

Bundle Quality, Safety & Experience Committee 7 September 2021

9.30am via Teams
Public Agenda v2.0

- 1 OPENING BUSINESS
- 1.1 09:30 - QS21/121 Chair's Report
- 1.2 09:32 - QS21/122 Amanda's Story - A Long Covid Patient Story : Gill Harris
Recommendation:
The Committee is asked to receive and reflect upon the patient story.
QS21.122 Patient Story.docx
- 1.3 09:42 - QS21/123 Apologies for Absence
- 1.4 09:43 - QS21/124 Minutes of Previous Meeting Held on 6th July 2021 in Public for Accuracy
QS21.124 Minutes QSE 6.7.21 Public v0.03.docx
- 1.5 09:46 - QS21/125 Matters Arising and Summary Action Log
QS21.125 Summary Action Log QSE Public.docx
- 1.6 09:56 - QS21/126 Matters Referred to or from other Committees
Verbal
- 1.7 10:01 - QS21/127 High Level Outputs from QSE Workshop Held 24.8.21 : Gill Harris and Lucy Reid
Verbal
- 1.8 10:06 - QS21/128 Declarations of Interest
- 1.9 10:07 - QS21/129 Lead Executive's Report - Gill Harris
Verbal
- 1.10 10:12 - QS21/130 Board Assurance Framework - Louise Brereton
Recommendation:
That the QSE Committee:-
(1) review and note the current position on the principal risks assigned to the Committee, as set out in the BAF risk sheets at Appendix 1
(2) note the plan for a wholesale review of the BAF to review the principal risks in line with the Living Healthier, Staying Well strategy, including a re-evaluation of risk appetites in light of the new Risk Management Strategy and Policy, a particular focus on any target score higher than the refreshed risk appetite, and a re-allocation of risks to committees in response to the governance review and resulting changes to the committee structure.
(3) note for information the full list of BAF risks assigned to Committees, as requested at the last QSE meeting.
QS21.130a BAF cover report.docx
QS21.130b BAF Appendix 1.pdf
QS21.130c BAF Appendix 2 key field guidance.docx
QS21.130d BAF Appendix 3 list of risks and leads.docx
- 1.11 10:22 - QS21/131 Corporate Risk Register - Simon Evans-Evans
Justine Parry to attend
Recommendation:
That the Committee review the details recommendations as set out within the paper
QS21.131a CRR Report.doc
QS21.131b CRR Appendix 1.doc
QS21.131c CRR Appendix 2.doc
QS21.131c CRR Appendix 3.docx
- 1.12 10:32 - QS21/132 Quality Awards, Achievements & Recognition : Gill Harris
Recommendation:
The Committee is asked to note this report.
QS21.132 Quality Awards.docx
- 1.13 10:37 - QS21/133 Committee Terms of Reference : Louise Brereton
Recommendation:
The Committee is asked to note the Terms of Reference and recommend their approval to the Board through the Committee Chair's Report
QS21.133a ToR.docx

2 THE FUTURE - Developing New Strategies or Plans

No agenda items

3 THE FUTURE - Monitoring Existing Strategies or Plans

3.1 10:42 - QS21/134 Ionising Radiation Policy (RP01) : Adrian Thomas

Recommendation:

The Committee is asked to approve the minor amendments to the RP01- Ionising Radiation Protection Policy in order to comply with the requirements of regulations related to the safe use of ionising radiation principally Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation(Medical Exposure)Regulations 2017 {IR(ME)R17}

QS21.134a Ionising Radiation Protection Policy report template.docx

QS21.134b Ionising Radiation Protection Policy v4 Appendix 1.docx

QS21.134c Ionising Radiation Protection Policy EqIA Appendix 2.docx

4 THE PRESENT - Quality, Safety & Performance

4.1 10:47 - QS21/135 Quality & Performance Report

Recommendation:

Members of the Quality, Safety and Experience Committee are requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.

QS21.135a QaP Report.docx

QS21.135b QaP Report August 2021 (July Position) FINAL.pptx

4.2 11:02 - QS21/136 Vascular Steering Group Update : Nick Lyons

Neil Rogers to attend

Recommendation:

The Committee is asked to receive the update from the Vascular Steering Group and note the updated approach in responding to the first stage of the Royal College of Surgeons report on the Vascular Surgery Service

QS21.136 Vascular.docx

4.3 11:12 - COMFORT BREAK

4.4 11:17 - QS21/137 Pharmacy & Medicines Management Key Risks - Nick Lyons

Recommendation:

The Quality, Safety and Experience Committee is asked to note the Pharmacy & Medicines Management key risks and actions being taken to mitigate them.

QS21.137 Pharmacy Medicines Management Risks.docx

4.5 11:27 - QS21/138 Covid19 Update - Gill Harris

Presentation slides to be delivered at the meeting

4.6 11:47 - QS21/139 Board Commissioned External Review – Ysbyty Gwynedd Outbreak 2021 : Gill Harris

Recommendation:

The Committee is asked to receive the report, subsequent findings and recommendations. It is also requested to receive the progress report against each of the actions and the update against the Safe Clean Care (SCC) improvement programme.

QS21.139 YG IPC Review.docx

4.7 11:57 - QS21/140 Patient Carer Experience Report April to July 2021 - Gill Harris

Recommendation:

The Committee is asked to note the report

QS21.140 PCE Report.docx

4.8 12:07 - QS21/141 Review of Urology services and patient experience - Gill Harris

Recommendation:

The Committee is asked to note the paper and approve the suggested actions to address the issues identified namely:

- *Support the commissioning of an external clinical review of urology services from the Royal College of Surgeons. The lead time for such a review is likely to be 6 months*
- *Approve the immediate establishment of a North Wales Improvement Plan for urology to assess standards, identify current good practice and gaps in practice, with executive leadership and QSE oversight.*
- *Note the development of a business case to achieve a sustainable capacity position, taking into account the backlog arising during the pandemic, and the potential for Regional Treatment Centres. In the interim the Board will proceed with additional clinical appointments*
- *Acknowledge that action plans have been developed in response to previous and current PSOW reports which will need to be refreshed.*
- *Note the recruitment actions being taken*
- *Support the progression of the Getting it Right First Time (GIRFT) work*

QS21.141a Urology Review.docx

QS21.141b Urology Appendix 1.docx

- 4.9 12:17 - QS21/142 Nurse Staffing Levels (Wales) Act Triennial report - Gill Harris
Recommendation:
The Committee are asked to:
 1. Note the updated report of the Triennial Nurse staffing report with updates from closed investigations for the 2020/21 reporting period.
 2. Continue to support the ongoing recruitment and retention initiatives already in progress.
 3. Note Paediatric requirements in line with the revisions to the Nurse Staffing levels (Wales) Act are subject to a separate report and business case once triangulated reviews are complete
QS21.142a Nurse Staffing report.docx
QS21.142b Nurse Staffing Appendix 1 Three Year Assurance Report April 2018-April 2021.docx
- 4.10 12:27 - LUNCH BREAK
- 5 ANNUAL REPORTS - FOR INFORMATION
- 5.1 12:47 - QS21/144 Annual Return - All Wales Standard for Accessible Communication & Information for People with Sensory Loss - Gill Harris
Recommendation:
The Committee is asked to note this report.
QS21.144a Accessible Healthcare Report.docx
QS21.144b Accessible Healthcare Appendix 1.docx
- 6 LEARNING FROM THE PAST
- 6.1 12:52 - QS21/145 Investigation into Quality Concerns at Llandudno Hospital - Gill Harris
Verbal
- 6.2 12:57 - QS21/146 Mental Health – Ligature Risk Reduction and Adult Inpatient Service Development Exception Report - Teresa Owen
Recommendation:
The Committee is asked to note this update from the Mental Health Division on its progress with ligature risk reduction and adult inpatient service development.
QS21.146 Mental Health.docx
- 6.3 13:12 - QS21/147 Public Services Ombudsman for Wales Final Public Interest report - Gill Harris
Recommendation
The Committee is asked to note the Public Service Ombudsman for Wales' Public Interest Report for information and the Health Board's action plan response for assurance.
QS21.147a Ombudsman Public Interest Report.docx
QS21.147b Ombudsman Public Interest Report Appendix 1.pdf
QS21.147c Ombudsman Public Interest Report Action Plan Appendix 2.doc
- 7 SUB GROUP UPDATE REPORTS
- 7.1 13:17 - QS21/148 Patient Safety Quality Group - Gill Harris
QS21.148 PSQ Chair Report.doc
- 7.2 13:22 - QS21/149 Strategic Occupational Health and Safety Group - Sue Green
QS21.149 Chair's Report SOHSG 03.08.21.docx
- 7.4 13:27 - QS21/150 Patient and Carer Experience Group - Gill Harris
QS21.150 PCE Chair Report.doc
- 8 13:32 - CLOSING BUSINESS
- 8.1 QS21/151 Documents Circulated to Members
 23.6.21 Follow on action re staff redeployment
 21.7.21 Follow on action re Procedure Admission of Children to an Acute Psychiatric Inpatient Unit
 9.8.21 Briefing re Staff Vaccinations
- 8.2 QS21/152 Review of Meeting Effectiveness
Verbal - members are invited to reflect on the meeting effectiveness to inform and improve future meetings
- 8.3 QS21/153 Agree Items for Inclusion in Chair's Assurance Report to Board
- 8.4 QS21/154 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."
- 8.5 QS21/155 Date of Next Meeting
 2.11.21



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 7 September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Amanda's Story - A Long Covid Patient Story						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Awdur yr Adroddiad Report Author:	Sue Barnett (Patient Advice and Liaison Service) Hannah Hughes (Patient and Carer Experience Manager) Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)						
Craffu blaenorol: Prior Scrutiny:	Patient and Carer Experience Group Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director, Nursing and Midwifery/Deputy Chief Executive)						
Atodiadau Appendices:	1. Patient Story Transcript Form						
Argymhelliad / Recommendation:							
The Committee is asked to receive and reflect upon the patient story.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input type="checkbox"/>	Er gwybodaeth For Information	<input checked="" type="checkbox"/>
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	

Appendix 1

Betsi Cadwaladr University Health Board Patient Stories Transcript Form

Who took the story?	Facilitators name: Sue Barnett Facilitators role / department: PALS Date taken: 4.8.21 Venue taken: PALS Hub, WMH	
What is the title of the story?	Amanda's Story	
What area does the story relate to? E.g. Cancer Services	Long Covid	
What is the format of the story?	Written ✓ Audio ✓ Video Other:	Please note, Committee members can access the audio file on the Health Board network by clicking here.

Overview of the story

On Saturday the 4th of April 2020, I woke up with one of the worst headaches that I've ever had, which only got worse throughout the day to the point that I couldn't move my head without being in agony, my muscles were still sore from the day before which at the time I'd put down to spring cleaning! I was shattered and alternated between sweating profusely and shivering. Apart from the cough (which came later), I had many of the symptoms of Covid.

I hadn't improved by the Monday, so after speaking to my boss we agreed that I should self-isolate and not come into work. I had already been keeping apart from my family, as the days passed, being stuck in my room almost 24/7 and not being able to see my family was tough. I had separate handtowels, toothpaste etc to try and reduce the risk of spreading anything to the rest of the family, the little energy I had was. Used. Wiping down. Everything I touched. Meals were left outside my bedroom door and family and friends shopped for us, which we were so grateful for. The most difficult thing was having to strip and try and remake my bed with fresh sheets after sweating so much, I was so exhausted and really struggled this.

As the week went on, my bedroom started to feel like a prison, it wasn't helped by the fact that the weather outside was beautiful and I just felt so low, I haven't ever suffered in this way but I really felt so down. I couldn't even go and join in with the 'Clap for carers' with the rest of my family. One day my heartrate pretty much doubled just by getting dressed, that was the day I made a call and it was touch and go whether an ambulance should be called but thankfully it was decided not to be necessary.

There was a positive side to this in that I had no appetite so managed to lose few pounds, not that I'd recommend it!

By Thursday the 16th of April, I was starting to feel a little more human, I was still tired and the headache was still there but it was an improvement. I was signed off work for another week, which was necessary as I still needed to rest and sleep in the afternoon due to the exhaustion.

Once we came out of isolation, I naively assumed it wouldn't be long until I was back to normal. Unfortunately, a very short walk left me struggling to breath and then feeling shattered for the rest of the day, this was so frustrating as pre Covid I ran 3 times a week, one of those runs was usually a 10K, I'd run a few half marathons so was pretty fit. A simple job like mopping the floor left me exhausted, not just for the day but for days.

3 weeks of being off work, the HR department called and booked me in to go for a swab test that day, I went along on my own, it was the furthest I'd driven in over 3 weeks and it really took it out of me. The results came back negative, which wasn't a surprise really as it was so long after but there was no other no other explanation for the symptoms that I had, fortunately it was later confirmed that I had

antibodies so that clarified to me that I had had Covid and wasn't imagining it, not sure how I even thought I may have been imagining it though!

After a month or so off work I went back on a phased return, however it wasn't to my current role, I was re-deployed to a Covid Hub. I was still suffering with awful fatigue so I was lucky that I was able to return on less hours and over the weeks was able to increase the time that I worked, although by the time I got home it was an evening on the sofa for me. My manager was so supportive throughout and I think if I wasn't given the opportunity for a phased return I would have had to take more time off, by the 2nd week in June I was finally able to start back doing my usual hours.

In the mean-time a colleague informed me about a long Covid course that was run by the Trust, my boss was supportive of me taking up to two hours out of my working day, twice a week to attend this via video calls. The course was good as it focussed on exercise, diet and mindfulness among other things. It was good to hear other peoples' stories and talk about our mutual issues. However, through meeting these people I realised that I was one of the lucky ones as I was back at work, I could walk without losing my breath all the time, my muscles were stronger and my fatigue, while bad was so much better than theirs. I almost felt guilty for how I felt in comparison.

As the weeks passed, I felt strong enough to start running again, if you can call it that! I started by doing a very slow 2 and a half minutes, then slowly built up by running for a little longer, managing to do 10 minutes felt like climbing a mountain, quite literally, my breathing was awful and I was so tired afterwards but I'm very determined and competitive with myself so I pushed and pushed, more often than not I pushed myself too much and regretted it.

By September, I felt a lot stronger, almost back to normal, I was tired if I did too much and my lungs weren't brilliant, but I was so much better so I stupidly signed up to run the Virtual London Marathon with less than 5 weeks to go. I was realistic and knew I would be walking most of it but unfortunately, my naivety got the better of me again and walking/running 26 miles 6 months after having Covid was one of the worst decisions I have made and while the support from friends was amazing I should have realised that I just wasn't ready for it.

Christmas came and went, my running took a back seat but I slowly started to feel almost back to normal, the fatigue and breathing issues were always there in the background as a little reminder. Then almost a year to the day, I suffered what I call a relapse and could barely do anything, all the previous symptoms I had, came back and it was as if I had Covid all over again. My GP was amazingly supportive and signed me off week by week, always phoning me first to see how I was, I had another month off and then another month on phased return, and just like last time my boss was incredibly supportive too.

	<p>I always wonder if I will ever get back to where I was, yes, my running (which is hugely important to me) is improving but I still have lung issues, even walking up a hill is difficult these days. I'm a lot slower and usually have to rest for the remainder of the day after a run but at least I can run, I have been on the long covid course through work and I was one of the lucky ones, most of them are really struggling to this day. I feel guilty for being able to do what I can do, but frustrated with how I feel after doing too much and frustrated to think that I may never get back to where I am. I have terrible 'Brain Fog', especially when I'm tired, my daughter sometimes gets annoyed when she asks me something and I can't finish a sentence! I forget things, twice recently, I have put petrol in my diesel car, this has been a costly mistake.</p> <p>All in all, my concentration can be awful (reading a book takes weeks rather than days now), my lungs are not what they were, I still suffer from headaches and the fatigue often hits me like a bus. I worry that I will keep getting these relapses, it seems that every time I think I'm getting there, something sets me back. I now have to think about what I can and can't do and how it will affect me later if I do something, nothing is spontaneous now. I do believe that I am suffering Long covid as the 'relapse' really set me back and this is now my new normal.</p>
Key themes emerging and lessons learned	<ul style="list-style-type: none"> • Importance of rehabilitation support from the workplace: <ul style="list-style-type: none"> - Line Manager – Time off work and phased return, including adjusted days and hours worked and redeployment - HR Department – Covid Testing and Antibody Testing • Importance of support from the GP • Benefits of attending the BCUHB Long Covid Course – Education and meeting others in a similar situation for support • Impacts of Covid and Long Covid: <ul style="list-style-type: none"> - Physically: Headaches, fatigue and tiredness, unable to move head, muscle soreness, sweating, shivering, coughing, extreme exhaustion, increased heart rate, lack of appetite, breathlessness, lung problems and physical exertion - Mentally: Poor concentration, low mood, frustration, brain fog and forgetfulness - Emotionally - On Family - On Work - Relapses and set backs • Adjusting to a "New Normal"

	<ul style="list-style-type: none"> • Feeling like “one of the lucky ones” 	
Suggested service improvements to be made	<ul style="list-style-type: none"> • Acknowledgement of existence of ‘Long Covid’ and relapses • Joined up treatment and care pathway for Covid / Long Covid sufferers • Education for health professionals regarding Long Covid – Signs, symptoms, the impacts physically, mentally and emotionally and the impacts on family and work life • Learning from the sharing of this story as a good example of both workplace and GP support 	
Responsibility for actions required	<p>Information shared with relevant manager/s:</p> <p>Cara Spencer, Head of SALT Jan Jenkins, Deputy Head of SALT GP Practice Kim Warrington Davies, Covid 19 Project Manager</p>	<p>Date shared:</p> <p>Shared by Sue Barnett 13.08.2021</p>
Summary of where Story Shared: E.g. Patient & Carer Group, QSE, QSG etc	<ul style="list-style-type: none"> • PCE Group – August 2021 • PSQ Group – August 2021 • QSE Meeting – August 2021 	



Quality, Safety and Experience (QSE) Committee

DRAFT Minutes of the Meeting Held in public on 6.7.21 via Teams

Present:

Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
Cheryl Carlisle	Independent Member
Lyn Meadows	Independent Member
Mark Polin	Health Board Chair – observing (<i>part meeting</i>)

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC) (<i>part meeting</i>)
Louise Brereton	Board Secretary
Kate Dunn	Head of Corporate Affairs (<i>for minutes</i>)
Gareth Evans	Chair of Healthcare Professional Forum (<i>part meeting</i>)
Simon Evans-Evans	Interim Director of Governance
Gary Francis	Interim Secondary Care Medical Director (<i>part meeting</i>)
Sue Green	Executive Director of Workforce and Organisational Development (OD)
Arpan Guha	Acting Executive Medical Director
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Debra Hickman	Secondary Care Nurse Director (<i>part meeting</i>)
Patrick Johnson	Interim Acute Care Director (<i>part meeting</i>)
Matthew Joyes	Acting Associate Director of Quality Assurance
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (<i>part meeting</i>)
Justine Parry	Assistant Director Information Governance and Risk (<i>part meeting</i>)
Urvisha Perez	Audit Wales (<i>observing</i>)
Geraint Roberts	Divisional General Manager Cancer Services (<i>part meeting</i>)
Neil Rogers	Acute Care Director : Ysbyty Glan Clwyd (<i>part meeting</i>)
Mike Smith	Interim Director of Nursing for Mental Health and Learning Disabilities (MHLD)
Chris Stockport	Executive Director Primary and Community Services
Caroline Williams	Performance Lead (Cancer) (<i>part meeting</i>)
Kamala Williams	Acting Head of Performance (<i>part meeting</i>)

Agenda Item Discussed	Action By
QS21/90 Chair's Opening Remarks	
QS21/90.1 The Chair welcomed everyone to the meeting.	
QS21/91 Declarations of Interest	
QS21/91.1 None declared	

<p>QS21/92 Apologies for Absence</p> <p>QS21/92.1 Apologies were recorded for Jo Whitehead, Adrian Thomas, Dave Harries and Teresa Owen</p>	
<p>QS21/93 Minutes of Previous Meeting Held on 4th May 2021 in Public for Accuracy, Matters Arising and Review of Summary Action Log</p> <p>QS21/93.1 The minutes were approved as an accurate record pending an amendment to QS21/59.1 to make grammatical sense.</p> <p>QS21/93.2 In terms of matters arising it was reported that the external report into the outbreak at Ysbyty Gwynedd (YG) had only very recently been received within the organisation and was therefore not available in time to share at the Committee meeting. It would be shared at the Health Board on 15th July or sooner for members once factual accuracy had been checked. An Independent Member also enquired as to progress with delivery of the sepsis bundle and the Acting Executive Medical Director acknowledged there had not been the focus required to keep this on track but this would be more evident within the next quality and performance report. The Senior Associate Medical Director/Improvement Cymru Clinical Lead assured the Committee that there was no indication of a deterioration in performance from the latest mortality data but was more of a data collection issue.</p> <p>QS21/93.3 Updates were provided to the summary action log</p> <p><i>[Neil Rogers and Mike Smith joined the meeting. Gill Harris left the meeting]</i></p>	
<p>QS21/94 Patient Story</p> <p>QS21/94.1 The Acting Associate Director of Quality Assurance presented the patient story and confirmed that members had been able to access the audio link provided. He reported that the story had previously been shared at the Patient Safety and Quality Group (PSQG) and an action had been taken from that meeting to share the story across the wider organisation not just within the specific service.</p> <p>QS21/94.2 Members reflected that there were recurring themes around communication, liaison with families and making assumptions around an individual's needs and circumstances. It was also suggested that the situation could have been avoided if there had been better shared care arrangements. An Independent Member felt that the placement of specialist diabetic nurses within Emergency Departments (EDs) would also be beneficial although other members acknowledged that the core capabilities of ED clinicians should not be diluted.</p> <p><i>[Gill Harris rejoined the meeting]</i></p> <p>QS21/94.3 It was resolved that the Committee receive and reflect upon the patient story.</p>	

<p>QS21/95 Quality Awards, Achievements and Recognition</p> <p>QS21/95.1 The Chair welcomed the positive content of the paper.</p> <p>QS21/95.1 It was resolved that the Committee note the report.</p>	
<p>QS21/96 Quality Governance Review : Ysbyty Glan Clwyd (YGC)</p> <p>QS21/96.1 The Executive Director of Nursing and Midwifery introduced the paper and felt it was worth reminding members of the context to the multidisciplinary and data review which had been undertaken following the triangulation of a number of concerns around the YGC site. She assured members that although publication of the review had been delayed due to the pandemic, work had continued to ensure that progress could be made. It was noted that the new senior leadership team would be in post by early August but that other colleagues had ensured that immediate safety concerns had been addressed in the interim.</p> <p>QS21/96.2 The Acute Care Director (YGC) thanked the Committee for the opportunity to attend. He confirmed his opinion that the recommendations within the report were sound and that they offered an appropriate route to improvement. He could understand why a previous action plan had been rejected and added that he would wish to refocus the latest version to ensure it was more transformational and was able to deliver against the recommendations.</p> <p>QS21/96.3 In response to a question from an Independent Member, the Executive Director of Nursing and Midwifery confirmed that the new leadership team appointments were substantive and not interim as the paper suggested. The Independent Member suggested that the newly appointed team would need to read previous reviews and reports relating to YGC, and the Executive Director of Workforce and OD acknowledged that document review was clearly part of the discovery element of <i>Stronger Together</i> and would take into account a number of previous reviews, as well as listening to people.</p> <p>QS21/96.4 An Independent Member raised a point around ensuring that future reviews addressed other North Wales services that were based on the YGC site. The Acute Care Director confirmed that the Hospital Management Team were very aware that not all services on site were directly managed by themselves and this was on his radar. The Independent Member stated that Trade Union partners were looking forward to working with the new team.</p> <p>QS21/96.5 Another Independent Member welcomed the reference within the action plan to openness and shared learning in terms of patient harm. The Chair felt that the action plan was now far more focused but was concerned about how long it had taken to get to this point. She asked how progress would be monitored. The Executive Director of Nursing and Midwifery indicated there would be a combination of monitoring through the Hospital Management Team site structures and the corporate Patient Safety and Quality Group, with exception reports and scheduled updates to the QSE Committee.</p> <p>QS21/96.6 It was resolved that the Committee note the report.</p>	

<i>[Mr Neil Rogers left the meeting]</i>	
<p>QS21/97 Quality and Performance Report</p> <p>QS21/97.1 The Acting Head of Performance presented the report and highlighted the significant deterioration in CAMHS (Child Adolescent Mental Health Services) performance and that the report included supporting narrative around the actions being taken to address this. She suggested that in terms of the timeline for delivery of improvements, the impact would not be seen for a further couple of months. She also indicated that she had been contacted via email by an Independent Member regarding inconsistencies in infection prevention numbers in that low numbers but high rates were being reported. This had not yet been resolved.</p> <p>QS21/97.2 An Independent Member expressed concern at the CAMHS situation, in particular the face to face assessments for neurodevelopment. The Executive Director of Primary Care and Community Services recognised the work to be done but this work had started. He noted that the figures were presented in the paper as percentages and did not necessarily mean there had been a severe deterioration in how the service was responding and that it more likely indicated an increase in the numbers of referrals particularly since schools reopened. He acknowledged however that the matter remained of concern. The Interim Director for MHLDS noted the increase in morbidity and set out the challenges for the Division in maintaining a balance between responding to crisis and preventative work. The Chair suggested there might be opportunities to influence national mental health targets and what was measured to provide more meaningful performance reporting.</p> <p>QS21/97.3 An Independent Member noted that 11 patient falls with harm had been reported for May 2021 which was of concern. The Executive Director of Nursing and Midwifery indicated there was a planned conversation at the Executive Management Group around the falls programme and the Chair suggested that a thematic review on falls should be provided to the Committee.</p> <p>QS21/97.4 An Independent Member welcomed the Executive Summary section which she found helpful. She sought clarity around the statement that some infection prevention control (IPC) vacancies remained un-recruited to as having been hindered by the complex nature of recruitment processes. The Chair recalled a similar comment regarding CAMHS recruitment. The Executive Director of Workforce and OD did not believe the processes themselves were unnecessarily complex but suggested that some services did require additional support in terms of attracting applicants, and that the processes needed to be able to recognise complex roles. She agreed to take an action away to work through assumptions around recruitment processes that had caused this phrase to be used. The Executive Director of Nursing and Midwifery was of the view that IPC was not necessarily complex in terms of recruitment, however, there was certainly a high demand for people in that field. She added that interviews were scheduled that week for a senior IPC role.</p> <p>QS21/97.4 In response to a query regarding the reference in the report to a private provider having offered to deliver additional neurodevelopment assessments, the Executive Director of Primary Care and Community Services indicated this was a complex issue in terms of negotiation with the provider and the subject of ongoing</p>	<p>GH</p> <p>SG</p>

<p>debate amongst clinicians. He would be happy to provide a more detailed response outside of the meeting. The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this. The Executive Director of Primary Care and Community Services also clarified that the reference referred to Covid-19 consultations not overall GP consultations.</p> <p>QS21/97.5 Finally the Executive Director of Workforce and OD noted that Quadruple Aim 3 information appeared to be missing from the report. The Acting Head of Performance would look into this.</p> <p>QS21/97.6 It was resolved that the Committee discuss and receive the report.</p> <p><i>[Kamala Williams left the meeting]</i></p>	<p>CS</p> <p>KW</p> <p>KW</p>
<p>QS21/98 Board Assurance Framework (BAF)</p> <p>QS21/98.1 The Board Secretary presented the paper which included the 12 BAF risks mapped to the QSE Committee. She confirmed that following an individual review of each risk and discussion at the Audit Committee Workshop in May there were no material changes for approval in this report. It was noted that work was progressing on how to make the best use of time at the Risk Management Group (RMG) and also mapping work against the Annual Plan and preparing for the refresh of the Living Healthier Staying Well Strategy. The Board Secretary added that the Good Governance Institute would also be offering additional support to the organisation around the BAF.</p> <p>QS21/98.2 An Independent Member noted that the winter plan risk had been archived into BAF21-01 (unscheduled care) and asked that the next review strengthen the narrative to ensure it clearly covered the winter planning aspects. The Independent Member also enquired why there were no dates for delivering the target risk and the Interim Director of Governance stated that this had been discussed at the RMG with officers tasked to look at best practice to enable a timeline to be put against the target risk and to identify any gaps between that and risk appetite.</p> <p>QS21/98.3 The Healthcare Professional Forum Chair felt that the issue of lack of space in terms of the organisation's estate did not come across strong enough within the BAF. The Board Secretary indicated this would be captured within another BAF risk that reported to another Committee. She agreed to include a table within future reports that identified which BAF risk was aligned to which Committee. The Interim Director of Governance highlighted the importance of service areas logging individual risks so that the RMG can consider them in the context of other risks as combined they may need escalation to the Corporate Risk Register (CRR).</p> <p>QS21/98.4 The Chair referred to the appropriateness of the scoring of BAF21-12 regarding security services, which had been raised in the previous Committee meeting. She noted that it had been scored the same as the pandemic exposure risk for example and questioned whether the impact to the organisation was really comparable. The Executive Director of Workforce and OD responded that the risk level had been reviewed in light of available intelligence in terms of security incidents and breaches and the view was that nothing material had altered that risk. She reminded members that</p>	<p>LB</p> <p>LB</p>

<p>ligature incidents also came under security. She also advised that a deep dive review was being undertaken for security services in a future RMG meeting. The Board Secretary explained that there was work being undertaken on the comparability of scoring. The comments would be taken on board and the risk would continue to be reassessed.</p> <p>QS21/98.5 It was resolved that the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework.</p>	
<p>QS21/99 Corporate Risk Register <i>[Justine Parry joined the meeting]</i></p> <p>QS21/99.1 The Interim Director of Governance presented the report which set out progress on the Corporate Tier 1 Operational Risk Register. He reported there was a strong argument at the RMG to reduce the actual risk score on three further risks but this was not yet recommended to the Committee until the RMG had been assured on the evidence behind the actions. A point of accuracy was made in terms of the use of job title Associate Chief of Staff within CRR20-05 which was no longer in use.</p> <p>QS21/99.2 An Independent Member referred to CRR20-01 relating to asbestos and was surprised that the current risk had not been reduced given the number of completed actions. The Interim Director of Governance confirmed that whilst the actions had been completed, the RMG had not yet seen the evidence that they had had the required impact.</p> <p>QS21/99.3 A conversation took place around the rationale as described for a reduction in target risk score and similar rationale that would support the reduction in current risk score. The Interim Director of Governance referred to the issue of timeliness and he stated that as and when the working groups had implemented actions they may determine that a lower target risk score could be achieved than originally envisaged. So a reduction in target risk score might not necessarily mean that the actions had been delivered. The Chair clarified that the Committee were being asked to approve the reduction in the target risk score on the basis of a reassessment of what the risk owners believed could be achieved and not on the basis of the actions having been completed as described in the report recommendations.</p> <p>QS21/99.4 The Chair also pointed out that the graphs indicated that the target risk score was reduced in April but this was not approved at the time. The Interim Director of Governance accepted this point and would amend. He also confirmed that where actions were being archived, the controls in place would not be referred to in subsequent reports.</p> <p>QS21/99.5 A conversation took place around RAG rating and it was suggested a discussion at Executive Team was required around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete. The Executive Director of Workforce and OD noted that this had been helpful learning from a recent internal audit report.</p>	<p>SEE</p> <p>SEE</p> <p>SEE</p>

QS21/99.6 The Interim Director of Governance also clarified the naming conventions which applied when a risk was escalated from another Tier to the CRR.

QS21/99.7 It was resolved that the Committee review and note the progress on the Corporate Tier 1 Operational Risk Register Report subject to the clarification on the request to reduce the target risk score.

[Justine Parry left the meeting]

QS21/100 Infection Prevention and Control Sub Group Update

[Debra Hickman joined the meeting]

QS21/100.1 The Secondary Care Nurse Director presented the paper which set out the range of work being undertaken to address Infection Prevention and Control (IPC) risks against the ongoing Covid related challenges. She highlighted that Post Infection Review (PIR) compliance had improved and confirmed that a second round of reassessment of safety, care and accountability meetings were diarised before the end of July. She also confirmed that the initial findings from the report into the external review of the Ysbyty Gwynedd (YG) outbreak did not raise any immediate concerns.

QS21/100.2 In response to a question from an Independent Member, the Secondary Care Nurse Director confirmed that decant processes and hydrogen peroxide vapour (HPV) cleaning were both significant actions in high risk areas and that revisions to national cleaning standards were awaited, as was the outcome of a bid submitted by the Health Board. The Executive Director of Nursing and Midwifery highlighted environmental challenges and how these linked to unscheduled care patient flow in terms of the need to balance social distancing requirements within Emergency Departments (EDs). She assured members that teams were working to identify high risk patients and ensure a consistent approach across sites.

QS21/100.3 The Chair noted reference to an E-coli increase in April and enquired whether this was as a result of a community outbreak. The Secondary Care Nursing Director indicated this was not necessarily so and that many cases were linked to catheter utilisation and follow up. She also clarified that in terms of numbers this was not particularly significant but when reported in percentages looked more of a concern. The Chair asked how vigilance would be maintained in terms of the impact of Covid-19 community transmission rates and the Secondary Care Nurse Director explained that the Safe Clean Care (SCC) programme continued with a focus on clear and consistent messages, and the importance of staff engagement to address behavioural aspects. The Executive Director of Nursing and Midwifery added that the Executive Management Group (EMG) were receiving a Covid update at its next meeting, focusing on 'silent covid' ie; cases where the sufferer did not display any symptoms.

QS21/100.4 It was resolved that the Committee note the content of the report.

[Debra Hickman left the meeting]

QS21/101 Covid-19 Update

<p>QS21/101.1 The Executive Director of Nursing and Midwifery presented the paper and highlighted that the organisation was very much aware of the impact of the Delta variant across North Wales. In addition, whilst instances of Covid were being seen in those who had been double-vaccinated, these individuals were not necessarily being hospitalised so the impact was more on community services. In terms of the impact on the workforce there was currently no national modelling but BCUHB was undertaking some internally. Members were informed that an outbreak in the Heddffan Unit was being monitored and assurance was given that this had been contained. The Interim Director of MHLDS added that noticeably these cases did not include severe respiratory symptoms. He also stated that of the 9 people affected all had had at least 1 dose of a vaccine. Finally the Executive Director of Nursing and Midwifery reported there were high numbers of the workforce self-isolating and that changes to self-isolation guidance was expected.</p> <p>QS21/101.2 An Independent Member enquired as to what percentage of BCUHB staff had not been vaccinated and the Executive Director of Nursing and Midwifery agreed to circulate this figure, acknowledging it would be constantly changing. She confirmed there were a range of targeted actions in place to understand why staff were refusing the vaccination including intervention by line managers. The Executive Director of Workforce and OD added that processes were in place to ensure staff had easy access to vaccination opportunities and the system was also being validated as some individuals were receiving reminders when they had already received both jabs, and flowing through into GP records. The Healthcare Professional Forum Chair noted that the percentage of Medical/Dental and Non Agenda for Change staff not vaccinated appeared high (19%). The Executive Director of Workforce and OD did not feel this was an area of particular concern but she undertook to check the data and circulate a note outside of the meeting.</p> <p>QS21/101.3 The Chair referred to queries and changes to guidance around the Astra Zeneca vaccine and the potential impact on travel. The Executive Director of Nursing and Midwifery set out her hope that this was resolved nationally by the Welsh Government. Finally, the Chair wished to record the Committee's gratitude to all involved in implementing the successful vaccination programme.</p> <p>QS21/101.4 It was resolved that the Committee note the position outlined in the report and provide comments on progress of the programmes and issues raised.</p>	<p>GH</p> <p>SG</p>
<p>QS21/102 Serious Incident Report - April and May 2021 (including separate Never Event Thematic Report)</p> <p>QS21/102.1 The Acting Associate Director of Quality Assurance presented the report which provided the Committee with information and analysis on Serious Incidents and Never Events occurring in the last two months although it was noted that several months of trend data had been included to allow for period on period comparison in the last year. He indicated that longer-term thematic analysis was included in the quarterly Patient Safety Report. The Acting Associate Director of Quality Assurance highlighted that a new electronic reporting process had commenced from April 2021 and a strengthening of data could now start to be seen. He added that there was also a new NHS Wales reporting policy which would not impact upon internal BCU processes but would affect what was reported externally. He further highlighted that the Health and Safety Executive (HSE) had issued the Health Board with an improvement notice</p>	

in relation to falls management in June 2021. This specifically related to falls risk assessments and falls training and followed an investigation into two falls incidents which occurred in 2020. Members were informed that analytical work was being undertaken to review rates of falls and not just the absolute numbers. In terms of inquests, the Acting Associate Director of Quality Assurance confirmed that a Regulation 28 (Prevention of Future Deaths Notice) was received relating to an inquest occurring in mental health services and the response had now gone to the coroner. The MHLDS as part of their response had now introduced a daily third safety huddle at end of the day rather than at the beginning of the day.

QS21/102.2 The Chair referred to a recent Ombudsman public interest report and it was confirmed that this would be reported to the next meeting. The Executive Director of Nursing and Midwifery noted that a 'grand round' event would be taking place to share learning from the ED incident and that significant work had been commenced against the World Health Organisation (WHO) checklist including a revision and standardisation of policies and audit requirements.

QS21/102.3 With regards to the analysis of falls an Independent Member enquired whether this took into account the location in terms of ward, department or area. The Acting Associate Director of Quality Assurance confirmed this was the case however he added a caveat in that the Datix reporting element was poorly configured and meant that the extraction of data was difficult to separate out between where an event took place and another location/service the patient may also be accessing. The Executive Director of Nursing and Midwifery added that rapid reviews of all falls were being introduced as PDSA in real time on the Maelor site. The Chair enquired as to the current position with regards to patient safety alerts and the Acting Associate Director of Quality Assurance acknowledged the situation regarding overdue alerts was poor and disappointing. He noted that there were now more in depth LocSSIPs (Local Safety Standards for Invasive Procedures) available through a library which had been launched, and safety checklists from Healthcare Inspectorate Wales (HIW) were also widely used.

QS21/102.4 The Chair noted that she found the thematic analysis of Never Events very helpful and that as the findings were often superficial it was not surprising that the themes were recurring. The Acting Associate Director of Quality Assurance felt there was demonstrable progress and a more positive approach to ensure comprehensive responses to Never Events. The Chair referred to the urology-related Never Event and enquired what was being done to address issues of surgical culture. The Acting Executive Medical Director indicated there was an outstanding action in terms of culture which he was now minded to consider incorporating into the wider quality-related work at YGC to ensure improvement was sustained. The Executive Director of Nursing and Midwifery also made reference to use of the WHO checklist in terms of behaviours and added that she had asked the new Director of Regional Delivery to take on board aspects of identifying gaps in the service.

QS21/102.5 It was resolved that the Committee note the report and the significant increase in the number of falls with harm that have occurred over the last 18 months and the planned improvement work.

QS21/103 Vascular Services Update

[Patrick Johnson joined the meeting]

QS21/103.1 The Acting Executive Medical Director presented the paper and highlighted that a range of supporting documentation as referred to within the Action Tracker had been provided as background information for Committee Members. He indicated that the report demonstrated progress since the Royal College of Surgeon's (RCS) review of vascular services and that in summary the process had highlighted a need for improvement in some areas. He suggested that essential to this improvement was the need for a change in culture and a perspective of working together clinically to provide multidisciplinary professional services for vascular patients that may require input from other services. This would be operationalised through the pathway implementation phase.

QS21/103.2 The Acting Executive Medical Director went on to describe that the engagement with the vascular pathway work continued through the refreshed Task and Finish Group which was now being rebadged as a Steering Group. He acknowledged the valuable input of the Community Health Council (CHC) into redrafting the terms of reference. Members were advised that the diabetic arterial pathway was a good illustration of where something previously considered to be a vascular pathway had now become more joined up as a wider pathway of care. The Acting Executive Medical Director confirmed that the secondary care pathway work had now been signed off and work continued to join up the interface. The East Area had some good examples of tracking patients through a pathway.

QS21/103.3 The Acting Executive Medical Director suggested that fundamental to strengthening the hub and spoke model was the optimal utilisation of the hybrid theatre, and noted that there were a number of documents that reflected the breadth of conversations around this issue. He also indicated that active discussions around the number of beds were ongoing, particularly in the West, and he felt it was important to recognise that the original conversation was based on the number of vascular consultants available at that given time, and were reflective of target models at that time. These aspects had clearly changed, and he felt that the conversation now needed to be focused on appropriate bed space for the management of patients who may require vascular intervention, not purely the number of dedicated vascular beds. He gave an example where a patient may be in a vascular bed but requires a procedure to be carried out on their foot by an orthopaedic surgeon. This would require a different model of care and was not entirely dependent on ring-fenced beds for vascular patients.

QS21/103.4 The Acting Executive Medical Director reported that overall there was good progress in terms of an agreement regarding surgical care of the diabetic foot. The current guidance stated that some of this care could be provided by orthopaedic surgeons and he was pleased to report there was, for the first time, agreement across the patch from this group of surgeons. This would support a truly multidisciplinary approach for the patient as opposed to looking solely at their vascular issues. Members were informed that work to refresh consultant job plans to reflect this approach had commenced, but would not be a straight forward process. The Chair was pleased to see a reference to GP engagement in the diabetic foot pathway.

QS21/103.5 In terms of a communications plan to provide assurances to patients it was reported that an early draft was in preparation. The Chair suggested that experiences shared by vascular patients around service improvement could be used as formal patient stories for the next Committee meeting. She found the Appendix describing the vascular

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services being provided at each site very helpful. The Chair noted that the development of patient pathways and the review of the bed base was still being developed despite the length of time since the service reconfiguration and that the Committee would require ongoing assurance around progress and pace. She stated that this report provided more detail and confidence in terms of what has been progressed than previously and was also pleased to note that the Director of Regional Delivery would also be supporting the vascular work. The Chair stated that any changes made to pathways or services that differs from previous commitments made by the Board needed to be clearly communicated and explained. An Independent Member enquired how the hybrid theatre use would be monitored and the Acting Executive Medical Director set out the role of the secondary care Quality and Safety groups in terms of continuous learning. An Independent Member suggested that staff behaviours and commitment was so important that it should have been more prominent in the papers. The Acting Executive Medical Director referred to frank and encouraging discussions at a recent engagement event. The Executive Director of Nursing and Midwifery reiterated the importance of the *Stronger Together* approach and that the organisation needed to be clear around what was expected from the service.

QS21/103.6 It was resolved that the Committee receive the update from the Vascular Task and Finish Group.

[Mark Polin joined the meeting. Gareth Evans and Patrick Johnson left the meeting]

QS21/104 Health and Safety Annual and Quarter 4 Report

QS21/104.1 The Executive Director of Workforce and OD presented the report and acknowledged the earlier conversation and concerns around security risks. She then highlighted the impact of the pandemic in terms of training compliance particularly those areas which require face to face delivery. The issue of manual handling compliance had been raised at the Executive Team and additional investment agreed to move the matter forward. She also hoped it would be possible to start to release some resources from within the occupational health and safety teams as the organisation and Wales as a whole moved out of the pandemic. Finally, she reported that the relationship with the Health and Safety Executive (HSE) remained positive, with a good level of trust and confidence.

QS21/104.2 An Independent Member indicated she would wish to see more rigour and pace regarding agile working and the number of staff still working from home due to pandemic restrictions. She also wished to acknowledge the exceptional engagement by occupational health and safety teams with Trade Union partners. Finally, she noted the reference to a violence and aggression training package for managers and offered to circulate a useful video on social distancing.

QS21/104.3 The Chair referred to the comment in the report about the lack of adequate changing facilities for staff and the Executive Director of Workforce and OD confirmed this had been risk assessed and plans were in hand to increase capacity. Where this was not possible a booking system had been introduced and the team were also exploring the use of pods.

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<p>QS21/104.4 In response to a question from the Chair regarding the sad deaths of 2 members of staff the Executive Director of Workforce and OD confirmed that the investigations had not raised any points of concern that the organisation wasn't already aware of. The Chair also noted that non-covid related incidents in the central area seemed high. The Executive Director of Workforce and OD was aware of some issues within this area but there were also elements of proactive reporting in terms of resulting in higher numbers. She added that learning could be evidenced albeit not necessarily consistently applied and sustained. The Chair stated that the numbers provided activity but not necessarily assurance and suggested this could be included within the discussions at the forthcoming QSE workshop.</p> <p>QS21/104.5 It was resolved that the Committee note the position outlined in the Annual and Quarter 4 Report and support the recommendations identified within the findings within the delegated authority of the Committee:</p> <ol style="list-style-type: none"> 1. Implement year 2 of the Occupational Health and Safety (OHS) Strategy. 2. Ensure adequate staffing is available to provide an appropriate security function to BCUHB. 3. Ensure adequate staff and premises to provide Manual Handling training 4. Establish a permanent fit test program 5. Develop further policies and safe systems of work to provide evidence of practice. 6. Establish monitoring systems from the Divisions and Hospital Management Teams to measure performance including clear key performance indicators. 7. Train senior leaders and develop further competence in the workforce at all levels 8. Learn lessons from incidents and develop further the risk profile 	KD
<p>QS21/105 Mental Health – an Update from the Adult (MHLDS) Division and the Child and Adolescent Service (CAMHS)</p> <p>QS21/105.1 The Interim Director of Nursing (MHLDS) presented the paper. He suggested that future reports to the Committee be structured around the Targeted Intervention Improvement Framework (TIIF) domains. This was supported in principle, but the Chair suggested that including some thematic type reviews as appropriate would be helpful to ensure the Committee were sighted on any issues of significance that may sit outside of the maturity matrix. The Interim Director of MHLDS undertook to give some thought as to what might be the key themes for the next report – for example ligature risks.</p> <p>QS21/105.2 An Independent Member welcomed the summary of risks and issues within the paper but that it did not address what the next stages would be, nor gave milestones to improvement. The Interim Director of MHLDS stated that there were levels of maturity that could be reported on in terms of improvement but Welsh Government had not yet provided a timeline other than a broad expectation to move to level 1 and 2 fairly rapidly.</p> <p>QS21/105.3 In response to a question regarding interim appointments, the Interim Director of MHLDS acknowledged this remained an issue in terms of sustainability but there were complexities associated with some individual cases. The Executive Director of Workforce and OD reminded the Committee that there was always a role for interim expertise across the Health Board and she was working with the Executive Director of</p>	MS

<p>Public Health regarding the plan for the MHLD Division to ensure short term and longer term stability.</p> <p>QS21/105.4 The Chair acknowledged the amount of work to be delivered as part of the targeted intervention and the preventative and early intervention side of the service which will need the development of less medicalised service models. The increase in psycho-social cases will need good partnership working with Local Authorities. She referred to the need to significantly improve access to psychological therapies and that the Committee needs to see rapid progress on this. She requested a thematic analysis on psychological services to the November meeting.</p> <p>QS21/105.5 It was resolved that the Committee:</p> <ol style="list-style-type: none"> 1. Note the update from both the Mental Health and Learning Disabilities Division, and Child and Adolescent Mental Health Services (CAMHS). 2. Agreed to the proposed approach to reporting in future to include joint reporting between MHLDS and CAMHS. <p><i>[Mike Smith left the meeting]</i></p>	MS
<p>QS21/106 Primary and Community Care Quality Assurance Report</p> <p>QS21/106.1 The Executive Director of Primary Care and Community Services presented the paper, reminding members that primary care was wider than general medical services. He reported that bi-annual 'five domains' assessment of the sustainability of GP practices was being refreshed to take account of Covid related matters. In terms of access to primary care services he acknowledged that there was noise in the system but this was wider than just BCUHB. A related press release and media video was being launched in North Wales to try and address expectations of the service by members of the public. He noted that the triage aspect appeared to be the main point of dissatisfaction with patients but there were no plans to remove this process just yet. He reminded members that face to face consultations continued to be made available when they were needed.</p> <p>QS21/106.2 An Independent Member expressed concern at the backlog issue and the impact of the likely continuation of social distancing measures. She also felt that sustainability of the GP workforce was of concern. The Executive Director of Primary Care and Community Services indicated that refreshing the assessments would provide a clearer picture of any hotspots. In terms of sustainability, he confirmed that assessing the age profile of the workforce would provide an indication if there was a cohort of clinicians thinking about retirement or leaving the service. With regards to the backlog, work was being undertaken with practices to support them in triaging their chronic patients.</p> <p>QS21/106.3 An Independent Member enquired regarding the ability of general dental practices to offer the full range of services including aerosol generating procedures (AGPs) once social distancing restrictions were removed. The Executive Director of Primary Care and Community Services confirmed that all practices were currently providing these where needed, however it must be acknowledged there were increased risks and the Health Board and practices had a duty of care to their staff. The Chair enquired whether NHS dental waiting lists were being impacted upon by the prioritisation of private work. The Executive Director of Primary Care and Community Services noted</p>	

<p>that this tension would always be there but monitoring of Units of Dental Activity continued to be monitored. He would also check whether access standards continued to be reported to the Finance and Performance Committee.</p> <p>QS21/106.3 It was resolved that the Committee:</p> <ol style="list-style-type: none"> 1. Note the significant contribution to healthcare provision made across all primary care and community services during the pandemic; 2. Note the increased demands and challenges facing the primary care sector in particular, and actions being taken to support contractor services. 	CS
<p>QS21/107 Clinical Audit Forward Plan 2021/22</p> <p>QS21/107.1 The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the paper, highlighting that much audit work had been stood down in the previous year due to the pandemic. She confirmed that the Audit Plan had been discussed at the June 2021 Audit Committee and the Committee had noted concerns around resource issues for the COPD audits and also had felt that current services of concern (e.g., vascular) weren't appropriately reflected within the Tier 1 and Tier 2 schedules. To address this, an appendix had been included for the QSE Committee of Tier 3 audits to work towards the ability to consider whether some needed to move up to Tier 2. The QSE Committee were being asked at this stage to receive the documentation as work in progress. The Committee were however provided with assurance that leads had been identified for the Falls and Fragility Fracture audits which could now be progressed. The Acting Executive Medical Director added that audit teams were looking at thematic groupings of audits to draw out dominant issues as they emerge.</p> <p>QS21/107.2 The Chair was pleased to see reference to a compliance with LocSSIPs audit but felt that the start date of January 2022 seemed rather late. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated this was due to a resource issue but she would follow up the matter outside of the meeting to determine if the audit could be brought forward.</p> <p>QS21/107.3 The Interim Director of Governance clarified that once the Committee had approved the plan it would therefore not need approval at the Joint Audit and QSE meeting which would be stood down as part of the Integrated Governance Framework (if agreed by the Board later that month).</p> <p>QS21/107.4 It was resolved that the Committee approve the draft Clinical Audit Plan 2021/22 as the current working document.</p>	MM
<p>QS21/108 Mortality Report</p> <p>QS21/108.1 The Senior Associate Medical Director / Improvement Cymru Clinical Lead presented the slides which were cumulative and included information for the whole of 2020. She drew attention to the Medical Examiner service which had been in place on the YGC site for the best part of a year. Further capacity had been achieved through the recent commencement of a scanning element. Whilst early indications about the service were positive there was not yet sufficient comparative data. In terms of primary care it</p>	

was noted that as the Medical Examiner service rolled out and was awarded legal status, there would be a requirement for GPs to undertake mortality reviews also.

QS21/108.2 An Independent Member asked why in-patient mortality information had not been made available by YG. The Senior Associate Medical Director / Improvement Cymru Clinical Lead indicated that this site had traditionally utilised their morbidity and mortality meetings to review deaths and had struggled to align these to the Stage 2 audit process during the pandemic, and whilst lessons were shared internally there was a lack of evidence of lessons learned more widely. The site were however now starting to use the Datix system.

QS21/108.3 An Independent Member referred to the sepsis performance and the impact upon mortality. The Senior Associate Medical Director / Improvement Cymru Clinical Lead confirmed this was being tracked via the Comparative Healthcare Knowledge System (CHKS) and whilst there were some recent concerns that sepsis was increasing, it in fact wasn't and performance seemed in line with the rest of Wales. It was acknowledged that there could still be unavoidable deaths, and monitoring would of course continue. In response to a question around reporting of areas of concern, the Senior Associate Medical Director / Improvement Cymru Clinical Lead confirmed that CHKS data was scrutinized at the Clinical Effectiveness Group and that any key findings would be reported to the QSE Committee.

QS21/108.4 The Acting Executive Medical Director suggested that the utilisation of emerging data was key and that this function needed to be properly resourced. He indicated that a clinical lead for mortality was to be appointed for North Wales which would allow for easier gathering and oversight of pieces of work across both primary and secondary care.

QS21/108.5 An Independent Member noted reference to key learning that external and medical causes of death need to be better documented by staff within children's services, and it was confirmed that progress with this aspect relied on movement with the Medical Examiner approach.

QS21/108.6 The Chair welcomed the progress with mortality reporting however she made a general comment that some actions were more about monitoring requirements and not how the issue would be addressed. She felt that actions needed to be smarter going forward.

*[Melanie Maxwell left the meeting]
Committee agreement??*

QS21/109 BCUHB Corporate Safeguarding Annual Report 2020/21

QS21/109.1 The Executive Director of Nursing and Midwifery presented the paper on behalf of the Associate Director of Safeguarding. She noted that there was a substantial improvement in the collaborative work on the safeguarding agenda being undertaken across Wales. She indicated there had been some typographical errors on page 7 of the report and a corrected report was now available. The Chair confirmed that the Mental Health Act Committee had discussed the Deprivation of Liberties Annual report in detail at its last meeting.

<p>QS21/109.2 An Independent Member suggested that the acronym ACE (Adverse Childhood Experience) was not appropriate as the experience was not “ace” for the children and young people but far from it. The Executive Director of Nursing and Midwifery acknowledged this point and agreed that it would be fed back to the safeguarding team.</p> <p>QS21/109.3 Another Independent Member welcomed the report which she felt provided some excellent real life examples.</p> <p>QS21/109.4 The Chair made reference to the new liberty protection safeguards and that the Deputy Minister was seeking assurances that Health Boards were ready for the implementation and for the anticipated increase in applications. She requested that the Committee receive an update on this matter in November.</p> <p>QS21/109.5 It was resolved that the Committee receive the Annual Report for the period of 2020-2021 noting the progress, assurance and the innovative work led by the Corporate Safeguarding Team to implement learning throughout the organisation to help keep our patients, staff and organisation safeguarded.</p>	<p>GH</p> <p>GH</p>
<p>QS21/110 Planned Care Recovery Update <i>[Gary Francis joined the meeting]</i></p> <p>QS21/110.1 The Interim Secondary Care Medical Director presented the paper which set out progress against the recovery plan for planned care. He highlighted a range of key points. Firstly, he noted that the actions were currently mainly around the validation process and that the nature of waits varied from urgent cancer diagnosis, through to ophthalmology and orthopaedics. He reported that the approach for validation was similar across all specialties with recognition of the urgency of some cases. Secondly, he confirmed that a table-top post-validation clinical exercise was being undertaken as an added safeguard for patients following which a letter and questionnaire were sent to the patient. In terms of non-responders, GPs were currently not being asked to assist but this may potentially need to be the case if there were a large number of patients that the Health Board could not trace. Following the validation period the Board would move into the delivery phase, and it was noted that a range of options were described in the paper one of which was “pullback” (a long term project to return to pre-pandemic levels). The Interim Secondary Care Medical Director stated that an assumption for delivery was the ability to restart elective activity and that there be no further surge in Covid cases, together with the availability of support services such as endoscopy and diagnostics. He also reported that in the interim there were regular harm reviews of patients which unfortunately were identifying more patients in the later stages of disease/condition presentation.</p> <p>QS21/110.2 An Independent Member raised that the paper focused too much on numbers and not quality and safety aspects, and that it would be useful to link complaints relating to waiting times to the process. She also suggested that the patient questionnaire could ask additional questions around the economic impact to the patient, for example sick pay issues. The Interim Secondary Care Medical Director agreed to consider these suggestions further. The Independent Member also noted that the paper made reference to restarting a conversation around increase in bed numbers and wondered if this would create a conflict with the Safe Clean Care programme which</p>	<p>GF</p>

required increasing bed spacing. The Interim Secondary Care Medical Director acknowledged this was challenging as understandably infection prevention and control was essential but the requirements did impact on bed footprint. The Executive Director of Nursing and Midwifery felt that a risk assessed approach would need to be followed. Another Independent Member noted the reference to returning to pre-Covid levels and reminded the Committee of the long waiting times that the Health Board had before the pandemic. She referred to the need for a focus on transformation if waiting times were to be address to a safe, satisfactory level. The Interim Secondary Care Medical Director made the point that pre-covid performance levels were somewhat relative now but that the vision was to provide timely care for all patients and achieving improved outcomes through transforming care.

QS21/110.3 It was resolved that the Committee note the actions and mitigations being taken to recover the Planned Care waiting lists which have increased during the Covid-19 pandemic as a result of planned care activities having been curtailed to address the surge of admissions.

[Gary Francis left the meeting]

QS21/111 Suspected Cancer Pathway Update

[Geraint Roberts and Caroline Williams joined the meeting]

QS21/111.1 It was reported that a Suspected Cancer Pathway (SCP) was a new Welsh Government target which requires Health Boards to diagnose and treat at least 75% of cancer patients within 62 days of the first suspicion of cancer. The Divisional General Manager felt this was a realistic if challenging target and noted that BCUHB had persistently performed above the all Wales average with the May 2021 figure being 73%. He noted that urology and colorectal cancer performance was currently the most challenged. The paper set out a range of actions to improve performance further including pathway work, the introduction of Faecal Immunochemistry Testing (FIT) for symptomatic bowel patients. In addition £2m had been secured for further improvement work and a business case was being developed for one stop clinics.

QS21/111.2 An Independent Member enquired as to the timeframe for improvements to urology and the Performance Lead indicated that a South Wales pilot was being evaluated with a business case going to the Transformation Group later that week for approval. She was hopeful that a pilot could first commence in Bangor area. The Independent Member also enquired as to the timeframe for the business case for endoscopy capacity and the Performance Lead indicated that as it had a recruitment element it would take longer than hoped.

QS21/111.3 It was resolved that the Committee note the contents of the paper.

QS21/112 Sub Group Chairs' Triple A Reports

QS21.112.1 Patient Safety Quality Group 15.6.21
The report was noted.

QS21.112.2 Strategic Occupational Health and Safety Group 25.5.21
The report was noted.

<p>QS21.112.3 Clinical Effectiveness Group 27.4.21 and 17.6.21 The report was noted.</p> <p>QS21.112.4 Patient and Carer Experience Group 29.4.21 The report was noted.</p>	
<p>QS21/113 Issues Discussed in Previous Private Session</p> <p>QS21/113.1 It was resolved that the Committee note the report</p>	
<p>QS21/114 Documents Circulated to Members</p> <p>QS21/114.1 The following were noted: 10.5.21 Primary Care Mental Health Discharges Report 22.6.21 Limited Assurance Internal audit reports</p>	
<p>QS21/115 Issues of Significance to inform the Chair's Assurance Report</p> <p>QS21/115.1 To be agreed outside of the meeting, but to include concerns and risks around CAMHS.</p>	
<p>QS21/116 Date of Next Meeting</p> <p>Private workshop 24.8.21 Committee (public session) 7.9.21</p>	
<p>QS21/117 Exclusion of Press and Public</p> <p>QS21/117.1 It was resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'</p>	

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
2nd March 2021				
S Green	QS21/41.2 Include demographic breakdown including socio-economic and ethnicity factors into next H&S report, together with themes from the Make it Safe reviews.	21.4.21 (deadline for May papers)	26.4.21 Following agenda setting meeting, Chair had indicated she did not require stand-alone H&S report to May meeting. 4.5.21 L Reid would have wished to have seen H&S themes included within the Covid report. S Green confirmed that these elements had been provided and should have been incorporated. 22.6.21 The combined report on COVID did include H&S information. Sally Baxter has been approached for regarding the inclusion of this information in the Q1 report, as team were previously advised it was not required. 6.7.21 S Green advised that demographic vaccination data had been provided within the Covid paper and she would welcome advice on what further detail Committee members would wish to be included.	July September
A Gralton C Stockport	QS21/42.2 Provide information outside of the meeting on face to face and remote consultation figures for neurodevelopment assessments of children and young people	23.3.21	26.4.21 IMs have not received this information. A Gralton has been asked to expedite on his return from leave. 4.5.21 C Stockport agreed to follow up 6.7.21 C Stockport confirmed that the data had been received and he would circulate. 31.8.21 – This information will be circulated to members before the next QSE Meeting.	

4 th May 2021				
C Stockport	QS21/64.3 An Independent Member enquired as to the situation with the outbreak within HMP Berwyn and the Executive Director of Primary Care and Community Services confirmed this was under control and he undertook to provide some data outside of the meeting.	25.5.21	24.6.21 The HMP Berwyn outbreak was confirmed closed on 13 April 6.7.21 L Reid asked that the action be re-opened as data had not yet been circulated. C Stockport would follow up. 31.8.21 – Information will be shared with members before the next QSE meeting.	Closed End July September
M Smith	QS21/65.4 It was agreed that the Chair would meet with the Interim Director of Nursing for Mental Health and Learning Disabilities to go through the primary care discharges report and action plan.	June	29.6.21 the meeting took place as suggested and matter completed 6.7.21 L Reid reported that the meeting had been beneficial and agreement reached that recommendations relating to underlying culture and behaviours would be picked up under TIIF Maturity Matrix arrangements, although a clear audit trail would need to be maintained.	Closed
M Joyes	QS21/68.2 In response to a question regarding the timeframe for a pathway of age appropriate mental health beds, the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience undertook to obtain an update from the service and circulate this outside of the meeting.	1.6.21	11.6.21 The pathway has been approved and is now in place on the intranet. 6.7.21 L Reid noted that the update had not been circulated. M Joyes confirmed the pathway was in place and would share details. 21.7.21 Copy of Procedure for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit circulated to committee members.	Closed End July Closed
M Joyes C Stockport	QS21/68.5 Ensure clarity in future reports as to how issues raised regarding independent providers were followed up.		6.7.21 C Stockport reported that discussions had been held with primary care clinical governance teams and appropriate reports were shared at local Q&S meetings as in terms of oversight. If there were areas of concerns these would be followed up in terms of providing support and seeking	Closed

			assurances. Noted that this was also supplemented by HIW process too.	
T Owen	QS21/69.1 Check with the service how the first action from HIW maternity review relating to patient language of choice would be audited and confirm outside of the meeting.	June	<p>29.6.21 Action No.1: <i>“Ensure that women are aware of how they can request information or support in their language of choice”.</i></p> <p>Women are asked about their language of choice and in which language they wish to receive information at the very early starting point of the booking stage. Their choice is then recorded on the All Wales Hand Held Notes for all future visits and contacts and as per the Welsh Language Act (1993). We have in place a local policy that promotes the Welsh Language Act in addition to bilingual maternity documentation across all services. Should a woman require language assistance, for example an interpreter or other communication support, this will be arranged through the Wales Interpretation and Translation Service (WITS). This meets all types and levels of language needs. Information is also accessible in various formats, to meet sensory needs. Patient leaflets are available to provide the necessary contact information for WITS and is available on the intranet (ISU02). Patient Information Booklets for Maternity Services are also available through a wide range of languages to meet a variety of cultural needs. Local audits to validate whether language of choice has been promoted, takes place by Senior Matrons across acute and community services, reporting to the Head of Women’s Services and the North Wales Women’s Board. This is monitored via</p>	Closed

M Maxwell			<p>the Women's newly developed Clinical Effectiveness Group (previously WCD meeting) who monitors all audit activity.</p> <p>6.7.21 J Hughes not assured that the response answered the question around the language of choice in terms of making an active offer. G Harris suggested a quick point prevalence audit from hand held notes. M Maxwell to follow up with T Owen.</p> <p>19.7.21 M Maxwell confirmed that Women's undertake a monthly review of 5 records on each site with one of the questions being whether a patient's choice of language has been ascertained. July 2021 audit confirmed that 14 out of 15 had this documented. This information will be included in the division's report to CEG going forward. The division have also offered to do more targeted intervention if required in a certain area/team.</p>	<p>September</p> <p>Closed</p>
C Stockport	<p>QS21/73.1</p> <p>In terms of neuro assessments, the Executive Director of Primary Care and Community Services noted the challenges of undertaking these remotely with children and whilst face to face activity had increased there was a backlog. He would work with the team to provide a recovery projection over the next few months</p>	July	<p>24.6.21 Christina Billingham is preparing a position paper with Liz Fletcher, who has kindly stepped in to cover during Andrew Gralton's absence. The paper will then be developed further into a recovery plan.</p> <p>31.8.21 A further update will be circulated to members before the next QSE meeting.</p>	September
M Joyes G Harris	<p>QS21/72.3 The Chair was pleased to note evidence of improved triangulation coming through in the report, however, she still felt that the reporting of never events could be strengthened in terms of closing the loop.</p>	1.6.21	<p>11.6.21 The Chair, Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance met to discuss. A specific thematic paper on Never Events is being presented at the meeting in July 2021. Additionally,</p>	Closed

	She would wish to discuss further with the Executive Director of Nursing and Midwifery and the Acting Associate Director of Quality Assurance / Assistant Director of Patient Safety and Experience.		a workshop learning event is planned for August 2021. 6.7.21 L Reid asked that the action be re-opened to ensure a short update from the learning event can be provided within the action log at the next meeting.	September
S Green	QS21/76.2 In response to a question from the Chair as to whether people had returned to the organisation post redeployment, it was agreed that the Executive Director of Workforce and OD would follow up this data.	1.6.21	23.6.21 data circulated to Committee members. IMs subsequently sought further context around the issue which related to the numbers of (nursing) staff having left the organisation because of redeployments who then did or did not return and whether this was problematic. 6.7.21 S Green confirmed she was now clear on the action and was working with corporate nursing team to interrogate leavers information. The information to be circulated to members and if it was felt the matter needed more scrutiny this could be addressed within next nurse staffing report.	August
L Brereton	QS21/78.2 A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21. 31.8.21 Governance review complete and new Integrated Governance Framework approved by Board. Further work required to identify and determine approval groups for different categories of documents (policies/procedures etc.). The review of the Policy on Policies (PoP) has commenced. However, due to significant staffing issues within the Office of the Board Secretary, the expected completion date has been put back. Provisional target date for approval at Audit	September

			Committee is now December. A project support manager has been appointed to support policy work (start date pending recruitment checks).	
6th July 2021				
G Harris	QS21/97.3 QPR An Independent Member noted that 11 patient falls with harm had been reported for May 2021 which was of concern. The Executive Director of Nursing and Midwifery indicated there was a planned conversation at the Executive Management Group around the falls programme and the Chair suggested that a thematic review on falls would be helpful for the Committee at a later date.	TBA		
S Green	QS21/97.4 QPR In response to comments around delays in recruitment due to complex workforce processes The Executive Director of Workforce and OD agreed to take an action away to work through assumptions around recruitment processes that had caused this phrase to be used.	Sept		
C Stockport	QS21/97.4 QPR Provide more detailed response outside of meeting to a query regarding the reference in the report to a private provider having offered to deliver additional neurodevelopment assessments.	August	31.8.21 This information will be circulated to members before the next QSE meeting.	
K Williams	QS21/97.4 QPR The Chair also referred to a narrative comment about GP consultation	August	31.8.21 the separate COVID reports routinely include information on GP consultations.	Closed

	performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this			
K Williams	QS21/97.5 QPR Look into the comment made by the Executive Director of Workforce and OD noted that Quadruple Aim 3 information appeared to be missing from the report.	August	WOD measures are not currently reported in the QaPR for QSE, but are reported to F&P Committee and Health Board.	Closed
L Brereton	QS21/98.2 BAF Ensure that next review of BAF21-01 (unscheduled care) strengthen the narrative to ensure it clearly covered the winter planning aspects.	September	The Risk Lead has been asked to strengthen the narrative on winter planning	Closed
L Brereton	QS21/98.3 BAF Include a table within future reports that identified which BAF risk was aligned to which Committee.	September	Completed	Closed
S Evans Evans	QS21/99.1 CRR Correct point of accuracy regarding use of job title Associate Chief of Staff within CRR20-05 which was no longer in use.	August	Completed	Closed
S Evans Evans	QS21/99.4 CRR Amend the CRR to reflect that the graphs indicated that the target risk score was reduced in April but this was not approved at the time.	July	Completed	Closed
S Evans Evans	QS21/99.5 CRR Arrange for ET discussion around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete.	August		

G Harris	QS21/101.2 Covid An Independent Member enquired as to what percentage of BCUHB staff had not been vaccinated and the Executive Director of Nursing and Midwifery agreed to circulate this figure, acknowledging it would be constantly changing.	July	Circulated 9.8.21	Action to be closed
S Green	QS21/101.2 Covid Check data re the percentage of Medical/Dental & Non Agenda for Change staff not vaccinated which appeared high (19%) and circulate a note outside of the meeting.	July	9.8.21 Briefing note circulated	Closed
A Guha M Joyes	QS21/103.5 Vascular Work to utilise experiences shared by vascular patients around service improvement as formal patient stories for the next Committee meeting.	Sept		
J Hughes	QS21/104.2 H&S Circulate a useful video on social distancing.	July		
K Dunn	QS21/104.4 H&S Add to forward plan for August QSE workshop conversation around reporting consistency in that numbers often provided activity but not necessarily assurance.	August	Added to forward plan ahead of agenda setting	Closed
M Smith	QS21/105.1 Mental Health Give thought as to what might be the key themes for the next report – for example ligature risks.	November	21.7.21 Next divisional QSE report suggest a theme of Ligature harm reduction plans is appropriate on the broader actions to address the previously discussed risk of harm that emerged from the 2 low level ligature incidents in division. 31.8.21 Paper focuses on ligature as requested	Closed

M Smith	QS21/105.4 Mental Health Provide a thematic analysis on psychological services to the November meeting.	November	21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format.	
C Stockport	QS21/106.3 Primary Care Check and confirm whether dental access standards continued to be reported to the Finance and Performance Committee.	July	31.8.21 During the Covid pandemic dental access standards are not being reported as, in line with all Wales guidance, access to dental services is limited with the priority being urgent/emergency patients. As such no reporting has taken place this financial year to date. Once access to standard services fully commences reporting will be reinstated.	Closed
M Maxwell	QS21/107.2 Clinical Audit Determine if audit on compliance with LocSSIPs could be brought forward earlier than January 2022	July	7.7.21 M Maxwell confirmed that the start date quoted within the report was incorrect and the programme commenced in Q1 and is being reported to secondary care CEG within the site reports. The date will be corrected in future iterations.	Closed
G Harris	QS21/109.2 Safeguarding Feedback to the team that the acronym ACE (Adverse Childhood Experience) was not liked by children and young people and that it should not be used.	July	Safeguarding team alerted of this discussion	Closed
G Harris	QS21/109.4 Safeguarding Ensure update on readiness for new liberty protection safeguards be provided in November	November	Safeguarding team alerted of this request and matter added to forward plan / cycle of business	Closed
G Francis	QS21/110.2 Planned Care Take away the discussion for further consideration that the patient questionnaire could ask additional questions around the economic impact to the patient – for example sick pay issues and economic factors.	August	7.7.21 G Francis confirmed that being a national project all documents (letters and questionnaires) are owned by WG and BCUHB was not in a position to make unilateral amendments. The issue will however be escalated.	closed

2/9/21

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7.9.21
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Board Assurance Framework (BAF) Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Liz Jones, Assistant Director : Corporate Governance
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	Appendix 1 – Updated BAF principal risk sheets Appendix 2 – Key field, control and scoring guidance Appendix 3 – BAF risks as assigned to Committees

Argymhelliad / Recommendation:

That the QSE Committee:-

(1) review and note the current position on the principal risks assigned to the Committee, as set out in the BAF risk sheets at Appendix 1

(2) note the plan for a wholesale review of the BAF to review the principal risks in line with the *Living Healthier, Staying Well* strategy, including a re-evaluation of risk appetites in light of the new Risk Management Strategy and Policy, a particular focus on any target score higher than the refreshed risk appetite, and a re-allocation of risks to committees in response to the governance review and resulting changes to the committee structure.

