and target risk date have been reviewed and where appropriate 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.

The Health Board Estates strategy defines the current level of capital investment required to improve compliance across all Health Care premises. Due to the risks associated with Fire Safety nationally. The Health Board is progressing a number of business cases seeking Welsh Government (WG) capital to address and mitigate non-compliance. The ability to reduce the current risk will be determined by the availability of capital funding from Welsh Government as the scale of investment required is significantly greater than the Health Board's annual discretionary capital allocation.

Two Programme Business cases have been developed for Ysbyty Wrexham Maelor (already submitted to WG) and Ysbyty Gwynedd, both seek to reduce current risks and significantly improve patient environments and fire safety compliance.

This risk is being actively managed by the Executive Director of Planning and Performance with oversight by the Risk Management Group and the Executive Team

- **CRR20-05 – Timely access to Care Homes**
  Key progress since last submission to the Board: Further actions have progressed through to completion with the identification of new actions now incorporated. A review of the target risk score has also been undertaken to coincide with the completion of these new actions. This will help to strengthen the controls in place moving forward.

  This risk is being actively managed by the Executive Director with oversight by the Risk Management Group and the Executive Team.

During the Executive Team meeting on the 11th February, it was agreed to escalate the following operational risks onto the Corporate Tier 1 Risk Register:-

i. **Risk Reference – CRR20-08** – **Ophthalmology Service Risk** - Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients. If escalation approved.

ii. **Risk Reference – CRR20-09** – **Diabetes Service Risk** - Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients. If escalation approved.

iii. **Risk Reference – CRR20-10** – **GPOOH Service Risk** - GP Out of Hours IT System. If escalation approved. QSE are asked to note this for information. This risk will be reported to the D&IG Committee.

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

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-04 CRR20-09 BAF20-02 BAF20-06	
	Likely - 4				BAF20-13	CRR20-01 CRR20-02 CRR20-03 CRR20-05 CRR20-08 BAF20-08 BAF20-11 BAF20-12 BAF20-15 BAF20-16 BAF 20-24
	Possible - 3			BAF 20-10		BAF20-09 BAF20-14 BAF20-25
	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. National support agreed. 2) Identify improvement and project support for delivery of the objectives. 3) In line with Welsh Government (WG) directive, implement Phone First programme that will ensure patients are seen by the right person, in the right place, first time. 4) In line with the agreed standards implement a uniform model for patient access to and from EDs.	30 June 2021 31 March 2021 30 June 2021 30 June 2021
Q3 and Q4 Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer.	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.	28 February 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: Key controls, gaps and mitigations updated to reflect the current Covid position. Extension to the action timeframes have been agreed and the current reviewed but remains extant.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	3 February 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority 2: Essential Services and Planned Care

Risk Reference: BAF20-06		Risk Rating	Impact		Likelihood		Score		Appetite	
Pandemic Management										
There is a risk that the ongoing Covid-19 pandemic, through the second wave, could inhibit the Health Board`s ability to deliver timely access to high quality planned care to its patients. This may be caused by workforce absences or redeployment; infrastructure impact; reductions in, or overly cautious use of capacity; failure to prioritise or undertake risk stratification effectively; lack of support and collaboration across the whole healthcare system. This could lead to an impact on patient safety; deterioration in health; poor patient experience and reduction in well-being and impact on staff of being unable to meet patient needs.		Inherent Risk	4		5		20		Low 1 - 6	
		Current Risk	4	↔	5	↔	20	↔		
		Target Risk	3		2		6			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Primary Care Covid management forum meets weekly and reports into Primary Care Senior Management Team and Director of Primary Care and Community Services. Any issues requiring escalation are reported into Executive Team. Primary care pressures are reported nationally to WG.	1	Business continuity plans are continually reviewed, supported by the Emergency Preparedness and Resilience team, in line with requirements of the Civil Contingencies Forum. WG recovery plans in place and national toolkits circulated. Operational measures taken to support the overarching plan and response to Covid-19 include: Amended care pathways including remote consultations Provision of PPE across all contractors Regular Primary Care pressures report Red hubs available if required Escalation levels reported Area support to delivery of services at a cluster level Regular briefings/guidance to contractors	2	Urgent Primary Care Centres being developed from Welsh Government grant. Options appraisal regarding dental capacity being undertaken at pace.	31 December 2020
Area Senior Management Teams have oversight of pressures on community services and feed into the Primary Care Senior Management Team. Any issues requiring escalation re reported to Executive Team.	1	Business continuity plans are in place and are currently being reviewed - see identified gaps. Management oversight continues for service changes to accommodate Covid-19 response, reported as described through Senior Management Teams.	2	Business continuity plans currently being reviewed and updated with support from Emergency Planning Team for all community hospitals and health / wellbeing centres. Amended pathways submitted through Clinical Advisory Group as appropriate.	Ongoing 31 March 2021
Access meeting weekly chaired by Performance Director, reports into Planned Care Improvement Group.	1	Assurance against delivery of plan Risk stratification in place for Stage 4 planned care provides clinical priority for Stage 4 patients Head of planned care overseeing the Q3/4 plan and variance to the plan, reported through the monthly Operational Plan monitoring report to SPPH Committee and FP Committee.	3	Introduction of further validation staff in Q3/4 non-recurring. Scoping of Artificial Intelligence approach to validation. Waiting list initiatives introduced in Q3/4, planned introduction of insourcing to support Q3/4 and long waiting patients.	31 March 2021
Weekly operational group with DGMs to ensure operational co-ordination of the Once for North Wales approach.	1	Provides assurance that patients are booked across North Wales based on the risk stratification, reporting into the Access Group highlighted above.	2	Scoping of need to bring in further capacity in the form of theatres or wards to reduce long waiters backlog clearance.	29 January 2021
Planned Care Improvement Group has oversight of the service models and delivery of planned care performance.	1	Business continuity plans Q3/4 plans for planned care amended pathways (agreed via Clinical Advisory Group). Once for North Wales approach introduced to general surgery, orthopaedics, ophthalmology stage 4, urology and endoscopy reporting into the Planned Care Improvement Group and onward to Finance & Performance Committee.	2	Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to board and Welsh Government.	Ongoing 31 March 2021
Finance & Performance Committee receive regular Quality and Performance Reports which are reported on to the Health Board.	2	Regular performance reporting on delivery and quality. Assurance reports on planned care to COO and F&P on a monthly basis. Accountability framework in place.	2		
WG Quality & Delivery Group meets on a regular basis to review and respond to quality and performance risks and impacts, framed around the NHS Wales performance framework.	3	Assurance against delivery of plan Risk stratification in place for Stage 4 planned care provides clinical priority for Stage 4 patients. Head of planned care overseeing the Q3/4 plan and variance to the plan, reported to Quality & Delivery Group as an external scrutiny process as well as internally.	3		

Review comments since last report: It is proposed that this risk be closed due to the duplication and similarities with BAF Risk 20-24 – Impact of Covid 19. A new risk BAF 20-25 – Pandemic Management has been created which it is proposed should have oversight by Quality, Safety and Experience Committee.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary Care and Community Services	Quality, Safety and Experience Committee	26 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-	1	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.	1	The T4MH Board met on 22.January 2021, and the membership together with its programme of work is being refreshed. Interim Deputy Director leading this key partnership agenda.	30 June 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team report to the Executive Team 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.	1	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. This work is ongoing and interim roles are in place. The division has created 2 additional Deputy Directors in post reporting to the Director of Mental health to fill operating gaps in partnership and strategy development. 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. The Division is beginning an appropriate discussion with psychology regarding how they are represented and contribute to the work of the Division.	30 June 2021

Review comments since last report: Actions and target dates reviewed and updated.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	5 February 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. Sustainability needs to reviewed as a matter of priority to ensure continuity.	31 March 2021
Strategy approved and regular updates reported via Targetted Intervention to Welsh Government.	2	All key actions will be further developed and underpins the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group	2	Review Mental Health Structure to ensure fit for purpose and reflects new clinical pathways. There is on-going work to agree plan for 21/22	1 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	2	Implement the Mental Health Strategy in a consistent manner across the Health Board.	1 December 2021
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via 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.	30 June 2021
Quality, Safety and Experience Group meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	1	There is a clear governance structure whereby the Division will be working alongside corporate.	1		

Review comments since last report: Actions reviewed and expanded. Reference to Special Measures removed and replaced with Targeted Intervention.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	5 February 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. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG).	2	MH&LD Finalise and fully implement Operational Covid19 Winter Plan. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	Completed
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MHLD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scruitinise them through Senior Leadership Team.	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed.	30 June 2021
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	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	Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	Completed
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	Revisit and assess gaps in recruitment processes to support additional staff requirements. Heddfan Establishment review being discussed in Gold Command meeting, 5.2.21	31 March 2021
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group.	2	Process to ensure continuous mapping of staff to enable redeployment decisions.	Completed
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 21st December 2020	1	MH&LD Covid-19 Command Structure SOP operationalised	Completed
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. All Priority 1 laptops delivered across the MH&LD Division, priority 2 laptops delivery roll out planned before 31 March 2021.	30 June 2021

Review comments since last report: Key controls, mitigations and actions reviewed and updated together with target dates. Note some actions reported previously have been completed and are now incorporated within controls and mitigations.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Acting Chief Executive / Executive Director of Public Health	Quality, Safety and Experience Committee	5 February 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		3		15			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group.	2	Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. Finalise recruitment to increase IPC Team resource.	31 December 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3		
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	Strengthening of effective reporting arrangements through outbreak control groups and IPSG.	30 September 2021

Review comments since last report: New Lead Officer appointed. Controls updated and additional actions identified. Target risk score revised. Note this is now above current risk appetite level in view of operating currently within the pandemic environment.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	5 February 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		2		10			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology.	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: Target risk score - likelihood changed from 1 to 2 thereby giving an overall score of 10 (previously 5) - this is due to taking into account culture change required. The systems and processes will support the reduction of the score, however the embedding to change the culture will take longer. Lead is confident of achievement of those actions due for delivery by March 2021.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	2 February 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 (Inc. 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.	30 September 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement. 4. Build "role contribution" into Strategic OD programme specification. 5. Review feedback from NHS Staff Survey and update divisional improvement plans.	30 September 2021

Review comments since last report: Extensions to last two action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	18 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	30 September 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance	2	There is a lack of a structured approach to CCTV management and control. The systems are different In many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required.	30 September 2021

Review comments since last report: Extensions to last two action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	8 February 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.	30 September 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	30 September 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.	30 September 2021
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks.	30 September 2021

Review comments since last report: Extensions to all action timeframes have been discussed and agreed with the Executive Director of Workforce and Organisational Development since the risk was submitted to the Board on the 21 January 2021.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	8 February 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		3		15			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group.	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.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Establish a routine programme to ensure continuous review of dynamic plan for fit testing with plan being kept under review by IPSG	30 April 2021
Review of all buildings has taken place against new regulations in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates.	30 September 2021

Review comments since last report: New Lead Officer appointed. Controls and actions updated (including realistic delivery dates). Target risk score increased. Note this is above the current risk appetite level due to the current pandemic environment within which staff are operating.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	5 February 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	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: It is proposed that this risk be closed due to the duplication and similarities with BAF Risk 20-06 – Pandemic Management. A new risk BAF 20-25 – Pandemic Management has been created which it is proposed should have oversight by Quality, Safety and Experience Committee.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Quality, Safety and Patient Experience Committee	26 January 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2020/21

Strategic Priority: Essential Services and Planned Care

Risk Reference: BAF20-25		Risk Rating	Impact		Likelihood		Score		Appetite	
Impact of COVID-19										
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6	
		Current Risk	5		3		15			
		Target Risk	4		2		8			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place and meeting regularly. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate.	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. De-escalation and decommissioning plans to be implemented when appropriate.	1	1) Continuous updating of business continuity and escalation plans. 2) Surge plans / winter resilience plans to be tracked against modelling predictions. 3) Monitoring of options under escalation framework for escalation / de-escalation.	31 May 2021 30 April 2021 30 April 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	1) Ongoing updating of programme plans. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team. 3) Establishment of clear regularised reporting structures around newly established workstreams (care homes, long Covid).	28 February 2021 31 March 2021 31 March 2021
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	Review of programme and links into Executive Team / EIMT.	31 March 2021
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports.	2	1) Linking of dashboards for BIU users. 2) Ensure mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak. 3) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic.	31 March 2021 30 April 2021 30 September 2021
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	Ongoing work to ensure all records captured and indexed.	30 September 2021
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	Confirm mechanisms for ongoing collaborative arrangements for monitoring transition into recovery, and readiness for response in the event of future waves of the pandemic.	31 March 2021

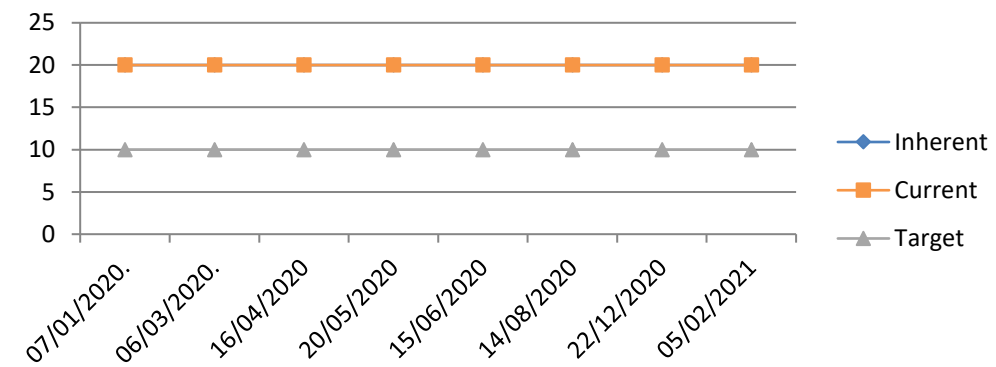
Review comments since last report: New Risk

Executive Lead:	Board / Committee:	Review Date:
Chris Stockport, Executive Director of Primary and Community Services	Quality, Safety and Patient Experience Committee	New Risk 9 February 2021

Linked to Operational Corporate Risks:

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:** 5 February 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 31 March 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place (refer to further action 12242). 2. A number of surveys undertaken (refer to further action 12241). 3. Asbestos management plan in place. 4. Asbestos register available (refer to further action 12250). 5. Targeted surveys where capital work is planned or decommissioning work undertaken. 6. Training for operatives in Estates. 7. Air monitoring undertaken in premises where there is limited clarity on asbestos condition (refer to further action 15032).	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**

Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

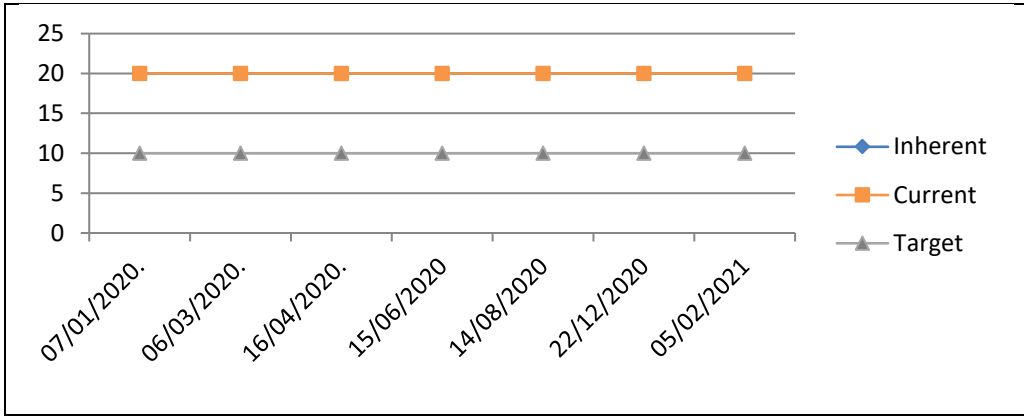
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This 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	31/03/2022	Re-survey of existing asbestos surveys, sample 10 – complete and assurance provided that surveys are robust. Resampling will be included with the updated management plan as an ongoing compliance work stream.	On Track
	12242	Update, review and implement the Asbestos Policy and Management Plan across the whole Health Board.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Partially completed - Updated Policy and Management Plan included on the agenda SOH&SG (02-02-2021). Policy partially implemented due to lack of complete asbestos registers on all sites.	On Track
	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Asbestos Registers and data storage – current data hosted on Client Server, work has commenced to commission MICAD as a Health Board wide property management system. The system will include an asbestos management portal.	On Track

	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Priority assessments and risk reviews – Actions complete and removal / management plan in place.	Complete
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Contractor management and control – actions complete with updated permit to work system and contractor control framework.	Complete
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Asbestos surveys – all site have access to site-specific registers (hard copy). Following the roll out of the asbestos management modal within MICAD, all sites will have access to digital register.	On Track
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Annual reinspections – Asbestos Management Group providing oversight and governance with escalation to SOH&SG. Appointed Independent Asbestos Consultants.	Complete
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Update Internet Pages and staff awareness – Intranet updated and working with Corporate Health and Safety on staff awareness.	On Track

	12249	QR Code identification to be provided on all areas of work with identified asbestos signage in non public areas.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	QR Codes to identify the location of asbestos – Updated asbestos management plan address identification.	On Track
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Action Closed 05/02/2021 - Corporate Health and Gap analysis – Action plan updated and progress against actions recorded and included within escalation report to SOH&SG.	Complete
	15032	Air Monitoring in all premises where there is limited clarity on asbestos condition.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Improve safety and ongoing compliance with the Regulations.	On Track

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:** 5 February 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *select low, moderate or high level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Control of contractors procedure in place (refer to further action 12260). 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board.	1.Health and Safety Leads Group. 2.Strategic Occupational Health and Safety Group. 3.Quality, Safety and Experience Committee.

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	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	31/03/2021	The Control of Contractors Guidance Document is currently being reviewed and updated.	On Track
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	The Control of Contractors Policy Document is currently being drafted.	On Track

	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.	On Track
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	On Track
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and	On Track

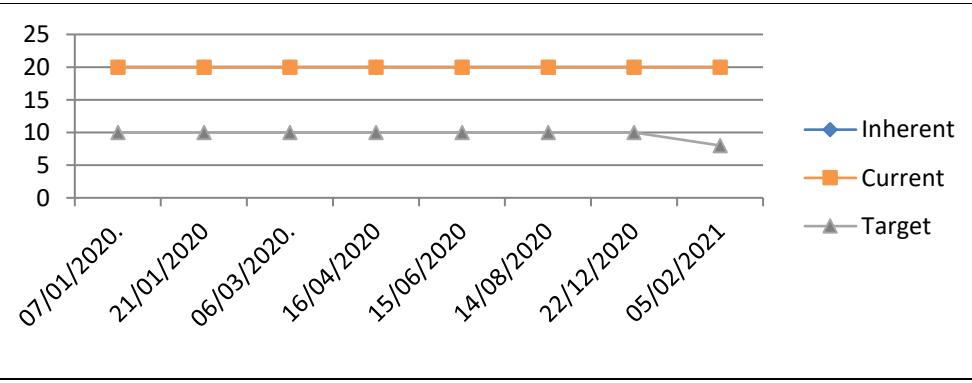
					Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	On Track

	12260	Standardise the implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan across the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12552	Develop a process so that the Induction process is completed by all current contractors and new ones as they are appointed.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track

	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2021	The Control of Contractors Guidance Document is currently being reviewed and updated.	On Track

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:** 5 February 2021
	Risk: Legionella Management and Control.	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**

1. Legionella and Water Safety Policy in place (refer to further action 12270). 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team.	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

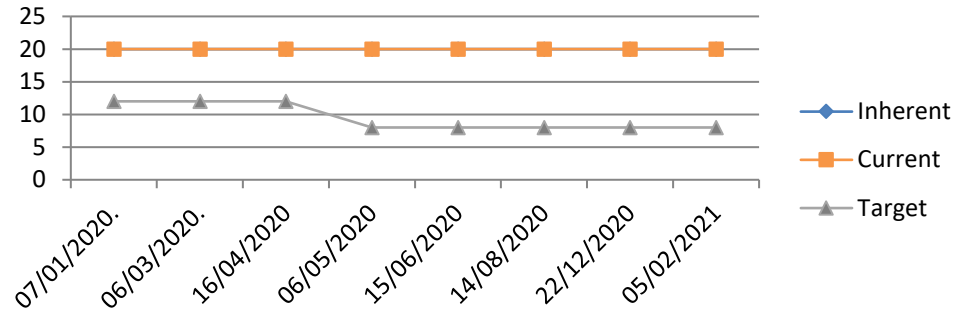
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up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

	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	On Track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	On Track
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track

	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track
	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.	On Track
	12269	Clinical and Microbiology support required to ensure that the assurance provided by the Water Safety Group that the Policy is being effectively implemented across all sites.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	On Track
	12270	Improve consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

CRR20-04	**Director Lead:** Executive Director of Planning and Performance	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 15 January 2021
		Target Risk Date: 30 September 2022
There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of		

incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Fire risk assessments in place (refer to further action 15036). 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

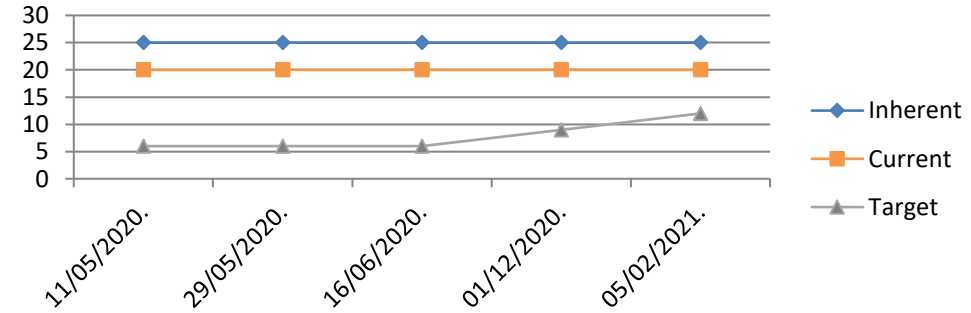
Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe, secure & healthy environment for our people	BAF20-15 BAF20-20

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	30/09/2022	Governance actions completed and operational elements are captured within the gap analysis areas below.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Complete with escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons.	On Track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Database located within the fire safety files, managed and updated by the fire safety trainer.	On Track
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team.	On Track

	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Independent, Shared Services (Specialist Estates Services) audits commississioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites.	On Track
	12555	Information from unwanted fire alarms and actual fires to be collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk Assessment process and appropriate action taken.	On Track
	15036	Ensure Fire Risk Assessments in place for all service areas across the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 5 February 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 15th January 2021
		Target Risk Date: 30 June 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)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in January 2021	unchanged		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact a day“ data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice.	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.

9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular formal communication channels with care homes at a local level and across BCU.	

Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	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	14936	Establish separate discharge cell to ensure system wide leadership and action to implement the revised step up step down hospital discharge requirements.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14937	Develop a BCU wide approach to primary care support and intervention, including GPOOH.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	On Track
	14938	Develop electronic daily reporting metrics that are robust and analysed at an organisational level.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track

	14939	Complete and implement a North Wales care home escalation and support tool that complements national work programmes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occuring.	On Track
	14941	Embed the new ways of working in all home first bureau.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14942	Develop communication with care homes at a local level and across North Wales.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14943	Work with Welsh Government and Health Boards across Wales to deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This action support access to care homes.	On Track
	14944	Adopt care home DES for primary care.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track

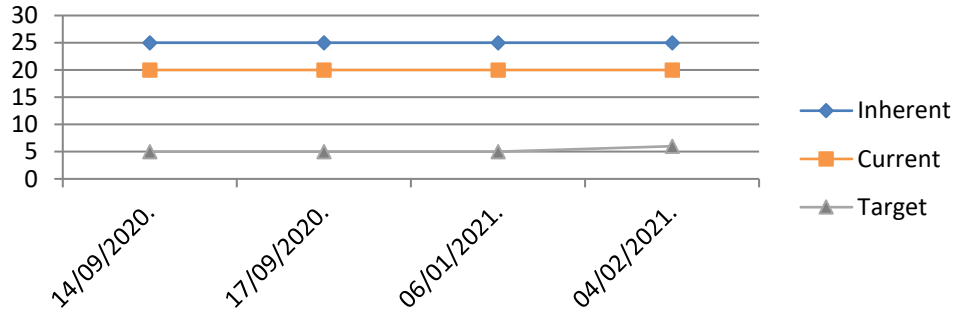
	14945	Increase the frequency for multiagency care home cell to weekly to support issues management.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will improve communication and support direct admission to care homes.	On Track
	14946	Update the 2020 care home monitoring levels and escalation framework.	Kathryn Titchen, Commissioning Manager CHC	30/04/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14947	Development of proactive risk triggers to support quality monitoring with a primary focus on infection prevent and control issues once an outbreak/ a single case decalred and identifying at risk homes for proactive intervention coordinated across Health and social care limited resources.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14948	Diversion of CHC priorities from routine reviews to crisis care home support maintaining D2RA and crisis step up assessments facilitating flow.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14949	Development of resources support capacity and demand for care homes and enclosed settings to support prioritisation of support.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track

	14951	Increase MDT Care Home group to weekly for issue resoltuion for period of enhanced second covid wave pressures.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will help eradicate delays in discharge through better co-ordination.	On Track
	14952	Implementation of reactive support to in crisis care homes and application of learning of covid issues to support HB working with LA's to have a proactive early identification of IPC at risk issues to reduce the risk of widerspread care home infection outbreak.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track
	14954	Working with developing national guidance to support proactive, supportive development of provider resilience through provider business continuity prompt, challenge and support.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	This will support the quality of provision in care homes and reduce demand on unscheduled care.	On Track

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 4 February 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** New Risk for Escalation
		Target Risk Date: 28 February 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients negatively through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration prolonged suffering and may result in falls from impaired vision due to cataract secondary to prolonged surgical l capacity during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in January 2021	*New Risk*		

Controls in place	Assurances
1. Proliferative diabetic retinopathy – Pan BCUHB pathway about to be implemented to get optometry review of the backlog. 2. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 3. Cataract - All cataracts have been stratified in order of visual impairment in order to deal with the most clinically pressing cases first. A plan is in progress to share patients across all three units in North Wales to ensure equity of access. 4. Increase capacity in existing clinics.	Risk is regularly reviewed at local Quality and Safety meetings.

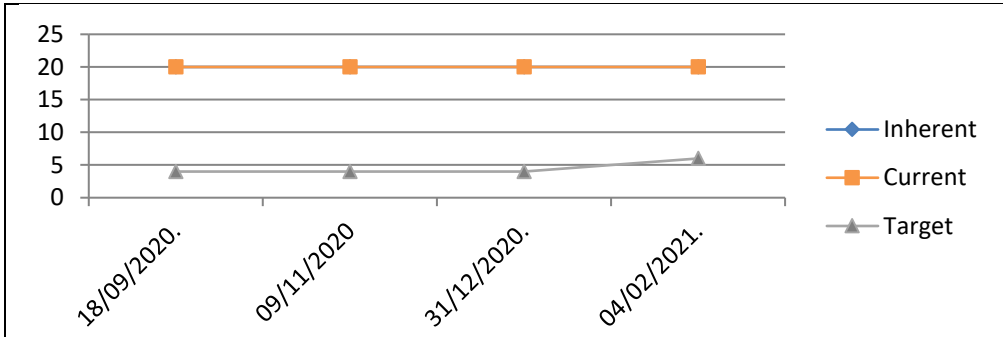
Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF20-03 BAF20-05

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	14907	Age related macular degeneration – A business case (central area only) is awaiting approval to increase staffing and treatment capacity.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On track

target risk score	14908	A second business case (Pan BCUHB) has been submitted for a retinal camera to enable virtual clinic working and increase capacity.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On track

CRR20-09	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 18 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 4 February 2021
	Risk: Patient care could be compromised due to no clinical Lead for Diabetes Speciality	**Date of Committee Review:** New Risk for Escalation
		Target Risk Date: 30 December 2022
There is a risk that diabetic patients and their families across the Health Board may not receive equitable high quality patient-centred timely care for their conditions due to the lack of consistent clinical pathways. This is caused by not having a clinical lead for the Diabetes speciality. This may lead to patient harm as care and treatment may not be current as per NICE guidance, poor patient experience and non-compliance with the all Wales standards and guidance, including the All Wales Diabetes Plan.		

	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20



Current Risk Rating	4	5	20
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in January 2021	*New Risk*		

Controls in place	**Assurances**
1. Concerns escalated to current Executive lead. 2. There is medical care provision for diabetic patients. 3. There is a diabetic nurse service in place. 4. There is a therapies service providing services eg. Podiatry and dietetics. 5. Multi-disciplinary approach to care in place.	Risk is regularly reviewed, monitored and discussed at the local service Quality and Safety meeting as well as PCC SMT.

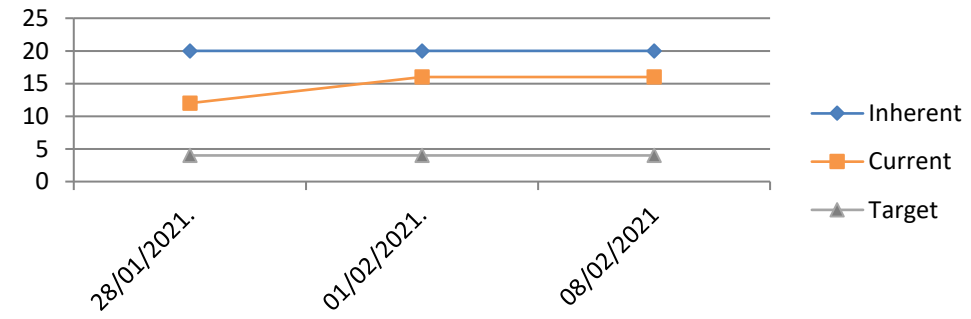
Links to	
Strategic Priorities	**Principal Risks**
Continuing to provide care under 'essential' services & safe stepping up planned care Effective use of our resources	BAF20-04

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	14913	A Diabetes clinical pathway to be developed for BCUHB.	Dr Bethan Mair Jones, Area Medical Director	30/09/2022	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On Track

target risk score	14914	Business case being developed and progressed via R&D, Academy for potential funding.	Eleri Roberts, Area Ops Manager	31/12/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On Track
	14916	Job Description and Person`s Specifications being developed in view of recruiting to the post of a Diabetes Lead.	Dr Bethan Mair Jones, Area Medical Director	31/03/2021	This action will enable the service to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise.	On Track

CRR20-10	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 January 2021
	Assuring Committee: Digital and Information Governance Committee	**Date Last Reviewed:** 8 February 2021
	Risk: GP Out of Hours IT System	**Date of Committee Review:** New Risk for Escalation
		Target Risk Date: 31 March 2022
There is a risk that clinicians delivering GP Out of Hours Services may not have access to patient records due to possible delay in the implementation of the new IT system that is led by a national procurement programme, which is yet to be built and tested.		

This may result in clinicians not being able to access patient information, the current automated booking/triage system failing, delays in the delivery of patient care and poor patient experience.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	1	4
Movement in Current Risk Rating Since last presented to the Board in January 2021	*New Risk*		

Controls in place	**Assurances**
1. The procurement has been led and managed nationally on behalf of WG. 2. The contract for the current system has been renewed and extended past the planned introduction of the new IT system. WG has agreed to fund the ongoing provision of the current system. 3. The Service keeps abreast of developments of the new IT system which will be managed by through the national group.	1. 111 Implementation Board in place for North Wales which will be kept informed of progress with the new IT system. 2. BCUHB GP OOH service represented on related national groups.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources Safe unscheduled care	BAF20-03 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	14879	Ensure updates are received from the national team in order to review the risk regularly.	Brennan, Mr Sefton Brennan, Divisional Lead GPOOH	31/12/2021	This action will help mitigate the likelihood and consequence of this risk.	On Track
	14880	National system to be in place by Autumn 2021.	Brennan, Mr Sefton Brennan, Divisional Lead GPOOH	30/11/2021	This action will assist in reducing the likelihood and/or consequence of this risk were it to crystallise.	On Track
	14881	Setup a Task and Finished Group linked to the implementation board of 111 to oversee the rollout of the new IT system (SALUS) which will be provided by Capital.	Brennan, Mr Sefton Brennan, Divisional Lead GPOOH	30/07/2021	This action will assist in reducing the likelihood and/or consequence of this risk were it to crystallise.	On Track

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 2nd March 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:**	Executive Director of Nursing and Midwifery
Atodiadau **Appendices:**	1. Presentation slides January data

Argymhelliad / Recommendation:

The Committee is asked to take assurance from the Infection Prevention presentation this month.

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 Infection Prevention presentation will update the Committee on the position of infection prevention performance and the associated risks relating achievement of our infection prevention agenda across the Health Board.

Last time the Committee received a deep dive report into our mandatory surveillance and Covid-19 infections. This month we have utilised the approach advocated by the performance team and kept the presentation short for the Committee. Focusing on performance, actions, timelines, and approach.

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 where required.

Asesiad / Assessment & Analysis:

Financial Implications

- Expand the significant gaps in the Infection Prevention and Control team to support the infection prevention agenda moving forward.
- Staff absence for COVID-19 self-isolating, shielding and symptom management.
- Complaints / potential litigation around avoidable harm

Risk Analysis

Infection prevention and the ability to deliver the transformation and improvement programme required to bring about behavioural change, policy review, preventative and innovation work, development of the Infection Prevention Control Team (IPCT) is currently on the Risk Register. We have two overarching infection risks on the Board Assurance Framework. These are managed through Patient Safety & Quality Group, Infection Prevention Sub Group, Local Quality & Safety Meetings and Local Infection Prevention Groups in each accountable area.

Legal and Compliance

- Reporting incidents for any Health Care Associated Infection clusters/ward closures and deaths confirmed on death certificates and complaint responses associated with these.
- Reporting to the 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.

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

APPENDIX 1

Infection Prevention Update

February 2021 (January data)

Infection Prevention Mandatory Surveillance January 2021

- Welsh Government trajectories have not been set for 2020/21, the number of cases have been measured alongside the trajectories for 2019/20. We are not an outlier and performing well in some when comparing ourselves with other Welsh Health Boards (see slide 3). We are unfortunately over our trajectories for all organisms except for E.coli, however, this is not a deteriorating picture in performance as you can see from the following graphs.

- In 2019/20 we had a large reduction in CDI trajectory, but have been unable to improve our position this year as much as we would have liked. This year to date we have seen 180 CDI cases, East 59 (trajectory 53), Central 72 (trajectory 38) and West 49 (trajectory 35). Three Welsh Health Boards, including BCUHB, have seen increases in Clostridium Difficile Infections (CDI).

- Methicillin Resistant Staphylococcus Aureus (MRSA) five cases year to date, all from samples collected in the Emergency Department and considered to be of community onset. In comparison to last year to date BCU has had 29% fewer infections and currently has the lowest rate of infection across Wales.

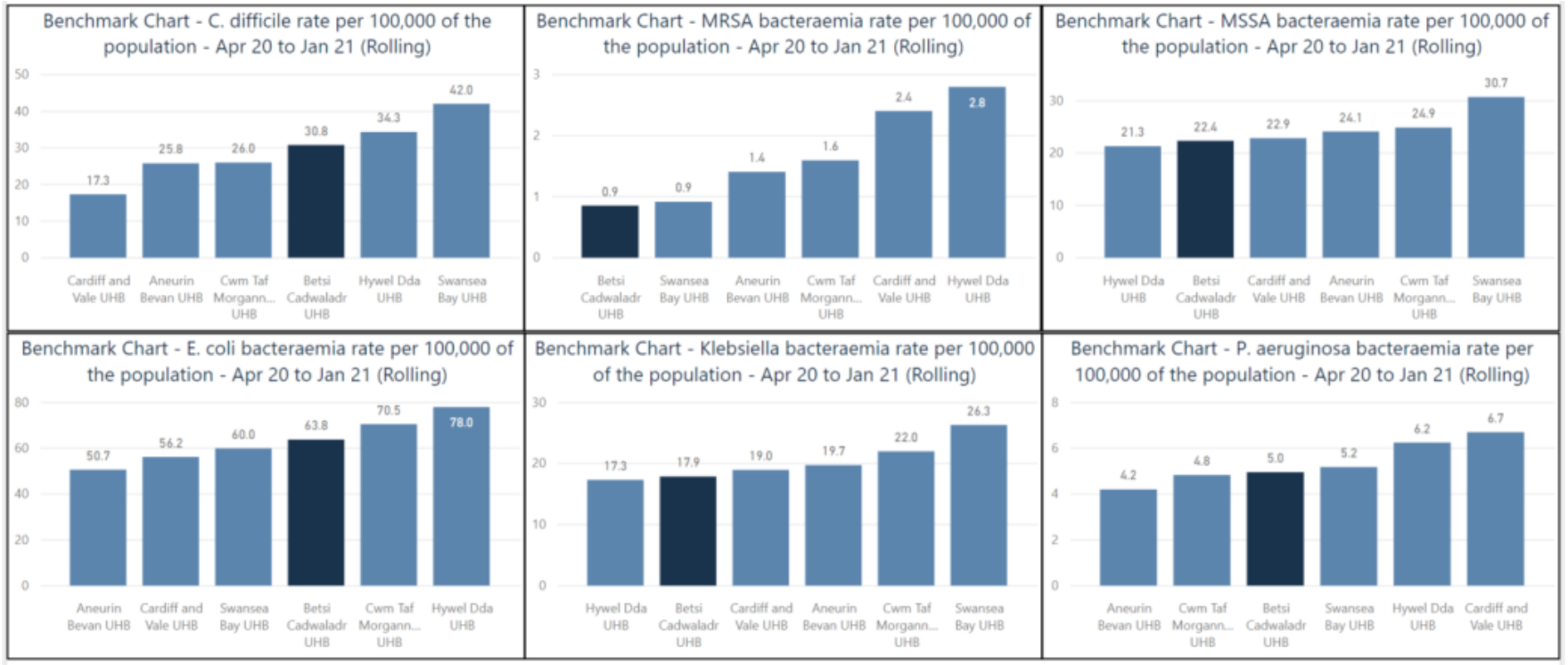
- Methicillin Sensitive Staphylococcus Aureus (MSSA) 133 cases year to date. East 48 (trajectory 48), Central 49 (trajectory 34) and West 36 (trajectory 32). Although this figure is above trajectory, BCU currently has 21% fewer infections in comparison with 2019/20.

- 375 E.coli cases year to date. East 132 (below agreed trajectory 162), Central 146 (trajectory 120) and West 97 (below agreed trajectory 109). Overall BCU have seen 23% fewer infections year to date (112 fewer infections). Fourth position across Wales. Overall infections are decreasing despite a national and international increase in gram negative infections.

- We are the second lowest Welsh Health Board with our performance around Klebsiella infections. Down 10% on last year compared to all Wales 4%. Klebsiella infections 105 cases year to date. East 33 (below agreed trajectory of 36), Central 46 (trajectory 26) and West 26 (trajectory 26).

- We have seen one Pseudomonas Bloodstream Infections (BSI) in January, with 29 cases year to date. East 12 (trajectory 9), Central 11 (trajectory 6) West 6 (trajectory 6).

All wales mandatory surveillance – infections January 2021



Source: PHW

- In comparison to other Welsh Health Boards we are not an outlier position between first and fourth comparing mandatory surveillance data April 2020 to January 2021

Board Assurance Framework – Safe & Secure Environment (1) 5 Feb 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		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
PPE monitoring and management in place with regular reporting to the Patient Safety and Quality Group.	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.	30 September 2021
Fit testing in place to prevent avoidable infection. This is monitored via IPSG and OH&SG.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG.	2	Establish a routine programme to ensure continuous review of dynamic plan for fit testing with plan being kept under review by IPSG	30 April 2021
Review of all buildings has taken place against new regulations in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified.	1	Ventilation and Environmental groups reporting into Infection Prevention Sub Group and Patient Safety & Quality Group with governance structure in place. Implementation of segregation and screening to clinical areas.	1	Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates.	30 September 2021

Review comments since last report: New Lead Officer appointed. Controls and actions updated (including realistic delivery dates). Target risk score increased. Note this is above the current risk appetite level due to the current pandemic environment within which staff are operating.

Executive Lead:	Board / Committee:	Review Date:
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**5 February 2021**

Board Assurance Framework – Safe & Secure Environment (2) 5 Feb 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		3		15		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
New leadership in place with revised governance arrangements supporting Infection Prevention.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via IPSG and Patient Safety & Quality Group.	2	Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangments in place across the Health Board. Finalise recruitment to increase IPC Team resource.	31 December 2021
Infection Prevention Sub Group in place providing regular oversight and gaining assurance that the key controls are in place and effective, reporting into Quality, Safety and Experience Committee.	2	Monitoring of performance and risk in place by Public Health Wales and Welsh Government.	3		
Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections.	2	Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	2	Strengthening of effective reporting arrangements through outbreak control groups and IPSG.	30 September 2021

Review comments since last report: New Lead Officer appointed. Controls updated and additional actions identified. Target risk score revised. Note this is now above current risk appetite level in view of operating currently within the pandemic environment.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**5 February 2021**

Infection Prevention Performance Update January 2021

Key Drivers of Performance

- + having a clear infection prevention plan with the ambitious aim of a zero tolerance approach to health care associated infections
- + understanding the risks *existing and potential' that enable harm to happen in our clinical settings
- + aligning the controls to mitigate eliminate the risk utilising behaviour science methodology
- - unable to access primary care prescribing data is hampering our ability to support community with antimicrobial and PPI prescribing practices
- - lack of decant facilities to enable routine HPV cleaning across all inpatient sits means there is a potential bioburden in our ward areas
- - clinical areas and rest areas not set up for infection prevention, transformations in how we deliver care is need to design infection prevention models for the future

Actions to reduce risk and close gaps in controls (not previously mentioned in the slides)

• align covid-19 improvement workstreams under three themes people, resources and environment	(February 2021)
• urinary catheter project group set up to strengthen controls e.g. audits, care bundles	(February 2021)
• external review of infection prevention & control across the Health Board	(March 2021)
• restructuring the infection prevention plans under the improvement umbrella of Safe Clean Care mobilisation	(March 2021)
• accountable areas infection prevention draft plans	(April 2021)
• aligned information and intelligence project around controls available for key governance meetings	(April 2021)
• clear programme of Safe Clean Care improvement and transformation pilot projects in place to support achieving our ambitious aims e.g. locker review, safe breaks, portable sinks, technology enabled ward rounds, inpatient duvets etc.	(April 2021)
• align infection prevention report to the AAA methodology applying good governance principles	(April 2021)
• Local care giving areas IPC champions programme inc staff engagement champions to support staff stay safe	(May 2021)
• Action plan to address non compliant ventilation to future proof our healthcare environments	(June 2021)
• key recruitment in IPC & Antimicrobial pharmacists to support all accountable areas	(July 2021)

Assurance - Our Infection Prevention Approach

- **Raise the focus** – Enhance targeted communications campaign to share simple clear messages, different formats, same messages, clear plan on a page for each accountable area, Safe Clean Care
- **People** – Training in a clear and simple way to do the right thing, improvement skills on the ground supporting transformation
- **Process** – Simple, easy to understand governance, plans, processes and guidelines for us to follow that are inline with current good practice
- **Practice** – Checking what we do and how we do it. Supporting good habits, poke yoke's, setting things up to reinforce infection prevention
- **Performance** – Agreed key performance indicators that align to the above. Clear accountability and line of sight from Board to care giving area (one version of the truth), aligned governance
- **Praise** – Strength based approach, understand what is good, what has gone well, foster pride, and share widely

Transforming Mind-sets

Infection prevention is everyone's business – we are in a pandemic

1. Treat everybody including ourselves as if we are infectious, because anyone could be
2. If we have to breach ours and someone else's safe space ensure we and they are appropriately protected
3. Changing habits takes time. We all need to use strength based language, supporting each other to do the safest thing every time for everybody

PROTECT OURSELVES

PROTECT EVERYBODY

SAVE LIVES

Cyfarfod a dyddiad: Meeting and date:	Quality Safety and Experience (QSE) Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Safety Update Report – COVID19
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:	Information within this report have been discussed at Strategic Occupational Health and Safety Group; Personal Protective Equipment (PPE) Steering Group and COVID19 Delivery Group.
Atodiadau Appendices:	N/A

Argymhelliad / Recommendation:

The Committee is asked to note the position outlined in the 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:

This report builds upon information provided in previous Health and Safety Update Reports and the recent Quarter 3 Health Safety Report considered by the Committee in January 2021. As a result, the report focusses on the period from 1 January 2021.

The 2019/20 annual report identified that the BCUHB Health and Safety (H&S) Strategic approach still required considerable work. With the declaration of the COVID19 pandemic in March 2020 and the experience across the 2nd and 3rd waves, the proactive work being undertaken to progress the 3-year strategy has, of necessity been refocused to support staff and patients during this challenging period.

Cefndir / Background:

1. **COVID19 Staff Cases**

Between March 2020 and 31 January 2021, the Health Board had undertaken circa 30,000 staff tests and recorded 2,490 positive staff cases, and sadly lost three staff members during this period.

In the period 1st to 31 January, the number of tests undertaken was 5,108 and positive cases 498. As we move into February, the numbers have started to fall again but it is too early to say the reasons for this but it is likely to be more related to lockdown and recovery from the Christmas Day impact than vaccination at this point.

Table 1 shows the profile of testing and all results and Table 2 shows positive cases split by Secondary Care and Area. This information is also being used to inform the modelling for planning purposes.

Table 1. – COVID19 Testing and case profile for BCU Staff

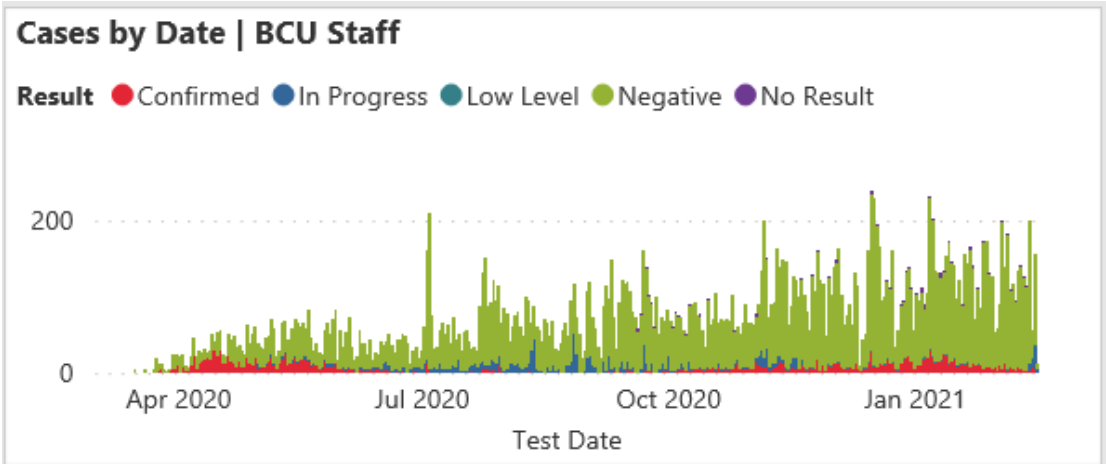
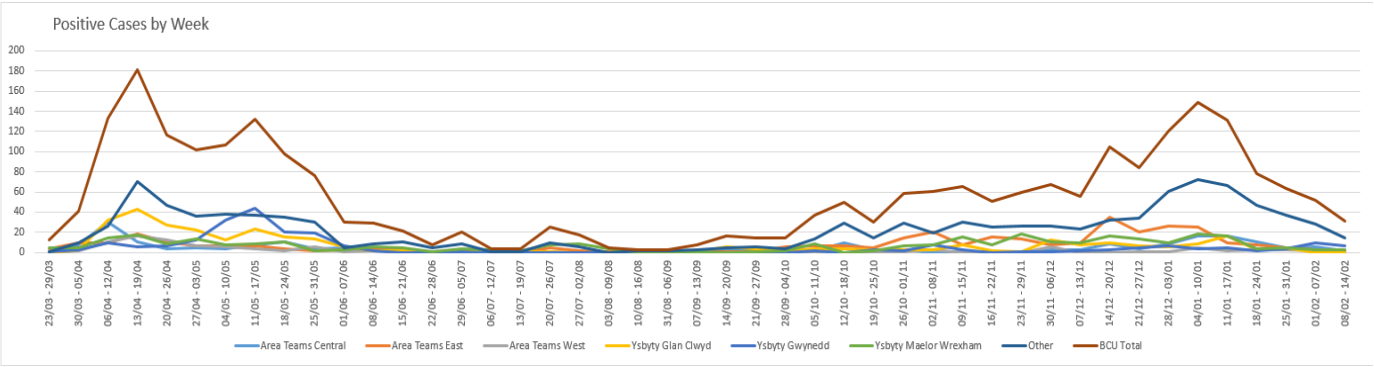


Table 2. – COVID19 Positive Cases by week for BCU Staff



It is worth noting that of the 498 staff tested positive in January 2021, 396 (79.5%) were aged 55 and below. This is slightly down from the previous trend of 82% of staff tested aged 55 and below.