(3) note for information the full list of BAF risks assigned to Committees, as requested at the last QSE meeting.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
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Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol
Y/N to indicate whether the Equality/SED duty is applicable

N

Sefyllfa / Situation:

The BAF incorporates the principal risks that the Board believes could adversely affect the achievement of its strategic priorities. There are currently 22 BAF risks in total, each with a risk sheet setting out risk scores, controls, mitigation and gaps for action. The risk sheets are live documents that are proactively re-assessed on a monthly basis and adjusted as necessary in response to the

changing risk environment. Each risk is allocated to a designated committee for scrutiny and monitoring purposes. Since the last QSE Committee meeting, the 12 principal risks allocated to it have been reviewed by the nominated Risk Lead, supported by the Office of the Board Secretary, and the latest risk overviews, setting out progress made, are presented at Appendix 1.

Cefndir / Background:

The current BAF design and monitoring arrangements were approved by the Board in January 2021. The BAF works in conjunction with the Corporate Risk Register, which is concerned with risks to the organisation's operational objectives as opposed to the BAF's focus on strategic level priorities.

Ownership of the BAF rests with the Board. Day to day responsibility for its co-ordination sits with the Board Secretary, whose team works closely with Risk Leads and other Risk Management colleagues to ensure that it remains a robust, responsive and visible tool. As well as scrutiny by nominated committees, the BAF's principal risks are subject to ongoing monitoring by the Executive Team, Risk Management Group and ultimately the Board itself.

The principal risks in the BAF have been mapped across to the strategic priorities or associated enablers as set out in the Annual Plan. A wholesale review of the BAF will be required in the coming months, to ensure that it remains relevant to the priorities as the Board refreshes its overarching *Living Healthier, Staying Well* strategy. As part of this, risk appetites quoted on each risk sheet will need to be re-evaluated in light of the new Risk Management Strategy and Policy, approved by the Board on 15.7.21. Particular focus will be needed on any target scores that are higher than the refreshed risk appetite. Allocation of risks to committees will also need to be re-mapped in light of the outcomes of the governance review and resulting changes to the committee structure. The services of the Good Governance Institute have been secured to provide expert support to this process in due course. Consideration is also being given to the potential for additional BAF risks around sustainability following the recent Board Workshop and around the Covid-19 public inquiry.

The latest review of the BAF risks allocated to the QSE Committee highlighted the following points (this information is also reflected within the relevant BAF risk sheet at Appendix 1):-

- **BAF21-01 – Safe and Effective Management of Unscheduled Care:** The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score is higher than the risk appetite. The Risk Lead has also been asked to strengthen the narrative on winter planning and to consider a potential increase in score in light of recent pressures.
- **BAF21-04 – Timely Access to Planned Care:** The inherent risk score was previously the same as the current risk score - this anomaly has been corrected, with the current risk score reduced from 25 to 20, and the target risk score reduced from 15 to 12. However, the target risk score remains higher than the risk appetite.
- **BAF21-06 – Safe and Effective Mental Health Services Delivery:** The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score remains higher than the risk appetite.
- **BAF21-07 – Mental Health Leadership Model:** The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score remains higher than the risk appetite.
- **BAF21-08 - Mental Health Service Delivery during Pandemic Management:** The procurement of additional IT equipment action is now shown as complete with a further action

added, as this project was initially progressed as a proof of concept which has been beneficial and is therefore supported by the Division for wider roll out. This project is aligned to Information Management and Technology (IM&T). The Risk Lead is considering the date by which it is anticipated that the target risk score will be achieved.

- **BAF21-09 – Infection Prevention and Control:** The controls have been refreshed and are now articulated as 8 key controls that underpin the risks, namely: Leadership, Buildings/Environment, equipment, cleaning, maintenance, training and supervision, behavioural change/transformation and policies/audits/observation. Two Gaps/Actions (1.1 and 1.2) have transferred from this control to the Behavioural Change/Transformation control. All impact scores have reduced from 5 to 4, resulting in the risk scores reducing from 25 to 20 (inherent), 20 to 16 (current) and 15 to 12 (target). The Risk Lead believes that the impact has reduced from a 5 to a 4 Major as lessons have been learnt over the last year around COVID-19 and the inherent, current and future impact is no longer as high. In addition it is anticipated that the likelihood score will begin to reduce as greater mitigating controls are put in place and their effectiveness becomes evident over the coming year. The Risk Lead is considering the date by when it is anticipated that the target risk score can be achieved, noting the dependency upon other initiatives and strategies. It is also noted that the target risk score is above the risk appetite.
- **BAF21-10 – Listening and Learning:** Target action dates have been reviewed and updated as appropriate, acknowledging the delay in roll out of the new Datix system. Implementation of the integrated Quality Dashboard was shown as complete following the last review, and is therefore now listed as a mitigation alongside the 'local and organisation-wide safety culture and quality improvement initiatives' control. In respect of the 'safety alerts procedure' control, the implementation date of the new skills pathway and passport has been pushed back by a month as only part of the training programme has been delivered due to capacity pressures on the team. The target risk score achievement date is quoted as 31 March 2023, reflecting that in addition to system and process improvements, culture improvement is a key component.
- **BAF21-11 – Culture-Staff Engagement:** The Risk Lead has been asked to provide an update on this BAF risk and will consider the anticipated date that the target risk score will be achieved.
- **BAF21-12 – Security Services:** Some completion dates have been extended. The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score is higher than the risk appetite. A deep dive of this risk will be undertaken in the October Risk Management Group meeting (deferred from August).
- **BAF21-13 – Health and Safety:** The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score is higher than the risk appetite. A deep dive of this risk will be undertaken in the October Risk Management Group meeting (deferred from August).
- **BAF21-14 – Pandemic Exposure:** The risk has been reviewed and updated and will mature over the coming couple of months. This month's changes consist of the first column of the risk sheet organised into a hierarchy of controls, namely Elimination, Substitution, Engineering, Administrative and Personal Protective Equipment (PPE). References to the vaccine programme, working from home, self-isolation, virtual ward rounds and visiting arrangements have been added. Safe Clean Care Harm Free is the underpinning transformation programme to bring about a reduction in the risk score, firmly supported by Infection Prevention Steering Group which oversees assurance and delivery against agreed trajectories of all infection and actions to risk mitigate and where possible risk eliminate. All impact scores have been reduced from 5 to 4 (inherent), from 5 to 3 (current) and from 5 to 3 (target). Overall risk scores have

reduced from 25 to 20, from 20 to 15 and from 15 to 12 respectively. The Risk Lead believes the impact scores have reduced because of the significant uptake of the vaccination programme, and whilst there is still a risk posed by the variants of concern (VoC), the vaccine industry is rapidly responding and updating the vaccines to cover the new VoCs. This is supported by all the evidenced Infection Prevention Control (IPC) work that has been undertaken throughout the Health Board and the future plans that are in place to address gaps in controls. It is also noted that the target risk score is higher than the risk appetite.

- **BAF21-19 – Impact of Covid-19:** The risk of demand has diminished, but the risk from reduced staffing due to isolation has increased. A prevention response plan has now been agreed with partners, however it is noted that there are gaps in capacity across all partners organisations to respond to rising community transmission, and also to respond to easing of restrictions at a different pace across the border. The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score is higher than the risk appetite.

The heat map illustrating the position on current risk scores allocated to the QSE Committee is as follows:

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			BAF21-14	BAF21-04	
	Likely - 4				BAF21-01 BAF21-09 BAF21-11	BAF21-06 BAF21-10 BAF21-12 BAF21-13
	Possible - 3			BAF21-08	BAF21-19	BAF21-07
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications

The BAF underpins the effective management of risks to the Board's ability to achieve its strategic priorities.

Opsiynau a ystyriwyd / Options considered

Not applicable.

Goblygiadau Ariannol / Financial Implications

The effective mitigation of risks has the potential to benefit the organisation's financial position, through better integration of risk management into business planning, decision-making and in

shaping how care is delivered to patients. This has the potential to lead to better quality care, reduced waste and fewer claims.

Dadansoddiad Risk / Risk Analysis

The individual risk sheets contain details of any related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal and compliance issues associated with the delivery of the BAF; the Board has a duty to manage risk to the best of its ability.

Asesiad Effaith / Impact Assessment

No specific or separate EqlA has been completed for this report, as a full EqlA has been undertaken for the new Risk Management Strategy and Policy, to which the BAF reports are aligned.

Strategic Priority 5: Improved Unscheduled Care Pathways

Risk Reference: BAF21-01

Risk Rating

Impact

Likelihood

Score

Appetite

Safe and Effective Management of Unscheduled Care (formerly titled 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	↔	4	16	
	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 Emergency Department Quality & Delivery Framework (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. 5) Primary Care Urgent Treatment (PCUT) Centre established in East	2	1) Roll out of YGC improvement plan to other sites as appropriate. National support agreed. (Update 23/07-All 3 localities have an USC Improvement plan with looks at the whole system with clear priorities set) [Update 21.7.21 - will become a mitigation] 2) Identify improvement and project support for delivery of the objectives. (As above update) 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.(Update 23/07-This is now part of 111 implementation- more work is needed to link 111 and SICAT to divert patients to the right place and manage demand) 4) In line with the agreed standards implement a uniform model for patient access to and from EDs. (Update 23/07- part of the EDQDF programme. BCUHB is working with WG to deliver this) 5) Fully implement across NWales the following to require maximising impact Same Day Emergency Care (SDEC) - currently in place in YG and YGC but further work required in East. SDEC is part of USC continuous improvement programme. (Update 23/07- developing a proposal bid to WG to secure funding to expand SDEC in all sites. The work on proposal for the new model will be done in August, recruitment and start implementation of the SDEC depends on the outcome of the WG funding) 6) D2R&A (discharge to rehabilitate and assess) - in progress; 7) 111 - on track to implement by June 2021 (Update: now implemented) and PCUT to be established in Centre and West.	Completed Completed 30 September 2021 31 December 2021 30 September 2021 31 December 2021 30 September 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	1) Monthly USC Improvement Group meetings Chaired by the Chief Operating Officer. 2) USC scoping review undertaken to develop strategic blueprint solution for unscheduled care	1	1) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care. (Update 23/07- Business case is being updated to reflect changes post Covid. BC will be ready for approval, however recruitment, training and delivering the model will be a longer piece of work) 2) Update as of beginning June 2021 - Executives have commissioned further work by Kendal Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. (Update 23/07 this work is in progress as part of the SDEC development, and there is a bid to the WG to secure funding for new acute medical model)	30 August 2021 30 September 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC 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. (Update 23/07- new senior clinical lead has been appointed, a programme director for the improvement programme has been appointed on interim basis, and there will be a new programme manager to support the work - will become a mitigation)	Completed

Review comments since last report: A new Senior clinical lead and programme lead started on USC Improvement Programme. Leads for each workstream and projects across each health economy have been identified. A new governance is put in place that will become operationalised in August. Work on acute medical model and Emergency Department workforce have developed further and will be ready for sign off mid August. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. The actions concerning roll out of the YGC improvement plan, improvement and project support and establishing permanent substantive posts will now become mitigations. June completion dates have been pushed back to August/September 2021. The Risk Lead is considering the date by when the target risk score will be achieved It is noted that this score is higher than the risk appetite. The Risk Lead has also been asked to strengthen the narrative on winter planning.

Executive Lead:

Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery

Board / Committee:

Quality, Safety and Experience Committee

Review Date:

21 July 2021

Linked to Operational Corporate Risks:

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04

Risk Rating

Impact

Likelihood

Score

Appetite

Timely Access to Planned Care

There is a risk that the Health Board may be unable to deliver timely access to Planned Care due to a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.

Inherent Risk

5

5

25

Current Risk

4

5

20

Target Risk

4

3

12

Low
1 - 6

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Finance and Performance Committee. Introduction of further validation staff in Q3/4 non recurring complete. [Update: review of validation techniques and validation SOP completed; now ready for deployment and adoption]	2	1) Scoping of Artificial Intelligence approach to validation requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan. [Update: this has now been scoped and the AI approach will not be available until May 2022 at the earliest. Action therefore to be deleted] 2) Validation staff being recruited on a fixed term basis to continue with validation work. 3) Subject matter expert reviewing validation exercises for planned care. [Update: Introduction of patient contact validation commenced in July for stage 1 and stage 4. This is a 9 week programme until end of Sept; this will therefore become a mitigation]	1) Closed 2) 31 August 2021 3) Completed
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1) Ensure the waiting list size is continually validated and patients appropriately communicated with. 2) Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support long waiting patients approved via Single Tender Waiver.	1	1) Introduce a system that allows patients to "opt in" for treatment, allowing a communication strategy to support the Q1/Q2 plan. [Update: linked to action 3 above - now implemented - will become a mitigation]. 2) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 3) Sites and areas are completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022. [Update: complete - will become a mitigation]	1) Completed 2) 1 September 2021 3) Completed
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Director of Regional Delivery and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care. Shortlisted candidates. [Update: currently, the post is being considered for an interim role whilst re-advertising for a permanent position]	30 September 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1) Weekly operational group with Divisional General Managers (DGMs) to ensure operational co-ordination of the Once for North Wales approach. 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. 3) Insourcing for ophthalmology introduced in February. 4) Over 52 week recovery plan for the 2019/20 end of March cohort as first phase agreed.	1	1) Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times [Update: out for expressions of interest] 2) Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Review of Ophthalmology Business Case in light of Welsh Government Strategy re Cataract Centres. [Update: complete - will become mitigation] 4) Additional internal activity above core is being mobilised via recovery plan. [Update: complete; will become mitigation] 5) Business case being developed for orthopaedic modular ward and theatre on each site. 6) Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector. [Update: outsourcing now awarded- will become a mitigation]	1) 30 September 2021 2) 31 August 2021 3) Completed 4) Completed 5) 31 August 2021 6) Completed

Review comments since last report: Actions relating to the 'manual validation' control have progressed. The review of validation techniques and the validation Standard Operating Procedure have been completed and are now ready for deployment - these will transfer to the mitigation column in the next iteration of the risk sheet. Actions relating to a treatment opt-in system and backlog clearance plans under the 'risk stratification' control have been completed and will become mitigations. The stage 1-3 risk stratification action has had its date extended from July to September. Actions relating to the 'plan' control have been updated to reflect consideration of an interim role. Actions under the 'Once for North Wales' control have either been completed (and will become mitigations) or have had their dates extended by a month. The tender for the outsourcing of orthopaedic activity has now been awarded and further specification for insourcing and outsourcing for other specialties is currently progressing through internal business process. The business case is progressing for an orthopaedic modular ward and theatre on each site. The inherent risk score was previously the same as the current risk score (suggesting that controls and mitigations are not being effective) - this anomaly has been corrected, with the current risk score reduced from 25 to 20, and the target risk score reduced from 15 to 12. The anticipated date that the target risk score will be achieved is 31 March 2022.

Executive Lead:

Mark Wilkinson, Executive Director of Planning and Performance

Board / Committee:

Finance and Performance Committee and Quality, Safety and Experience Committee

Review Date:

21 July 2021

Linked to Operational Corporate Risks:

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-06		Risk Rating	Impact	Likelihood	Score	Appetite
Safe and Effective Mental Health Service Delivery						
There is a risk to the safe and effective delivery of MHL 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
		Current Risk	5	4	20	1 - 6
		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	1) Key divisional roles in governance and safety are in the process of aligning to corporate reporting from the 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate.	2			
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 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 review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly (last met on 9 April 2021). Interim Deputy Director leading this key partnership agenda.		31 December 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). 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) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2021). 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.	2	1. Work is ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team. 2. Delivery of Targeted Intervention Framework outcomes for Mental Health.		01/09/2021 31 March 2022

Review comments since last report: Action and timelines reviewed which include:- 1. Work ongoing to address interim roles in the management structure. There is a "Head of Psychology" role now appointed to, with a start date of 1 July 2021. Work is ongoing to address the stability of the other interim roles within the senior leadership team.
2. Delivery of Targeted Intervention Framework outcomes for Mental Health - aligned to all TIF Measures. The Risk Lead is considering the date by when it is anticipated that the target risk score will be achieved.

Executive Lead: Teresa Owen, Executive Director of Public Health	Board / Committee: Quality, Safety and Experience Committee	Review Date: 18 June 2021
Linked to Operational Corporate Risks:		

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-07		Risk Rating	Impact	Likelihood	Score	Appetite
Mental Health Leadership Model						
<p>There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.</p>		Inherent Risk	5	5	25	Low
		Current Risk	5	3	15	1 - 6
		Target Risk	4	2	8	
Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (<i>actions to achieve target risk score</i>)		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 its roles and responsibilities.	2	Stabilise Senior Management with substantive posts. Sustainability needs to be reviewed as a matter of priority to ensure continuity.		1 September 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 (CAG).	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 December 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 the Division Clinical Advisory Group.	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.		01 September 2021
Divisional 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	Division has actively worked to ensure that the Divisions Governance Structure more accurately reflect and is coherent with BCUIHB's governance structure		Need to introduce a cycle of business to support effective reporting to the revised governance structure		1 September 2021

Review comments since last report: Actions reviewed and updated to reflect the current position with target dates amended. Action in relation to review of Governance Structures now completed and shown as mitigation. New action in respect of cycle of business to support effective reporting to the revised governance structure. The Risk Lead is considering the date by which it is anticipated that the target risk score will be achieved.

Executive Lead: Teresa Owen, Executive Director of Public Health	Board / Committee: Quality, Safety and Experience Committee	Review Date: 18 June 2021
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Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22									
Strategic Priority 6: Integration and Improvement of Mental Health Services									
Risk Reference: BAF21-08		Risk Rating		Impact	Likelihood	Score	Appetite		
Mental Health Service Delivery During Pandemic Management									
<p>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.</p>		Inherent Risk		4		4	16	Low	
		Current Risk		3	↔	3	↔	9	↔
		Target Risk		3		2	6	1 - 6	
Key Controls		Assurance level	Key mitigations		Assurance level	Gaps (actions to achieve target risk score)		Date	
<p>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.</p>		1	<p>1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)</p>		2				
<p>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.</p>		1	<p>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 scrutinise them through Senior Leadership Team.</p>		2	<p>Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed.</p>		30 August 2021	
<p>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.</p>		1	<p>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. 2) Approval by Corporate Business Continuity Lead for quality checking, and final sign off 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)</p>		1				
<p>Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.</p>		1	<p>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. 3) Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21</p>		2	<p>Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements.</p>		30 September 2021	
<p>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.</p>		2	<p>1) 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.</p>		2				
<p>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.</p>		1	<p>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.</p>		1				
<p>Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.</p>		2	<p>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.</p>		2				
<p>MH&LD Divisional Workforce meeting, currently meeting fortnightly to review workforce plan, reports into MH&LD Covid19 briefing meeting and the Divisional Governance meetings.</p>		1	<p>1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure SOP operationalised</p>		1				
<p>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.</p>		1	<p>Divisional prioritisation of IT equipment requirements completed and forwarded to IT.</p>		1	<p>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 ongoing. 2) This project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T) implementation.</p>		<p>Complete</p> <p>31 December 2021</p>	
<p>Review comments since last report: Procurement of additional IT equipment action now shown as complete with a further action added as this project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T). All action dates reviewed and updated. The Risk Lead is considering the date by which it is anticipated that the target risk score will be achieved.</p>									
<p>Executive Lead: Teresa Owen, Executive Director of Public Health</p>					<p>Board / Committee: Quality, Safety and Experience Committee</p>			<p>Review Date: 18 June 2021</p>	
<p>Linked to Operational Corporate Risks:</p>									

[illegible]

Key Controls	level *	Key mitigations	level *	Gaps (actions to achieve target risk score)	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons 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. This will address aspects 1, 2 and 3 of the risk.	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. This will address aspects 1, 2 and 3 of the risk.	31 October 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. This will address aspects 2 and 3 of the risk.	30 September 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. This will address aspects 2 and 3 of the risk.	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 an organisation-wide integrated Quality Dashboard.		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. This will address aspects 1, 2 and 3 of the risk.	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. This will address aspects 2 and 3 of the risk.	31 March 2022
				Implementation of a new Speak out Safely process for staff to raise concerns. This will address aspects 1, 2 and 3 of the risk. Update 12.7.21 - this action has been completed and this will now become a mitigation	Complete

Executive Lead: Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Board / Committee: Quality, Safety and Experience Committee	Review Date: 16 August 2021
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Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-11

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

Current Risk

4

4

16

Target Risk

4

3

12

Low

1 - 6

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	Revised new Speak Out Safely process agreed by Remuneration and Terms of Service Committee 1st February 2021. Implementation Plan in place, key elements being: 1. External platform commissioned - Work in Confidence - to replace Safe Haven to enable staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardian and/or members of wider Multi-disciplinary Team. 2. Role outline for Speak Out Safely Guardian completed, Guardian will report directly to CEO, with an independent board member now also identified to support and scrutinise Guardian role and new Multi-Disciplinary Team being established, the role of which will be to review concerns raised, agree actions required; and, monitor themes to identify learning; 3. Role outline for Speak Out Safely Champions has been refreshed and network of champions being created 4. Communications and promotion strategy under development with support of corporate communications; 5. WP4a policy (Raising Concerns) has been revised to reflect the transition to the new process	1	1. Launch of Work in Confidence platform now anticipated to be early July 2021, having received approval of DPIA (received Friday 11th June) [Update - launched] 2. Advert has been placed to appoint first Speak Out Safely Guardian, closing date of 25th June and interviews during first 2 weeks of July [Update - appointments now made] 3. Full membership of MDT now agreed with first meeting arranged for 29th June; 4. Overarching SOP in development, inclusive of agreed role outlines for Guardian, Speak out Safely Champions and independent member and terms of reference for MDT, with process map for Speak out Safely to be completed to support completion of SOP; 5 Communications strategy includes development of intranet pages. 6. WP4a policy (Raising Concerns) revised to reflect new process; 7. Evaluation metrics to monitor impact of new process under development. 8. On-going concerns raised through Safehaven process being managed to ensure they are not 'lost' during transition phase	31st July 2021
3. Dignity at Work Policy - Now Respect and Resolution 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: The go live date for new Speak Out Safely process was extended to ensure all supporting actions were in place as outlined above. It is considered that the collective impact of the actions for Raising Concerns will mitigate the risk. The Risk Lead is considering the anticipated date that the target risk score will be achieved.

Executive Lead:

Sue Green, Executive Director of Workforce and Organisational Development

Board / Committee:

Quality, Safety and Experience Committee

Review Date:

14th June 2021

Linked to Operational Corporate Risks:

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-12		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	4	20	
			Target Risk	5	2	10	
Key Controls		Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)		Date
1)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 2022 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. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.		1	Staff Training (which is V&A, module c and module d (breakaway and restrictive physical intervention) 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	1) 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. 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. 2) Business case under further review to identify [gold] minimum standard approach. 3) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas in Mental Health and Community/Acute areas.		30 September 2021 1 Aug 2021 30 September 2021
Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.		1	Data capture and reporting systems for V&A. A 0.8 WTE 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 Wales Police. A plan is in place to review V&A training and with funding, can be implemented.	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 is required. To ensure appropriate care, 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 and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. [Update 1.7.21 - currently, V&A training is at 41% compliance.]		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. Estates have committed to upgrade CCTV systems in a number of premises.		30 September 2021

Review comments since last report: Scoring has been reviewed and remains static; some timelines have been extended - completion dates in respect of actions relating to the first control (security provision at main hospital sites) have been pushed back from June to August and September 2021. The reference in the second control to a 'Security Group established to review workstreams' has been deleted. The associated mitigation has been updated to clarify that the V&A Case Manager is 0.8 WTE, and to reflect the fact that a plan is in place to review V&A training which, with funding, can be implemented. The gap column now includes a statement on V&A training compliance being at 41%. The Risk Lead is considering the date by which it is anticipated that the target risk score will be achieved. It is noted that the target risk score is higher than the risk appetite.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	Board / Committee: Quality, Safety and Experience Committee	Review Date: 1 July 2021
Linked to Operational Corporate Risks:		

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-13		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
		Current Risk	5	4	20	1 - 6
		Target Risk	5	2	10	
Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)		Date
Health and Safety short courses for managers and staff, and mandatory e-learning are in place, 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 (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUIHB.	2	1) 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 non 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. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented subject to business case approval.		30 September 2021 31 October 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 the Annual plan 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	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. (Welsh Government are likely to be providing additional support post 'Grenfell' to support the new Fire Bill.) 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 BCUIHB for Asbestos and Violence at work shortly. 2) Actions arising from the Legionella review to be implemented.		30 September 2021 31 October 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 820 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 BCUIHB provided on 24th October was lifted at the beginning of April. 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. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing. <u>A review of the business case has been requested by Executives to explore alternative arrangements to implement a safe system of work, including external fit testing programme.</u>		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: The controls, mitigations and timelines have been reviewed, and scores and dates remain unchanged. The reference to the Leadership and Management Training Programme has been deleted from the first control. The wording of the associated mitigation has been amended to make it clear that implementation of the plan to establish a robust safety competence and leadership training programme is subject to approval of the business case. The Risk Lead is considering the date by when it is anticipated that the target risk score will be achieved. It is noted that the target risk score is higher than the risk appetite.

Executive Lead: Sue Green, Executive Director of Workforce and Organisational Development	Board / Committee: Quality, Safety and Experience Committee	Review Date: 1 July 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 2021/22									
Strategic Priority 1: Covid 19 response									
Risk Reference: BAF21-14		Risk Rating		Impact	Likelihood		Score	Appetite	
Pandemic Exposure									
<p>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 lead to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.</p>		Inherent Risk	4	↓	5	↔	20	↓	Low 1 - 6
		Current Risk	3	↓	5	↑	15	↓	
		Target Risk	3	↓	4	↑	12	↓	
Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (actions to achieve target risk score)				Date	
Elimination (physically removing the hazard): Covid-19 vaccine programme in place. Visitors undertaking lateral flow test before visiting. Front line staff and staff that come into contact with them undertaking routine lateral flow tests.	2	Ensuring all staff, visitors and patients are double vaccinated to reduce transmission of infection in our care giving settings.	2	Getting access to data is problematic because of how data is collated e.g. people using their personal email addresses rather than their work email addresses. Need to look at a local method for understanding who is not vaccinated and ensure appropriate risk mitigation is in place to reduce risk of potential transmission to other staff and patients. Lateral flow testing has now come in-house so managers can see how many test kits are being handed to staff. Random quality assurance for staff around lateral flow to take place by managers, alongside spot checks in technique to assure test performing quality.				30 October 2021	
Substitution (replacing the hazard): A review of all buildings has taken place against new regulations/guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified. Enough isolation rooms with ensuite facilities in place to house all infected and potential infected patient. One way control through the buildings. Routine and deep cleaning in place to reduce/eliminate bioburden.	1	Review of ventilation has taken place. 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 to reduce risk of transmission	1	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, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. 3b) All modernisations or new builds to have single rooms and where this is not achievable beds achieve ISBN guidance (3.6m bed spacing). 4) Safe clean care programme has a front door improvement project running. 3) C4C audits to be further acted upon in particular the estates elements as is an infection and reputational risk.				30 September 2021 31 December 2025 31 December 2021 31 December 2021	
Engineering (reducing potential transmission): Reducing footfall in clinical settings, working from home where possible and self-isolation requirements in place. Risk assessed visitation, Flow through our buildings. Change facilities for all hospital based staff.	2	Managerial staff working from home where possible/peripatetic working. Ten day self isolation period when come into contact with a positive case where no PPE was worn e.g. outside work, breaks etc. Risk assessed visitation to our care facilities. Clear signage to areas and footfall managed by local lead.	1	1) Need to understand impact of amended WG guidance (AUG21) around self isolation and potential risk of transmission to vulnerable staff and patients. 2) Spot checks to be developed as part of the ward accreditation programme to test robustness of visiting risk assessments and compliance.					
Administrative (change the way that work is performed): Virtual ward/board rounds and visiting, Safe break improvements. Staff and patient moments reduced	1	Virtual visiting is preferred option for visiting. IPADs available for patients use. Board rounds being reviews as part of the unscheduled care transformation programme. Wandering patient project (SCC-HF Safe Action project)	1	1) Need to link in with Unscheduled Care Programme to ensure board and ward round improvements focus also on less footfall and more virtual interfaces. 2) STREAM to be operationalised throughout acute care to support virtual board and ward rounds - options appraisal developed by IT.				30 March 2021	
PPE: Adequate PPE stocks in place and maintained. Monitoring and management in place to check sufficient availability	1	PPE steering group (PPESG) and reporting into Infection Prevention Sub Group, Patient Safety & Quality Group with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality, Safety and Experience Committee.	2	Continuous PPE supply is secure. Still remain an issue with masks being upgraded / discontinued which them means all staff need to be re-fit tested on new masks. PPE meetings stood down from weekly to fortnightly now because of more secure position.				30 September 2021	
PPE: Fit testing in place to ensure the right mask to prevent avoidable infection.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG. Any escalations sent through to This is monitored via IPSP and OH&SG.	2	Trainers to be part of the local workforce. To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group.				30 September 2021	
Clear Leadership & Governance in place to support delivery of the clinical and admin improvements required to lower the risk score through embedding mitigating actions.	1	Safe Clean Care Harm Free reports through PSQB to QSE. All accountable areas have 2020/21 plans on a page they delivering against. All accountable areas have undertaken their second HARMS self assessment with underpinning assurance and where appropriate improvement actions managed through Local Infection Prevention Groups (LIPG) through to Infection Prevention Steering Group (IPSG) to QSE.	1	Recruit to key posts to support delivery out in the accountable areas of their Safe Clean Care Harm Free Infection Prevention plans on a page 2021/22. Ensure accountable areas are represented at the SCC-HF steering group meetings, to drive focus, pace and grip. Ensure standardised agendas at LIPGs to align to assurances sort by IPSG				31 October 2021	
<p>Review comments since last report: The whole BAF submission has been reviewed and updated and will mature over the coming couple of months. This month's changes consist of the first column of the risk sheet organised into a hierarchy of controls, namely Elimination, Substitution, Engineering, Administrative and PPE. References to the vaccine programme, working from home, self-isolation, virtual ward rounds and visiting arrangements have been added. Safe Clean Care Harm Free is the underpinning transformation programme to bring about a reduction in the risk score, firmly supported by Infection Prevention Steering Group which oversees assurance and delivery against agreed trajectories of all infection and actions to risk mitigate and where possible risk eliminate. All impact scores have been reduced from 5 to 4 (inherent), from 5 to 3 (current) and from 5 to 3 (target). Overall risk scores have reduced from 25 to 20, from 20 to 15 and from 15 to 12 respectively. The Risk Lead believes the impact scores have reduced because of the significant uptake of the vaccination programme, and whilst there is still a risk posed by the variants of concern (VoC) the vaccine industry is rapidly responding and updating the vaccines to cover the new VoCs. This is supported by all the evidenced IPC work that has been undertaken throughout the health board and the future plans that are in place to address gaps in control. It is also noted that the target risk score is higher than the risk appetite. However That said because of the constraints within our health system without a significant rebuild/redesign (eg a significant number of isolation rooms with ensuites) alongside radical process and practice transformation, the risk appetite of 6 is unachievable and the Risk Lead has requested that the Board reviews its appetite accordingly.</p>									
Executive Lead: Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery			Board / Committee: Quality, Safety and Experience Committee				Review Date: 10 August 2021		
Linked to Operational Corporate Risks:									

Strategic Priority 1: Covid 19 response

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps (<i>actions to achieve target risk score</i>)	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. EIMT is now phasing down (now meeting fortnightly) as business as usual returns.	2	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 are being implemented. Surge plans/winter resilience plans are being tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Fully updating Updating of all business continuity and escalation plans. 2) Decommission Ysbytai Enfys in Bangor and Llandudno. 3) Deeside to be retained as local vaccination centre and for surge capacity.	31 Aug 2021 31 July 2021 31 March 2022
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 now stood down but reporting continues through EIMT for significant decisions.	2	1) 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) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Updating of programme plans and development of new plans in response to new Welsh Government guidance as it arises. 2) Prevention and response plan to be refreshed with partners. [Update 12.7.21 - now complete; will become a mitigation]	31 July 2021 Complete
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2		
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. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic.	30 September 2021
Executive Incident Management Team has been established and is meeting as required (frequency dropped since original inception), with formal reporting to the Board as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via 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 has stood down. Recovery Co-ordinating Group remains in place and is continuing surveillance and managing recovery. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis. Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery.	3	1) Prevention response plan to set out remobilisation. [Update 12.7.21 - Plan approved; will become a mitigation, noting that there are gaps in capacity across all partners organisations to respond to rising community transmission, and also to respond to easing of restrictions at a different pace across the border]	[next review point 31 July]

Executive Lead: Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery			Board / Committee: Quality, Safety and Patient Experience Committee		Review Date: 12 July 2021
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Linked to Operational Corporate Risks:

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability that the risk will be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Control	Definition	<p>These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.</p> <p>A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]</p> <p>A measure that maintains and/or modifies risk (ISO 31000:2018(en))</p>
	Examples include, but are not limited to:	<ul style="list-style-type: none"> - People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	<p>This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).</p>
	Examples include, but are not limited to:	<ul style="list-style-type: none"> - A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Trained staff - Insurance procured
Assurance Levels	1	<p>The first level of assurance comes from the department that performs the day to day activity, for example the data is available</p>
	2	<p>The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance</p>
	3	<p>The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE, and Internal/External Audit etc.</p>

Appendix 3 – Full list of BAF risks with nominated Committee, Executive Lead and Risk Lead

BAF ref	BAF Risk	Exec Owner/ Risk Lead	Assurance Committee	Risk Score	Target Risk Score
BAF21-01	Emergency Care	Gill Harris, Meinir Williams	QSE	16	12
BAF21-02	Sustainable key health services	Teresa Owen Gwyneth Page	SPPH	15	10
BAF21-03	Primary Care sustainable health services	Chris Stockport, Clare Darlington	SPPH	20	12
BAF21-04	Timely Access to planned care	Mark Wilkinson, Andrew Kent	F&P & QSE	20	12
BAF21-05	Mental Health-effective stakeholder relationships	Teresa Owen, Amanda Lonsdale	SPPH	9	4
BAF21-06	Safe and effective Mental Health delivery	Teresa Owen, Mike Smith	QSE	20	9
BAF21-07	Mental Health leadership model	Teresa Owen, Carole Evanson	QSE	15	8
BAF21-08	Mental Health service delivery during pandemic	Teresa Owen, Carole Evanson	QSE	9	6
BAF21-09	Infection Prevention and Control	Gill Harris, Sally Batley	QSE	16	12
BAF21-10	Listening and Learning	Gill Harris, Matt Joyes	QSE	20	10

BAF21-11	Culture	Sue Green, Ellen Greer	QSE	16	12
BAF21-12	Security Services	Sue Green, Peter Bohan	QSE	20	10
BAF21-13	Health & Safety	Sue Green, Peter Bohan	QSE	20	10
BAF21-14	Pandemic exposure	Gill Harris, Sally Batley	QSE	15	12
BAF21-15	Value Based Improvement Programme	Sue Hill, Geoff Lang	F&P	12	8
BAF21-16	Digital estates and assets	Chris Stockport, Dylan Williams	DIGC	20	12
BAF21-17	Estates and assets development	Mark Wilkinson, Rod Taylor	F&P	9	6
BAF21-18	Workforce optimisation	Sue Green, Nick Graham	F&P	16	12
BAF21-19	Impact of Covid-19	Gill Harris, Sally Baxter	QSE	12	8
BAF21-20	Annual Plan	Mark Wilkinson, John Darlington	SPPH	6	3
BAF21-21	Delivery of a planned annual budget	Sue Hill, Rob Nolan	F&P	15	10
BAF21-22	Estates and assets	Mark Wilkinson, Neil Bradshaw.	F&P	15	10

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7 th September 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Authors:	Justine Parry, Assistant Director: Information Governance and Risk David Tita, Head of Risk Management
Craffu blaenorol: Prior Scrutiny:	Risk Management Group on the 16 th August 2021 Executive Team on the 25 th August 2021
Atodiadau Appendices:	Appendix 1 – QSE Corporate Tier 1 Operational Risk Report Appendix 2 – QSE Operational Risks for Escalation Appendix 3 – Corporate Risk Register Key Field Guidance / Definitions of Assurance Levels

Argymhelliad / Recommendation:

That the Committee:-

1. Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1:

CRR20-01:

- a) **Note** the Risk Management Group (RMG) recognise the progress in implementing actions including the update of the Policy and Management Procedure for the management of Asbestos across the Health Board, in addition to the Estates and Facilities (E&F) team continuing to work through the actions identified within the Corporate Health & Safety (H&S) Gap Analysis Action Plan. The RMG also noted that a draft Internal Audit report has been received for statutory asbestos management, which provides a reasonable level of assurance to the Health Board on asbestos management and compliance.
- b) **Approve** the reduction in the current risk rating score from 20 (Impact = 5 X Likelihood = 4) to 10, which will imply (Impact = 5 X Likelihood = 2). The Asbestos Management Group is making progress to reduce the risk score and therefore based on the above progress that has been made in mitigating and managing the risk of asbestos, the Director of Estates and Facilities has recommended for a reduction in the current score. Both RMG and the Executive Team (ET) at their meetings of 16th and 25th August respectively, supported and recommended approval for the reduction in the current score.

CRR20-02:

- a) **Note** the RMG recognise the progress in implementing actions which include the update of the Control of Contractors Guidance document which was approved at the Strategic Occupational Health Group meeting on 3rd August 2021. Funding has been approved for procuring the SHE software to facilitate with contractor management and we have now selected a suitable framework to purchase it. The Data Protection Impact Assessment (DPIA) has been completed and submitted to Information Governance. It has now been returned to Operational Estates for

consideration of comments captured. In addition the operational procedure for the control of contractors has been updated whilst waiting for the SHE software.

- b) **Approve** the reduction in the current risk rating score from 20 (Impact = 5 X Likelihood = 4) to 15, which will imply (Impact = 5 X Likelihood = 3). Based on the aforementioned progress that has been made in mitigating and managing this risk and taking cognizance of the controls in place, the Director of Estates and Facilities has recommended for a reduction in the current score of this risk. Both RMG and ET at their meetings of 16th and 25th August respectively, supported and recommended approval for the reduction in the current score.
- c) **Note** the update to the action due dates (as they had initially been assigned the same date throughout) as advised by the RMG and approved by ET. The Director of Estates and Facilities has updated the due dates of the following as detailed in Appendix 1:- 12254, 12255, 12256, 12258, 12259 and 12260.

CRR20-03:

- a) **Note** the RMG recognise the progress in implementing actions which includes presentation of the updated Water Safety Policy at the Strategic Occupational Health and Safety Group on 3rd August 2021. Estates and Facilities are progressing with the development and mobilisation of the Water Safety Plan. Discretionary funding has been allocated to improve compliance with Water Safety.
- b) **Approve** the reduction in the current risk rating score from 20 (Impact = 4 X Likelihood = 5) to 16, which will imply (Impact = 4 X Likelihood = 4). Based on the aforementioned progress that has been made in mitigating and managing this risk and taking cognizance of the controls in place, the Director of Estates and Facilities has recommended for a reduction in the current score of this risk. Both RMG and ET at their meetings of 16th and 25th August respectively, supported and recommended approval for the reduction in the current score.
- c) **Note** the update to the action due dates as advised by the RMG and approved by ET. The Director of Estates and Facilities has updated the due dates of the following as detailed in Appendix 1:- 12263, 12264, 12265, 12266, 12268, 12269 and 12270.

CRR20-04:

- a) **Note** the RMG recognise the progress in implementing actions which includes completion of the annual 2020/21 Fire Audit Returns which are required by specialist Estate Services as part of an All Wales Annual return, an Independent review of Fire Safety Precautions at Eryri Hospital undertaken by an authorising engineer from Shared Service Partnership (NWSSP – Specialist Estates Services) reveals 36 recommendations with 9 in red which all reflect things we are aware of and are progressing via an action plan. A Fire Officer for the East Area has been appointed to post and a programme of work funded by EFAB (Estate Funding Advisory Board) has been instigated to address the items identified in the most recent fire Audit that was undertaken by the Health Board's Fire Adviser.
- b) **Approve** the reduction in the current risk rating score from 20 (Impact = 4 X Likelihood = 5) to 16, which will imply (Impact = 4 X Likelihood = 4). Based on the aforementioned progress that has been made in mitigating and managing this risk and taking cognizance of the controls in place, the Director of Estates and Facilities has recommended a reduction in the current score of this risk. Both RMG and ET at their meetings of 16th and 25th August respectively, supported and recommended approval for the reduction in the current score.
- c) **Note** the update to the action due dates as advised by the RMG and approved by ET, the Director of Estates and Facilities has updated the due dates of the following as detailed in Appendix 1:- 12273, 12274, 12275, 12279 and 12555.

CRR20-05:

- a) **Note** the RMG recognise the progress in completing and implementing actions and recommended that the due dates in `red` for delayed actions be considered and revised with the service. RMG recommended further work was undertaken to capture further actions to support any reduction in the current score, given that the number of Covid-19 cases in Care Homes/Domiciliary workforce is creeping up again. RMG did not feel two actions remaining was sufficient to achieve the target score of 6.
- b) **Note** the completion of the actions 14939, 14940, 14942, 14948, 14951 and 14954 so that they can be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.
- c) **Note** the extension to the due dates of the following actions: 14943 and 14949. Extension of due date for 14949 will facilitate implementation of the Quality Assurance Framework which has been designed.

CRR20-08:

- a) **Note** the RMG recognise the progress in implementing actions including the insourcing work that has been done in ophthalmology. The group also noted that this risk is linked to Board Assurance Framework risk on Planned Care. Therefore contact will be made with other risk lead offices from services like urology to discuss appropriate management and escalation of their risks.
- b) **Note** the completion of the action 14907 so that it can be archived and removed from the next report, recognising that its implementation will be captured as part of the controls within the next iteration of the risk.

CRR21-13:

- a) **Note** risk ID1976 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce) which was approved by the QSE on 6th June 2021 and which has been added onto the CRR and Tier 1. The RMG recognise the progress in implementing some of the actions and approved a request for an extension of the due date for action 15635 from 01/07/2021 to 30/09/2021.
- b) **Note** the extension to the due date for 15635 to allow completion and approval of the business case.
- c) **Note** the completion of the actions 15633, 15634, 17279, 17280, 17281 and 17434 so that they can be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

2. Approve the following new risks which are being presented following escalation approval from the RMG and ET for escalation onto the Tier 1 Operational Risk Register as set out below and in detail at Appendix 2:

- a) Risk ID 4024 - **The potential risk of delay in timely assessment, treatment and discharge of young people accessing Child & Adolescent Mental Health Services (CAMHS) out-of-hours.**
- b) Risk ID 3893 – **Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.**
- c) Risk ID 3766 – **There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.**
- d) Risk ID 2548 - **There is a risk that the increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.**

Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	Ar gyfer Trafodaeth For Discussion	✓	Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N to indicate whether the Equality/SED duty is applicable							
N							
<p>The Corporate Risk Register (CRR) demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.</p> <p>The design of both the Board Assurance Framework (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, the BAF is reported separately.</p> <p>Each Corporate Risk has been reviewed and updated. The full CRR will next go to the Board in January 2022.</p>							
Cefndir / Background:							
<p>The implementation of 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 CRR reflects the Health Board's continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.</p> <p>Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees.</p>							
Corporate Risk Register:							
<p>The Board ratified the Health Board's updated Risk Management Strategy and Policy on 15th July 2021 and the Corporate Risk Management Team continues to implement the Strategy which has been widely populated across the Health Board through global emails, weekly bulletins, local Quality and Safety meetings or governance meetings and training sessions.</p> <p>Changes captured in updated Strategy include:-</p> <ul style="list-style-type: none"> • A simplification of the Health Board's vision and strategic approach to risk management. • A clarification of the Health Board's risk appetite statement and an inclusion of one for use during extreme circumstances like pandemics. • Focus on developing staff capacity and capability in risk management while encouraging exemplary leadership in creating an enabling environment for a positive risk-aware culture to flourish. • Greater emphasis on encouraging an agile, dynamic, comprehensive and a horizontal collaborative approach to risk management. • Good use of risk intelligence in informing better decision-making, continuous improvement in 							

patient care, outcomes and strengthening organisational learning.

The current tier 1 risks for QSE Committee oversight and their full details and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	Movement*
CURRENT RISKS – appendix 1				
CRR20-01 - Asbestos Management and Control	20	20	8	Unchanged
CRR20-02 - Contractor Management and Control	20	20	8	Unchanged
CRR20-03 – Legionella Management and Control	20	20	8	Unchanged
CRR20-04 - Non-Compliance of Fire Safety Systems	20	20	8	Unchanged
CRR20-05 – Timely access to Care Homes	25	20	6	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	25	20	6	Unchanged
CRR21-13- Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	20	16	6	Unchanged
ESCALATED RISKS – appendix 2				
Risk ID 4024 - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	20	16	8	New Risk
Risk ID 3893 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	20	16	4	New Risk
Risk ID 3766 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	20	16	12	New Risk
Risk ID 2548 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	25	20	6	New Risk

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

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

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR20-03 CRR20-04 2548	
	Likely - 4				CRR21-13 4024 3893 3766	CRR20-01 CRR20-02 CRR20-05 CRR20-08
	Possible - 3					
	Unlikely - 2					
	Rare - 1					

Asesiad / Assessment & Analysis

Strategy Implications

The implementation of the 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

Continuing with Corporate Risk Register.

Financial Implications

The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

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 Risk Management Strategy and Policy.

Impact Assessment

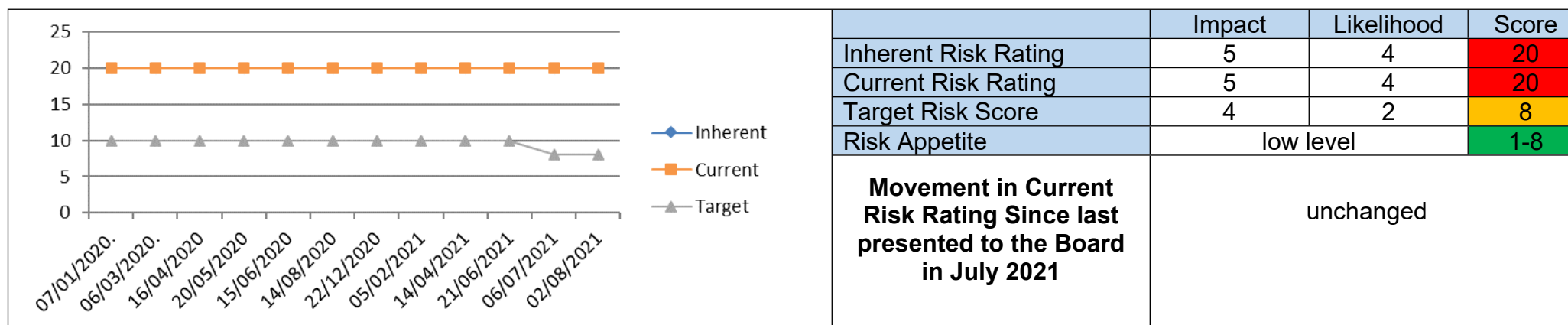
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which CRR reports are aligned.

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

Appendix 1 – QSE Corporate Tier 1 Operational Risk Report

CRR20-01	Director Lead: Executive Director of Planning and Performance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 02 August 2021
	Risk: Asbestos Management and Control	Date of Committee Review: 06 July 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.



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Asbestos Policy in place. 2. A number of surveys undertaken. 3. Asbestos management plan in place. 4. Asbestos register available. 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. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Gaps in Controls/mitigations

1. We are unable to achieve compliance with awareness and training as not everyone is able to undertake the training within a specified timescale.
2. There is a weakness that our asbestos management surveys don't define all locations of asbestos containing materials.

Progress since last submission

We have updated the Policy and Management Procedure for Asbestos across the Health Board. We are currently working through the actions identified within the Corporate H&S Gap Analysis Action Plan. We have completed 7 out of the 12 actions for improvement which improve our overall compliance score.

Links to

Strategic Priorities

Effective use of our resources
Safe, secure & healthy environment for our people

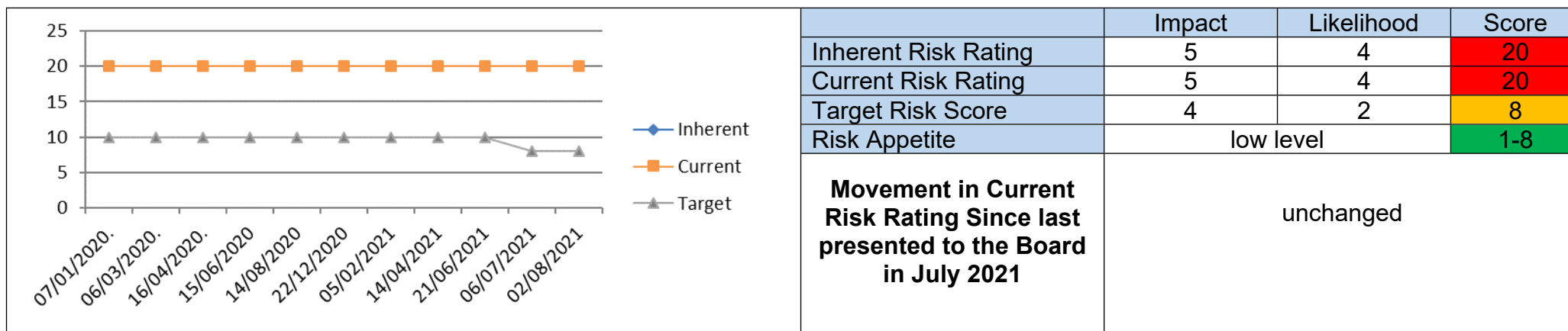
Principal Risks

BAF21-13
BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk	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	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On track

score	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	Creating staff awareness of the presence of asbestos thus reducing may potential impact.	On track
	18298	To develop and implement a Management Action Plan in response to the Internal Audit report.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	The Management Action Plan will support current mitigation and management of the risk.	On track

CRR20-02	Director Lead: Executive Director of Planning and Performance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 02 August 2021
	Risk: Contractor Management and Control	Date of Committee Review: 06 July 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.		



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

Gaps in Controls/mitigations

1. We may fail to adhere to the Health Board's Control of Contracts Management Guidance due to lack of training and awareness.
2. Due to the complexity and number of projects undertaken by the contractors, there is a weakness that the Health Board has insufficient management capacity to safely manage contractors on Site.

Progress since last submission

We have now completed the review and updated the Control of Contractors Guidance document which has been approved by the Strategic Occupational Health Group at their meeting on 3rd August 2021. Funding has been secured to procure the SHE software and the operational procedure for the Control of Contractors has also been updated whilst awaiting the implementation of the SHE Software.

Links to

Strategic Priorities

Safe, secure & healthy environment for our people

Principal Risks

BAF21-13

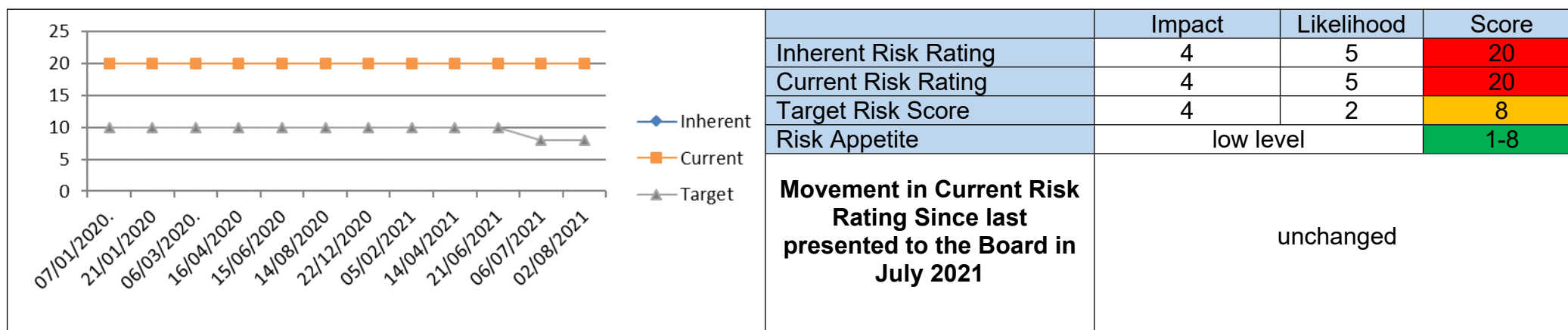
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S 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

	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 New due date suggested for 31/01/2022	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.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 31/01/2022	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 New due date suggested for 31/01/2022	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	On track

					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.	
	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 New due date suggested for 31/03/2022	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 New due date suggested for 31/03/2022	A Permit to Work system will be adopted as part of implementation of SHE software.	On track
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 31/05/2022	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	On track

					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.	
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	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

CRR20-03	Director Lead: Executive Director of Planning and Performance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 02 August 2021
	Risk: Legionella Management and Control	Date of Committee Review: 06 July 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.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and 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. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

9. Internal audit of compliance checks for water safety management regularly undertaken.	
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Gaps in Controls/mitigations
<p>1. There is a weakness that little used outlets are not reported to Estates for management and control. e.g. we can have a ward shower temporarily used as a store, therefore it isn't part of Estate flushing programme.</p> <p>2. There is a weakness that alterations to pipe works are not undertaken with consent from local Estate Water Management Team. However, this has been mitigated through implementation of the Permit to Work System.</p>

Progress since last submission
We have now re-written and updated the Water Safety Policy and Plan which will be presented to the Strategic Occupational Health and Safety Group.

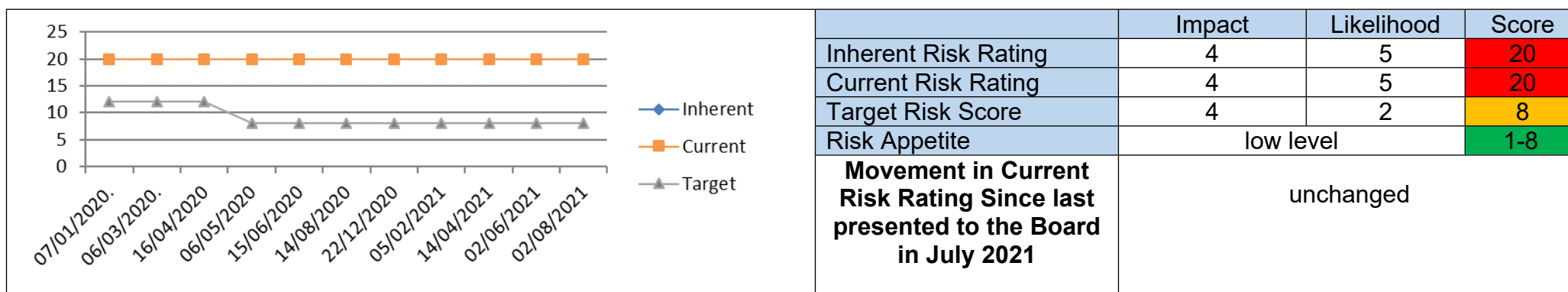
Links to Strategic Priorities	Principal Risks
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13 BAF21-17

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

	12263	Departments to have information on all outlets 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 New due date suggested for 30/06/2022	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 New due date suggested for 30/06/2022	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 New due date suggested for 31/12/2021	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 New due date suggested for 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 New due date suggested for 30/11/2021	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	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 29/10/2021	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	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 31/01/2022	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: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 02 August 2021
	Risk: Non-Compliance of Fire Safety Systems	Date of Committee Review: 06 July 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.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Fire risk assessments in place. 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. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. Insufficient revenue funding to maintain compliance with fire equipment and infrastructure. 2. Insufficient capital to upgrade fire detection and compartmentalisation of the fire safety infrastructure.

Progress since last submission

Estate and Facilities has completed the annual 2020/21 Fire Audit Returns which are required by specialist Estate Services as part of an All Wales Annual return.

Links to**Strategic Priorities****Principal Risks**

Effective use of our resources

Safe, secure & healthy environment for our people

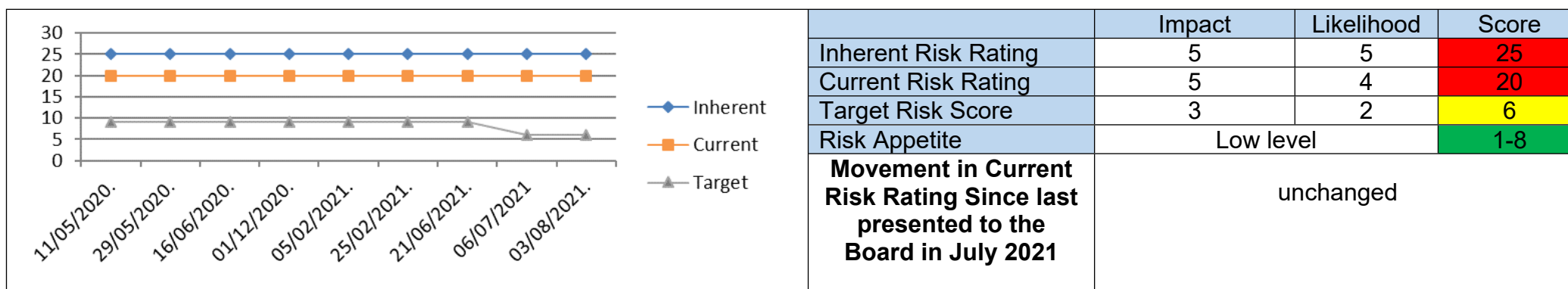
BAF21-13

BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 31/12/2021	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 New due date suggested for 31/03/2022	Escalation through Hospital Management Teams, Area Terms and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding.	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 New due date suggested for 30/06/2022	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 New due date suggested for 30/11/2021	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 commissioned 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 is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022 New due date suggested for 29/04/2022	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	Fire Risk Assessments in place Pan BCUHB.	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: 03 August 2021
	Risk: Timely access to care homes	Date of Committee Review: 06 July 2021
		Target Risk Date: 31 December 2021
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



Controls in place	Assurances
<ol style="list-style-type: none"> Multi-agency care home cell established as part of the emergency planning arrangements. PPE distribution system operational including identification and support for residents with aerosol generating procedures. Testing for residents and staff in place aligned with national guidance. Unified "One contact a day" data gathering from care homes established with 6 Local Authorities. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. Personalised care and support plans promoted led by specialist palliative care team. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. Remote consulting offered by general practice. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making 	<ol style="list-style-type: none"> Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). Oversight via Gold and Silver Strategic Emergency Planning. Oversight as part of the Local Resilience Forum via SCG. Oversight by the Recovery

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.	Group.
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Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. PHW has now pulled out of the MDTs which they used to attend daily and Chaired but we can now contact them if we have a problem. 2. The representation on the Care Home Cells didn't have discharge coordinators on but this is being reviewed at the moment. 3. It remains unclear who is leading on outbreaks in Independent Hospitals which are mainly MH hospitals. 4. There is a massive shortage in accessing domiciliary care support. 5. There is a real issue sorting out staff for Agency last minute cancellation when a home turns red or has a positive case. 6. Changes in Government Strategy is affecting the Nursing Homes.

Progress since last submission
We have successfully managed the outbreaks in Care Homes and we have worked really closely with Environmental Health Officers in the Local Authorities to create infection control support and advice to Care Homes. The role of the Clinical Leads in the MDT and in general, providing advice to Care Homes and dealing with other issues of Covid-19 has been established. A strong working relationship with Local Authorities has been established.

Links to Strategic Priorities	Principal Risks
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14939	Complete and implement a North Wales care home escalation and support tool.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	<p>ACTION CLOSED 03/08/2021</p> <p>This will help eradicate delays in discharge through better co-ordination.</p> <p>Tool has been designed and is being used.</p>	Complete

	14940	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	ACTION CLOSED 01/06/2021 Ongoing weekly reviews will ensure that regular guidance is shared and implemented to reduce the risk likelihood of the risk re-occurring.	Complete
	14942	Develop communication with care homes at a local level and across North Wales.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	ACTION CLOSED 03/08/2021 This will help eradicate delays in discharge through better co-ordination. Weekly Care Homes Briefs and Weekly/regular phones with Local Authorities)	Complete
	14943	Deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	02/08/2021	This action will support access to care homes.	Delay
	14948	Diversion of CHC priorities.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	ACTION CLOSED 28/06/2021 This will help eradicate delays in discharge through better co-ordination. This facility remains in place in principle in the event of a significant further covid wave, but are currently no longer required. Long term business cases are in development to support the dual functions with appropriate structures in CHC teams for a) CHC reviews and b) commissioned provider support to run in parallel effectively as business as usual.	Complete

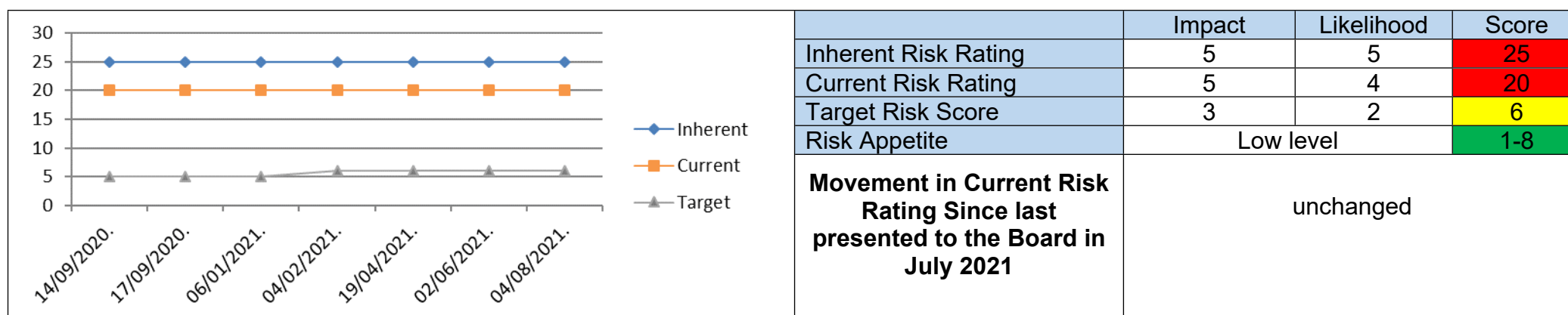
	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021 New due date requested: 28/02/2022	This will help eradicate delays in discharge through better co-ordination. Draft framework is in place and we have setup 6 different work streams to implement the various strands of the Quality Assurance Framework. Requesting extension of completion date until 28/02/2022 to facilitate implementation)	Delay
	14951	Increase MDT Care Home group to weekly or as the need arises due to C-19 pressures.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/06/2021	ACTION CLOSED 01/03/2021 This will help eradicate delays in discharge through better co-ordination.	Complete
	14954	Contribute to the development and implementation of national guidance.	Kathryn Titchen, Commissioning Manager CHC	30/06/2021	ACTION CLOSED 02/07/2021 This will support the quality of provision in care homes and reduce demand on unscheduled care.	Complete
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	It will improve patient flow by enabling patients to be discharged to their own homes.	On track
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/12/2021	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.	On track



for Independent
Providers.



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: 04 August 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Date of Committee Review: 06 July 2021
		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 through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 	<ol style="list-style-type: none"> 1. Risk is regularly reviewed at local Quality and Safety meetings.

4. More clinic slots are being made available to accommodate clinically pressing patients	
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Gaps in Controls/mitigations	
<p>1. They are continuing to stratify patients into R1, R2 and R3 to enable prioritisation of permanent sight lost. However, further table-top risk stratification is challenged by reduced OBD (Office Based Decision) making by clinicians as a consequence of their return to expanded clinical activities.</p> <p>2. Surgery has recommenced but the Pan-BCU cataract PTL (to reduce inequality) has yet to be operationalised.</p> <p>3. Diabetic retinopathy in place in two of the three Sites with West Site still to achieve flow to Primary Care.</p> <p>4. Current partnership pathways which mitigate waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical conditions, however, a significant number of patients do not have a clinical conditions logged on the system (Central 2290; East 3600 and West 910).</p>	

Progress since last submission	
<p>1. Partnership data gathering with Primary Care have progressed from quarter four 2020 till date with two out of the three Sites delivering pathways for glaucoma patients and two of three Sites for diabetic retinopathy.</p> <p>2. All the three Sites have now recommenced one-stop cataract clinics (with expansion of sessions via two out of three Sites).</p>	

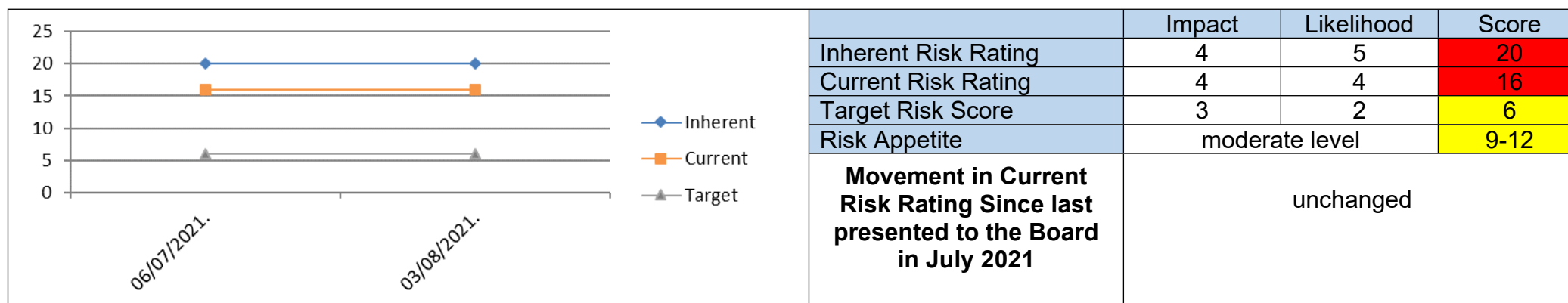
Links to	
Strategic Priorities	Principal Risks
Continuing to provide care under 'essential' services & safe stepping up planned care	BAF21-02 BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14907	Age related macular degeneration – A business case is awaiting approval to increase staffing and treatment capacity. The resources have been identified in the HBs Annual Business Plan for 2021/22 and is being progressed to final approval stages.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	ACTION CLOSED 31/03/2021. This action will enable the service to robustly mitigate and manage this risk to its target score.	Complete
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals are being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Eoin Guerin, Consultant Ophthalmologist	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On track

CRR21-13	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee Quality and Safety Group	Date Last Reviewed: 03 August 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	Date of Committee Review: 06 July 2021
		Target Risk Date: 30 December 2022

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. 2. Double sign off of nursing rosters to ensure effective deployment. 3. Nurse staffing policy outlines standards and escalation. 4. Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. 	<ol style="list-style-type: none"> 1. Risk is regularly reviewed and monitored at the Site Quality and Safety meeting. 2. Review exercise of all nurses working in corporate services and elsewhere with the Health Board.

5. District Nursing principle compliance review undertaken bi annually in line with AW approach 6. Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to QSE/Board. 7. Workforce recruitment and retention strategy in place. 8. Recruitment and Retention operational group insitu with HB wide representation 9. Targeted Recruitment Campaign for Band 5 nurses developed and rolled out 10. Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information 11. International Nurse recruitment programme in place informed by data analysis 12. Clinical Fellows for Nursing programme being rolled out 13. AND appointment to lead and support nurse recruitment. 14. Workforce/Service planning process to triangulate requirements. 15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable. 16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. 17. MDT staffing support across the Health Board during surge due to inability to respond to demand 18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity.	3. Risk is regularly reviewed and monitored at the Senior Nursing Meeting.
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Gaps in Controls/mitigations

1. There is inconsistency adherence to the rostering Policy in relation to application of rotas, approval and KPIs. e.g. Annual Leave.
2. There is heavy reliance on paper-based rotas rather than electronic rotas which lead to manual checking of staffing on daily basis which wastes time and less efficient.
3. Not all Nursing staff Groups are on electronic Rotas and not everyone is IT savvy, hence a lack of system support leads to poor housekeeping which could lead to inaccurate data.

Progress since last submission

Lead for focus in recruiting to nursing vacancies has been appointed. There has been the HEIW have confirmed commissioned provision for registrants at Glyndwr University, hence there will be two campuses for nursing education. The Open University pathway numbers have been increased.

Links to Strategic Priorities		Principal Risks
Continuing to provide care under 'essential' services & safe stepping up planned care Effective use of our resources Safe unscheduled care		BAF21-02 BAF21-09 BAF21-11 BAF21-18

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	15633	Analysis of current vacancy, turnover and recruitment data to better inform recruitment intentions.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/05/2021	ACTION CLOSED 31/5/2021.	Complete
					Gain a clear understanding of the current position which will help drive the way forwards in terms of mitigating the risk. A new suite of metrics have been developed that better inform our current vacancies, but also enable us to forecast future trends taking planned recruitment activity into account. In having this information, we can monitor performance on our recruitment campaigns and take timely action when necessary. A new suite of metrics have been developed that better inform our current vacancies, but also enable us to forecast future trends taking planned recruitment activity into account. In having this information, we can monitor performance on our recruitment campaigns	

					and take timely action when necessary.	
	15634	Development of a clinical fellowship model for nursing.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/05/2021	ACTION CLOSED 31/5/2021. This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This is a further pipeline for staff into the organisation, it is an attraction method which in turn will also support retention.	Complete
	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	01/07/2021 Request extension till 30/09/2021 to enable completion of action.	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register.	Delay
	17279	Extension of the International Nurse Programme.	Mr Nick Graham, Workforce Optimisation Advisor	01/07/2021	ACTION CLOSED 01/07/2021. The pipeline of international recruits has been developed and strong links with overseas partners have been created. The anticipated	Complete

					<p>approval of extending this programme will see new recruits joining each month through to spring 2022, offering a consistent and manageable number of nurses to integrate into our workforce.</p> <p>This action will assist to create a sustainable workforce in the longer term whilst continuing to recruit nationally.</p> <p>The pipeline of international recruits has been developed and strong links with overseas partners have been created. The anticipated approval of extending this programme will see new recruits joining each month through to spring 2022, offering a consistent and manageable number of nurses to integrate into our workforce.</p>	
	17280	Put in place a targeted specialist recruitment campaign Band 5 nurses.	Mr Nick Graham, Workforce Optimisation Advisor	30/07/2021	<p>ACTION CLOSED 30/07/2021.</p> <p>We have enlisted the support of a specialist company to run a comprehensive marketing campaign. To date, the marketing material has been created and the campaign is due to launch in the early July.</p> <p>A further campaign has been initiated for Mental Health and Learning Disability division, which includes CAMHS, to increase our numbers of mental health trained staff, across a range of staff groups. A key factor in this is that a new team will be established which can</p>	Complete

					<p>be mobilised to respond to situations more readily.</p> <p>To assist this campaign, a new SharePoint site of online guidance and material has been created that supports our recruiting managers.</p> <p>Moreover, a series of proposals to streamline the recruitment process have been taken forward which will shorten the time it takes to recruit, but also reduce the admin burden on Ward managers.</p> <p>This action will assist with creating and delivering an innovative, digital attraction strategy and help limit the over-reliance on temporary agency staff.</p> <p>To assist this campaign, a new SharePoint site of online guidance and material has been created that supports our recruiting managers.</p> <p>Moreover, a series of proposals to streamline the recruitment process have been taken forward which will shorten the time it takes to recruit, but also reduce the admin burden on Ward managers.</p>	
	17281	Introduce targeted monitoring across rosters, through KPI management to reduce	Mrs Alison Griffiths, Associate Director of	30/07/2021	<p>ACTION CLOSED 30/07/2021.</p> <p>A new suite of metrics are in development to provide a clearer picture of how rosters are</p>	Complete

		agency expenditure and maximise substantive staff usage.	Nursing Workforce		<p>being managed, which in turn will enable us to monitor staffing levels for patient safety and staff wellbeing. These metrics will link roster data together with recruitment and temporary staffing information to provide a rounded picture of wards in difficulty.</p> <p>This action will put in place a formal Review and Approve process to maximise e-Rostering efficiency and support the creation of safe and effective rosters in line with Health Board KPIs.</p>	
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	<p>This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.</p>	On track
	17434	Review of band 4 roles across the HB as to maximising opportunity.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/08/2021	<p>ACTION CLOSED 03/08/2021.</p> <p>This action will continue to further develop career pathway opportunities and aid stability within the current workforce.</p>	Complete

	17508	Development of collaborative Career Clinics supported by Workforce & Organisational Development.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/08/2021	This action will continue to further develop career pathway opportunities and aid stability within the current workforce.	On track
	17509	Exploration of the Global Learning Programme.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/08/2021	<p>The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS</p> <p>This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development.</p>	On track

Appendix 2 – QSE Operational Risks for Escalation

4024	Director Lead: Executive Director of Primary and Community Care.	Date Opened: 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee.	Date Last Reviewed: 18 August 2021
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Date of Committee Review: New Risk
		Target Risk Date: 31 March 2022

There is a risk that young people in crisis presenting out of hours with suicidal behaviour/ideation and actual self-harm to our Emergency Departments and Paediatric wards and those detained under a s136 may not always receive timely access to CAMHS assessment and treatment to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:

- Current operational hours of CAMHS is 9am-5pm over 7days a week.
- CAMHS psychiatrists are limited in how they can respond out of hours to complete a s136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section which is not available out of hours.
- increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
- crisis presentations to ED with associated social care placement breakdowns leading to young people who are deemed medically fit for discharge, remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
- awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environment within Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered age appropriate they are also not designed to meet this type of need within their environments. This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	2	8
	Risk Appetite	Low Level		1-8

	Movement in Current Risk Rating Since last presented to the Board in - To be populated following approval	New Risk
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Controls in place	Assurances
<ol style="list-style-type: none"> 1. Local individual risk assessment which includes environmental factors undertaken by nursing staff as part of the Paediatric admission process. 2. CAMHS practitioners provide a 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 3. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 4. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5 pm for young people up to their 18th birthday and out of hours telephone on-call rota. 5. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 6 Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 7. Safeguarding discharge SOP for young people in place. 8. Daily SITREP reporting and regular safety meetings (3 x weekly) held between Paediatrics and CAMHS. 9. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements. 10. 1:1 care provided on wards/s136 suite to ensure enhanced provision and safety of the young person. 	<ol style="list-style-type: none"> 1. A scoping exercise or SBAR of CAMHS Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed and managed Regionally within a Pan-BCU approach. 3. Risk also regularly discussed at the Area - Quality and safety groups. 4. Risk controls, mitigation and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. Inability to meet growing demand in crisis presentations fully which has been exacerbated by the lockdown arising from Covid-19. 2. Lack of suitable LA placements or shared safe environments within which young people can be assessed or discharged to 3. Lack of agreed criteria, threshold and standardisation for reporting related incidents.

Progress since last

New risk. This section will be populated in the next iteration.

Links to**Strategic Priorities****Principal Risks**

Effective Use of our resources.
Safe integration and improvement of Mental Health Services.

BAF21-01
BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways.	On Track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to meet the needs of young people before a crisis occurs as most of their needs are psycho-social and not just MH.	On Track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Martin McSpadden, Head of Nursing	29/10/2021	Ensure a safe environment by identifying all ligature points on the ward.	On Track

	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will enable us to provide more out-of-hour response.	On Track
	17963	Task and Finish Group to review SCH03 policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On Track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ A&E staff, Local Authority and North Wales Police	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On Track
	18334	Identification and development of suitable shared (non-hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	On Track

3893	Director Lead: Executive Director of Workforce and Organisational Development	Date Opened: 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 18 August 2021
	Risk: Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Date of Committee Review: New Risk
		Target Risk Date: 20 June 2023
There is a risk that insufficient Manual Handling training could lead to staff and patient injury, lost work time, HSE enforcement action (current related Improvement Notice for Patient Falls) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, particularly in the West region, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	1	4
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - To be populated following approval	New Risk		

Controls in place	Assurances
<ol style="list-style-type: none"> 1. An additional trainer recruited via Bank to provide additional training sessions. 2. A blended approach has been put in place for inanimate load handling, although this does not meet the practical requirements outlined within module B of the Passport. 3. Face to face training stopped in March 2020, recommenced in July 2021 although the numbers of trainees reduced to 6 in-line with social distancing rules and the Covid secure environment. 4. ESR bookings for courses for staff to self-book onto sessions, right up to the day of courses is 	Initial review at the Strategic Occupational Health and Safety Group 25.05.21 and agreement to escalate at the SOHS Group 03.08.21.

now available.	
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Gaps in Controls/mitigations

1. Additional trainer is currently working through bank and they are not contractually obliged to attend for work. This is a weakness for the provision of training, as may result in reduced capacity if no hours worked.
2. Training particularly in the West region has been impacted by a lack of training venues. The last dedicated training space in Llandudno Hospital has now been recalled for use, rendering it unavailable for training/office use for both trainers.
3. The All Wales Passport sets minimum standards for training, with module B of inanimate load requiring practical training. The current blended approach does not allow for module B practical to be covered, but does cover all other elements required for module A & B from the Passport.
4. Numbers reduced due to social distancing requires increased classes to be offered and ensure the numbers of staff requiring training can attend. This is difficult to achieve without training rooms and additional trainers.
5. Difficulties in ordering of ppe through Oracle and delivery from central point to other training rooms. This is relied on trainers informing when stock level is low, ordering without delays through Oracle and stock being available.
6. ESR systems not easy to use. Staff often ring trainers or email for help to book onto courses. ESR contact emails not always up to date, unable to contact attendees booked of changes to session booked or cancelled courses.
7. Review the rate of DNA's and evaluation of causes of none attendance is a gap in the system.
8. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the MH Passport Scheme. The business case has been agreed for two years but this remains a gap in the controls until recruitment has been agreed. Current compliance for Patient Handling refresher is now at 58%.

Progress since last submission

New risk. This section will be populated in the next iteration.

Links to

Strategic Priorities	Principal Risks
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Safe, secure & healthy environment for our people	BAF21-13
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Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
					ACTION CLOSED - 19/07/2021	Complete
	17594	Insufficient training rooms.	Ms Jillian B-J Hughes, Manual Handling Manager	30/09/2021	<p>1. The additional rooms will allow the manual handling department to provide mandatory training for staff and increase compliance for manual handling to the targeted 85% required.</p> <p>2. Having clinical band 6 trainers will provide BCUHB with the correct level of qualified staff as per the All Wales Passport for people handling, along with the minimum standard on ratio of trainers to attendee for classes.</p> <p>5. Completing a training needs analysis to target areas that would benefit from training first. Those that have high Datix reports with training issues in inanimate load handling, or areas with patients that may require more assistance with people handling. These areas targeted to provide training earlier should result in reduced Datix, reduced potential injuries and possible work related sickness from a musculoskeletal injury.</p>	
Actions being implemented to achieve target risk score	17978	Renting of temporary training rooms in West, Central & East. SBAR has been approved for 2	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing an increasing the number of courses that can be delivered, increase the number of staff trained and increase compliance for BCUHB.	On track

		year leases on the premises, awaiting contracts to be finalised.				
	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB.	On track
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Ms Jillian B-J Hughes, Manual Handling Manager	29/10/2021	Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.	On track

3766	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 20 August 2021
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Date of Committee Review: New Risk
		Target Risk Date: 01 April 2022
There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	Low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - To be populated following approval	New Risk		

Controls in place	Assurances
1. Risk Management has been embedded into the processes of the Reporting Framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums Agendas. Triple A reports ensure risks are identified and reported on to support mitigation. 2. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 3. All mandatory training was amended to ensure compliance with the SSW [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 4. Named Doctor Safeguarding Children - this post remains vacant. The Children's	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis.

Division BCUHB are managing the recruitment process for the replacement of the Named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor.	5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews.
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Gaps in Controls/mitigations
<p>1. The increase in safeguarding activity, with enhanced complexity has resulted in the prioritisation of aspects of service delivery. This is supported by the data reporting activity and the identification of risk. This has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions.</p> <p>2. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated, this is due to the challenge and inability of safeguarding specialists attendance at all of the requested BCUHB meetings.</p> <p>3. Safeguarding mandatory fields are in place within Symphony and other departments have limited digital patient records. However, the lack of comprehensive digital clinical patient records reduces the identification of risk, results in the delay of information and communication and is time consuming.</p> <p>4. The development of multi-agency guidance and intervention as a result of new Legislation and National guidance, overseen by the North Wales Safeguarding Boards support collaboration with partner agencies. However, Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance.</p> <p>5. The additional two sessions for the Named Doctor have supported the recruitment process, the post remains vacant and the statutory meetings are supported by community paediatricians and overseen by Corporate Safeguarding Team Members, however the level of multi-agency and local clinical engagement is limited.</p>

Progress since last submission
New risk. This section will be populated in the next iteration.

Links to Strategic Priorities	Principal Risks
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Effective use of our resources Safe, secure & healthy environment for our people Safe unscheduled care	BAF21-13
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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	15701	The agreement and consultation of the Safeguarding Business Case is to take place by the Executive Team in August 2021. This is to include additional sessions for the Named Dr Children at Risk (Safeguarding).	Miss Andrea Davies, Personal Assistant	31/08/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	On track
	15702	The inclusion of an identified domestic abuse [VAWDASV] post to be agreed as part of the Business Case August 2021.	Miss Andrea Davies, Personal Assistant	31/08/2021	Additional resource will enable implementation of the VAWDASV priorities and statutory regulation and will reduce risk.	On track
	15703	The safeguarding annual report 2020/2021 highlighting high risk areas and non-compliance with the SSW [Wales] Act 2014 was presented to QSE in July 2021.	Miss Andrea Davies, Personal Assistant	30/07/2021	ACTION CLOSED - 06/07/2021 Additional resource will enable implementation of the SSW[W] Act and the identified safeguarding priorities for 2021/2022, which will reduce risk. The Corporate Safeguarding Annual Report 2020/2021 was presented at the QSE meeting on the 06/07/2021.	Complete

	18113	Implementation and Monitoring of Workforce Safeguarding Responsibilities SoP [SSWWACT 2014].	Michelle Denwood, Associate Director Safeguarding	20/12/2021	The process and the development of KPI's can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	On track
	18115	Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk.	Michelle Denwood, Associate Director Safeguarding	20/12/2021	Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met.	On track
	18116	To Implement and Monitor strengthened governance and reporting pathways for SARC.	Michelle Denwood, Associate Director Safeguarding	10/01/2022	Compliance with legislation and early identification of risk and harm.	On track
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	The revised procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks.	On track

2548	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 20 August 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 20 August 2021
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Date of Committee Review: New Risk
		Target Risk Date: 01 April 2022
This may be caused by the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	5	5	25
	Current Risk Rating	4	5	20
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - To be populated following approval	New Risk		

Controls in place	Assurances
1. Formal reporting and escalation of activity, mandatory compliance and exception reports are reported to the Mental Health Act Committee, Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory training is in place for MHLA and key departments and is included within the mandatory adult at risk level 2 and 3 training. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised DoLS Procedure [SOP] is in place and it provides a clear process and guidance to reduce legal challenge [21a].	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding

5. DoLS COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact.	ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews.
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Gaps in Controls/mitigations

1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not in our control. We have developed training and guidance for 16/17 year olds but to achieve compliance as a result of Cheshire West and the pending new Liberty Protection Safeguards is dependent upon capacity and available resource and expertise.
2. The increase in safeguarding activity, with enhanced complexity has resulted in the prioritisation of aspects of service delivery. This is supported by the data reporting activity and the identification of risk. This has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions.
3. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated, this is due to the challenge and inability of safeguarding specialists / Deprivation of Liberty Team members attendance at all of the requested BCUHB meetings.
4. The development of multi-agency guidance and intervention as a result of new Legislation and National guidance, overseen by the North Wales Safeguarding Boards support collaboration with partner agencies. However, Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance.
5. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the DoLS co-ordinator to wards relating to timescales and legal duties, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training however, the complexity of cases and the outcome of audits and reviews recognise increased training provision at ward/unit level is required to embed understanding and improve practice.

Progress since last submission

New risk. This section will be populated in the next iteration.

Links to

Strategic Priorities	Principal Risks
Effective use of our resources Safe, secure & healthy environment for our people	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15704	The Business Case to support the structure will be presented to the Executive Team in August 2021.	Miss Andrea Davies, Personal Assistant	31/08/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	On track
	15705	The National Task and Finish Group Finish Group will support the implementation of the [LPS] legislation and Code of Practice ensuring National consistency for NHS organisations.	Miss Andrea Davies, Personal Assistant	31/12/2021	The National Task and Finish Group will develop indicators specific to the NHS which will reduce unlawful detention and risk.	On track
	15706	LPS Training and guidance documentation and review of the DoLS forms has been agreed to be reviewed and developed by a leading Barrister and is supported by an agreed memorandum of understanding.	Miss Andrea Davies, Personal Assistant	20/10/2021	An informed workforce will comply with revised legislation which will reduce unlawful detention and risk	On track
	15707	Finance to be secured due to cost pressures for S12 Dr activity, external BIA assessments and CoP activity. (To be included within the Business Case to the Executive Team in August 2021).	Miss Andrea Davies, Personal Assistant	31/08/2021	Additional resource will enable the implementation of the SSW[W] Act and compliance with the MCA and the new Mental Capacity [Amendment] Act 2019 and will reduce risk.	On track

	15708	The DoLS Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non-compliance with legislation for the both the Managing Authority and Supervisory Body.	Miss Andrea Davies, Personal Assistant	31/08/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention.	On track
	15709	The BCUHB LPS Implementation Task and Finish Group will be implemented and will support the transition of DoLS as guided by the new LPS legislation.	Miss Andrea Davies, Personal Assistant	27/08/2021	Additional resource will enable the implementation of the SSW[W] Act and Mental Capacity [Amendment] Act 2019 and will reduce unlawful detention and risk.	On track
	18117	Recruitment to new posts required due to implementation of LPS.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	Additional resource will ensure the legal requirements of LPS will be implemented and will reduce the number of unlawful detentions.	On track
	18118	Implement and Monitor a Court of Protection Engagement and Procedure SoP for DoLS / LPS.	Michelle Denwood, Associate Director Safeguarding	14/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the COP and meet the needs and safeguards of service users.	On track

Appendix 3: Corporate Risk Register Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
Control	Definition	<p>These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised.</p> <p>A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]</p> <p>A measure that maintains and/or modifies risk (ISO 31000:2018(en))</p>
	Examples include, but are not limited to:	<ul style="list-style-type: none"> - People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	<ul style="list-style-type: none"> - Service or Pathway Redesign - Business Case Development - Staff Training - Risk Assessment - Evidential data sets

		- Taking out insurance
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE etc.

RAG Status		
Red		Delayed
Amber		On Track
Green		Completed Action



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 7 September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality Awards, Achievements and Recognition						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Awdur yr Adroddiad Report Author:	Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Atodiadau Appendices:	None.						
Argymhelliad / Recommendation:							
The Committee is asked to note this report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This paper provides an outline of quality related awards, achievements and recognitions. It is important to note that the COVID-19 pandemic has had a significant impact in this area, with the focus rightly being on service delivery and services changes in response to the pandemic, and many award and recognition schemes were deferred or cancelled.							
Cefndir / Background:							
During the last two months, a number of staff, services and initiatives have received a quality related award, achievement or recognition, a summary of which is below:							
<ul style="list-style-type: none"> The Health Board held two virtual question and answer (Q&A) sessions on COVID-19 vaccinations for pregnant and breastfeeding women in August, living in Flintshire and Wrexham. Stacey Jones, Matron of the COVID-19 Vaccination Programme, led the sessions to discuss the latest information for women who are pregnant or currently breastfeeding on the COVID-19 vaccinations and answer any questions and dispel any fears. These were held in partnership with the Association of Voluntary Organisation. 							

- Patients with Long-COVID are working in partnership with the Health Board to help shape future services for people with the condition. Claire Jones, Advanced Physiotherapy Practitioner, has recently been appointed as Therapy Lead for Long-COVID for the Health Board and is working with the Long Recovery Programme Group established to help shape the new service.
- The Health Board has also established the first Long-COVID Education Programme in the UK that is educating patients to self-manage their symptoms and minimise the effect on their lives.
- 'Words aren't enough' – A Wrexham patient praised the vascular team after surgery for a life-threatening bleed. Ricky Allen, 78, was rushed into Ysbyty Glan Clwyd towards the end of June 2021 with extreme pain in his abdomen. He was placed under the care of Consultant Vascular Surgeon, Mr Soroush Sohrabi, who diagnosed a ruptured abdominal aortic aneurysm (AAA), which could be fatal if left untreated. Prompt intervention, with Ricky being taken to the Radiology Interventional Suite where Mr Sohrabi carried out keyhole surgery to place a stent into his aorta to stop the bleed. After a few days recovering on the ward he was able to go home.
- The new Executive Medical Director appointment announcement has been shared and Dr Nick Lyons has taken up his post.
- Nia Boughton, Consultant Nurse for Primary Care has been shortlisted for a prestigious Royal College of Nursing (RCN) award, under the Advanced Nursing Practice category. Nia is passionate about broadening the skills of others in her profession. The profession's top accolades celebrate innovation, skill and dedication in nursing across 15 categories. The finalists were chosen from 550 entries, and one category winner will receive the coveted title of RCN Nurse of the Year 2021 at an awards ceremony on 12 October. Nia, who has worked in the profession for over 20 years, has been recognised for her work to improve the quality and consistency of training provided to nurses working in primary care settings across North Wales. This includes introducing a training framework based on a social model of care – which examines the range of factors that contribute to a person's health, rather than just their medical presentation. Practitioners using Nia's framework have reported a significant improvement in their training experience, while an initial evaluation suggests it has improved patient outcomes and led to greater consistency in the quality of consultations carried out by Advanced Nurse Practitioners.
- A patient was thrilled to have ticked off her dream of riding a large red American-style truck from her bucket list. Edna Pomeroy, 58, from Llandudno Junction in Conwy, was diagnosed with ovarian cancer in 2014, and has been receiving treatment at the North Wales Cancer Treatment Centre, at Ysbyty Glan Clwyd.
- A new drive-through spirometry service has opened at Ysbyty Maelor Wrecsam to test patients with breathing difficulties, increasing the testing capacity by 30%. The service allows patients, who have been referred to the drive-through by a consultant, to undergo lung function tests from the comfort of their vehicle. Spirometry is a lung function test that is used to help diagnose and monitor certain lung conditions such as asthma, interstitial lung disease, and chronic obstructive pulmonary disease (COPD). The test measures how much air you can breathe out in one forced breath using a device with a mouthpiece called a spirometer.

- Ysbyty Gwynedd has been awarded for their commitment to patient safety after successfully completing a national programme of local data audits. The National Joint Registry monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes for the benefit of patients, clinicians and industry. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards of quality of care, and overall cost effectiveness in joint replacement surgery. The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high quality standards relating to patient safety and reward those who have met registry targets in this area. In order to achieve the award, hospitals are required to meet a series of six ambitious targets during the audit period 2019/20. One of the targets which hospitals are required to complete is compliance with the NJR's mandatory national audit aimed at assessing data completeness and quality within the registry.
- Cardiac patients in North Wales are trialling innovative new technology that allows clinicians to monitor their health and recovery via mobile phone. Having teamed-up with healthtech company Huma to assess whether people with heart problems can be supported in their homes using an app that reports on their condition. The pilot programme has been funded by Welsh Government, and Huma's revolutionary application means any changes in the patient's health or response to medication could be identified sooner. The technology allows people to record their symptoms and vital signs, such as weight and blood pressure, which will be reviewed by the clinician and fed-back to the patient to record progress and any concerns. The technology also allows patients to have consultations by video, which can help avoid unnecessary visits to clinics or hospitals.
- New spinal clinics in North Wales brings care closer to home for patients with spinal conditions, as they can now access specialist care in satellite clinics. These have been introduced into North Wales for the first time. The Walton Centre, is working with the Health Board alongside the Robert Jones and Agnes Hunt NHS Foundation Trust (RJA) to provide care for spinal patients in North Wales. Up until now, patients in the region who required a consultation with a spinal specialist were referred to the Walton Centre or the RJA for further investigations. Currently spinal clinics are held every other week in Holywell or Llandudno Community Hospitals.
- Two caring members of staff from Rhuddlan Children's Centre have transformed an overgrown area into a 'sanctuary' for all staff to use. The wellbeing garden was created by green thumbs Suzanne Harris, and Don Wasdell, both Community Children Support Workers. The garden showcases new pots, chairs, tables and plants which were sourced or donated by the local community. The garden also has hanging baskets with strawberries and summer plants, as well as boxes with runner beans, tomatoes and onions. Gardening has become a real therapeutic benefit for Suzanne who has had her own wellbeing challenges.
- A former Assistant Manager of a restaurant who became an Administration Assistant for the COVID-19 vaccination programme is going back to school to train as a nurse. Tom Jones, 20, from Caerwys, who went straight into hospitality after school, has been working as a vaccination assistant at Deeside Mass Vaccination Centre (MVC) after he was furloughed three times from his hospitality job last year. Tom is now studying for Access for Nursing at Deeside College, as well as his Level 3 NVQ in health. He then plans to go to university to train as a qualified nurse.

- Patients who are receiving cancer treatment in North Wales are participating in a study looking at how online psychological support can improve their wellbeing. The North Wales Cancer Treatment Centre are participating in the Finding My Way UK Study that is investigating how well a self-directed online support programme works in reducing distress and improving well-being for people with cancer. Patients are currently being recruited into the trial, which is led by The University of Chester, from across North Wales and North West England.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Committee Terms of Reference						
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary						
Awdur yr Adroddiad Report Author:	Kate Dunn, Head of Corporate Affairs						
Craffu blaenorol: Prior Scrutiny:	None						
Atodiadau Appendices:	1. QSE Committee Terms of Reference V7.01						
Argymhelliad / Recommendation:							
The Committee is asked to note the Terms of Reference and recommend their approval to the Board through the Committee Chair's Report							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input checked="" type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The Committee's Terms of Reference have been refreshed as part of the wider Integrated Governance Framework led by the Interim Director of Governance.							
Cefndir / Background:							
The Board approved the Integrated Governance Framework at its meeting of 15 th July 2021 which included refreshed Terms of Reference for the QSE Committee. Subsequently some typographical errors and inaccuracies in terminology have been noted. These are highlighted within V7.01 attached to this paper.							
Asesu a Dadansoddi / Assessment & Analysis							
The Committee is being presented with this amended version in respect of good governance and version control.							
Opsiynau a ystyriwyd / Options considered							
Not applicable							

Goblygiadau Ariannol / Financial Implications Not applicable
Dadansoddiad Risk / Risk Analysis Not applicable
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance The Committee is required through the Health Board's Standing Orders to operate within its terms of reference
Asesiad Effaith / Impact Assessment Not applicable

Quality, Safety and Experience Committee



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Terms of Reference and Operating Arrangements

1. INTRODUCTION

- 1.1. The Board shall establish a committee to be known as the Quality, Safety and Experience Committee (QS&E). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

- 2.1. The purpose of the Committee is to provide advice and assurance to the Board in discharging its functions and meeting its responsibilities with regard to the quality of services including clinical effectiveness, patient safety and patient and carer experience whether delivered directly or through a partnership arrangement and health and safety issues.

3. DELEGATED POWERS

- 3.1. The Quality, Safety and Experience Committee is required by the Board, within the remit of the Committee to:
- 3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.
 - In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.
 - In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.
 - 3.1.2. Provide evidenced based assurance that there is compliance with The Health and Social Care (Quality and Engagement) (Wales) Act 2020.
 - In discharging its duty the Committee will have 'due regard' to the duty of quality.
 - 3.1.3. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.
 - 3.1.4. Provide evidence based and timely advice to the Board on developing strategies.

- 3.1.5. Provide evidence based and timely advice to the Board on the delivery of strategies including quality, clinical effectiveness, patient safety and patient and carer experience.
- 3.1.6. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.
- 3.1.7. Provide relevant evidence based and timely advice to the Board on quality of citizen centred health in relation to patient services, public health, health promotion and health protection including (but not limited to):
 - Clinical effectiveness
 - Patient Safety
 - Patient and carer experience
 - Safeguarding
 - Health and Safety
 - Infection, prevention and control
- 3.1.8. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Quality, Safety and Experience Committee is authorised by the Board to:

- 3.2.1. Seek assurance that outcomes for patients are delivered through partnership arrangements where that is beneficial for the patient.
- 3.2.2. Ensure that arrangements for the quality and safety of patient care are in accordance with its corporate goals, stated priorities within the Quality Strategy and the principle of continuous quality improvement including organisational learning.
- 3.2.3. Ensure the adequacy of safeguarding and infection, prevention and control arrangements.
- 3.2.4. Provide assurance in relation to improving the experience of patients, citizens and all those who come into contact with the Health Board's services, as well as those provided by other organisations or as part of a partnership arrangement.
- 3.2.5. Provide assurance in relation to improving clinical effectiveness and the safety of patients within the Health Board's services, as well as those provided by other organisations on behalf of the Health Board or as part of a partnership arrangement.
- 3.2.6. Seek assurance on the robustness and appropriateness of Health and Safety arrangements across the Health Board including aspects affecting patient care, quality and safety and experience.

- 3.2.7. Ensure that all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality and safety of care provided and in particular that.
- Sources of internal assurance (including clinical audit) are reliable.
 - Recommendations made by internal and external reviewers are considered and acted upon on a timely basis
 - Appropriate review is carried out and corrective action is taken arising from incidents, complaints and claims known collectively as 'Concerns'.
- 3.2.8. Receive assurances from the Quality Strategy to allow the Committee to review achievement against the Health and Care Standards including accessible health care to inform the Annual Quality and Annual Governance Statements.
- 3.2.9. Seek assurance on the quality and safety of services commissioned from external providers (including care homes) and others who provide a commissioning role on behalf of the Health Board e.g. Welsh Health Specialised Services Committee (WHSSC); Emergency Ambulance Services Committee (EASC).
- 3.2.10. Review and seek assurance on the appropriateness of the quality indicators defined within the ~~Integrated~~ Quality and Performance Report (~~I~~QaPR) and scrutinize the quality dimensions contained within the ~~I~~QaPR.
- 3.2.11. Review the sustainability of service provision across the Health Board in terms of quality of service, patient and carer experience and model of care provided.
- 3.2.12. Provide advice and assurance to the Board regarding the quality impact assessment of strategic plans as appropriate.
- 3.2.13. To receive periodic updates in respect of the workforce flu vaccination.

4. AUTHORITY

- 4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::
- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,
 - Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

- 4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;
- 4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning quality, safety, patient and carer experience matters.
- 4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

- 5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. Members

- 6.1.1. A minimum of three Independent Members of the Board.

6.2. In attendance

- Executive Director of Nursing and Midwifery (Lead Executive).
- Executive Medical Director.
- Executive Director of Therapies and Health Sciences.
- Executive Director of Primary Care & Community Services.
- Executive Director of Workforce & Organisational Development.
- Executive Director of Public Health.
- Director of Performance.
- Associate Director of Quality Assurance
- Director of Mental Health & Learning Disabilities.
- Senior Associate Medical Director.
- Chair of Healthcare Professionals Forum (Associate Board Member)
- Representative of Community Health Council.

6.3. Right of Attendance

- 6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Chair of the Audit Committee.

- Board Secretary.

6.4. By Invitation

- A patient representative.
 - A staff representative.
 - Executive Director of Planning and Performance.
- 6.4.2. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.
- 6.4.3. Trade Union Partners are welcome to attend the public session of the Committee

6.5. Member Appointments

- 6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.
- 6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up to a maximum period of 8 years.

6.6. Secretariat

- 6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to ~~Group~~ Committee Members

- 6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

- 7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair

or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2. Frequency of Meetings

- 7.2.1. Meetings shall normally be held bi-monthly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

- 7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

- 7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

- 8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.
- 8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,
- 8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

- 8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.
- 8.5. Receive assurance and exception reports from

- Executive Delivery Group for Quality Improvement.
- Clinical Effectiveness Group.
- Patient and Carer Experience Group.
- Patient Safety and Quality Group.
- Strategic Occupational Health and Safety Group.
- Infection Protection-Prevention and Control-Steering Group.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

- 9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.
- 9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.
- 9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 7.01	
Committee	Date of approval
QSE	7.9.21
Audit Committee	
Health Board	



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Ionising Radiation Policy (RP01)						
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Adrian Thomas, Executive Director of Therapies and Health Sciences						
Awdur yr Adroddiad Report Author:	Mr Peter Hiles, Radiation Protection Advisor						
Craffu blaenorol: Prior Scrutiny:	Overarching Radiation Protection Committee Clinical Effectiveness Group – Chair's action						
Atodiadau Appendices:	1. RP01 – Ionising Radiation Policy 2. Supporting EQIA						
Argymhelliaid / Recommendation:							
The Committee is asked to approve the minor amendments to the RP01- Ionising Radiation Protection Policy in order to comply with the requirements of regulations related to the safe use of ionising radiation principally Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation(Medical Exposure)Regulations 2017 {IR(ME)R17}							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input checked="" type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
EQIA is applicable – the amendment to the policy is a correction of terminology related to equality for the transgender community							
Sefyllfa / Situation:							
The RP01 is the policy that underpins how BCU ensures compliance with various regulations related to ionising radiation and safe use. In the March Healthcare Inspectorate Wales (HIW) IR(ME)R inspection in radiotherapy it was noted that the policy referred to females of child bearing age as opposed to individuals of child bearing age, as required in IR(ME)R 17. The revised version of the policy corrects this error. The revised version has also been amended to include latest guidance from professional and regulatory bodies in relation to the various regulations. The action plan for HIW agreed a completion date of September 2021 for this amendment. HIW have announced a further IR(ME)R inspection of BCU for October 2021 and the revised policy is required to be forwarded to HIW by the 22 nd September 2021.							
Cefndir / Background:							

In order to safely use ionising radiation for both diagnostic and therapeutic purposes BCU must comply with a wide variety of regulations. The primary regulations are IR(ME)R17 and IRR17. This policy sets out how the Health Board will meet its obligations under the regulations. Following the revision of IR(ME)R2000 to IR(ME)R17 there was a change in terminology in relation to pregnancy status from females of childbearing age to individuals capable of childbearing. Although department pregnancy procedures as required by the regulations had included the change, it was noted by HIW during the March 2021 inspection the BCU policy contained the former terminology. The opportunity has also been taken to update the policy following recent releases of guidance from regulators and professional bodies.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This policy enables BCU to comply with ionising radiation regulations. Without this policy in place BCU would not be able meet its regulatory responsibilities for radiation safety. Regulators could remove authority to use ionising radiation on BCU premises. This would result in suspension of both diagnostic and therapeutic use of ionising radiation i.e. radiology and radiotherapy.

Opsiynau a ystyriwyd / Options considered

There are no alternative options as this policy is required from a regulatory point of view.

Goblygiadau Ariannol / Financial Implications

Failure to follow regulatory compliance could have enforcement consequences including suspension of services, which would have financial consequences. However, the policy allows for continued compliance with regulations as part of current daily business and does not have any financial implications if approved.

Dadansoddiad Risk / Risk Analysis

This is not a risk that sits on the risk register as it a small amendment to terminology. However, if the policy is not approved then a risk will be raised.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Compliance with a variety of legislation related to the safe use of ionising radiation

Asesiad Effaith / Impact Assessment

An equality impact assessment has been carried out as the terminology change is in relation to pregnancy status. The impact is positive as it is more inclusive i.e. from "females" to "individuals capable of".



IONISING RADIATION PROTECTION POLICY

Date to be reviewed:	June 2024	No of pages:	21
Author(s):	Mr P Hiles Dr J MacDonald	Author(s) title:	Radiation Protection Advisers
Responsible dept / director:	Executive Director of Therapies and Health Sciences		
Approved by:	Betsi Cadwaladr University Health Board Overarching Radiation Protection Committee (18/06/21) / Clinical Policies and Procedures Group (28/06/21)/ Clinical Effectiveness Group		
Date approved:	18 th June 2021		
Endorsement by:	Quality, Safety and Experience Committee of the Health Board		
Date endorsed:	??		
Date activated (live):	??		
Date EQIA completed:	March 2011		
Documents to be read alongside this policy:	Health and safety policy HS01		
Review	Purpose of Issue/Description of current changes: Issued to provide direction and arrangements for the safe management of ionising radiation within the Betsi Cadwaladr University Health Board in compliance with Statutory Duties. <u>Version 4</u> Revised Appendix 1 on governance structure and added reference to Radioactive Waste Adviser in Appendix 2. Updated for new guidance [Royal College of Radiologists (RCR) 2020a; RCR 2020b; Faculty of General Dental Practice (FGDP) 2020]. Revised references to state 'individuals' who may be pregnant to comply with Health Inspectorate Wales request during inspection of North Wales Cancer Treatment Centre.		
First operational:	April 2011		
Previously reviewed:	Nov 2014	Sept 2017	
Changes made yes/no:	Yes	Yes	

PROPRIETARY INFORMATION

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IONISING RADIATION PROTECTION POLICY

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Appendix 1 Radiation protection organisation

Appendix 2 General guidance on entitlement

Appendix 3 Management of reportable Incidents and Inspections under IR(ME)R from HIW

Appendix 4 Radiation incident reporting flowchart

Appendix 5 Abbreviations

1. Introduction

- 1.1 Ionising radiation can be hazardous at high exposures and even at low levels of exposure there are long term risks to health, mainly through induction of cancer and genetic damage.
- 1.2 The risks are controlled by a set of procedures, which implement three key principles of radiation protection [ICRP 2007]:-
 - Justification - exposure to radiation must produce sufficient benefit to the exposed individuals or society to offset the potential radiation detriment.
 - Optimisation - implementing procedures and techniques to keep all exposures as low as reasonably practicable, economic and social factors being taken into account.
 - Dose Limitation - keeping all radiation doses received within specified limits.
- 1.3 The use of ionising radiation in health establishments in the UK is governed by a series of statutory instruments (refer to section 9). Many are enforced as health and safety regulations made under the Health and Safety at Work Act 1974. They cover general health and safety of staff and members of the public and impose responsibilities on both the employer and employees with regard to medical exposures.
- 1.4 There are additional legal requirements concerning radioactive substances (refer to section 9), covering the diagnostic and therapeutic use of

radioactive medicinal products; controls on transport, storage, security and disposal.

- 1.5 This policy document sets out the Betsi Cadwaladr University Health Board (BCUHB) aims and objectives in connection with the use of ionising radiation on its premises. It also outlines the general arrangements in force within the Health Board for implementing the policy.
- 1.6 Under the authority of this policy, Departments using ionising radiation are required to produce their own operating procedures and local rules for implementing the Policy within their area of responsibility.
- 1.7 The Policy has been endorsed by the BCUHB Executive Board and forms part of the Health Board's Health and Safety Policy.

2. Policy Statement

- 2.1 The BCUHB is committed to providing and maintaining a safe working environment for all its employees, patients and any other persons who may be affected by its activities involving ionising radiation.
- 2.2 The Board's commitment applies to all premises and activities involving ionising radiation within its control.
- 2.3 The Board is committed to establishing good communication between all those involved in the implementation of this Policy.

3. Aims

The purpose of this policy is to ensure that radiation doses to staff, patients and members of the public resulting from work carried out in the BCUHB are as low as reasonably practicable. The policy also aims to ensure that Best Available Techniques (BAT) will be employed to minimise radiation exposure of members of the public resulting from the disposal of radioactive waste.

4. Objectives

The Health Board, in pursuing this Policy, is committed to the following key objectives for its use of ionising radiation:

- 4.1 To comply with all relevant statutory requirements
- 4.2 To identify radiation hazards, assess and control risks and prepare contingency plans;
- 4.3 To ensure that diagnostic procedures are performed in such a way that the radiation dose to the patient is as low as reasonably practicable and that therapeutic procedures are consistent with the required clinical outcome;

- 4.4 To ensure that radiation exposure to the public as a result of the creation and disposal of radioactive waste is minimised through the application of the "Best Available Techniques" (BAT) principle at all stages.
- 4.5 To ensure that employees, contractors and others are adequately informed of identified radiation risks and, where appropriate, ensure they receive instruction, training and supervision;
- 4.6 To consult with employees' representatives on radiation safety issues;
- 4.7 To make arrangements for liaison with other employers, where the activities of one employer could affect the safety of individuals associated with the other;
- 4.8 To safeguard the environment from the effects of the Health Board's activities;
- 4.9 To make available records at the request of authorised external agencies;
- 4.10 To monitor and review the effectiveness of the Policy and, where appropriate, implement improvements.

5. Organisation and Responsibilities

5.1 The Chief Executive

Under the ionising radiation legislation [SI 2017a and SI 2017b] the Employer is ultimately responsible for the radiation protection of all workers, patients and members of the public on its premises and for work with ionising radiation carried out by its staff at other sites. For the BCUHB this responsibility rests with the Chief Executive.

5.2 The Health Board

- 5.2.1 The responsibility for monitoring of the operation of this Policy lies with the Board of the BCUHB and its Chief Executive.
- 5.2.2 The employer is also responsible for establishing a Radiation Protection Committee (RPC) to assist it in the discharge of its duties.
- 5.2.3 The BCUHB is responsible for appointing one or more Radiation Protection Advisers (RPAs) [SI 2017a, HSE 2017] to advise on compliance with statutory requirements concerning the use of ionising radiation. The RPAs are members of, and report to, the RPC.
- 5.2.4 The BCUHB is responsible for appointing one or more Medical Physics Experts (MPEs) [SI 2017b] to act or give advice on matters relating to radiation physics applied to exposure in specified areas of medical physics. A representative number of MPEs are members of, and report to, the RPC.
- 5.2.5 BCUHB is required to appoint one or more Radioactive Waste Advisers (RWAs) to advise on compliance with Environmental Permits issued under SI 2016 and SI 2018.

- 5.2.6 The Health Board will also appoint an Approved Dosimetry Service for monitoring staff radiation doses.

5.3 Board Level Directors

- 5.3.1 The Chief Executive has appointed the Executive Director of Workforce and Organisational Development as Board level director for health and safety.
- 5.3.2 The Chief Executive has appointed the Executive Director of Therapies and Health Science to be responsible for the co-ordination of radiation-related Health Board activities. This board level director shall be responsible, through a process of nomination, for the implementation of this policy, facilitating the Overarching Radiation Protection Committee and acting as the Board representative in communications with external radiation inspectorates, including Natural Resources Wales (NRW), Healthcare Inspectorate Wales (HIW) and Health & Safety Executive (HSE).

5.4 Overarching Radiation Protection Committee (RPC)

- 5.4.1 The Overarching RPC is responsible for overseeing the management of radiation safety throughout the organisation; it reports to the Clinical Effectiveness Group (CEG) of the Quality and Safety Group and hence to the Executive Board (see Appendix 1).
- 5.4.2 The Overarching RPC is responsible for formulating and reviewing this Policy on ionising radiation, and for recommending appropriate action to the Chief Executive via the formalised route where necessary.
- 5.4.3 In addition, three local RPCs, chaired by the Assistant Director of Therapies and Health Sciences or RPA, will consider operational issues and report to the BCUHB Overarching RPC chaired by the Executive Director of Therapies and Health Science.

5.5 Departmental Responsibilities

- 5.5.1 The Health Board management arrangements place the responsibility for the day to day operational delivery of services on the Heads of Department.
- 5.5.2 In every department where radiation is used, the responsibility (under the Chief Executive) for ensuring compliance with this Policy and the requirements of legislation and guidance and Local Rules lies with the Head of Department. However, these responsibilities may be delegated to a designated senior member of the Department.
- 5.5.3 Within each Department the designated officer has the following responsibilities:
- 5.5.3.1 To ensure that responsibilities for radiation protection are documented.

- 5.5.3.2 To ensure that there exist written Local Rules and Operating Protocols and that these are reviewed regularly.
- 5.5.3.3 To ensure that, for medical exposures, there exist for each procedure, protocols that describe the eligible Referrer(s), the Practitioner(s) and the Operator(s) [SI 2017b].
- 5.5.3.4 To keep a record of the training of Practitioners and Operators [SI 2017b].
- 5.5.3.5 To ensure that each request for a medical exposure (including research, and non-medical imaging using medical radiological equipment) is justified and authorised and that this process is recorded prior to the exposure [SI 2017b].
- 5.5.3.6 To ensure that for medical exposures, rigorous patient and subject identification procedures are followed [SI 2017b, Welsh Office 1997].
- 5.5.3.7 To ensure that up-to-date copies of appropriate Environmental Permits issued by Natural Resources Wales [SI 2016 and SI 2018] are displayed in areas where work with radioactive substances is carried out.
- 5.5.3.8 To ensure that, when a member of staff declares they are pregnant, a risk assessment of working conditions is carried out to ensure that the fetal dose is unlikely to be more than 1 mSv for the remainder of the pregnancy [SI 2017a].
- 5.5.4 In every department where radiation is used the Head of Department will appoint in writing sufficient competent persons as Radiation Protection Supervisors (RPS) to assist the Head of Department to ensure that protection measures are implemented. Their role as RPS should be specified in their appointment letter. General guidance on entitlement to appoint an RPS is covered in Appendix 2.
- 5.5.5 Before introducing new procedures or equipment, radiation risk assessments will be undertaken, in conjunction with the RPA. Thereafter, risk assessments should be dated and reviewed regularly.
- 5.5.6 The Head of Department is also responsible for ensuring that all radiation equipment is selected, installed, critically examined, commissioned and maintained to satisfy radiation safety requirements, and included in their equipment inventory and planned equipment replacement programme [WSAC 2005].
- 5.5.7 Where diagnostic X-ray equipment is used outside Radiology the overall responsibility lies with the Head of Radiology in collaboration with the Head of Department involved. Specific areas of responsibility are defined in Local Rules.
- 5.5.8 The medical supervision of staff is the responsibility of the Occupational Health & Wellbeing Service.
- 5.5.9 North Wales Medical Physics provides a radiation protection service including Radiation Protection Advisers [SI 2017a], Medical Physics

Experts [SI 2017b] in all relevant fields, and Radioactive Waste Advisers [SI 2016 and SI 2018].

<http://howis.wales.nhs.uk/sitesplus/861/page/41807>

5.6 Individual Responsibilities

- 5.6.1 It is the duty of all members of staff to protect themselves and others from any hazard arising from their work. Members of staff must not knowingly expose themselves or any other person to ionising radiation to an extent greater than is reasonably necessary for the purposes of their work, and shall exercise reasonable care while carrying out such work. Failure to comply with Local Rules or written procedures and protocols for medical exposures may result in disciplinary action.
- 5.6.2 Employees must wear a personal dosimeter, if supplied, at all times during occupational exposure.
- 5.6.3 Members of staff must make full and proper use of any personal protective equipment provided and shall report to the RPS or Head of Department any defect in such equipment or any suspected fault in a safety facility or interlock.
- 5.6.4 Staff must not act as Operator in the exposure of patients under IR(ME)R [SI 2017b] unless they have undergone relevant training. The role should be agreed and reflected in the Health Board's procedures
- 5.6.5 Individuals who may be pregnant engaged in work with ionising radiation should inform their RPS and Head of Department as soon as they discover or believe that they have become pregnant, or if they are breastfeeding. For a declared pregnancy, a risk assessment of working conditions will then have to be carried out to ensure that the fetal dose is unlikely to be more than 1 mSv for the remainder of the pregnancy.

6. Protection of Staff

6.1 Local Rules

- 6.1.1 Local Rules should be issued for every department using ionising radiation. They should be regularly reviewed and major changes reported to the RPC. Relevant sections should be displayed in the locations to which they refer.
- 6.1.2 Radiation Controlled Areas are identified in the Local Rules. Health Board staff and visitors may only enter these in accordance with the written Systems of Work. So-called "Outside workers" [SI 2017a] employed by other employers who carry out work in a BCUHB Controlled Area are subject to special procedures, which should be outlined in the Local Rules. Patients may enter a Controlled Area for the purpose of undergoing medical exposures.

6.2 Training

Heads of Department must ensure that adequate training is provided for all staff working in departments using ionising radiation or who regularly enter Controlled Areas.

6.3 Designation and Monitoring of Staff

- 6.3.1 Staff will only exceptionally be designated as Classified Persons. The need to classify staff will be determined through risk assessment. Classified Persons [SI 2017a] are required to have annual medicals, arranged by their Head of Department as per Health Board Health Surveillance Policy HS19.
- 6.3.2 All staff who regularly work with ionising radiation and who have to enter Controlled Areas will be monitored. The type and frequency of monitoring should be assessed by means of a risk assessment.
- 6.3.3 Staff who are regularly monitored must wear their dosimeter whenever they enter a Controlled Area. The dosimeter must be worn in the manner described in the risk assessment e.g. for a whole body dosimeter it may be worn on the trunk at waist or preferably chest level, under any radiographic protective apron that may be worn. In some circumstances it may be desirable to measure the dose to additional parts of the body to ensure that other relevant dose limits are not exceeded.
- 6.3.4 Persons who may be exposed to radiation but do not have a regular personal dosimeter may be monitored using one of the following categories: job dosimeter, holding dosimeter, or environmental dosimeter (e.g. on C-arm of mobile fluoroscopy units). The RPS is responsible for ensuring all staff and other persons are appropriately monitored.
- 6.3.5 Employees are required to return any dosimeters supplied to them in a timely fashion at the end of each monitoring period. Failure to do so could result in a prosecution (under criminal law) of both the individual and the Health Board.
- 6.3.6 Dose investigation levels should be defined in the Local Rules. All dose results must be reviewed on receipt, and investigated when any of these thresholds are exceeded. Dose records must be kept for a minimum of 2 years. Annual summaries of radiation doses received by staff will be prepared in conjunction with the Approved Dosimetry Service. These will be reviewed by the RPA and reported to the Radiation Protection Committee.

6.4 Radon Gas

- 6.4.1 Employers have a duty to protect their staff from radiation exposure as a result of radon inhalation and consequently the health board must review the potential radon hazard in all of its premises.
- 6.4.2 All below ground workplaces must be monitored to assess radon levels.
- 6.4.3 All above ground workplaces that are situated in radon Affected Areas must be monitored for radon levels.
- 6.4.4 The Action Level for workplaces is an annual average of 300 Bq m⁻³ and for residences is 200 Bq m⁻³.
- 6.4.5 Occupied areas that are above the relevant Action Level must have remedial work undertaken to reduce levels. These premises must then be re-monitored every 2 years to ensure ongoing effectiveness of remediation.
- 6.4.6 Areas where the radon level is below the Action Level will be re-monitored on a less frequent basis (10-yearly if levels are less than 75% of the Action Level; 5-yearly otherwise)
- 6.4.7 The health board must consult with the RPA to ensure that relevant premises have been assessed, appropriate actions taken and that there is a suitable re-monitoring programme in place.

7. General Management of Radiation Sources

7.1 Radioactive Materials and Radioactive Waste

- 7.1.1 All departments must comply with relevant BCUHB waste management procedures and guidance documents.
- 7.1.2 All departments using radioactive materials or generating radioactive waste must have written procedures for receipt, storage, security, handling and disposal. Amounts handled and disposed of must be consistent with the allocations for individual departments issued by North Wales Medical Physics on behalf of the Health Board. North Wales Medical Physics is responsible for maintaining environmental permits and summary disposal records, and for liaison with the Natural Resources Wales (NRW) on all issues regarding radioactive substances regulation [SI 2016].
- 7.1.3 All departments and the Health Board as a whole must use Best Available Techniques (BAT) [SI 2016] to minimise the volume and activity of discharges and disposals of radioactive waste. BAT includes both provision of machinery and equipment, and also supervision of relevant operations. BAT requires the consideration of these aspects at key stages of the decision making process in several aspects including: Planning new and modified processes involving radioactive materials, minimisation of radioactive materials and waste, discharge routes and waste sampling and analysis. To this end a BAT assessment must be carried out by the Health Board to identify, justify and optimise the use and disposal of radioactive materials.

- 7.1.4 Sealed radioactive sources are subject to a regulatory regime managed by the National Counter Terrorism Security Office (NaCTSO). Depending on the nature of the sources held, this may require the Health Board to have a Site Security Plan to demonstrate that the appropriate security arrangements are in place, and an Information Security Plan to show adequate protection of relevant records.

7.2 Equipment Quality Assurance Programmes

All departments undertaking medical exposures must have appropriate quality assurance (QA) programmes which include:-

- 7.2.1 Acceptance testing of new equipment before it is used for clinical procedures [WSAC 2005]. All new radiological equipment must be provided with a means of indicating patient dose.
- 7.2.2 Adequate testing of the performance of the equipment at appropriate intervals and after any major maintenance procedure [HSE 2006].
- 7.2.3 A programme for testing active engineering controls and warning devices, including lights.
- 7.2.4 Regular assessments of doses delivered to persons undergoing medical exposures.
- 7.2.5 An up-to-date inventory of radiation equipment at each installation.
- 7.2.6 The QA programme shall specify action levels and appropriate remedial actions, including removal from service when necessary [IPEM 2005]. Special attention should be given to equipment used for medical exposures of children, as part of health screening programmes, and equipment delivering high radiation doses (e.g. radiotherapy, CT and interventional radiology).

7.3 Incidents, Overexposure, Accidental or Unintended Exposure (of patients)

All radiation work shall be conducted with due regard to minimising exposure of persons (patients, staff and public). Suspicions of over-exposure and equipment faults leading to a person's exposure being greater than intended must be investigated by following procedures for reporting and dealing with incidents involving ionising radiation. In some cases, e.g. radiotherapy, suspected or actual under-exposure should also be investigated.

Procedures must include: the advice of the RPA, MPE or RWA, the decision-making and reporting process regarding external notification if required, and information on timescale. Radiation Incidents will be entered on Datix Web and a summary will be reported to the Radiation Protection Committee.

In cases where staff doses exceed $3/10^{\text{th}}$ s of any dose limit, a record of the assessment must be kept until the person to whom the record relates has or would have attained the age of 75 years but in any event for at least 30 years from the date of the relevant accident [SI 2017a].

Further details in respect of the incident and reporting process can be found in the Appendices 3 and 4 and the BCUHB Incident reporting and Investigation Procedure.

8. Protection of Patients

The *Ionising Radiation (Medical Exposure) Regulations 2017* [SI 2017b] define duty holders for medical exposures. The duty of the Employer is to provide a framework by means of Standard Operating Procedures (SOPs). Each department must prepare detailed local SOPs for the following 14 issues relevant to their medical exposures in IR(ME)R Schedule 2 [SI 2017b]:

8.1 Patient Identification

All departments performing medical exposures must have a written procedure for identifying the correct patient prior to the exposure. This must state clearly which operator is responsible for this task. Particular care must be taken when identifying children, patients with language or learning difficulties, patients with hearing or sensory impairment, and patients in theatre or A&E who are unable to respond.

8.2 Identification of Referrer, Practitioner and Operator; training requirements and duties.

These terms are defined in the legislation [SI 2017b]. Appropriately trained health professionals take personal responsibility for aspects of individual medical exposures in accordance with the employer's procedures. Training records (which must be separate from general personal records) must state the role for which the individual is trained, the nature of the training and the date(s) on which adequate and relevant training took place.

Only registered health care professionals acting in accordance with the Health Board's written procedures, may receive entitlement to refer patients for medical exposures. The signature or electronic signature on the request identifies the individual acting as the Referrer.

It is the responsibility of the Referrer to provide unambiguous patient details, together with sufficient medical data, such as previous diagnostic information or medical records relevant to the proposed exposure, to enable the Practitioner to decide whether the procedure is justified.

Particular care must be taken to check that the correct patient has been specified when details are retrieved electronically, or using addressograph labels. The Referrer is also responsible for informing the Practitioner on the patient's pregnancy status, where applicable.

Incomplete or illegible requests will be returned to the Referrer unless sufficient supplementary information can be provided to uniquely identify the patient and the examination required. The same standards of legibility and completeness are required for all requests, including those made in person by the Practitioner.

A Practitioner must justify individual medical exposures. Authorisation to proceed with the exposure must be recorded, normally as a signature or electronic signature added to the request card or referral. Where it is not practicable for the Practitioner to consider every request for a medical exposure, the Practitioner must produce Delegated Authorisation Guidelines to enable an appropriately entitled Operator to authorise certain procedures.

Exposures will be optimised by Operators following departmental procedures and protocols for practical aspects of exposures.

General guidance on entitlement to appoint a Referrer, Practitioner or Operator is covered in Appendix 2.

8.3 Individuals of Childbearing Age, Pregnant and Breast Feeding Patients

All departments performing medical exposures must have a written procedure for identifying possible pregnancy, when examining or treating the abdominal area or administering radioactive substances, prior to exposure of individuals of childbearing age (or capacity). Childbearing age should be taken as between 12 and 55 years, unless there are known exceptional circumstances applying to an individual patient.

Departmental procedures must be consistent with HPA *Protection of pregnant patients during diagnostic medical exposures to ionising radiation* [HPA 2009].

All individuals of childbearing age (or capacity) must also be advised not to become pregnant during courses of radiotherapy or for a specified interval following therapeutic nuclear medicine procedures.

Bilingual signs are to be prominently displayed in all relevant departments asking patients to inform staff if they think that they are, or may be,

pregnant (and/or breast feeding in the case of radionuclide examinations or treatment).

When a pregnant individual requires an examination or treatment in which the primary beam irradiates the fetus, or which requires administration of radioactivity, or is required to undergo any radiotherapeutic procedure, the examination should be specifically authorised in writing by the Practitioner. In all cases, greater than usual care must be taken to minimise the dose, especially to the fetus. However, these precautions should not be taken to the detriment of the clinical value of the procedure. In such cases, a written fetal dose estimate prepared by the MPE should be recorded in the patient's notes.

All departments performing nuclear medicine exposures must have a written procedure for ascertaining whether individuals are breast feeding. Where a nuclear medicine procedure requires restrictions on breast feeding then the operator who performs the medical exposure must take the appropriate action as recommended in the latest revision of the ARSAC *Notes for Guidance on the Clinical Administration of Radiopharmaceuticals* (ARSAC).

In all the above, procedures must state clearly which duty holder is responsible for the various tasks.

8.4 Quality Assurance Programmes

All department procedures must be subject to 'document control'. Procedures must be signed and dated, and a system of review and audit must be defined.

In addition, departments should have an equipment quality assurance programme, developed in consultation with the MPE, which specifies the frequency of testing and remedial action levels.

8.5 Assessment of Patient Dose

Local procedures should identify a measurement relating to patient radiation dose which should be recorded for all medical exposures. The units of measurement will depend on the examination or treatment being performed and the equipment being used, and must be specified for each type or group of exposures.

8.6 Diagnostic Reference Levels (DRLs) for Radiodiagnostic Examinations

All departments undertaking diagnostic and interventional medical x-ray exposures shall establish local DRLs, following guidance in IPeM Report

88 [IPEM 2004]. These shall take account of National and European DRLs where available, and be defined in conjunction with the Medical Physics Expert (MPE).

Ongoing Audit programmes shall be established to re-survey patient doses at defined frequencies and to review DRLs on an annual basis [IPEM 2004]. If DRLs are exceeded, departments will take corrective action, with the advice of the MPE. All such reviews will be reported to the Radiation Protection Committee.

DRLs for Nuclear Medicine should be set by the Employer, in consultation with the MPE, using ARSAC Guidance Notes (ARSAC) and local optimisation to keep doses as low as reasonably practicable.

8.7 Research Exposures

See separate BCUHB R&D02 policy for research involving ionising radiation.

8.8 Advice following Medical Exposures using Radioactive Materials

Where appropriate, patients shall be provided with relevant information to enable them to restrict doses to family and members of the public. Written information is preferable, and must always be provided for therapeutic medical exposures.

Standard procedures should define contact restrictions that keep the predicted dose to members of the public within the relevant dose limit [SI 2017a] or within appropriate dose constraints in the case of 'carers and comforters' [SI 2017b] who knowingly and willingly accept the additional risks. These procedures should take account of national guidance and should be written in consultation with the RPA/MPE.

8.9 Information on Benefits and Risks

Departments must have a procedure outlining how they inform patients (or their representative) prior to an exposure taking place, of the benefits and risks associated with the radiation dose from the exposure.

8.10 Evaluation of Medical Exposures

No medical exposure may be performed unless a clinical evaluation of the outcome will take place and will be recorded. Where images are returned to other departments for reporting (e.g. A&E, wards), or if there are no images recorded (e.g. during a fluoroscopically guided procedure or

therapy procedure) it is the responsibility of the referring clinician to ensure that the outcome is documented in the patient's records. The referring clinician who carries out this function is defined as an Operator under IR(ME)R (see 8.2).

8.11 Accidental or Unintentional doses and other Incidents

All medical exposures shall be conducted with due regard to eliminating or minimising accidental and unintended doses to patients. Department procedures must include those tasks which are undertaken by Operators as their standard practice to reduce errors.

8.12 Reporting and Investigating Incidents

Incidents involving accidental or unintended exposures must be investigated by following procedures for reporting and dealing with incidents involving ionising radiation. Procedures must include: the advice of the RPA/MPE/RWA, the decision-making and reporting process regarding external notification, if required, and information on timescale. Radiation Incidents will be entered on Datix Web and a summary will be reported to the Radiation Protection Committee.

Departments need to address how the referrer, practitioner and patient are informed when a clinically significant unintended or accidental exposure occurs and of the outcome of the analysis of the exposure.

Further details in respect of the incident and reporting process can be found in Appendix 3 and the BCUHB Incident reporting and Investigation Procedure.

8.13 Non-Medical Imaging Exposures

“non-medical imaging exposure” means any deliberate exposure of humans for imaging purposes where the primary intention of the exposure is not to bring a health benefit to the individual being exposed; This includes occupational health surveillance; radiological health assessment for employment, immigration or insurance; concealed objects within human body; age assessment; athlete development or selection (non-medical care); physical development of children;

If such exposures are carried out a specific procedure is required.

Medico-Legal exposures should only be requested based on specific medical advice, and if they are expected to show a net benefit to the subject. They should only be performed if no results of a previous examination giving the suggested information can be obtained. All departments performing medico-legal exposures must have a written procedure that specifies the individuals able to justify the examination and

requires that the examination should be recorded as a Medico-Legal exposure.