2. COVID19 Staff Cases reported to Health and Safety Executive

In the period 1st January 2021 to 22nd February, there have been 62 COVID19 staff diagnosis reported as occupational diseases to the HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

These break down into 6 identified COVID-19 staff clusters:

- 3 in East involving 25 staff,
- 2 in Central involving 18 staff and
- 1 in West involving 19 staff.

The Corporate Health and Safety Team continues to provide support and guidance to the three area COVID19 Outbreak Incident Management Teams.

In addition to this, the Corporate Health and Safety Team has undertaken 79 social distancing/health and safety visits since January 1st 2021, across the organisation and re-reviewed 168 separate staff COVID19 diagnosis reported through Datix since 1st September 2020. The purpose of these re reviews is to consider cases in light of learning since the first review to identify any further themes and/or any further learning to be taken forward to reduce further transmission.

The above, together with the joint 'Make It Safe' (MIS) reviews that are held in conjunction with Clinical Services, Infection Prevention and Control (IPC), Public Health Wales (PHW) and H&S on all related COVID19 outbreak clusters have identified a number of potential transmission sources. These include:

- Potential breaches of Personal Protective Equipment (PPE) when providing hands on care, which includes caring for challenging patients
- Donning and doffing of PPE that is not of an appropriate standard
- Cramped staff rest/welfare areas making social distancing difficult
- Non-adherence to social distancing or the mandatory wearing of face coverings by both staff and patients
- Ineffective/insufficient cleaning regimes for high touch surfaces and equipment
-

In each one of these cluster outbreaks, remedial action has been implemented to prevent reoccurrence. It is also now a mandatory requirement to have a COVID19 Workplace Risk Assessment in place. A template has been developed by the Corporate H&S team to support managers for BCUHB wide communication and implementation. This is in addition to and compliments the All Wales Individual Workplace Risk Assessment.

The development of an Enhanced PPE Risk Assessment for the Management of Challenging COVID 19 patients and the implementation of segregated teams and work areas in both clinical and corporate teams e.g. Estates and Facilities should ensure reduction in COVID19 risks and enhanced business continuity plans.

Throughout the pandemic response, the Corporate Health and Safety Team (as well as Infection Prevention Control/PPE teams) have worked collaboratively with our Trade Union partners to identify and respond to risks and emerging issues/trends. The policies and processes developed and implemented, together with feedback and advice from key teams/services e.g. Public Health Wales, Health and Safety Executive, Microbiology/Epidemiology have all been shared and considered in partnership.

This has provided an environment of constructive challenge and support both in the content of guidance etc. but also in the communication and reinforcement of best practice. As this virus is a "Novel" virus, all organisations and agencies are learning how best to manage the associated risks, particularly when new variants develop, bringing new challenges. This has meant that the close liaison with the Health and Safety Executive has been even more important as advice and requirements change. Throughout the Pandemic, the Health Board has been clear that full

transparency of reporting was required and over the period since March 2020 a total of 700 cases have been submitted under the RIDDOR requirements. Following a challenge by one of our Trade Unions, the Health and Safety team has sought further advice from the Health & Safety Executive (HSE) and has received confirmation that the process for consideration and reporting being undertaken by the Health Board is appropriate. To ensure that the rationale for this is properly understood by all Trade Union partners and to provide further assurance to the Trade Union raising the issue, a joint meeting with HSE/Corporate Team and Trade Union representatives has been arranged.

3. PPE - Face Mask Fit Testing

The Improvement Notice JB24820 served by the HSE on Betsi Cadwaladr University Health Board and specifically the Ysbyty Glan Clwyd (YGC) hospital site on the 24th of August 2020 identified the following measures that needed to be taken. Against each of the requirements we are now in a position to confirm compliance as set out below:

Requirement - Every employee working in higher risk acute areas with possible or confirmed case(s) of COVID-19 and / or aerosol generating procedures (AGPs) should be face fit tested by a competent face fit tester

Action - At the time of the Improvement Notice there was a combination of qualitative and some level of quantitative fit testing using the PortaCount machines. The Health Board decision to progress with quantitative fit testing only, enabled the retraining of fit testers directly. As part of the Procurement exercise to purchase additional PortaCount machines, the training provided by the suppliers was assessed to ensure it was provided by an accredited fit2fit trainer, further details of this are given under requirement. A further nine PortaCount machines were procured bringing the total for the Health Board to eighteen.

On the Ysbyty Glan Clwyd site the fit testing leads supported by the Hospital Management Team identified the list of staff working in higher risk acute areas.

This list was inclusive of all support services to these areas. Once the additional Portacount machines had arrived and fit testers had been trained to fit test using this, the site commenced the refit of all of these staff. A total of 1,380 tests were carried out using the 1863 respirator by the 15th of December 2020. The stock levels of this respirator were depleted at a National level and in December the need to refit to another respirator was required. On the 16th of December the fit testers commenced fit testing to the 1863+/9330+ respirator and to date the site has undertaken 1,222 tests to this respirator. All reusable Corpro silicone half face respirators have been fitted using the quantitative method in YGC. All fit testing across the Health Board has moved to the quantitative method and can only be carried out by staff who have attended the training.

To ensure that the fit testing program remains on track, the Health Board has put plans in place for a Fit Testing Team. This team incorporates a Fit Testing Program Lead, 3 Fit Testing Coordinators, and one H&S Information Systems Support Officer. These posts have been offered internally to staff as a secondment pending consideration of the business case for the permanent/longer fixed term posts. Throughout the Health Board, there are 110 trained fit testing staff volunteers supporting the program.

Fit testing centres have also been set up on two of the three District General Hospital sites, with the third requiring minor works to make this suitable. Fit testing is now recorded on the Electronic Staff Record (ESR) system and for both the fit testers and the staff fitted to a specific model using the quantitative method. The new process is now recorded in the Fit Testing Protocol which remains a working draft until all aspects are finalised and this replaces the previous guidance document.

Requirement - Demonstrate that your face fit tests achieve the following minimum requirement defined in the British and European Standard entitled; Respiratory Protective Devices. Selection Use and Maintenance Part 3 Fit Testing Procedures: BS ISO 16975-3:2017 and which are summarised in HSE Guidance on RPE fit testing INDG 479.

Action - The training for BCUHB fit testers is now provided by a company called RPA who have confirmed that the trainer for each session is Fit2Fit accredited and they are TSI's PortaCount training partners for the UK. RPA have confirmed that the course content covers the Competent Fit Test Operator criteria set out in INDG 479.

Requirement - Demonstrate that your arrangements allow sufficient time to conduct an adequate face fit test procedure.

Action - The Portacount dictates the time taken to undertake the fit test where all exercise stages are timed, this cannot be modified and so is standardised. Fit testing is now by appointment only and the appointment times have been standardised to 30mins, which allows for explanation, fitting and demonstration of fit check and product features, along with the test itself.

The summary of actions taken, together with evidence to support is being compiled for submission to the HSE.

4. Immunisation – Staff COVID19 Vaccination

The COVID-19 immunisation programme provisional recommendations for the use of the vaccine The objectives of the COVID-19 immunisation programme is to protect those who are at highest risk from serious illness or death. The Joint Committee of Vaccination and Immunisation (JCVI) have set out a prioritisation for persons at risk. JCVI ranked the eligible groups according to risk, largely based on prevention of COVID-19-specific mortality.

Evidence from the UK indicates that the risk of poorer outcomes from COVID-19 infection increases dramatically with age in both healthy adults and in adults with underlying health conditions. Those over the age of 65 years have by far the highest risk, and the risk increases with age. Residents in care homes for older adults have been disproportionately affected by the COVID-19 pandemic. The objective of occupational immunisation of health and social care staff is to protect workers at high risk of exposure who provide care to vulnerable individuals. Although there is yet no evidence on whether vaccination leads to a reduction in transmission, a small effect may have major additional benefit for staff who could expose multiple vulnerable patients and other staff members. Potential exposure to COVID-19, and therefore the priority for vaccination, may vary from workplace to workplace.

For the Health Board staff, we have applied the Clinical Guidelines based on the Green Book and in line with national policy.

Direct Patient Contact used the criteria set out in the Green Book Chapter 19 for Influenza, plus Porters, Domestics, Ward clerks, reception, bank and locum staff working in DPC roles/areas in last 6 months and vaccination staff. Finally, we added in all DPC students on placement/due to be on placement, together with microbiology staff employed through Public Health Wales and Security staff employed by Samson.

The Health Board has:

Offered first dose vaccination to 100%:

- Group 2 BCU frontline workers
- Group 3 BCU non DPC staff 75 years and over
- Group 4 BCU non DPC staff 70 years and over and clinically extremely vulnerable

Administered first dose vaccination:

79% - Group 2 BCU Frontline workers
100% substantive alone/48% Inc. bank - Group 3 BCU non-DPC staff 75 years and over
78%- Group 4 BCU non DPC staff 70 years and over and clinically extremely vulnerable
43% Groups 5 and below (subject to continued validation as part of dose 2 plan.)

In total, 17,675 staff had received first dose vaccination. This included 2003 bank staff in groups 1-4 and 520 staff who work in BCUHB but are not employed by BCUHB.

In the region of 13,500 first dose vaccinations were undertaken at Hospital Vaccination Centres, 3,600 at Mass Vaccination Centres and 600 at various vaccination sites (Inc. GPs etc.)

Administration of the 2nd dose will be undertaken at the same venue as first dose and will be undertaken between 15 February and 12 March 2021.

Asesiad / Assessment & Analysis

Strategy Implications

The response to the COVID19 pandemic has been extremely challenging for all teams and whilst this has resulted in slower progress against the 3-year improvement plan, it has provided a catalyst for the importance of adherence to health and safety good practice to be valued and understood. As we move from response to recovery there will be new challenges, not least of which focussing on the backlog of work such as immunisation and surveillance.

Financial implications

Funding for the activity related to COVID19 has been available within a controlled framework. Funding for core health and safety has been minimal historically and as such, the 3 year improvement plan has a case for investment aligned to it. This is subject to the business case process and will form part of the budget setting and planning for 2021 – 2024.

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.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	The Impact of Covid-19 on Child Health Services within BCUHB
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Chris Stockport, Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Louise Bell, Acting Assistant Area Director, Childrens Services, Central
Craffu blaenorol: Prior Scrutiny:	Bethan Jones, Central Area Director Clare Darlington, Assistant Director Primary Care & Community Services
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The QSE Committee is asked to endorse this 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:

During the COVID pandemic all services for children, young people and their families have been delivered following the guidance of BCUHB, Welsh Government (WG) and Public Health Wales (PHW), ensuring that essential services are delivered safely in our hospital and clinic settings, in the family home, or provided remotely.

Although children are fortunately not as affected by COVID-19 as adults our children's services have needed to be maintained both in urgent and emergency situations, but particularly for children where delaying diagnosis or ongoing treatment could impact on the rest of their lives.

Our normal pathways of care have been interrupted and other sources of support for children and young people, at school or in social networks, have been disrupted both in the initial lockdown period in March 2020 and the lockdown we are currently in. It has been extremely challenging to maintain our services and protect children and young people during this time.

Partnership working has been vital during this period with close links required with the six local authorities during the pandemic.

Cefndir / Background:

At the beginning of the COVID-19 outbreak Childrens Services stood down some (non-essential) routine, non-urgent treatment in line with WG and BCUHB guidance. All face to face clinics were cancelled as were group community clinics and elective routine surgery and medical day cases. However, most of our services continued under the WG Essential Services Framework.

The importance of protecting the welfare of children and young people has been the key priority in decision making within Childrens Services, and at the start of the pandemic immediate action was taken to carry out risk and impact assessments across all services. New ways of working were rapidly developed locally and within Clinical Networks in line with Royal College guidance which informed the development of new and adjusted clinical pathways to deliver care. Services prioritised were:

- Life-saving or life impacting paediatric services in both Acute and Community settings including diagnostics and treating children with additional / continuous healthcare needs
- Neonatal Services including transport
- Health Visiting - time critical vaccinations, screening
- Mental Health
- Safeguarding and vulnerable children and families.

Systems to ensure all consultations and paediatric assessments that could be virtual or by telephone, were put in place to reduce the risk of Covid virus transmission to staff or families. Caseloads were risk assessed to determine appropriate mode of contact. Only essential face to face contacts either in hospital, the clinic setting or in the family home were undertaken when clinicians had to physically examine, treat or observe children and young people. In early summer when lockdown restrictions eased Childrens Services restarted planned elective care and restored services with careful planning, scheduling and organisation of clinical activity.

Asesiad / Assessment & Analysis by Service

Acute Paediatrics & Neonatal Services

Unscheduled Care - delivery of urgent and emergency care has continued across all three hospital sites. There has been a significant reduction in demand with hospital admissions to acute paediatric inpatient wards. Admissions are down by 45% regionally when compared with previous 2 years admissions during the same time period. Childrens emergency department attendances have also significantly reduced with a 42% reduction on last year's figures at the end of quarter 3.

There has been a reduction in respiratory illness usually seen to date, this is thought to be due to schools being closed reducing transmission of respiratory viral infection in children.

Intensive care pathways have not changed from the usual care arrangements with children in need of intensive care transferred to the appropriate Paediatric Intensive Care Unit (usually Alder Hey Hospital).

Elective Care - All routine planned care for Childrens Acute Services was stopped at the start of the pandemic in line with guidance. Elective activity was re-started in June 2020 with clinicians undertaking telephone/video review clinics and prioritising children and young people who are in need of the most urgent care and requiring physical assessments (face to face). Demand for outpatient

services has reduced by 40%. Some elective paediatric surgery and medical day cases have also re-started.

During quarter 1 of 2020/21 Referral to Treatment (RTT) waits for children increased to over 26 weeks during the time we were not delivering elective care. However with reduced demand seen during the pandemic and restarting of clinics and surgical lists the service are now achieving the WG access targets across all areas.

Patients and families attending outpatient departments are required to maintain social distancing and departments are following infection prevention advice and Personal Protective Equipment (PPE) guidance. As many outpatient appointments as possible continue to be conducted remotely over the telephone or using 'attend anywhere' video link.

Sub-Regional Neonatal Intensive Care Centre (SuRNICC) - The Neonatal Service including the Neonatal transport service, has been classed as essential and as such continues to function following the normal pathways of care. Pregnant women and babies continue to be transferred across North Wales and into the North West of England, ensuring they are cared for in the most appropriate unit to deliver the level of care required.

Risks/Impact

- Reduction in children attending emergency departments and paediatric assessment units and referrals to secondary care, possibility of these delays resulted in harm to children.
- Services affected with need for surge capacity in secondary care

Mitigation/Contingency Planning

- Adopted 'Consultant Connect' and GP helplines.
- Improve public health messaging for parents - good links with primary care through cluster groups
- Following national advice and guidance to monitor delayed presentations.
- Surge planning with Acute services and Area Team in place

A recent study by the Welsh Paediatric Surveillance Unit, which is affiliated with the Royal College of Paediatrics and hosted by Cardiff and Vale University Health Board, reported a 14% rate of delayed presentations causing harm in Wales. New diagnosis/diabetic ketoacidosis was by far the most common but also sepsis and malignancy. BCUHB were not part of this particular study, participants were predominantly from Health Boards in South Wales. Reassuringly, there have been no deaths or serious harm reported in BCUHB where delayed presentation was considered a contributing factor. Monitoring and reporting of delayed diagnosis is in place through Childrens Governance structures.

CAMHS

Child and Adolescent Mental Health Services (CAMHS) have seen fluctuations in demand over the pandemic with a reduction in demand for assessment and intervention during initial lockdown followed by an increase in demand as schools returned. We are seeing an increase in concerns relating to low mood and anxiety directly related to the effects of the pandemic, in addition to high acuity crisis and eating disorder presentations.

The length of treatment has increased in many cases due to slower patient/therapist engagement, the impact of efficacy of evidence based therapies due to remote delivery, and the additional time required

to adapt face to face therapies for remote delivery. Recovery is taking longer for some children, young people, and families faced with adversity due to instability of employment, poverty, trauma, and other stressors brought about by the pandemic. These factors have an impact on the number of new cases that can be treated. There has been a change in demand patterns with:

- Reduction in routine referrals at start of pandemic enabling the service to divert staffing resources to extend acute crisis services, continue with core work, deliver support to education
- Significant increase in demand following first lockdown, identification of unmet need on return to school
- Increase in urgent cases and acuity of cases including eating disorders
- Referrals have decreased to a lesser degree in this second lockdown with need being better recognised due to clinicians linked to school clusters.

Risks/Impact

- New to review rates increased impacting capacity to take on new cases due to engagement taking longer with young people when working remotely, efficacy of treatment impacted in some cases as delivery is designed to be face to face, additional stresses for young people challenges recovery
- Group programmes have been suspended as no technical platform to run virtually
- Higher levels of stress due to barriers in delivering services (rooms, IT, efficacy) and own personal challenges
- Delivering sensitive and emotive work in more isolated conditions and at home
- Challenges introducing new staff and supporting clinical development of less experienced staff due to lower opportunities for face to face joint working and team accessibility
- Lack of IT for staff with backlog in supplies available

Mitigation/Contingency Planning

- Acquiring IT equipment for remote working. Using Microsoft 365 and Attend Anywhere to support remote delivery but these are now being started again after installation of higher functionality Teams in BCUHB
- Additional capacity has been commissioned to support timely access.
- Increased Multi Disciplinary Teams (MDTs) to support decision making/patient flow and regular briefings to reduce isolation
- Training for schools and closer links and pathways within education to support identification of unmet need and avoid late presentation during second lockdown
- Increased capacity into Eating Disorder pathway
- Embedding staff in primary care GP services and other statutory agencies to support

North Wales Adolescent Service (NWAS) - Inpatient CAMHS has continued to be provided with infection control measures in place for young people, family visitors and staff. An additional two beds were made available on the 2nd ward for any young people requiring isolation due to COVID, these have been used following transfer back from Ysbyty Glan Clwyd (YGC) whilst waiting on swab results.

Risks/Impact

- It has been evident that young people have lost some of their support and anxiety has increased, resulting in longer admissions and difficulties discharging.
- Transition to Adult services challenging due to increased demand for inpatient mental health beds

Mitigation/Contingency Planning

- Increase discussions with local authorities to enable safe discharge.
- Developed closer working links with Adult Mental Health colleagues to support timely transition

Health Visiting & School Nursing

All areas are delivering the Healthy Child Wales Programme (HCWP) and Flying Start Programs as in line with WG guidance with increased use of remote contacts and risk assessments to ensure informed decisions regarding children at risk. HCWP national review of data and contacts across all Health Boards in Wales has commenced however this is paused currently while WG validate some data issues.

Local BCUHB data indicates improvements from quarter 1 2020/21 data where contacts were reduced in initial lockdown. From quarter 2 there has been an increase in home visiting, prioritising the most vulnerable with positive progress. Clinic based activity is planned dependent on ability to social distance and provide infection control protective measures and availability of space.

An initial report indicates a very successful Influenza immunisation program delivered in the Autumn term with full engagement and participation from our local authorities' education departments.

Risks/Impact

- Safeguarding – all vulnerable families known to services have had support from social services and health however, it is likely that that there are children and young people who are experiencing harm with no support system to enable them to disclose this or to protect them. Domestic abuse figures expected to rise during this second lockdown and once again those experiencing this have had limited access to support.
- Clinically – some families have been reluctant to access services for babies and children for support with feeding, development or wellbeing.
- Emotional wellbeing –low mood and anxiety, and worsening of pre-existing mental health problems.
- Young Carers – children supporting a parent with their health needs, impacting on their own wellbeing.
- Inability to deliver drop in informal groups for peer support, ad hoc advice and reassurance from a health professional. Important arena for disclosure, follow on contacts within the first 1000 days as well as a platform for health promotion and breastfeeding support.
- Lack of IT resources for the service has hindered remote

Mitigation/Contingency Planning:

- All staff have continued to attend case conferences and core groups to ensure safe plans are in place for those children identified as at risk and monthly safeguarding partnership meetings have also been established with our Local Authority partners to improve working together and reduce risk.
- Sustained support for families' during lockdown will continue to be our priority to prevent and identify incidences of harm.
- Approval has been gained, more recently, for increased online platforms to extend our virtual capacity from a clinical based system which is more accessible for many families and allows us to introduce virtual online health promotion, parenting sessions and baby massage demonstrations.

- Welsh Government agreed funding for laptops to enable increased remote working.

Given the disruption to the preventative focus of our work in Health Visiting and School Nursing, the full impact of this pandemic may not be felt for some time to come.

Community Paediatrics

Community Paediatrics – The team have continued to deliver Child Protection on call and urgent face to face work where needed and have converted their follow up work to telephone consultations for the majority of patients. All families of the young people on current caseloads are regularly contacted and offered support and advice. Resources to aid interventions are being sent to family homes and liaison with other professionals continues virtually. Staff are also supporting children attending special schools across all areas.

Neurodevelopment (ND) - There was a temporary suspension of ND assessments due to the pandemic as it has been difficult to continue to work with these children due to the assessments being play based. We have re-introduced services and have adapted assessments with alternative approaches and resources in line with national guidance where possible, via telephone appointments, gathering information from other services, and providing socially distanced face-to-face appointments.

Risks/Impact:

- Waiting list backlogs within the Community Paediatric and Neurodevelopment Service
- The demand for child protection medicals and attendance at Safeguarding meetings may increase
- The referrals may increase significantly as schools fully open.
- Families are unsupported whilst trying to parent children with complex needs.
- Children have undiagnosed needs

Mitigation/Contingency Planning:

- A daily 'Single Point of Access' (SPOA) for families to ring in for advice established across all areas and intervention service in ND continues.
- Agreed outsourcing to private provider to deliver assessments agreed as part of Regional Recovery plan.
- Additional capacity in community paediatrics identified to address backlog through telephone and video review to improve access. For existing case-loads it is anticipated that the majority of these cases will continue to be undertaken via telephone clinics, however due to the need to see, particularly those cases with complex needs, some face to face care and management in a community setting is required.
- Statutory medicals and urgent child protection medicals to continue as priority service.
- Childrens Community Nurse Teams will continue to support families to remain in their own homes, increasing the number of home visits as required following a risk assessment of the caseload.
- Special school nurses have returned to supporting special school attendance.
- Work with acute colleagues to offer Care Closer to home in line with WG All Wales Essential services guidance.
- Specialist nurses have offered telephone advice and review calls to assist with admission avoidance during this time. The will now work with their acute consultant colleagues to deliver

telephone clinics, skype clinics to facilitate an MDT clinic while observing social distancing rules and face to face clinics.

Childrens Continuing Care (CCC) - Teams have continued to deliver a service throughout the lockdown period. Some packages have been suspended at the request of parents and staff redeployed on the understanding that these packages of care will resume at the request of the parents or a change in the young person's health needs. The team have worked closely with community teams to ensure that the risks in suspending these cases have not increased any risks to the young person. Childrens CCC panels continue to be held virtually and have continued to business as usual. Virtual Joint commissioning panel meetings are now going ahead with the local authorities in North Wales.

Safeguarding Children

Child at Risk Reports - Initially there was a significant decrease in referrals to Safeguarding resulting in a reduction in the number of child at risk reports *(Fig 1)*. One of the reasons for this was the level of contact by schools and health services, presentations in emergency departments, closure of schools and reduced home visits/face to face working.

With the ease of lockdown in the summer months referrals increased to above pre-Covid levels compared to 2019 figures with a further increase in referrals once all pupils returned to school in September 2020 and teams worked closely with education colleagues to manage this. Since the firebreak in October 2020 and the introduction of the Level 4 restrictions BCUHB has seen a further reduction. This is in line with the National picture.