8.14 Carers and Comforters

Departments must have a procedure outlining the guidance to be provided for carers and comforters, including risks when supporting patients and defining dose constraints for radiation exposure.

9. References

- 9.1 The use of ionising radiation in health establishments in the UK is governed by a series of statutory instruments. General health & safety of staff and members of the public is specified in the *Ionising Radiations Regulations 2017* [SI 2017a] and the associated Approved Code of Practice [HSE 2017]. The *Ionising Radiation (Medical Exposure) Regulations 2017* [SI 2017b] impose responsibilities on both the employer and employees with regard to medical exposures.
- 9.2 There are additional legal requirements covering radioactive substances. The *Ionising Radiation (Medical Exposure) Regulations 2017* control the administration of radioactive medicinal products to humans. The *Environmental Permitting (England and Wales) Regulations 2016* [SI 2016], as amended 2018 [SI 2018] control the storage and use of radioactive substances and their disposal, including discharge as radioactive waste. The principle of "Best Available Techniques" (BAT) must be applied to all aspects of radioactive waste creation and disposal to ensure that doses to members of the public are kept "as low as reasonably achievable" (ALARA). The *Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009* [SI 2009] (as amended [SI 2011 and SI 2019]) covers the transport and movement of radioactive materials, including driver training. Other regulations, regulatory regimes, codes of practice or guidance apply to security of radioactive substances on user premises, e.g. the National Counter Terrorism Security Office's "Security Requirements for Radioactive Sources".
- 9.3 Written guidance on good practice is provided for both sets of Ionising Radiation Regulations, and further guidance is given in WHC(95)24 *Health Service Use of Ionising Radiations*, WHC(97)44 *Medical Use of Ionising Radiation – Patient Booking and Authorisation Procedures* (Welsh Office 1995 and 1997), and in the *Notes for Guidance on the Clinical Administration of Radiopharmaceuticals and Use of Sealed Radioactive Sources* published by the Department of Health (ARSAC). It is the policy of the Health Board that such guidance should be followed except where specifically agreed by the Radiation Protection Committee.

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<http://www.legislation.gov.uk/ukxi/2011/1885/contents/made>

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SI 2017a. The Ionising Radiations Regulations 2017. Statutory Instrument 2017 No 1075. London: HMSO.

<http://www.legislation.gov.uk/ukxi/2017/1075/contents/made>

SI 2017b. The Ionising Radiation (Medical Exposure) Regulations 2017. Statutory Instrument 2017 No 1322. London: HMSO

<http://www.legislation.gov.uk/ukxi/2017/1322/contents/made>

SI 2018. The Environmental Permitting (England and Wales) (Amendment) (No.2) Regulations 2018. Statutory Instrument 2018 No 428. London: HMSO

<https://www.legislation.gov.uk/ukxi/2018/428/contents/made>

SI 2019. The Carriage of Dangerous Goods (Amendment) Regulations 2019. Statutory Instrument 2019 No. 598. London: HMSO

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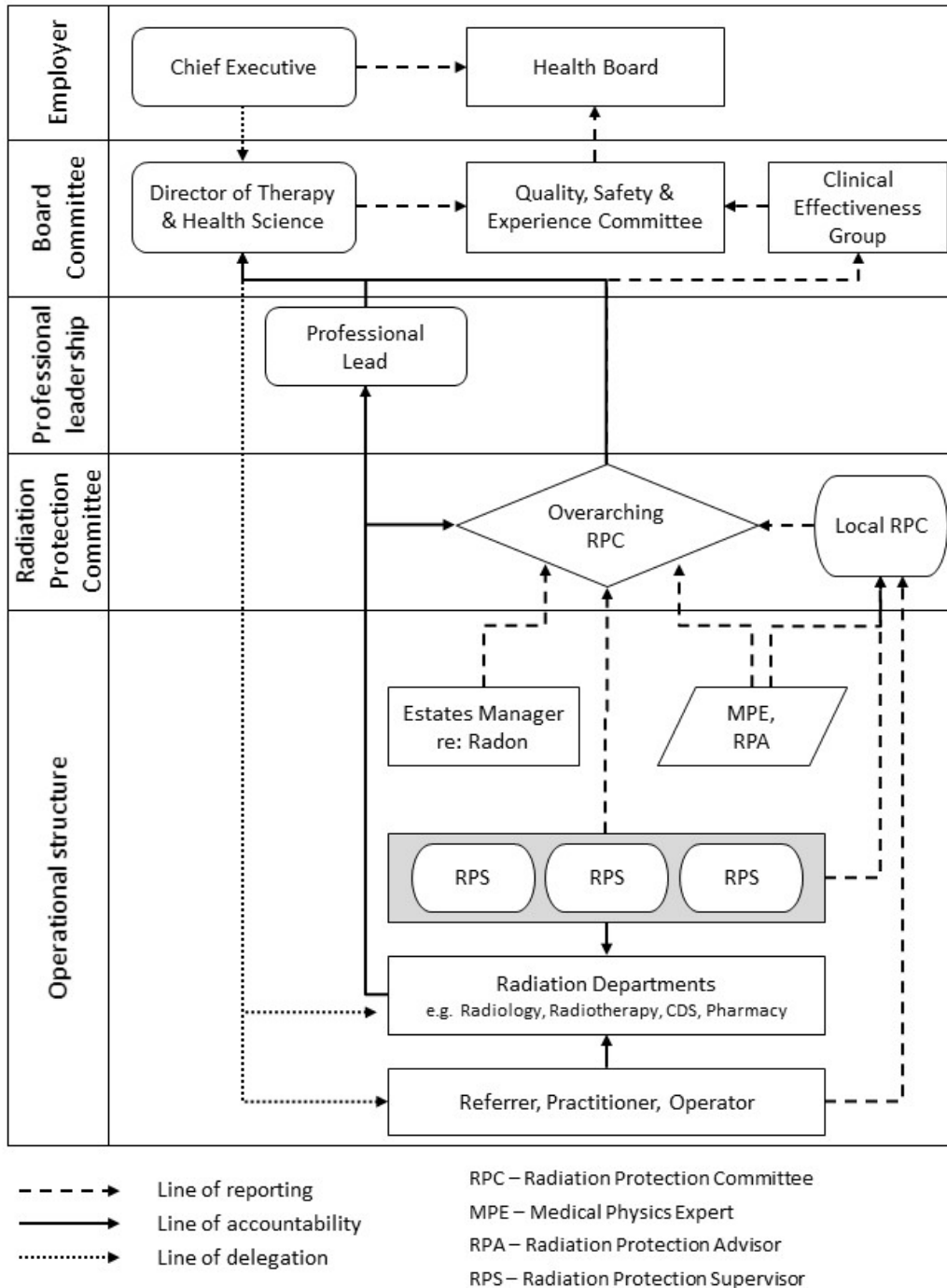
Welsh Office 1997. Medical use of ionising radiation – patient booking and authorisation procedures. Welsh Health Circular WHC(97)44. Cardiff: Welsh Assembly Government.

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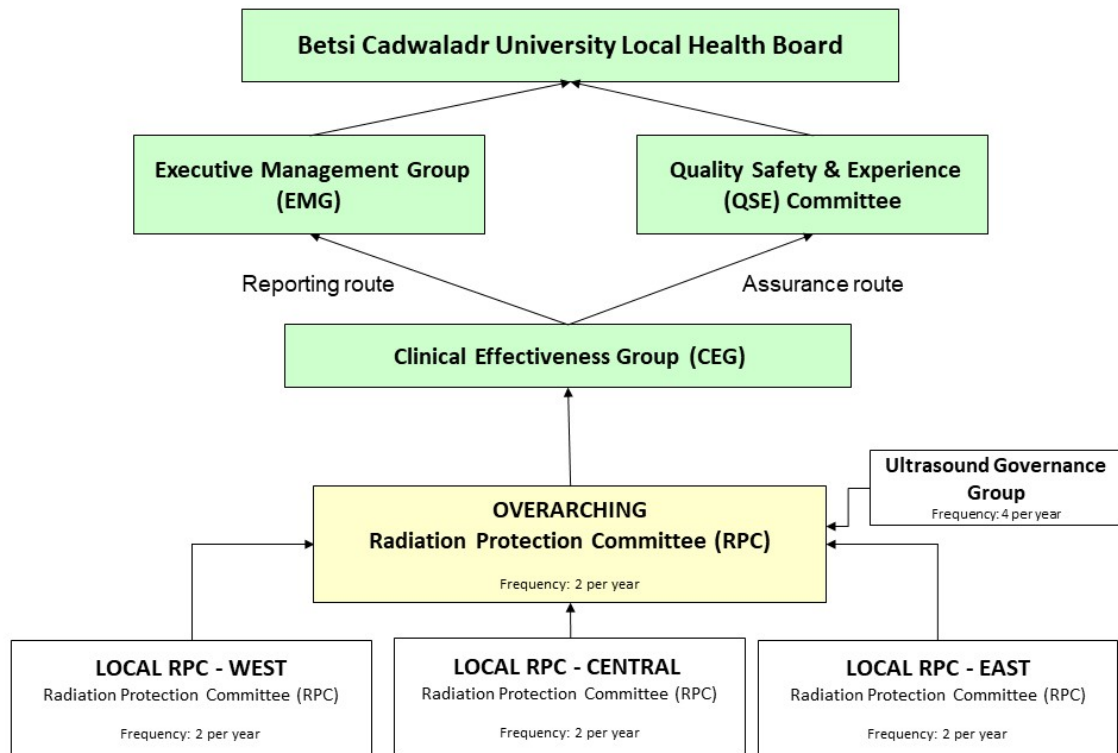
<http://wales.gov.uk/topics/health/cmo/committees/scientific/reports/equipment/?lang=en>

APPENDIX 1 Radiation Protection Organisation

Employer Line of Delegation, Radiation Protection Governance Structure



A1.1 Management Structure



APPENDIX 2 General Guidance on Entitlement

As discussed above, the legislation [SI 2017a and SI 2017b] requires the appointment of specified officers. The following gives general guidance on who is permitted by the Health Board to appoint staff into such positions.

A2.1 **Radiation Protection Adviser (RPA)**

Since RPAs are required to provide advice throughout the organisation, they should be appointed by the BCUHB Executive Director of Therapies and Health Science.

A2.2 **Radiation Protection Supervisor (RPS)**

Due to the need to appoint staff who are aware of and can deal with local issues, they should be appointed by the Clinical Director or Head of Department responsible for the member of staff.

A 2.3 **Radioactive Waste Adviser (RWA)**

Since RWAs are required to provide advice throughout the organisation, they should be appointed by the BCUHB Executive Director of Therapies and Health Science.

A2.4 **Referrer**

The Executive Director of Therapies and Health Science has overall responsibility for deciding who can act as a Referrer.

The Clinical Director responsible for the member of staff should appoint the Referrer, with the agreement of the Clinical Director of the Service responsible for subjecting the patient to ionising radiation.

For non-medical referrers to radiology, the responsibility for appointment to referrer will be with the radiology department in accordance with the BCUHB procedure *T&HS01 Guidance and procedure for non-medical/dental referrals for radiological investigations* <http://howis.wales.nhs.uk/sitesplus/861/page/55488> .

A2.5 **Practitioner**

The Executive Director of Therapies and Health Science has overall responsibility for deciding who can act as a Practitioner.

The Clinical Director or Head of Service responsible for the member of staff should appoint the Practitioner.

A2.6 **Operator**

The Executive Director of Therapies and Health Science has overall responsibility for deciding who can act as an Operator.

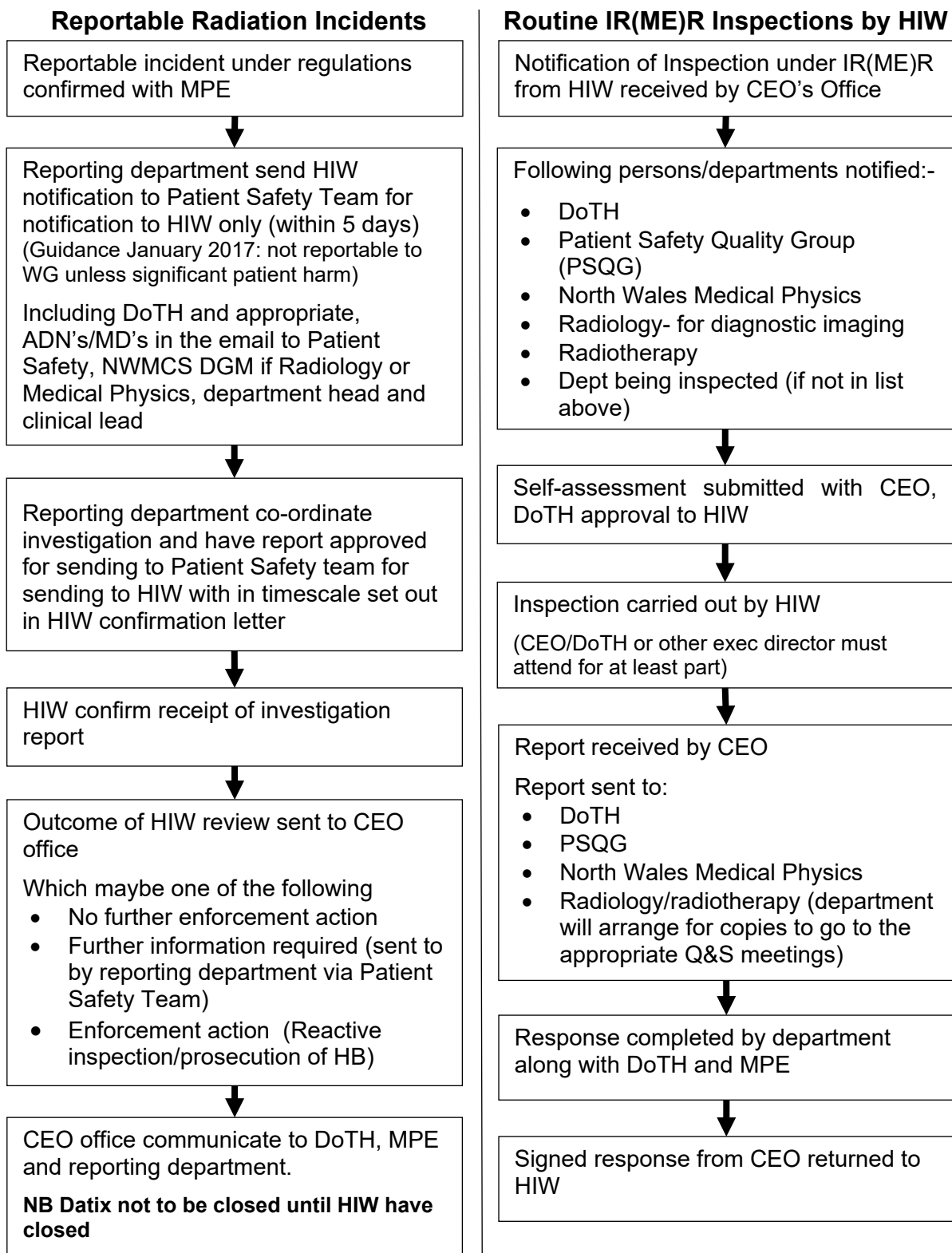
The Clinical Director or Head of Service responsible for the member of staff should appoint the Operator. If the Operator is to use equipment which is the responsibility of another service then agreement should be

sought from the Clinical Director of the service responsible for the source of ionising radiation

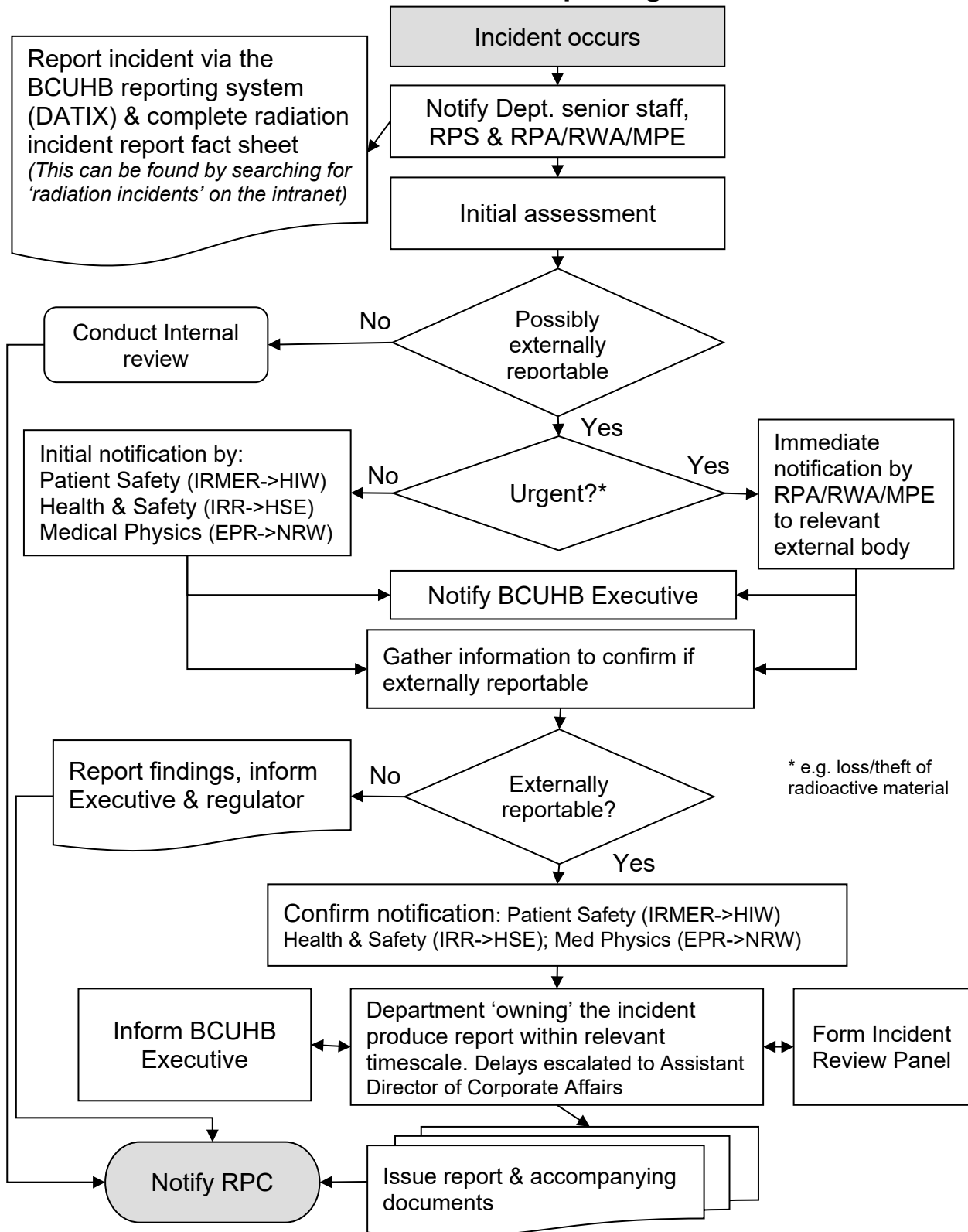
A2.7 Medical Physics Expert (MPE)

Due to the need to appoint staff who are aware of and can deal with specific applications of Medical Physics, and since they are required to provide advice throughout the organisation, they should be appointed by the BCUHB Executive Director of Therapies and Health Science.

APPENDIX 3 Management of reportable Incidents and Inspections under IR(ME)R from HIW



APPENDIX 4 Radiation incident reporting flowchart



APPENDIX 5 **Abbreviations**

ADN	Assistant Director of Nursing
BAT	Best Available Techniques
CEG	Clinical Effectiveness Group
CEO	Chief Executive Officer
DGM	Directorate General Manager
DoTH	Executive Director for Therapies and Health Science
DRL	Diagnostic Reference Level
EMG	Executive Management Group
HB	Health Board
HIW	Healthcare Inspectorate Wales
HSE	Health and Safety Executive
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IRR	Ionising Radiations Regulations
MD	Medical Director
MPE	Medical Physics Expert
NaCTSO	National Counter Terrorism Security Office
NWMCS	North Wales Managed Clinical Services
NRW	Natural Resources Wales
PSQG	Patient Safety Quality Group
QSE	Quality, Safety and Experience Committee
RPC	Radiation Protection Committee
RPA	Radiation Protection Adviser
RPS	Radiation Protection Supervisor
RWA	Radioactive Waste Adviser
SOP	Standard Operating Procedure

Members of the Working Group:

Title
Head of Quality and Governance, Radiology
Head of Radiography
Radiology Services Manager (West)
Radiology Services Manager (East)
Radiology Services Manager (Central)
Principal Nuclear Medicine Radiographer
Radiotherapy Services Manager
Head of Radiotherapy Physics and MPE
Head of Radiation Physics, RPA & MPE
Head of Radioisotope Physics, RPA, RWA & MPE
Deputy Head of Radiation Physics and MPE



PARTS A (Screening – Forms 1-4) and
B (Key Findings and Actions – Form 5)

<u>For:</u>	<i>The BCUHB Ionising Radiation Protection Policy 4th edition</i>
<u>Date form completed:</u>	<i>22nd June 2021</i>



PARTS A: SCREENING and B:
KEY FINDINGS AND

ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "...all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A

Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	The Ionising Radiation Protection Policy (4 th edition)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The use of ionising radiation in health establishments in the UK is governed by a series of statutory instruments, many are enforced as health and safety regulations made under the Health and Safety at Work Act 1974.</p> <p>This policy is issued to provide direction and arrangements for the safe management of ionising radiation within the BCUHB in compliance with Statutory Duties as detailed in the Ionising Radiations Regulations 2017, the Ionising Radiation (Medical Exposure) Regulations 2017 and other relevant legislation, codes of practice and guidance.</p> <p>The current revision is due to requirements of an HIW inspection of Cancer Treatment Centre in March 2021 and due for action by September 2021.</p>
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	<i>Executive Director of Therapies & Health Sciences</i>
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<p>Health and safety policy HS01</p> <p>EqlA originally completed in 2011, last reviewed June 2021.</p>
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	BCUHB Board, all radiation users, staff and service users
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	<p>Lack of engagement by staff in the implementation of the Policy</p> <p>Inadequate training and staff understanding of the procedure</p> <p>Inability to get up-to-date information to staff on radiation safety</p>
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Policy covers radiation safety for all employees, patients and members of public.

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	<p>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here</p>	<p>How will you reduce or remove any negative Impacts that you have identified?</p>
<p>Guidance for Completion</p> <p><i>In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered ‘Yes’, you need to indicate if the potential impact will be positive or negative. Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.</i></p> <p><i>The information that helps to inform the assessment should be listed in this column. Please provide evidence for all answers.</i></p> <p>Hint/tip: do not say: “not applicable”, “no impact” or “regardless of...”. If you have identified ‘no impact’ please explain clearly how you came to this decision.</p> <p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>			
Yes	No	(+ve)	(-ve)

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Age		No		<p>No negative impact identified. However, it is recognised that there are further considerations for the exposure of young people. The policy follows national guidance and complies with the Ionising Radiations Regulations 2017 (IRR17), Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) which make express provision that no young person under the age of 18 can be employed to work with ionising radiation where they would need to be designated as classified. There are also specific dose limits for young people (under 18) who may be exposed to ionising radiations while undertaking training or studying.</p> <p>IR(ME)R Regulation 12(8) mandates that the practitioner and the operator must pay particular attention in relation to the medical exposure of children.</p> <p>Whilst it is recognised that dementia can affect younger people, it is more common in people over the age of 65 (alzheimers.org.uk). For patients suffering with capacity issues, consent to treatment will also require further consideration. IR(ME)R Regulation 12(6) provides for the provision of written instruction and information for patients deemed to have the capacity to consent, children and for instances where the patient is an adult who lacks the capacity to consent.</p>	No negative impact identified. The requirements of the legislation are reflected in the policy.
Disability		No		<p>Cancer is a recognised disability under the Equality Act 2010. It is recognised (National Cancer Institute) that ionising radiation, has enough energy to damage DNA and cause cancer. Certain diagnostic medical procedures, such as chest x-rays, computed tomography (CT) scans, positron emission tomography (PET) scans, can cause cell damage that leads to cancer. In the case of radiation therapy, the aim is to destroy cancerous cells whilst limiting the exposure to healthy cells.</p>	Whilst there is the potential for negative impact, the benefits of treatment outweigh the risks. All clinicians have a professional duty of care to ensure that patients are fully and properly informed of the

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					In all cases, a justification process (IR(ME)R regulation 11) must be followed to ensure the benefits outweigh the risks and an optimisation process (IR(ME)R regulation 12) must be in place to ensure the radiation dose is as low as reasonably practicable.	potential risks associated with any proposed treatment.
Gender Reassignment		No			<p>Trans and non-binary people make up at least 1.5% of the UK population and 41% have reported that they avoid seeking healthcare due to fear of ridicule, harassment or violence (The Society of Radiographers). The policy has been updated to reflect gender neutral language – ‘individuals of child bearing age’ when identifying potential pregnancy. This is important as a patient may not have undergone any specific hormone treatment or surgery and may be at any stage in the transition process. Therefore, there may be a disconnect between their appearance and their ‘legal’ name or gender.</p> <p>This also raises issues as to patient confidentiality, annotating a patient’s notes to show they have a Gender Recognition Certificate and may have what would be considered ‘typically female’ reproductive organs, may be in contravention of the Gender Recognition Act 2004, s 22.</p> <p>See also: <u>Improving communication with the gender diverse community in diagnostic imaging departments</u></p>	Whilst there is the potential for negative impact, all clinicians are bound by the common law of confidentiality, their professional codes of conduct, and the BCUHB Confidentiality Policy.
Pregnancy and maternity		No			There is a potential for negative impact on pregnancy. However, the regulations (IRR17) stipulate specific dose limits for employees during pregnancy and IR(ME)R pays particular	Whilst there is the potential for negative impact, the legislation and the policy

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					attention to the medical exposure of pregnant individuals and the unborn child. This is reflected in the policy.	mitigates this by making it explicit that 'All departments performing medical exposures must have a written procedure for identifying possible pregnancy'.
Race		No			No negative impact identified. As per NICE guidelines (Radiation dose monitoring software for medical imaging with ionising radiation), the main equality considerations are age and pregnancy - <i>Children are at higher risk than adults because they are more sensitive to radiation. Pregnant women and their fetuses are also at higher risk of damage from radiation exposure.</i> There is insufficient evidence or research to establish whether ionising radiation treatment / exposure has differing effects upon race.	No negative impact identified / insufficient data
Religion, belief and non-belief		No			There may be issues identifying pregnancy where the patient is unwilling or afraid to answer truthfully (unmarried). Joint guidance by the Institute of Physics and Engineering in Medicine, the Society & College of Radiographers and the Royal College of Radiologists provides a table of actions to consider where the response is 'yes', 'no' or 'unsure'.	Whilst there is the potential for negative impact, the legislation and the policy mitigates this by making it explicit that 'All departments performing medical exposures must have a written procedure for identifying possible pregnancy'.

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Sex		No			No negative impact identified. However, as per NICE guidelines (Radiation dose monitoring software for medical imaging with ionising radiation), one of the main equality considerations is pregnancy - <i>Pregnant women and their foetuses are also at higher risk of damage from radiation exposure.</i>	No negative impact identified, however it is recognised that one of the main risks associated with the treatment is for pregnancy.
Sexual orientation		No			No negative impact identified. As per NICE guidelines (Radiation dose monitoring software for medical imaging with ionising radiation), the main equality considerations are age and pregnancy - <i>Children are at higher risk than adults because they are more sensitive to radiation. Pregnant women and their foetuses are also at higher risk of damage from radiation exposure.</i>	No negative impact identified.
Marriage and civil Partnership (Marital status)		No			No negative impact identified. As per NICE guidelines (Radiation dose monitoring software for medical imaging with ionising radiation), the main equality considerations are age and pregnancy - <i>Children are at higher risk than adults because they are more sensitive to radiation. Pregnant women and their foetuses are also at higher risk of damage from radiation exposure.</i>	No negative impact identified.
Socio Economic Disadvantage		No			The treatment must be carried within BCUHB premises. Some patients may experience difficulties in meeting travel costs. Patients who have difficulty in attending appointments due to financial circumstances can apply for reimbursement as per F09 – Reimbursement of travel to hospital costs.	Patients may incur travel costs to hospital sites. Reimbursement may be available.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: <http://howis.wales.nhs.uk/sitesplus/861/page/42166> and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker <https://humanrightstracker.com>.

The Articles (Rights) that may be particularly relevant to consider are:-

- Article 2 Right to life
- Article 3 Prohibition of inhuman or degrading treatment
- Article 5 Right to liberty and security
- Article 8 Right to respect for family & private life
- Article 9 Freedom of thought, conscience & religion

Please also consider these United Nations Conventions:

[*UN Convention on the Rights of the Child*](#)

[*UN Convention on the rights of people with disabilities.*](#)

[*UN Convention on the Elimination of All Forms of Discrimination against Women*](#)

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	No				This policy follows national guidance and complies with The Ionising Radiations Regulations 2017,	<i>Please explain how you intend to remove or reduce any</i>

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

					Ionising Radiation (Medical Exposure) Regulations 2017. No negative impacts have been identified	<i>negative impacts you have identified. Be specific.</i>
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Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	x		x		Welsh language is considered with all necessary radiation warning signage. This policy will be translated once approved.	None identified
Treating the Welsh language no less favourably than the English language		No			Welsh language is considered with all necessary radiation warning signage. This policy will be translated once approved.	<i>Please explain how you intend to remove or reduce any negative impacts you have identified. Be specific.</i>

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p><i>Representatives of all ionising radiation user groups via local and overarching Radiation Protection Committees (RPC)</i></p> <p><i>This is the fourth edition of this policy. The first edition passed through the EQIA process in 2011 and involved engagement with Staff representatives, equalities and human resources</i></p>
<p>Have any themes emerged? Describe them here.</p>	<p>Pregnancy and age. Both are thoroughly considered and provided for by the legislation and the BCUHB policy</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>As per above – provision made within the policy in accordance with the legislation.</p>

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- <http://howis.wales.nhs.uk/sitesplus/861/page/44085>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	The BCUHB Ionising Radiation Protection Policy (4 th edition)
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The use of ionising radiation in health establishments in the UK is governed by a series of statutory instruments, many are enforced as health and safety regulations made under the Health and Safety at Work Act 1974.</p> <p>This policy is issued to provide direction and arrangements for the safe management of ionising radiation within the BCUHB in compliance with Statutory Duties as detailed in the Ionising Radiations Regulations 2017, the Ionising Radiation (Medical Exposure) Regulations 2017 and other relevant legislation, codes of practice and guidance.</p> <p>The current revision is due to requirements of an HIW inspection of Cancer Treatment Centre in March 2021 and due for action by September 2021.</p>
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

<p>High significance may mean:</p> <ul style="list-style-type: none"> - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. <p>GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/</p>			
4. Did your assessment	<p>Yes <input type="checkbox"/></p> <p>No <input checked="" type="checkbox"/></p>		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	<i>Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?</i>	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	<i>Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.</i>	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
How is it being monitored?	Any incidents involving radiation (including missed pregnancies) are logged via datix and sighted on by Head of Department. A summary of radiation incidents (including trend analysis) is routinely reviewed at the radiation protection committee (RPC) meetings. Regular audits of compliance with the legislation and this policy are performed in each department using ionising radiation	
Who is responsible?	Head of department using ionising radiation	
What information is being used?	Datix and audit results	
When will the EqIA be reviewed?	June 2024 in line with the periodic policy review or as required (changes in legislation / best practice).	
7. Where will your policy or proposal be forwarded for approval?	June 2021	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity Senior sign off prior to committee approval:	Name	Title/Role
	Peter Hiles.	Head of Radiation Physics, Medical Physics
	Helen Hughes	Radiology Head of Quality & Governance
	<i>Name of senior sign off prior to committee approval</i>	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	<i>none</i>		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	<i>None</i>		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	<i>None</i>		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	<i>None</i>		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	None		



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality and Performance Report to 31 st July 2021						
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Mark Wilkinson <u>Mrs Sue Hill</u> , Executive Director of Planning and Performance <u>Finance</u>						
Awdur yr Adroddiad Report Author:	Mrs Kamala Williams, Interim Director of Performance Mr Ed Williams, Head of Performance Assurance						
Craffu blaenorol: Prior Scrutiny:	The data and information in this report has been scrutinised by the Interim Director of Performance						
Atodiadau Appendices:	<u>1. Quality and Performance Report</u> None						
Argymhelliad / Recommendation:							
Members of the Quality, Safety and Experience Committee are requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.							
Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	<input checked="" type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input checked="" type="checkbox"/>
Sefyllfa / Situation:							
Delivery Measures							
<p>Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published (due mid to late August 2021).</p> <p>The Committee are asked to note the following: Whilst we have restarted the recovery of our planned care services, we are continually monitoring COVID-19 rates and have plans in place to ensure that we can continue to deliver services safely.</p> <p>Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout Quarter 4, 2020/21 at 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of <u>measles, mumps & rubella</u> (MMR) vaccinations by age 5.</p> <p>Over the past 12 months, the cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population has increased at an all Wales level. This is in contrast to the position in BCUHB, which has seen improvement in EColi, S.aureus bacteraemia and C Difficile rates per 100,000 population over the same period.</p> <p>The infection prevention and control teams continue to work on reducing the number of infections alongside their work on COVID-19.</p>							

For Adult Mental Health performance has remained stable with 63% adults assessed within 28 days of referral in June compared to 61.99% in April. The number of patients starting therapy within 28 days of assessment remains above the 80% target at 82.4% a slight improvement on the April position of 80.9%

Performance remains poor against the $\geq 80\%$ target for children assessed within 28 days of referral at 26.8% in June. The rate for children starting therapy within 28 days of assessment was lower again at 18.5%. The comparative figures for April were 23.68% and 19.64% respectively.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy, with the target $\geq 80\%$ achieved and exceeded in July 2021 at 84.62%.

The number of patients experiencing a delayed transfer of care (DToC) within our mental health service remains static at 16 in July 2021 (compared to 15 in May 2021), the length of stays slightly increased in July at 580 bed days lost compared to 565 in May but compares favourably to the position in April 2021 at 631 days.

Performance against the 26 Week target $\geq 80\%$ for children awaiting neurodevelopment assessment remains poor at 32.79%, however this represents an improvement on the 26.84% reported in May 2021. Recently approved plans should increase capacity for assessment to 120 children a month, which will continue to support improved performance.

There were no New Never Events reported in July 2021.

The percentage closure rate of complaints managed under Putting Things Right (PTR) < 30 working days (target 75%) – 64% in July compared to 57.39% May 2021. Although not achieving the target, compliance at circa 62% over the last 7 months has been a sustained improvement compared to previous years where performance has been as low as 30%.

Crude Mortality under 75 years old has decreased to 0.96% in June 2021, which is lower than the Wales average of 1.16%.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments and the Office of the Medical Director is currently reviewing this. Reporting is due to recommence by end of August 2021.

A Quality Surveillance Group (incorporating, performance, corporate, medical and nursing services) has been established (First meeting held on 14th June 2021) to review quality and identify hotspots and risks.

COVID-19 is now subject to a separate report to the Board and is therefore no longer included in the Quality & Performance report.

Cefndir / Background:

This report outlines performance against the key performance and quality measures identified as a priority for the Health Board and reported to the Quality, Safety and Experience Committee.

The Executive Summary pages of the QAP sets out performance against the key measures contained within the 2020/21 Welsh Government National Delivery Framework. Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020/21 NHS Wales Delivery Framework until such time as the Framework for 2021/22 is published (due mid to late August 2021).

The National Delivery Measures are derived from the Framework and are aligned to the Quadruple Aims set out in 'A Healthier Wales', Welsh Government's long term plan for health and social care.

Asesiad / Assessment & Analysis

Strategy Implications

The National Delivery Measures align to the National Delivery Framework, which supports 'A Healthier Wales' and the Health Boards Annual Plan.

Options considered

Not Applicable

Financial Implications

The delivery of the measures contained within the Health Board's Annual Plan will have direct and indirect impact on the financial position of the Board.

Risk Analysis

The COVID-19 pandemic has produced a number of direct and indirect risks to the delivery of care across the healthcare system.

Legal and Compliance

This report will be available to the public once published for Finance and Performance Committee

Impact Assessment

The Report has not been Equality Impact Assessed

Quality and Performance Report

Quality, Safety & Experience Committee

Performance to 31st July 2021

Presented on 7th September 2021

Title	Page	Title	Page
Cover	1	Quadruple Aim 3: Quality	17 to 21
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About this Report	3	Additional Information	26
Executive Summary	4	Quadruple Aim 2: Charts - : Children's & Young Adults Mental Health Services (CAMHS)	27
Quadruple Aim 1: Improved population health and Wellbeing	5	Quadruple Aim 2: Charts – Adult Mental Health	28 to 29
Quadruple Aim 2: Better Quality and more accessible healthcare	6	Charts – Impact of COVID-19 on Activity	30 to 33
Quadruple Aim 2: Infection Prevention & Control	7 to 9	Further Information	34
Quadruple Aim 2: Children's & Young Adults Mental Health Services (CAMHS)	10 to 12		
Quadruple Aim 2: Adult Mental Health	13 to 16		

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published (due late August 2021).

Report Structure

The format of the report reflects the latest published National Delivery Framework which relates to 2020-21 and aligns to the quadruple aims contained within the statutory framework of 'A Healthier Wales'.

The report is structured so that measures complementary to one another are grouped together. Narratives on the 'group' of measures are provided, as opposed to looking at measures in isolation.

This report contains data showing the impact of the pandemic on referrals, planned care activity and waiting lists.

Performance Monitoring

Performance is measured via the trend over the previous 6 months and not against the previous month in isolation. The trend is represented by RAG arrows as shown below.



Performance has improved over the last 6 months



Performance has got worse over the last 6 months



Performance remains the same

Ongoing development of the Report

The Quality & Performance Report for this Committee, together with the sister report for Finance & Performance Committee and for the Health Board are in the process of being redesigned.

The Integrated Quality & Performance Report will take a proactive approach towards providing assurance. It is supported by a set of frameworks and methodologies that will provide objective and replicable levels of assurance on content.

The Committee are asked to note the following:

Quadruple Aim 1: Prevention

Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout Quarter 4, 2020/21 at 95.4% of eligible children receiving 6 in 1 Hexavalent and 95.2% of eligible children receiving 2 doses of MMR vaccinations by age 5.

Quadruple Aim 2: Infection Prevention

Over the past 12 months, the cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population has increased at an all Wales level. This is in contrast to the position in BCUHB, which has seen improvement in E.Coli, S.aureus bacteraemia and C Difficile rates per 100,000 population over the same period.

The infection prevention and control teams continue to work on reducing the number of infections alongside their work on COVID-19.

Quadruple Aim 2: Mental Health

For Children's & Young Adults Mental Health Services (CAMHS) performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 26.80%, and starting therapy within 28

days of assessment at 18.50%.

Although improved, Performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 32.79%, compared to 26.84% reported previously. It is expected that plans recently approved will enable us to increase capacity to see 120 children per month and this will translate to a much improved performance.

For adult mental health services performance has improved as predicted, compared to the previous report, with percentage adults assessed within 28 days of referral at 63%. The number of patients starting therapy within 28 days of assessment remains above the 80% target at 82.40%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy and at 84.62% in July 2021 has for the first time exceeded the 80% target rate. This is a significant and sustained improvement from a low of 20.1% in September 2020.

The number of patients experiencing delayed transfer of care (DToC) within our mental health has increased slightly at 16 in July 2021 (compared to 15 in May 2021), the length of stays has also increased slightly to 580 (compared to 565 in May 2021). The

service is working to resolve issues that lead to DToC and it is expected that the number and length of DToC's will fall over the coming months.

Quadruple Aim 3: Quality & Safety

There were 0 new Never Events reported in July 2021.

The percentage closure rate of complaints managed under PTR < 30 working days (target 75%) – 64% July 2021. Whilst not reaching the set target the process is currently stable and delivering at around 62% compliance for the last 7 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Quadruple Aim 4: Mortality and Timely Interventions

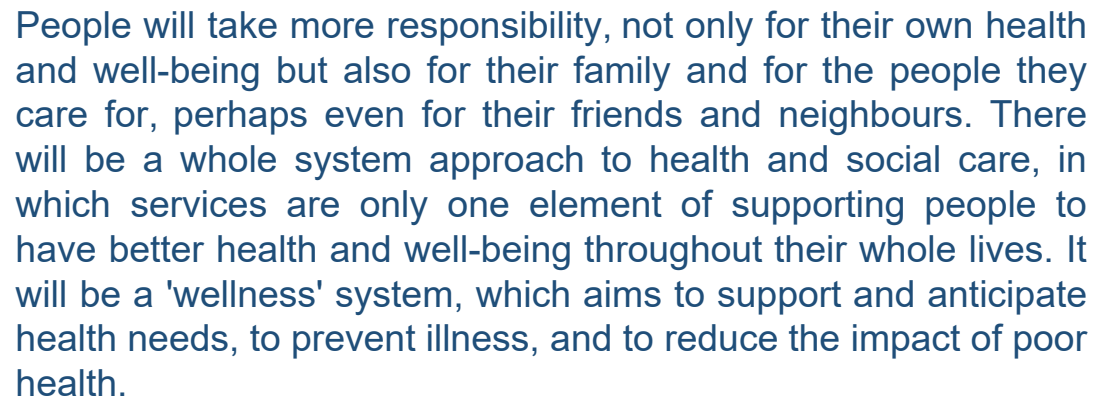
Crude Mortality (under 75 years old) has decreased to 0.96%. The mortality rate for BCU is lower than the Wales average of 1.13%. As BCU has not been an outlier for mortality for at least 24 months, it is suggested that there is no longer a need to provide an exception report on this.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our

Emergency Departments. The Office of the Medical Director is currently reviewing this. Reporting of emergency Department data and reporting has recommenced as of July 2021

Performance management

The Quality & Performance Report is currently being redesigned with a view to presenting a new Integrated Quality & Performance Report to the Health Board and it's committees during Quarter 3 of 2021-22.



Childhood
immunisations
continue at a high
rate despite
COVID-19

Timely provision of
Care Treatment
Plans for Adults and
Children remains on
or above target

Period	Measure	Target	Actual	Trend
Q4 20/21	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	>= 95%	95.40%	<div></div>
Q4 20/21	Percentage of children who received 2 doses of the MMR vaccine by age 5	>= 95%	95.20%	<div></div>
Q4 20/21	Percentage of adult smokers who make a quit attempt via smoking cessation services*	>= 5%	3.55%	<div></div>
Jun 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)**	>= 90%	96.80%	<div></div>
Jun 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)**	>= 90%	90.40%	<div></div>

* Performance compared to same quarter previous year

Presented on 7th September 2021

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.



There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.

Key Messages

CAMHS continues to face challenges in meeting demand.

Decrease in number of Mental Health beds days lost to Delayed Transfers of Care

Performance against Adult Psychology 26 weeks waits has exceeded the 80% target

Key Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Jun 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	26.80%	<div></div>
Jun 21	Percentage of mental health (CAMHS) therapeutic interventions undertaken within 28 days of assessment	>= 80%	18.50%	<div></div>
Jul 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	84.62%	<div></div>
Jun 21	Percentage of mental health (Adult) therapeutic interventions undertaken within 28 days of assessment	>= 80%	82.40%	<div></div>

Quadruple Aim 2: Infection Control Measures

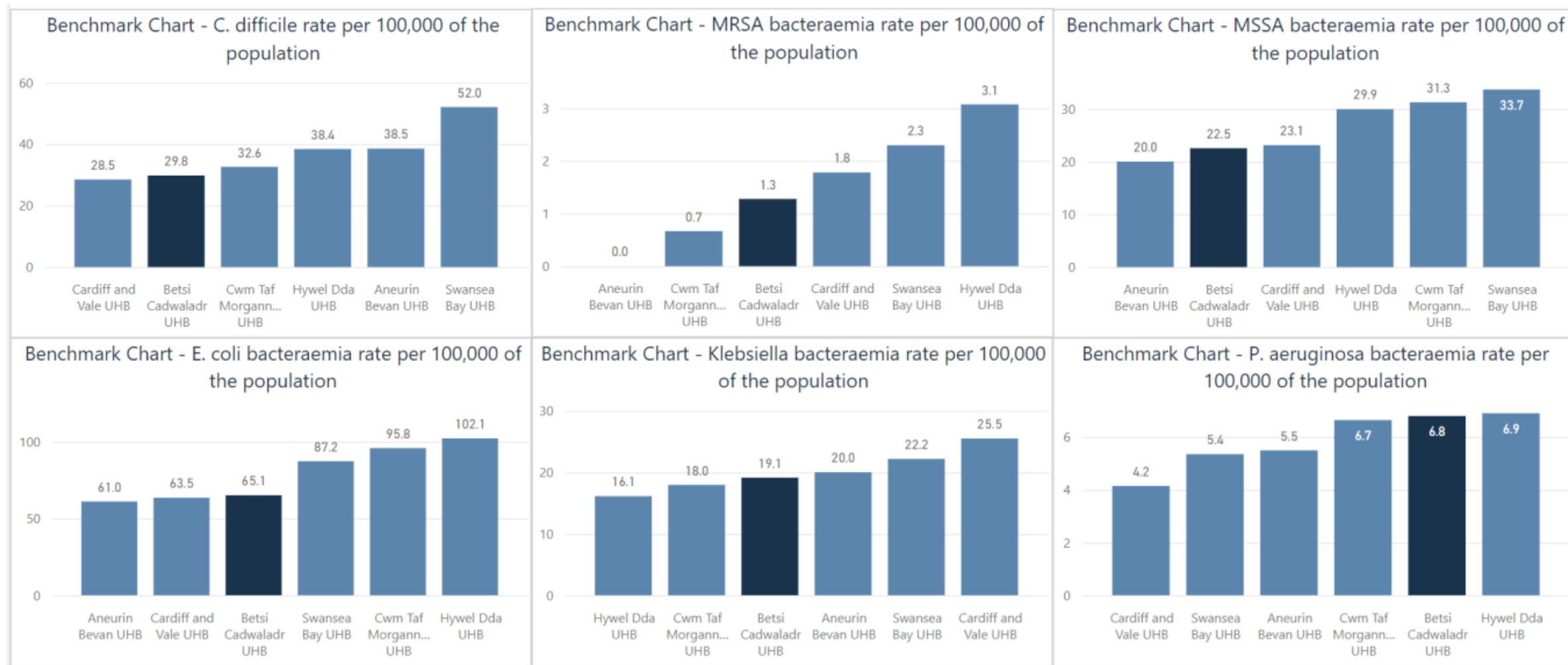
Period	Measure	Target	Actual
Jul 21	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	TBC	65.08
Jul 21	Cumulative number of laboratory confirmed E-Coli cases	TBC	153
Jul 21	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	TBC	24.25
Jul 21	Cumulative number of laboratory confirmed S.Aureus cases	TBC	57
Jul 21	Cumulative number of laboratory confirmed C.Difficile cases	TBC	71

Period	Measure	Target	Actual
Jul 21	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	TBC	30.20
Jul 21	Cumulative number of laboratory confirmed MRSA cases	TBC	3
Jul 21	Cumulative number of laboratory confirmed MSSA cases	TBC	54
Jul 21	Cumulative number of laboratory confirmed Klebsiella cases	TBC	45
Jul 21	Cumulative number of laboratory confirmed Aeruginosa cases	TBC	16

Notes to table:

- To be confirmed (TBC):** Awaiting confirmation of Health Board specific targets, these will be available when the 2021/2 NHS Wales Delivery Framework is formally published.

Comparison Charts to all Health Boards in Wales – July 2021



Rolling period refers to Cumulative April 2021 to Date (July 2021)

Quadruple Aim 2: Infection Prevention

Issues Affecting Performance

- Infection Prevention & Control (IPC) Team requires a multidisciplinary Team (MDT) approach utilising expertise from Anti-Microbial Pharmacists (AMPs), senior qualified Infection Prevention & Control (IPC) leads, project managers and quality improvement leads to provide the skillsets needed to support the frontline staff in reducing incidences, transmission, and risks of infections. Although funding for additional IPC staff was agreed several months ago, some vacancies remain un-recruited to, hindered by the by the complex nature of the recruitment processes.
- The increasing need to bring more people (patients and visitors) into hospital during a pandemic without expanding the facilities/redesigning how we deliver care.
- Isolation is the key control mechanism in infection prevention and control, this includes isolating suspected and know infected patients, physical distancing and sterile/effective fomite cleaning to stop the spread of infection.
 - We do not have enough appropriate facilities to provide rapid effective isolation for our suspected and confirmed infected patients.
 - We do not have enough people available to ensure effective fomite cleaning efficiently e.g. in between every contact.
 - How we use our facilities prevents us from maintaining enough physical distance to reduce the risk of infection transmission.
- Inability to find appropriate decant space to run a routine deep clean programme throughout our facilities.
- Inappropriate antimicrobial/PPI prescribing.
- Having the time to complete care bundle paperwork effectively upon insertion and maintenance of devices.
- Inability to have the information/intelligence needed at our fingertips to understand and minimise risk.
- Time it takes to get test results back - from test taken to results being acting upon. The national target is that tests be turned around within 12 hours and currently over 99% of tests meet this timeframe. However, we are proposing an ambitious project to significantly reduce the average test turnaround times. This work could form part of the improvement works of the laboratories and completion of the end-to-end process mapping of tests. The Executive Director for Public Health is overseeing the possibility of linking these two work-streams.

Actions and Outcomes

- Developing the Board Assurance Framework (BAF) to show short/medium and long term actions to drive performance improvement.
- Safe Clean Care Harm Free programme begin mobilised to support pan Health Board transformation and behavioural change, developing a bid for capacity and capability funding to provide full time support to drive improvements.
- Safe Clean Care Harm Free has six underpinning work streams Safe Place, Safe Space, Safe Action supported by Informatics, Communications and Staff Engagement to release time to deliver harm free care through mobilising the underpinning 38 projects.
- Second round of HARMs self assessment to see how the divisions are embedding the changes required to achieve the national IPC guidance and the remaining gaps.
- Accountable areas Infection Prevention Plans on a Page developed to set the road map for 2021/22 to reduce harms fostering an approach of zero tolerance to Health Care Associated Infections.




Timeline for delivery of improvement

April 2022

Risks and Mitigations

- Risks are set out on the corporate risk register and the Board Assurance Framework (BAF).
- New risk to flag is opening up our facilities to more visiting could significantly increase our risk of possible infection transmission and Health Care Associated Infections (HCAI).

Quadruple Aim 2: Children & Young Adult Mental Health Services

Frequency	Measure	Target	Actual	Trend
Jul 21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	32.79%	
Jun 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral	>= 80%	26.80%	
Jun 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment	>= 80%	18.50%	

Quadruple Aim 2: Children & Young Adult Mental Health Services (CAMHS)

Issues Affecting Performance

- Referrals increasing in comparison to pre-pandemic levels
- Children & Young People (C&YP) presenting with high acuity and complexity in Community teams and to Crisis teams, requiring additional support
- Reduced efficacy of evidenced based treatments delivered remotely leading to increased new to follow up ratio
- Reduced physical capacity within CAMHS accommodation due to social distancing requirements

Actions and Outcomes

- Progress has been made within the priority work streams under Targeted Intervention, recruitment to infrastructure posts is underway
- Funding secured for Eating Disorders, Psychological Therapies, Crisis services and Specialist CAMHS including Outreach team and recruitment underway. Discussions supported by workforce colleagues with regard to workforce strategy and recruitment options
- Funding secured for roll-out of Schools In-Reach project and recruitment underway
- Further regional single tender waivers being processed to support regional recovery
- Ongoing validation of waiting lists to ensure compliance against Mental Health Measure (MHM) targets
- Training opportunities for all staff groups being discussed with universities and Health Education & Improvement Wales (HEIW)
- Tender for private provider closed with 5 bids received, evaluation session arranged 20/08/2021. Requirement for Board & Ministerial approval of award
- Local discussions underway to support an increase in face to face activity in line with clinical need

Timeline for delivery of improvement

- Workforce plan being supplemented with additional Multidisciplinary Team (MDT) opportunities - now in recruitment stage
- Tender process to be completed with contract in place by December 2021. Single tender waivers in place to support additional capacity until final contract award

Risks and Mitigations

- Current vacancies and additional posts cannot be recruited to - to be supported by workforce plan.
- Demand for services and acuity and complexity increases
- Non-delivery on Mental Health Measures (MHM) targets included on service risk register – reviewed regularly at regional and local meetings and through Targeted Intervention (TI) Access work stream

Quadruple Aim 2: Neurodevelopment (ND)

Key Drivers of performance

- Current waiting list 2,437 an increase of 13% since April 21. Longest wait is at 200 weeks, this case is booked for September, after previously declining external provider offers.
- There are currently 1,695 children waiting over 26 weeks. A validation exercise on the waiting list was to commence at the end June 2021, but this has been delayed and will now start early September 2021.
- Internal activity from within establishment remains below trajectory – due to a backlog of cases that were put on hold during the pandemic and now being progressed and due to the complexity of some of these cases. A review of internal capacity is to take place to establish post pandemic capacity, this will be reported end of Qtr 2.
- Referrals have returned to pre-COVID-19 levels, but too early to know if this will be sustained going forward.

Actions being taken

- Position paper sent for board review, outlining requirement, that going forward the ND service will require significant investment into the service to meet demand, to alleviate the pressure on current staff and to prevent staff taking up alternative employment with competitors.
- Position Paper requests the approval/release of £1.4m set out in the BCUHB Plan for ND services; this will cover the External Provider costs until year end (see below point)
- External provider remains on target with agreed trajectory and confirmation received that they can deliver an enhanced trajectory of 1,104 by end March 2022. The External Provider had offered to deliver 1,500 or even 1,700 assessments by year end, however, this would require additional funding.
- Additional tender for interventions on hold due to lack of identified funding.






Timelines

- WL Validation exercise to commence early September 2021.
- Recommendation to release £1.4 m to fund capacity with external provider until March 22.
- Further recommendations in position paper to be considered by exec team including further funding for existing contract to continue next financial year and new tender. Procurement request funding commitment by April 22. Current external provider will reallocate current capacity on a quarterly basis without funding being released.

Risks

- The size of the service is insufficient to meet current demand. The waiting list (WL) has grown by more each year than internal capacity can deliver. Without a review a longer term solution will not be possible
- There is internal workload created by the use of external providers whether that's the current provider or future providers, we have to ensure that the balance between management of current caseloads and support of WL initiative is balanced.
- Release of current allocated WL funds (£1.4M) if delayed will result in current external provider allocating capacity elsewhere, without identification of additional funding sources, additional capacity from current external provider or ability to seek additional providers is not possible resulting in WL increase.
- Workforce retention and recruitment challenges - there are increasing opportunities for our specialised staff to choose their work setting, particularly as non NHS services offer higher rates of pay and alternative ways of working. This needs to be factored into our workforce planning, recruitment and service delivery strategy.

Quadruple Aim 2: Adult Mental Health

Frequency	Measure	Target	Actual	Trend
Jun 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral	$\geq 80\%$	63.00%	
Jun 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment	$\geq 80\%$	82.40%	
Jul 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	$\geq 80\%$	84.62%	
Jul 21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	16	
Jul 21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	580	

Quadruple Aim 2: Adult Mental Health Measures

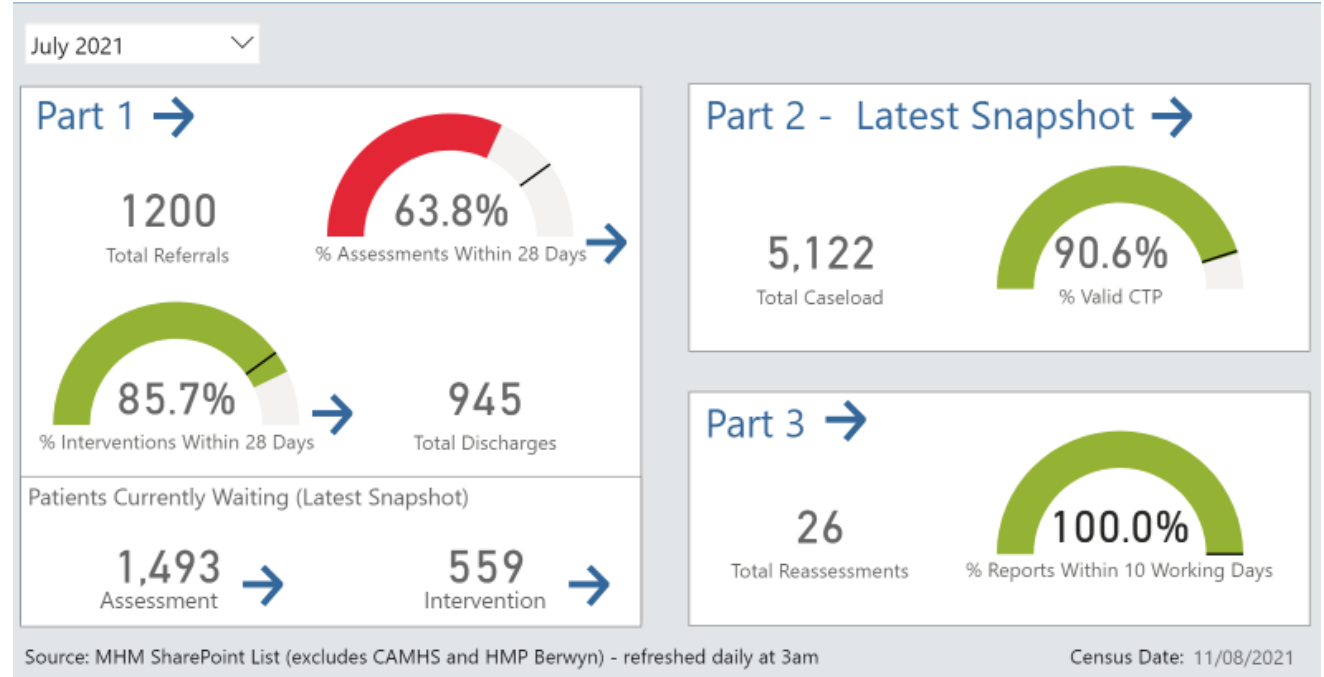
- The Division continues to experience challenges in achieving and sustaining compliance under Part 1A of the Mental Health Measure.
- The Division continue to be compliant Under Part 1B - in the delivery of Therapeutic intervention within 28 days .
- The Division continue to be compliant under Part 2 and Part 3 of the Mental Health Measure.

Issues Affecting Performance

- Current Capacity and Demand.
- Significant Vacancies and subsequent timeliness of Recruitment Process.
- Sickness absence
- COVID-19 Restrictions affecting service delivery, creating waiting lists for group interventions and producing barriers to a timely interventions and service user discharge experience.

Actions and Outcomes

- Divisional Action plan formulated by the Senior Leadership Team, Including Weekly Part 1 Scrutiny meetings, Fortnightly Mental Health Measures Action planning meeting.
- Mental Health Measures Performance discussed in all management meetings as standard agenda item.
- Policy and process reviewed to ensure accuracy and consistency across BCUHB Mental Health & Learning Disabilities (MH&LD) Division.
- Senior leads and Service Managers working closely to ensure timely recruitment process and proactive management of vacancies within the division.



Quadruple Aim 2: Adult Mental Health Delayed Transfers of Care

Since February 2021 the MH&LD Delayed Transfers of Care (DToC) performance has improved significantly due to a multi-disciplinary approach to effective discharge management resulting in reduced patient numbers and bed days lost. Whilst the target is for zero DToC, the complex nature of some of our patients who have combined and complex, physical health and mental health and/or learning disability needs, means we expect to see some DToCs as a consequence of providing care where discharge to an appropriate setting is not possible. This can be due to issues that are outside of our control, such as availability of bespoke placements and nursing homes COVID-19 status. The current performance as expected for June and July 2021, however, we are not complacent and DToC remains a priority for the division. Implementation of recommendations within the DToC Review report will continue to demonstrate improvement.

Issues Affecting Performance

- Analysis of weekly figures, barriers to change, appropriate coding of registration, actions and reduction/ increase in DToC for that period.
- National database updated and all related training given, this is now single source of DToC information, to allow parity and consistency across division
- Estimated Date of Discharge (EDD) requested for all registrations to allow monitoring of process and appropriate actions.

Actions and Outcomes

- Policy and process reviewed to ensure accuracy and consistency across the MH&LD Division.
- Divisional scrutiny panel weekly data considered, barriers identified and support and guidance offered by panel members.
- Delayed Transfer of Care Review Report presented to MH&LD Senior Leadership Team (SLT) with recommendations.
- Significant reduction in registered DToC's since scrutiny process enabled- **Overall reduction 77.5%** since inception of process.
- Since the review commenced reduced bed days lost to DToC from 3,000 to 676 – an increase of 35% is noted since May reporting.

Timeline for delivery of improvement

- Delayed Transfer of Care Report completed April 2021, Action Plan developed aligned to recommendations, updates provided monthly at Operational Leadership meeting and assurance report presented monthly at Divisional SLT.
- Acute Care Management (ACM) Task and Finish group established with first meeting 6/07/2021, actions relating to standardisation of ACM will be addressed at this group and fed into this overarching plan.
- Community Mental Health Team (CMHT) Standard Operating Procedure (SOP) review to progress with actions aligned to allocation of Care coordination feed into overarching DToC plan.
- Training actions aligned to recommendations to be discussed at Divisional Training and Development group to agree next step
- Set up project group regarding commissioning needs of Mental Health in relation to housing
- Pilot project developed supported with 3rd sector for 24hr enhanced supported living scheme in Wrexham.
- Cycle of business in place to meet with the six Local Authority Leads regarding Continuing Health Care (CHC) disputes.

Risks and Mitigations

- All risks managed through weekly scrutiny panel review and reported to divisional leads, with mitigation plans. Timelines, and Estimated Discharge Dates.
- All significant barriers identified and reported to Command meeting, where additional senior support is identified as a need to ensure timely resolution.

Quadruple Aim 2: Adult Psychological Therapy

Issues Affecting Performance

- Capacity/demand .
- Sickness, vacancies, retention
- COVID-19 restrictions

Actions and Outcomes

- WG funding and recruitment of small increase in Adult Mental Health (AMH) secondary care psychology specialist resource was targeted at waiting times/demand hotspots.
- Sustained stepped care pathway work over last 3 years has resulted in incremental improvements re: target compliance.
- The set up and roll out of the new AMH Psychology Stepped Care Initiative has increased psychological therapies provision from the MDT workforce across multiple services (as per Matrics Cymru) through a rolling supervision & training programme.
- This initiative has also developed and delivered increased direct provision of evidence based psychological therapy group interventions across Primary Care Mental Health (PCMH) and Community Mental Health (CMHT) pan BCUHB
- During the Covid 19 pandemic this initiative has also developed and increased availability of digital resources and adaptations, making these accessible to mental health MDT clinicians pan BCUHB Mental Health Learning Disabilities services to support increased access and delivery of Cognitive Behavioural Therapy, Dilatectical Behavioural Therapy, and Coping Skills via group and individual input.
- Two rounds of external support have been organised to address the Wrexham legacy waiting list, now cleared.
- Outcome is AMH secondary care specialist Psychological Therapies (PTs) compliance July 2021 is the highest since target was introduced .
- Outcome is also long term sustainability supported by increased psychological therapies competences and skills in the wider MDT workforce across services as per the stepped care model (Matrics Cymru), enabling wider service user access.
- Ongoing recruitment and retention plans for psychology staff resource in CMHTs, Inpatient Services, Perinatal Services.
- Achieved funding for increase dedicated resource for the North Wales Traumatic Stress Initiative, and recruitment underway.
- Achieved funding for dedicated psychology resource embedded in PCMH to further develop PTs in PCMH and outreach across stepped care mental health services, and recruitment underway.
- Strategic and Clinical Lead Consultant Psychologist recruitment underway. This will enable PTs development in Early Intervention Psychosis (EIP) services pan BCUHB, alongside other EIP service aims.

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable



New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnerships will support this with education providers and learning academies focussed on professional capability and leadership.

Key Messages



Measures

Period	Measure	Target	Actual	Trend
Q2 21/22	Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	64.00%	<div></div>
Jul 21	Number New Never Events	0	0	<div></div>
Jul 21	Doctor Appraisal / revalidation rate*	95%	84.17%	<div></div>

Failure to complete an appraisal due to COVID-19 issues will be logged as an approved missed appraisal. Everyone who has not completed an appraisal so far in 2021 is entitled to an approved missed appraisal. The adjusted figures should read 100% for all areas.

Quadruple Aim 4: Serious Incidents (Reportable)

Serious Incidents (Welsh Government Reportable)

Key Drivers of performance

- Key performance indicators set by Welsh Government. (New National Incident Reporting Policy implemented 14th June)
- BCUHB core values: Putting Patients First.
- Putting Things Right (PTR) Regulations.

Actions being taken and timelines

- Daily incident review meeting in place inclusive of moderate incidents.
- Local daily safety huddles remain in place.
- New incident management commenced June 2021; current systems aligned in preparation.
- Serious Incident Learning Panel reviews undertaken each week to discuss quality and content of Concise and Comprehensive investigations.
- Introduction of new incident investigation skills passport – launch to be confirmed.
- New Datix system planned for implementation –to be delivered to the Health Board in September
- Implementation of new national incident reporting framework (from 14 June 2021).

Impact upon performance should be visible by

- Reduction in time taken to report to Delivery Unit (DU)/ Welsh Government (WG) reported within 7 days: July performance = 75%% (target = 90%).
- Improvement in completion time of SI investigations completed within 60 working days. New criteria means less incidents reported to DU with the option to downgrade if appropriate.

Risk

- The quality of investigations is variable – investigating officer training will mitigate this risk.
- The timeliness of investigation is below target – the new process will mitigate this risk.
- The level of patient and family involvement in investigations is variable - the training and new process will mitigate this risk.

Quadruple Aim 4: Serious Incidents (Reportable)

Falls, Hospital Acquired Pressure Ulcers (HAPU) and medication errors reported as serious incidents

Key Drivers of performance

Key performance indicators set by Welsh Government. (New National Incident Reporting Policy implemented 14th June)

BCUHB core values: Putting Patients First.

Putting Things Right (PTR) Regulations.

Actions being taken and timelines

Local daily safety huddles in place.

Daily Incident review meetings in place.

Falls and Hospital Acquired Pressure Ulcers (HAPU) dashboards in place to provide local access to data and trends.

Strategic Falls Group re-commenced with a focus on accurate and consistent data and reporting to support identification of themes and areas for improvement.

New falls action plan being developed building on work of the falls collaborative.

All Wales Review Tool for Pressure Ulcers now available on Datix. Falls review tool also now on Datix and being tested. (July 2021)

Introduction of specific Falls and HAPU incident learning panels to identify themes and trends, encouraging colleagues from specialist areas to attend.(July2021)

Risk

Identifying those falls that result in severe i.e. permanent harm. Previously all falls resulting in fracture would have been reported, how to identify those incidents that result in permanent harm within 7 days is a challenge.

HAPU Data

179 pressure ulcers Grade 3, 4 and unstageable reported in July 2021. Of these 179 many are still under investigation. 59 of these incidents where investigation complete, 3 were deemed as avoidable pressure ulcers, 56 unavoidable according to Datix system.

Falls Data

1 patient fall with severe (permanent) harm was reported in July 2021 (Central Acute).

Medication Error Data

No Serious Medication errors reported

Quadruple Aim 4: Complaints

Key Drivers of performance

- Key performance indicators set by Welsh Government (criteria narrowed as of 5th January 2021 due to conflicting pressures of COVID- 19).
- BCUHB core values: Putting Patients First.
- Putting Things Right (PTR) Regulations.

Actions being taken and timelines

- Weekly PTR meetings in place across services, daily meetings in place, led by senior members of the team for services to raise queries and receive guidance.
- Improved joint working between Complaints Team and PALS to address complaints through EarlyResolution (single phone line introduced at the end of April).
- New Complaints process implemented in May 2021, complaints allocated to services who appoint Investigating Officer to lead (previously led by Governance Teams)
- Training on the process rolled out (General Overview and Complaint Investigation) with further modules in progress.
- New Datix roll out under preparation, awaiting confirmation of implementation date and staff allocated to work groups.
- New process Investigation Reports – redacted examples available to assist staff with learning and development of investigative skills.

Impact upon performance should be visible by:

- % of formal complaints acknowledged in 2 working days (target 90%) – 86.47% July 2021.
- % of complaints managed under PTR < 30 working days (target 75%) – 64.00% July 2021.
- Whilst not reaching the set target the process is currently stable and delivering at around 62% compliance for the last 7 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Risk

- Services continue to report issues identifying staff as Investigating Officers and also co-ordination of complaints where multiple services involved. This can cause delays in commencement of investigation.
- The quality and timeliness of investigations is variable (support and training available to support staff with complaint investigations).
- The level of patient and family involvement in investigations is variable, despite the emphasis on robust and prompt communication with complainants and maintaining that communication. There are also good examples where robust communication is leading to prompt resolution of formal complaints.
- The recent COVID-19 second wave has contributed to a backlog of overdue complaints (159 in total as of July 2021)

Top 3 reasons (primary subjects) identified:

1. Consent, confidentiality or communication;
2. Access, appointment, admission, transfer, discharge;
3. Treatment, procedure.

Quadruple Aim 4: Learning from Never Events

Never Events

There were no Never Events reported in July 2021.

A Never Event Learning workshop will be launched on 2nd September. These workshops will take place across the Health Board and look to engage all services to address how we can better understand why Never Events occur.

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation enabled by data and focussed on outcomes.

Key Messages

Mortality Rate at 0.96% remains below peer average

Increased system working to link Health and Social Care Data

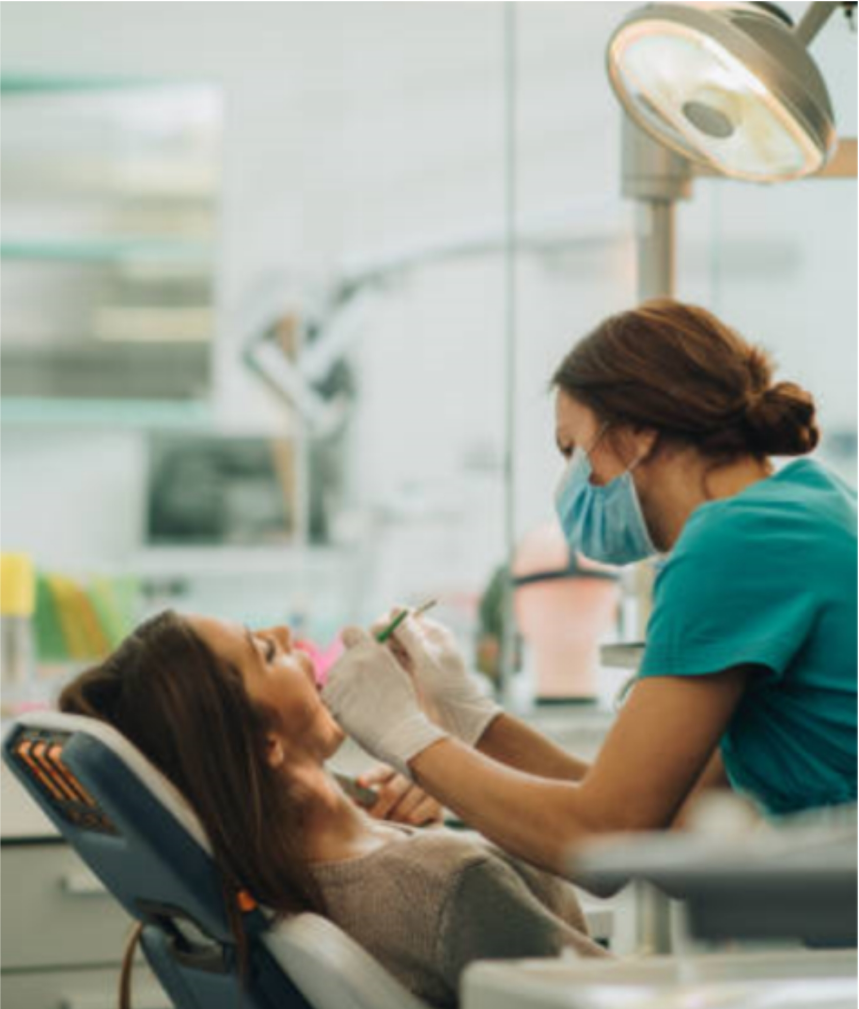
Work underway to resume reporting of Sepsis Six Bundle

Measures

Period	Measure	Target	Actual	Trend
Jun 21	Crude hospital mortality rate (74 years of age or less)*	Reduction	0.96%	<input type="checkbox"/>
Jul 21	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	No Data	
Jul 21	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening	Improve	34.62%	<input type="checkbox"/>
May 21	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours *	Improve	66.10%	<input type="checkbox"/>
Jul 21	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Improve	95.50%	<input type="checkbox"/>

* Reported 1 month in arrears

Data for **July 2021** (unless otherwise stated)
Presented on 7th September 2021



Quadruple Aim 4: Narrative - Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the peer group (0.96% v 1.10% (Other Welsh HBs ex Powys) to June 2021). This has reduced during further as COVID infections have lessened and is similar to the previous year. The highest number of deaths was in those patients admitted with COVID-19 (113) , Sepsis (84) and pneumonia (73 – lobar and unspecified).

Key Drivers of performance (for year to June 2021 against other Welsh health boards excluding Powys reported by CHKS)

- Crude mortality- overall (2.10% v 2.47%) this is similar to previous year.
- Mortality- sepsis (17.97% v 21.48%) remains below the peer; variation seen over the past year is common cause with mortality “as expected” overall.
- Mortality- cerebrovascular disease incl. stroke (11.92% v 13.33%) variation seen over the past year is common cause with mortality “as expected” overall.

Actions being taken

- Nationally there is a review of the mortality review framework; this is currently in draft format and the implications locally are being worked through.
- The DATIX module is being replaced by a system to better support the ME function; all local training has ceased. We will be able to access the information in the current DATIX module as a legacy system; However in the East and West, the doctors have reverted to paper. The expectation is the new system will be in place by the end of October. Currently, ensuring the outstanding stage 2 reviews are closed appropriately; weekly lists are sent to the sites as part of quality assuring the backlog data.
- The roll out of the Medical Examiner service (MES) continues. The ability to scan notes has been agreed. Currently the MES in North Wales does not have sufficient capacity to review all inpatient deaths and some deaths are being reviewed remotely.
- Hospital Acquired COVID-19 reviews are continuing. However, the agreement for additional resources has not yet been approved. Progress is slow.

Timelines

- Clinical Mortality Lead - Interviews are planned for 28th August 2021
- Medical Examiners– aim all deaths on acute sites will be scanned by August 2021. There is a lack of space in Wrexham to house the scanner within the mortuary and this is being reviewed. However, all sites are providing some scanned notes at this time.
- HCAI COVID-19 deaths - Sites have lists of all deaths for review; process in place to update monthly. Review process has started to roll out on all sites. Completion date will depend on resources available and cannot be confirmed at this time. YG are up to date
- Learning from Deaths Policy – on hold pending the appointment of the Clinical Lead and agreement of the new national review framework..

Risk

- The COVID-19 pandemic has reduced the capacity for staff to undertake routine mortality reviews. This, together with the need to complete HCAI death reviews has led to a backlog of stage 2 reviews. Nursing colleagues have been identified on all sites to support mortality reviews. Additional resources are required to ensure these are completed. Other health boards in Wales are in a similar position. Failure to complete these in a timely way may impede safety and also cause reputational damage to the Health Board. A proposal document has been written for Executive review.
- Lack of agreed mortality review process across all acute sites may result on the three areas working differently. Mitigation - all sites are using the same tools. Working towards an all Wales solution by year end.

Quadruple Aim 4: Narrative – Timely Interventions - Sepsis

Issues Affecting Performance

- Data collection remains a challenge on all sites as reported previously. Completed forms as a percentage of septicaemia admissions is approximately 40% (to June 2021). In YG they have noted this is part is due to delays in data entry due to lack of resources. Symphony has removed paper forms that were used to prompt sepsis 6 completion; and also to monitor compliance.
- Long ambulance waits, delays in Emergency Dept. doctor reviews and sometimes lack of nurses contribute to delays in diagnosis and treatment in YG

Actions and Outcomes

- All sites are aware of this issue and it has been escalated to Secondary Care division and corporate Clinical Effectiveness Group (CEG).
- YG ongoing unscheduled care improvement work stream will address some process delays; reminding staff to note if entries in Symphony are retrospective and explore whether a prompt can be introduced in to Symphony. They are trying to identify additional staff to support data entry.
- YGC has identified a new Sepsis lead for the site who is developing a plan.
- YWM has identified sepsis champions for all clinical areas that will start to support a programme led by Acute Intervention Team; sepsis bundle included in local teaching with additional targeted education focussing on new starters.

Timeline for delivery of improvement

- YG by end of August they will define the denominator to enable real time monitoring and reinforcement.
- YWM above actions now in place; improvement is anticipated by September 2021.
- Secondary care have been asked to provide an improvement plan; this will be followed up at secondary care CEG in June 2021. An improvement plan has not been provided; therefore this will be escalated to the Clinical Effectiveness Meeting to agree a way forward (Sept)

Risks and Mitigations

The risk is the organisation is not sighted on Sepsis 6 bundle compliance because of poor data capture. This has been escalated within sites, to Secondary Care Medical Director and CEG and corporate CEG. There is no mitigation in place, although clinical staff are aware of the requirement for this care to be delivered. At the current time mortality from sepsis is within expected limits and below the Welsh average peer group in the Comparative Healthcare Knowledge System (CHKS).

YG = Ysbyty Gwynedd YGC = Ysbyty Glan Clwyd YWM = Ysbyty Wreccsam Maelor

Quadruple Aim 4: Narrative – Timely Interventions – Orthogeriatrician Review

Ortho-geriatrician Review within 72 Hours

Issues Affecting Performance

YG – The average annual compliance for all 60+ trauma patients is on an upwards trajectory currently at 68% with month on month improvement since December 2020. Cover for planned leave has been agreed with the Care of the Elderly Team (COTE)

YGC - The average annual compliance for all 60+ trauma patients is on an upwards trajectory currently at 94.5%, which is better than the national average at 63% (reported in August but May 2021 position). There is a full time physician in this role and a dedicated Physicians Associate attached to Ortho-Geriatrics.

YWM- Ortho-geriatrician is available on site with 4 planned ward rounds per week. There is no cover for leave.

Actions and Outcomes

YG - Limited sessional cover secured for planned annual leave (10 sessions/year of COTE).

YGC – no additional actions.

Timeline for delivery of improvement

Plans pre-COVID-19 for Delivery Unit (DU) led National Networking Group needs to be re-established – Action held by DU.

YG – this is dependent on funding a business case

Risks and Mitigations

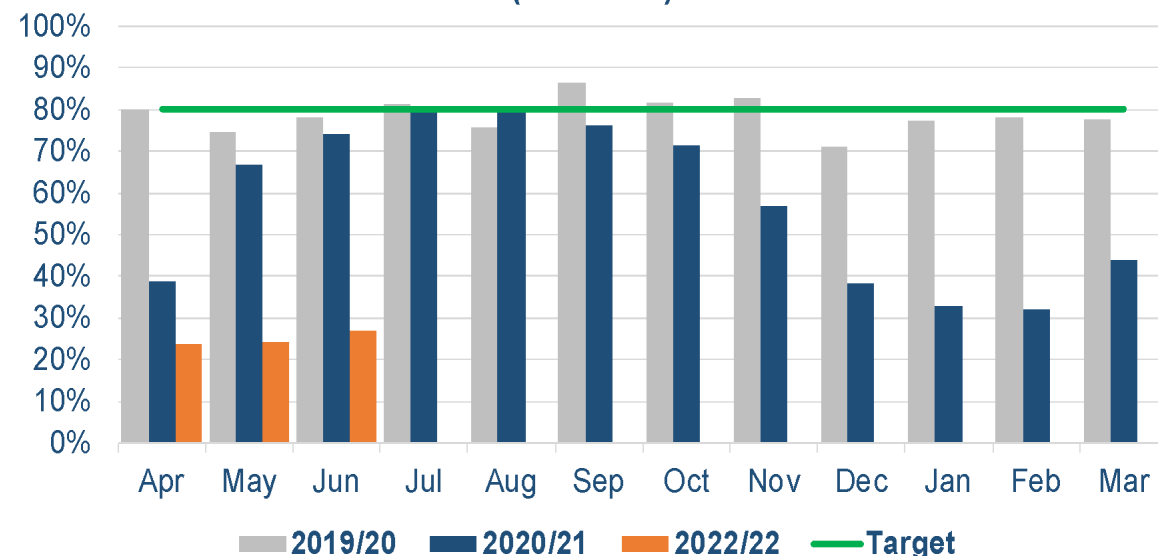
The risk is that patients' health is not maximised before surgery and comorbidities not managed well peri-operatively with the potential for avoidable morbidity and mortality. Performance has improved over the past 3 years across the Health Board with additional resources. However, these are not consistent across the sites and in YG a business case is being developed as above.

YG = Ysbyty Gwynedd YGC = Ysbyty Glan Clwyd YWM = Ysbyty Wrecsam Maelor

Additional Information

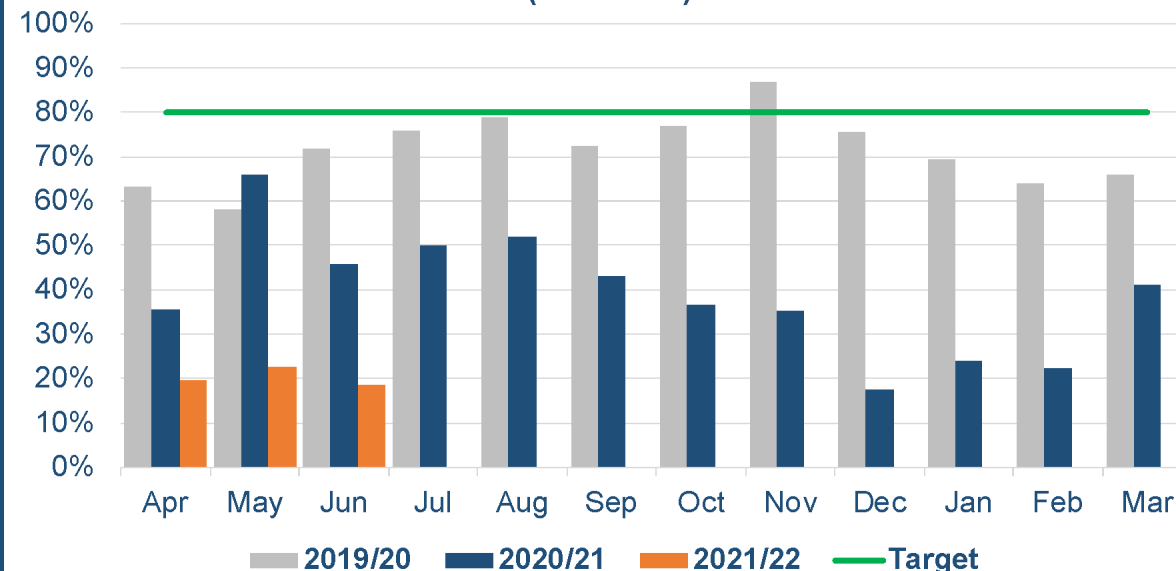
Quadruple Aim 2: Charts CAMHS

Percentage Mental Health Assessments (CAMHS) within 28 days of Referral (June 2021)

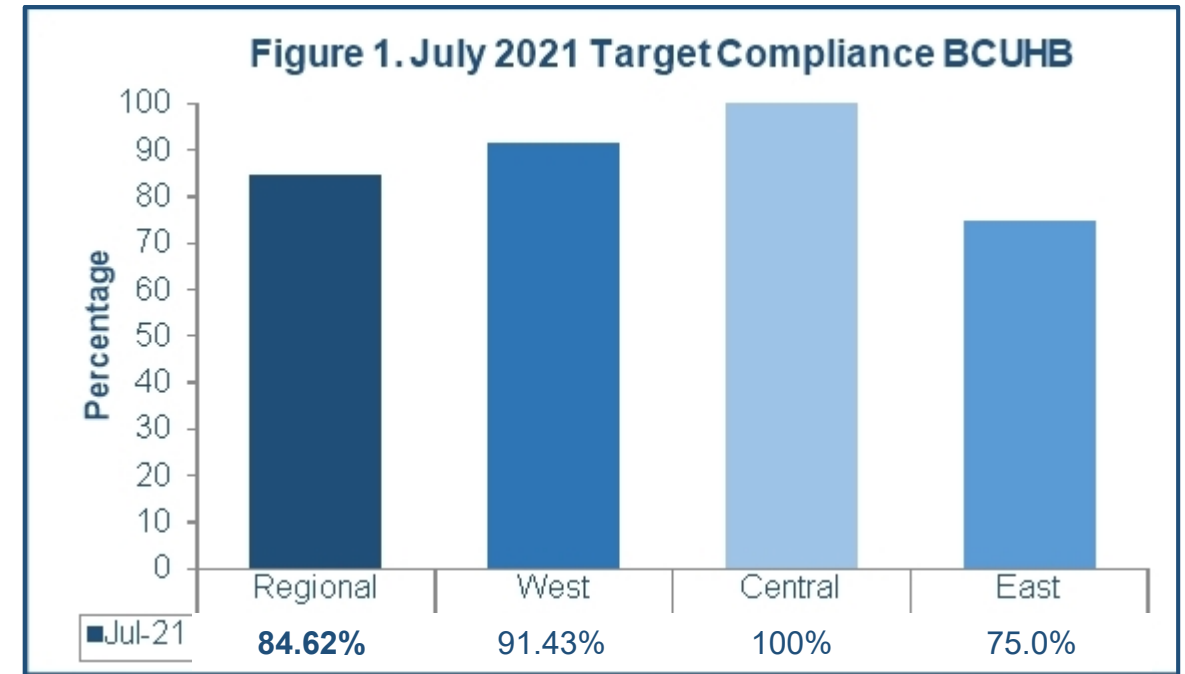
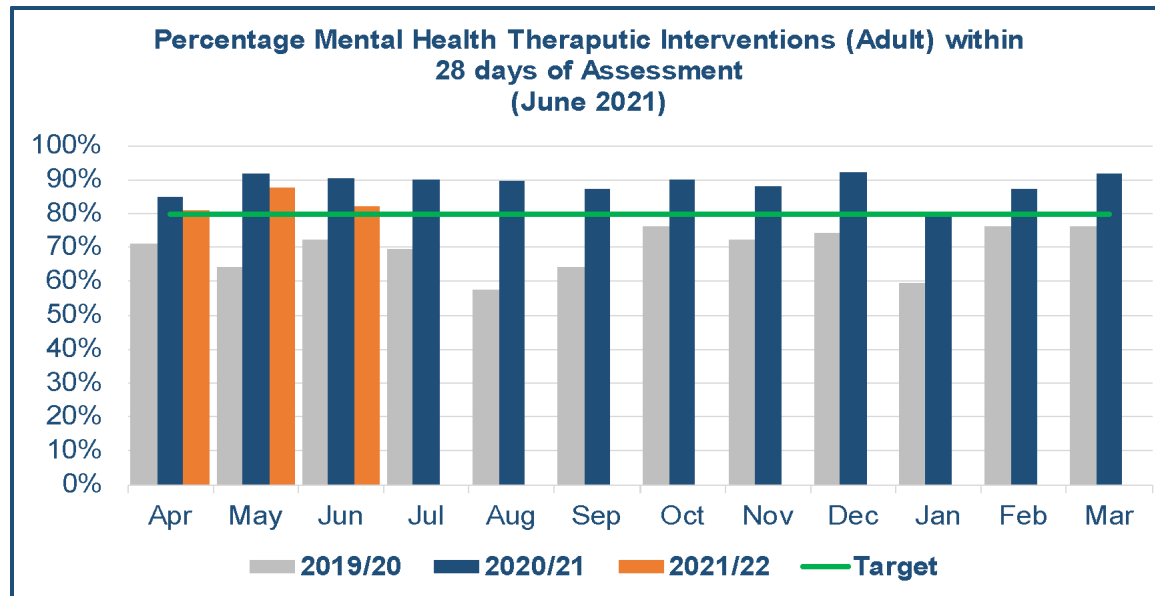
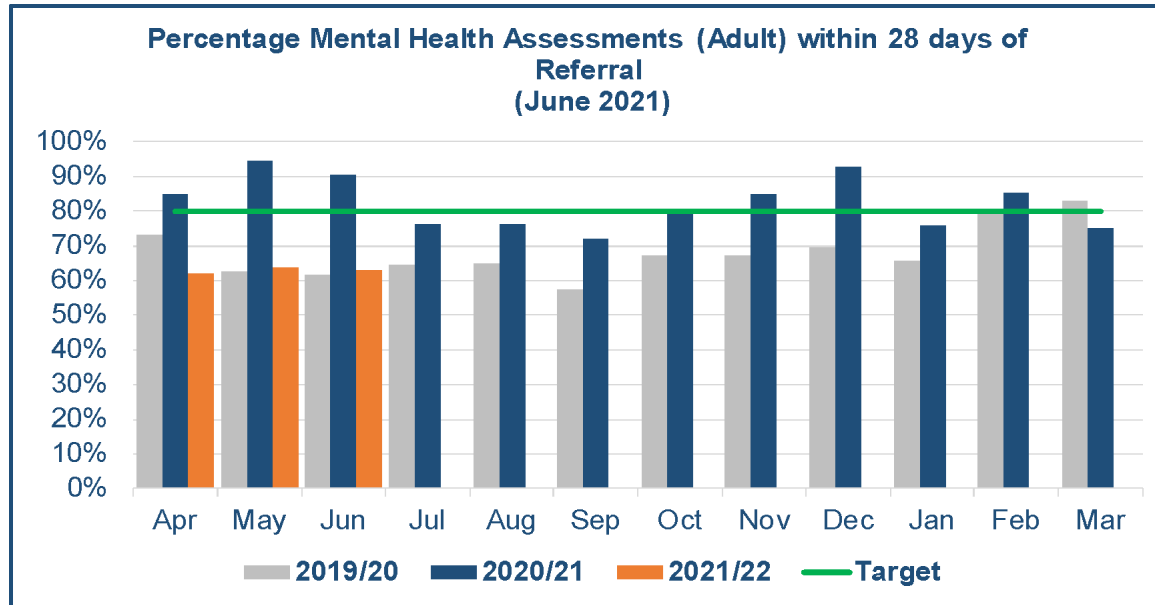


Data is reported 1 month in arrears

Percentage Mental Health Therapeutic Interventions (CAMHS) within 28 days of Assessment (June 2021)

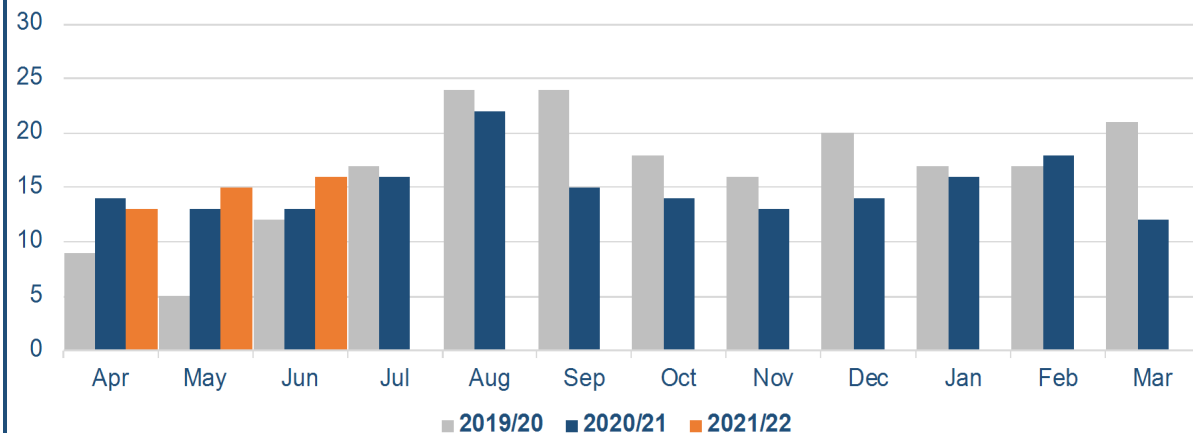


Quadruple Aim 2: Charts Adult Mental Health

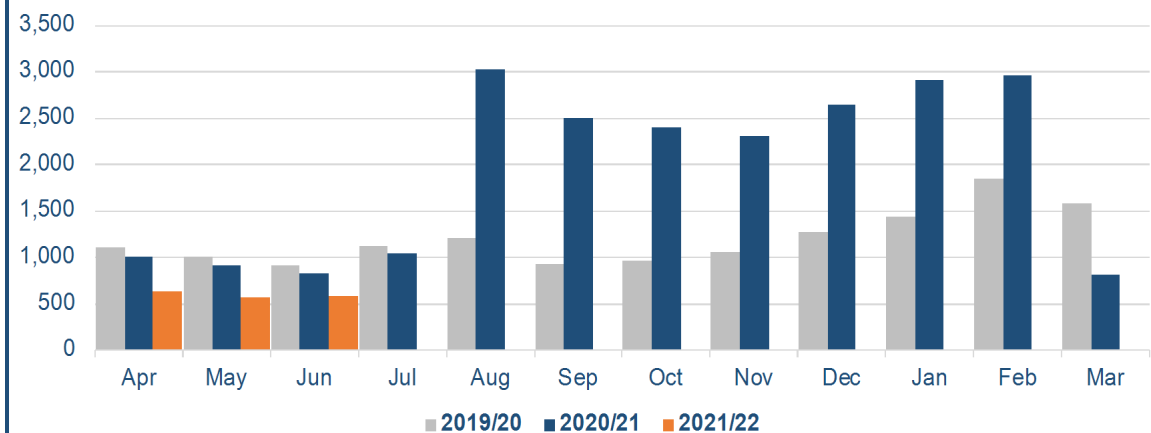


Quadruple Aim 2: MH Delayed Transfers of Care

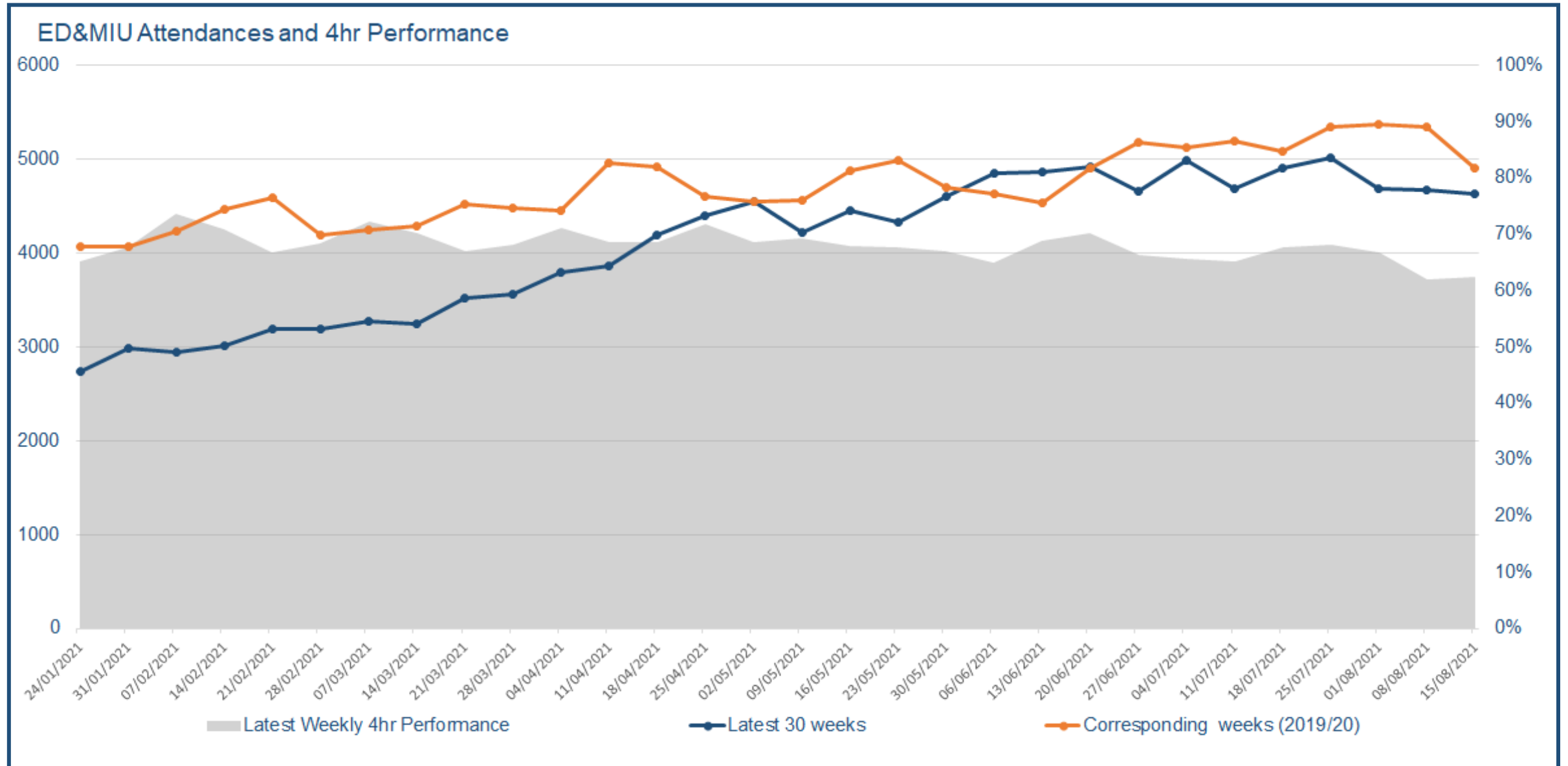
Number of Delayed Patients (BCU Mental Health)
 2021/22 comparison to 2020/21 and 2019/20
 July 2021



Number of Delayed Bed Days (BCU Mental Health)
 2021/22 comparison to 2020/21 and 2019/20
 July 2021



Impact of Covid-19 Pandemic on Unscheduled Care



Impact of Covid-19 Pandemic on Unscheduled Care

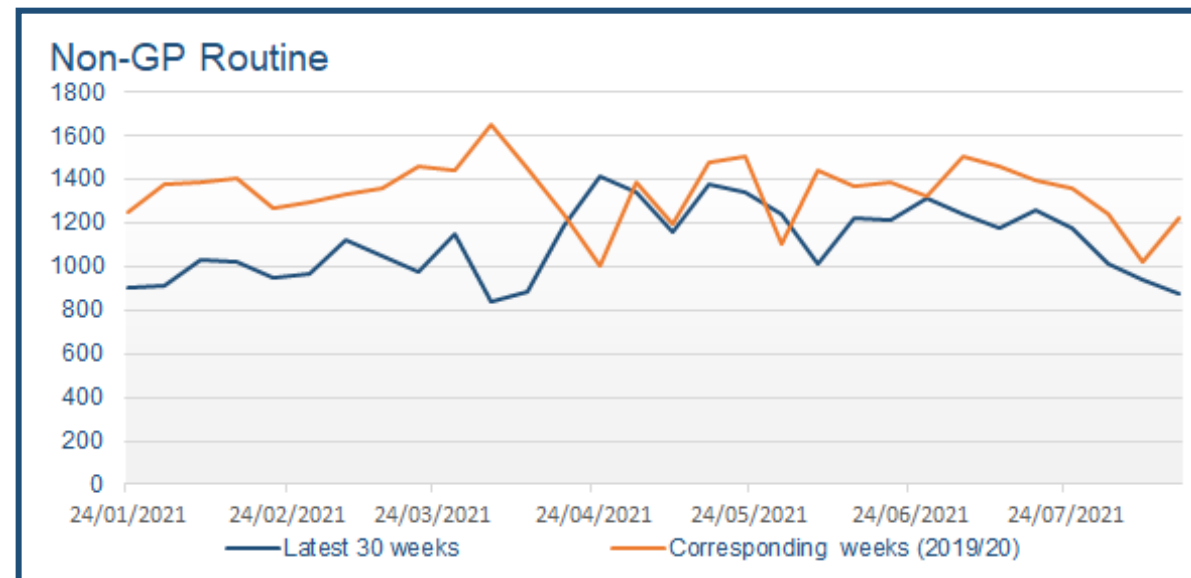
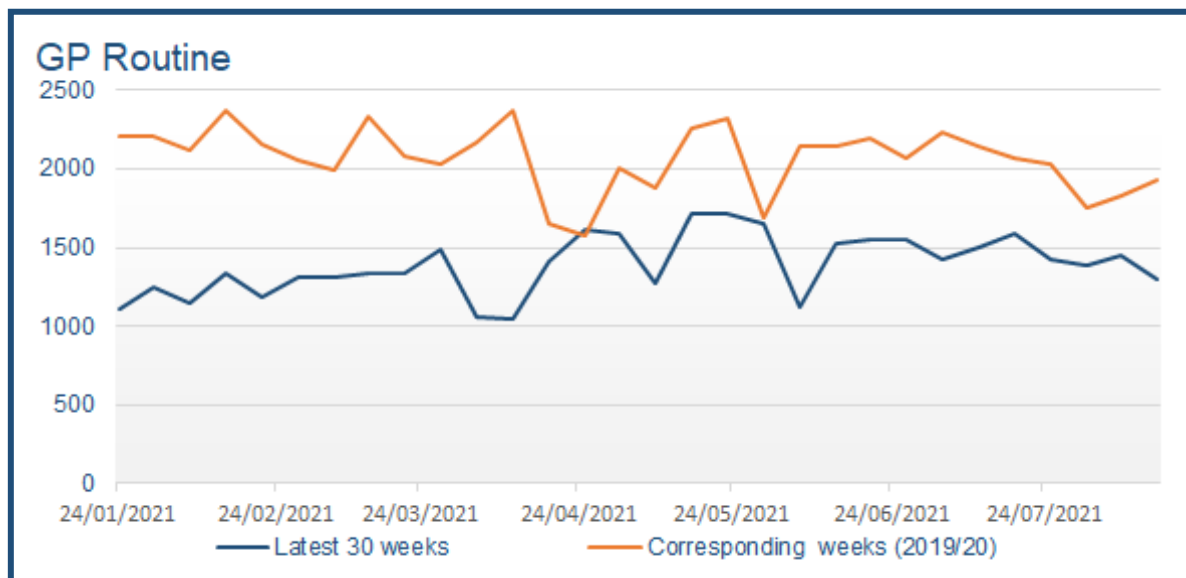
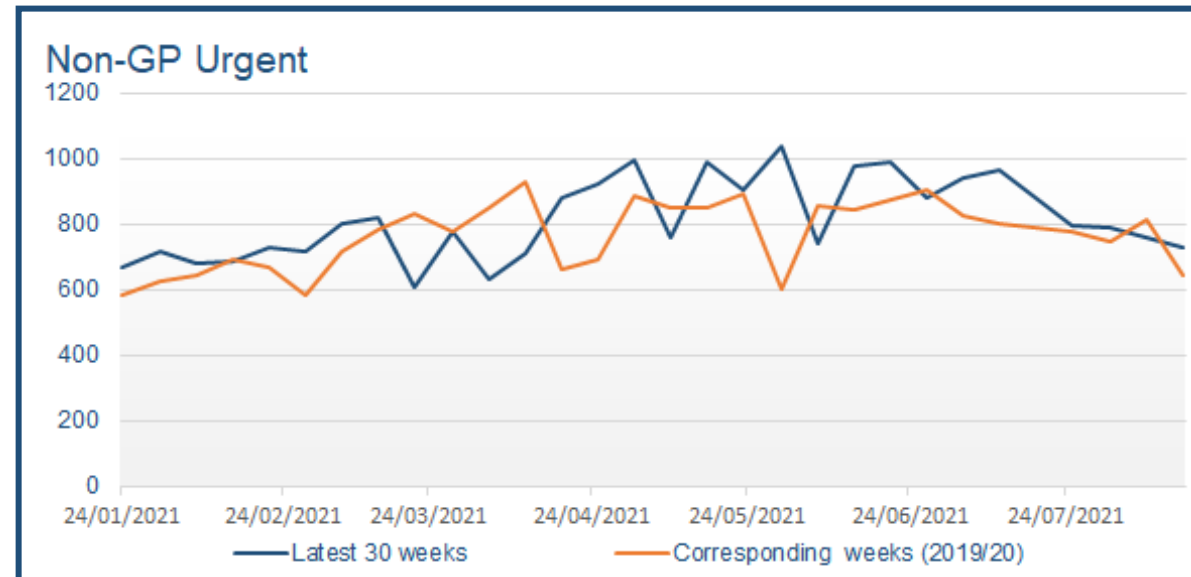
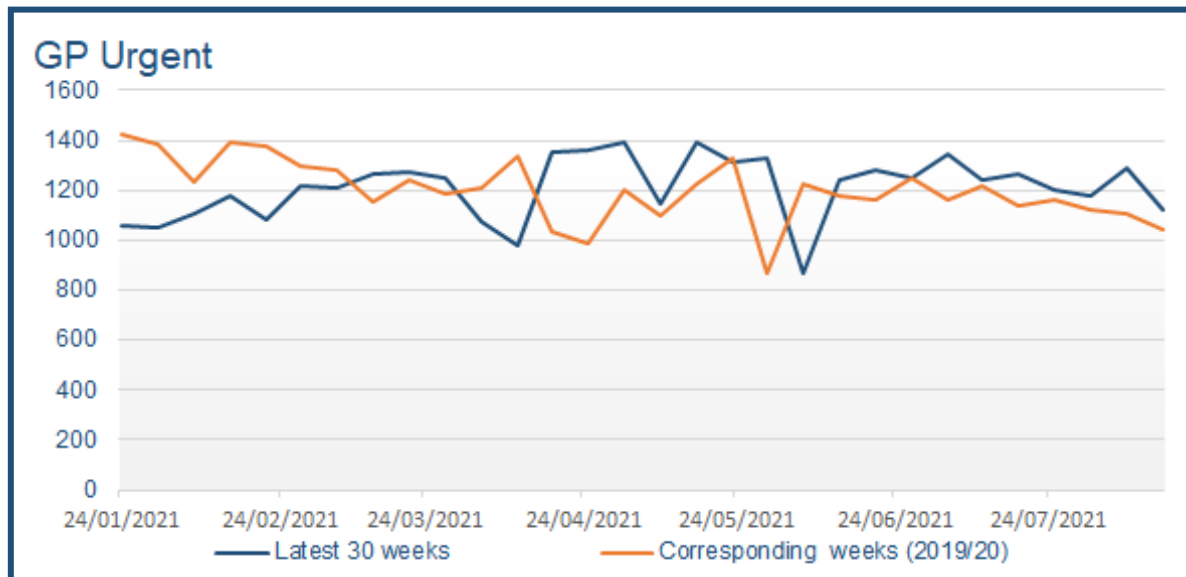
Unscheduled Care Performance by Site 9th August - 15th August 2021

Measure	West	Centre	East	BCU
ED&MIU Number of Attendances	1532	1803	1288	4623
ED&MIU 4 Hour Performance	61.62%	70.66%	52.02%	62.47%
ED Number of Attendances	1131	1291	1144	3566
ED 4 Hour Performance	48.54%	59.02%	45.98%	51.51%
ED 12 Hour Performance	182	215	255	652
1 Hour Ambulance Handover Breaches	109	148	120	377
Red 8 Minute Ambulances	#VALUE!	#VALUE!	#VALUE!	#VALUE!
Red 8 Minute Performance	#VALUE!	#VALUE!	#VALUE!	#VALUE!

Red 8 Minute Ambulance data is unavailable due to technical issues

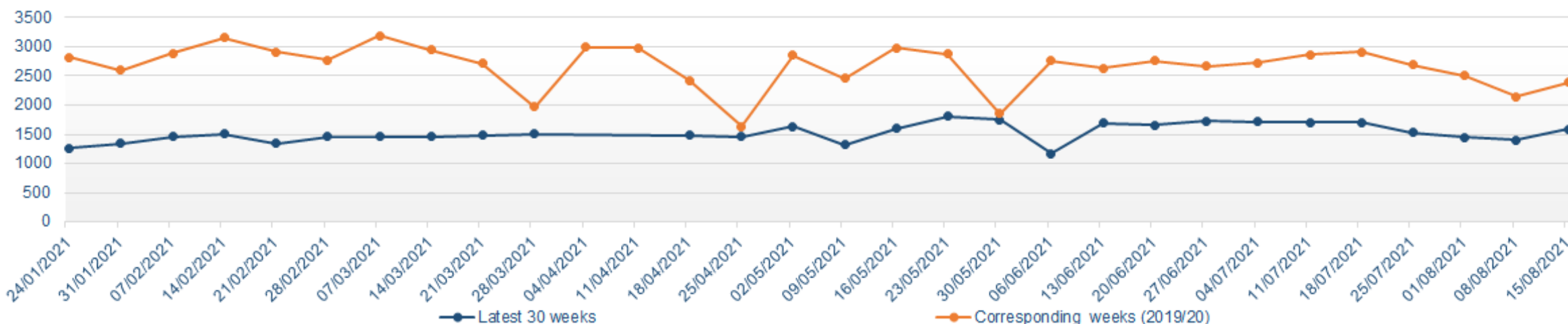
Sources: Red 8 Minute - WAST Health Board Area Report; ED and Handover - IRIS, accessed 16/08/2021

Impact of Covid-19 Pandemic on Referral Rates

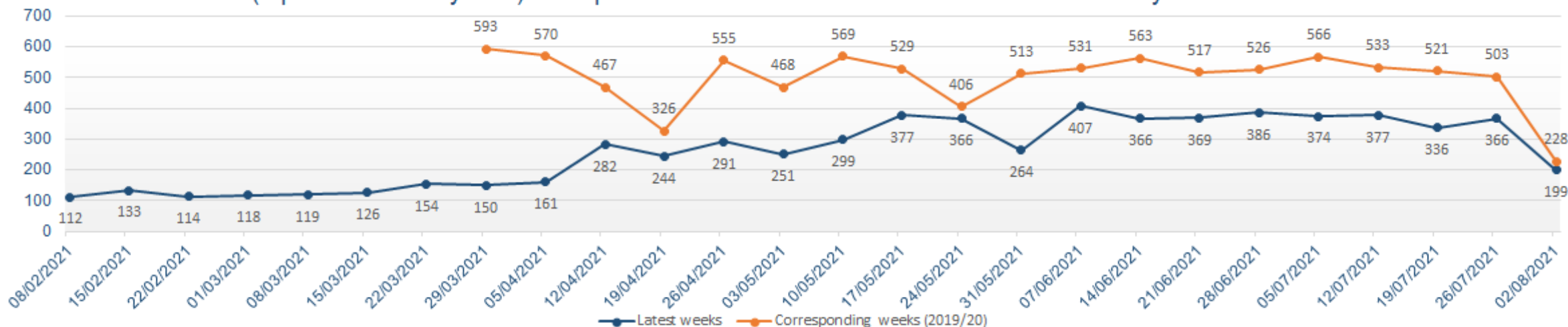


Impact of Covid-19 Pandemic on Planned Activity

RTT High Level Report - Core Outpatient Activity (new, RTT, face to face attended appointments)



Theatre Procedures (Inpatient and Daycase): Completed Elective Cases in Planned Elective Lists by Week



Further Information

Further information is available from the office of the Director of Performance which includes:

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website www.bcu.wales.nhs.uk
- Stats Wales <https://statswales.gov.wales/Catalogue/Health-and-Social-Care>

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb
<http://www.facebook.com/bcuhealthboard>



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Vascular Steering Group Update						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director						
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director (Central) Dr Nick Lyons, Executive Medical Director						
Craffu blaenorol: Prior Scrutiny:	Vascular Steering Group						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Committee is asked to receive the update from the Vascular Steering Group and note the updated approach in responding to the first stage of the Royal College of Surgeons report on the Vascular Surgery Service							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	X
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>This last report to the Committee provided an update on the work undertaken and overseen by the Vascular Steering Group following the Royal College of Surgeons (RCS) initial review of the vascular service.</p> <p>The next meeting of the Steering Group has been brought forward to 16th September and will be chaired by the Executive Medical Director.</p> <p>A review of the leadership and oversight of the vascular improvement programme was completed in week commencing 23rd August 2021 and a new Vascular Oversight Group has been formed. This is a small group, which will meet fortnightly, is chaired by the Executive Medical Director, and includes senior medical leadership from all 3 acute sites.</p> <p>An experienced interim manager (Sally Morris) has been recruited as Network Manager who starts week commencing 31st August 2021 and renewed efforts are being made to recruit to the substantive post. The Vascular Network Manager will co-ordinate the timely progression of actions on a day-to-day basis and will also sit on the Vascular Oversight Group.</p>							

In week commencing 6th September 2021 the action plan will be reviewed to ensure that the actions are correctly owned and that mitigations are in place and that these are appropriate and sufficient. The action plan in its current state needs considerable work to provide clear assurance on progress made and clarity on the mitigations.

The implementation of the work will be overseen and supported by the Vascular Oversight Group but formal reporting will remain with the Steering Group with oversight continuing via QSE

The Acute Director of the hub site will ensure that the “hub and spoke” arrangements are properly implemented in liaison with the other two Acute sites and Area teams where appropriate.

The newly appointed Executive Medical Director, Nick Lyons will take over the role of Senior Responsible Officer for the programme of work.

Project management and data management support to the work are currently under review.

Cefndir / Background:

As part of assessing the potential for improving the vascular services following the changes in provision of arterial services in North Wales in 2019, the Health Board commissioned an external and independent review of the vascular service from the Royal College of Surgeons of England (RCS). The first stage of this culminated in a report, based on stakeholder interviews and examination of documents, which was provided to the Health Board in March 2021.

The second stage of this review, based on the analysis of 50 case notes, took place on 19th July 2021, and was led by Professor Ian Loftus (St George's, London.) It is anticipated that the report from this second stage of the review will be made available to the Health Board by the end of September.

This second stage review is expected to give further information and insight into both patient safety and patient experience within the service. This is expected to lead to additional actions being taken forward or revision of existing actions.

Asesiad / Assessment & Analysis

Strategy Implications

The action plan has been monitored closely at the Quality, Safety and Experience Committee and the current refresh of the governance arrangements around the response to the review and the review of progress in delivering the action plan reflect the comments received at previous meetings.

The action plan is not attached to this report, pending the current review but key issues include:

RCS recommendations

- Need for an agreed pathway for timely and effective treatment at the hub site
- Bed capacity and associated nursing resources should be adequate to allow timely transfer from spoke to hub sites

- More effective use of the hybrid theatre
- Vascular consultant presence to enable patient review within 24hrs at spoke sites
- Finalise pathway for management of patients post major arterial vascular surgery to ensure timely rehabilitation and repatriation
- Develop non-arterial diabetic foot pathway
- Finalise other pathways currently in draft
- Confirm pathway for non-complex/low risk vascular interventions at spoke sites
- Improve effectiveness of clinical governance process

Recommendations for service improvement

- Clarify progress in centralisation plans (services accessible at spoke sites)
- Improve communication and team working across hub and spoke sites

The changes to the Steering Group's structure and function, including the Terms of Reference, have been implemented. A review of the governance to ensure that all existing Terms of Reference and memberships have been formally agreed is also taking place. The agreed Task and Finish Groups are in place with an improving level of clinical engagement.

The vascular services currently provided at Wrexham Maelor Hospital (WMH) and Ysbyty Gwynedd (YG) as the "spoke" sites comprise outpatient clinics, day case surgery and provision of reviews for patients referred via the Emergency Department or from inpatient settings. There have been some challenges in the staffing of these services at consultant level due to unanticipated gaps, and discussions with each of the sites about provision of junior doctor support from General Surgery (there being no designated vascular juniors on either of the sites) are ongoing and this will be detailed within the revised action plan.

All inpatient activity is currently carried out at Ysbyty Glan Clwyd (YGC). It had been identified previously that there were around 300 patients per annum whose condition would be best treated in the specialist hybrid theatre created at YGC, where the supporting infrastructure is in place.

The summary position on key recommendations is as follows:

Develop the non-arterial diabetic foot pathway.

The diabetic and podiatry teams are at the heart of this pathway and both those services require additional resources to deliver a fully effective service. Work is currently underway to establish what this resource need is, what mitigations are in place now and the timeline for providing needed resource.

The pathway review has also highlighted the potential need for additional orthopaedic resource and work is underway to establish the exact requirements in all 3 sites.

There are documented pathways in both primary and secondary care which comply with NICE guidelines. However, an analysis has shown that the knowledge and utilisation of these pathways is not consistent across BCUHB and work is currently underway with the primary care team and lead podiatrist to respond to the situation in primary care in order to ensure consistency in the access, quality and patient experience across the Health Board. This will be reflected in the revised action plan.

Pathways and alignment of vascular inpatient bed base

A review of the capacity and demand for inpatient beds across the service was completed at the commencement of the Steering Group and previously reported, All pathways have been agreed and will now be audited to ensure that they are being used effectively.

More effective use of the hybrid theatre

A number of actions have been identified that will be taken to improve theatre utilisation. Standard operating procedures have been agreed and these will now need to be monitored to ensure effective use. Consideration will also be made as to how these can be effectively presented to both the clinical and operational teams.

Vascular consultant presence to enable patient review within 24hrs at spoke sites

The RCS report has prompted a further detailed examination of how the medical workforce is deployed across the network to ensure that the agreed hub and spokes model is strengthened. A revised rota has improved the situation, with presence across all sites on all five days of the week. Access to a Consultant of the week and an on call consultant is always ensured.

Further substantive Consultant recruitment is underway with the advert now live for 2 FTE posts which will close on 27th September 2021. The Appointment Advisory Committee (AAC) has been scheduled for 22nd October 2021.

It is also now clear that the medical cover at both medical and junior levels needs review and this work has now commenced.

Communications plan

To support the North Wales vascular service and highlight the progress being made, a communications plan has been completed. The key elements of this are to build confidence in the service by showcasing innovation and staff achievements, highlight positive patient experiences, outline progress against the improvement plan that has been approved by the Board and clearly communicate next steps.

The dedicated [vascular services page](#) on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available. The detail of this will be included in the revised action plan.

Opsiynau a ystyriwyd / Options considered

Next steps

- Vascular Network Manager commences 31st August 2021
- Review of the current action plan week commencing 6th September 2021
- Review of current risks to ensure consistency with the action plan week commencing 27th September 2021
- First Steering Group chaired by Executive Medical Director as SRO on 16th September 2021
- Establishment of the Vascular Oversight Group, meeting fortnightly from September 2021
- Second phase of RCS report anticipated by end September 2021

Goblygiadau Ariannol / Financial Implications

As part of the initial work on the gap analysis it is now clear that additional workforce is likely to be required in some parts of the service to deliver fully on the recommendations. The detail and timescale for this will now be included in the updated action plan.

Dadansoddiad Risk / Risk Analysis

The risk register is now a standing item on each Steering Group meeting.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal implications associated with this report.

Asesiad Effaith / Impact Assessment

Impact assessments will be completed as part of the development and approval of clinical pathways as required by the Clinical Advisory Group.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Pharmacy & Medicines Management Key Risks						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons Executive Medical Director						
Awdur yr Adroddiad Report Author:	Dr Berwyn Owen Chief Pharmacist Louise Howard-Baker, Assistant Director Pharmacy & Medicines Management (East) Susan Murphy, Assistant Director Pharmacy & Medicines Management (West) William Duffield, Assistant Director Pharmacy & Medicines Management (Central)						
Craffu blaenorol: Prior Scrutiny:	None						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Quality, Safety and Experience Committee is asked to note the Pharmacy & Medicines Management key risks and actions being taken to mitigate them.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						No. SEIA relates to strategic decision. This paper is an update. Therefore not required	
Sefyllfa / Situation:							
Pharmacy and Medicines Management are holding a number of risks relating to the safe use of medicines within BCUHB. These cover availability, distribution, safe storage, prescribing, preparation and administration activities (including digitalisation) which also have an impact on finance.							
Cefndir / Background:							
1. Community Pharmacies (This is a risk managed by pharmacy on behalf of the Executive Director of Primary Care and Community Services) <p>Community pharmacies are experiencing significant workforce challenges due to a shortage of pharmacists. The reasons for this include many European pharmacists leaving the UK during 2020 and not returning, self-isolation, annual leave backlogs and an overall scarcity of locum pharmacists. As a result, there has been an increase in temporary closures of pharmacies. This has an impact on patients not being able to collect prescriptions or access community pharmacy</p>							

services for advice on a range of treatments. Pharmacies are also reporting an increased workload, made more difficult by limited access to GP practices and physical working conditions in community pharmacies (social distancing). There was a substantial growth between May and June 2021 in consultations for both common ailments (62%) and prescribing services (18%). The BCUHB strategic lead pharmacist for community pharmacy has been working with Community Pharmacy Wales (CPW) to explore ways to ameliorate the situation. A new process has introduced by the Health Board in July 2021 to ensure the contractor has taken all possible steps prior to closure.

Mitigation: We are regularly meeting with contractors and work is on-going to develop a recruitment campaign for pharmacy staff for north Wales.

2. Medicines shortages (This is a Pharmacy specific risk and is managed by the Chief Pharmacist)

Significant national medicine shortages and the national COVID medicines reserve stocks continue to be managed centrally by the Welsh Government Medicines Shortages Advisory Group, for which BCUHB provides membership. This early intelligence allows the BCUHB pharmacy procurement team to efficiently and effectively plan for any shortage with the potential to pose a risk to the BCUHB population.

Most current shortages have simple solutions, which involve using alternative products that have similar therapeutic properties, or different strengths to make up a dose. Some shortages however have the potential to impact on patient safety. Such shortages require careful assessment and planning to ensure smooth transition from one product to another to manage the supply disruption.

Critical COVID medicines continue to be in good supply, however supplies of the higher strength tocilizumab used treat COVID have been affected due to increased global demand. This supply disruption will be mitigated within BCUHB by utilising lower strength preparations to make up standard doses to ensure patients continue to COVID treatment in a timely fashion.

Mitigation: Pharmacy procurement team reviews all shortages. Each shortage requires a collaborative approach using intelligence from the pharmacy procurement teams, patient safety lead pharmacists and the medicine information department to develop communications on how to safely implement alternative products.

3. Vaccination and Medicines Distribution (This is a risk managed by Pharmacy on behalf of the Executive Director of Primary Care and Community Services)

The pharmacy workforce has provided significant support to the development and implementation of processes to deliver of the COVID-19 vaccination campaign within vaccination centres and GP practices/community pharmacies across North Wales. This support is ongoing, with pharmacy staff continuing to provide leadership and assurance around clinical delivery, pharmaco-legal considerations, vaccine governance, supply chain/logistics, safety, and waste minimisation. Involvement within the programme has uncovered a widespread lack of knowledge and understanding of the risks associated with cold chain breaches and sub-optimal vaccine preparation processes. In response, a business case has been developed for sufficient pharmacy workforce to provide ongoing support for all vaccination programs delivered in North Wales (including the ongoing COVID-19 programmes) which includes;

- Governance and pharmaceutical oversight of BCUHB-managed vaccination sites to ensure the safe and secure handling and management of vaccines, from ordering and delivery through to administration.
- Advice and support to independent contractors providing vaccinations with respect to the safe and secure handling and management of vaccines and delivery of vaccination programmes within legal and regulatory frameworks
- Clinical and technical expertise on the preparation, and use, of vaccines
- Development, dissemination and supporting the implementation of vaccination Patient Group Directions (PGDs) and other legal frameworks that facilitate vaccination programmes (e.g. protocols, written instructions, patient specific directions).
- Supporting delivery of vaccination training and education for healthcare staff
- Oversight of stock and database management

Wrexham Maelor Hospital was granted a Wholesaler Dealers Authorisation (WDA licence) by the Medicines and Healthcare Regulatory Authority (MHRA) at the end of 2019. This enables the hospital to carry wholesale supply activities lawfully with customers such as Hospices, Welsh Ambulance. It is an unusual situation in that only one of the three acute sites has the WDA and was granted on the basis that the remaining two sites would work towards their licences. However, it is a significant piece of work to develop and implement the necessary procedures to enable these additional sites to meet the standards set out as Good Distribution Practice (GDP). Several competing priorities have, to date, delayed this work, in particular, the COVID-19 pandemic and subsequent support provided to the vaccination programme, as well as installation of a new pharmacy system, WellSky. To ensure that BCUHB complies with its licence, until the other sites are WDA-ready, all wholesale supply of vaccines must be from Wrexham, with Ysbyty Gwynedd and Ysbyty Glan Clwyd acting as spokes.

In order to deliver the above support, and facilitate the supply chain locally, there is a staffing implication that will need to be met. The staffing requirements are being included within a vaccination and medicines distribution business case for consideration by the Health Board and include:

- To support overall governance all vaccination programmes, provide clinical and pharmacological advice, and support the safe and effective use of vaccines in all vaccination settings
- to enable all three acute sites to achieve compliance with a hub and spoke distribution model that supports the WDA license.

Mitigation: Currently Pharmacy are working with best endeavours to support all vaccination programmes and the distribution of medicines.

4. Electronic Prescribing, Medicines Administration (EPMA) and electronic transmission of prescriptions (WP10) written in primary care (This is a risk managed by pharmacy on behalf of the Office of the Medical Director)

There is significant pharmacy input into the mitigation of prescribing and administration errors, yet these still pose significant risks to patient safety. Fortunately, most prescribing errors are intercepted before they cause harm, with 419 Datix incidents being recorded in the last 12 months classified as moderate to negligible. It is acknowledged that this is an area that is significantly under reported with on-going work being undertaken triangulating incidents, concerns and litigation to quantify the number of incidents causing serious harm.

In addition, there are concerns about agency staff related prescribing and administration errors. Datix can identify incidents where an error has been made by an agency nurse, however, it remains difficult to identify agency/locum doctors involved in prescribing errors.

Pharmacists, pharmacy technicians and medicines management nurses are involved with:

- Teaching medicines management to new registrants (doctors and nurses), foundation doctors and nurses new to the organisation or returning to work.
- Development and implementation of policies and procedures to support safer medicines management.
- Working in clinical areas to ensure patients get the right medicines, in the right way, at the right time and by the right person.
- Supporting the incident learning process, involvement with investigations and providing expertise on medicines.

In spite of all of this, medication incidents remain a concern. Access to IT on wards is difficult and resources to support safe prescribing and administration can be hard to locate on the intranet. Work to modify the All Wales Medicines Administration Chart, which was an important safety solution in itself, has been suspended on the basis that health boards will be moving to electronic prescribing and administration systems.

The Welsh Health Board Chief Executives received a report on e-Prescribing in Wales from Andrew Evans, the Chief Pharmaceutical Officer for Wales at the end of July, which they were asked to support and endorse. An announcement is expected from Welsh Government in the near future. BCUHB must be one of the pathfinder sites in Wales to implement EPMA.

Concerns have also been raised around the lack of progress to enable electronic transmission of prescriptions written in primary care. Across Wales GP practices continue to print or handwrite WP10 prescriptions and then the patient is required to take their chosen community pharmacy for dispensing. During the pandemic this has caused many issues – prescriptions have got lost, stolen and have been duplicated.

Welsh Government has conducted a review with regards to the electronic transfer of prescription data in Wales across all health sectors that was completed in April 2021, and officials are currently assessing the outputs of the review to identify the way forward. It is intended that an ePrescribing Programme, to cover all care sectors as well as improving the abilities for public and patients to manage their medications will commence this financial year. This programme of work would bring together four key areas of work: Primary Care Prescribing, Welsh Hospital ePrescribing and Medicines Administration, Digital Services for Public and Patients functionality (to allow patients to reorder medication via the new NHS Wales app), and the National Medicines Repository Project. The findings of the review will be published later this year and include recommendations pertaining to implementing such arrangements. The Welsh Government has committed to implementing electronic prescribing as part of its programme of government published on 15 June this year.

5. Pharmacy Services in Mental Health (This is a risk managed by pharmacy on behalf of the Executive Director of Public Health)

A thematic report from Healthcare Inspectorate Wales (HIW) and Health and Social Care Advisory Service (HASCAS) highlighted the variable standards in medicines management with mental health services. HIW have made clear recommendations for dedicated pharmacy input recognising the role that they play in medicines governance and optimisation. The current pharmacy workforce

to mental health patients across BCUHB is just 4 whole time equivalent, which is minimal and only sufficient to provide a core service to acute and forensic inpatient units. The initial project phase will focus on three key deliverables:

1. Increasing team capacity
2. Improving concordance and patient satisfaction/empowerment
3. Robust medicines management and prescribing processes

Community Mental health teams in BCUHB currently have little pharmacy input and HIW reports have highlighted the need for improved medicines management.

Current issues and risks:

- Red drugs (hospital only meds) are not consistently recorded on GP systems. These may have significant interactions with other medication, it is important that all healthcare staff have access to the full medication reconciliation
- High dose antipsychotic / long term psychotropic prescriptions are frequently continued without secondary care involvement or advice
- There is a lack of routine monitoring/physical health checks for those on antipsychotic medicines
- Outpatient letters or transfer of care documents do not contain complete medication information
- There is a lack of clarity around prescribing responsibility for high-risk medicines, for example sodium valproate, lithium and depot injections.
- Service gaps exist where shared care guidelines are not fully utilised

Where there is a lack of access to medicines or medication advice, there is a risk that patients may inadvertently discontinue treatment and/or relapse leading to more crises that are acute.

Mitigation: A business case was approved in August 2021 for pharmacy staff to work with community mental health team and the old people's mental health teams. These new mental health posts will be included in the Pharmacy recruitment campaign.

6. Pharmacy capacity to support the Pandemic Recovery Programme (This is a risk managed by Pharmacy on behalf of the Executive Director of Nursing and Midwifery)

Medicines supply and medicines management play a significant role in all aspects of patient care. This includes areas identified in the recovery programme for example paediatrics, cancer treatment, critical care and surgery. Pharmacy, as a support service, can often be overlooked in the planning of increased activity but currently does not have the capacity to support an increase in workload without a commensurate uplift in staffing.

7. Technical Services (Sterile Medicines Production) (This is a Pharmacy specific risk and is managed by the Chief Pharmacist)

A refurbishment of the aseptic production facility at Ysbyty Glan Clwyd commenced on 7th March 2021. Phase 1 work, which affected the over labelling and packing down of medicines took place throughout March. Completion of the works and then the commissioning and validation of the unit was conducted in May 21. Phase 2 work, which affects the sterile production of medicines, is

underway, there will be a period of commissioning and validation in September, and the unit is planned to reopen at the end of September 2021.

Mitigation: The contingency plans in place to ensure continued access to medicines prepared in a sterile environment are:

- Chemotherapy at Ysbyty Glan Clwyd is being prepared in the cancer centre
- Ysbyty Gwynedd and Ysbyty Wrecsam Maelor are supporting necessary Central intravenous additive service (CIVAS) for the preparation of readymade product for wards.
- Some products are being purchased readymade e.g. Total Parenteral Nutrition bags.
- Welsh Health Care Courier services are supporting the logistics.

The Transforming Access to Medicines (TrAMS) is progressing. Welsh Government approved the business case for this project to set up three regional hubs to supply sterile medicines across Wales. There has been a period of consultation with the staff working in sterile production units. A project director has been appointed and progress has been made, starting with a specification for the southeast Wales hub. The project director will be visiting all three acute hospitals in North Wales in September 2021.

An anticipated 20% increase in systemic anticancer treatments between July 2021 and Spring 2022 is of concern. Technical Services and cancer lead pharmacists are working with Cancer Services to develop plans to mitigate the impact. These include:

- Outsourcing products
- Staff skills reviews, with a view to upskilling where possible.
- More efficient scheduling of patients
- Dose banding where clinically appropriate (producing a core set of strengths and then rounding the dose up or down to the nearest available strength).
- Producing products on a 'campaign' basis.

8. Patient Safety Notice (PSN)55 Safe Storage of Medicines (This is a risk managed by Pharmacy on behalf of the Executive Director of Nursing & Midwifery and the Executive Director of Primary Care and Community Services)

The safety lead pharmacists and medicines management nurses have spent a significant time auditing all clinical areas where medicines are stored within the acute and community hospital sites. Although PSN55 has replaced PSN 15 and PSN 30, the risk assessment covers much of the same areas. A full audit report will be going to the BCUHB Patient Safety and Quality Group, but of concern to note is that many of the issues identified in the 2019-20 audit remain outstanding. The PSN highlights the following action in the safety notice: *All new builds and refurbishments commissioned after issue of this notice must comply with the requirements of this notice. For all existing clinical areas, a risk assessment of medication storage areas and facilities must be undertaken and remedial action undertaken proportionate to identified risks by 30 September 2021.*

Estates need to be involved in the feedback so that any remedial actions identified from the audit will be addressed and there needs to be a commitment from estates that pharmacy will be included in any planned new builds and refurbishments to ensure that the Health Board is compliant with PSN55.

Mitigation: The updated audit will identify areas of non-compliance.

9. Pharmacy support for Community Hospitals and Primary care (This is a risk managed by the Executive Director of Primary Care and Community Services)

The inpatient acuity and model of care on community hospital wards has changed significantly in the past 5 years. In addition, the range of day case and outpatient services has increased in clinical complexity. These changes mean the historic model of pharmaceutical support is outdated. Shorter lengths of stay and consequential increased admission and discharge rate combined with more complex medication regimens has significantly increased medicines workload. Weekly pharmacy visits are no longer sufficient to ensure efficient and safe transfer of patients in to community hospitals or onwards to their homes. The introduction of MTED electronic transcribing systems is essential to improve the safety and timely transfer of patient medicines information in this faster moving environment. The frequency of pharmacy visits is also inconsistent, while some site have the benefit of daily support others are visited weekly, and often have no cover service for periods of holiday or sickness. A business case is in development to address this risk.

Across North Wales, there are joint policies in place for the administration of medicines to patients in their domiciliary setting. However domiciliary carers are unable to undertake level 2 administration and support patients to take their medication. The six local authorities do not commission medicines support above incidental and ancillary calls. They do not support level 2 administration and there is no agreement around risk sharing, funding or training and competency assessment programmes. This results in citizens deteriorating due to poor compliance or being admitted to hospital due to taking the wrong medication or inadvertently overdosing themselves.

Mitigation: Currently Pharmacy are working with best endeavours to support all community hospitals and domiciliary care.

10.Homecare (This is an Pharmacy specific risk and is managed by the Chief Pharmacist)

The pandemic continues to cause problems with service delivery resulting in patients having delayed or missed treatment. Several Homecare Providers have been impacted by the “ping-demic” and shortage of delivery drivers. In addition, Lloyds Clinical Homecare suffered a large COVID outbreak in July. New patients were not accepted for a period of six weeks. This has resulted in services needing to be re-directed to alternative providers and supply from the acute sites.