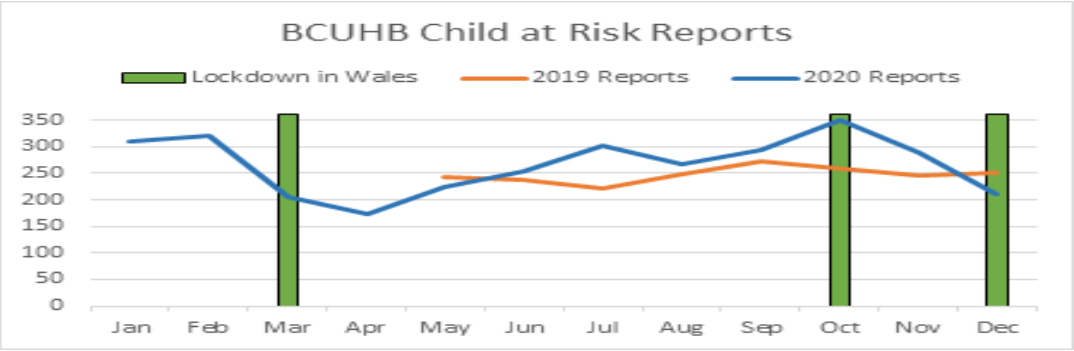


Fig.1: BCUHB Child at Risk Reporting Timeline (May 2019 – December 2020) with Wales Lockdowns highlighted

The potential risk of this reduction in activity by BCUHB is that a hidden child might suffer serious harm.

An increase in the number of complex Child and Adolescent Mental Health (CAMHS) cases, access to inpatient adolescent services due to tighter admission measures and the moving of the age appropriate bed from the Heddfan Unit Wrexham to the Hergest Unit Bangor, has resulted in some challenging young people, remaining on paediatric wards. Although the reports to the Local Authority have reduced the need for enhanced safeguarding advice and guidance has increased, delaying some strategic safeguarding activities required to driving improvements to be put on hold, for example, the IRIS project – training for GP's in domestic abuse.

Non – Accidental Injuries (NAI's) in Children - There was a 27% decrease in Child Protection Medical referrals year to date at the end of Quarter 3, 86% of which were related to alleged cases of physical abuse with a 63% reduction in sexual abuse cases reported; 49 in 2019 and 18 in 2020. The cases identified during the pandemic have been of a greater complexity with children suffering greater harm. This evidences the need for health services to continue face to face working arrangements with families in the home environment.

Local Authority colleagues questioned if the change in activity was related to a lack of health surveillance, due to the initial reduction in face to face visits by Health Visitors at the beginning of lockdown. To provide assurance all identified cases were reviewed jointly with Health and Local Authority and all concluded that the challenge was not substantiated. The closure of childcare settings and schools has meant that some children may have lost access to a place of safety. Children could be at greater risk of adverse childhood experiences (ACEs) due to a range of factors dependent on the family situation.

Overall, demand for Childrens Services has dropped during the pandemic. This is likely to be due to government advice about restricting travel and concerns about risk of infection in a clinical context. However, as detailed within the report, many of our Childrens services within BCUHB have concerns about unwell and vulnerable children not being able to access care and the risks of a post-covid surge in demand and what that would bring.

The full impact of the coronavirus outbreak on children and families has yet to emerge, with anticipated hidden harm. The impact of the outbreak on the mental health of children and young people has been significant and this is seen nationally. The re-opening of schools following this second lockdown period is a key marker for change for families, children and our health services.

Staffing has been a challenge due to staff sickness and shielding, although this has not been as high as initially anticipated, it has been necessary to redeploy staff from across the service to support other areas and this has been achieved without additional risk to the delivery of children's services in BCUHB.

However there have been positive impacts too with the rapid increase in use of digital technology, which has helped out teams to stay connected with each other and support our families to access our services. The staff response to challenges has been excellent and overall the transition to more online working has gone well. Some young people have said that they prefer virtual rather than face-to-face contact because it fits better with their lives and is the way that they communicate with other people.

We have a dedicated children's workforce in BCUHB and our teams have worked extremely hard in facing the challenges the pandemic has brought to ensure that children and young people across North Wales continue to receive safe and effective care in every setting.

Strategy Implications

Service changes required have been aligned to the wider corporate Covid planning within the Health Board and the Royal College of Paediatrics and have embedded the principles set out under the WG Essential Services Framework.

Options considered

Not required for this report.

Financial Implications

There are no financial implications to report. Adaptions to Childrens services accommodation/estates to meet infection prevention requirements have been funded by the WG Covid-19 funding made available to the Health Board.

Risk Analysis

Included in the body of this report

Legal and Compliance

There are no legal considerations relating to this report

Impact Assessment

Not required for this report. Considerations relating to equality requirements continue in line with pre-pandemic arrangements

Cyfarfod a dyddiad: Meeting and date:	Quality Safety & Experience Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	COVID-19 Mortality report
Cyfarwyddwr Cyfrifol: Responsible Director:	Professor Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell
Craffu blaenorol: Prior Scrutiny:	Clinical Effectiveness Group (February 2021)
Atodiadau Appendices:	1. Supporting powerpoint slides

Argymhelliad / Recommendation:

The Committee is asked to review the attached report that documents deaths from COVID 19, findings from reviews undertaken and the associated learning.

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:

This paper provides an overview of deaths where Covid 19 was a direct or contributory factor. It provides information about excess deaths including health care acquired infections, current learning from investigations and actions being taken to address it.

Cefndir / Background:

COVID-19 is a disease caused by a coronavirus (SARS-CoV-2); it causes a range of symptoms that can be mild but some groups of the population are at higher risk of severe infection including those in older age groups, with obesity and people with underlying heart and lung conditions such as heart and lung problems, diabetes and cancer.
The evidence about this new disease is constantly being updated. In addition different variant strains have emerged over the past year that have different characteristics such as infectivity.

BCUHB has played an important part in delivering the research agenda during Covid to improve knowledge and treatment of the disease -recruiting over 2000 participants to 23 studies. Emerging evidence has been rapidly deployed across our services.

Asesiad / Assessment & Analysis

Strategy Implications
Reducing mortality associated with the delivery of, and care given by health services is a key outcome when considering clinical effectiveness. Covid 19 has led to excess deaths across North Wales.

Options considered
Not relevant

Financial Implications
Not relevant

Risk Analysis
Not completed.

Legal and Compliance
A number of patients have died with healthcare acquired infection; investigations have identified a number of improvements that are currently being implemented. Ultimately, this may lead to litigation against the Health Board impacting on reputation and finances.

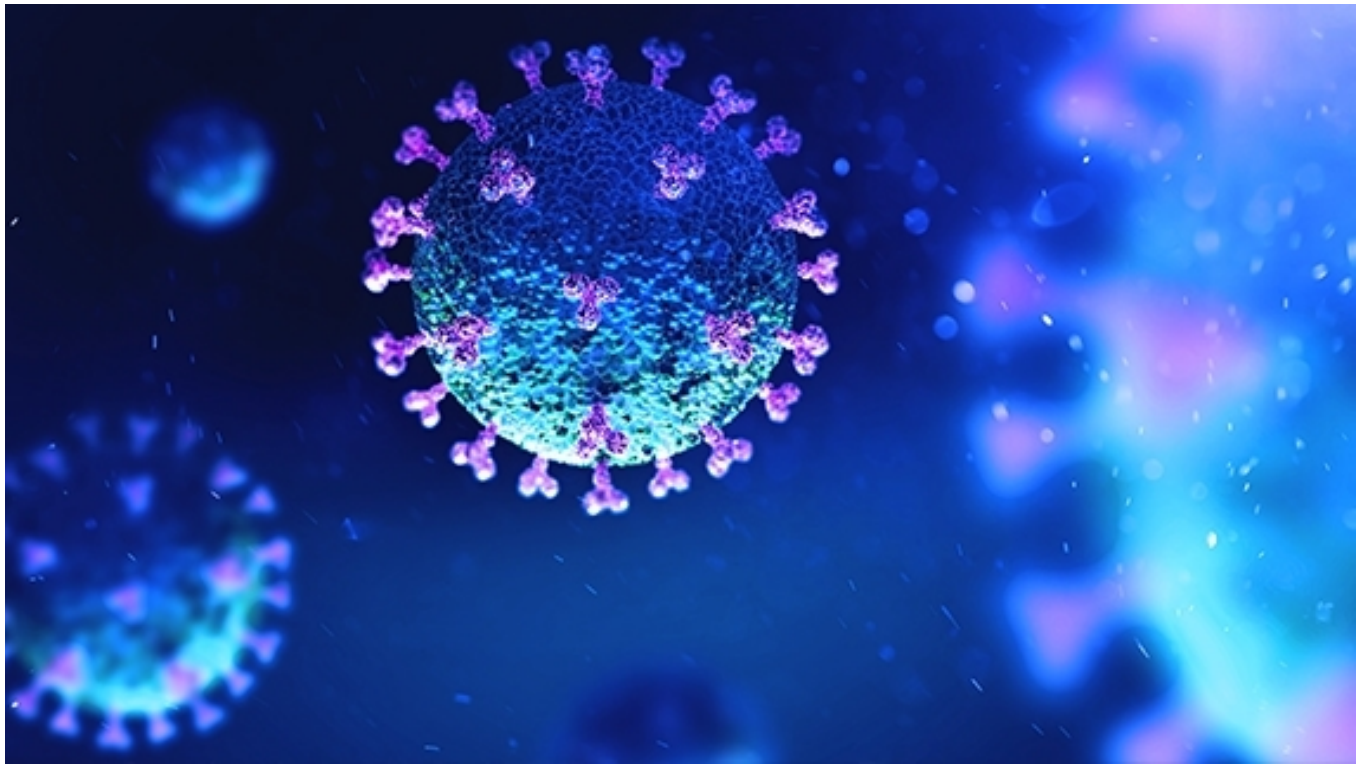
Impact Assessment
Not required

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

COVID-19 deaths

(March 2020 –February 2021)



Dr Melanie Maxwell

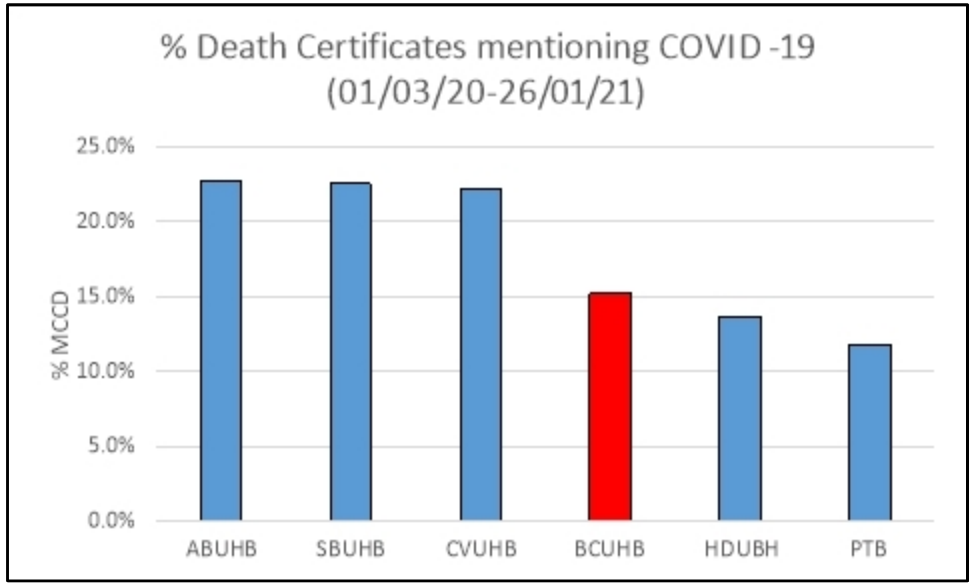
Senior Associate Medical Director/Improvement Cymru Clinical Lead

Reporting – Reviewing – Learning

Age Standardised Death Rates – All Causes by Residency

Area comparison of deaths and excess deaths over specified date period (see slider below) - numbers and age standardised rates (ASR)

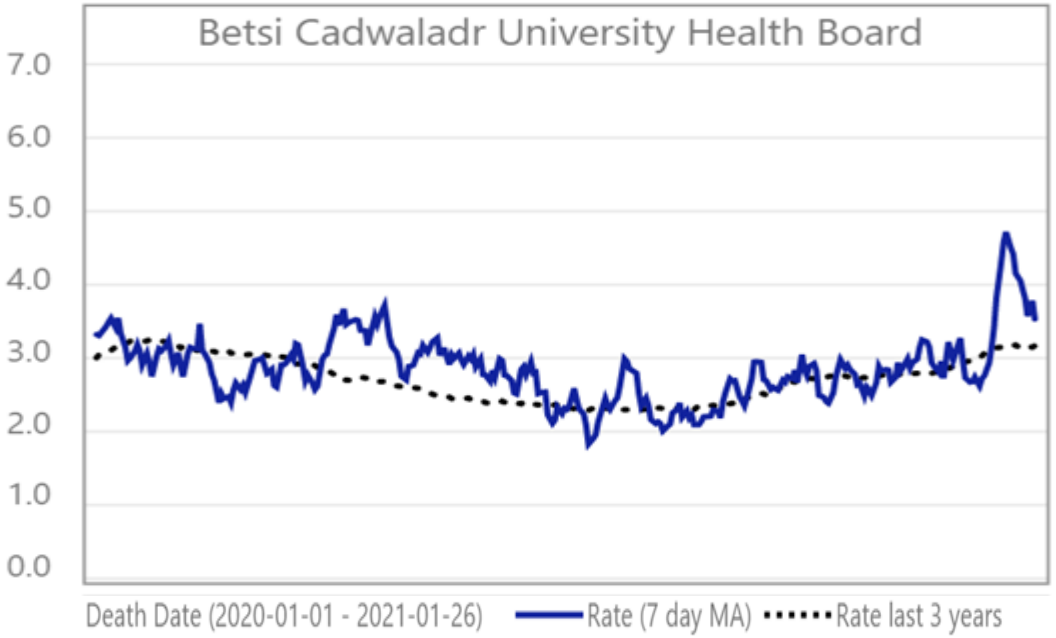
Area	Deaths	Deaths previous 5 years	Excess deaths	% Excess deaths	ASR per 100,000	ASR per 100,000 (previous 5 years)	Excess Rate	% Excess deaths (age adjusted)
Aneurin Bevan University Health Board	6330	5486	852	15.5%	1063.0	923.2	139.8	15.1%
Betsi Cadwaladr University Health Board	7661	7074	562	7.9%	933.7	868.9	64.8	7.5%
Cardiff and Vale University Health Board	4231	3702	516	13.9%	996.7	871.5	125.3	14.4%
Cwm Taf Morgannwg University Health Board	5401	4278	1113	26.0%	1257.4	1000.2	257.2	25.7%
Hywel Dda University Health Board	4386	4072	299	7.3%	909.3	856.5	52.8	6.2%
Powys Teaching Health Board	1546	1425	117	8.2%	847.5	791.4	56.1	7.1%
Swansea Bay University Health Board	4381	3807	567	14.9%	1099.8	959.1	140.7	14.7%



To note as of 26/01/2021, for residents in North Wales.

- The table above shows there were 562 excess deaths – 7.5% more than expected based on the previous 3 years deaths; this is less than most of the other Health Boards. BCUHB has experienced the surge later than the rest of Wales and ONS registrations lag by about 2 weeks for cause of death, therefore it is likely that the excess deaths will rise. However, trend data from across Wales would suggest we will not experience the levels seen in other Health Boards.
- COVID-19 was noted on the death certificates for 15% of deaths registered; this is lower than the Health Boards in South Wales.
- Increases in mortality do relate to COVID-19 surges – current surge peak was significantly worse that first. However, the first surge was more sustained than the second surge data suggests.

Source: ONS data



Deaths with a COVID -19 diagnosis

(to 5/2/21)

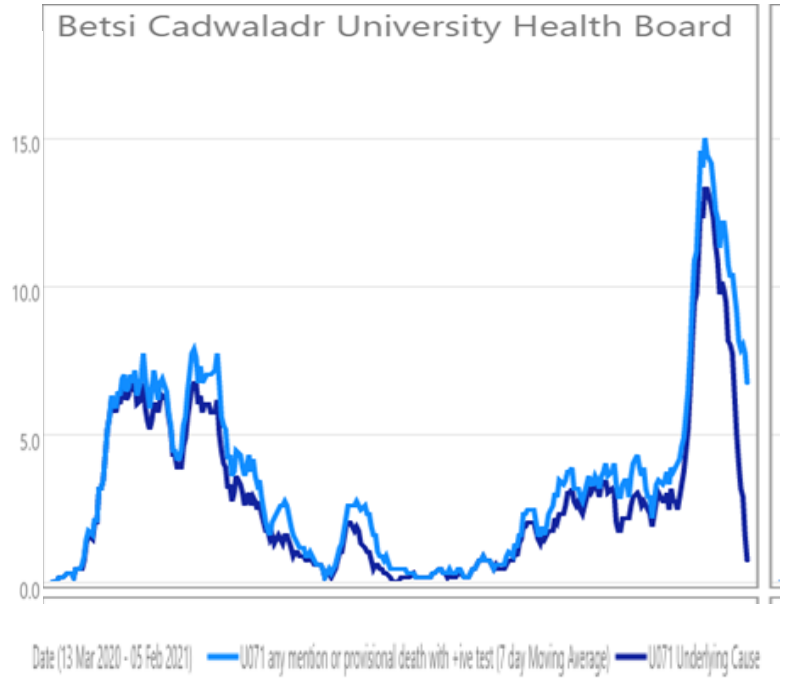
Total Covid Deaths 13 Mar to 05 Feb

Local Health Board Name	U071 Underlying	U071 Any Mention	U071 or U072 Underlying	U071 or U072 Any mention	U071 any mention or provisional death with +ive test	U071 or U072 or provisional death with +ive test
Cwm Taf Morgannwg University Health Board	1223	1380	1305	1471	1441	1532
Aneurin Bevan University Health Board	1239	1373	1280	1422	1439	1488
Betsi Cadwaladr University Health Board	930	1085	971	1128	1166	1209
Cardiff and Vale University Health Board	810	896	906	1014	951	1069
Swansea Bay University Health Board	835	942	881	992	964	1014
Hywel Dda University Health Board	501	565	523	589	601	625
Powys Teaching Health Board	155	178	184	211	183	216
Total	**5693**	**6419**	**6050**	**6827**	**6745**	**7153**

Death Date

3/13/2020 2/5/2021

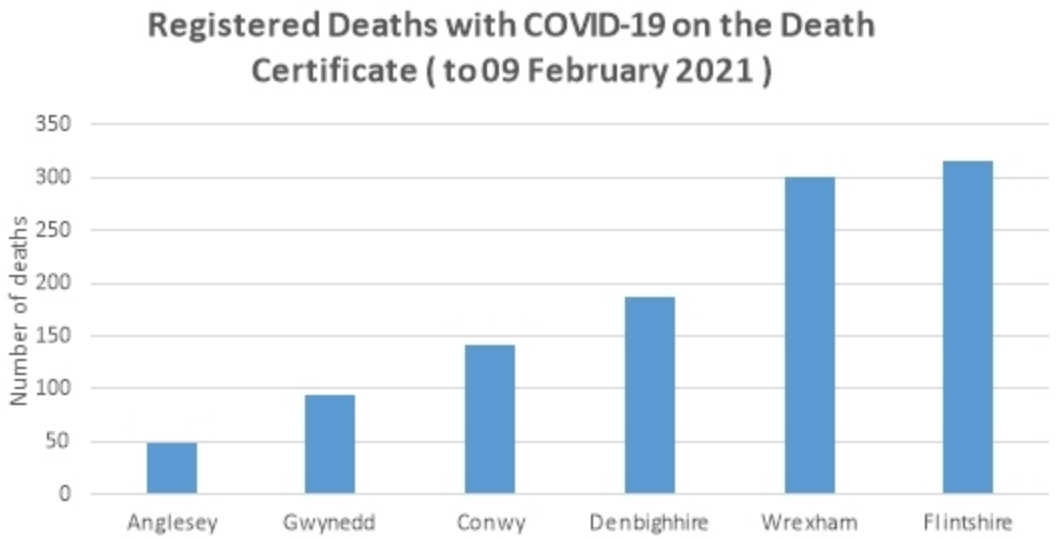
- U071 is the code for COVID -19; U072 – clinical diagnosis; no positive test
- 1128 deaths have been registered with COVID-19 mentioned on the death certificate of which 971 deaths it was an underlying cause (86%).
- Note similar shape curve with 2 surges and a smaller increase in activity between, as seen in the previous all causes graph.
- Note the fall in U071 (underlying cause) at the end is due to delays in the death registration processes.



Source: Public Health Wales

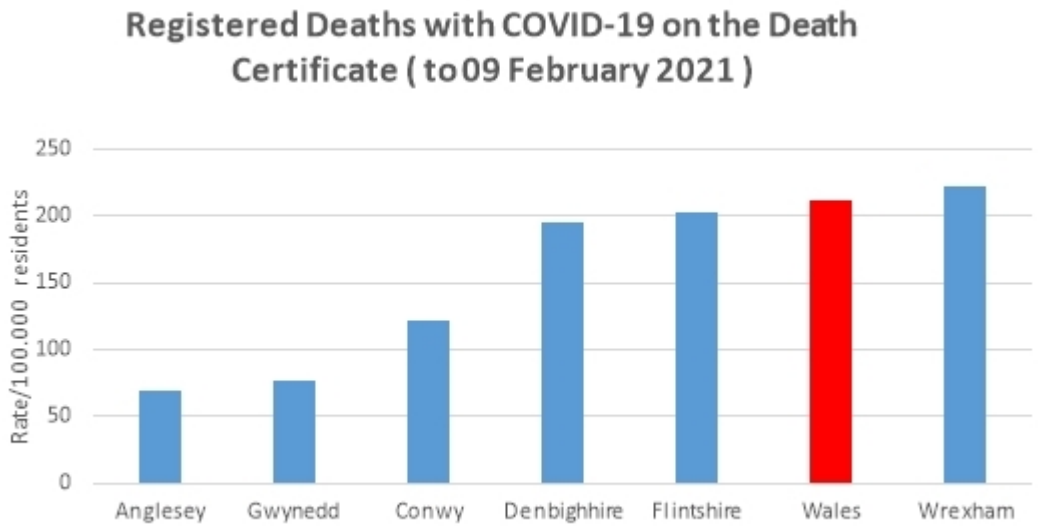
REPORTING

Covid Deaths by Local Authority



- 1,088 registered deaths with COVID-19 on the death certificate (16% of All Wales total)
- Worst affected – Flintshire & Wrexham, both these areas have pockets of deprivation, increase population density and larger households than other authorities in North Wales.

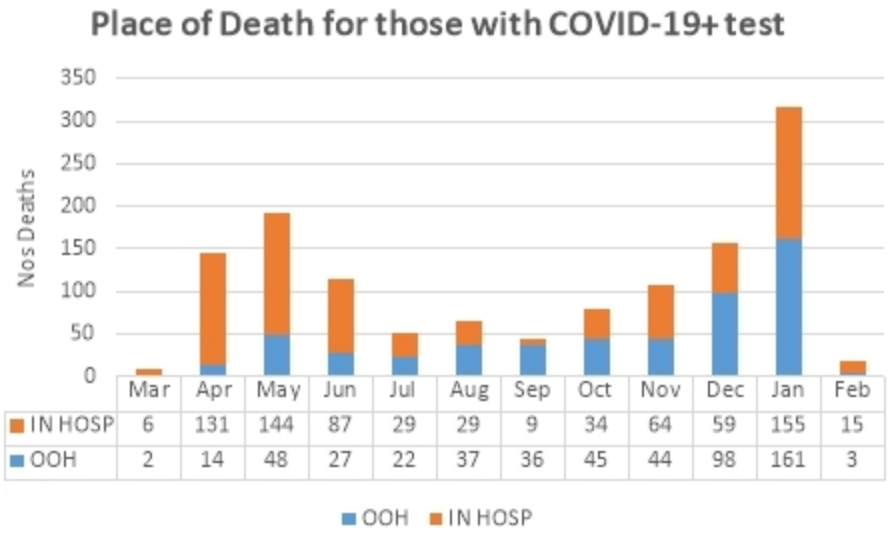
- Wrexham had a higher rate of deaths registered per 100,000 population than the all Wales rate.
- There have been periods of increased COVID-19 transmission in Wrexham care homes and inpatient facilities (including health care associated nfections).