There has been a subsequent increased demand for homecare provision over the past year – as specialities have aimed to move care closer to home to reduce footfall into the acute sites during the pandemic particularly for patients receiving immunotherapies. Homecare prescription volume has increased by 11.7% when compared to this time 12 months ago. An increased number of homecare prescriptions will impact the Pharmacy team in two ways:

- a. An increased demand for a clinical check – note: several specialist Pharmacist posts are currently vacant across BCU and
- b. Increased workload for the centralised homecare team; also operating at reduced staffing levels. The latter is likely to improve during the next quarter following appointment into the Homecare and Procurement Lead Pharmacist posts.

Mitigation: Currently Pharmacy are working with best endeavours to support home care patients to receive their medication on time.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

These risks align to several strategies including:

- Quality improvement
- Unscheduled care
- Planned care
- Care closer to home
- Financial balance

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

There are potential financial implications to mitigate each of the risks outlined above and include:

- Workforce;
- Purchase of IM & T hardware and EPMA systems;
- Estates costs to rectify medicines storage deficiencies;
- Budget (where higher cost medicines have to be purchased in shortages).

Business cases have either been developed or are in development or are planned for development. Impact assessments will be included and those in development will be appropriately impact assessed

Dadansoddiad Risk / Risk Analysis

The risks outlined in the narrative above are recorded on the BCU risk register. Several risks are currently being developed by 30th September 2021. Several of these risks currently sit with Pharmacy and Medicines Management but further discussions are necessary to agree where the risks should lie going forward.

Item	Risk number	Grade	Current score	Risk Owner
1. Community Pharmacy	Risk in development	High	16	Executive Director of Primary Care and Community Services
2. Medicines shortages	BCU 2266	Moderate	6	Chief Pharmacist
3. <ul style="list-style-type: none"> • Vaccination • Medicines Distribution 	Risk in development	High	16	Executive Director of Primary Care and Community Services
	BCU 1237	High	10	
4. <ul style="list-style-type: none"> • Electronic Prescribing, Medicines 	BCU 1109 BCU 1030	High High	12 10	Executive Director of Medical Director Executive Director of Nursing & Midwifery

	Administration (EPMA) • Electronic transmission of prescriptions written in primary care	Risk in development	High		Executive Medical Director
5.	Mental Health Pharmacy Staffing	BCU 611	High	9	Executive Director of Public Health
6.	Pharmacy capacity to support the Pandemic Recovery Programme	Risk in development	High		Executive Director of Nursing and Midwifery
7.	Technical Services (Sterile Medicines Production)	PHA9 C1517	High High	9 12	Chief Pharmacist
8.	Safe Storage of Medicine	BCU 1107	Moderate	6	Executive Director of Nursing & Midwifery
9.	Pharmacy support for Community Hospitals and Primary care	PHA5 C1386	High High	8 8	Executive Director of Primary Care and Community Services
10.	Homecare	2816	Moderate	6	Chief Pharmacist

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The plans being put into place to use Wrexham Maelor Hospital as the hub and Ysbyty Gwynedd and Ysbyty Glan Clwyd as the spokes for wholesaling activities will ensure that BCNUHB is acting lawfully and within the terms of its authorisation for the supply of medicines to its customers.

Asesiad Effaith / Impact Assessment

This is purely an administrative report to update and inform the Committee on the pharmacy and medicines management related risks. The report does not have a negative impact on equality, socio economic disadvantage or human rights beyond what is highlighted in the risks identified.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Board Commissioned External Review – Ysbyty Gwynedd (YG) Outbreak 2021						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery / Deputy Chief Executive						
Awdur yr Adroddiad Report Author:	Debra Hickman Secondary Care Nurse Director						
Craffu blaenorol: Prior Scrutiny:	Executive Director of Nursing and Midwifery / Deputy Chief Executive						
Atodiadau Appendices:	1. Peer Review of Infection Prevention & Control (IPC) Covid-19 guidelines and practice at Ysbyty Gwynedd (YG) Hospital, Bangor May 2021 (incorporating jointly agreed Terms of Reference for the review) 2. 'Safe Clean Care' - Harm Free Care progress report						
Argymhelliad / Recommendation:							
The Committee is asked to receive the attached report, subsequent findings and recommendations. It is also requested to receive the progress report against each of the actions and the update against the Safe Clean Care (SCC) improvement programme.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	X	Er gwybodaeth For Information	x
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>The Health Board as part of its response to the outbreak in March 2021 of COVID -19 at Ysbyty Gwynedd committed to commission an independent review, with defined Terms of Reference agreed by both Executive and Independent Board Members. This paper includes the final report of the review, update on work undertaken against the recommendations and informs the committee on the current position against the work of the 'Safe Clean Care' improvement group.</p> <p>Any gaps identified between the report and the improvement work will be incorporated within <i>Safe Clean Care</i>.</p>							
Cefndir / Background:							
<p>The Scope of the external review was defined by the terms of reference and was to consider:</p> <ul style="list-style-type: none"> • Governance & Board to Ward Leadership • Infection Prevention Practice • Leadership 							

- Site coordination / engagement and placement
- Environmental issues
- Testing

The Review took place early to mid May 2021, utilising the following methodologies:

1. Focus Groups with the following teams: Estates & Facilities, Clinical staff, Infection Prevention team

2. Onsite visits reviewing signage, well-led processes, Patient placement, facilities, equipment, communication, assurance mechanisms, Infection Prevention Control (IPC) audit plan and general observation of compliance.

In parallel the Health Board commenced an improvement plan building on the Safe Clean Care initiative and lessons learned from our pandemic experiences.

Asesiad / Assessment & Analysis

Key findings from the Ms Gwilliams report included:

- Good Compliance with Personal Protective Equipment (PPE), hand hygiene and social distancing.
- There were Clear pathways on entry into the Emergency Department.
- Staff were knowledgeable regards IPC requirements when questioned and able to articulate clear understanding.
- A sense of commitment to the prevention of nosocomial transmission.
- There was good communication and engagement between the Infection Prevention team and site Management.
- Good access to gel facilities and decontamination stations on entry.
- There had been refresher training introduced for domestic staff.
- The visiting teams overall observation is that of an aged estate although maintained overall, it provided challenges.

Key recommendations in line with the Terms of Reference are outlined in appendix 3 of the review and a position statement against these is included within this report.

There were no immediate concerns raised at the time of the review or within the report. Whilst several of the recommendations are new, it is clear from the report that some of the lessons learned from previous outbreaks had not been fully embedded, including the restrictions for staff communal areas. It further questioned the effectiveness of the current cross site communications. We are now exploring alternative methods to better ensure these critical messages are received and acted upon.

It has previously been noted that the outbreak was not escalated in a timely way to help mitigate spread of the outbreak. The Hospital Management Team (HMT) has reflected on their experience and shared their learning in various fora across the Health Board. Changes within the Hospital Management Team have since taken place to strengthen operational delivery.

Next Steps:

The report has been widely shared across the organisation and will be subject to further discussion at the Infection Prevention & Control Strategic Group (IPSG) which is chaired by the

Executive Nurse Director.

Some of the recommendations have already been identified during the course of the outbreak and now form part of the Safe Clean Care Harm Free (SCCHF) programme. These include the 'Toyota' review of the COVID 19 admission screening pathway and development of a Risk Assessed approach to flexing / reducing capacity and review of all communications and posters supporting COVID guidance. Those that are not currently included will immediately be incorporated.

The programme, which was mobilised at pace to respond to ongoing COVID 19 pandemic learning in order to further minimise the risk nosocomial transmission and its subsequent impact of service users and staff requires resource to fully implement sustainable transformation based on previous/existing and new evidence / learning across the Health Board.

The Health Board has now received confirmation of funding to support the implementation of the revised cleaning standards bid submitted to Welsh Government and these are being implemented.

A progress report against the 'Safe Clean Care' programme, which is the Health Board's vehicle for system wide improvement, is included for the Committee's information at Appendix 2.

Goblygiadau Strategol / Strategy Implications

This report underpins the Board strategic direction around delivery of services.

Opsiynau a ystyriwyd / Options considered

n/a

Goblygiadau Ariannol / Financial Implications

Additional Service Improvement / Project management support identified through the SCCHF programme

Dadansoddiad Risk / Risk Analysis

As per Infection Prevention Board Assurance Framework (BAF)

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Healthcare Inspectorate Wales Framework for Inspection
Welsh Government Priorities for Service Delivery
Putting things Right Framework

Asesiad Effaith / Impact Assessment



Ysbyty Gwynedd District General Site Bangor
Betsi Cadwaladr University Health Board

Peer review of IPC COVID-19 Oversight and Assurance
in line with best practice

Focus groups: 07 May 2021

On-site visit: 14 May 2021

Date of Report: 9 August 2021

Report authors:

Hilda Gwillilams MBE, Executive Director of Nursing

Dr Andrea Denton, Independent Nurse Consultant

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1 Executive Summary

1.1 Introduction

A Board Assurance Review incorporating a series of focus group interviews and an on-site visit to Ysbyty Gwynedd (YG), a district general site in Bangor, Gwynedd, Wales was carried out on 07 May 2021 and 14 May 2021 respectively. This report provides you with the findings and recommendations from the review.

The visit was led by Hilda Gwilliams, Executive Director of Nursing, alongside Dr Andrea Denton, an Independent Nurse Consultant in Infection Prevention and Control (IPC).

The review was requested by the Deputy Chief Executive, Executive Director of Nursing and Midwifery on behalf of the Betsi Cadwaladr University Health Board (BCUHB) in response to a significant number of nosocomial infections and outbreaks at BCUHB.

Introductory discussions in the form of focus groups were held with the following teams: Estates and Facilities, IPC Team and a clinical group. These were particularly helpful in understanding the context and issues specific to the YG site. For the on-site visit, a variety of areas were visited including the Emergency Department (ED), a Medical Admission Unit, a designated COVID-19 ward/area, a general surgical ward and an outpatient area as well as a general walkabout around patient entrances, staff restrooms and the restaurant. This was in order to observe the patient journey and staff movement and review compliance with IPC principles for the prevention and management of COVID-19 including the YG site's response to the reintroduction of 'business as usual'. In addition, the review was undertaken to observe any lessons learnt from recent nosocomial spread and outbreaks that had occurred in YG and other sites within the BCUHB.

1.2 Background

The YG site is one of a number of sites that forms the largest health organisation in Wales, BCUHB. The organisation has a budget of £1.3 billion and a workforce of over 17,000 staff, providing primary, community, mental health and acute services for the population of North Wales.

In addition to three main sites at Ysbyty Gwynedd (YG) in Bangor, Glan Clwyd (YGC) in Bodelwyddan and Wrexham Maelor (WMH), the BCUHB provides services in the following specialties: urgent and emergency care, general and specialist medicine, surgery, trauma and orthopaedics, women and children, oncology and haematology intensive and coronary care units, and renal dialysis.

1.3 Purpose of Review

The purpose of the review was to determine the preparedness of the YG site for risks around COVID-19 nosocomial transmission and outbreak prevention. Furthermore, the review was undertaken to analyse previous recommendations made, following outbreak report(s) from WMH and YGC sites and how lessons shared with YG informed practice and management of patients across elective and non-elective pathways.

In addition, the reviewers were to identify areas of good practice and areas for improvement. The review was undertaken in a constructive manner and feedback provided via a professional, courteous and supportive approach. All staff within the YG site were extremely engaging, helpful contributed learning and were very respectful of any areas that may benefit from improvement.

1.4 Terms of Reference

The Terms of Reference for the review were provided by the Deputy Chief Executive, Executive Director of Nursing and Midwifery on behalf of the BCUHB (Appendix i).

1.5 Scope

For the review, five IPC Key Lines of Enquiry (KLOE) were identified. The KLOE are based on the Welsh Government's 'COVID-19 16-point plan, to limit, minimise and mitigate the risks associated with transmission in a healthcare setting'. These were:

- **Governance and Board to Ward leadership:** Compliance with the 16-point plan.
- **IPC practice:** Observations of adherence to basic IPC practice.
- **Leadership:** Explore leadership inclusive of IPC, relationships and interdependencies with other specialties and current challenges and successes.
- **Site co-ordination, engagement and patient placement:** Review urgent and emergency care, pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative), review COVID-19/non-COVID-19 patient pathways, review the interface between site co-ordination teams and IPC Teams (IPCT) and ED flow and impact on IPC.
- **Environmental:** Observations of the estate, including bed spacing and processes to mitigate against environmental shortfalls e.g. ventilation.
- **Testing:** Compliance with screening protocols and turnaround times.

1.5.1 YG site staff participating in review:

- Mandy Jones, Director of Nursing.
- Eleri Evans, Head of Nursing for Emergency Care.
- Ward and department-based staff, nursing, medical and allied health professionals and Soft Facilities Management (FM) colleagues.

1.6 High Level Feedback

High level feedback was provided to the site during and at the end of the visit, in addition to follow up discussion at Executive level.

1.7 Focus Group Feedback

Focus group meetings were held the week before the on-site visit. These included Estates and Facilities, clinical staff and the IPC Team. The purpose of these were to explore with different groups of staff any areas of concern, how effective the learning across the BCUHB was shared and enabled informed decision making in terms of patient pathways.

The following feedback was provided in relation to the level of preparedness of the YG site for a COVID-19 wave 2 surge, prior to the declaration of the level 3 outbreak in February 2021:

- Policy development and Standard Operating Procedures (SOPs).

The BCUHB policies were developed in line with Public Health England (PHE) and Public Health Wales (PHW) guidance and were in place prior to the COVID-19 outbreak on the YG site. In addition, local SOPs had been developed. This was an improvement action following the learning identified from the WMH and YGC sites and had been completed.

- The Emergency Preparedness, Resilience and Response (EPRR) process was clear, operationally in place and senior leadership and oversight in Gold/Silver Command. A single point of contact was established for the flow of information, inclusive of the COVID-19 patient pathways. Unfortunately, the YG site did not have an electronic readily available data system in place.
- There were robust training plans in place prior to the outbreak, with high compliance rates. The Personal Protective Equipment (PPE) training included 'Donning and Doffing' processes. However, due to the length of time before the surge occurred on the YG site, staff confidence had lapsed. Remedial action was implemented by providing a refresher training programme, ensuring staff remained COVID safe.
- Staff articulated that there had been a failure to recognise the long-standing members of the domestic team had not maintained up to date training in new technology such as Microfiber products, which was the system utilised during COVID-19 outbreaks. The competency issue was immediately addressed via additional training being provided, although this occurred during the surge as opposed to being in a state of preparedness.
- Staff described the monitoring and reporting processes embedded prior to the outbreak which included: IPC Board Assurance Framework in place and discussed in Quality & Safety site meetings, reporting to the BCUHB corporate committee structure. The monitoring and compliance performance included indicators from the COVID-19 toolkit (WG 2020) and reflected good practice. The Board to Ward thread was evident.

- Staff shared that the learning from WMH and YGC outbreaks failed to reach all frontline staff in a timely manner, the feedback suggested this was as a result of the mode of communication being an 'all staff email'.
- Evidence of learning from the post infection review (PIR) process identified an increase in the number of student nurses testing positive for COVID-19. On further review, it was identified that students in the clinical environment had not been trained in enhanced IPC measures by the University or BCUHB. This action was addressed prior to the outbreak.
- In triangulating the learning across sites, it was apparent that similar themes were identified in relation to complaints and incident reporting.
- The culture of encouraging questions and challenging observed lapses in IPC measures was reported to have relied heavily on the nursing profession, rather than all members of staff. Embedding the values and behaviours improved over the course of the pandemic, an example provided related to challenges in non-clinical areas, i.e. not social distancing.
- The Estates Team had worked closely with clinical teams to map out isolation facilities, which demonstrated a lack of cubicles in the event of a surge. Actions were implemented in the case of a surge preparation but due to building contractors' availability, these were not developed in time, which led to difficulties in isolating COVID-19 positive patients.
- The organisation has invested in domestic services; however, there was a lag in recruitment timeframes impacting on their ability to meet the increased demands of the new cleaning schedule (16-point plan), prior to outbreak. This issue was resolved during the surge.
- There was visiting guidance in place prior to the outbreak, however staff described patient compliance issues, such as patients leaving the Ward to visit family and friends and not wearing their face masks. This was identified as a theme across all sites.
- Staff stated that there are communication challenges, as the relaxation of COVID-19 community controls, coupled with the vaccination programme is

giving rise to a false 'sense of security', leading to a sense of complacency.

- Clinical workforce challenges including reduced bank capacity and temporary staff availability, thereby relying on core staff working extra hours. Staff fatigue was quoted several times during the review.
- The IPC team structure required strengthening prior to the outbreak, as it was reactive during surge and reported as being heavily reliant on an individual rather than the wider team. A business case was developed and approved and this issue is now resolved.

In addition, it was recognised that the IPC Team and champions require support and development, as they were relatively junior in terms of subject matter experience, leading to a lack of consistency with advice.

- In terms of limiting staff movement to reduce the risk of nosocomial spread, staff were aware of the lessons from other sites prior to the outbreak and managers had ensured rosters delivered compliance. However, the workforce profiling and preparedness did not include bank staff who contributed significantly as the surge and outbreak continued.
- Robust plans in place for designated COVID-19 positive Wards were evident during the surge and outbreak on the YG site, all staff were aware of escalation areas. Unfortunately, as the outbreak and nosocomial spread receded and the site tried to resume to 'business as usual', the staff felt the plans for escalation became less clear. Staff described poor communication, leading to challenges on a daily basis, compounded by out of hours decisions and action without the relevant risk assessments being undertaken.
- Signage was highlighted in previous learning reports as requiring improvement. Staff felt that the YG site had not been sufficiently prepared prior to the outbreak in both clinical and general areas. Remedial action was taken during the outbreak and this was supported by the Health and Safety Team.
- There were clear discharge SOPs in place for patients who were COVID-19 positive and prior to the outbreak, the documents were in line with best practice guidance. Regrettably, clinical staff provided an example of a palliative patient who was

discharged home with the right support in place, however the patient's spouse was vulnerable and became COVID positive and passed away. The immediate learning was the lack of information sharing in relation to isolation at home and the discharge SOP was amended to improve the sharing of information with relatives. The SOP has been shared across the BCUHB to ensure wider learning.

- Staff described feeling the immense pressure, but the team spirit remains high and the pride in the site is exemplary.

1.8 Key focal points for on-site review

- Review of policies, procedures and guideline management as they have evolved since the start of the pandemic.
- Well-led processes (EPRR) and leadership support in line with best practice.
- In line with 16 point plan, review front door signage and signage in main corridors to ensure it aids social distancing.
- Review the placement of COVID-19 positive patients to ensure they are managed in the most suitable area, in line with COVID-19 patient pathways.
- In non-COVID-19 areas, ensure the placement of patients' beds allows for social distancing (16-point plan). Explore the use of additional physical separation barriers such as screens when social distancing is difficult.
- Consider the use of screens or other types of barriers in the ED Department to maintain separation of patients. Explore how patients are triaged in ED and admissions units.
- Check staff rooms, offices and other shared areas for clear signage and spacing for the correct amount of people. Ensure the signage includes the maximum number of people at any one time.
- Inspect equipment and ensure there are processes in place for decontamination and removal (where applicable), including labeling equipment to show "I am clean", and appropriate segregation.

- Ensure staff rooms/canteens and offices comply with COVID-19 safe measures.
- Explore lines of communication to ensure all staff receives messages in an appropriate and timely manner.
- Check the methods in place for compliance with testing regimes as per current guidelines and 16-point plan.
- Review the IPC audit plan for assurance on compliance.
- Evaluate any behavioural factors and subsequent escalation that have contributed to the outcome of the YG incident.

1.9 Key findings

During the visit, areas of good practice were highlighted. These included:

- Capacity increased by creating 3 field sites in response to the surge, inclusive of piped oxygen.
- Compliance with PPE use, social distancing and Hand Hygiene and the areas visited appeared clean and well maintained. The implementation of screens around ward clerk areas/nurses' stations on wards was particularly useful in preventing congregation and helping social distancing.
- In line with best practice guidelines, there were clear pathways, separate entrances and triage/risk assessments for patients entering ED to minimise risk of mixing possible/probable COVID-19 positive patients with those who were possible/probable negative.
- All staff spoken to on the visit and in the focus groups understood the enhanced IPC measures required for their role and were knowledgeable in relation to COVID-19 transmission and mitigating actions required.
- Motivated and enthusiastic staff who were engaging and willing to share good practice but also listen to advice and recommendations in areas where

improvements could be made.

- Staff were committed to preventing nosocomial transmission and delivering safe care, management and treatment.
- Good communication between the IPC Team and Patient Flow Team.
- Estates and Facilities developments and continuous improvements:
 - When the number of positive cases decline, the newly installed isolation PODs between the designated COVID-19 ward and the Admissions Unit could be utilised for patients who were COVID-19 positive, to assist in maintaining separate pathways. The 6 PODs were awaiting handwashing facilities and the staff would need to explore waste/body fluid removal if these were used as inpatient care management areas.
 - Clear screens surrounding nurses' stations assisting in the prevention of congregation around the area and maintaining social distancing.
 - Proactive window opening in the areas visited during the day.
 - Established gelling and decontamination stations.
 - All domestic staff undertook refresher training in the new cleaning technology system, Microfiber.
 - Continued decontamination with chlorine-based products throughout the sites. The organisation has invested in additional decontamination equipment such as ultraviolet cleaning (UVC) robots and Hydrogen Peroxide Vapor (HPV) systems since 2013.
 - Collaborative working with Eco laboratory in terms of the UVC robot and trialing hydrochloric acid as an alternative to HPV which is an example of innovative practice.
 - Disposable curtains utilised in admission and COVID-19 positive areas.
 - Decommissioned field sites re-purposed as support mass vaccination centers.
 - Undertook work on oxygen infrastructure, supply and distribution, improving flow rates and the ability to monitor flow.
 - Innovative collaboration with Bangor University in relation to ventilation including learning from new technology.
 - Monitoring of COVID-19 variants through waste management in conjunction with Bangor University.

2 Main Report

2.1 Context

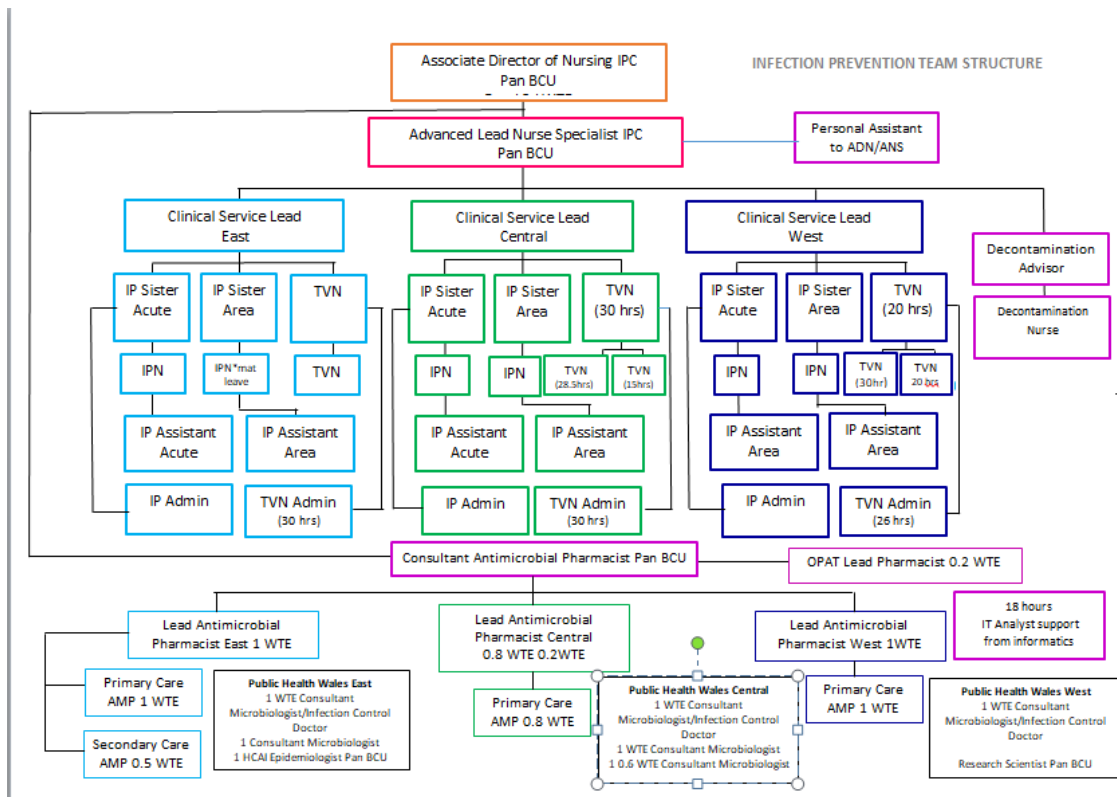
The University Health Board is stable, the BCUHB governs the organisation and membership consists of the Chairman, the Vice Chair and Independent Members who are appointed by the Minister for Health and Social Services.

2.1.1 Infection Prevention and Control Team Structure (IPCT)

The IPCT is led by the Director of Nursing for Infection Prevention and Control, a very experienced and knowledgeable senior nurse. It was observed during the site visit that BCUHB had a robust IPC structure in place, in comparison with peer reviews undertaken across the North West of England (34 acute Trusts), inclusive of on-site Microbiology services and utilizes the ICNet electronic surveillance system, to monitor and record healthcare associated infections (HCAI).

In line with best practice guidance, all sites were also supported by a surgical site infection team and have dedicated administrative support. Furthermore, BCUHB had implemented national recommendations, such as IPC Safety Officers who are employed across sites on a temporary basis due to COVID-19. These roles underpin the governance arrangements by supporting and providing challenge to staff regarding PPE and social distancing and carried out audits of enhanced IPC practice to evidence the level of compliance.

Following a recent successful business case, the new substantive IPC team model is as follows, reflecting national recommendations of robust senior leadership:



Key note:

- In terms of the investment into the IPC Service: an additional 3 (Band 7) posts and 3 (Band 4) posts to support Area/Primary Care and Mental Health were recruited.

2.2 Governance and Assurance

The reviewers observed an embedded clinical governance model across sites, providing assurance from Board to Ward via its corporate committee structure, embedded prior to the COVID-19 pandemic. Each site has daily IPC meetings and YG has twice weekly Matron observational WalkRounds. In addition, there is a monthly IPC meeting with representation from all care organisations. The IPC meetings' aim, and shared purpose is to achieve no nosocomial COVID-19 infections across all sites and community settings.

The BCUHB has an IPC Board Assurance Framework; there is evidence that this has been continually updated in line with national guidance.

In addition, audit programmes have been refreshed with additional COVID-19 management metrics, as new guidance has been published. There is an IPC dashboard in place, inclusive of key metrics such as COVID-19 screening and

continuous monitoring of compliance performance, in line with best practice.

Weekly communication had continued across the BCUHB regarding COVID-19, via the daily take bulletins.

2.3 IPCT Leadership

Each care organization (site) had access to an on-site IPC Team and felt well-supported in the care organisations. In terms of monitoring improvements, the IPC Cell continues with weekly meetings to oversee the IPC action plans.

The BCUHB continues to consider the impact of IPC measures on the experience of patients as nationally advocated, for example with the gathering of patient feedback in relation to the instillation of ventilation systems in patient bays, to ensure the patient's voice is heard.

2.4 Testing

All COVID-19 testing is carried out on-site. The YG site is currently reporting testing times of approximately 12 hours (May 2021), meeting the required standards. There was some feedback that there was limited supply of 40 rapid tests per day for use in ED and AMU, however following a discussion with the Deputy Director of Nursing, it was established staff had access to adequate supplies. There appeared to be a lack of awareness of stock control.

In addition, the YG site was compliant with admission, 5- and 10-day testing as per BCUHB guidance and the 16-point plan. Monitoring arrangements have been in place prior to the outbreak.

Reporting arrangements via Quality & Safety Committee were clear, with associated minute's available, demonstrating good governance, oversight and clear escalation processes to the BCUHB by exception reporting.

2.5 Environmental

The estate did have some challenges, with limited side rooms on the wards (between 5 and 6 and only 2 rooms with en-suite). However, the YG site has a plan in place to increase side room capacity. Alternatively, there are temporary 'pop up' units available such as a Bioquell Pod.

Social distancing challenges have been well documented, supported by audit information from the Estates Team in terms of highlighting resolution proposals, enabling informed decision-making via the BCUHB committee structure. As an example, there were a number of 6 bedded bays that have been reduced to 4 in some areas to increase social distancing between bed spaces, in line with the 16-point plan, reducing the risk of nosocomial spread.

There was a system for flexing the capacity in the bays depending on bed pressures and surges, which did lead to some confusion at times amongst the staff as to what was the required spacing between beds. On further discussion, it would appear that the national guideline is 3.6 meters mid-point to mid-point of adjacent beds. This was the ideal and could be reduced on risk assessment, depending on the nature of the Ward and patient group, maintaining compliance with established COVID-19 patient pathways.

Where there were 5 or more beds in the bay areas, it was suggested by the reviewers that the staff look to have a systematic approach of where furniture was placed in relation to each patient; for example chair, bed, locker and ensuring that this is repeated throughout that bay/area for consistency.

YG had invested in 6 new isolation pods that are positioned between the current COVID- 19 ward and Medical Admissions Unit (MAU). The pods were currently empty when the review took place. It was suggested that during periods of reduced incidence of COVID-19, if further estates work was completed e.g. a sink unit and waste disposal system, the area would be COVID-19 safe and significantly reduce the risk of nosocomial spread.

The BCUHB has fitted clear screening around nurse/ward clerk stations, which during the review, appeared to reduce staff congregating around the stations and promoted social distancing. The YG site has also implemented a procedure for natural ventilation, e.g. proactive window opening, in line with best practice.

2.6 Site co-ordination, engagement and Patient Placement

The consolidated learning from both WMH and YGC had more time to be shared prior to the 3rd outbreak on the YG site in February 2021. Whilst the shared

learning across sites occurred, unfortunately the mode of communication was via an 'all staff email' or disseminated to management teams via Gold Command. As expected, frontline staff focused on direct patient care which led to a delay in accessing the information/emails in a timely manner.

Established COVID escalation plans were in place prior to the outbreak, however once the YG site was running with high occupancy levels, this became increasingly challenging. As a result, the impact operationally led to poor cohorting of COVID-19 positive and non-positive patients, pathways were mixed in the same ward environment. This was a key recommendation from the learning at the WMH and YGC site in order to reduce the nosocomial spread that unfortunately was missed/not embedded.

Staff portrayed an overwhelming loss of situational awareness during these surge periods, and as a result, there was evidence of deviation from agreed COVID-19 pathways by mixing different COVID status patients in the same area.

At the time of the visit, the YG site was using part of one ward to accommodate patients with COVID-19 and the site was maintaining a level of 'business as usual' activity. Given the current reduced number of patients with COVID-19, the designated COVID-19 ward had a mix of both red (COVID-19) and green (non-COVID-19) patients. On visiting the ward, it was not evident both at the ward entrance and once in the ward which areas were red, and which were green. There was a corridor within the 'red' area so that staff were able to 'don and doff' in the 'red zone' and at the time of the visit, there were no patients requiring aerosol generating procedures (AGPs).

The signage on the bay door, as well as the front of the ward door, was not clear and there was a large array of different signage in the ward and across the YG site as a whole, which at times was unclear and busy with too much information.

The majority of the information on the signage was written rather than pictorial, which could result in difficulties in getting key messages across.

2.7 IPC BCUHB Wide Practice

The BCUHB had visiting guidance in place prior to the outbreak on the YG site (inclusive of all inpatients, outpatients and visitors) which requested the wearing of a facemask when entering the building, if this can be tolerated. These were available at the entrances to the YG site. Unfortunately, there was an initial delay in implementing the agreed surgical mask rather than handmade material masks. This issue has since been rectified.

The YG site entrance was staffed by predominantly health care assistants, who also had the responsibility of checking equipment at the other entrance which meant that they were not always on hand to assist staff and the public and reinforce mask usage (where able) and hand hygiene. The staff were not at the entrance at the time the reviewers entered the building but were when they were leaving.

All visiting continued to be restricted to essential visiting only, in line with national guidance.

2.8 Clinical Visit

An on-site visit was conducted on the 14 May 2021 to undertake observational assessment of IPC practice in clinical and non-clinical areas.

2.8.1 YG site only

In relation to the sites preparedness, BCUHB's policies, procedures and guidelines had been adopted across all sites. However, once in surge, it quickly became apparent the ED SOP was not fit for purpose, as the estate was different to other sites and the risk to maintaining segregated COVID-19 pathways was exposed.

The designated area for COVID-19 probable/possible patients was sectioned off but only by a portable plastic screen that had taped signage on one side to indicate that it was for COVID-19 patients. The signage had been moved on one side and tape residue was left across the top. The observed factors were in place prior to the outbreak and were not in line with best practice guidance.

The corridor area that was the demarcation zone was ideal for a permanent concertina type door/screen to be added so that the segregation was more robust during surge periods. This was suggested at the time at the time of the visit.

On the day of the visit, the reviewers were shown the ED. It was noted the ED was not at capacity, but all patients being cared for at the time wore face masks. There was a separate area for ambulance and ambulant patients if they were COVID-19 suspected and there was a robust system in place to triage all patients.

Ambulance crews were aware of segregated areas and where to place patients on admission. They also had available areas to clean and disinfect the ambulance if required as well as having designated areas on-site at the ambulance station. The ambulance staff were observed wearing PPE, but this was mixed on the day of the visit with some ambulance staff wearing the correct PPE (level 1) when within 2 meters of the patient and others wearing gloves only. The rest of the staff were compliant with PPE. Monitoring and reporting in relation to compliance with PPE standards has been regularly overseen via the Quality & Safety Committee and EPRR in line with COVID-19 preparedness governance arrangements.

The ambulant areas of the ED were also well-managed with a robust system in place for entrance and triage and separate entrances for patients who were suspected of being COVID-19 positive. These pathways were designed in preparation for the pandemic and are consistent across all sites, reducing the risk of nosocomial spread.

As previously highlighted, the COVID-19 posters displayed around the YG site were too detailed and this was compounded by the posters having to be in dual language (Welsh and English). There was, however, other signage (not related to COVID-19) that was visually appealing and used animation rather than words alone which helped with key messages. It was suggested that this may be something that the BCUHB could adopt going forward.

The floor signage incorporated the use of black and yellow tape, which in certain areas of the YG site, had become loose and damaged thereby incurring risk of a trip hazard. It was stated that the use of the circular signage with the 2 meter arrows between/interspaced along corridors may have been more useful and less

damaging to the floor, as it was less liable to cause a trip hazard. The signage aids were available and nationally advocated to reduce the risk of nosocomial spread, unfortunately these were not used. Signage was a theme identified on other sites from reviews undertaken, regrettably remedial actions had not been implemented by the time of the visit to the YG site.

2.8.2 Leadership

In preparation for the pandemic, clear EPRR process had been implemented with senior leaders in Gold Command. In the early phase of the surge, prior to the outbreak, staff articulated delays in communication and sharing of information. However, senior leaders could evidence the timeliness of information sharing that then appeared to stall at middle management level. The volume of rapid updates and amendments to protocols as new evidence emerged, proved challenging for staff to keep up with, meaning they may not have been aware of the latest changes in guidance.

The EPRR process enabled robust and timely escalation of concerns leading to remedial action. The example shared related to the agreed COVID-19 pathways pre-surge and how the site deviated when experiencing significant increases in capacity, resulting in pathway crossover and COVID positive and non-positive patients being placed in the same area.

Throughout the pandemic, the elective pathways have been maintained with robust triage, screening and monitoring arrangements in place.

Earlier in the pandemic, there was limited relationship between the IPC Teams across sites, and the Infection Control Doctor. However, learning from the first wave of COVID-19, new communication channels were implemented providing peer support and professional coaching during this unprecedented time.

In addition, there were also some communication challenges within the IPC senior leadership team, due to a number of management changes. However, the situation was rectified due to a very senior lead returning to the site, which provided strong leadership, proactive visibility and accessibility on a daily basis.

During the course of the visit, the motivation and energy the staff displayed in relation to preventing nosocomial transmission and delivering safe care and treatment was apparent throughout. The nurses and all the healthcare professionals were especially welcoming and engaging. They were happy to share areas of good practice but equally willing to listen to alternatives and suggestions in any areas where improvements could be made. The senior nurse that accompanied the reviewers on the visit was particularly helpful and had a great rapport with all the staff in the wards and areas. The Director of Nursing who received the initial feedback at the end of the visit was open, transparent and expressed a willingness to learn lessons leading to changes in practice, enabling improvements in the quality and safety of care to patients.

2.8.3 Testing and Tracking

Testing regimes were clearly established in preparedness for the pandemic, in line with national guidance. Prior to the outbreak, the monitoring and reporting of compliance was high. However, once in surge and during the outbreak, the sheer numbers of tracking including contacts was overwhelming and relied heavily on the IPC Team. The Ward staff shared that initially they lost situational awareness of the patients requiring screening on particular days and quickly rectified the situation by implementing regimented testing regimes, to ensure compliance was met.

At the time of the visit, there were limited numbers of patients who were COVID-19 positive.

There were some issues in turnaround times for swab results with the average being around 12 hours and up to 24 hours. Close monitoring and daily reporting of swab turnaround time performance was available through the EPRR process and Silver Command, improvements in swab turnaround times have been seen over the pandemic period.

2.8.4 Environmental

The YG site had prepared communal facilities (break rooms on wards) prior to the outbreak and on the whole provided adequate social distancing; however over time, 'natural creep' had evolved, resulting in additional chairs returning to rooms increasing the risk of staff nosocomial spread. The reviewers observed this issue during the visit, this was highlighted at the time of the visit.

In addition, the environment was cluttered with a variety of equipment, consistent with the themes identified on the WMH and YGC sites. It was evident during the visit that the communal areas throughout the YG site were being used as storage areas, including for condemned equipment.

There was no clear screening between bed spaces, in areas where bay capacity had to be increased to 6 patients instead of 4. The bays were able to accommodate 4 or 6 patients dependent on a risk assessment. However, this needed to be made clearer as to when and how this could be achieved, and what the required spacing between beds should be at any given time, to promote social distancing. The use of screens was in evidence around nurses' and ward clerk stations. Furthermore, we observed windows were open in all areas.

Whilst there was a plan for cleaning all areas and designated staff to do this, the feedback from frontline staff was that it appeared a little 'ad hoc' and there was no demarcation between clean equipment, dirty equipment and equipment that needed to be condemned. In one area, there were stickers to designate 'I am clean'. It was suggested that there needed to be a robust process in place.

The outpatient areas that were visited had notices on seats to indicate that seats should not be used (to assist with social distancing) but in some areas, it was observed that all notices ended up on one chair, which was confusing for patients and visitors. The suggestion was for the notices to be taped to the chairs that should not be used, to help reduce the risk of notices being removed from chairs. There was one area in Outpatient X-ray where the chairs in the small waiting area were not 2 meters apart; which was highlighted to staff at the time.

There was tape across the floor to designate 2 meter spacing, which at times had come unstuck creating a trip hazard. It was suggested to use a circular 2 meter

Sign spaced out along the corridors. See figure 1 below:



Figure 1: Example of 2 meters floor sign.

The team visited a number of inpatient areas and the ED; we reviewed both the old and newer estate stock. All areas we visited appeared clean and well-maintained.

2.8.5 IPC Practice in the Clinical Environment

The preparedness of the YG site prior to the outbreak had considered storage for PPE, utilising trolleys as stations at the entrance of each Ward environment. However, once in full surge, there was some acknowledgement by the senior team that the storage facilities for the gloves and aprons were not ideal and they were looking to purchase alternatives that were more user friendly and facilitated the PPE being kept on rolls and housed in appropriate containers.

Recognising the lack of isolation facilities prior to the outbreak, YG had commissioned and installed 6 new isolation PODs. However, due to builder constraints, further work was required prior to the PODs being fit for purpose, including the installation of hand hygiene and waste facilities.

During the site visit, good compliance with PPE use, social distancing and hand hygiene was observed throughout with some anomalies with PPE used by ambulance personnel.

Appropriate levels of PPE were available including additional protection for aerosol generating procedures.

All staff spoken to understood the IPC measures required for their role and were knowledgeable in relation to COVID-19 transmission and mitigating actions

required. Senior staff we spoke with were clear about the patient pathways, although they recognised the challenges in having mixed red and green areas at times when COVID-19 admissions were reduced. The use of the 6 isolation PODs suggested at the time was seen to be a useful alternative.

Donning and doffing training had been provided in a timely manner, in preparation for a COVID-19 surge. However, due to a longer than anticipated period before COVID-19 community prevalence increased and the YG site saw increasing numbers of patients, staff had become unfamiliar with the procedures and required immediate refresher training.

On reflection, the staff recognise that the preparation undertaken in readiness for COVID-19 was robust and felt confident and competent in terms of having policies, training and pathways designed and implemented, with clear escalation processes in place via EPRR. However, they described a sense of it was 'happening all around them' but not seeing any impact which was not what they expected. The feedback from senior managers who had returned to the site at the start of the outbreak was one of shock, in that the site had lost situational awareness and appeared complacent in approach. It was stated by staff members they had lost their battle rhythm due to little COVID exposure.

Similarly, post-outbreak and moving to a different phase of the pandemic, whereby there were lower community prevalence rates, a reduction in the numbers of COVID-19 positive patients in the YG site and the national lifting of enhanced IPC measures across the country, had led to a false sense of security and complacency.

Whilst the focus had moved to that of recovery and restoration, this does not apply to the enhanced IPC measures in place as a result of the pandemic. The early indicators from England demonstrate that the enhanced measures need to remain in place throughout the pandemic; otherwise nosocomial cases can significantly increase in a very short space of time, endangering the safety of patients.

3 Summary Findings against Terms of Reference

3.1 Preparedness of the YG Site

There is documented evidence via the following methods of robust preparedness of the YG site in relation to the national COVID-19 pandemic;

- Policies, procedures and guidelines in place including locally developed SOPs.
- Clear EPRR processes and signal point of contact as in Gold Command Centre in place, led by very senior staff.
- Developed COVID-19 pathways for elective and non-elective patients.
- Training plans implemented ahead of the surge with good compliance.
- Risk assessments tools developed and readily available.
- Streamlining of data, enabling triangulation of challenges to be visible.
- Estates work underpinned the delivery of social distancing measures by mapping out areas, installed screens between bed spaces or administrative desks.
- Easy access via the intranet to relevant documents, toolkit and key messages.
- Communication channels established albeit limited to mainly electronic solutions, inclusive of Executive key messages. During surge episodes, staff were heavily focused on direct patient care and less active on the intranet, therefore missing information.
- Staff feedback is they felt confident, competent and fully supported in the lead up to the pandemic.

3.2 Level of compliance of YG with BCUHB policy including the COVID-19 toolkit

The monitoring and reporting of compliance against best practice guidance, policy documents and the COVID-19 toolkit was captured in the following methods:

- Assurance reporting via the Quality and Safety Committee
- COVID-19 dashboard inclusive of the key national IPC metrics
- Audit programmes aligned to key IPC indicators
- PIR reviews undertaken
- Incident reporting

Other sources of assurance including the BCUHB incident reporting system, PIR processes and Executive led outbreak meetings.

The YG site demonstrated a good level of compliance prior to the surge and outbreak in February 2021, however the evidence shows at this point, the site lost situational awareness for a short space of time.

3.3 Compliance with YG PIR – learning and how the learning was implemented

The context of the outbreak at YG differed to that of earlier outbreaks experienced on other sites due to:

- The more recent predominance of the B.1.1.7 variant of concern (the Kent variant) associated with higher rates of transmission than previous variants.
- The outbreak occurring when the YG site had resumed elective work and was thus at, or near to, capacity.
- Increasing vaccination coverage of patients and staff.
- The outbreak also included a time when there was considerable concern around levels of community transmission.

The actions identified by the outbreak control groups have been achieved and closure of the outbreaks happened with assurance monitoring of actions in place via governance processes.

However, similar themes in terms of lessons learned were identified to those at the WMH and YGC sites that would help reduce the risk of nosocomial spread:

- Increased capacity relating to COVID-19 positive patients' increased risks.
- Reducing avoidable patient movement between wards.
- Reducing the potential within the YG site for spread due to patient behaviours.
- Limit staff movement between wards reducing the risk of nosocomial spread.
- Reducing the overall ward and site footfall.
- Re-enforcing a socially distanced culture across BCUHB.
- Addressing challenges within the current site infrastructure.
- Vaccination of staff and patients.
- Achieving and maintaining high standards of PPE use, hand hygiene and appropriate behaviour within the work environment for all staff groups.
- Maintaining 24 hour vigilance.
- Communication and learning.

Actions that had wider whole system impacts have been captured within the Safe Clean Care work streams and there are nominated leads driving progress, but it is a constantly evolving field, therefore monitoring of control measures is paramount, particularly as lockdown is easing outside of the BCUHB.

It is a real risk that as lockdown measures ease, there will be a rise of complacency. It is recommended that risks are identified and recorded via local risk registers and monitored by local governance arrangements.

3.4 Review of test, track and prevent practice

Staff were observed adhering to the test, track and prevent practices for both patients and staff, with documented evidence of high compliance relating to swabbing.

A. Patient Monitoring Process

- **Testing Regime**

During open discussion with staff, there was good awareness and knowledge of when patients should be tested throughout the patient journey, in line with national recommendations.

There were some issues shared relating to the access and provision of rapid tests to assist with patient placement on COVID-19 pathways, however on further discussion with senior nurses, these were available. It was recommended that this information was shared more readily with frontline staff across the clinical teams.

- **Track, Trace and Prevent**

- At the outset of the YG site COVID-19 patient outbreak, the site was well-supported by the IPC team who provided assurance regarding the tracking of positive patients and their contacts.
- Once the site became more confident in managing the outbreak, the Business Intelligence Team (BI), supported the patient flow team, by producing daily information regarding COVID status reports including contacts by Ward.
- Daily monitoring of patient isolation period, in line with PHW guidance, facilitating early discharge or change of COVID pathway.

- Daily MDT meetings in place monitoring performance, tracking actions and ensuring support was provided where necessary.

B. Staff Monitoring Process

- **Testing Regime**

BCUHB have an embedded staff testing regime, LFT kit issued with instruction for use. Staff were knowledgeable and confident with the process.

- **Track, Trace and Prevent**

Data was available to verify how many LFT kits had been supplied to staff and sickness data detailing the number of staff isolating. However, there is no evidence available that staff provided with COVID testing kits completed the test. In direct contrast, local care homes have robust processes in place, comprising of a lateral flow test twice a week and a weekly PCR test. Staff have to provide evidence to managers they have submitted their test.

3.5 Establish how actions and learning from outbreaks were shared

Staff articulated there had been an 'all staff email' to share lessons learned from the previous outbreaks at the WMH and YGC sites. Senior staff recognised this had not been ideal for busy practitioners working on the 'shop floor'; as the email could be missed by a large proportion of direct care givers.

During the surge, improvements in communication were seen in cross-site discussion with wider involvement from Ward/Unit managers. The sharing of information and learning was felt to be valuable and would have been helpful to have received prior to the outbreak.

On review of the action plan developed from other site outbreaks, there is evidence of improvements on the YG site; however similar themes were identified such as, patient cohorts mixed in same environment, during the visit suggesting not all actions have been implemented and completed in a timely manner.

3.6 Timeline of COVID-19 related policies, procedures and guidelines

One of the recommendations from the learning at WMH and YGC was to implement a document management system, to ensure policy documents are archived correctly and have robust version control processes in place. The reviewers were informed that this

was now in place.

A timeline of COVID-19 related policies, procedures and guidelines has been produced, please refer to appendix ii.

3.7 Is BCUHB's practice in line with national standards and best practice guidance?

From the evidence available to the reviewers, the focus group feedback and the observational audit undertaken during the site visit, there was demonstrable evidence that the BCUHB's practice in relation to the YG site is in line with best practice.

In addition, staff, patients and relatives were asked about discharge processes and all were fully informed on discharge guidance and information both in terms of tests confirming a COVID-19 positive result or when waiting for results. Patients and their families were also provided with follow up advice relating to COVID and non-COVID information.

3.8 Evaluation of Behavioural Factors and Escalation

Fundamentally, an acute site is part of a wider community; increased community rates mean an increased risk of introduction of COVID via asymptomatic and symptomatic staff and patients. Once an undetected infection is introduced to the BCUHB, the behaviours and operation of the site will have a profound influence on further transmission.

There have been several examples provided in the report, across all sites, whereby operational placing of different non-elective COVID pathway patients have crossed, multiple patient and staff moves, and the initial loss of situational awareness reduced testing and tracking rates that led to increased nosocomial spread. Of note, the elective pathway screening, isolation and discharge processes are robustly embedded.

Once in full EPRR mode, there was an operational outbreak control team (meeting 7/7 days) and a strategic outbreak control group (meeting 3/7 days) in place, providing operational and strategic response throughout the period of the outbreak. PHW has supported these groups.

3.9 Dissemination and shared learning from previous BCUHB learning linked to WMH

Feedback from the focus groups, staff in the clinical areas during the visit and flow team shared how they received the learning from outbreaks across the wider BCUHB:

- Dissemination of learning from their outbreaks was described as being a challenge, due to the 'all staff email' not reaching frontline staff.
- Covid daily audits and the Covid Toolkit have been developed based upon the learning and it is the Ward's duty to complete the audits each day and upload the findings to the dashboard. The elements of the audit are all based on required control measures and learning from previous outbreaks from all 3 sites.
- IPC dashboard data is reported via BCUHB governance structure including Quality and Safety Committee.
- There are new corporate HCAI and COVID-19 review panels that have been implemented, which are joined by members from each site. Learning slides are shared during and post-meeting summarising the key learning and actions, and there is an opportunity for wider discussion during the reviews.
- The IPC Team across BCUHB now meet each week and also have an electronic discussion board (padlet) to share learning across from one site to another rapidly.
- The learning and full timelines including genomics and epidemiology have been presented at Grand Round (attended by medical staff in particular but free to all staff).

It is worth noting that some of the themes identified correlated with earlier review findings from the WMH and YGC in relation to lessons learned which suggests not all learning had been implemented prior to the outbreak on the YG site.

However, since this time, there is robust assurance and monitoring of information, actions and key learning points throughout the BCUHB, from the frontline to the Board via its committee structure.

4.0 Recommendations and Assurance Mechanisms

The outbreak response has highlighted a range of factors relevant to the outbreak, and to the risk of future outbreaks both in and across BCUHB. Local action, steered by the strategic outbreak control group, is now being undertaken to address and obtain assurance around control measures.

At the time of the visit, verbal feedback was provided throughout to members of the Senior Leadership Team. There were no significant concerns observed during the visit that required immediate action. Several recommendations were provided that aim to contribute to the continued reduction and ongoing mitigation against nosocomial COVID-19 cases and reduce the number of outbreaks.

4.1 Areas for improvement

1. Emergency Department (ED)

- The demarcation zone requires a permanent solution to safely segregate patients with COVID-19, for instance a concertina type door/screen.
- Ensure ED and AMU has adequate stock control measures in place for the supply of rapid tests per day.
- Liaise with the Welsh Ambulance Service to highlight the inconsistency in practice regarding level 1 PPE requirements in order to maintain staff and patient safety.
- Carry out a review of the use of screens in ED and inpatient areas in order to maintain social distancing.

2. New Isolation PODs

- Ensure ongoing estates work relating to the installation of isolation PODs between the designated COVID-19 ward and the Admissions Unit remains a priority specifically regarding handwashing facilities. These could be utilised for patients who were COVID-19 positive when there is a decline in the numbers of positive cases, to assist in maintaining separate pathways.
- Further exploration required regarding waste removal processes in the new isolation POD area, including body fluid waste, if these were used as inpatient care management areas.

3. Procure storage units for aprons and gloves for all inpatient areas to ensure that PPE is stored appropriately.
4. All staff rooms, offices and other shared areas should have clear signage and chairs for the correct amount of people. Remove additional chairs and add signage regarding the maximum number of people at any one time.
5. Develop an IPC patient placement algorithm to help staff with decision-making inclusive of designated areas and escalation programme, improving situational awareness during surge episodes. Avoid crossover of COVID-19 pathways.
6. Review the placement of patients with COVID-19 to ensure they are treated in the most suitable area. Consider creating a system of whole wards. This would improve patient flow and reduce the risk of nosocomial spread.
7. Undertake an audit of equipment, decontamination processes and action improvements particularly around labeling of equipment to show “I am clean” and ensure appropriate segregation.
8. An audit of the process for equipment deemed as condemned needs to be completed and broken or condemned equipment needs to be stored in a designated area, to avoid a health and safety risk.
9. Review non-clinical staff training needs analysis to ensure staff receive refresher training in a timely manner, including any new or long-standing members.
10. Update business continuity plans to ensure any student cohorts and bank workers are included to ensure their training needs are met, for example IPC donning and doffing.
11. Review cross-site communication methods to include various methods rather than an ‘all staff email’ to reach as many staff members as possible.
12. Reduce staff movement by allocating staff to areas for a specific period and avoid

daily changes in order to reduce the risk of nosocomial spread.

13. Improve/add signage in clinical and non-clinical areas, inclusive of:

- 2 meter social distancing floor sign.
- Signage in inpatient bays to denote the maximum number of beds in order to maintain social distancing and achieve compliance with national guidance.
- A fixed solution for seating arrangements in public areas and Outpatients.
- Standardised Ward entrances signage indicating to staff the COVID status (red/green).
- Improve signage in the general pathfinder routes (floors and stairwells) to aid public awareness.

The above recommendations are relevant to improving site resilience to COVID-19, inclusive of the operational workings, estate and infrastructure improvements and patient and staff behavioural elements, in order to reduce nosocomial spread. It is essential that lessons learnt from the management of all site outbreaks are recorded, retained and acted upon. They may have wider relevance to other health care settings across Wales and to an extent reflect lessons learnt from earlier nosocomial COVID-19 outbreaks, as articulated in a previous Public Health Wales briefing paper (Nosocomial COVID-19 in Wales: Lessons learned from hospital outbreaks).

Triangulating the findings against the Terms of Reference (section 3) and those identified through observational audit during the YG on-site visit (section 2), all recommendations have been compiled in appendix iii.

Continuous oversight and assurance should be maintained via the BCUHB Board Assurance Framework, corporate committee structure, and local risk registers until nationally, the pandemic is declared closed.

5 Final Note

In conclusion, I would like to thank the organisation for its hospitality, and the friendly and open approach that all the staff demonstrated throughout the focus groups and the on-site visit. There were numerous examples of good practice and some areas for improvement, which have been highlighted as part of the review.

It is hoped that the outcomes from the review can be used in a supportive and developmental way, but also to provide constructive feedback to help improve the quality of care provided and reduce the risk of further outbreaks and nosocomial spread.

For any further queries regarding the review process or feedback, please contact:

Hilda Gwilliams - Email: h.gwilliams@nhs.net

Andrea Denton - Email: andrea.acinconsultants@gmail.com

Ysbyty Gwynedd District General Site Bangor

Betsi Cadwaladr University Health Board

Terms of Reference

- Establish the facts around the preparedness of the YG site for a COVID-19 wave 2 surge prior to the declaration of the level 3 outbreak established on the 23 February 2021.
- Establish the level of compliance of YG with BCUHB policy specifically around managing a covid 19 pandemic response in particular the use of the Covid 19 Tool Kit (WG 2020)
- To identify compliance with YG Post Infection Reviews (PIR) what learning was identified from them and how this was implemented.
- Review of test, track and prevent practice of staff and patients who attend YG for both non elective and elective episodes of care.
- Establish how actions and learning from outbreaks in the other acute sites in BCUHB were shared with YG, implemented and compliance monitored.
- To establish a timeline of Covid 19 related policies, procedures and guidelines as they have evolved since the start of the pandemic.
- Review and consider if BCUHB practice are in line with National standards and Best Practice cited.
- Evaluation of the factors around behaviors and subsequent escalation that have contributed to the outcome of the incident.
- Determine how the information from previous BCUHB learning linked to WMH and YGC outbreaks was disseminated and shared across the BCUHB.
- Provide recommendations to reduce the risk of recurrence and/or elimination. This will include assurance mechanisms the BCUHB may choose to adopt to provide evidence of compliance with national/international best practice.

Ysbyty Gwynedd District General Site Bangor

Betsi Cadwaladr University Health Board

Policy/Procedure/Guideline Timeline

DATE	DOCUMENT
1 June 2021	Updated to add requirements on local risk assessments and information around use of respiratory protective equipment and valved respirators. Clarified glove use in amber pathway.
15 April 2021	Removed IPC highlight quick reference guide.
21 January 2021	Addition of mental health appendix and title change for IPC guidance to 'Guidance for maintaining services within health and care settings.' Guidance amended to strengthen existing messaging and provide further clarity where needed, such as care pathways to recognise testing and exposure.
20 October 2020	Added COVID-19: infection prevention and control dental appendix.
16 October 2020	Re-arranged document order and moved 'COVID-19: epidemiological definitions of outbreaks and clusters in particular settings' from this page (see link in Details section).
16 September 2020	Added IPC highlights quick reference guide.
9 September 2020	Removed 'Considerations for acute personal protective equipment (PPE) shortages'.
21 August 2020	Added COVID-19 risk pathways to support returning services.
7 August 2020	Added 'Epidemiological definitions of outbreaks and clusters in particular settings'.
23 July 2020	Added recommendations for the use of face masks in primary care.
18 June 2020	Clarification of aerosol generating procedures in the complete guidance PDF and in the COVID-19 personal protective equipment (PPE) page.
12 June 2020	Addition of new operational guidance from NHS England.
21 May 2020	Amends to the PDF of complete guidance (added text in the appendix, and a corrected link to evidence review). Corrected link to evidence review also added to the PPE page.
19 May 2020	Added new PDF version of complete guidance; updated 'Introduction and organisational preparedness', 'Transmission characteristics and principles of infection prevention and control', 'COVID-19 personal protective equipment (PPE)', 'Explanation of the updates to infection prevention and control guidance' 'Reducing the risk of transmission of COVID-19 in the hospital setting'.
3 May 2020	Added HSE statement about use of FFP2 respirators to the 'Considerations for acute personal protective equipment (PPE) shortages' attachment.
27 April 2020	Added statement following NERVTAG review of cardiopulmonary resuscitation as an aerosol generating procedure, and added same statement into the PDF of the complete guidance.
24 April 2020	Added PDF version of the complete suite of guidance. Added clarification that chest compression is not an aerosol generating procedure to the PPE page.

17 April 2020	Added Considerations for acute personal protective equipment (PPE) shortages.
12 April 2020	Added a statement to clarify that the UK is currently experiencing sustained community transmission of
10 April 2020	Updated guidance, Tables 1,3 and 4, and added links.
7 April 2020	Removed reference to 'first responders' in PPE table 3 and guidance.
6 April 2020	List of guidance updates now included in 'Explanation of the updates to infection prevention and control
5 April 2020	Added Frequently Asked Questions on wearing Personal Protective Equipment (PPE).
4 April 2020	Added explanation of the updates to the infection prevention and control guidance.
3 April 2020	Updated 'A visual guide to safe PPE' poster.
2 April 2020	New tables describing PPE use across different clinical scenarios and settings; advice on sessional PPE use and reusable PPE; change in close-contact distance; advice on washing forearms if exposed; advice on acceptable respirators; general formatting to improve usability.
27 March 2020	Revised sections on aerosol generating procedures and theatres.
23 March 2020	Moved guidance for personal protective equipment (PPE) for aerosol generating procedures and for non-aerosol generating procedures to new, separate pages.
21 March 2020	Added new guidance for putting on and taking off personal protective equipment (PPE) for non-aerosol generating procedures.
21 March 2020	Added new guidance on when to use a face mask or FFP3 respirator.
13 March 2020	Added 'Infection prevention and control guidance for pandemic coronavirus'
6 March 2020	Changes to PPE and mask and respiratory recommendations for different situations; incorporated existing advice on safe use of point-of-care tests including blood gas machines and updated advice on IPC in operating theatres.
3 March 2020	Added quick guides and videos for donning and doffing of personal protective equipment (PPE).
19 February 2020	Added posters for donning and doffing Personal Protective Equipment (PPE).
14 February 2020	Revised guidance.
3 February 2020	Updated section on 'Waste' with new information.
31 January 2020	Updated waste categorisation and terminology for novel coronavirus (2019-nCoV).
15 January 2020	Updated document with new edition.
10 January 2020	COVID-19 guidance first published.

Ysbyty Gwynedd District General Site Bangor

Betsi Cadwaladr University Health

Recommendations in line with Terms of Reference

	Terms of Reference	Lessons learned	Recommendations to reduce risk of reoccurrence
1.	Establish the facts around the preparedness of the YG site for a COVID-19 wave 2 surge prior to the declaration of the level 3 outbreak established on the 23 February 2021.	The site was well-prepared in advance of and in the lead up to the pandemic, however by the time of the outbreak, education and awareness had been lost, due to the length of time between initial preparedness and the outbreak occurring.	Local EPRR policy to be reviewed, to ensure that there is a process in place for the management of outbreaks across the Health Board, inclusive of drill or table-top exercises and ongoing education and training programme for staff. The staff groups need to include students.
2.	Establish the level of compliance of YG with BCUHB policy specifically around managing a covid 19 pandemic response in particular the use of the Covid 19 Toolkit (WG 2020).	There was evidence of a good level of compliance prior to the surge and outbreak; however situational awareness was lost for a short period at the height of the YG site outbreak.	Ongoing monitoring and audits to be undertaken in the use of the Covid 19 Toolkit. Any risks identified in terms of compliance are to be identified, recorded and monitored via local risk registers.

3.	To identify compliance with YG Post Infection Reviews (PIR) what learning was identified from them and how this was implemented?	<p>Learning and actions from the WMH and YGC outbreaks had not been fully implemented across sites. This was a contributory factor in the YG site outbreak occurring.</p> <p>Similarly, learning from the YG PIR's was observed during the on-site visit, suggesting not all actions had been completed.</p>	<p>To undertake a review of process / practice in respect of:</p> <ul style="list-style-type: none"> A. Staff and patient movement – Review processes to ensure staff and patient movement is minimised as far as possible and social distancing is maintained. B. Social distancing – Ensure the placement of patients is in line with social distancing guidance. C. Signage – Review and implement clear signage to maintain social distancing measures across BCUHB, including in clinical and non-clinical areas, staff rooms, and pathfinder routes. D. Infrastructure – Continue with ongoing infrastructure work including identifying alternative placements and fixtures e.g. ED demarcation zone, isolation PODs, screens in inpatient areas, to ensure social distancing is maintained. E. PPE – Audit compliance of PPE usage and monitor compliance via local audit plans and governance arrangements.
4.	Review of test, track and prevent practice of staff and patients who attend YG for both non elective and elective episodes of care.	<ul style="list-style-type: none"> A. There were issues identified in the procurement of rapid tests, although it was later identified these were available. B. Whilst staff contact tracing was undertaken, there was no follow-up on completion and submission. 	<ul style="list-style-type: none"> A. Stock control measures are to be reviewed to ensure there is an adequate supply of rapid tests and area leads are to raise awareness with staff on how to access the tests. B. Undertake a review of staff tracing procedures, to include:

			<ul style="list-style-type: none"> • A follow-up process for staff tracing. • Compliance with staff tracing to feature on local KPI dashboards. • Consider use of an alternative model e.g. SMART Release programme, to minimise staff isolation (and support working from home) where possible.
5.	Establish how actions and learning from outbreaks in the other acute sites in BCUHB were shared with YG, implemented and compliance monitored.	Communication channels were limited to 'all staff' emails, resulting in key information being missed and learning from the WMH and YGC sites not being implemented.	To review communication methods to include a variety of sources e.g. intranet, computer screensavers, team briefings, to ensure key messages reaches frontline staff.
6.	To establish a timeline of Covid 19 related policies, procedures and guidelines as they have evolved since the start of the pandemic.	None identified – Document Management System implemented.	
7.	Review and consider if BCUHB practice are in line with National standards and Best Practice cited.	None identified – BCUHB practice in line with national and best practice standards.	
8.	Evaluation of the factors around behaviors and subsequent escalation that have contributed to the outcome of the incident.	It was identified that patient pathways were in place to minimise nosocomial spread, but were not always followed.	A. Undertake a review of Covid 19 pathways, to ensure the process is clear to prevent mixing of positive and non-positive patients.

			<p>B. Consider the use of a patient placement algorithm, to maintain the separation of positive and non-positive patients.</p> <p>C. Audit of compliance with practice to be undertaken and ongoing monitoring via local governance arrangements.</p>
9.	Determine how the information from previous BCUHB learning linked to WMH and YGC outbreaks was disseminated and shared across the BCUHB.	It was identified that learning from the WMH and YGC outbreaks had not been shared widely and consequently remedial actions were not implemented at the YG site	<p>A. Local action plans to be developed to include cross-site learning from the WMH and YGC outbreaks, implemented and monitored via local governance arrangements, to ensure actions from previous outbreaks have been completed.</p> <p>B. Risks to implementation of actions to be identified, recorded, and monitored via local risk registers.</p>
General Recommendations			
	Issue Identified	Lessons learned	Recommendations to reduce risk of reoccurrence
10.	Emergency Department (ED) Ambulance crews not wearing correct PPE within ED	Ambulance Service - Inconsistent application of PPE	Liaise with the Welsh Ambulance Service to highlight the inconsistency in practice regarding level 1 PPE requirements.

11.	YG site No PPE product holders	There is a risk of contamination due to products being handled / retrieved from the same location	Procure and install PPE product holders.
12.	YG site Decontamination of equipment process not being fully completed	There is a risk that contaminated equipment will be reintroduced into circulation	Audit decontamination process inclusive of 'I am clean' stickers for assurance. Local risk registers to identify any decontamination risks and mitigation measures.
13.	YG site Condemned equipment process was not fully completed and equipment was stored incorrectly	There is a potential Health and Safety risk	Review SOP and monitoring arrangements for condemned equipment including safe storage areas.

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
1	Establish the facts around the preparedness of the YG site for a COVID-19 wave 2 surge prior to the declaration of the level 3 outbreak established on the 23 February 2021.	The site was well-prepared in advance of and in the lead up to the pandemic, however by the time of the outbreak, education and awareness had been lost, due to the length of time between initial preparedness and the outbreak occurring.	Local EPRR policy to be reviewed, to ensure that there is a process in place for the management of outbreaks across the Health Board, inclusive of drill or table-top exercises and ongoing education and training programme for staff.	IP05 is in place. SCCHF self assessment table top confirm and support is in place quarterly (though this quarter has not yet taken place due to site postponing. Quarterly IP plan on a page meetings are going in the diary chaired by GH. Q1 undertaken and presentation received. The IP plan on a page is assured through LIPG monthly. August LIPG was cancelled due to leave. SCC-HF self assessment third round is due by 1 October, table top support and confirm meetings will be in diary for early October with all accountable areas.
			The staff groups need to include students.	Education and training programme is in place. IPC champions being rolled out to every ward every shift. Practice placements booklet includes supervisor assessments of PPE competency
2	Establish the level of compliance of YG with BCUHB policy specifically around managing a covid 19 pandemic response in particular the use of the Covid 19 Toolkit (WG	There was evidence of a good level of compliance prior to the surge and outbreak; however situational awareness was lost for a short period at the height of the YG	Ongoing monitoring and audits to be undertaken in the use of the Covid 19 Toolkit.	Daily COVID 19 checklist is embedded. Matrons checking as part of their oversight. Assurance reported monthly through LIPGs and IPSG. LIPG agendas have been strengthened and aligned to IPSG governance.

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
	2020).	site outbreak.	Any risks identified in terms of compliance are to be identified, recorded and monitored via local risk registers.	No central database to capture the compliance, matrons to evidence compliance through the SCC-HF self assessment quarterly process to HMT.
3	To identify compliance with YG Post Infection Reviews (PIR) what learning was identified from them and how this was implemented?	Learning and actions from the WMH and YGC outbreaks had not been fully implemented across sites. This was a contributory factor in the YG site outbreak occurring.	To undertake a review of process / practice in respect of:	
		Similarly, learning from the YG PIR's was observed during the on-site visit, suggesting not all actions had been completed.	A. Staff and patient movement – Review processes to ensure staff and patient movement is minimised as far as possible and social distancing is maintained.	This is still an issue on sites and patient movement need to be tightened again. Major issue with flow and patient not able to access the correct ward first time which results multiple bed moves in which increases risk of transmission. MDT Board rounds are being looked at as part of USC programme with assurance that footfall will be minimised and virtual.
			B. Social distancing – Ensure the placement of patients is in line with social distancing guidance.	H&S review of the site had been undertaken and implemented ongoing during the outbreak
			C. Signage – Review and implement clear signage to maintain social distancing measures across BCUHB, including in clinical and non-clinical areas, staff rooms, and pathfinder routes.	Signage is throughout the hospital.

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
			D. Infrastructure – Continue with ongoing infrastructure work including identifying alternative placements and fixtures e.g. ED demarcation zone, isolation PODs, screens in inpatient areas, to ensure social distancing is maintained.	ED has clear pathway for patient presenting with suspected COVID-19 and are separated from non suspected covid - based on clinical symptoms. POD in AMU up and running now (only 5 single rooms). All outstanding infrastructure work is sent to estates and brought to LIPG for escalation where required moving forward.
			E. PPE – Audit compliance of PPE usage and monitor compliance via local audit plans and governance arrangements.	PPE usage monitored and controlled from central area. PPE audit in place and IPC champions to support all staff in donning, wearing and doffing effectively.
4	Review of test, track and prevent practice of staff and patients who attend YG for both non elective and elective episodes of care.	A. There were issues identified in the procurement of rapid tests, although it was later identified these were available.	A. Stock control measures are to be reviewed to ensure there is an adequate supply of rapid tests and area leads are to raise awareness with staff on how to access the tests.	Limited number of rapid test available between 8am till 20:00hrs. But the laboratory supported IP request with test. Part of Safe Clean Care - HF Safe Space workstream led by Karen Mottart.
		B. Whilst staff contact tracing was undertaken, there was no follow-up on	B. Undertake a review of staff tracing procedures, to include:	

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
		completion and submission.	<ul style="list-style-type: none"> A follow-up process for staff tracing. 	All clinical staff are required not to attend the workplace in line with National Guidance – there have been some instances when some have been re-deployed, particularly if they are working in a high risk area, but this is agreed by their Manager. All internal procedures are reviewed inline with National Guidance changes.
			<ul style="list-style-type: none"> Compliance with staff tracing to feature on local KPI dashboards. 	If issues with staff non-compliance are raised, these are escalated to WOD and IPC.
			<ul style="list-style-type: none"> Consider use of an alternative model e.g. SMART Release programme, to minimise staff isolation (and support working from home) where possible. 	Although there have been discussions at a national level about SMART Release, no further information or guidance has been received. Implementation of revised guidance of isolation standards has been introduced. Agile working policy currently being supported by WoD.
5	Establish how actions and learning from outbreaks in the other acute sites in BCUHB were shared with YG, implemented and compliance monitored.	Communication channels were limited to ‘all staff’ emails, resulting in key information being missed and learning from the WMH and YGC sites not being implemented.	To review communication methods to include a variety of sources e.g. intranet, computer screensavers, team briefings, to ensure key messages reaches frontline staff.	Learning from outbreaks now within IPSG report and shared with LIPGs regularly. Lessons learnt from PIR also on LIPG agenda. Site self review report undertaken post outbreak - shared with IPSG Trialling of e-mail communications requiring actions including a response button is being introduced

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
6	To establish a timeline of Covid 19 related policies, procedures and guidelines as they have evolved since the start of the pandemic.	None identified – Document Management System implemented.		
7	Review and consider if BCUHB practice are in line with National standards and Best Practice cited.	None identified – BCUHB practice in line with national and best practice standards.		
8	Evaluation of the factors around behaviours and subsequent escalation that have contributed to the outcome of the incident.	It was identified that patient pathways were in place to minimise nosocomial spread, but were not always followed.	A. Undertake a review of Covid 19 pathways, to ensure the process is clear to prevent mixing of positive and non-positive patients.	Pathway for positive patient to be Cohort onto one ward, no mixing of negative and positive patient. Clear pathway identified for positive patient
			B. Consider the use of a patient placement algorithm, to maintain the separation of positive and non-positive patients.	Not required
			C. Audit of compliance with practice to be undertaken and ongoing monitoring via local governance arrangements.	Patient movement monitored locally. SCC workstream in place but not yet finalised.

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
9	Determine how the information from previous BCUHB learning linked to WMH and YGC outbreaks was disseminated and shared across the BCUHB.	It was identified that learning from the WMH and YGC outbreaks had not been shared widely and consequently remedial actions were not implemented at the YG site	A. Local action plans to be developed to include cross-site learning from the WMH and YGC outbreaks, implemented and monitored via local governance arrangements, to ensure actions from previous outbreaks have been completed.	IP 2021-22 plans developed to have a pan BCU wide zero tolerance to HCAI's. Q1 Confirm and escalate meeting already taken place chaired by the Executive Nurse. Future quarterly meetings being scheduled in the diary - October 21 next round.
			B. Risks to implementation of actions to be identified, recorded, and monitored via local risk registers.	Local IP risk register part of LIPG moving forward.
	General Issue Identified	Lessons learned	Recommendations to reduce risk of reoccurrence	
10	Ambulance crews not wearing correct PPE within ED	Ambulance Service - Inconsistent application of PPE	Liaise with the Welsh Ambulance Service to highlight the inconsistency in practice regarding level 1 PPE requirements.	WAST are challenged by ED staff around correct use of PPE and escalated if non compliance
11	Pan site No PPE product holders	There is a risk of contamination due to products being handled / retrieved from the same location	Procure and install PPE product holders.	Lack of PPE stations remains an issue – and continues to be rolled out but gaps still in place across BCUHB. Full implementation plan requested from Estates colleagues
12	Pan site decontamination of equipment process not being fully completed	There is a risk that contaminated equipment will be reintroduced into circulation	Audit decontamination process inclusive of 'I am clean' stickers for assurance.	Decontamination green tape available and used on equipment – to be included in audit programme going forward.
			Local risk registers to identify any decontamination risks and mitigation measures.	Local IP risk register part of LIPG moving forward. Decontamination is part of the escalations to IPSG.
13	Pan site condemned equipment process was not fully completed and equipment was	There is a potential Health and Safety risk	Review SOP and monitoring arrangements for condemned equipment including safe storage areas.	Declutter relaunch Sept 2021

No	Terms of Reference	Lessons learned	Report Recommendations to reduce risk of reoccurrence	Assurance
	stored incorrectly			

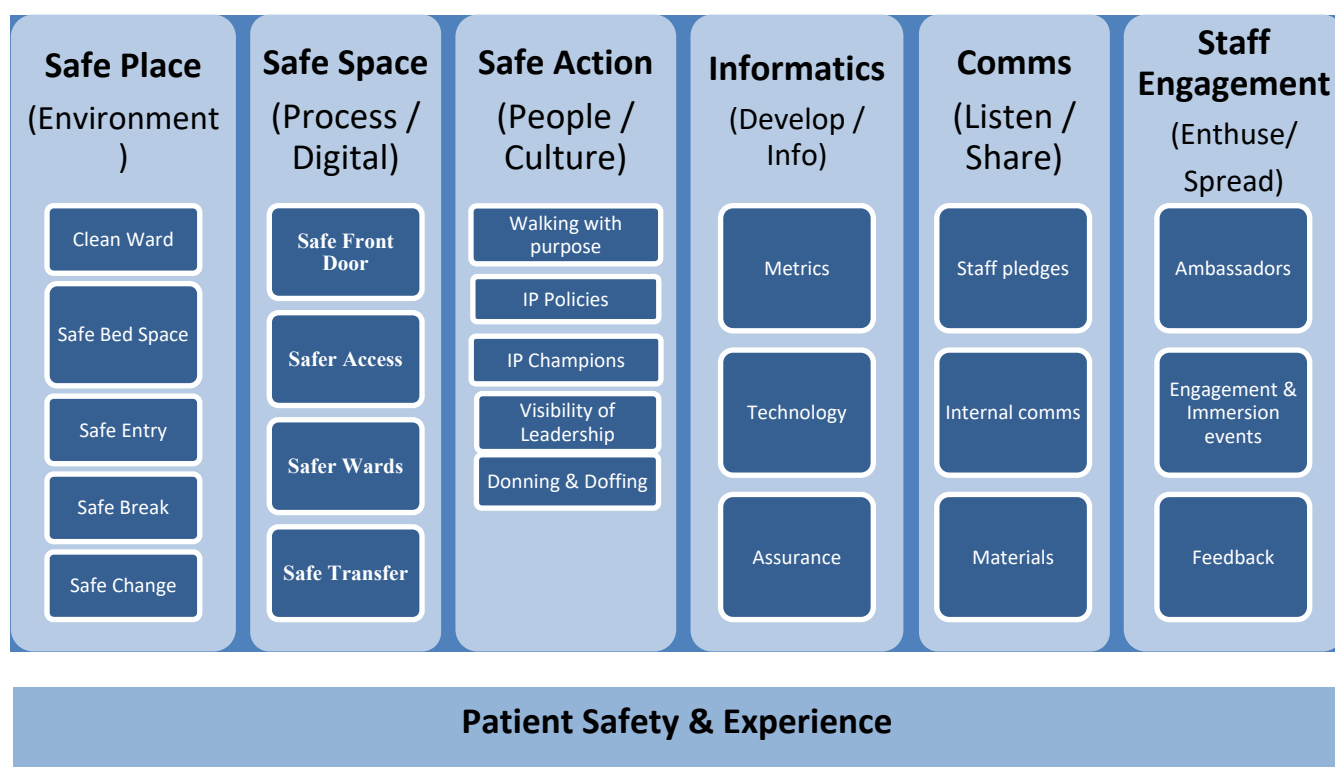
'Safe Clean Care' - Harm Free Care progress report

The programme is a local clinical based behavioural improvement plan, with the overall SRO being the Executive Director of Nursing. This initiative remains the vehicle for infection prevention improvement. Each workstream has a senior SRO from either operations, medical or nursing with input from local delivery leads in each of the accountable areas.

It is focussing on identified gaps within infection prevention controls and includes:

- Learning from past infection transmissions (PIRs)
- Accountable areas within the 2021/22 infection prevention plans
- 40 point Harms Self-Assessment (Welsh Government IPC guidance)
- Pan BCUHB themes

The workstreams incorporate the following:



Safe Place

	High level actions	Risk and issues requiring escalation
Clean ward / hospital	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Bulk recruitment requests from each Area Develop and finalise documents relating to cleaning pathways and responsibilities Update SOP for each task 	<ul style="list-style-type: none"> Recruitment Risks – a staggered approach may be required, aligned to the resources available. Any increase in recruitment pace will need further support. Unforeseen pressures being put onto SCC-HF from schemes being created by RRT <p>Additional workload demand associated with recruitment campaign (staff recruitment, induction and training). This campaign would benefit from some dedicated capacity. WOD are already engaged in this process.</p>
Safe Change	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> The uniform policy has been reviewed by the group and areas of support for staff discussed. Immersion event questions confirmed. Site/Area reps with the support of T&F group chair and service improvement support to arrange immersion events to take place before 08/09/21. Review HBN guidance to complete baseline review. 	None
Safe Bed Space	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Baseline review of current bed configurations has now been completed for all community and acute sites. Further scope of reductions required if Health Board was to enact 3.6m bed spacing has largely been completed (there are a couple of missing areas within WMH which requires further information from estate colleagues). Review has been mapped against funded bed base for each site and current configuration changes due to previous COVID-19 management. Copy of configuration review work was sent for Director (Area, Mental Health and Acute) sign off 29.07.21 Review of Infection Prevention Escalation Matrix to be undertaken to understand process of escalation / process interaction. Meeting to be arranged with Andrea Ledgerton to discuss further. 	None


03/09/2021

Safe Space

	High level actions	Risk and issues requiring escalation
Front Door Isolation/ Segregation – Results Management	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Significant progress so far – POCT/rapid testing been rolled out across 3 EDs KPI's under review/development – plan for dashboard to be developed by early September Safe Waiting Areas - Obtain H&S waiting area risk assessments - clarity regards social distancing / face mask use that IP recommend to be able to avoid contacts if an unexpected positive is sitting waiting – KM to discuss with IPT/HMT's Front door teams to monitor PowerBI dashboard & escalate any exceptions KM to meet with AB (MHLD) to discuss rapid swab requirement for MHLD, and community management Lab managers have confirmed they have requested staff from the 'kick-start' scheme - recruitment in progress Health check of all POD systems Recruitment of lab staff to support testing 08:00-22:00 7 days / week Business case to SMT AMU in YG has not yet included in this project – POCT needed POCT meeting to be established with appropriate membership – governance under TTP 	Capacity for informatics team to complete the dashboard to provide assurance against KPI's Variation in Lab opening times - YG
Safer Access :Roaming staff	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Meeting set for mid-September with possible clinical lead (delay due to annual leave) 	None
Safer Ward: Ward Rounds	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Awaiting result of submission to Bevan Commission Meeting to be held with Education to research the needs of trainees – on 26th August 	None
Safer Ward: Rapid Isolation of newly suspected IP risk patients/ Routine Inpatient Testing	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> First T&F to be held on Tuesday 24th August 21 Agree TOR and KPIs Finalise baseline estates assessment for all inpatient sites – include MHLD, paed's women's, pods, com hosp's (IPC will double check and collate) Confirm hierarchy/template/risk assessment and include the non IP risks in that list. That will need to be agreed at T&F group. Develop an online audit tool to provide assurance of facilities use. Investigate capability of Teams and / or AMaT Comms help to ensure ward staff are aware of hierarchy of need for isolation facilities to include isolation risk matrix and daily assessment tool (when finalised) Review current protocol for routine in-patient testing, and discuss revised programme (informed by modelling) 	None

03/09/2021

Safe Action

	High level actions	Risk and issues requiring escalation
Patients Walking with Purpose 	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Data gathering to identify the number of wandering patients within operational services, a snapshot view Trial of Allocate flagging module proposed for Glaslyn Ward, YG. SOP / risk assessment being produced from an IP perspective for reinstating group activities. Two pieces of work have now been identified, producing a patient algorithm and producing a behavioural quality action plan. Bevan Exemplar submission 	None
Infection Prevention Policies & Procedures	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> SB to meet with Microbiologists regarding 10 & 15 day screening concerns. "Which Clean do I Mean" documentation. New Hand Hygiene Tool / Metric via IRIS (E Form to be developed). Acuity Matrix 	None
Infection Prevention Champions	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Final names / nominations for Phase 1 Champions TBC. Programme of Education has commenced – additional comms required to ensure all Champions (Phase 1) are aware. Champions to complete survey re preference for identification (e.g. badge, arm band, not required etc). 	None
Visibility of Leadership	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Final Phase 1 Immersion Event (summarise findings of events held with front of house and leaders) rescheduled for 13.09.21. Phase 2 planning / scheduling of events. 	None
Donning & Doffing	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> ESR quiz being developed to mitigate ESR system issues (to provide assurance that video(s) have been watched (when link followed via ESR to YouTube & Gov.uk)). Develop / enhance Comms Plan. 	None

03/09/2021

Safe Action

	High level actions	Risk and issues requiring escalation
Safe Patient Discharge & Transfer	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Working Group meeting to review (from IPC Lens only): NU01; NU19; SBAR handover; Transfer documentation (Care / Nursing Homes, District Nursing & Home First). 	None
Visiting Guidance	<u>Plan - High Level Actions last week and next steps - CLOSED</u> <ul style="list-style-type: none"> Metric to be developed to monitor compliance with the Guidance (Process measure). 	None
CAUTI	<u>Plan - High Level Actions last week and next steps:</u> <ul style="list-style-type: none"> Project Plan to be developed; Catheter pathway E Form development (Point Prevalence & reporting of Catheterised Patient numbers pan BCUHB – incl Community); Comms Plan for CAUTI Awareness Week. 	None
Lateral Flow Testing	<u>Plan - High Level Actions last week and next steps: WVG Update awaited</u> <ul style="list-style-type: none"> Task & Finish group lead/ members identified to support phased approach Scoping via vulnerability for phased implementation: <ul style="list-style-type: none"> Maternity Paediatrics Neonates Gastro MHLD 	None

03/09/2021

High level actions	Risk and issues requiring escalation
Plan - High Level Actions last week and next steps: Delivered communications session (including introduction to SCC-HF intranet page) as part of IPC Champions training Review SCC-HF comms calendar and progress updates scheduled Review self assessment results and consider case studies	Clarify circulation cascade for safety huddle briefings – SB Establish SCC email box? – SB



A driver diagram articulating the individual work programmes is described above.

An immersion event has been held with staff and has identified some key areas for consideration and confirms the level of fear and fatigue being experienced. More visibility from leaders is requested alongside protected time for support, advice and guidance.

Interventional quick wins include:

- Support with routine audits data collection;
- Formal QI support;
- Shadowing 'walking in each other shoes';
- Leadership talks/sessions via Teams;
- Coffee & Catch up;

- Protected times for face to face updates minimum weekly;
- Attending Safety huddles;
- Review amount of Teams meetings to free up time;
- Celebrate success!

Programme next steps and challenges:

The '*Safe Clean Care*' – harm free improvement work is embedding across the organisation, but the focus does need to be maintained, particularly given the size and scale of the programme.

Unscheduled care pressures continue to add a level of concern to the programme with bed distancing and staffing being dynamically assessed to facilitate flow. This does create additional risk of outbreak but is part of the mitigation for wider patient safety.

Workforce gaps, specifically, but not exclusively, within the PMO and domestic services remain a challenge and recruitment is on-going.

Further input from informatics has been requested alongside digital solutions to help manage patient transfers and support early identification of patient or staff risk.

The interdependencies of other programmes, including the USC transformation work and Stronger Together is well recognised and the teams are working to minimise any unintended overlap of workstreams.



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7 September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Patient & Carer Experience Report - April to July 2021						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Awdur yr Adroddiad Report Author:	Carolyn Owen (Acting Assistant Director, Patient Safety & Experience) Sian Youssef (Complaints Lead) Yvonne Williams (Complaints Lead) Eleri Anderson (Senior Patient and Carer Experience Manager) Kim Warrington-Davies (Covid-19 Project Manager)						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Atodiadau Appendices:	1. Patient & Carer Experience Report - April to July 2021						
Argymhelliad / Recommendation:							
The Committee is asked to note this report.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient and carer experience issues arising during the 4-month period under review (April to July 2021), alongside longer-term trend data, and information on the learning and improvements underway. The aim is to provide the Committee with assurance on the Health Board's work to improve patient and carer experience.							
Cefndir / Background:							
The Health Board has responsibilities for improving patient and carer experience under the following key statutory responsibilities and policy frameworks;							
<ul style="list-style-type: none"> NHS Delivery Framework 2019/2020 (NHS Wales, April 2019); Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015); 							

- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – The Health Board's approved current Patient Experience Strategy (June 2019) is being reviews and will develop into the next Quality Strategy.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – The Health Board has responsibilities for improving patient and carer experience under the following key statutory responsibilities and policy frameworks;

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

Asesiad Effaith / Impact Assessment – Not applicable.

Patient and Carer Experience Report April-July 2021/22

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

1. INTRODUCTION

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

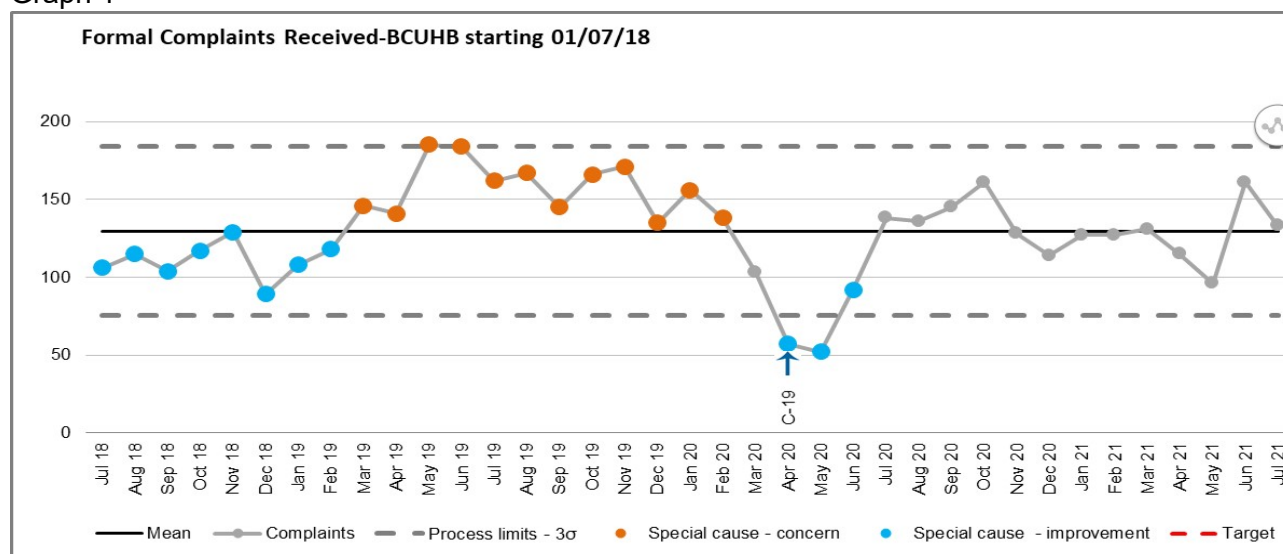
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

2. COMPLAINTS PERFORMANCE

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

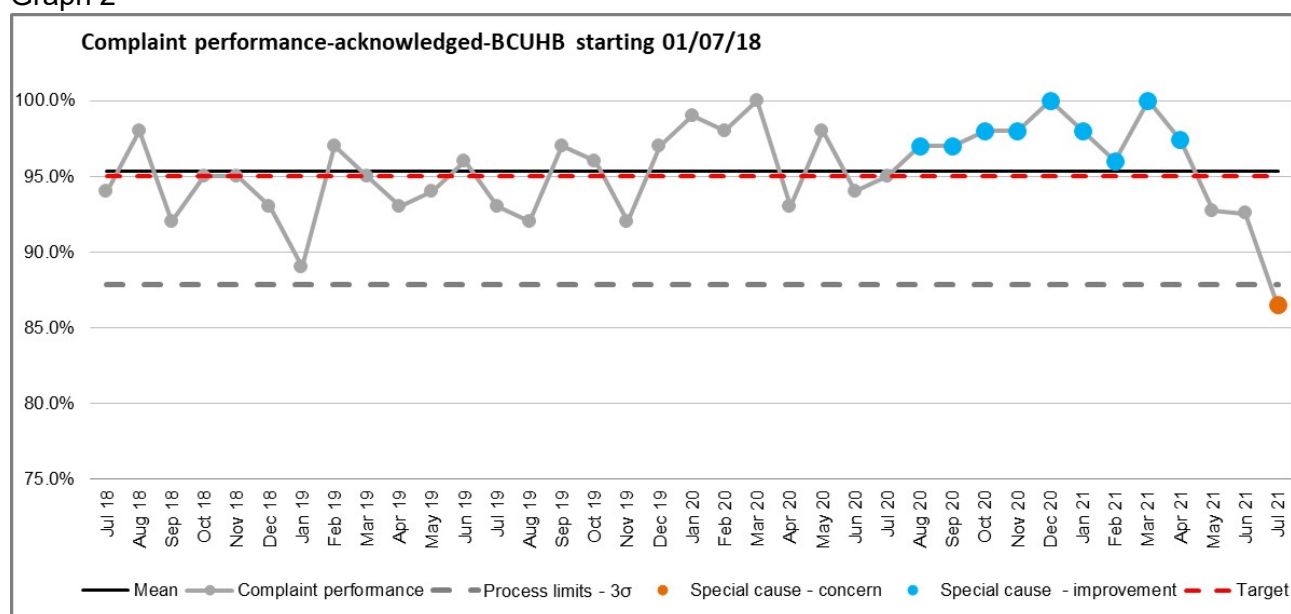
2.2 As can be seen in Graph 1, as of the end of July 2021, the Health Board had received 505 formal complaints, an increase on the previous 4-month period.

Graph 1



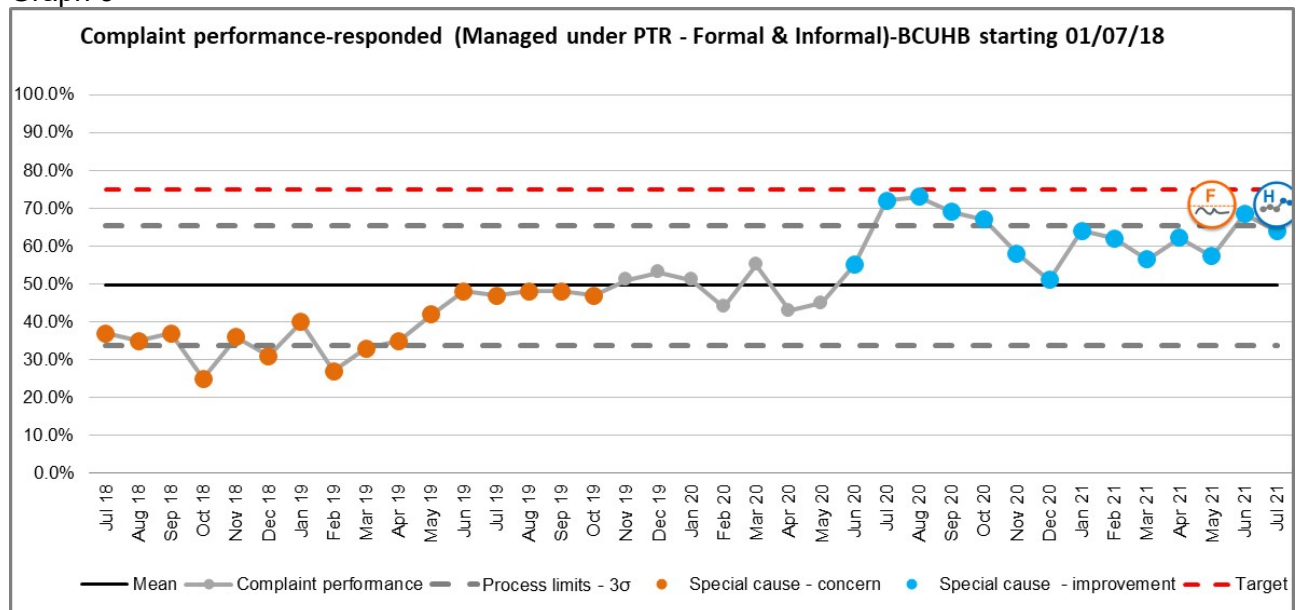
2.3 As demonstrated in Graph 2, as at the end of July 2021, an average of 92.3% of complaints were acknowledged within 2 working days against a target of 95%. This rate has fallen from the previous quarter and reflecting the increased volume of complaints being received.

Graph 2



- 2.4 At the end of July 2021, performance remained below the all Wales target of 75%, however has improved on the previous period from 60.8% to 63.08% for complaints closed within 30 working days. This has been achieved in spite of a rise in the number of complaints received (graph 3).

Graph 3



- 2.5 The 75% target for 30-day response rate is not being met by Secondary Care Teams (graph 4). This has led to an increase in the number of overdue complaints during this period – specifically for complaints falling within the new process.

The number of legacy complaints continue to fall week on week and has fallen from 156 in mid-May, to 54 at 31st July. This has involved significant proactive work across all services and dedicated support to secondary services in particular. Attendance at weekly complaints review meetings, providing clarification on complaints which should be referred to the Ombudsman and agreeing complaint responses and closure, have seen a turnaround both in the reduction in number of 'legacy' complaints and increased quality of complaint responses.

The increase in the number of complaints received has impacted on the new complaints process, increasing the number of overdue complaints for new process complaints. At 31 July the number of overdue complaints had increased to 114. While there is a 'bedding-in' period for the new process with new staff at the beginning of understanding the complaint process and embedding their training, a similar process to that of legacy complaints is being followed. Key staff are attending all service weekly complaint review meetings and although the data available is demonstrating improvements in overdue numbers at time of writing, efforts will remain to ensure new complaints overdue are reduced and that staff are confident in the new complaint process.

East Secondary Care

East have shown an improvement in 30-day response rates with a noticeable upward trend from October 2020. In April 2021 they had a 43.75% response rate, in May a 52.63% response rate, in June 42.31% and in July 51.92% improving their response rate to response rate with an average of 47.65% 30 day response rate in this 4 month period which gives them an overall improvement when compared to the response rate in Q4 (31.71%).

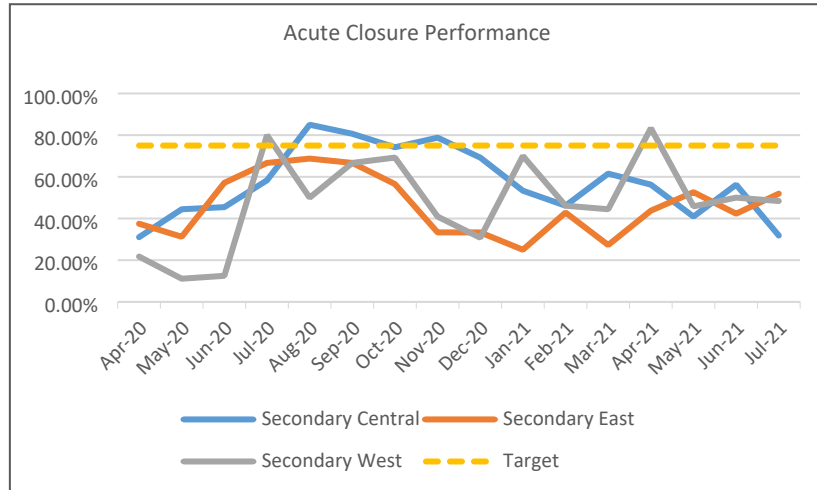
Central Secondary Care

Central has seen a drop in 30-day response rate from 53.67 in Q4 to 46.35 in the 4 month period (April to July), largely due to the increasing number of complaints received. In April they had a 56.25% response rate, in May 40.91% response rate, in June 56.25% and in July 31.82% response rate.

West Secondary Care

West have had a drop in their 30-day response rate from January 2021. In April 2021 they had a 83.33% response rate, in May 45.83%, in June 50.00% and in July 48.39% response rate. This gives an average 30-day response rate of 56.89% in Q1 which is an improvement when compared to 53.53% in Q4.

Graph 4



- 2.6 As demonstrated below in Graph 5, the 75% target for 30-day response rates are not being met by all Area Teams.

East Area

East Area have shown a consistent 30-day response rate in this 4-month period. In April 2021 they had a 53.57% response rate, in May 2021 a 72.50% response rate, in June 84.85% and in July 85.56% response, rate which gives them an average of 74.12%.

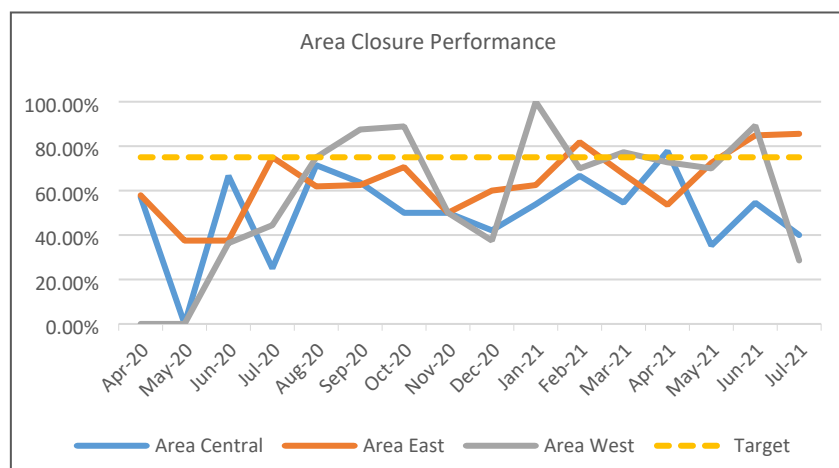
Central Area

Central Area has seen a drop in 30-day response rate in this period. In April 2021 they had a 77.78% response rate, in May 2021 a 35.29% response rate, in June 2021 a 54.55% and in July 40% response rate which gives them an average of 51.90% for this period, which is a drop compared to 58.33% in the previous quarter, again due to the increasing number of complaint received.

West Area

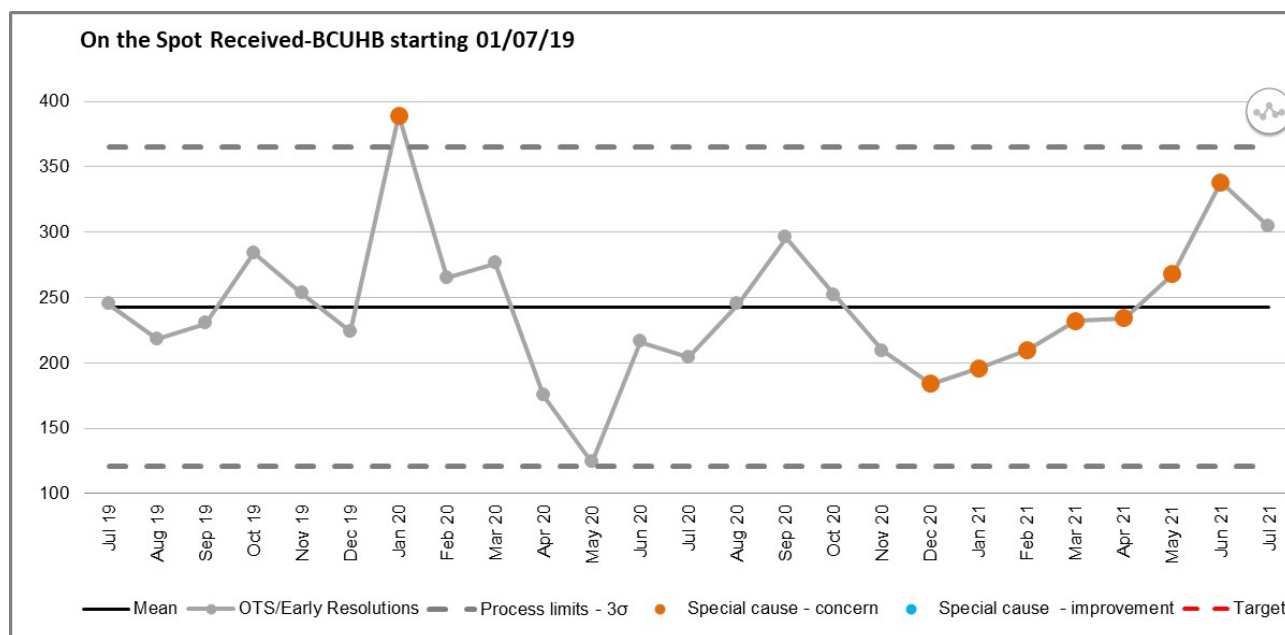
West Area has seen a significant drop in the in 30-day response rate for July; April 2021 showing as 72.73%, in May 2021 a 70.00% response rate, June 2021 a 89.29% and July falling to 28.57% response rate which gives them an average of 65.15% for this period.

Graph 5



- 2.7 The Mental Health and Learning Disability Division continue to have good performance at closure.
- 2.8 As can be seen in Graph 6, during the April to July period 1,144 Early Resolution (ER) cases were recorded, of which approximately 6.5% were upgraded to formal. This compares to 638 cases in Q4 (Jan to Mar '21), of which 63 were upgraded to formal (9.8%).

Graph 6



- 2.9 Reasons for failure to manage ER include the inability to resolve the matter within 2 working days. This is mainly a result where initial enquiries establish that the issue is more complex than initially thought; this would also trigger conversion to the formal (PTR) process. Other issues that influence ability to manage ER within the timeframe is highlighted in primary care at present; this is an area usually successful at resolving matters promptly, however they are currently experiencing significant difficulty in speaking with staff and obtaining prompt responses to queries due to amalgamation of practices and phone lines and general pressures on GP practices. Many of these ER are around phone lines, appointments and access, availability of GP appointments. These take a significant amount of corporate complaint team capacity in trying to resolve and manage; we are currently working collaboratively with Primary Care colleagues in East to take a pragmatic approach in attempting to manage these cases.
- 2.10 The commencement of the Daily Sitrep report in May 2021 allows services to get an overview of the ER and Formal complaints logged for their areas and enables services to determine themes and trends so that these can be addressed swiftly to avoid further complaints. This is distributed on a daily basis to services via the Daily Quality Alert.

3. COMPLAINTS LEARNING

- 3.1 In addition to the complaint investigation arrangements relating to training provided and information circulated, a daily SITREP report has been developed as referred to in 2.9 above. The SITREP summarises the information received within the Patient Experience Team and is circulated both internally within the Patient and Carer Experience Team and senior operational managers for review and escalation as required. This has proved to be a valuable source of information, facilitating further exploration of complaints and escalation, e.g. serious incident investigations as required.

- 3.2 The new complaints process endorses the importance of learning as a key element of complaint investigation and analysis. The complaint investigation process is facilitated by the application of an investigation report template and guidance for the Investigating Officer to follow. When completed and written up, the allocated Adjudicator signs off the investigation report, (the role of Adjudicator is at Director of Service level). The Adjudicator role also supports the emphasis on learning as a key part of a complaint investigation and assurance and governance arrangements and that identified actions and improvements will be completed.
- 3.3 During the training sessions on Complaint Investigation, the need to ensure learning is identified where applicable and the actions completed within the timescales noted, is emphasised as a key part of the complaint management process. The learning stems from identification of an issue and, forms part of the analysis of why the situation arose along with what could be done to prevent something similar happening again.
- 3.4 The new complaints process reinforces the importance of ownership and the need for services to have a detailed awareness of what is happening within their area, why complaints are arising and actions required to address them, preventing similar occurrences.
- 3.5 One of the key changes resulting from implementation of the new process is that an Investigating Officer nominated by the lead service to which the complaint is allocated, now undertakes the complaint investigation. The previous process meant that investigations and responses were compiled by members of the Governance Teams.
- 3.6 The allocation to services will support the focus on management of the majority of complaints in real time and wherever possible, addressing the matter at source at a very early stage, i.e. early resolution.
- 3.7 Early resolution is often achieved by efficient and effective communication with the complainant at the outset, to avoid matters escalating and being clear about the detail of the complaint. An example of the benefit of robust communication is shown in the case study.

Lessons Learned – Case Study: Communication and understanding in relation to consent
<p><i>A complainant contacted the concerns team in relation to care and treatment of her mother who had been diagnosed with cancer and sadly died shortly after the diagnosis. The complainant was the daughter of the patient and in line with usual process; a 3rd party consent form was issued for completion prior to information being shared.</i></p> <p><i>Upon receipt of the consent paperwork, the complainant who confirmed that it was her stepfather who was recorded as next of kin made further contact. She advised she did not feel it was appropriate for her to trouble him at this time, as he was grieving.</i></p> <p><i>Information was sought from the patient records to ascertain what communication may have been recorded in relation to the patient's daughter but the primary communication was with the patient's husband, the complainant's stepfather. In view of the sensitive situation, a decision was taken that some of the key members of the clinical team would meet with the complainant.</i></p> <p><i>During the meeting, it was apparent that the complainant's mother had made a decision not to share details of her diagnosis with her daughter and protected her and possibly other family members from this information in the early stages of her diagnosis. The complaint made was based on a perception that there was a late diagnosis but the meeting and communication gave assurance that this was not the case and care and treatment had been appropriate.</i></p>

At the start of the meeting the complainant was very angry but having been provided with the opportunity to meet staff involved in her mother's care and gain a better understanding of the situation, she was relieved to hear that the Health Board had not failed her mother, as she initially thought.

The supportive and sympathetic management of this situation by the staff involved enabled the complaint to be closed with a positive outcome that may not have been achieved in the absence of such a meeting. It also demonstrates the fact that adherence to data protection and information governance regulations whilst mandatory does require sensitive handling in some situations. This may involve looking at alternative solutions to gain evidence of compliance, in this example through the case notes and speaking to the staff involved, along with engagement with the Corporate Concerns Team in order to establish a way forward.

The proactive management of communication by the service involved was instrumental in this satisfactory resolution.

- 3.8 As the new process becomes embedded, and the focus can move from performance management, this section of the report on learning will be significantly strengthened.

4. COMPLAINTS PROCESS UPDATE

- 4.1 Training on the new complaints procedure commenced in January 2021 with sessions outlining the key elements of the new procedure and summarising the main changes. The sessions were delivered to staff members throughout January, February and March with more ongoing sessions from April onwards. To date, members of the Corporate Team have delivered 'New Process' training via TEAMS to 833 members of staff, 'Investigating Officer' training has been attended by 205 staff. In some instances, two or three individuals have attended via the same link so numbers trained are in excess of 833 for this period. All staff have been urged to attend and details of the rolling training programme shared on the 'all user bulletin board'. It has been noted that requests for training has fallen during July and into August as a result of staff annual leave, so the number of bookings over summer is significantly less. A targeted approach continues to be taken where it is noted that key staff have not yet taken up the offer of training. The new procedure is awaiting launch following ratification.
- 4.2 The training emphasises the key changes to the way we manage complaints and emphasises the benefit of addressing matters at the stage of first contact, focussing on early resolution and robust communication at source. The training also covers the importance of scrutiny of the detail of the communication upon receipt. The procedure emphasises the importance of ascertaining whether a matter is a complaint, enquiry or opinion, in order to signpost to the most efficient route for speedy resolution. Feedback from the consultation of the new procedure along with the training sessions held from staff to date has been very positive.
- 4.3 A modular training approach (a passport to training) will be taken, where staff members, depending upon their role, will be offered training for different elements of the steps in the complaint process, for example investigation training for individuals who will be undertaking the role of Investigating Officer, report writing training for those staff who will be responsible for writing reports.
- 4.4 To ensure collaborative working with the Patient Advice and Liaison Service (PALS) team, we have a combined phone line, which is part of the centralised call team (known as CCC); this facilitates the management of telephone calls across the three sites. This system pools skills and knowledge and places less reliance on staff being based on individual sites.
- 4.5 The CCC function facilitates a North Wales approach where initial contact, review and decision on the most appropriate steps to achieve an early resolution can be managed in one contact.

This centralised approach allows for review of all first contact correspondence and enables teams to facilitate the most effective way of enabling rapid resolution to concerns presented by patients and carers. This closer working relationship will facilitate efficient communication and sharing of knowledge of services and key contacts for signposting to swift resolution.

5. COVID-19 REVIEWS

- 5.1 It is vital to reflect on the impacts the ongoing pandemic has had on our patients, employees and services to establish whether BCUHB have been a contributory factor in causing harm (*harm relates to the harm occurring as the result of nosocomial transmitted Covid-19*). Being open and honest is prime to ensuring patient safety, protecting the health and wellbeing of NHS staff, maintaining our reputation and maintaining public confidence. The aim is to conclude fair, transparent and proportionate reviews in relation to Covid-19 health care acquired infections (HCIA).
- 5.2 A National Wales Framework Guidance has been implemented to provide a consistent approach for NHS Wales Organisation's to identify, review and report patient safety incidents following nosocomial transmission of Covid-19 in compliance with the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.
- 5.3 The Framework states that the purpose of undertaking investigations into cases of nosocomial transmission of Covid-19 is to determine instances of actual or potential harm, and to learn lessons to improve communicable disease control in the future. Investigations should be proportionate to the degree of actual or potential harm identified.
- 5.4 The National Framework is underpinned by the requirements of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, and the associated supporting guidance; Putting Things Right – Guidance on dealing with concerns about the NHS from 1 April 2011. These requirements place a legal obligation on health bodies in Wales to investigate where an unexpected or unintended incident, concerning patient safety, did lead, or could have led to harm of a patient.
- 5.5 The complexity of the on-going Covid-19 pandemic does however present unique challenges to health bodies in investigating:-
- Significant number of patients affected potentially by nosocomial transmission of Covid-19.
 - Evolving knowledge base of the disease resulting in changing national policy for infection prevention and control (IP&C), as more was learned regarding spread of the disease
 - Unprecedented pressures on NHS services at times of peak demand
- 5.6 These complexities make the requirement to investigate these patient safety incidents under the Putting Things Right arrangements a large and protracted exercise, requiring significant resources, which could otherwise be engaged in supporting the reset and recovery programme now required across NHS Wales. Whilst learning from the experiences of the pandemic is essential for future care provision, some learning has already been identified and implemented locally and nationally through other formal procedures such as ongoing IP&C measures, and through individual and outbreak procedures, coordinated nationally via the Nosocomial Transmission Group.
- 5.7 A request has been received by the NHS Wales DU (Delivery Unit) to present a sample of 10 investigations (health care acquired Covid-19) to be audited. Health bodies were asked to select ten individual cases, which reflect a combination of 'probable' and 'definite' instances of

nosocomial transmission of Covid-19 and where the patient outcome has been death. The purpose of the sample audit of investigations, submitted by Health Boards and Trusts across Wales, is to assess the type and quality of evidence available. The assessment will consider which investigation methods have been selected by organisations as appropriate, taking into account any specific technical enquiries needed to investigate nosocomial transmission of Covid-19. The findings will be used to update the Framework with regards to the appropriate depth and parameters of future investigative requirements.

- 5.8 19 formal complaints have been received in relation to health care acquired Covid-19, the patients and families are awaiting for our investigations to progress to conclude whether harm was caused. The prevailing message that has been communicated thus far by the patients and families (some of whom are deceased) is a need for clarity, a response and closure mitigating the urgent requirement to conduct a proportionate and fair review to meet these needs. Health care acquired Covid-19 infections are recognised as being those diagnosed after 72 hours in hospital with the early ones considered indeterminate (up to 5 days). Screening all admissions did not start until July 2020 and therefore it is not possible to determine if infections were truly healthcare acquired in advance of this date.
- 5.9 The total number of probable and definite health care acquired Covid-19 patients affected within BCUHB is 658. Conducting a proportionate review into the indeterminable cases would bring the total requiring investigation to 866 cases.
- 5.10 The National Review Framework states that reviews must be proportionate and it's stated that all health care acquired Covid-19 deaths will undergo a mortality review. There are as currently over 250 outstanding mortality reviews. The objective is to complete the reviews upon appointment of the additional resources requested in an Executive Paper. An electronic system to capture the stage 2 reviews has been implemented; we have enhanced the standard All Wales stage 2 by adding in elements of structured judgement review to support learning.
- 5.11 An increase in correspondence from patients/families affected by health care acquired Covid-19 within the Health Board highlights the need for pro-active engagement. This presents itself following the increase in publications in the media regarding the subject and pressures on the Welsh Government for a Public Enquiry. A pro-active approach to engage with the public by form of an announcement with information in relation to the intention to review is necessary to maintain public confidence and engagement.
- 5.12 Due to the limitations of resources that the current team are presented with, additional resources have been requested via presentation of an Executive Paper to support the reviews, they include a need for experienced clinicians to investigate and experienced administrators to join the team. The aim is to conclude the investigations within a 1 years' time frame with consideration to a possible increase in health care acquired Covid-19 infection due to any future wave.
- 5.13 In line with Putting Things Right, learning from the investigations are fundamentally important in preparation for future waves, to support this the Patient and Carer Experience Team attend 'The Wandering Patient Task and Finish Group'. The Wandering Patient Task & Finish Group is one of 5 Task & Finish Groups developed to support and deliver the Safe Clean Care, Harm Free work stream agenda. The aim of the group is to develop a BCUHB algorithm for Wandering Patients in all Inpatient Wards / Units to support a zero tolerance approach to Infections (nosocomial)". The Group have identified the following:-

- There is an urgency to review Patient Transfer Procedure in the context of the Covid Environment (NU19) – this impacts beyond the Wandering Patient Task & Finish Group.
- An urgent need for a process for re-commissioning therapeutic space
- Imminent need for data gathering to identify the number of wandering patients within operational services, a snapshot view.

The work has influenced the following:

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

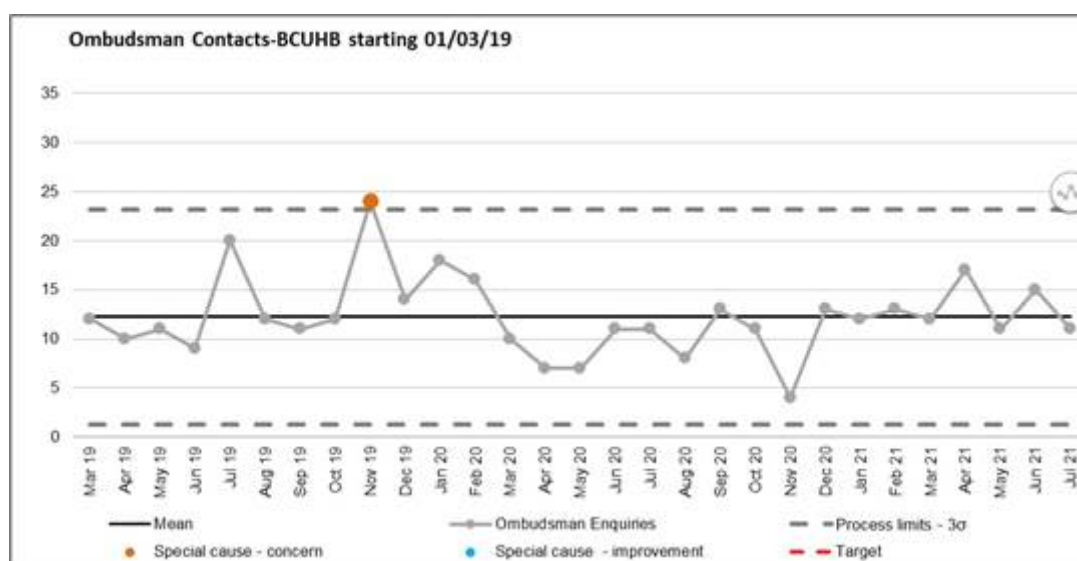
5.14 The Patient and Carer Experience Team has worked collaboratively to support the development of a Long Covid-19 Recovery Pathway to Treatment and Rehabilitation. This has meant pro-actively engaging with patients who are experts by experience as well as relevant professionals to develop the pathway.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

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

6. OMBUDSMAN

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

6.2 During the months under review, the Ombudsman contacted the Health Board regarding 54 new concerns (compared to 37 in the previous comparable period).



6.3 During the period under review the Health Board has received notification that a further 20 new complaints will be fully investigated by the Ombudsman, (compared to 13 in the prior comparable period).

- 6.4 The Health Board currently has 73 Ombudsman Investigations ongoing across the Health Board, of which 18 are within the West, 40 within Central and 15 within East.
- 6.5 The Public Service Ombudsman for Wales' Annual Letter was received in November 2020 and following rearrangements due to meetings postponed, was presented as an Appendix to the Q4 2020/21 Patient and Carer Experience Report at the meeting on 5th May 2021. The Health Board responded to the Ombudsman's Annual Letter on 10th November 2020 outlining the ongoing improvements. This includes the changes to how the Health Board manages complaints. Once the new procedure has been ratified, the full suite of documentation will be shared with the Ombudsman's office.
- 6.6 Following previous meetings between members of the Patient and Carer Experience Team and the Ombudsman's Complaints Standards Authority team (CSA), a number of training sessions were delivered in April 2021. These sessions, facilitated by the Ombudsman's CSA comprised of session topics relating to Handling Complaints & Negotiating and on Complaint Investigation Skills. Members of the Patient and Carer Experience Team attended the initial sessions delivered and there is a plan to roll out the training to other staff members involved in the investigation of complaints, with dates of this further roll out to be confirmed by the Ombudsman's team. The training was designed to support and enhance complaint handling throughout public services by considering best practice from multiple sectors from around the world.
- 6.7 An Ombudsman Procedure was ratified at the Patient and Carer Experience Group on 29th April 2021. This procedure sets out the requirements under the Public Services Ombudsman (Wales) Act 2019 for the management of and learning from Public Services Ombudsman for Wales investigations of concerns. A period of consultation had been carried out to include the Public Services Ombudsman for Wales, Health Board senior clinical staff, Governance Teams as well as the Community Health Council.
- 6.8 Quarterly calendar dates have been scheduled with the Ombudsman's Improvement Officer to promote partnership working with the Ombudsman's office. The Health Board met the Ombudsman's Improvement Officer on 22nd April 2021 with further regular meetings timetabled throughout the year, the next meeting due to be held on 12th August 2021.
- 6.9 **Ombudsman Public Interest Report.**

The Health Board received a Public Interest report issued under section 23 of the Public Services Ombudsman (Wales) Act 2019 on 21 July 2021. The Ombudsman has investigated the care and treatment received by Mrs M at Ysbyty Glan Clwyd and Llandudno General Hospital, namely:

- Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset and weight loss which she developed following bowel surgery
- Clinicians failed to accurately assess Mrs M's frail condition and discharge her without appropriate home care support in place. This was subsequently provided by the Council but was inadequate and, within days, Mrs M was readmitted to hospital.
- The decision to remove Mrs M's nasogastric tube led to further weight loss and deterioration.
- A secondary cause of Mrs M's death – an ischaemic bowel – was not identified from scans or investigations conducted during her admissions
- The Health Board and the Council failed to coordinate their response to the complaint. The council's response was received 6 months after the response provided by the Health Board.

The Ombudsman found that senior clinicians at both hospitals (including the colorectal MDT) failed to identify that Mrs M had developed a post-operative blockage in the small bowel. He found that despite conspicuous radiological and clinical evidence pointing to this, physicians

inappropriately excluded a physical cause for Mrs M's symptoms and attributed her weight loss and aversion to eating to a 'food phobia'. The Ombudsman could not definitively conclude that the failure to identify and treat the small bowel obstruction meant that Mrs M's death was preventable. This was because it was unclear whether she could have sustained further surgery, given her frail condition and comorbidities. The Ombudsman nevertheless considered this to be an alarming, systemic misdiagnosis and considered the uncertainty surrounding whether an opportunity to surgically intervene was lost to be, in itself, an injustice to Mrs M and her family.

The Ombudsman also found that the attempt to discharge Mrs M failed due to multiple shortcomings on the part of both the Health Board and the council in relation to pre-discharge planning and to the post discharge support Mrs M received. The Ombudsman also found that although difficult to detect, ischaemia might have been preventable had the clinical suspicion of a small bowel obstruction been considered and pursued. Complaint handling failings were also found.

The Health Board has accepted the findings outlined in the report and an action plan has been drafted in order to implement the following recommendations made by the Ombudsman:

- i) Provide Mr D with a fulsome written apology for the clinical, care and communication failings identified in the report.
- ii) Share the report with the Equalities Officers to facilitate training on the principles of human rights in the delivery of care.
- iii) Make a payment to Mr D of £5,000 in recognition of the distress and a further £250 in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about these matters to the Ombudsman.
- iv) Demonstrate that the report has been shared with the Clinical Director(s) responsible for the relevant Surgical and Medical physicians involved in Mrs M's care (along with lead physicians in the Colorectal MDT) and that its findings have been reflected upon and directly discussed with those physicians (where possible) including at those physicians' appraisals and revalidation.
- v) Evidence that these physicians have undergone training/revision in regard to: the diagnosis and treatment of small bowel obstruction's; the theory and practice of the use of the contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered' the medical management of nutritional needs.
- vi) Demonstrate that the relevant nursing teams referred to in the report have undergone revision/training in respect of the Health Board's Discharge Policy and are reminded of the importance of documenting actions, plans and developments surrounding the discharge process.

6.10 Emerging Themes

One emerging theme is the increased number of cases being returned to the Health Board by the Ombudsman with instruction that they are to be re-investigated under the Putting Things Right Regulations in order to consider Redress. This is due to the poor quality and inadequate initial investigation held by the Health Board where qualifying liability has not been considered. There are currently 9 cases which the Ombudsman has recommended they be considered for Redress. The new complaints process, a new weekly redress clinic and a planned review of the redress process will help address this.

6.11 Own Initiative Powers of Investigation under the PSOW Act 2019

There are currently 3 investigations being carried out by the Ombudsman under his own initiative powers of investigation under the PSOW Act 2019.

- i) The Ombudsman has a reasonable suspicion that there are possible incidents of service failure and maladministration in relation to the care and treatment provide to

16 patients on a Urology waiting list. At the time when COM39714 was placed on an urgent priority list during August 2019 there were a total of 17 patients on the same urgent clinical priority awaiting the same procedure.

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

7. COMMUNITY HEALTH COUNCIL

7.1 The North Wales Community Health Council (NWCHC) has undertaken a limited number of inspections. The reduction in inspections undertaken remains because of restrictions arising from COVID-19, also reflecting the fact that hospital visiting in general has not been fully established due to ongoing arrangements and restrictions because of the COVID-19 pandemic.

7.2 The CHC continues to focus on engagement activities and providing advocacy service for complainants.

8. PATIENT FEEDBACK

8.1 Patient feedback and listening to the voices of patients, carers and service users, is a key tenet of effective service improvement. It is paramount that the Health Board fully takes into account the feelings, views and experiences of patients, carers, and service users, and how such feedback can positively influence service change and development.

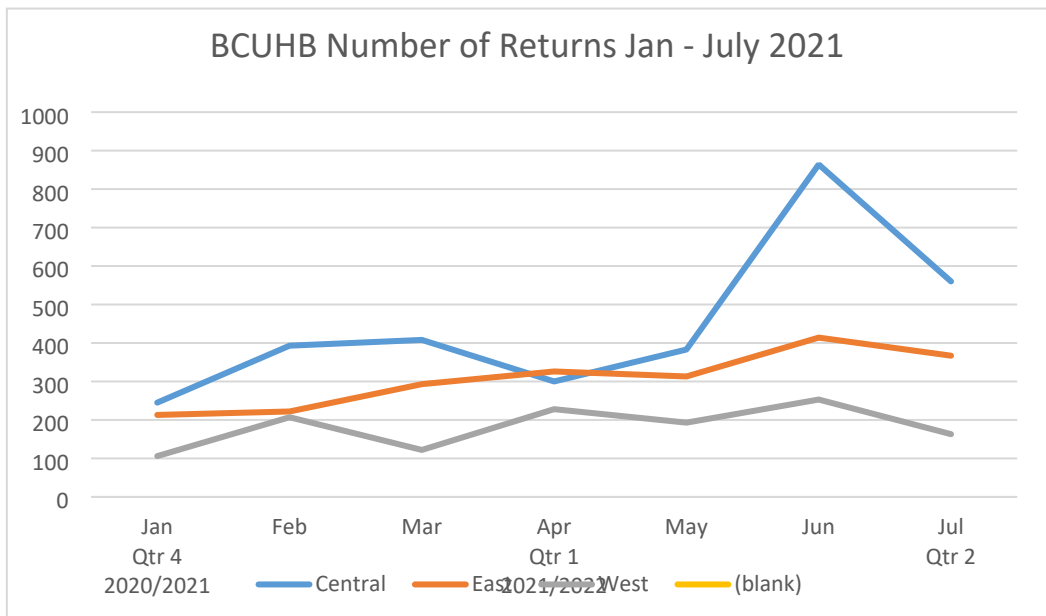
Despite the challenges presented by COVID-19, the Patient and Carer Experience Team have continued to support services in the process of capturing feedback, and to provide evidence that all services are working towards the stated aim of capturing 20% of patient/care/service user experience, which is key performance target inherent in the Patient Experience Strategy (BCUHB, 2019).

Since the use of CRT Viewpoint was discontinued in April 2020, the Patient Experience Team have continued to collect service user feedback through various in house methods including; paper questionnaires, analysis of social media, increased media visibility and via the PALS service which has recently incorporated a bilingual shared phone line and inbox with the Concerns team. We have also introduced a fully accessible internet based service user experience questionnaire supported by the use of QR codes across all service points. iPads and other smart devices are also utilised within clinical settings to support digital feedback, to provide a link to the on-line patient experience survey and to support virtual visiting.

Phase one of the deployment of the new CIVICA™ Once for Wales Patient Feedback System was successfully implemented in July 2021 and will become the prime mechanisms to support real/near time patient and service user feedback. The platform provides the HB with the facility to support the development and deployment of multiple surveys across multiple channels, along with standard reporting, alerting and enhanced text analytics, and signals an important milestone in providing ever patient and service user with an opportunity to have their voices heard and acted upon.

The number of returns from the real/near time patient/service use feedback survey have been gradually increasing, throughout Q2 2020/2021 and have roughly returned to pre C19 response levels, at a time of restricted inpatient activity and visiting. (Please see table: No of Returns Jan-July 2021, for more detail)

No of Returns	Central	East	West
2020/2021 -Qtr 4			
Jan	245	213	106
Feb	393	222	207
Mar	408	293	122
2021/2022 -Qtr 1			
Apr	300	326	228
May	383	313	193
Jun	864	414	253
2021/2022 -Qtr 2			
Jul	560	367	163
Total	3153	2148	1272



8.2 Feedback continues to guide practice, and is the driver of positive service improvement; however, feedback is also pivotal in demonstrating learning as it is compulsory that these improvements are firstly embedded into all demonstrated practices.

The ‘So what’ is now taking president in all methods of feedback gathered, as it standardises the real reason and purpose why feedback is collected. This assurance is now reinforced by the new complaints procedure, whereby any complaint, that has received a comprehensive investigation, will have to be signed off by a senior service manager. This offers the assurance that any recognised learning is instigated and monitored by the actual service itself.

This coupled with close collaboration and co-working between the Patient and Carer Experience Team and Complaints Team ensures that responses to all enquiries and potential concerns are better coordinated and dealt with effectively, and by most appropriate process in order to reduce the levels of escalated complaints.

8.3 Positive feedback not only shares good practice, but also raises staff morale and job satisfaction. The Patient Experience team continues to select a ‘Friday Feel-good Comment of the Week’.

This is presented to the relevant ward/department along with the comment publicised on the Health Board's social media pages.

Examples of Feel Good Friday comments received in Quarter 2

'I felt safe and very well looked after and well cared for by very patient, dedicated nurses and staff. Excellent from beginning to end, nothing appears to be too much trouble for any one of them. I could say I'm sad to be leaving with my mind and body and brain intact and working well. With many, many thanks to everyone here '

Our 5 year old son came to your emergency department with an injured elbow. I would like to express my most heartfelt appreciation to all your wonderful staff in ED from the reception staff to the Nurses and Doctors who couldn't have done more to reassure our son, and turned a traumatic experience into quite an exciting memory for him. He returned from hospital with stickers from your staff and told me continuously how everyone said he was 'brave' and a 'superstar' and how all the 'nurses and doctors smiled at him'. I cannot thank your incredible staff enough; they have all been wonderful'.

8.4 There are always aspects of care where feedback suggests that improvements should be implemented, and changed to be practice implemented.

Key themes associated with a negative patient experience within Q2-2021 are;

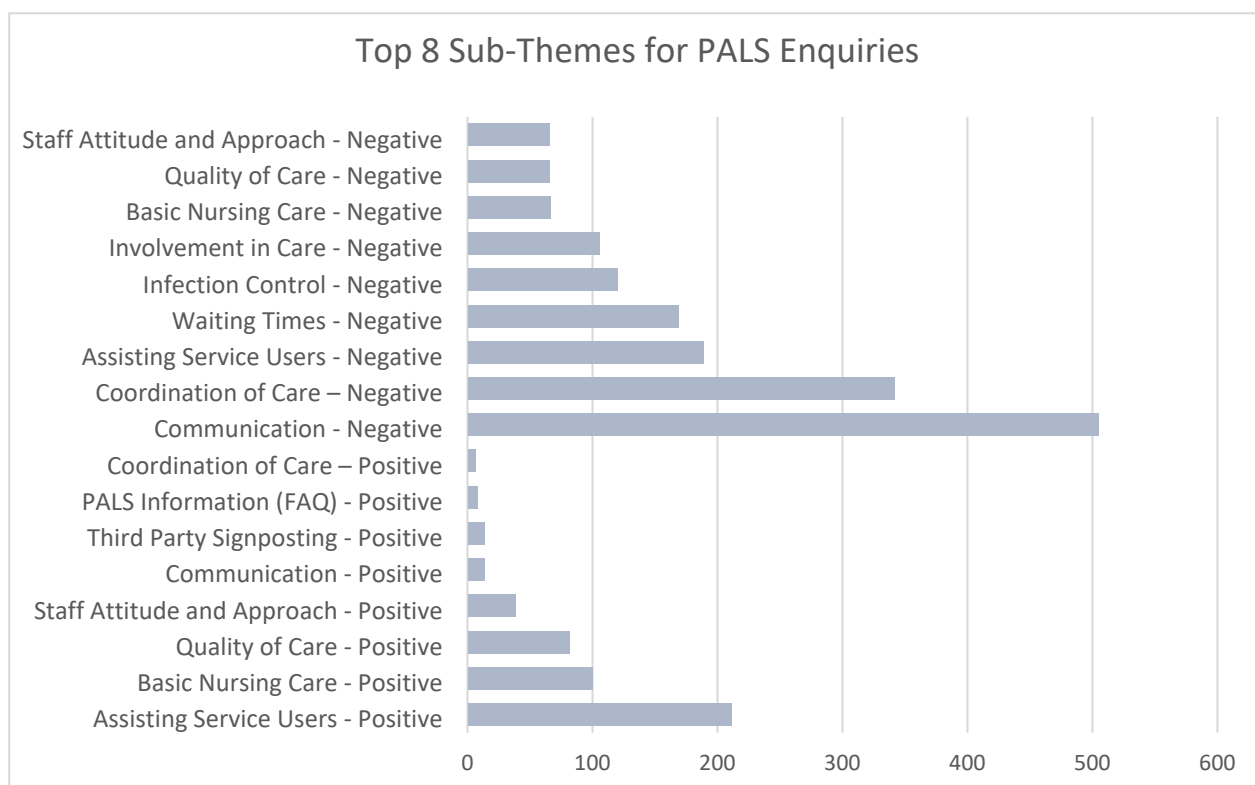
- **Communication**, key examples include; families and carers being unable to access information regarding the care of their relatives and loved ones, which in many cases was exacerbated by visiting restrictions, patients unsure of 'what is happening next', as well as patients reporting that communication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

8.5 There have been positive efforts within service areas to address these issues, such as the proposal of twenty-four-hour ward clerks delegated to update relatives and loved ones, and dedicated family members calling the wards to gain information regarding their loved ones.