Source: ONS/PHW

REPORTING

COVID-19 death reporting



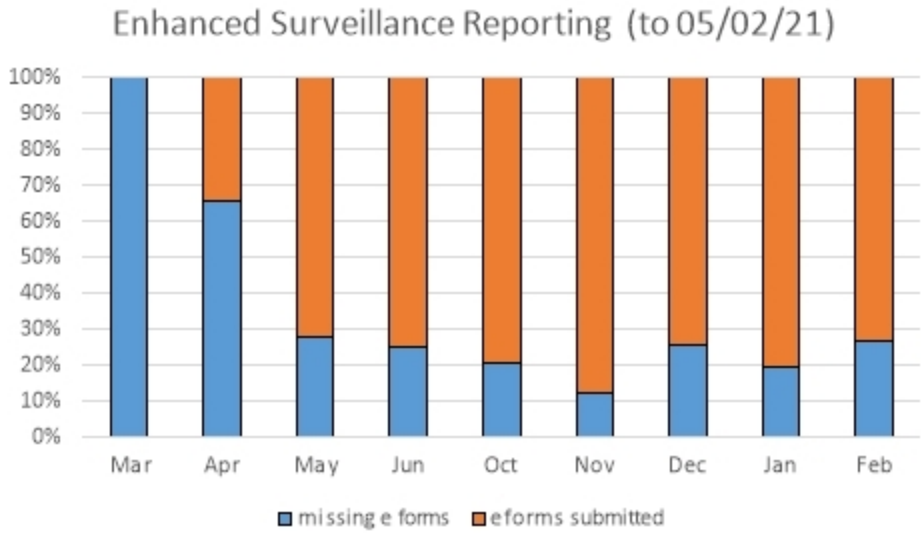
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
IN HOSP	6	131	144	87	29	29	9	34	64	59	155	15
OOH	2	14	48	27	22	37	36	45	44	98	161	3

First COVID-19 positive deaths:

- in hospital -16/03/20
- out of hospital - 29/03/20
- Note change in place of death over time with increasing deaths outside of hospital

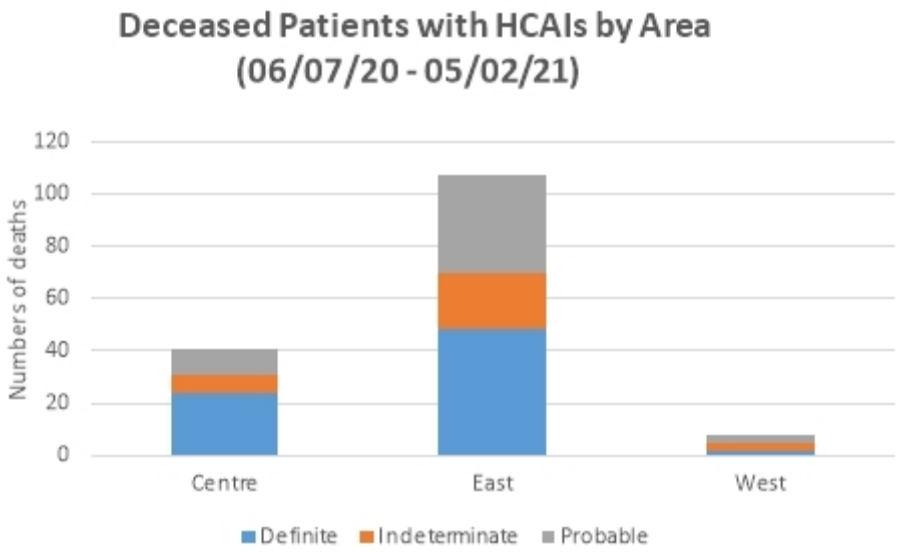
PHW enhanced surveillance form:

- Introduced April 2020 for inpatient admissions only.
- Purpose to support rapid epidemiological information
- Early recognition of high risk groups
- Recognise 56 deaths unrelated to COVID-19 (8%)
- Community hospital deaths most difficult to capture



Source BCU Informatics Dept

Healthcare Associated Infection (HCAI)-COVID-19



Definite healthcare associated infection (HCAI) >14 days between admission and specimen date

Probable HCAI 8 - 14 days (inclusive) between admission and specimen date

Indeterminate HCAI 3 – 7 days (inclusive) between admission and specimen date

Whilst data is available before July 2020, it is likely to be inaccurate as routine testing on admission was not in place.

Between 6th July 2020 and 5th Feb 2021:

- There were 595 patients with HCAIs; 571 had been discharged and 156 of these subsequently died (27%)
  - Of these discharges 439 were probable (50/159) or definite HCAIs (74/280), and 124 of these patients died (28%)
  - 134 deaths (85%) has their confirmatory test taken in hospital (proxy measure for exposure location)
- The percentage of patients discharged following HCAI who died, varied by area – East (32%); Centre (21%); West (13%). This is likely to reflect the number and size of clusters and outbreaks in the Areas.

Source: Public Health Wales

Summary / Key Points:

- The number of excess deaths noted is about half the number of COVID-19 related deaths reported. This reflects the significant comorbidity in those patient who died.
- The excess deaths have occurred predominantly at surge times with increased COVID-19 infections circulating. However, a small spike can be seen that reflects the outbreak in Wrexham Maelor hospital last Summer.
- After the first surge, the age-adjusted death rate returned to expected levels. It is too early to identify if this will be repeated once the current surge is over.
- Wrexham and Flintshire have seen the largest number of deaths.
- Patients reported to have a HCAI are more likely to die during the admission than those who have an community infection. These are likely to be the most amenable to prevention. Key themes have been identified and actions are in progress to address the findings across BCUHB (see learning section).
- BCUHB have provided enhanced surveillance data to PHW – for 2021 (to 05/02/21) 88% of eligible deaths were reported.

Review process for COVID -19 deaths

- COVID-19 as a cause of death is considered natural and therefore does not automatically trigger a review.
- Deaths following a HCAI may be investigated in a number of ways - Post Infections Review (PIR), Serious Incident Review (SIR), RIDDOR (Coroner), Stage 2.
- The Medical Examiner Service will automatically refer any death where there has been an HCAI for further learning
- Specific cluster reviews:
  - "Make it safe" review on Renal Unit YGC included mortality review 6 patients (Mar/Apr 2020).
  - Wrexham outbreak - death review was a sample; developed additional data collection form in addition to the stage 2 hybrid form (All Wales form + structured judgement review) used PIR forms as well. (July/Aug 2020)

Learning from (COVID-19)Deaths

- The learning from the mortality review of patients who died during outbreak in Wrexham did not identify any new issues, rather it reinforced themes identified by the Infection Prevention and Control team and others during Post Infection Reviews and “Look Back” exercises.
- Stage 2 reviews and those deaths referred from the Medical Examiner have not identified deficiency in care specific to COVID-19 deaths to date; the case notes do not commonly include reference to ward transfers, availability of PPE, social distancing etc. One Datix form was completed as family refused to follow IPC guidance. However, Stage 2 reviews are not yet completed.
- There is work in progress at a national level to agree how HCAIs are reviewed including deaths, due to inconsistencies across Wales.

Review Findings - Renal unit - YGC

"All patients that died were male with a mean age of 76.5, were dialysing on the same shift on Tuesday afternoon except for one patient.

They all had comorbidities and short life expectancy except one who the group felt that without COVID 19 infection his survival was for at least 6 months and therefore his death was preventable.

Due to the close proximity between dialysis stations, if fluid repellent surgical masks were implemented earlier for the patients to use the risk for cross infection would have been minimised."

Seven deaths occurred - All patients had chronic lymphopenia and the group raised the question whether chronic lymphopenia was a risk factor for contracting severe COVID 19 infection and death, this has not been described in the literature.

Action:

- Separate entry point for C19+ patients
- Different sessions for C19+ patients (cohorting)
- Risk assessed reduction in sessions for 50% patients
- Increased cleaning and deep clean done
- PPE – Observe in practice; refresher training for handwashing
- (Face masks for patients implemented)

Generalised learning has been to support standardised policies and processes across all sites.

LEARNING

Review Findings – Post Infection Reviews (Nov 2020)

NB:*These themes are not specific to deaths*

- Delay in screening - inaccurate diagnosis
- Delays in transferring confirmed cases into isolation
- Compliance with PPE requirements
- Transfer of patients between areas before results obtained
- Environmental issues –bay doors not closing; limited storage etc

ACTIONS

- Sticker to prompt screening
- Increased domestic hours on wards in the evening
- Daily COVID checklist audits at ward level with escalation to HMT
- Additional storage containers as an interim solution
- Report non closing bay doors

IMPACT

Individual actions have not been assessed for benefit as many changes have occurred in a short time. Taken together, they have reduced onwards transmission.

LEARNING

Review Findings – Wrexham Maelor

- 37 HCAI deaths from July/August 2020 were reviewed by senior doctors not involved in the patient's care.
- Findings were inline with the PIR findings – this is unsurprising as reviewed documentation was the PIR/ a stage 2 review/ additional questions
- Clear absence of documentation in the case notes of some of the key factors involved in person to person transmission.

Positive findings

- Well documented discussions with families
- Regular reviews
- Early consultant care and good communication

LEARNING

Findings	Planned Actions (majority completed now)
Number of in-hospital transfers - third had 3 or more moves.	Stop non clinical transfers – policy written; being monitored
Delay in COVID-19 testing in hospital – circa 80%	Admission screening pathway including process for when to re-swab
Quality of PIRs	Information shared with IPC
Inadequate use of PPE by staff & patients; hand hygiene not followed ; patients not wearing masks; wandering patients; doctors not doffing properly	Adequate provision; IPC champions; Check and Challenge staff
Lack of social distancing & lack of isolation facilities/cubicles on wards	Bed spacing; need for cubicles; reduce doctor movement between wards; segregation in Emergency Department/Acute Medical Unit
Delay in investigation/management/ transfer to cohort ward after testing positive for covid	Implementation of new pathways; review Covid capacity on wards; timely closure of C19+ bays
Delayed discharge/inadequate discharge planning – lack of policy on persistent COVID19 positive patients	Review discharge planning process
Inadequate/poor documentation – 27% - incorrect diagnosis; poor recording the deteriorating patient; DNACPR not countersigned; lack of location detail; falls not reported on DATIX,	Regular check and challenge to staff ; reminders to document events carefully
Poor quality of case-notes	Review of casenote filing system for deceased patients (links to need for scanned notes to the Medical

LEARNING

Further actions from COVID-19 HCAI learning

- Group has reviewed learning from all investigations including deaths:
  - Launched the Covid Outbreak Toolkit; this is an e learning package on the intranet that holds all relevant guidance to standardise management across the sites.
- Behaviour change work
  - Work has started , facilitated by PHW to complete work based on the psychology of change. This is part of the relaunch of the Safe Clean Care campaign with three pilot projects – “safe change”, “safe break”, “safe Ward round (virtual)”. These projects were identified during a recent staff workshop. Whilst these early projects are within secondary care there is opportunity to spread these to Community sites and Primary Care
- Launch of a HCAI investigation toolkit
  - Likely to get national approval at end of March
  - Need to embed use in the reviews of deceased patients where HCAIs was implicated
  - Need to ensure consistent use of Datix where harm has occurred

Acknowledgements

- Mortality reviewers
- Infection Prevention Team
- Patient Safety Team
- Health & Safety Team

LEARNING

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Safety Report – Q3 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Gill Harris, Executive Director of Nursing and Midwifery/Deputy Chief Executive
Awdur yr Adroddiad Report Authors:	Matthew Joyes, Assistant Director of Patient Safety and Experience Kath Clarke, Head of Patient Safety Sarah Musgrave, Incidents Lead Manager Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager
Craffu blaenorol: Prior Scrutiny:	Review by the responsible Directors and Executive Director
Atodiadau Appendices:	Patient Safety Report – Q3 2020/21

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to:
1. Note the concerns about the introduction of the Once for Wales Concerns Management System incidents module.
2. Receive the report and provide feedback on its evolving content and layout.

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, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient safety. This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.

Cefndir / Background:

This new format report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the committee. The period under review is primarily October 2020 to December 2020 (inclusive); however, longer-term data for the previous 27 months (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.

Asesiad / Assessment & Analysis

Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.

Patient Safety Report
Q3 2020/21

Produced by the Patient Safety and Experience Department,
Office of the Executive Director of Nursing and Midwifery

1. INTRODUCTION

1.1 Patient safety is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, learning occurs from the errors that do occur and a culture of safety is fostered that involves health care professionals, partner organisations, patients and their carers/families.

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

1.3 Statistical process control (SPC) charts or run charts are used were 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.

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

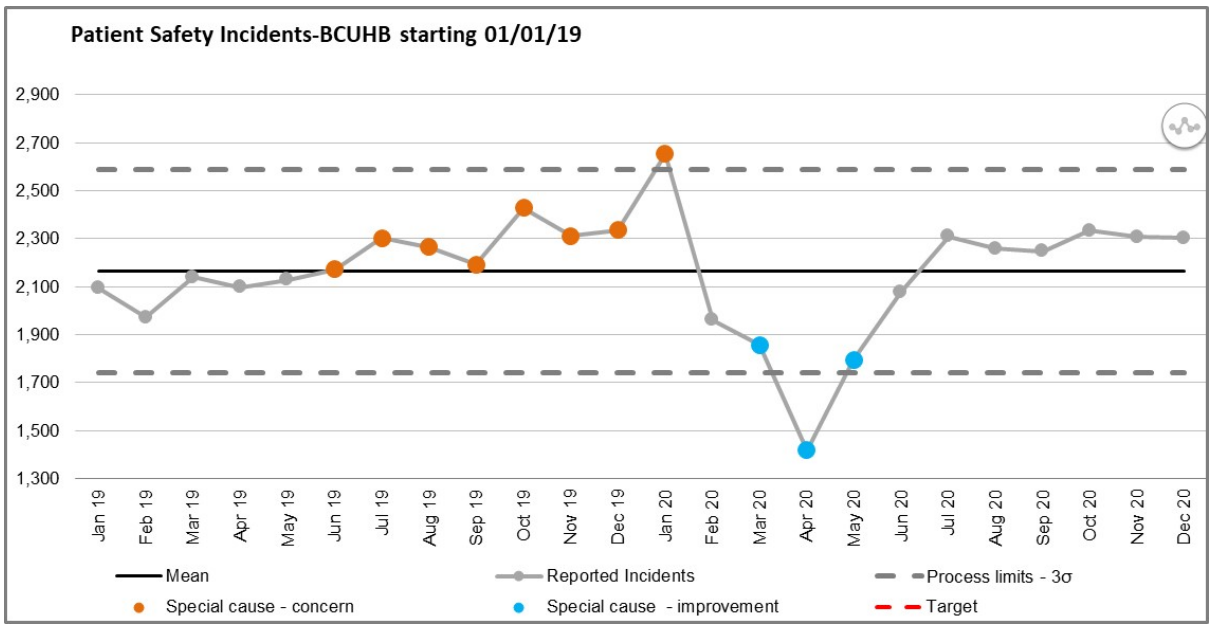
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

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

2. PATIENT SAFETY INCIDENTS

2.1 Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix, the integrated risk and safety management system used by the Health Board.

2.2 The graph below demonstrates the number of patient safety incidents reported during Quarter 3. In total, 6,945 patient safety incidents were reported in this period. The number of incidents reported has shown a very slight increase for this Quarter. In addition, the reporting of COVID-19 patient related incidents account for 511 incidents compared to 349 last quarter which reflects the increased number of patients hospitalised with COVID-19– these include the inappropriate transfer of patients; inappropriate discharge of patients; and the reporting of COVID-19 cluster outbreaks.



2.3 The number of new major and catastrophic incidents reported in Q3 (n=315) has increased by 34% from Q2 (n=209). This increase can be accounted for by an increase in the number of Datix raised relating to staff with positive Covid test. Current process is for staff to allocate severity as major on reporting. This is then downgraded following 72 hours review if appropriate.

2.4 A “soft” implementation of the new incident management process is currently underway with the introduction of “Daily Incident Review Meetings” which commenced on 8th December 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.

2.5 In addition, a trial of newly developed templates for concise and comprehensive investigations has commenced. Feedback thus far has been positive from services.

3. REPORTABLE SERIOUS INCIDENTS

3.1 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:

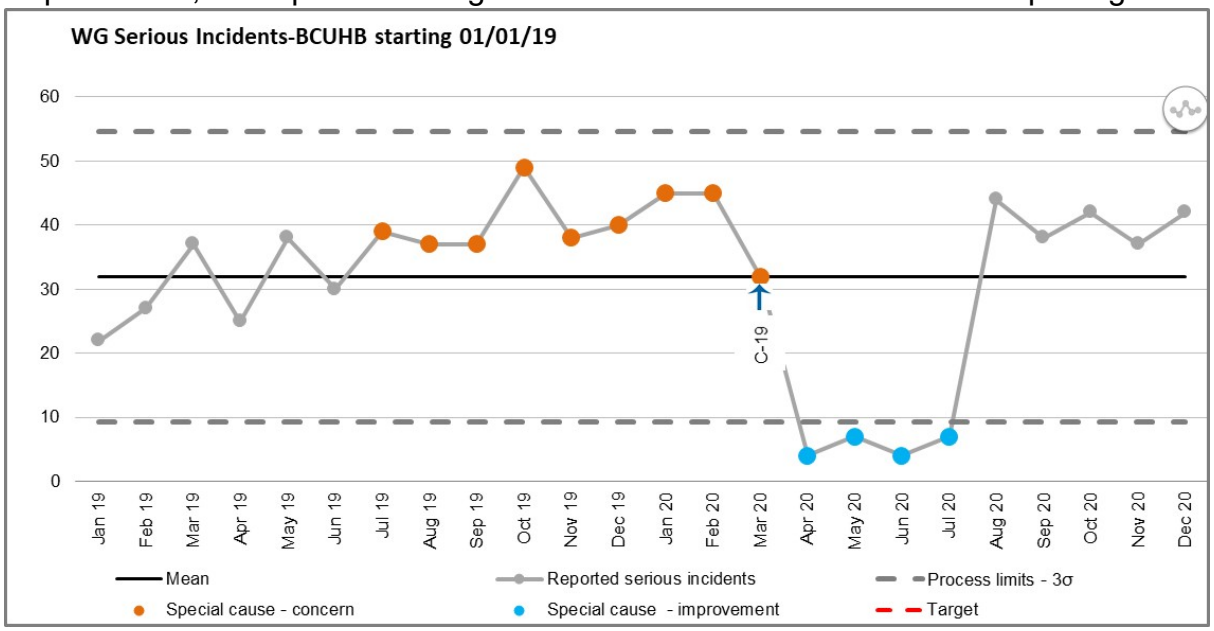
- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life 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

3.2 Welsh Government provide a list of serious incidents that require formal notification if reported. This list is not exhaustive and notification of any incident resulting in serious harm must always be considered as Welsh Government reportable.

3.3 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 met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

3.4 During the initial Covid-19 outbreak, Welsh Government reduced their list of reportable serious incidents, including healthcare acquired pressure ulcers (avoidable) and falls with harm, consequently resulting in a sharp decrease in the number reported during Quarter 1 (see graph below). Reporting returned to the previous (pre-Covid-19) process as of August 2020 and a clear increase in reporting was seen in Quarter 2, (see graph: WG SI starting 01/01/19). As of 4th January 2021, in response to increased pressure to services as the number of patients admitted with and staff testing positive for Covid-19, the Welsh Government reintroduced their

reduced list of reportable serious incidents. Whilst helpful in reducing administrative requirements, the repeated changes at short notice affect overall data reporting.



3.5 With the introduction of the "Daily Incident Meeting," the Patient Safety Team have now taken on the responsibility of completing the Serious Incident Notifications for those incidents reviewed at the meeting with the exception of radiology incidents. This has been met with approval from governance teams and has slightly lightened their workload, but as a Health Board this also means that compliance with meeting the target of reporting of Serious Incidents within 24 hours will increase. Early improvement is being seen rising from an average 10% to 25% in December 2020 (against a target of 95%).

3.6 Significant Serious Incidents in Q3:

- Two incidents (Ysbyty Glan Clwyd - YGC) where patient presented with an overdose and a delay in treatment is being investigated as a contributory factor to the death of both patients. Investigations in progress.
- Death of patient recently discharged into care of district nurses who were tasked with education of family to administer insulin. Family notified GP Pout of Hours that BMs very high and ambulance called. Paramedic noted oxygen saturations of 80%. Patient declined to be admitted. Family member found patient deceased later that night. Full investigation ongoing.

With the ongoing conflicting priorities placed on services and staffing levels diminished, finding resources to carry out robust investigations to identify meaningful learning is proving to be a challenge. There is an ongoing risk that the backlog of serious incidents requiring thorough investigation (especially where they are for inquest) will increase.

3.7 Since the end of the quarter, until the time of writing this report (17 February 2020), 25 serious incidents have been reported taking into account the national reporting changes outlined above. This includes a number of falls (n=6) and pressure ulcers

(n=10). There are no noticeable hot spots of themes at this stage; investigations are underway. The following incidents are highlighted to note:

- Palliative patient receiving ward based CPAP died when oxygen tube became disconnected from mask. Reported to Health & Safety Executive (HSE) and Healthcare Inspectorate Wales (HIW) are aware and have requested attendance at the Serious Incident Review (SIR). Staffing levels 1 Registered Nurse to 4 patients. Immediate action was taken by the service and Electrical Biomedical Engineering (EBME) to check the equipment and an alert was cascaded across services.
- Covid-19 outbreak on Hebog Ward, Ysbyty Gwynedd.
- Neonatal death at Wrexham Maelor Hospital.

3.8 The most common categories of reported serious incidents (SI) for the quarter include:

- **Self harm in primary care, or not during 24-hour care** (n=24) (to note Q3 2019 n=30). Of the 24 reported,19 have been reported under Mental Health Community Services, making them the highest reporter of SI within BCUHB to Welsh Government/Delivery Unit. Of these nineteen incidents, sixteen are recorded as 'Unexpected death whilst under the care of a health professional' (n=16). All sixteen of these have been reported by the Mental Health and Learning Disability (MHLD) Division (community teams), who are required to report all unexpected deaths of patients open to services, regardless of whether the death was contributed to by healthcare services (as per the national Serious Incident Framework) or was from natural causes.

- **Patient falls resulting in severe harm or death** (n=42)**.** During the time period, falls with harm have been recorded by unit as follows: Ysbyty Gwynedd (12), Ysbyty Glan Clwyd Hospital (10), Wrexham Maelor Hospital (6), Heddfan Mental Health Unit (5), Mold Community Hospital (3), Colwyn Bay Community Hospital (1), Holywell Community Hospital (1), Chirk Community Hospital (1), YGC North Wales Cancer Treatment Centre (1), Ysbyty Alltwen (1), Ysbyty Cefni (1). No significant learning was identified from the reviews; however the Health Board's Falls Group is being reformed to provide greater scrutiny to incidents and to drive learning and improvement across services. A workshop was held in November 2020 and plans are in place to launch the group early in 2021.

- **Avoidable grade 3/4 pressure ulcers, unstageable or deep tissue injury** (n=20). Of the 20 incidents reported during Q3, ten of these were related to delay or failure to monitor. Gaps in intentional rounding is identified as theme across all pressure ulcer Datix – this learning has been shared with senior nursing leads. The Health Board's Health Acquired Pressure Ulcer (HAPU) Group is being reformed and will launch in early 2021 to drive further improvement across services and to monitor themes. Services took part on a workshop in November 2020 to plan this work.

At the end of Quarter 3, 82 serious incidents remain open with Welsh Government of which 23 are overdue (reduced by 1 from the last report). Of these, the predominance of overdue incidents relate to Central Acute (4), West Acute (3),

MHLD Services (4), Corporate (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 (4) and these relate to matters subject to Procedural Response to Unexpected Death in Childhood (PRUDiC) or police investigation. A number (5) are overdue by 6-12 months.

Overall completion of reportable serious incident investigations within the 30 day national target remains improved at around 65% (against a target of 75%).

4. PATIENT SAFETY STRATEGIC PLAN

4.1 In Q2 it was reported that a Patient Safety Strategy for BCUHB was in development. A proposal was submitted to the Quality and Safety Group outlining how engagement with key stakeholders and staff could be done under the current COVID-19 restrictions. A patient safety culture questionnaire was piloted within the Heddfan Unit during August 2020 and was launched BCUHB-wide in September 2020. In addition, interviews with key stake-holders also took place. Analysis of the survey and the interviews has been completed. The Health Board has since reviewed its need for a Patient Safety Strategy and has requested a Patient Safety Strategic Plan which will form a suite of strategic plans (with Patient and Carer Experience and Clinical Effectiveness) that will sit underneath the overarching Quality Strategy. The Strategic Plan is now in draft format and approval will be sought during quarter 4 ahead of the proposed launch in April 2021, subject to pressures arising from the pandemic.

5. NEVER EVENTS

5.1 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.

5.2 During Quarter 3, one Never Event was reported as follows:

Division/Team	Type of Event	Description	Harm	Learning
Ysbyty Glan Clwyd, Ward 3	Overdose of Methotrexate for non-cancer treatment	Patient discharged from ward with 8 weeks' worth of medication which the patient inadvertently took over a 2 week period resulting in hospital admission for treatment of methotrexate toxicity.	Major	The investigations remains underway. The patient remained in hospital for two days for treatment and monitoring until toxicity levels resolved. A joint comprehensive investigation is being undertaken with input from Acute, Pharmacy and GP to identify lessons learnt. A rapid review has been completed and Pharmacy have instigated immediate learning points.

In total, five Never Events were reported in 2020 – three fall into the "wrong site surgery" bracket and the lack of or failure to use a LocSSIPs (Local Safety Standards for Invasive Procedures) is a theme. Progress has been made by the Patient Safety Team in the design of a virtual library for LocSSIPs and NatSSIPs (National Safety Standards for Invasive Procedures) with the use of Office 365 SharePoint to store the documents that can be accessed by QR code on any device, or through a link on the intranet.

6. INQUESTS

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

HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board. These cases are logged on the Datix system and managed by the Inquest Team.

6.2 Inquests Opened

The Health Board has received notification that the Coroner has opened 71 new inquests during Q3 requesting information from the Health Board. The breakdown across acute services (excluding MHLD) is:

Central: 30
East: 32
West: 3

The following chart shows the inquests opened by region and overarching service

	Specialist Medicine (secondary)	Division of Mental Health and Learning Disabilities	Surgery (Secondary)	Cancer Services (Secondary)	Women's and Maternal Care (Secondary)
BCUHB Central	21	8	0	0	0
BCUHB East	19	8	2	1	1
BCUHB West	5	2	2	0	0

6.3 Inquest Listings / Hearings

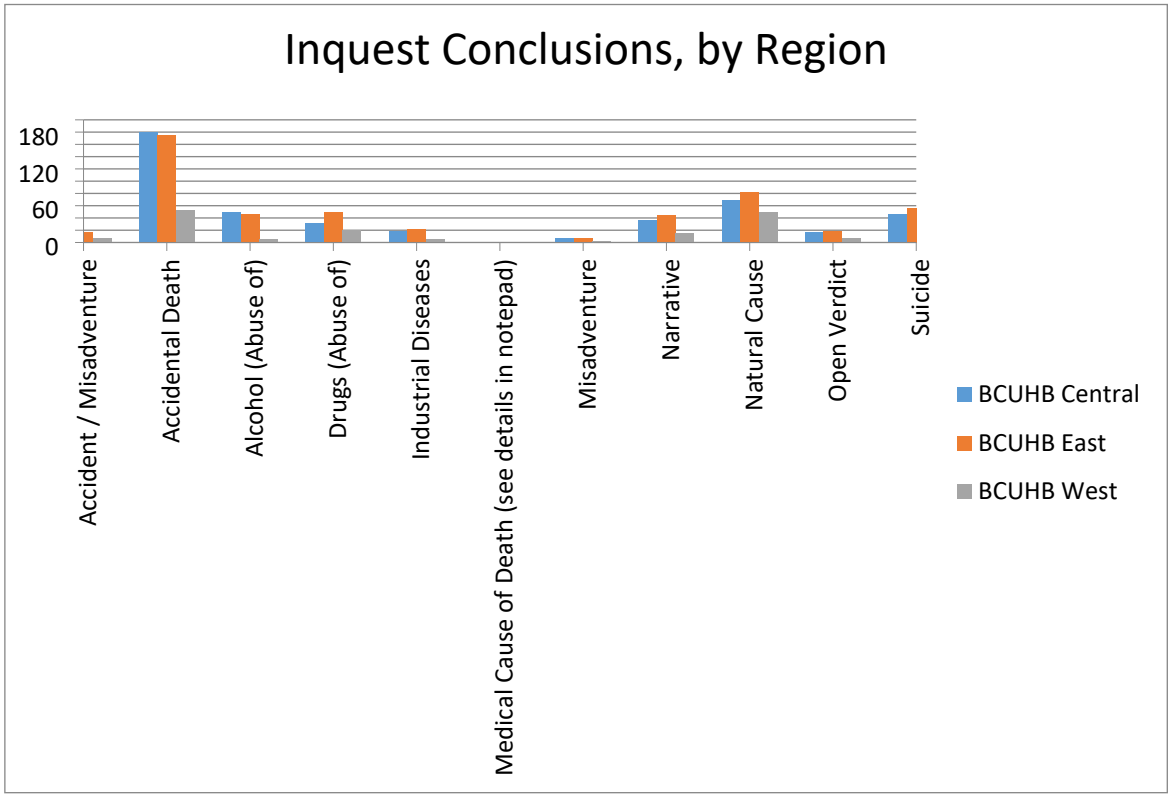
In total, 115 inquests were concluded during Q3:

Commencing September 2020, HM Coroner resumed listing inquests in North Wales. All of these inquests were heard under Rule 23 (no witnesses were required to be present in the Court, with all evidence being submitted in written format and read during the inquest).

HM Coroner had planned to recommence listing Inquests with witnesses called in the New Year (Q4) however due to ongoing demands with COVID-19 this has again been postponed at the request of the Health Board recognising the pandemic pressures and the need to ensure clinical staff are focused on front line care.

6.4 Inquest conclusions and Prevention of Future Deaths (PFD)

The chart below shows the inquest conclusions for those listed and closed during Q3 (this is currently shown by regional area, the new Datix system will provide greater breakdown to organisational division).



At the conclusion of each inquest, HM Coroner has a duty to consider whether to issue a Regulation 28 report, or PFD report. As part of the inquest process, where there is learning associated with an inquest, the Inquest Team ensures that the most up-to-date version of the relevant action plan is shared with HM Coroner in order to provide evidence that the Health Board is already taking appropriate remedial measures.

> *"PFDs are not intended as a punishment; they are made for the benefit of the public"* and are *"intended to improve public health, welfare and safety"* - Chief Coroner's Revised Guidance Nov 2020

During Q3, no PFDs were issued by HM Coroner to the Health Board.

6.5 Inquest learning

6.5.1 With the rescheduling of inquests with witnesses planned for January 2021, the following elements have had to be addressed:

- Ensuring adequate preparation of witnesses, whilst maintaining social distancing for meetings; or in the case where preparation is by means of virtual meeting, ensuring that witnesses feel appropriately supported.
- Due to the extended timescales from evidence submission to HM Coroner and inquest date (attributed to delays related to Covid-19 in the main part), some witnesses have increased levels of anxiety and require more regular support.
- Identification of appropriate rooms within the organisation for witness preparation and for virtual inquests to take place is variable across the regions.

6.5.2 Review of case notes as part of inquest preparation across the region has been impacted by increasing Covid-19 infection levels, travel restrictions and the need to limit staff numbers in the office at any one time resulting in minor delays in moving inquest investigations to the next stage.

6.5.3 Due to the impact of Covid-19 on Services across the region, clinical staff are being affected by increased workload, staff sickness, redeployment, leaving little capacity for the provision of statements and evidence. Where this is the case, the Inquest Team has kept in touch with contributors' teams (via the Weekly Inquest Board Round, e-mail or direct communication), and has appraised HM Coroner and their Officers of the constraints.

6.6 Inquest Awareness Training

During Q3 Inquest Awareness Training continued to be provided, by way of face-to-face training sessions, held in a socially distanced environment, as well as the introduction of digital training via Teams. Feedback from the training sessions is excellent, with staff commenting positively regarding the level of support available, and the informative nature of the sessions.

6.7 Inquest Board Round

The Inquest Board Round continues to be held virtually via Teams each week. The meeting purpose is to track progress and escalate any issues or delays in order to support an efficient process and enable effective communication of responses/timescales to the Coroner.

During Q3, Inquest Board Rounds for all three regions has been aligned to run consecutively on Wednesday mornings; Central 10:00, East 11:00 and West 11:45.

6.8 Future Development of Inquest Processes

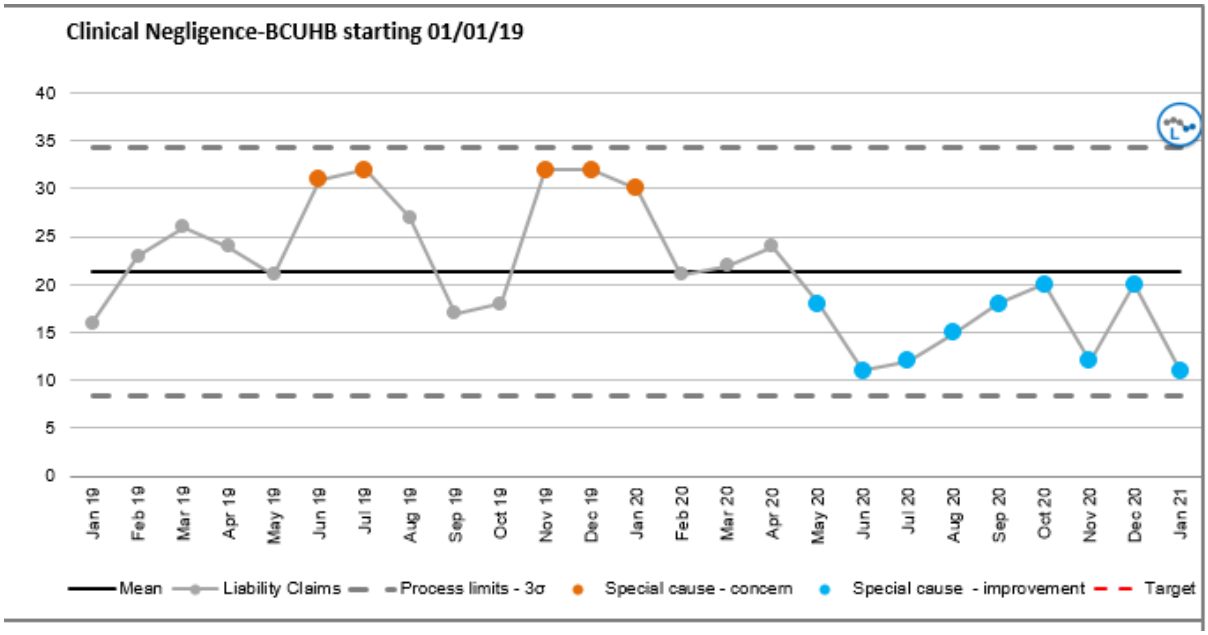
As part of the Patient Safety and Experience Department's planned review of the inquest process, to be conducted in co-production with divisions and other stakeholders, a stakeholder questionnaire was issued to staff members across the organisation during October. This work is being slowed due to pressures from the pandemic. The development and implementation of the Inquests module as part of the new Datix IQ Cloud system is ongoing, however target dates have not been met due to the increasing impact of Covid-19 during Q3.

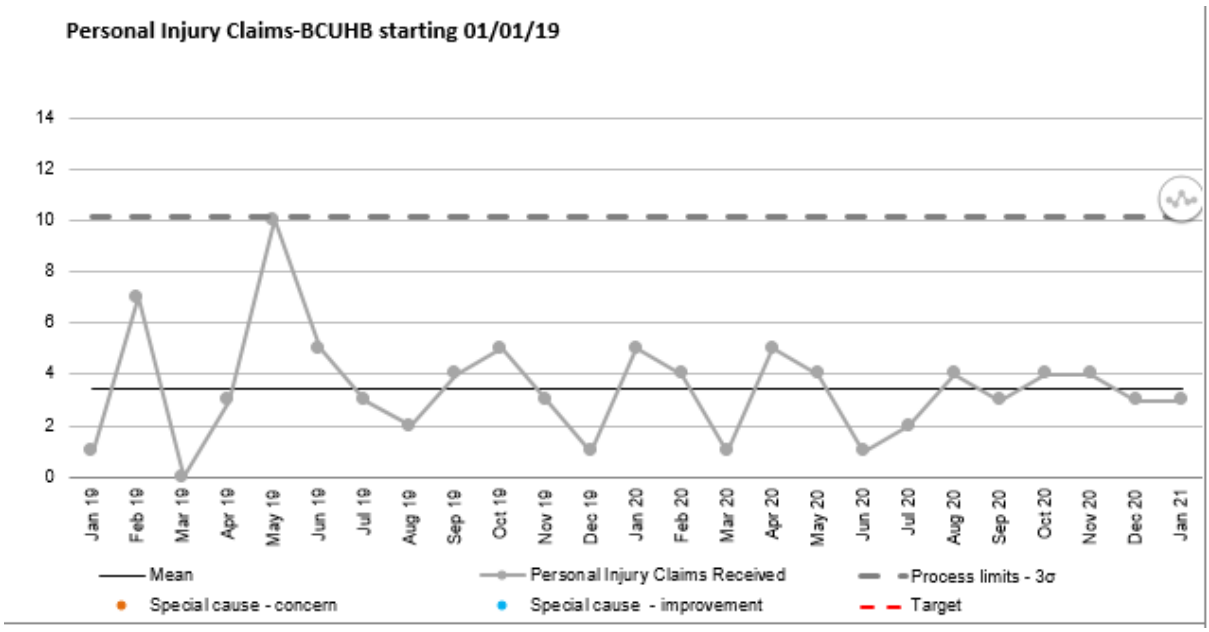
The Inquest Team continues to be involved in the All Wales Inquest process review, and have shared the Health Board Inquest Standard Operating Procedure and associated tools with the Inquest Network in order to help facilitate development of a generic procedure. Unfortunately, the meetings planned for Q3 had to be postponed due to the impacts of raising Covid-19 levels.

7. LITIGATION

7.1 During quarter 3, 53 claims or potential claims were received against the Health Board. Of these, 43 related to clinical negligence and 10 related to personal injury. These figures are broadly similar and remain steady when compared with the previous quarter.

7.2 Claims overall have been on the rise since the beginning of Q2 and into Q3. Whilst the numbers have fluctuated a little throughout Q3, it is anticipated by Legal and Risk Services (Health Board solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. The figures are currently under the mean average and the reasoning behind that in this quarter could be as a result of lack of planned activity in the Health Board since the start of the pandemic in 2020 resulting in routine surgery and many appointments being cancelled etc.





7.3 During quarter 3, 59 claims were closed. Of these, 51 related to clinical negligence and 8 related to personal injury. The total costs for these closed claims amounted to £7,168,738.74 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

7.3.1 Failure to diagnose and a treat a subarachnoid haemorrhage in Emergency Department resulting in death. (Total: £857,630.90)

Learning:

Discussions of this case took place at the time of the event and again through training sessions within the department's rolling programme specifically focussing on subarachnoid haemorrhages, their presentation and action to take in Emergency Department (ED).

7.3.2 Delay in diagnosis of septic arthritis in outpatient Orthopaedic clinic following diagnosed fracture. (Total: £432,272.88)

Learning:

Discussions of this case took place at the time of the event and more recently by the dissemination of a Lessons Learnt Flyer within the ED Department highlighting the importance of re-assessment and re-examination of patients who make unscheduled returns to the ED Department and the importance of keeping detailed, complete and contemporaneous clinical notes.

7.3.3 Delays/failure in conducting adequate investigation and providing treatment for Crohn's disease by Gastroenterology. (Total: £179,232.40)

Learning:

This case was discussed at the Audit Meeting amongst consultants and junior colleagues to raise awareness of the presenting condition and key findings that would have pointed to this diagnosis.

7.4 A trend has been noticed with the treatment and management of tears during vaginal delivery in potential maternity claims received by the Health Board. In addition, this quarter has seen an increase in the number of Early Reporting Scheme cases identified by the Women's and Midwifery Division (5). These all relate to the potential brain injuries in babies sustained during birth and require early investigation.

As expected the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS and is the same as the previous a quarter.

7.5 The following themes have been identified during Q3 for personal injury:

1. Slips/trips
2. Manual handling

7.6 Personal Injury claims savings due to discontinued or favourable settlements for this period were £124,200.66

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

7.8 The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. BCUHB's share of the increase is forecast at 17.07% predicting an additional cost of £2.35m in addition to the contribution already made, creating a significant impact on the overall financial position. The Finance Division are aware and it is included as a potential risk until matters are finalised late 2021 once all case settlements are known.

7.9 The Health Board is prioritising its outstanding reports required for submission to the Welsh Risk Pool for scrutiny of learning and reimbursement, although due to the Covid-19 pandemic delays are experienced from the clinical teams who are focusing their efforts on front line care. The Risk Pool have relaxed the 60 day deadline for submission of these reports.

7.10 The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state that where a person is seeking Redress, the findings of the investigation must be provided within 12 months of first receipt of the concern.

During Q3 2020-21, 11 Redress cases were concluded (54% within 12 months) as follows:

- 2 offers of financial compensation as redress were accepted totalling £20,000
- 2 written apologies
- 4 proceeded to become a clinical negligence claim
- 1 became a personal injury claim
- 1 was dealt with under lost property procedure
- 1 was advised to pursue a clinical negligence claim

14 other complaint responses were sent during the period which had been reviewed for redress but deemed to have no qualifying liability.

7.11 Redress offers accepted during this quarter were about the following issues:

- patient suffered fall after reportedly becoming trapped in the bed rails and dislocated her shoulder;

- alleged delayed diagnosis and treatment of a stroke dealt with as a clinical negligence claim but returned to Putting Things Right (PTR);
- failed bathroom handrail caused patient fall;
- poor catheter management with Minor Injuries Unit.

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

7.13 On November 18th 2020 the Welsh Risk Pool attended the Emergency Department within YGC to review governance arrangements. This was in response to lack of evidence being submitted to the Welsh Risk Pool to support learning from claims. The report was extremely positive and recommended that there is now substantial assurance that appropriate systems are in place.

7.14 The Patient Safety and Experience Department is planning a comprehensive review of the claims and redress process and this will be conducted in co-production with divisions and other stakeholders including Legal and Risk Services from the NHS Wales Shared Services Partnership. Due to COVID-19, this work is now planned to commence in 2021.

8. PATIENT SAFETY ALERTS

Ref	Alert description	Deadline	Exception Notes	Division / Who	Expected Compliance Date
PSN034	Supporting the introduction of the National Safety Standards for Invasive Procedures (NatSSips)	28/09/17	Action 1 – 2 completed/compliant - require evidence Action 3 – 4 work is underway, expected completion 28 Feb 2021	Secondary Care	28 February 2021
PSN055 replaces PSN030	The safe storage of medicines: Cupboards	30/09/2021		Secondary Care	August 2021

PSN056	Foreign body aspiration during intubation, advanced airway management or ventilation	01/07/2021		Secondary Care	June 2021
WRP001	Consent to Treatment		Section 1 -3 Approved and Submitted 14 October 2020 Section 3-5 Approved and Submitted 30 December 2020 Section 6 – 7 Due 31 March 2021		

9. ONCE FOR WALES CONCERNS MANAGEMENT SYSTEM (OFWCMS)

9.1 There remains no detailed national project plan or key milestones with dates from the National Team which is impacting on the ability of the organisation to develop an implementation plan for the Health Board. The risk is shared by Health Boards across Wales and has been raised in the HoPE (Heads of Patient Experience) Network and in the National Steering Group and Programme Board meetings. Despite this, the complaints modules, clams and redress modules as well as the incidents module are expected to go “live” on 1st April 2021.

9.2 The Health Board has developed a readiness plan for the introduction of the new system.

9.3 The main concern for the Health Board is the implementation of the incidents module due to the wide scale usage of that module across the Health Board and the limited time available from being provided the new system to the launch date (which could be a matter of a few weeks at most). A proposal is being presented to the Patient Safety and Quality Group.

9.4 The existing Datix system will continue to be read/write for a period of three months to enable records prior to a transition date to be closed, and then the “write” facility will be disabled. The information on the existing system cannot be migrated across electronically, therefore all open incidents will need to be transferred over manually unless they have been investigated and closed within that three month period of read/write.

9.5 To date (December 2020) the Health Board have not submitted an updated list of users and their access permissions (profiles and security groups) i.e. staff who handle/manage concerns. Concerns were raised with the National Team when the

Health Board was asked to map these against out dated location and service hierarchies; this issue has since been resolved but will limit our submission to the National Team to key staff groups. Work will be ongoing to collate the information post submission but with no indication of when we will receive the functioning system prior to implementation we are left unclear how what time we will be given to add this to the system ourselves.

9.6 The Health Board Concerns and Quality Management System Group continues to monitor the implementation very closely. And is taking dynamic action to ensure a smooth transition, within the constraints identified here.

10. CONCLUSIONS AND RECOMMENDATIONS

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

10.2 The Quality, Safety and Experience Committee is asked to:
10.2.1. Note the concerns about the introduction of the Once for Wales Concerns Management System incidents module.
10.2.2 . Receive the report and provide feedback on its evolving content and layout.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety & Experience (QSE) Committee 2nd March 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Update on the planned care recovery and Essential service delivery within planned care
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Gill Harris, Executive Director of Nursing / Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Mr Andrew Kent- Interim Head of Planned Care Transformation
Craffu blaenorol: **Prior Scrutiny:**	Mr Gavin McDonald, Interim Chief Operating Officer Dr Kate Clark, Acting Deputy Medical Director
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee are asked to note the approach that is part of the six-point plan and its link to maintaining patient safety and quality

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:

Previous papers have described the approach by the Planned Care Transformation Group (PCTG) on the work it is doing to ensure, during the covid pandemic, it continues to treat patients as effectively and safely as possible.

Cefndir / Background:

Planned care activity continues to suffer from the pandemic situation and will continue for the near future. This paper gives an update on the actions undertaken to deliver the recovery plan and maintain essential services within planned care.

Asesiad / Assessment & Analysis

Introduction

Previous papers have described the approach by the planned care transformation group (PCTG) on the work it is doing to ensure, during the covid pandemic, it continues to treat patients as effectively and safely as possible. This paper continues this story and the steps undertaken to treat patients whilst mitigating potential harm to patients waiting longer than expected.

Context

The organisation continues to maintain essential services at stage 1 and stage 4 during this current pandemic surge, the table below highlights the status of each acute site

Site	Status	Mitigations
East	Upper GI and Urology laser only	all other essential surgery transfers to West
Centre	Essential services only	Insourcing Ophthalmology at weekends (Abergele)
West	Essential services only treating East essential patients	Insourcing of Ophthalmology at weekends

During this covid surge a contingency plan was established to move essential services across North Wales under the 'Once for North Wales' approach. This is an extension of the programme launched after the first pandemic and reported previously.

The significant change is that all patients being transferred are Cancer or very urgent surgery, predominantly the specialties of Breast surgery, Urology, Ear Nose & Throat (ENT) and lower Gastro-Intestinal (GI). This began on the 18/01/2021. This mutual aid has so far treated 65 patients who required urgent surgery, by either straight transfers of care from East to West or the surgeons moving over with their patients to undertake the operations.

This approach allows the organisation to move the services around North Wales to the site with the lowest covid incidence at any particular time.

To date all operations have been successful at the West with no Datix reports or reports of harm. The approach is reviewed weekly in conjunction with the Covid intelligence data, daily at the operational team level and finally reported to Executive Incident Management Team (EIMT) on a weekly basis to ensure the approach remains safe for patients.

Specialty	Procedures undertaken up until 06/02/2020
Urology	28
Colorectal	4
Breast	16
ENT	17
Total	65

For patients needing treatment in the East, which is the significant upper GI surgery requiring whole system care, 2 patients were delayed due to no Intensive Therapy Unit (ITU) capacity, one required "holding non-surgical treatment" but it is pleasing to report all have now received their surgical treatment. Any cases which have been required to be undertaken at Ysbyty Maelor are considered by the Medical Director and Nurse Director.

This approach has now been agreed to continue to the 11th of March protecting patients by treating them in the lowest covid environment possible. However, we are monitoring the increased covid burden in the West to ensure planned activity can be safely maintained, and when it can be increased elsewhere on a weekly basis.

Although all other routine activity is paused at stage 1 and stage 3, urgent and cancer Out-Patient Department (OPD) activity continues across all three sites, this approach was undertaken due to the volume and the desire not to cause further covid spread.

In December and January, we have been able to re-enact and maintain an insourcing contract for ophthalmology. This has begun at the West site focusing on cataract surgery. It was paused at the East site due to the pandemic surge. Arrangements have been made to continue this activity at the Abergele site from early February at weekends. Therefore, we now have two sites operational at weekends. This process is allowing long waiting cataracts to be treated, which would previously have been further delayed. It also allows the substantive team to focus on the Intravitreal injection therapy (IVT) element that is recognised as the high clinical risk.

Routine activity

Unfortunately, we recognise all routine activity at all stages in the pathway is paused due to the pandemic surge.

The PCTG has been working with insourcing providers and our clinical body to formulate a plan to commence seeing these patients as soon as possible.

To this effect, we have agreed a single tender waiver with immediate effect that will allow us to use the similar model to ophthalmology but for more specialties. The table below illustrates the activity that will be undertaken between February and end of March:

Specialty	**Activity**
Urology	P1
Surgery	P1
Orthopaedics	P1 and P4 daycase
Maxillofacial surgery	P1
Ophthalmology	P1 and P4

The approach is similar to the once for north Wales, now that we have that model established in that our clinicians will review the transfers of care. Protocols are being established for when patients are converted.

Our overarching plan is to focus substantive staff on cancer and P2 activity during the recovery period and insourcing for long waiters P1 and P4, thus ensuring that long waiters will commence being treated. The logistics, which the committee will understand, is significant and is currently being worked through, including input with support services.

Conclusion

The PCTG is being proactive in ensuring essential services within the secondary care service is continued to ensure we have the least effect of secondary harm possible due to patients waiting. Processes are established using a ‘Once for North Wales’ and pan BCU MDT approach to ensure each patient is assessed and risk stratified and then moved across North Wales in the model described.

The insourcing model will shortly begin tackling the routine long waiters across key long waiting specialties in attempt to give equity and patient safety to those waiting the longest, whilst supporting substantive staff.

Risk Analysis

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 2nd March 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Vascular Task and Finish group update
Cyfarwyddwr Cyfrifol: Responsible Director:	Prof Arpan Guha, Acting Executive Medical Director
Awdur yr Adroddiad Report Author:	Joanne Garzoni, Vascular Network Manager
Craffu blaenorol: Prior Scrutiny:	Vascular Task and Finish Group
Atodiadau Appendices:	Appendix 1 – Royal College of Surgeons Invited Review Terms of Reference Appendix 2 – Vascular Task and Finish Group Highlight Report Appendix 3 – Amputation mortality action plan Appendix 4 – Elective AAA repair mortality action plan

Argymhelliad / Recommendation:

The Committee is asked to note the progress made by the Vascular Task and Finish Group

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:

This report provides an update to the Quality, Safety and Experience (QSE) Committee on the work undertaken to date by the Vascular Task and Finish Group. The Task and Finish group last met on 8th February 2021.

Cefndir / Background:

In July 2019, following the centralisation of the major arterial vascular service in April 2019, it was agreed that a review would be prepared with the principle objective of assessing the impact of the vascular services provided across the North Wales Vascular Network in the post implementation period. The presentation of the report was delayed due to the COVID19 pandemic. This review was presented to the Health Board in May 2020 with recommendations to address areas for improvement.

The Health Board approved the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations. This group would consider the draft action plan

to identify any further required actions and recommend key performance indicators. It was agreed that progress reporting arrangements would be via the Quality, Safety and Experience Committee.

Asesiad / Assessment & Analysis

Strategy Implications

This report examines the progress of the Vascular Task and Finish Group in implementing the vascular services review recommendations.

Updates to the Quality, Safety and Experience Committee

The Vascular Task and Finish Group has met monthly since June 2020. The last meeting was held on 8th February 2021. There have been two Task and Finish Group meetings since the last QSE report. There is a good range of representation from multidisciplinary team members as well as patient and Community Health Council (CHC) presence. The action plan is being tracked by the group with regular updates provided to QSE and Welsh Government.

Vascular Task and Finish Group

North Wales Vascular Task and Finish Group Action Plan – Progress against actions within the highlight report (appendix 2) were reviewed at the last meeting of the Vascular Task and Finish Group on 8th February 2021.

Key points include:

Alignment of vascular inpatient bed base

A review of the capacity and demand for inpatient beds across the service has been completed. Following discussion within the Task and Finish Group, it was agreed the alignment of the bed base should be part of the development of clinical pathways. With pressures related to COVID-19 and winter, non-recurrent winter funding has been secured to increase the bed base of the vascular unit from 18 to 24 beds. The development of the pathways will determine the long-term bed requirement and alignment.

Pathways of care

Completed pathways for implementation

- *Vascular angioplasty pathway*

The angioplasty pathway was reviewed by the Clinical Advisory Group (CAG) on 4th December 2020 and further clarity was requested on points in the document. This was discussed and agreed by the relevant services and an amended pathway was approved by CAG on 20th January 2021.

- *Pathway for patients post vascular intervention requiring rehabilitation or palliative care*

The pathway for patients post vascular intervention requiring rehabilitation or palliative care was agreed by stakeholders and was submitted and approved by CAG on 27th January 2021.

Pathways in progress

- *Non-arterial diabetic foot pathway*

Dr Kate Clark, Interim Deputy Executive Medical Director, acknowledged that progress had been slower than anticipated, however, this was now improving. Dr Clark reported that the Health Board's National Diabetic Lead had shared the current overview of services and compliance with the National Diabetic Foot Pathway and NICE guidelines. The Health Board meet the majority of requirements set out by NICE, however, not consistently. The Health Board's Diabetic Delivery Group is chaired by Dr Bethan Jones, Area Medical Director (West). Funding for both a pan-BCU clinical lead for diabetes and a clinical lead for the diabetic foot pathway have now been secured and the expressions of interest for these posts will be advertised. It is proposed that the Diabetic Foot Group will be a subgroup of the Diabetic Delivery Group. An Orthopaedic Foot and Ankle Task and Finish Group has also been established which will be linked to the Diabetic Foot pathway. A draft pathway document will be presented to the next Task and Finish Group on Thursday 18th March 2021.

- *Pathways for patients that use drugs intravenously presenting with groin abscesses*

The submission date to CAG for the pathway for patients that use drugs intravenously presenting with groin abscesses was amended in December 2020 recognising the progress that has been made in engaging with stakeholders but further time required to ensure agreement of all involved. This work was supported by the Site Medical Directors and the pathway will now be submitted to CAG on 19th February 2021.

<u>Communication and Engagement</u>

A review of patient information provided to vascular patients, led by the patient experience team, has been completed. The vascular service has worked collaboratively with the Community Health Council (CHC) and patient and carer representatives to review information and ensure that it meets the standards for producing patient information detailed within the Health Board's Patient, Service User and Carer Procedure For The Production Of Written Information.

The service has recently piloted and evaluated ward information that was developed in conjunction with the CHC, with vascular inpatients in Glan Clwyd Hospital. The feedback was positive and this is now being provided to patients in line with the Health Board standards.

The vascular service is now progressing the development of online resources.

Quality and Safety

Following an organisational wide survey to assess the safety culture, an interim report has been produced by the Patient Safety and Experience department. As this report does not allow the granularity required to identify staff working within the vascular service, the Executive Medical Director has commissioned a targeted survey to those working within vascular. This was sent out on 10th February 2021 for three weeks, following which an analysis will be completed and presented to the next Task and Finish Group meeting on Thursday 18th March 2021.

Clinical Effectiveness

External invited review of the vascular service

The Royal College of Surgeons (RCS) of England commenced an external, independent multi-disciplinary review of the vascular service in January 2021. The Terms of Reference for the review were agreed in collaboration with the CHC (Appendix 1). The full review will involve:

- Consideration of background documentation regarding the vascular surgery service.
- Interviews with members of the vascular surgery service, those working with them to provide the service and other relevant members of BCUHB staff, including those no longer working in the Health Board. It also included representatives from the Community Health Council. There were 37 interviews undertaken over the following dates; 11th, 12th, 13th and 28th January 2021.
- A clinical records review of 50 specific cases put forward by BCUHB. It has been agreed with the RCS review team that the records will include any serious incidents, amputation mortality cases and the last 10 consecutive AAA and amputation cases from the end of 2020. There will also be a review of the management of cases pre-centralisation.

The initial feedback from the RCS following the interviews was that there were no immediate patient safety concerns. The reviewers had very positive comments about the service post-reconfiguration, and noted the degree of enthusiasm and positive comments at both hub [Ysbyty Glan Clwyd] and spoke sites (Wrexham Maelor Hospital and Ysbyty Gwynedd). The review team supported that the model of care being delivered was the right one.

NVR Annual Report

The National Vascular Registry (NVR) Annual Report was published in November 2020. The NVR records index vascular procedures and the annual report presented analysis of data submitted from 2017-2019. The group received a presentation from the Clinical Director of the Vascular Network detailing the recommendations of the report and the actions being taken to deliver the recommendations. It was noted that the COVID – 19 pandemic has affected major vascular procedures across the UK, with a reduction in the number of major cases performed with significant variation were seen across the UK.

It was noted at the last meeting that an error had been made in the reporting of the Vascular Task and Finish Group by a CHC representative to CHC members. The error was the 16% mortality rate following elective AAA repair, which in fact is the NVR mortality rate for 2017-2019 for 30 day mortality after amputations. The CHC representative in attendance fully acknowledged that this had been an error. It was explained that the mortality rate following major amputations had been transposed with the elective AAA mortality rate.

Mortality reviews

Major Amputation

The vascular service was identified as having a 15.9% risk adjusted 30-day in-hospital mortality rate following major amputation (for the period of 2017 – 2019) in the NVR Annual Report 2020. There were 52 amputations over the period and 8 deaths reported. This was in comparison to the overall national average of 4.6%. The vascular service have developed an action plan to provide a multi-disciplinary review and identify learning from these cases (appendix 3). It has been agreed that the Royal College of Surgeons will review the deaths in the case note review and the last 10 consecutive amputations done in 2020.

	2017		**2018**		**2019**		**NVR published data 2017-2019**		**Unpublished data 2020**	
Procedure	**Procedures**	**Outcome**	**Procedures**	**Outcome**	**Procedures**	**Outcome**	**Procedures**	**Outcome**	**Procedures**	**Outcome**
Amputation	1	0 deaths	8	2 deaths	43	6 deaths	52	Adjusted mortality rate within 30 days: 15.9 %	95	2 deaths Mortality rate within 30 days: 2.11 %

Elective AAA repair

The NVR published data for elective AAA mortality for the review period 2017–2019 is 1.4% [National] and 0.9% for BCUHB.

The mortality rate in Jan- Dec 2020 following elective AAA repair is 6.12% and a 12 month data is not comparable with 3 year average data, as suggested by NVR. There is no comparable UK data for this period during Covid 19. A recent report published by the NVR in November 2020 describes the impact of the Covid-19 pandemic on the provision of vascular surgery in the UK National Health Service and the lack of coverage of surgical activity to measure outcomes in 2020. The vascular service is currently reviewing in-hospital mortality following elective AAA repair to identify any lessons learned in order to improve the service. An action plan has been developed (appendix 4) and shared with the Royal College of Surgeons and it has been agreed that the RCS will review the last 10 consecutive AAA repairs done in 2020.

Management of elective abdominal aortic aneurysms (AAA)

The report recommends a reduction in the time from referral to treatment for elective abdominal aortic aneurysms (AAA) to 8 weeks. The current process has been reviewed and the network has recently implemented a nurse led pathway, adopted in South Wales and in line with the Welsh Abdominal Aortic Aneurysm Screening programme (WAAASP), to improve the coordination of care for patients utilising the skills of the vascular nurse specialists on all sites. The vascular service is now complying with the standard that 90% of patients should be discussed at a vascular Multi Disciplinary Team (MDT) as all patients are now discussed.

Compliance with data entry

The report recommends that data is entered into the NVR on all lower limb revascularisation and major amputation procedures. The network is improving compliance with entering data for index procedures. Improvement is required on the compliance with entering angioplasty procedures which are done by radiology. A recommendation of the report is to review the provision of administrative support.

Peripheral artery disease and amputation

It is recommended that the vascular service reviews its pathways of care for peripheral arterial disease to ensure that patients admitted non-electively with chronic limb threatening ischaemia have their lower limb bypass within 5 days. The network has seen an increase in the number of bypasses undertaken since centralisation of the arterial service. The network are reviewing the pathway and are working to ensure timely MDT decisions, anaesthetic review and surgical intervention.

The NVR report recommends that the vascular service reviews its pathways of care for amputation to ensure that when required, below knee amputations should be undertaken where possible (the above knee amputation to below knee amputation ratio should be less than 1). The vascular service is complying with this. The network is currently reviewing the pathways of care to ensure that patients undergoing major amputation are admitted in a timely fashion to the arterial centre from the spoke hospitals. The network is also reviewing outcomes of surgery.

Carotid endarterectomy

It is a recommendation of the report to review and improve referral pathways and access to theatre within the network to ensure carotid endarterectomy within 14 days of patients experiencing symptoms. The percentage of patients receiving surgery within 14 days of symptom is 52% in comparison to the national figure of 60%. The vascular service is currently reviewing referral pathways with stroke and ophthalmology teams to improve time to referral, timely review and access to theatre. The network agreed a pathway in 2019 following centralisation of the

service with the stroke teams for the management of patients requiring carotid endarterectomy.

Conclusion

Progress has been made with the implementation of the vascular services review recommendations. The Royal College of Surgeons invited interviews have been completed and the report is expected in April 2021. Three out of five of the clinical pathways have been approved by the Health Board's Clinical Advisory Group, with a further one to be submitted on 19th February 2021. Progress on the non-arterial diabetic foot pathway, whilst initially slow, is now moving with pace. The outcomes from the agreed pathways will be monitored within the secondary care governance structure which the vascular service sits within. The next meeting of the Vascular Task and Finish Group will be held on Thursday 18th March 2021.

Legal and Compliance

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

APPENDIX 1

TERMS OF REFERENCE FOR SERVICE REVIEW

Review of the vascular surgery service at Betsi Cadwaladr University Health Board under the Invited Review Mechanism.

Background

The integrated Vascular Network was established in April 2019 to provide vascular services through a hub and spoke model of patient care; a centralised service at the Ysbyty Glan Clwyd (YGC) site, a lower limb service at the Ysbyty Gwynedd (YG) site and a service treating non-complex vascular cases across both these two acute sites and the Wrexham Maelor (WM) site.

Following concerns raised by patients, carers and staff (which were included in a report by the North wales Community health Council), an internal review was undertaken of the vascular services provided by the integrated Vascular Network model. The subsequent report was presented to the Betsi Cadwaladr University Health Board (BCUHB) in May 2020[1] and an external review was requested as part of the process to improve the service and to enable greater assurance of its safety and quality. This invited review of the vascular surgery service was to be undertaken by the Royal College of Surgeons of England under the Invited Review Mechanism.

The review was to address the challenges identified to be associated with the implementation of the provision of the integrated Vascular Network, which had contributed to concerns raised. This would be done by considering the standard, safety and quality of care provided by the vascular surgery service, including specific reference to a number of key areas.

Review

The review will involve:

- Consideration of background documentation regarding the vascular surgery service.
- A clinical records review of 50 specific cases put forward by BCUHB.
- Interviews with members of the vascular surgery service, those working with them to provide the service and other relevant members of BCUHB staff.

[1] There was understood to have been a delay in this report being presented to BCUHB due to the Covid-19 pandemic

Terms of Reference

In conducting the review, the review team will consider the standard, safety and quality of care provided by the vascular surgery service under the current integrated vascular network, including with specific reference to:

1. Both established and developing clinical pathways in providing optimal clinical care, including consideration of:

   (i) The effectiveness of referral pathways in enabling timely access for patients to effective interventions.

   (ii) The effectiveness of the "diabetic foot pathway," in the management of diabetic foot disease in line with national standards.

   (iii) Clinical decision making.

2. The effectiveness of the multidisciplinary team (MDT) in ensuring continuous and optimal patient care.

3. Clinical governance, including the effectiveness of:

   (i) Mortality and Morbidity (M&M) in discussing cases as part of learning and taking forward actions.

   (ii) The processes in place for concerns and incidents to be reported and addressed.

   (iii) The appropriate communication of outcomes following reported concerns and incidents.

4. Clinical outcomes, complications and mortality for both the service and individual surgeons in the context of accepted national and international standards/norms.

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

6. Behaviours, communication and team working, including specific reference to:

   (i) The team of consultant vascular surgeons.

   (ii) The wider vascular surgery service.

   (iii) The multi-disciplinary team (MDT).

   (iv) Engagement and communication between the vascular surgery service and:
   - The spoke sites,

- The relevant community services.

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

   (i) The effectiveness of providing information to patients in supporting and enabling shared decision-making.

   (ii) The adequacy of the provision of patient clinical information to the appropriate primary and community health care teams

Conclusions and recommendations

The review team will, where appropriate:

- Form conclusions as to the standard of care provided by the vascular surgery service including whether there is a basis for concern in light of the findings of the review.

- Make recommendations for the consideration of the Medical Director for secondary care of the Betsi Cadwaladr University Health Board as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on 14th December 2020.

Name: Vascular Task and Finish Group		
Overall Work Status		A

T&F Group	**Date: 09/02/21**		
Senior Responsible Officer:	Arpan Guha, Interim Executive Medical Director	Report Authors:	Jo Garzoni (Vascular Network Manager)

Executive Summary

The Vascular Task and Finish Group commenced in June 2020 and there have been eight meetings. The last meeting was held on Monday 8th February 2021. There is a good range of representation from multidisciplinary team members as well as patient and CHC presence. The action plan is being tracked by the group with regular updates provided to QSE and Welsh Government.

Progress has been made with the implementation of the vascular services review recommendations. The Royal College of Surgeons invited interviews have been completed and the report is expected in March 2021. Three out of five of the clinical pathways have been approved by the Health Board's Clinical Advisory Group, with a further one to be submitted on 19th February 2021. Progress on the non-arterial diabetic foot pathway, whilst initially slow, is now moving with pace. The outcomes from the agreed pathways will be monitored within the secondary care governance structure which the vascular service sits within. The next meeting of the Vascular Task and Finish Group will be held on Thursday 18th March 2021.

High level Milestones

Milestone	**Indicative date**

Key Milestones:	**Planned Date**	**Actual / Forecast Date:**	**Status:**	**Schedule RAG:**
External invited review of the vascular service				
Royal College of Surgeons invited review interviews	11th, 12th, 13th, 28th January 2021		37 interviews undertaken	Complete
RCS invited review report	Beginning of April 2021 (indicative date given)		In progress	Progressing
Clinical records review (50 case notes)	End of March 2021		In progress	Progressing
Alignment of bed base				
Review of the capacity and demand for inpatient beds across the service	16/06/20	16/06/20		Complete
Clinical pathways				
Development of a non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines	30/04/21		• Diabetic Delivery Group led by Dr Bethan Jones. • Orthopaedic foot and ankle T&F group established • Funding secured for a	Progressing

			Diabetic Clinical Lead and a Diabetic Foot Pathway Clinical Lead • CAG clinical pathway template, including clinical outcome measures, drafted	
Review and refine angioplasty pathway	30/11/20	20/01/21	Approved at CAG.	Green
Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses	30/11/20	19/02/21	Discussion with Hospital Medical Directors and Clinical Director – agreement reached. Submission to CAG on 19/02/21	In progress but overdue
Review and refine pathway for patients post major arterial surgery requiring rehabilitation	30/11/20	27/01/21	Approved at CAG..	Green
Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	23/10/20	27/01/21	Approved at CAG.	Green
Communication and Engagement				
Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	16/06/20	01/09/20	Complete and shared	Complete
Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	01/09/20	01/09/20	Detailed plan to support this action provided	Complete
Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	15/10/20	01/11/20	Update from AG that review of process for freedom to speak up is underway to create a uniform policy. To be brought to the group once finalised.	Green
Development of a stakeholder engagement plan to maximise opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and Learning group	16/06/20	23/06/20	Complete and shared	Complete
Review of patient information and accessibility (including travel) with the support of the patient experience team	16/06/20	16/06/20	Review completed in collaboration with the Community Health Council representatives. Development of inpatient information and successfulo piloting and evaluation on the vascular unit.	Complete
Quality and Safety				
Baseline Safety culture survey to be undertaken to inform areas for improvement	17/07/20	08/03/21	Interim organisational report drafted. Segmentation not granular enough to identify vascular services. Chair has commissioned a targeted sample to those who work in	In progress but overdue

			vascular services. To be sent out 08/02/21 for 3 weeks.	
Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	17/07/20	20/08/20	Report completed and discussed	Complete
Explore the potential to work with a high reporting service to share good practice	01/09/20	01/09/20		Green
Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures	17/07/20	17/09/20	Workforce indicators identified and discussion with Information whether these can be incorporated on the dashboard.	
Training Needs Analysis to be undertaken to support the emerging clinical pathways and future workforce model	27/11/20	31/05/21	Complete for all pathways except the non-arterial diabetic foot pathway.	Progressing
Issues of significance report from Vascular Task and Finish group to Quality, Safety and Experience Committee	01/09/20	01/09/20	Regular reports to QSE and Welsh Government on progresss.	
Clinical Effectiveness				
Consider all opportunities for national/international benchmarking including the National Vascular Registry and national audits to assess, evaluate and review opportunities and improve the service	16/06/20	17/09/20	Detailed update on the audits currently underway within the service and the opportunities to benchmark provided	Complete
Development of quality and safety E-Dashboard, aligned to corporate dashboards, triangulation of complaints, incidents, compliments and lessons learnt trends to provide assurance from ward to board	17/07/20	17/07/20	Patient experience data to be incorporated. Further workforce metrics to be reviewed and included as data available. Development team continuing to work on accessing data. Workforce indicators monitored through accountability with DGM and HoN. Dashboard in use by the service.	Complete
Review of PROM/PREM measures to improve patient experience alongside existing patient experience data	16/06/20	16/06/20	Business case for funding research project to develop a PROM will be required to progress. No PROMS in the service.	
Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	16/06/20	Ongoing	Reporting template completed and provided to QSE meetings	Complete
Monitor vascular waiting times	16/06/20	Ongoing	Ongoing reporting and monitoring in line with Secondary Care structures	Complete
Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified	16/06/20	16/06/20	Template shared	Complete

Exception/Issues within Month	
Issue	**Resolution Plan/ Option**
Diabetic Foot Pathway meeting chaired by the Area Director (East) on 21/01/21 was cancelled due to pressures	Awaiting future date

Cost Issues *(see Finance report for further details)*			**A**
Issue	**Resolution Plan/ Option**		
Additional resource required due to COVID to electronically provide casenotes including administrative resourse to check for co-mingling and redaction and the scanning and collating of notes.	Proposal to be drafted following quote from Scan and Collate company.		

Decisions / Actions Required of the Group		
Decision Required	**Decision Maker**	**Required by**
Nil		

Appendix 3

Major Amputation Mortality Review Action Plan

Critical issue / issue for escalation:	Outlier for major amputation mortality in NVR report between 2017-2019
What are the implications? (Clinical, Governance and/or financial)	The 30 day mortality rate post amputation for the time period 2017-2019 is 15.9% in the NVR annual report (2020).
Action undertaken to date:	Reported to site Clinical Effectiveness Group - 19th January 2021 Reported to site Quality and Safety Group – 4th February 2021

No.	Action	Lead	Deadline	Update
1	Stage 2 mortality review to be undertaken for all cases	Mr Soroush Sohrabi, Clinical Director	26/02/21	In progress
2	Multi-disciplinary clinical case review with representation anaesthetics and vascular	Dr Emma Hosking, Hospital Medical Director	Week commencing 8th March 2021	In progress
3	Report of cases following the MDT clinical case review (action 2), including recommendations and lessons learned, to be completed and approved	Dr Emma Hosking, Hospital Medical Director	Week commencing 22nd March 2021	Not due
4	Report to local quality and safety group and clinical effectiveness group post review	Soroush Sohrabi, Clinical Director Joanne Garzoni, Vascular Network Manager	April 2021 meetings	Not due
5	Discussion and dissemination of learning points and reflection in clinical governance to the vascular and wider MDT post review	Soroush Sohrabi, Clinical Director	22/04/21	Not due
6	Royal College of Surgeons to review 10 consecutive case notes of major amputation patients from the end of 2020 (following discussion with the review panel)	Joanne Garzoni, Vascular Network Manager	End of March 2021	In progress

	Please identify:	For decision/ approval	⚑	For discussion	⚑
		For assurance		For information	
	Other:				

Appendix 4

Elective AAA Repair Mortality Review Action Plan

Critical issue / issue for escalation:	Identified increase in elective open AAA repair mortality
What are the implications? (Clinical, Governance and/or financial)	There have been 4 mortality cases after elective open AAA repair between November 2020 and the beginning of January 2021.
Action undertaken to date:	Reported to site Clinical Effectiveness Group - 19th January 2021 Reported to site Quality and Safety Group – 4th February 2021

Action	Lead	Deadline	Update
Stage 2 mortality review to be undertaken for all cases	John Glen, Consultant Intensivist	04/02/21	Complete
Multi-disciplinary clinical case review with representation anaesthetics, vascular and critical care	Dr Emma Hosking, Hospital Medical Director	04/02/21	Complete
Report of cases including recommendations and lessons learned to be completed and approved	Dr Emma Hosking, Hospital Medical Director	26/02/21	In progress
Report to local quality and safety group and clinical effectiveness group post review	Dr Emma Hosking, Hospital Medical Director	March 2021 meetings	Not due
Feedback to WAAASP via the mortality template for identified cases	Joanne Garzoni, Vascular Network Manager	02/03/21	Not due
Discussion and dissemination of learning points and reflection in clinical governance to the vascular and wider MDT	Dr Emma Hosking, Hospital Medical Director Joanne Garzoni, Vascular Network Manager	22/04/21	Not due
Royal College of Surgeons to review 10 consecutive case notes of open AAA repair patients from the end of 2020 (following discussion with the review panel)	Joanne Garzoni, Vascular Network Manager	End of March 2021	In progress

Please identify:	For decision/ approval		For discussion	
	For assurance		For information	☞
Other:				

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or Division/Area reporting in	**Strategic Occupational Health & Safety Group**
Chair of meeting or lead for report	**Sue Green - Executive Director Workforce and Organisational Development** **Peter Bohan – Director of Health Safety and Equality** **Sue Morgan – Head of Health & Safety**
Date of meeting; **only if a Sub-group reporting, otherwise 'Not Applicable' (N/A)**	**2nd February 2021**
Version number	**1.0**
List Appendices, if applicable	**N/A**

Reporting To	
Name of meeting	**Quality, Safety & Experience Committee**
Date of meeting	**2nd March 2021**
Presented by	**Sue Green – Executive Director Workforce and Organisational Development**

1. Alert

RIDDOR's reported from the 1st of January to the of 15th February 2021

There have been 63 RIDDOR's reported within this timescale. 52 of these are COVID-19 'occupational diseases' and four are patient falls with specified injuries where enhanced supervision was required and not in place at the time of the fall. The details of the seven non-COVID staff related incidents are below:

Patient handling injury where the staff member sustained a soft tissue injury to their hand
Object handling injury where the staff member sustained a shoulder injury
Staff member slipped and fell on ice on a pedestrian pathway, outside Ysbyty Glan Clwyd which resulted in a fractured wrist
Medical Records staff member dropped a tracking gun on their foot, sustaining bruising

Patient handling incident in which a staff member sustained a back injury. It was identified that there had been an insufficient discharge plan in place.
Slip on black ice in which the staff member sustained a fractured wrist
A staff member trapped their hand in a door causing bruising

A total of 700 COVID-19 related RIDDORs have been reported since the start of the pandemic.

Manual Handling Training

The compliance rate for Patient Handling training has dropped since the start of the pandemic from 67% to 60% which is significantly lower than the Health Board compliance rate of 85%. Mid-January 2021 an additional two temporary MH trainers were recruited for 6 months and more training courses are being established. There is however, difficulty getting training rooms particularly in the West and courses have been suspended from this area from the beginning of January. A temporary solution is being considered but access to a more permanent training venue is required. This will also potentially become an issue in Central if Ysbyty Enfys Llandudno is no longer available as a training venue.

Corporate Health and Safety Compliance Audit 2019/20 – Resource GAP analysis

Following completion of the Corporate Health and Safety self-assessment audit and identification of areas of statutory compliance requiring improvements, a financial business case was submitted as part of the 2020-21 financial planning programme. The joint business case with Estates and Corporate Health and Safety identified additional resources required for Estates and Facilities on a recurrent basis. The Business Case is being further developed and awaiting approval. A number of the risks identified in the GAP analysis require funding to mitigate the risks and improve compliance to achieve the target risk score on the Corporate Risk Register, which is within the Health Boards risk appetite.

HSE updates

The HSE have notified the Health Board of concerns raised by staff working in a specific area following an outbreak of COVID-19. The H&S team have done a thorough investigation and a verbal response has been given back to the inspector with a written response to follow. The HMT are also involved and monitoring the area to ensure the H&S recommended controls are being implemented.

2. Assurance

Health and Safety Leads Group

An update was given from the meeting held 11th of December 2021. The items of significance to raise from this group were noted as a lack of changing facilities for staff and the Meixin respirator (resolved). Work is underway to provide additional pod changing facilities on site in the near future to alleviate these concerns.

Health and Wellbeing Subgroup

The report received from the subgroup noted the external consultant supporting the Health and Wellbeing Strategy and an update on the counselling service, sickness absence, pre-

employment checks, needle stick data, skin assessments and the advice line are part of the scoping work being undertaken.

Union representative's feedback

Issues escalated to this group included staff with contact dermatitis which will require further investigation into the extent of this and whether some will be RIDDOR reportable. Occupational Health are currently reviewing these cases. Other items escalated were in regards to estates staff not having access to vaccination and H&S training for TU representatives had not been put in place. The vaccinations have now been completed for Estates staff and for there is a business case going forward for additional training.

Security Management Subgroup

This group has been stood down since March 2020. Plans to restart this group to commence shortly.

Strategic Occupational Health and Safety Group

Estates Triple A report

A report was received from the Director of Estates and Facilities to give an update on the review of the Board Assurance framework and risk register along with updates from the meetings. Below is a brief summary of the risks discussed.

Asbestos Management Group

The Asbestos Management Group has met and reviewed the key elements of the Board Assurance framework and risk register. The Asbestos Management and Control - Corporate Risk Register CRR20-01 gives a current risk rating of 20 and a target risk score of 10. Actions to achieve the target risk score included updating the policy and plan, commissioning Micad for data storage, contractor management and control, surveys and re-inspections of previous surveys have provided assurance of suitable controls in asbestos management in services reviewed.

Fire Safety Group

The fire safety group have reviewed CRR20-01 Non-Compliance of Fire Safety Systems – Corporate Risk Register which has a current risk score of 20 and a target risk score of 8. The draft fire policy was brought to the SOH&SG for agreement as an interim policy. A review of Ysbyty Gwynedd is being undertaken and additional controls being implemented to minimise the risk of lack of suitable compartmentation.

Water Safety Group

The Water Safety Group have reviewed the Legionella Management and Control – Corporate Risk Register CRR20-03 which has a current score of 20 and a target score of 10. There are a number of actions being updated for this risk, which includes the roll out of Micad for schematic drawings, a policy for the management of safe water systems, removal of deadlegs, testing, flushing, escalation and training processes.

A review of Legionella is also being undertaken by a Corporate H&S Advisor specifically for supporting the Estates team to achieve compliance. A report for this has been drafted and will be provided along with internal audit review of the water safety arrangements.

Contractor Management and Control

Contractor Management and Control – Corporate Risk Register CRR20-20 has a current risk rating of 20 and a target risk score of 10. To achieve the target risk score the Control of Contractors Guidance Document is currently being reviewed and updated, a business case for additional resources has been completed and the team are looking at the implementation of a Management of Contractor software SHE.

The issues of significance are provided to support the significant contribution of all teams involved however, there is a lot more worked required before complete assurance can be achieved due to volume capacity and financial restraints. The outstanding risks are escalated through the risk register and BAF. Action plans and audits are being progressed to reduce risks associated with statutory compliance.

Health and Safety Team Key Performance Indicators KPI's / Site visits and reviews

The Health and Safety team KPI's are being developed with the first two now in place. The first is in relation to the number of H&S reviews to be undertaken each month which in January was amber (12 /16). The second is the attending sites upon department request within 2 weeks of that request being made which in January was 'green' with all 41 requests being actioned by the team.

Security

A review of the current security provision is being undertaken, with an updated business case being drafted. An SBAR has been provided which gives an overview of the current challenges within the security function and the phases required to effect change. This is being developed further as part of the business case with an options appraisal section.

3. Achievement

- There was a site visit by the Local Authority (EHO) to the MVC Llandudno and they provided assurance that the safety management was of a high standard.
- A North Wales Police visit to the Bangor MVC identified good security management systems on site.
- Significant progress is being made to complete the action plans and gap analysis following the Corporate Health and Safety Compliance Audit undertaken in 2019/20.
- Development of a Programme Business Case (PBC) for Infrastructure and Fire Safety Compliance for Ysbyty Gwynedd.
- The Health Board has appointed Shared Services - Specialist Estates Services, Authorising Engineers for Fire Safety, Medical Gases, Water Safety, Electrical Safety and Ventilation.
- Ongoing appointment of Authorised/Responsible person appointments within Operational Estates. Estates and Facilities Resources Business Case submitted to Finance for consideration and support to improve statutory compliance.
- Working with strategic partners including enforcing authorities to respond to the Covid19 pandemic.

  PPE - Fit Testing Improvement Notice compliance
  The refitting of staff working in high risk areas to the 1863 respirator in YGC was fully completed (1,380 tests) and there has been significant progress on the refitting of these staff to the 1863+/9330+ respirator (1,222 tests completed to date).

Refitting of staff working in high risk areas across BCUHB will be dependent on the decision of whether to stay with the 1863+/9330+ or move to the 8833 respirator which has more of an assured stock level. There was a recall in Q4 of two batches of the 8833 respirators that provided most of the Health Board stock and significant work has been undertaken across all areas to refit staff to the 1863+/9330+.

The recruitment to the three-month secondment posts has now been completed and the team will be fully in place from the 1st of March 2021. The business case is being completed for these posts to be permanent. Fit testing hubs are in place on the YG and YGC sites and an area has been identified for Wrexham with some minor works required before the team can move into this.

The RPE Fit Testing Task and Finish group closed down in December 2020 as the majority of actions had been completed. The action plan will be kept updated.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	Patient Safety and Quality Group
Chair of meeting	Gill Harris Executive Director of Nursing and Midwifery/Deputy CEO
Date of meeting	17 February 2021
Version number	1
List Appendices, if applicable	None

Reporting To	
Name of meeting	Quality, Safety & Experience (QSE) Committee
Date of meeting	02 March 2021
Presented by	Gill Harris Executive Director of Nursing and Midwifery/Deputy CEO

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

There are no matters for formal escalation for the Committee to act upon.

A number of high risk and important issues are detailed in the assure section for the Committee to be aware of.

The Executive Director of Nursing and Midwifery highlighted a number of concerns that services were asked to address:

- The number of incidents reported was lower than may be expected especially considering the current pandemic pressures and resulting staff movement and skill mix – services were asked to assure themselves that reporting was taking place.
- The number of Make it Safe, incident reviews and complaint responses within timeframes was lower than acceptable – services were asked to take action to address.
- The reports from services did not demonstrate triangulation with known corporate risks and needed improvement – a working group will be formed to strengthen the reporting content.

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

The Group met with a reduced agenda recognising the current COID-10 pandemic pressures.

A report was received regarding the implementation of the Once for Wales Concerns Management System. The report set-out the work to implement the complaints, redress and ombudsman modules from April 2021. The mortality module, which is being launched across Wales at the same time, is already being piloted in the Health Board so will continue. The report asked for the group to approve a decision to defer full implementation of the incident module from April 2021 and instead work towards a phased implementation period, recognising current pandemic pressures on staff and recognising the nationally developed module will not be available until early March at the earliest. The group approved this subject to a risk assessment document being shared with members.

A report was received regarding open and overdue incident records in Datix, in preparation for the implementation of the new system outlined above. 3,094 records are currently open and overdue dating back to 2018 at the longest. The report recommended these records were split into three tranches 1) low risk incidents that can be batch closed, 2) incidents that can be closed by the corporate Patient Safety Team or escalated back to services and 3) those that needed service review before closure. This proposal would ensure transition to the new system is more efficient and save 407 hours of clinical time. The group approved the proposal with the request that a report on themes, trends and hot spots for the cohort of incidents is shared.

The Health Board response to the Healthcare Inspectorate Wales (HIW) National Maternity Review was approved. The response will be submitted to QSE Committee at its next meeting for assurance. The Executive Director of Nursing and Midwifery directed that services assess against the broader learning aspects of the review and the Quality Assurance Team will develop a reporting template.

A Chair's Report from the Safeguarding Governance and Performance Group was received. This report covered:

- In 2019, the Health Board evidenced an unexpected rise of still birth rate, which instigated the current review of stillbirths. The service presented the findings of a review which explored the cause, associated or predisposing factors for stillbirth in 2019, identifying areas of improvement or factors associated with stillbirth and proposed where applicable, changes in service provision for the improvement of care for pregnant women to reduce the stillbirth rate in BCUHB.
- In 2019-2020, the Deprivation of Liberty Safeguards (DoLS) team received 1014 applications; there have been 556 applications for DoLS so far in 2020-21, which is a trajectory in excess of 1100 applications by the end of the year. This is an estimated 10% increase in activity on last year's numbers.
- There are currently six (6) reviews taking place across North Wales. Key themes from recent Child Practice Reviews (CPR's) include disguised compliance, the lack of professional curiosity, and the lack of consideration for the completion of a Health Pre Birth Assessment (HPBA) by midwives and health visitors. A key finding from recent Domestic Homicide Reviews (DHR's) identified the need for BCUHB staff in high-risk areas, such as Emergency Departments, to carry out the Routine Enquiry for Domestic Abuse (REDA). This lack of opportunity for a victim to disclose is increasing the potential risk of continued abuse and/or death. A task and finish group has been established to complete this work.

- Concern was raised with regards to Disclosure & Barring Service (DBS) checks in some areas; this will be taken forward in discussion with colleagues in Workforce and Organisational Development (OD).

A Chair's Report from the Infection Prevention and Control Group was received. This report covered:

- The Interim Associate Director of Infection Prevention & Control (IPC) reported that infection prevention controls need strengthening across the Health Board to prevent further outbreaks
    - Patient/staff movement not conducive to prevent transmission.
    - Isolation doors being left open without appropriate risk mitigation in place.
    - Lack of decant facilities to facilitate Hydrogen Peroxide Vapour (HPV) routine cleaning is increasing the risk of infections across the Health Board.
    - Clinical areas and rest areas not set up for infection prevention under current practice.
    - Key audits both nursing and doctor led not being undertaken/visible to support strengthening infection prevention practices.
    - Need to strengthen how staff are supported in the working environment to ensure they are effectively donning, wearing and doffing Personal Protective Equipment (PPE) to keep themselves and everyone else safe.
- Key positions to support infection prevention are vacant (e.g. antimicrobial pharmacist, infection prevention team members) and recruitment in process which is impacting upon specialist infection prevention support required across the Health Board.
- National workshop for nosocomial transmission taking place on 15 February – work will then be underway between Patient Safety and IPC to develop a local investigation procedure.
- Lack of primary care prescribing data is impacting on the ability to support the prevention change in antimicrobials and proton pump inhibitors (PPI).
- An infection prevention and control dashboard is to be scoped and developed to support operational and strategic staff.
- 167 patient and families who received 'potential involvement in the Covid-19 outbreak investigation' letters are still awaiting feedback – the Executive Director of Nursing and Midwifery highlighted this unacceptable delay and required services to address rapidly.

A Chair's Report from the Safer Medicines Group was received. This report covered:

- Throughout the COVID pandemic, pharmacy procurement staff have been undertaking regular stocktakes (daily during surges) of the top 20 critical care medicines, liaising with consultants to put alternative plans in place if stock is running low e.g. recently atracurium stocks were running low, so to preserve these for patients unable to have other neuromuscular blockers, rocuronium was used instead.
- Due to the complexities with the storage of the Pfizer vaccine, which requires storage at -70oC and then has a limited shelf life of 120 hours in a fridge, pharmacy staff have been involved with putting in the governance and procedural arrangements to ensure that cold chain requirements are met, and that there has been no, or minimal wastage wherever it has been administered and that it is used within its shelf life. They have been on hand to answer clinical and technical queries. Since the 7th December, 179,400 doses of the Pfizer vaccine have been given in a care home, GP cluster sites, mass vaccination centres, hospital vaccination centres and local vaccination centres. A further 93,460 dose of the Astra Zeneca COVID vaccine have been receipted into the acute hospital sites since the 4th January 2021 for onward distribution to GP

practices via Welsh Courier Services. The decision to hold the responsibility was taken to ensure that in combination with Pfizer vaccine, all eligible patients in cohorts 1-4 would be able to access a vaccine at either a mass, hospital or local vaccination centre or their local GP practice with minimal need to redistribute the vaccine to meet any areas of deficit. From the middle of February, GP practices will be responsible for ordering their own AZ vaccine.

A Chair's Report from the Concerns Management and Quality Systems Group was received. This report covered:

- The group is closely considering and managing a number of risks:
    - Lack of national Implementation plan
    - Lack of information regarding the safeguarding module
    - New modules not being available to BCU before March (ahead of April go live)
    - Incident module not to be developed until March – limited time to review suitability (ahead of April go live)
    - Training not available for BCU system managers until March – limited time to roll-out cascade training for staff
    - Tight deadlines for service and location hierarchy and user import mapping
    - Some proposed changes from BCU to the draft complaints and redress modules have not been enacted prior to go live
    - Concerns around integration of the mortality module with the medical examiner service
- The Once for Wales Patient Feedback System has been successfully procured. The new system, from CIVICA, is a significant improvement on the prior system in regards to functionality and cost. The local business case has been submitted to Executives for review.
- The Quality Dashboard programme is progressing well.

A Chair's Report from the PPE Group was received. This report covered:

- Following concerns from 3 Health Boards in Wales and the recent notification from All Wales Procurement to quarantine recent stocks of 8833 (lots ending in 17 and 22) the Health Board has completed the internal quarantine process. The identified stock has been internally quarantined and inspected by Corporate H&S Team and the stock will be returned.
- All Wales Procurement is awaiting the arrival of a consignment of 1.33 million 8833s FFP3 Masks due week commencing 8th February 2021. Due to the requirement to quarantine the above supply of 8833s our operational teams continue to carefully manage our internal non affected stock of 8833s. Health Board residual stock of unaffected FFPS 8833 is reportedly circa 1500.
- An active daily stock stake is underway with local plans in place to identify and FIT Test staff members solely reliant on the 8833 FFP3 Mask.
- Urgent refit testing is placing further pressure on staff in frontline clinical roles due to competing demands.
- The use of sensitive masks appear to be increasing in recent weeks. Suggestion of skin irritation experienced by some staff using Corpro mask. PPE discussed the need to ensure the decontaminated masks were totally dry before donning. Operational leads also considered some staff tightening the straps to the extreme, which could also be exacerbating the condition.

Due to the reduced nature of the agenda, divisional reports were tabled and updates provided on of key risks and issues. Of note from these:

- The Executive Director of Nursing and Midwifery requested a written paper and specific agenda item at the next meeting for the Secondary Care Division to update on the work underway to improve surgical safety following a recurrence of Never Events in 2020.
- The Executive Director of Nursing and Midwifery noted that incident and complaint performance had been affected and services were directed to ensure this was addressed.
- West Area noted risks in care homes - over 80 incidents with COVID-19 13 deaths, with 2 Incident Management Teams (IMTs) running, and a link with the South African variant.
- There has been an increase in self-harming incidents at HMP Berwyn due to the level of lockdown during COVID-19 outbreaks.

3. **Achievement** – include any significant achievements and outcomes

A number of achievements are noted in the above sections including the effective work to organise and deliver vaccines to the highest risk groups.

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	**11th February 2021**
Version number	**1**
Appendices	**N /A**

Reporting To	
Name of meeting	**Quality, Safety and Experience (QSE) Committee**
Date of meeting	**2nd March 2021**
Presented by	**Prof Arpan Guha, Acting Executive Medical Director**

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: - Radiation Protection Committee (RPC)

Issue: Lack of awareness around radiation regulations

- Following a recent audit of doctors, this has been demonstrated as an action to address awareness.

Explanation:

- Significant lack of awareness around the radiation regulations and the risks from radiation exposure.

Action undertaken to date:

- RPC referred to CEG for the doctor's induction to be reviewed to raise awareness and were advised to

- To link in with Workforce & Organisational Development (W&OD) to review induction and amend to add to the agenda for induction for discussion. This included discussions regarding possible e-learning packages.

Date of Completion:
- To be followed up at the next CEG with a completion date.

Issue: Clinical Evaluation
- Ionising Radiation (Medical Exposure) Regulations requires all images to have a documented outcome known as clinical evaluation. This is usually in the form of the formal report from radiology

Explanation:
- Some examinations such as general X-ray for orthopaedics, are not reported by radiology.

Action:
- The service is required to ensure there is a documented outcome in the notes, staff evaluating have appropriate training, and records are available for inspection by Healthcare Inspectorate Wales (HIW).
- It has been recommended that this be a Tier 2 audit for 2021 onwards so that the employer has assurance of compliance.

Date of Completion:
- March 2022

Reporting group: North Wales Managed Clinical Services Quality Committee

Issue: Audiology
- Current risk of unmanaged hearing and communication difficulties services, tinnitus and balance problems due to reduced capacity

Explanation:
- Cases are being triaged to ensure those with greatest need are prioritised but this add inefficiencies into the pathway.

Action:
- To provide assurance, further discussions have taken place and escalated to the following groups:
- Risks are being partly mitigated by telephone of video consultations however; the majority of people will need face-to-face appointments for examination, assessment and intervention, NHS Wales Informatics Service (NWIS) Quality and standards
- Plans are under development at West with Ear, Nose & Throat (ENT) clinical colleagues, where demand is specifically high, to develop referral criteria and priority categories

Date of Completion:

- Ongoing update to be brought back to CEG

Reporting group: Mental Health & Learning Disabilities Clinical Effectiveness Sub-Group

Issue: Personal Protective Equipment (PPE)

Explanation:

- An audit was undertaken during the first wave of the pandemic and this needs to be completed again. The findings of the first audit were that staff on 2 inpatient psychiatric units were not fully adhering to donning and duffing techniques.
- Due to learning this from the audit the decision was to re-audit again

Action:

- PPE audit has been identified as Tier 2 audit for 2021/2022.
- It will be a blind audit to observe real behaviour and will be random spot check to include observing night shifts and learning will be shared via CEG.

3. Achievement – include any significant achievements and outcomes

Reporting group: North Wales Managed Clinical Services Quality Committee

Pathology

Two papers published on digital pathology last month by BCU cellular pathology

https://f1000research.com/documents/10-57

https://www.jpathinformatics.org/article.asp?issn=2153-3539;year=2021;volume=12;issue=1;spage=4;epage=4;aulast=Babawale

Point of Care

Verification of PLGF (Placental growth factor) assay for diagnosis of pre-eclampsia has been completed and the pilot study at Wrexham Maelor Hospital (WMH) has started. If the data shows that this test prevents unnecessary admissions on Maternity then a business case will be submitted to roll this out to all Maternity Units in BCUHB

Evaluation of cotinine assay is planned; this is to support the Breast Reconstruction Surgical team. Nicotine can cause graft failure due to its effect on blood supply; the current carbon monoxide test is not suitable for patients that use vaporisers. This test will be used to ensure patients are not reducing their chances of successful surgery

Audiology research awards

Joanne Goss, senior audiologist is Chief Investigator of the first Research for Patient and Public Benefit (RfPPB) funded awarded to a Welsh Audiology study, the ‘HEAR IT’ study into the effectiveness of hearing aids for people with tinnitus and mild

hearing loss. Jo developed the application through a Pathway to Portfolio funded feasibility study last year.

Jane Wild, co-applicant on National Institute for Health Research (NIHR) funded FAMOUS study led by Manchester University; Jenny Townsend (Principal Investigator on UK Portfolio SeaShel study.

Reporting group: ***Research & Innovation Strategic Partnership Sub-Group***

We were the only Health Board who achieved the target of a 10% increase in recruitment to portfolio studies in 2019/2020, increasing the previous year's performance by 23%.

Two BCU staff successfully won funding to support their research time in a national *Research Time Award* in 2019, joining three other BCUHB staff who are part way through the three year award. A further member of BCUHB was successful in winning grant funding in a *Research for Patient and Public Benefit* national competition in 2019, and two bids have been submitted by BCUHB research teams this year, in partnership with Bangor University.

We were the only health board in Wales to participate in a study led by the Centre for Health Services Studies, *Identifying and improving the capacity of healthcare staff to conduct research.* The full report will be presented to policy makers, and our local contribution is helping us to plan our approach in BCUHB.

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 2nd March 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 15.1.21

- Discussion on quality governance review at Ysbyty Glan Clwyd