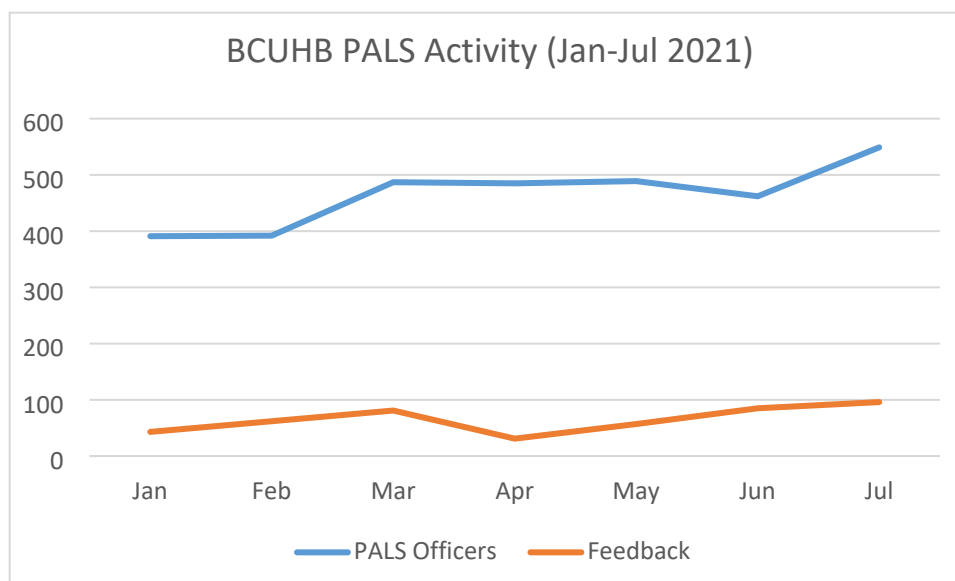
There are also efforts made to update the Patient and Carer Experience Team of specific changes in the visiting. The team are providing valuable support in this area such as the phone number linked to the matron on call in Ysbyty Maelor Hospital (YMH). Relatives who contact the PALS team in YMH after failing to contact the ward are given a designated phone number to contact the matron on call to facilitate direct communication with the ward.

Additionally, the Patient and Carer Experience Team are coordinating the distribution of iPads and other smart devices to wards and departments to support virtual visiting and during this reporting period these devices will be updated to support real-time feedback via the CIVICA™ platform. A key deliverable of Phase I of the CIVICA™ implementation plan has been the acquisition of an additional 60 iPads which in Q3&Q4 2020/2021 will result in enhanced capacity to support a variety of real/near time patient feedback and virtual visiting/communications.

8.6 The following feedback has been collected within the last quarter, and passed on to the relevant services so that changes can be made.



8.7 There has been a significant rise of almost 50% in the combined activity of the PALS teams in Q1. This is indicative of the high number of enquiries attributed to specific communication, and problems in coordinated care.



9 PATIENT STORIES

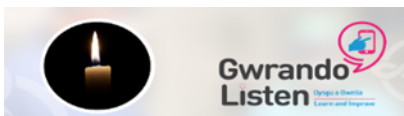
9.1 Stories told by individuals from their own perspective regarding a health care setting, or the care they have received, has been identified as a powerful tool to understand their lived experience. This is acknowledged as an influential and compelling method of collecting patient feedback, and can identify specific opportunities for future service improvement as they come directly from the patient themselves.

The updated patient story procedure has recently been ratified, with planned training intended to be rolled out across all areas for all staff members of BCUHB, to enable individuals to have the

confidence and ability to gather both staff and patient stories in a quality assured format. The procedure and training is also intended to give services the confidence to collect their own-targeted patient stories with the plan now for our service is to move to a more thematic review of the Patient stories, and for these stories to be themed and shared in all board meetings, concentrating on such pertinent subjects as Long COVID-19 and Bereavement.

The development of the digital story work stream has resulted in the deployment of digital with voice recorders utilised to record patient stories, and thus provide staff and managers with direct experience of their services as the basis for identifying exemplars of practice as well as targeting service improvements. Video equipment has also been procured, with training presently taking place for the team with a local production company, with the first filmed Patient Story already been collected and edited a member of the team.

10 PATIENT EXPERIENCE BEREAVEMENT AND LIAISON SUPPORT



- 10.1 During the continuing COVID-19 pandemic, it was a thought that the volume of families BCUHB Bereavement Officers will be supporting, would increase. As a continuation of this service, the Patient Experience Team, continues to work in partnership with these existing services, with the embedded 'bereavement and liaison support service' remaining firmly in place, listening, offering advice and support when required. Whilst the implementation of this service, was initially in response to a potential crisis, it remains positive that we continue to co-work with such important services, providing a far greater understanding of our position, and how we at times provide the same advice and guidance.

Standing membership on the Quality Bereavement Group continues to enable a consistent planning of service delivery, offering a high quality service to those who are bereaved, and there is currently a scoping of bereavement models taking place, such as the Swan Model, to provide a framework and planned approach in bereavement care across the Health Board.

During Q1 there has been 248 views on social media to the Bereavement Patient Experience page, 244 in English and 4 in Welsh.

- 10.2 Following a successful funding application to Awyr Las, we have been in regular consultations with the Health Boards arts therapist, and there is now a commissioned piece of artwork presently being produced across the acute and community sites. This will incorporate the 'knitted hearts' produced by Awyr Las volunteers in a Perspex piece of artwork, to be displayed in the specific designated areas in the acute sites. A commemorative book outlining the pandemic is also in the process of commissioning, which will include photographs of staff, poetry, stories, and recollections of their experiences and thoughts.

Our aim is that we can not only remember this period in time, but also continue to produce funds through the sale of this book, to support those affected by the pandemic. The final portion of the money from Awyr Las has been utilised to buy mobile IPAD stands, to enable those who are too weak to hold the devices to communicate privately with their loved ones at the end stages of life.

11 LETTERS TO LOVED ONES



11.1 As previously acknowledged, during the COVID-19 pandemic, visitation to all to hospital sites throughout BCUHB has been restricted. Letters to Loved Ones was implemented by our service as a response of this measure, and to maintain communication between loved ones and patient. It continues to be a successful service, with a good uptake of messages sent on a weekly basis. A message can be sent either via email, or passed over the phone, and that message will then be delivered to the patient on the wards. This remains a popular service, whilst the restrictions in visiting remaining in place. Over the last quarter there have been 1,131 views over social media to this page (4 in Welsh).

11.2 Letters to Loved Ones received over April to July 2021 (data available for this period only at this stage)

- Centre 173
- East 77
- West 34

The following feedback was received:

Many thanks for your reply. Especially in these times, this is a terrific service and very much appreciated.'

12 CARERS STRATEGY

12.1 The Carers Strategy now sits operationally within the Patient Safety and Experience Department, with work already undertaken to operationalise the strategy. The Patient and Carer Experience Team fully recognises the challenges that carers routinely face, challenges that have being exacerbated by COVID-19 pandemic. In response to the strengthening of the carers strategy is recognised as being instrumental in providing the direction that the carers pathway requires which emphasises the need for collaboration and co-production. which builds on the extensive links being forged between carers, BCUHB staff, existing carers agencies, carers representatives, and young carers. Such an approach has ensured that Patient Experience Leads gaining membership on many carers groups, including both statutory agencies and specialist services such as dementia care.

13. PATIENT & CARER CHAMPIONS

13.1 The Patient and Carer Champion is a BCUHB initiative developed by the Patient and Carer Experience Team and following a successful recruitment campaign, which remains ongoing, we have currently have recruited eighty-one champions across North Wales, and to date have hosted twelve induction sessions. These induction sessions are ongoing, and being positively received, with the range of those who have volunteered being diverse. This diversity will ensure that all services will have a designated person(s) with the willingness to promote the Patient Experience and Carer agendas.

13.2 Staff that have signed to be Champions are from all different working areas, and of different grades, including domestic staff, doctors, nurses, ward clerks, health care assistants, consultants and other administrative and clerical staff. These leads have also established links with Bangor University to link in with the student population, in a range of health professions, to become roving Champions.

- 13.3 The Patient and Carer Champions have made a significant impact in the number of patient feedbacks returned to the service, with the number of feedback forms received during June totalling over 900 across BCUHB. This can be attributed to the Champions taking responsibility for the clinical areas they are aligned to, striving to raise standards by combining prior knowledge with new information from the Patient and Carer Experience Team. It is considered that they will enhance services by working together and by sharing good practice
- 13.4 The Patient and Carer Champion Award Scheme has been introduced with the Champions having three levels of awards to achieve should they wish; Bronze, Silver and Gold. They can also achieve certificates of attainment. Through this scheme, we can help standardise the approach of public facing information such as ward noticeboards.
- 13.5 We are currently in the process of a recruitment drive to try and gather more interest in a diverse membership of BCUHB staff becoming Champions, and have been publicising this drive through social media, health board meetings, quality meetings and posters across the three sites.

14. ACCESSIBLE HEALTH CARE

- 14.1 The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. Throughout 2020/2021, BCUHB's COVID-19 pandemic response has resulted in a suspension of many face-to-face approaches of collecting feedback from service users, interacting with front line staff, and developing direct relationships with remote service points. Visiting restrictions within clinical areas have provided an additional challenge in relation to providing an effective Patient Advice and Liaison Service (PALS) and this has necessitated the development of new, remote ways of working. The COVID-19 pandemic has negatively impacted continued roll out of patient feedback questionnaire to managed practices, which enable segmentation of feedback sensory loss, as the basis for service improvement, however, this has been identified as a priority and is an integral component of the PALS work stream moving forward into 2021/2022. The work stream and action plan within the Patient Safety and Experience Department are working towards the aim of ensuring increased organisational awareness and compliance with the Accessible Healthcare standards, with the key actions relating to this area for 2021/2022 being:
- The utilisation of the Evaluation Tool to increase compliance with Accessible health care standards and the development of services which increasingly meet the needs of people with sensory loss.
 - In collaboration with BCUHB managers and staff, service users and the COSS review the content of the Toolkit to ensure that it is commensurate with the standards, technological developments and the needs of our service users.
 - Continued development of the capacity to report in near/real time the experience of patients', carers and service users with sensory loss as the basis for service development.
 - Development of the PALS and Patient Champions roles to specifically understand and respond to the needs of patients', carers and service users with sensory loss which includes the development of Care2Share and Patient Stories, as the basis for placing the voice of the patient and service user at forefront of service delivery
 - We have now re introduced the Sensory loss/ accessible health care training so as to increase staff awareness, which has been successfully received by all services, with 52 having completed the session since it's re introduction in May.

The Patient and Carer Experience Team continue to work jointly and successfully with mental health services, to explore accessibility to mental health services, for those with hearing loss.

15. CONCLUSION AND RECOMMENDATIONS

- 15.1 This report aims to provide the Quality, Safety and Experience Committee with information and analysis regarding significant patient experience issues arising during the quarter under review, alongside information on the improvements underway. The aim being to provide the committee with assurance on the Health Board's work to improve patient experience.
- 15.2 The Committee is asked to note this report.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Review of Urology services and patient experience						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery / Deputy Chief Executive						
Awdur yr Adroddiad Report Author:	Dr Gary Francis Mr Clive Walsh Mr Matt Joyes						
Craffu blaenorol: Prior Scrutiny:	Executive Team						
Atodiadau Appendices:	1. Analysis of complaints in 2 year period						
Argymhelliad / Recommendation:							
<p>The Committee is asked to note the paper and approve the suggested actions to address the issues identified namely:</p> <ul style="list-style-type: none"> • Support the commissioning of an external clinical review of urology services from the Royal College of Surgeons. The lead time for such a review is likely to be 6 months • Approve the immediate establishment of a North Wales Improvement Plan for urology to assess standards, identify current good practice and gaps in practice, with executive leadership and QSE oversight. • Note the development of a business case to achieve a sustainable capacity position, taking into account the backlog arising during the pandemic, and the potential for Regional Treatment Centres. In the interim the Board will proceed with additional clinical appointments • Acknowledge that action plans have been developed in response to previous and current PSOW reports which will need to be refreshed. • Note the recruitment actions being taken • Support the progression of the Getting it Right First Time (GIRFT) work 							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	x	Ar gyfer Trafodaeth For Discussion	x	Ar gyfer sicrwydd For Assurance	x	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This paper sets out the background, current mitigations, and planned further actions in tackling the complex issues confronting urology services across North Wales. It includes an overview of a number of serious incidents and reports into deficiencies in the services provided.							

Cefndir / Background:

Urology is a multi-disciplinary service which is delivered across the three acute sites and has placed sub-specialties in different locations, with robotics to be located at Ysbyty Gwynedd (YG), laparoscopic surgery at Ysbyty Glan Clwyd (YGC) and stone surgery at Wrexham Maelor Hospital (WMH), in order to provide economies of scale, and optimal utilisation of equipment.

The All Wales procurement of robotic surgery is expected to conclude in September 2021, at which point the implementation at YG will commence.

The volumes of activity for urology across the three acute sites in 19/20 was:

	West	Central	East
OP	5994	10848	13657
IP el em & DS	5154	3898	2253
WL @ 31 Mar	1473	2295	2387

The above chart demonstrates a necessity to align activity on a North Wales basis to ensure equity.

Between March 2020 and July 2021 the numbers of patients waiting to be seen has grown by 8,000 people from 6,000 people to 14,000 people, with more than 9,000 patients waiting over 36 weeks. The Covid-19 pandemic exacerbating an existing mismatch between demand and capacity in North Wales.

This mismatch in demand and capacity has continued to be managed by commissioning additional activity from the NHS in England, the independent sector and by the use of waiting list initiatives. Whilst BCUHB's cancer performance is generally one of the best in Wales, waiting times for the management of some urological cancers is now a challenge. This is the second most common cancer in terms of numbers of patients treated in North Wales (after skin). The latest reported waits (% achieving standard) are:

	West	Central	East	N Wales
June	82	58	27	50
July	48	48	47	48

This compares to the 75% standard for the treatment of patients within 62 days. For all cancers the BCUHB value in June is 73% and All Wales is 68%. The figures reveal a degree of inconsistency over time and between different areas of North Wales. The Board has implemented some general changes, which will also benefit urology patients. These include:

- The process for reviewing cancer performance has changed, and harm reviews are undertaken for any referral to treatment times over 104 days.
- In future, overall cancer performance will be assured through the North Wales Cancer Partnership Group. This is modelled on the Manchester Cancer Board experience, which has led to sustained improvements in cancer outcomes. The Manchester team will offer support as we develop the group and provide a 'critical friend' role. This will enhance oversight of improvements to the effectiveness of the urology multidisciplinary team, in managing the care of locally treated patients and those referred to other providers.

There are a number of positive developments within urology, such as:

- Development of new roles – recruitment of physicians assistant
- Commencing cystectomy surgery locally at YG (this is part of a general plan to repatriate more complex treatments to local hospitals to improve patients' access to healthcare)
- We have agreed with Welsh Government the early adoption of PSA patient self management, ahead of the intended All Wales scheme
- Completion of priority stratification for patients waiting for treatment in line with the P1 – P4 categorisation.

A serious Never Event was reported in 2019. At the time of the incident an external review of the incident was requested, but undertaken locally. The review was completed by a senior clinician employed by BCUHB but from outside the urology service. A follow-up action plan was developed. An external review of the investigation was commissioned to provide further assurance that all matters had been fully identified and subsequently mitigated. However this gave limited assurance. Further concerns remain that the learning identified within this review has not been embedded in the routine operation of the service. In the light of this and other concerns, a revised process for the investigation of serious incidents has been put in place, with Executive Director oversight of the initial investigation including allocation of investigating officer and any recommendations.

The Public Services Ombudsman for Wales (PSOW) has conducted an “own initiative” investigation into 16 patients placed on the prostatic cancer pathway. This is due to be issued as a public interest report 9th September 2021. The investigation was in response to a complaint received by the Ombudsman in 2019 whereby a patient paid for private treatment as a result of excessive waiting times (this report was also issued as a public interest report). The PSOW identified that a number of patients who had been placed on the prostatic cancer pathway had been referred to healthcare providers in England and had breached the cancer pathway target, with the breaches not reported or subject to harm reviews being shared with the Health Board (although at the time of referral this was not a requirement in Wales). The Board has since reviewed the contractual relationship with hospital providers to ensure that referred patients are tracked and the pathway stages reported.

The Ombudsman commented that he remains concerned that urology services had not improved despite previous recommendations by him, and further to a Healthcare Inspectorate Wales Urological Cancer Peer Review in February 2014. The Ombudsman commented on several specific concerns:

- A lack of clinically or managerially led consensus for the delivery model of urological cancer services in North Wales.
- The Multi-Disciplinary Team stated that patients had been lost or delayed in follow-up and have deteriorated while waiting for an appointment.
- A lack of succession planning for the service “compounded by the lack of strategic direction from management on the delivery of urological services for the population.”

One of the recommendations for the Board is to undertake a capacity and succession planning review. BCUHB is responding to these issues by developing a specialty Improvement Plan; and appointing a clinical lead and additional clinical staff. There is a further recommendation within this paper to support an external review of the service.

The Ombudsman has other open investigations underway regarding urology, related to individual patient concerns. The publication dates for these reports are not yet known.

The current Clinical Director for urology has announced his intention to step down from the role, and this post has been advertised (along with a robotic surgeon), with an appointment panel arranged for 22 October 2021. This is the minimum lead time to ensure a strong field and ensure there is appropriate clinical engagement in the recruitment process.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implication

The Health Board has previously agreed to a plan to locate discrete sub-specialised services at each of the three acute hospitals. As part of this plan, BCU has determined that robotic surgery will be located at YG (this is part of an All Wales procurement programme). One BCU robotic surgeon has resigned citing delays in developing the robotic service, in addition to the lack of a cohesive clinical leadership for the service.

Implementing the strategic vision will promote the service's attempts to recruit and retain sufficient numbers of trained staff to sustain a viable service across North Wales (certain disease groups are already being referred outside BCUHB through lack of availability of suitably trained clinical staff).

The Urology service is an important element of the Board's major strategic ambition for the development of Regional Treatment Centres, which is currently being considered for approval by Welsh Government. To make effective use of this capacity an expanded consultant workforce will be required and the Executive Team has agreed to proceed with this expansion on the basis of the initial demand and capacity analysis. In the interim, the Board is seeking additional capacity through contracts with the independent sector.

Implementing the strategic vision will ensure patients are treated as close to their home in a timely and equitable fashion, and this is consistent with the Board's direction of repatriating patient treatments, rather than relying upon out-sourcing of activity. A full complement of clinical staff will also ensure sustainability of unscheduled care services in urology and this would be in line with the Health Board's commitment to 24/7 emergency services on three acute hospital services.

Opsiynau a ystyriwyd / Options considered

Despite implementing the findings from the previous internal and external reviews, there is insufficient evidence-based assurance of the quality of urology services, and several concerns from stakeholders such as the Ombudsman exist. Therefore, it is recommended that the Health Board considers commissioning a Royal College of Surgeons (RCS) review of the services. Such an exercise would form the sound basis of future improvement work. In discussion with the RCS, it seems that the lead time for such a review is likely to be 6 months, and the Board will need to take more urgent steps to mitigate the existing concerns and gaps in assurance through an improvement plan.

A separate Getting it Right First Time (GIRFT) assessment is being scheduled for November 2021, and the results will be used to improve the service in the interim.

A local review has been considered but due to the ongoing nature of the concerns, it is considered that an expert independent multidisciplinary review by a Royal College provides the most reliable and robust solution. Equally, consideration has been given to reopening the previous serious incident but given the passage of time, and the fact that underlying factors are likely to be systemic, it is believed that an independent review would equally identify fundamental issues needing improvement.

It is therefore, recommended that the Board commission a Royal College review. The results of this review will be managed through the Board's standing governance arrangements.

Capacity Shortfall:

There are significant issues in relation to the underlying capacity of the service to deliver the required demand, and this has been exacerbated by the rise in the waiting list due to the pandemic. An increase in consultant manpower is recommended, and this is linked to the Board's strategic aim of developing Regional Treatment Centres (RTC). The method of delivery is under discussion with the Welsh Government at present, and the options for expanding capacity in urology need to reflect the settled route for RTCs.

It is recommended a pan-North Wales improvement plan for urology would be put in place ahead of the College review, in part as a response to the PSOW public interest report, but fundamentally to enhance the quality of the service.

A number of actions are already in place or underway:

- An action plan was prepared in relation to the PSOW report from 2020.
- An initial action plan has been drafted in response to the wider PSOW review due to be published in September 2021.
- A revised process for the investigation of serious incidents, with direct Executive Director oversight
- The recruitment process is underway for the clinical lead in urology and a replacement consultant with an interest in robotic surgery.
- The Executive Team has agreed to proceed at risk with additional consultant appointments if suitable candidates are found during this recruitment process.
- It has been agreed that urology service will be an early participator in a Getting It Right First Time (GIRFT) review in November 2021

Goblygiadau Ariannol / Financial Implications

The service will be asked to produce a business case covering the regional area (a business case for the service in the East area is already in draft form). This will need to be developed in parallel with any RTC initiative.

This will need to interlock with the plans for RTCs, as part of the manpower cost is likely to overlap with this programme.

A number of urology patients are currently treated outside Wales, through outsourcing of activity to the independent sector and through local waiting list initiative activity.

An initial calculation suggests that to recover the backlog on the waiting list, it will be necessary to double the number of urology consultants in the system (12), with a potential cost of £1.5m - £2m. It is likely that some of this cost will sit with the RTC programme and within current spend for additional activity. The Executive Team has agreed to proceed with the recruitment of additional consultant staff.

A single service, with equality of access, would be promoted by the integration of the PAS across the three acute hospitals, which is underway, with completion expected in 2023/24, and this is within current capital and revenue plans.

Argymhelliad / Recommendations

The Committee is asked to:

- Support the commissioning of an external clinical review of urology services from the Royal College of Surgeons. The lead time for such a review is likely to be 6 months
- Approve the immediate establishment of a North Wales Improvement Plan for urology to assess standards, identify current good practice and gaps in practice, with executive leadership and QSE oversight.
- Note the development of a business case to achieve a sustainable capacity position, taking into account the backlog arising during the pandemic, and the potential for Regional Treatment Centres. In the interim the Board will proceed with additional clinical appointments
- Acknowledge that action plans have been developed in response to previous and current PSOW reports which will need to be refreshed.
- Note the recruitment actions being taken
- Support the progression of the GIRFT work

Dadansoddiad Risk / Risk Analysis

Sustainability of services - a minimum of four clinicians is required to safely provide a sustainable out of hours service. Four of the current twelve budgeted consultant posts are filled with locum staff. These locum positions are filled at risk as the incumbents could resign at short notice, thereby destabilising the service.

Financial - it is inefficient for the Health Board to outsource patient treatments. There are a significant number of cases being outsourced to manage the increasing waiting lists. A fully recruited team will be able to deliver the Planned Care delivery plan in a more cost efficient manner.

Reputation - an inability to provide a comprehensive urology service will discourage future applicants for posts. The Ombudsman has completed a number of investigations, including two public interest reports (one to be published shortly), with further investigation planned – these investigations, highlighting repeated concerns, will undermine the confidence of the community and clinicians in the service.

Opportunities foregone - should a medical and health sciences school be located in North Wales, opportunities for joint appointments will become possible, thereby making roles more attractive to prospective candidates.

Clear clinical leadership – the lack of leadership and clinical engagement is a barrier to the successful delivery of the improvement plan

Patient Experience – A thematic review of complaints has been undertaken and is included as Appendix 1. In total 335 complaints were reported in the 2 year period to June 2021. Of those logged 123 were formal complaints. Approximately half the complaints were logged in relation to the category of Access, Appointment, Admission, Transfer and Discharge.

Patient Safety - In total 450 incidents were reported in the same 2 year period. The largest groupings were pressure sores and falls, trips and falls. One incident was categorised as catastrophic and 9 as major.

Litigation - In total, 8 claims were closed over an 18 month period. Of these, 5 were discontinued in some way, 1 was settled (failure to remove urinary stent, delay in surgery) and 2 are currently under negotiation (failure to provide palliative pelvic radiotherapy, delay in diagnosing prostate cancer). There are 16 open claims.

Never Event - re-opening the never event investigation would be counter-productive. A number of actions were agreed and delivered. The separate external review made a recommendation in relation to team work and behaviour and is intended to be followed through outside the Serious Untoward Incident (SUI) process which dealt with clinically remedial issues. However, medical engagement in the investigation outcome remains a barrier to doing this effectively (in the context of how the investigation was undertaken) with the opportunity to dramatically learn and improve likely to be missed. The expectation is that the learning will need to be sufficient to effect behaviour and organisational culture within the specialty. This further reinforces the recommendation for an external, independent Royal College review to provide a robust, unquestionable foundation for future improvement.

A number of relevant risks exist on the risk register as follows:

ID	Title	Opened	Type	Risk level	Risk Rating	Last review	Next review
2902	There is a risk that secondary care will not be able to provide a major Urology Cancer service	Sep 19	Tier 2	High	9	Feb 21	May 21
2271	Urology surgical capacity	July 18	Tier 2	High	12	Aug 21	Oct 21
3993	Urology service has had a historical mismatch of capacity and demands	June 21	Tier 2	Undefined		tbc	
2904	Repeated failure of Urology Stack Theatre 10	Sep 19	Tier 3	Moderate	6	Aug 21	Nov 21

Risk 2902 is overdue for review, and this will be undertaken by 10 September 2021.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

It is clear the service is not meeting agreed Welsh Government standards. While magnified by the COVID pandemic, many of the issues and underlying factors existed prior to the pandemic.

The ongoing concerns indicate the service may not be meeting the Health and Care Standards for Wales, and an assessment of this would form part of any consideration for the terms of reference for an external review. In the immediate future, the pan North Wales improvement plan will need to address the current risks and mitigation.

Asesiad Effaith / Impact Assessment

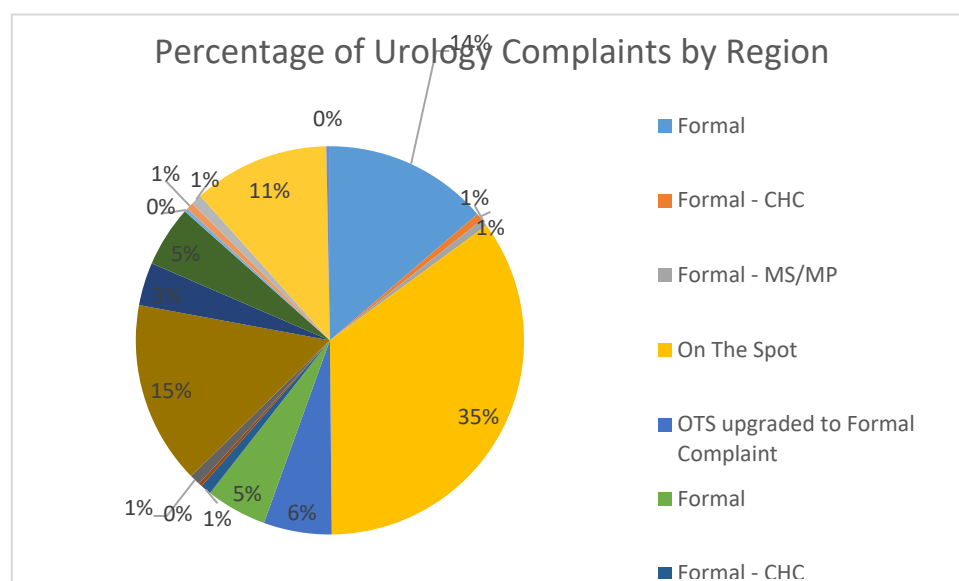
An impact assessment is not required for this paper.

Urology Complaints

Between 1st August 2019 and 31st July 2021 the Health Board received 335 complaints for Urology (Secondary).

Complaints by Region

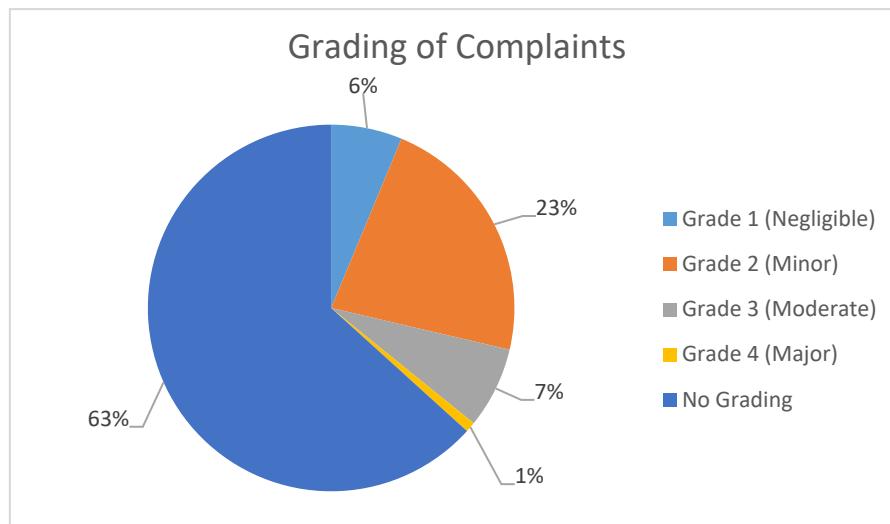
56% of complaints relating to Urology were in Central, 26% in East and 18% in West.



Grading of Complaint

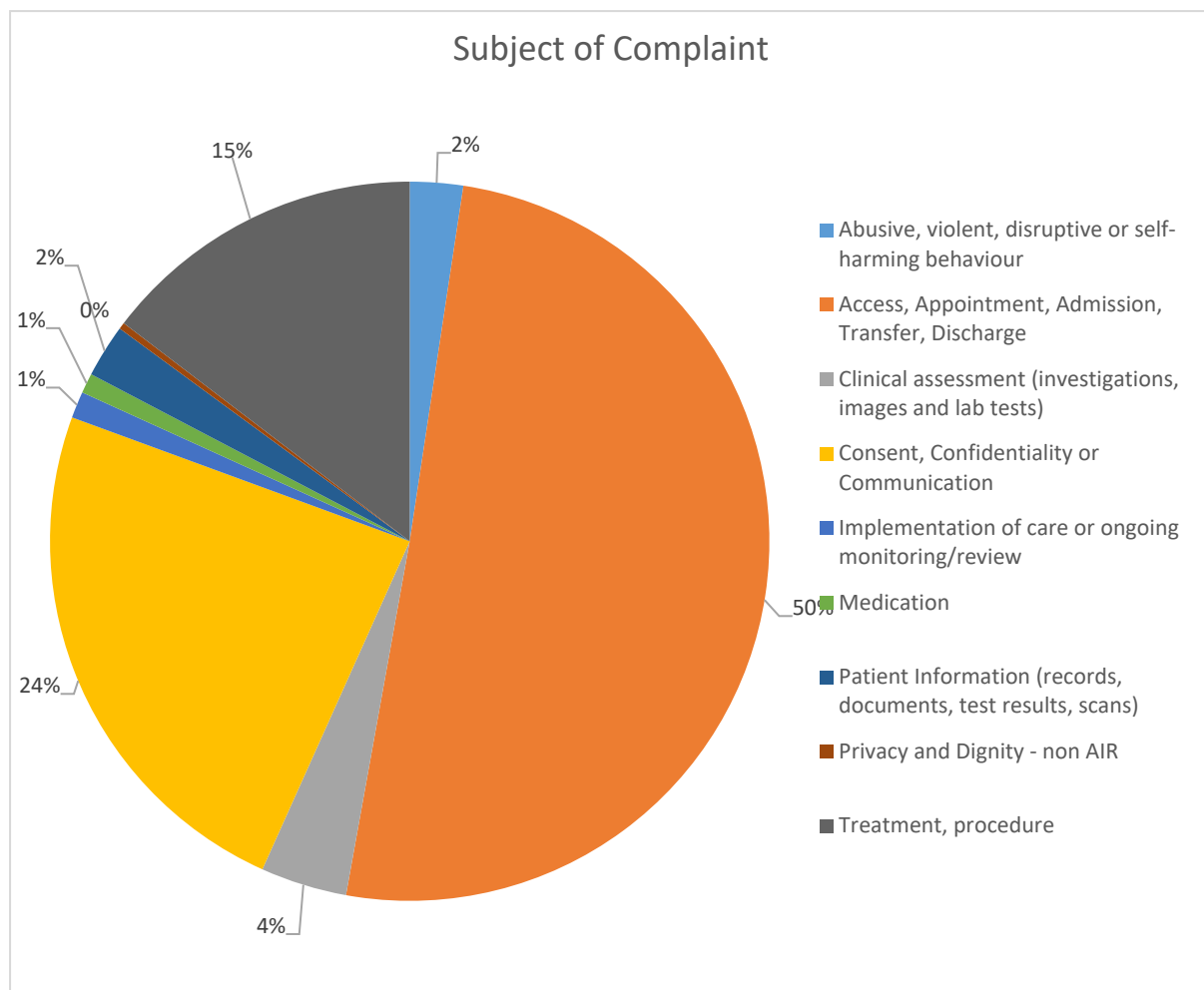
212 (63%) of the complaints received were resolved under the early resolution 'On the Spots'; and 123 (37%) were Formals.

Of the Formal complaints 21 (6%) were Grade 1s, 75 (23%) were Grade 2s and 24 (7%) were Grade 3s. There were 3 Grade 4 and no Grade 5 complaints.



Subject of Complaint

169 (51%) of the complaints received were in relation to Access, Appointment, Admission, Transfer or Discharge; 80 (30%) were in relation to Consent, Confidentiality or Communication; 49 (15%) were in relation to Treatment, Procedure

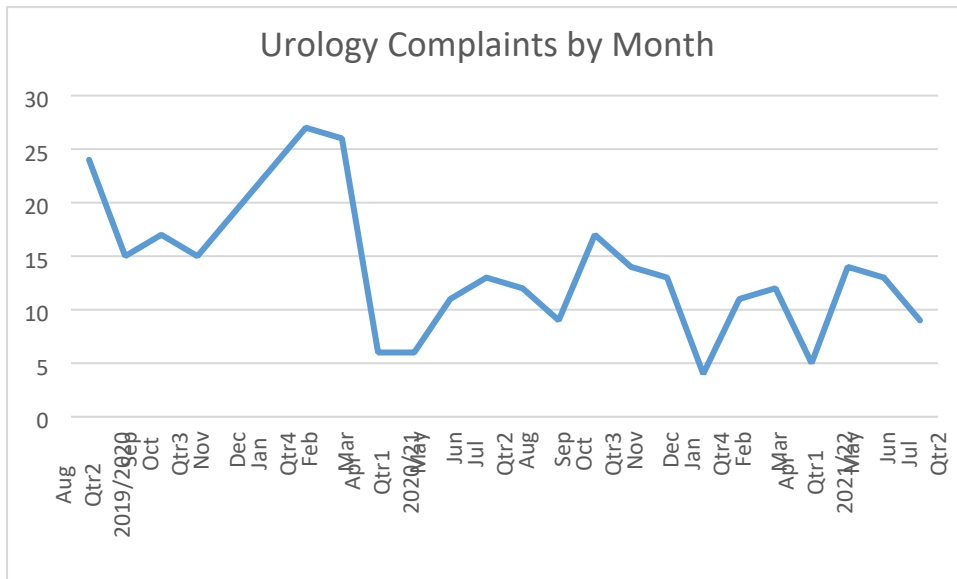


Sub-subject of Complaint

95 (28%) of the complaints were in relation to Unacceptable waiting time, Coordination of medical treatment; 61 (18%) were in relation to Communication with patient (other than consent issues); 30 (9%) were in relation to Coordination of medical treatment.

Trend line

In the period Aug 2019 to July 2021 there were an average of 14 complaints a month relating to Urology, with a range of 27 to 4. The period with the highest number of complaints was Quarter 4 2019/20 with an average of 25 complaints per month.

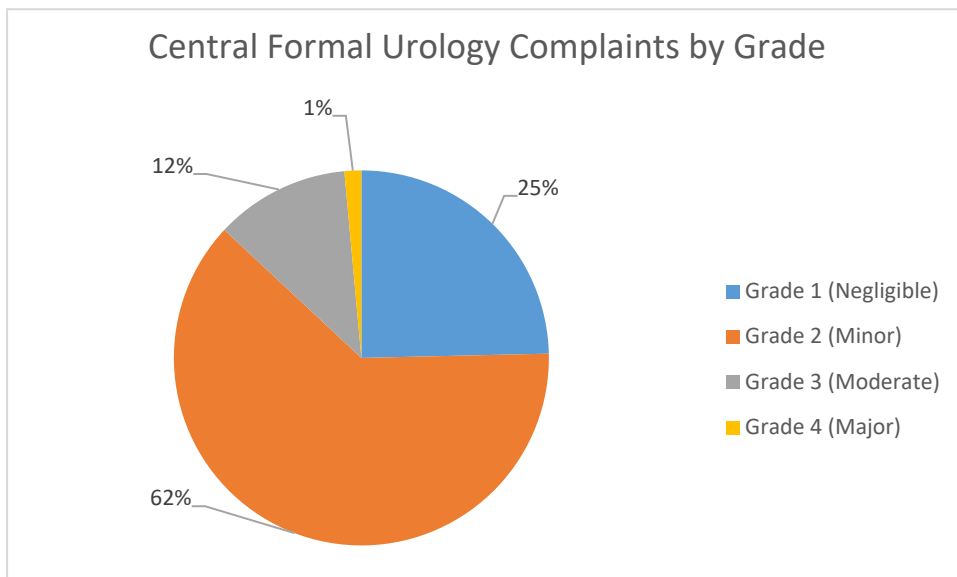


Central Urology Complaints

Of the 186 complaints relating to Central Urology, 117 (63%) were OTS and 69 (37%) were Formal complaints.

Grading of Complaint

Of the Formal complaints 17 (25%) were Grade 1s, 43 (62%) were Grade 2s and 8 (12%) were Grade 3s. There was 1 Grade 4 complaint.



Details of Grade 4 Complaint

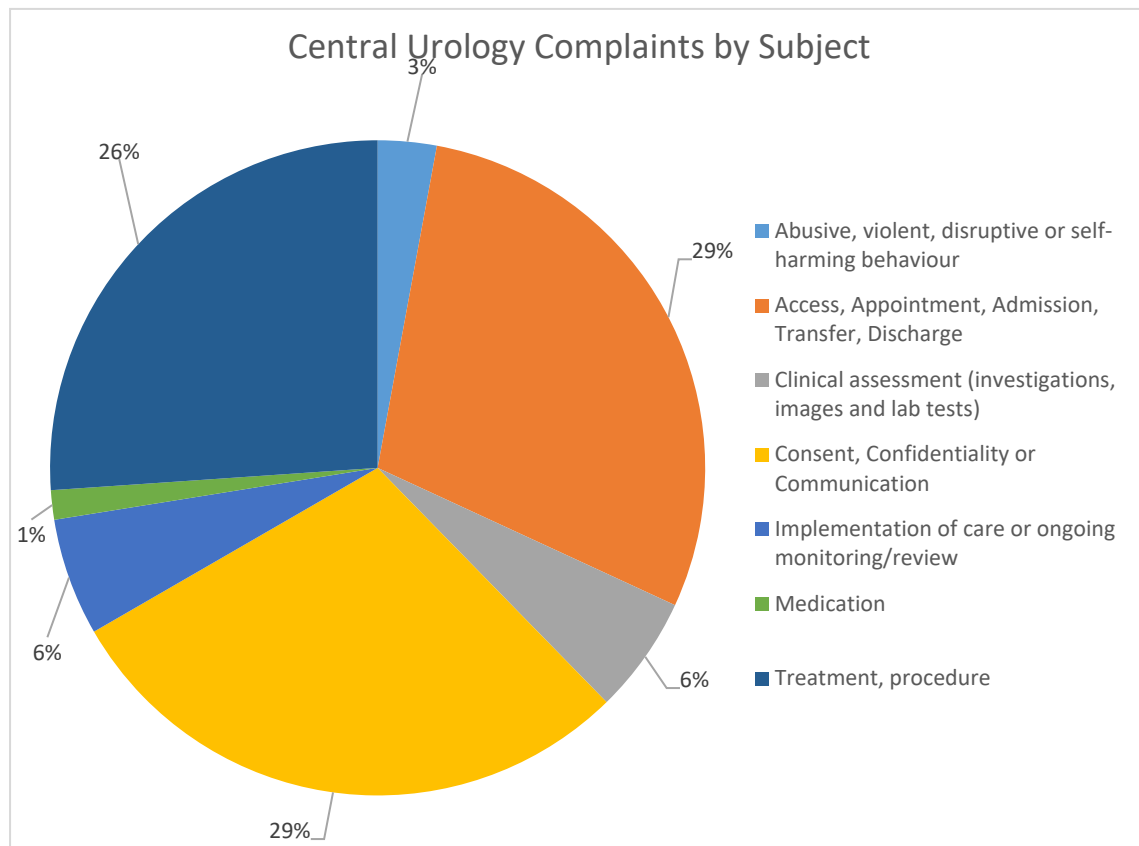
COM47645

Complaint regarding:

- Failure by the Health Board to take action following the discovery of a tumour in a CT scan on 31 March 2019, which led to a significant delay in diagnosis and treatment and was a breach in duty and care.
- Treatment provided by the Health Board at Glan Clwyd Hospital in September and October 2019 fell below a reasonable standard.
- Incorrect diagnosis of Urachal Tumour by the Health Board.

Subject of Complaint

20 (29%) were in relation to Access, Appointment, Admission, Transfer or Discharge; 20 (29%) were in relation to Consent, Confidentiality or Communication; and 18 (26%) of the complaints received were in relation to Treatment, Procedure



Examples:

Access, Appointment, Admission, Transfer or Discharge

Complainant very angry regarding the delay in her husband's urology template biopsy after being diagnosed with Grade 5 Cancer. She referred to Hospital guidelines for appointments and said it is already double what it should be. Would be willing to go anywhere across the UK to have it.

Consent, Confidentiality or Communication

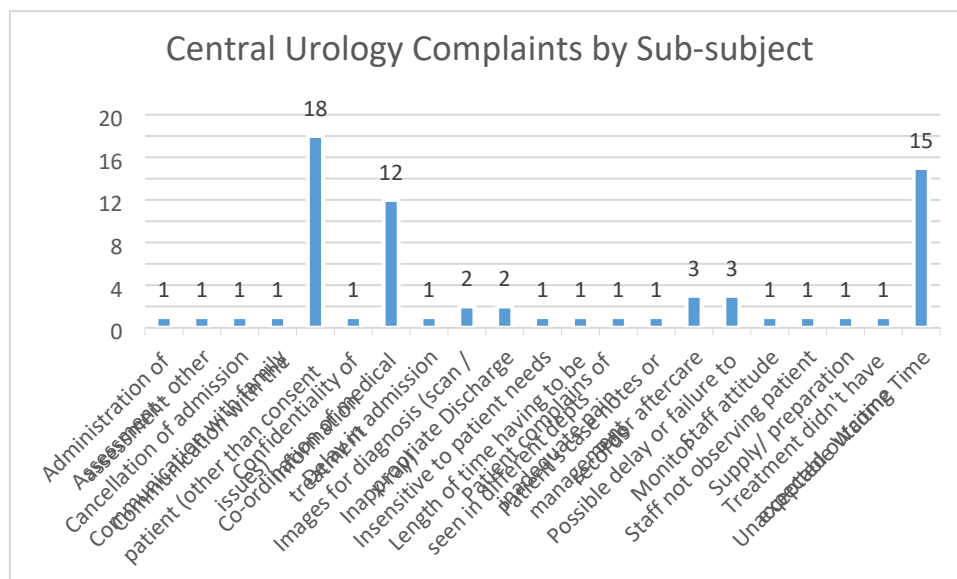
Complainant unhappy about his wife being told about her having cancer whilst having a cystoscopy procedure. She was told this without her husband in attendance, was dealt with insensitively and has had no information or follow up other than to be told she would hear something 'after Christmas'.

Treatment, Procedure

Complainant unhappy about the delay in seeing Urology to have his catheter removed and blames this on his current problems. Has been promised an urgent prostate scraping procedure to help resolve his problems but has now been told it will be at least 6 months. Would like to know why this has happened and if he can have it quicker as we're to blame.

Sub-subject of Complaint

18 (26%) of the complaints were in relation to Communication with patient (other than consent issues); 15 (22%) were in relation to Unacceptable Waiting Time and 12 (17%) were in relation to Coordination of medical treatment



Examples:

Communication with Patient

Patient is reported to have a rare Urinary retention issue called Fowler's Syndrome. Fowler's Syndrome is a cause of urinary retention (inability to pass water normally) in young women. The patient was expecting to be referred to the Fowler's department in London to confirm/dismiss diagnosis. This does not seem to have taken place yet. Would like the following answered: A clear answer of what is wrong with her and appropriate treatment in a timely manner

Unacceptable Waiting Time

Patient received a kidney cancer diagnosis on 5th February and was told would be in hospital to remove the kidney within 2-3 weeks and has heard nothing. Wife rang Consultant's secretary who advised would leave the notes out for Consultant but have heard nothing.

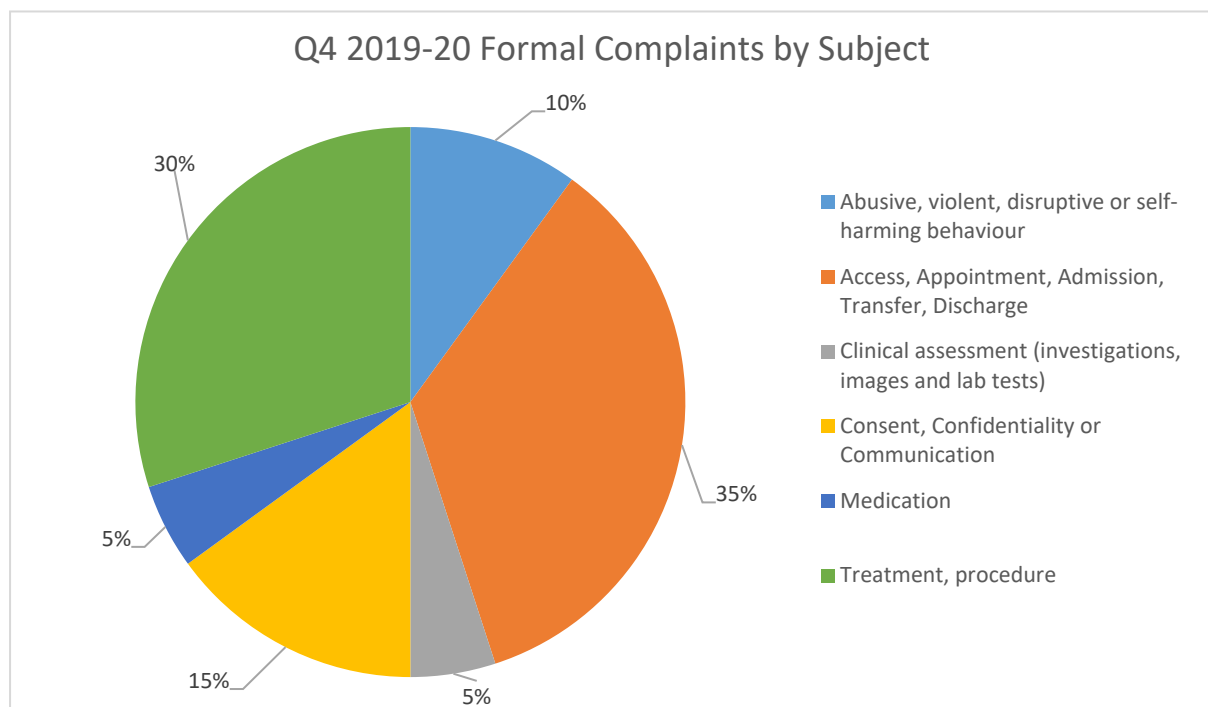
Coordination of Medical Treatment

Patient attended at DOSA urology, awoke to 2 intravenous drips and was told one would be antibiotics. However, neither were antibiotics and he notes had not been written up to reflect this so it was missed. He is now very anxious as he is hasn't had any antibiotics and wants our help.

Quarter 4 2019-20

There were 76 Urology complaints received in Quarter 4 2019-20. Of these 55 (72%) related to Central, 15 (20%) related to East and 6 (8%) related to West. Of the Central complaints 15 (27%) were Formal complaints and 40 (73%) were OTS. Of the East complaints 5 (33%) were Formal complaints and 67% were OTS. All the West complaints were OTS.

Of the 20 Formal Urology complaints received in Quarter 4 2019-20, 7 (35%) related to Access, Appointment, Admission, Transfer or Discharge, 6 (30%) related to Treatment, Procedure and 3 (15%) related to Consent, Confidentiality or Communication.



Of the 20 Formal complaints received in Q4 2019/20 5 (25%) related to Unacceptable Waiting Time, 4 (20%) related to Co-ordination of Medical Treatment and 3 (15%) related to Communication with patient (other than consent issues).



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Three Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery						
Awdur yr Adroddiad Report Author:	Debra Hickman, Secondary Care Nurse Director Alison Griffiths, Associate Director of Nursing Workforce						
Craffu blaenorol: Prior Scrutiny:	<p>The designated person has the responsibility of presenting an Annual Assurance report to the Board.</p> <p>Staffing Breaches and Harms reported via the Patient Safety Quality Group with escalation of significant issues reported via Quality, Safety and Experience Committee (QSE).</p> <p>Both the Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act 2016 and caveated Three Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016 were presented to QSE on 4th May 2021 and the Health Board on 20th May 2021 utilising the All Wales templates.</p>						
Atodiadau Appendices:	Appendix 1 –Three Year Assurance Report						
Argymhelliad / Recommendation:							
Committee are asked to:							
<ol style="list-style-type: none"> 1. Note the updated report of the Triennial Nurse staffing report with updates from closed investigations for the 2020/21 reporting period. 2. Continue to support the ongoing recruitment and retention initiatives already in progress. 3. Note Paediatric requirements in line with the revisions to the Nurse Staffing levels (Wales) Act are subject to a separate report and business case once triangulated reviews are complete 							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
In line with the All Wales approach provide assurance to the Health Board with regards to the compliance with the Nurse Staffing Levels (Wales) Act 2016 where by any associated harms are as a result of breaches in Nurse staffing establishments and actions taken to mitigate any risk identified.							

Cefndir / Background:

The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to ensure sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive Lead approves Nurse Staffing reviews ahead of presentation to the Board, having delegated the operational activity as outlined in the Act and referenced in the Health Board's Nurse Staffing policy to the Secondary Care Nurse Director. As part of the triangulated approach special consideration is given to those quality indicators that are particularly sensitive to care provided by a Nurse: Patient falls with serious harm (levels 4&5), Pressure Ulcers with serious harm (grade 3&4), serious Medication Never Events and Complaints associated to Nurse staffing and Nursing care.

The report contains the finalised triennial report, which aggregates the 3 annual reports from the reporting period 5th April 2018 – 6th April 2021, using the All Wales reporting template. This is a statutory requirement of the Nurse Staffing Levels (Wales) Act 2016.

The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric workstream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatients.

The BCUHB Paediatric Nurse Staffing Levels (Wales) Act Implementation Group convened in October 2020 and has been meeting on a monthly basis. Group membership includes Children's Wards Nursing staff, Ward Managers, Matrons and Heads of Children's Nursing, along with Area Director of Nursing, Associate Director for Professional Regulation, Workforce, Finance and Informatics with support as required from the National Project Lead.

Asesiad / Assessment & Analysis

All staffing reviews have been undertaken in line with the Act as referenced in the Health Board's Nurse Staffing policy. These have all been reviewed and approved by the Executive Director of Nursing and Midwifery and presented to the Health Board's designated committee in line with the All Wales reporting calendar.

We can confirm mitigating actions have been taken to ensure safe compliance on our Inpatient Adult Acute Medical and Surgical wards, these are referenced in the Health Board Safe Care system. However, we recognise our vacancy levels across the Health Board remain a significant challenge with work ongoing to affect these positively with a range of initiatives in progress.

The challenge associated with the Covid 19 pandemic, existing vacancy rates and variable skill mix cannot be under estimated. The competency, skill and experience of the Nurses providing care to patients remains a crucial and influential component in the calculation of Nurse staffing. The appointment of new graduates via the streamlining process has been a success but the skill mix on many wards identified the need for additional registrants to provide supervision and practice development and/or Health Care Support Workers (HCSW) due to the higher acuity/dependency of patient cohorts. As the skill mix improves, it is anticipated that the bi annual calculation will reflect this.

There have been increases in Registered Nurse (RN) establishments required over the reporting periods. A reduction in staffing requirements during the 3 year period due to a major refurbishment on the Ysbyty Glan Clwyd (YGC) site that came to completion in 2018 saw ward capacity reducing from 28 beds to 24 across the majority of its inpatient areas. Respectively for Ysbyty Wrexham Maelor (YWM) inclusion of assessment areas in the 2018/19 to the 2019/20 reporting period. Respectively for Ysbyty Gwynedd (YG) due to skill mix changes in the 2018-2019 reporting baseline period.

In 2019/2020 the staffing establishments included escalation beds that had been escalated for the last 12 months plus.

In 2020/2021 we have seen a reduction in both RNs and HCSWs which is due to the repurposing of wards due to COVID 19 requirements and therefore exclusion from reporting at the point of time of the establishment reviews being completed.

Significant recruitment has been undertaken (both substantive and temporary) as part of the organisational response to the COVID 19 pandemic preparation and also the COVID 19 vaccination programme.

In preparation the Health Board also provided a range of upskilling opportunities for nursing teams, non-clinical staff, allied health professionals and public volunteers which further facilitated the Health Board's response to the first wave of the unprecedented COVID 19 pandemic which has then continued throughout with support from our University colleagues.

Staffing reviews have evolved during the reporting triennial period and now involve a pan-Health Board compare, contrast and professional challenge session involving senior site level and service level representation, peers and external support.

Surge plans were developed in response to the COVID pandemic data modelling issued by Welsh Government, these were monitored alongside actual data and amended accordingly reflecting the staffing position in the Health Board.

The 2021 review and comparisons with previous reviews should be noted with caution due to the number and frequency of wards being repurposed throughout the pandemic and a reduction in bed numbers to ensure social distancing.

However, in the absence of National Acuity data for the Spring 2021 review as per other reviews, evidence available from professional judgement, peer review and safe care suggests themes of patients requiring higher levels of observation due to complex care requirements e.g. cognitive impairment and physical dependency. There has also been an additional impact due to the increase of segregation requirements to ensure patients are appropriately cared for in line with COVID 19 infection prevention guidance and the addition of the Enfys Deeside to support capacity and flow at times of extreme demand.

There is also a further emerging pressure on inpatient registered Nurse staffing with the requirement to further enhance separation of the inpatient elective pathway, this impact was assessed and recommendations made as part of the staffing review. Also acknowledged is the additional requirements to allow safe donning and doffing during care delivery to patients and the requirement to ensure appropriate fit testing of staff and the impact of COVID 19 on staff themselves with

particular note to that of sickness, health and wellbeing and maintaining resilience to deal with all challenges the pandemic presented.

Harms, as referenced in the Act, have been subject to an incident review 'make it safe' process, learning has informed the work undertaken using the quality improvement collaborates led by the Nursing Quality Team. This work is ongoing and is currently being reenergised with the additional learning acquired during the COVID 19 pandemic. It should be noted that reporting to Welsh Government was reduced during surge periods during the COVID 19 pandemic.

Comparative data between reporting periods shows a decline in incidents between the first and second annual reports for Hospital Associated Pressures Ulcers (HAPUs) and falls with serious harm. The increase of HAPUs for YG between year 2 and year 3 was due to a backlog of completion of 'make it safe' incident reviews. Please note, the HAPUs that occurred during year 2 were fully reported at the time and an initial review was undertaken, all HAPUs that were not closed were captured and reported within the next reporting period. Therefore averaging over the 2year reporting periods of 2019/20 and 202/21.

There is an increase in falls reported, on review none were directly linked to staffing shortages however, we recognise the challenges in increased temporary workforce reliance, an increase in acuity and dependency of patients as well as recognising the challenges associated with isolation and segregation to minimise the risks associated with Covid 19 transmission which constricted line of sight in some areas.

The number of medication incidents and complaints are too small to make a statistical analysis.

An action plan was devised to ensure readiness for the extension of the Act to paediatrics in October this year, 2021, ensuring national milestones are met. Staff have been familiarising themselves with the methodology as the Paediatric Welsh Levels of Care are already well embedded. Both acuity and staffing data is collected daily basis and validated through the Senior Nursing teams to ensure consistency across the Health Board.

Staffing calculations are currently being reviewed using a triangulated approach for all our paediatric inpatient areas in readiness for presentation to the Health Board in September 2021. Following this, biannual calculations will be undertaken in line with the Adult Acute Surgical and Medical Inpatient areas as defined in Section 25B.

A case to support any necessary increase in paediatric staffing levels is currently being developed to reflect the requirements of the Act. It should be acknowledged that it may not be possible to fully meet revised staffing establishments at the point of extension of the Act in October 2021 due to gaps in workforce availability. Paediatric escalation plans and business continuity plans have also been reviewed to ensure appropriate mechanisms are in place to meet staffing requirements in the interim period.

Future commissioning of Nurse education placements has taken in to account the potential requirements for additional staffing to meet the requirements of the extension of the Act. Work is ongoing to operationalise reporting arrangements to meet the requirements of the Act and will be completed prior to October 2021.

Goblygiadau Strategol / Strategy Implications

Inability to provide appropriate Nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Board's ability to deliver healthcare effectively. One of the most significant challenges of the Covid 19 pandemic was/is making sure there are enough Nurses to deliver care sensitively. The joint statement issued by the Chief Nursing Officer (CNO) / professional bodies outlined the expectations of meeting the Nurse Staffing Levels (Wales) Act 2016 requirements within the reality of an abnormal emerging situation using clinical judgment, applying core principles to assess risk and maintain professional standards.

Opsiynau a ystyriwyd / Options considered

Ongoing analysis of recruitment and retention plans.

Improvement collaborates under review as part of the Health Board's Quality Improvement approach.

Goblygiadau Ariannol / Financial Implications

IT support required for real time data to inform early warning approach to quality improvement.

Changes to the Nurse-staffing establishment's in-line with the triangulated approach as determined within the Act.

Escalation capacity of which is unfunded and therefore does not support the Nurse staffing establishment.

Focus on dedicated recruitment & retention work programme and additional resource to deliver.

Dadansoddiad Risk / Risk Analysis

BAF 21-19 Impact of Covid 19

There is a risk that the ongoing Covid-19 pandemic will lead to the Health Board 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 Test, Trace & Protect (TTP); and the Health Board's ability to deliver its plans and corporate priorities.

Corporate Risk Register 21-13: Nurse staffing (Continuity of service may be compromised due to a diminishing Nurse workforce)

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic. This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Nurse staff Calculations are presented annually to the Health Board. Changes to ward establishments outside of the Biannual Calculation are approved by the Executive Director of Nursing.

Asesiad Effaith / Impact Assessment

Undertaken as part of the Biannual calculations.

Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government	
APPENDIX 1	
Health board	Betsi Cadwaladr University Health Board
Reporting period	<p>The reporting period is 6th April 2018 - 5th April 2021.</p> <p>Please note: An initial caveated Three-yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act went to Board in May 2021, however due to the timeframe for closing serious incident reports the caveated version only included data relating to serious incidents closed by 28th February 2021.</p> <p>This report is the final version of the Three-yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act and includes all serious incident reports that occurred prior to April 5th 2021.</p>
Requirements of Section 25A	<p>The Health Board under section 25A of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to ensure there are sufficient nurses in all settings, including when services are commissioned from a third party. Furthermore, under section 25A of the Act the Health Board is required to ensure robust workforce plans, recruitment strategies, and appropriate structures and processes are in place to ensure appropriate Nurse staffing levels across the whole organisation.</p> <p>This report will proceed to demarcate the wards that come under Section 25B of the Nurse Staffing Levels (Wales) Act¹ and are subject to bi-annual reviews, however in line with the requirements of Section 25A a calendar of reviews are also undertaken for all areas to ensure there are sufficient Nurses to provide timely and patient sensitive care across all Health Board settings.</p> <p>The Director of Nursing for each of their areas of responsibility leads the local review in collaboration with the Heads of Nursing, Directorate Matrons, Ward Sister/Manager, and senior colleagues from Workforce and Finance departments. A Health Board wide review is then subsequently undertaken, led by the Secondary Care Nurse Director, to ensure a consistent Health Board wide approach is adopted. A Health Board wide position with regards to Nurse staffing levels is subsequently presented to the Executive Director of</p>

¹ Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to acute medical and acute surgical inpatient wards. Excluded from the definition of Section 25B wards is Outpatient departments, admission portals/assessment units, critical care/high dependency units, day case areas, rehabilitation areas, theatres, procedural units, coronary care units

Nursing and Midwifery as the confirmed designated person² and on approval, this is formally presented to the designated Committee/ Board.

The process for review is outlined in the Health Boards Nurse staffing policy <http://howis.wales.nhs.uk/sitesplus/861/page/48259>.

Please note: In the reporting period of 2020/2021 the Health Board was informed regards COVID 19 pandemic impact. As part of the pandemic planning the Health Board was required to consider the repurposing requirements of wards to support pandemic surge activity, in addition to nurse staffing ratios and skill mix requirements in order to maintain services. The acuity audits required to inform bi-annual establishment reviews were deferred. Nurse staffing reviews however proceeded during this time, dynamic in nature with a requirement to respond to the changing capacity demands and the clinical needs of patients. In preparation for the first wave of COVID 19, surge plans were developed and daily staffing deployment meetings were introduced in order to respond to the fluid situation presented. Reporting governance structures were via the Executive led Incident Management Team.

	2018/2019	2019/2020	2020/2021
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	2 nd May 2019	23 rd July 2020	4 th May 2021
Number of adult acute <u>medical</u> inpatient wards where section 25B applies	Ysbyty Glan Clwyd (YGC) 7 Ysbyty Wrexham Maelor (YWM) 7 Ysbyty Gwynedd (YG) 7 – became 8 in quarter 3 Annual report 2018 2019	YGC 8 YWM 9 YG 7 Annual report 2019 2020	YGC 8 YWM 9 YG 7 Annual report 2020 2021

² The designated person must act within the Health Boards governance framework authorising that person to undertake the nurse staffing calculation on behalf of the Health Boards Chief Executive Officer. In view of the requirement to exercise nursing professional judgement, the designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment, such as the Executive Director of Nursing and Midwifery.

Number of adult acute <u>surgical</u> inpatient wards where section 25B applies	YGC 6 YWM 6 YG 5	YGC 5 YWM 4 YG 4	YGC 4 YWM 4 YG 3
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	YGC 3 YWM 0 YG 2	Due to the Covid 19 pandemic the structured approach to the bi-annual Nurse staffing level reviews was interrupted. Therefore, the calculations were undertaken in addition/outside of the bi-annual calculation cycle as detailed below: YGC 9 YWM 11 YG 5	Due to the ongoing Covid 19 pandemic the structured approach to the bi-annual Nurse staffing level reviews was interrupted. Therefore, the calculations were undertaken in addition/outside of the bi-annual calculation cycle as detailed below: YWM 4 YG 3 YGC 11
Changing the purpose of the adult acute medical and surgical wards to support the management of COVID or opening new COVID wards.	Not applicable	YGC 2019-2020 Ward 1 Medical – April 2020 – May 2020 Ward 2 Medical – April 2020 – May 2020 Ward 9 Medical – March 2020 – May 2020 Ward 11 Medical – March 2020 – June 2020 Ward 12 Medical – March 2020 – May 2020 Ward 5 Surgical – April 2020 – May 2020 Ward 6 (Abergele Hospital) Surgical – March 2020 – ward closed as elective orthopaedic service was suspended to enable pandemic planning. Staff were redeployed to the YGC site. This ward remained closed for the duration of this reporting period. The ward re-opened to elective orthopaedic services on the 16 th August 2021 and will be reported within the requirements of section 25B in 2021/2022 reporting period.	YGC 2020-2021 Ward 1 Medical – December 2020 – April 2021 Ward 2 Medical – December 2020 – April 2021 Ward 4 Medical – December 2020 – April 2021 Ward 9 Medical – December 2020 – April 2021 Ward 12 Medical – December 2020 – March 2021 DOSA Medical – December 2020 – May 2021 YWM 2020-2021 Evington Medical – October 2020 – March 2021 Erddig Medical – April 2020 (from 6 th) – September 2020 Bromfield Medical – March 2020 – transferred to Women's Services Bonney Medical – April 2020 – April 2021 ENT Surgical – December 2020 – March 2021 Prince of Wales Surgical – October 2020 + January 2021 – March 2021

		<p>YWM 2019-2020</p> <p>Mason Medical – April 2020 – June 2020</p> <p>Erddig Medical – April 2020 (up to 5th) – September 2020</p> <p>Bonney Medical – April 2020 – April 2021</p> <p>Prince of Wales (27 funded) Surgical – March 2020 – August 2020</p> <p>YG 2019-2020</p> <p>Aran Medical – April 2020 – continues to date as designated Covid ward</p> <p>Dulas Surgical – April 2020 (up to 5th) – February 2021</p> <p>Enlli Surgical – April 2020 – continues to date as designated Covid high care area</p>	<p>YG 2020-2021</p> <p>Aran Medical – April 2020 - continues to date as designated Covid ward</p> <p>Moelwyn Medical – April 2020 – continues to date as high care non Covid</p> <p>Dulas Surgical – April 2020 (from 6th) – February 2021</p> <p>Ogwen Surgical – April 2020 – March 2021</p>
	<ul style="list-style-type: none"> • Dependency, occupancy and acuity data is collected on a shift-by-shift basis (typically 3 times a day). The Nurse in charge/shift lead enters the data into the Health Boards designated software system <i>SafeCare Allocate</i>³. This information assists in the dynamic assessment of staffing on a shift by shift basis and records the mitigating actions taken to ensure the delivery of timely, patient sensitive care. A record of the mitigating actions undertaken provides supporting evidence of staffing management. • In preparation for the first wave of the COVID 19 pandemic surge plans were developed. A number of Section 25B acute inpatient wards were identified for repurpose in the planning stage of the pandemic in order to adhere to infection prevention and control requirements; to ensure that patients with the highest care needs were in a physical environment that was suitable; and to ensure the availability nursing staff with the necessary skills to care for patients requiring Aerosol Generating Procedures (AGP)⁴. Dynamic decisions have been taken throughout these unprecedented times regarding the repurpose of wards to ensure patients receive the right care, in the right place at the right time. The pandemic demand remains fluid. The wards that have been repurposed have been subject to a review outside of the biannual calculation cycle and nurse staffing plans have been outlined in SBAR format to the Board, and subsequently agreed. • Surge plans described above also indicated additional suitable capacity provisions available across the Health Board in existing estate. A separate Executive group undertook the oversight of the development of additional temporary surge capacity in 		

³ SafeCare Allocate is a daily staffing software system that matches real time nurse staffing levels to patient acuity enabling informed decision making on staffing levels across a hospital. It enables to visibility of staff to support deployment of resource in addition to the recording of red flags and professional judgement.

⁴ AGP is a medical procedure that can result in the release of airborne particles - these types of procedures are associated with the increased risk of respiratory COVID 19 transmission. Examples of these procedures include manual ventilation, tracheal intubation and exubation, tracheostomy care, respiratory suctioning, Non –invasive ventilation (NIV), CPAP, high flow nasal oxygen

	partnership with key stakeholders. It should be noted that throughout pandemic planning a significant defining factor has been that of staffing.
The process and methodology used to inform the triangulated approach	<p>Recognising that not all patients needs will be the same, a triangulated method to calculate the appropriate Nurse staffing levels is used. This triangulated approach considers patient acuity, quality indicators, and professional judgement. National guidance and best practice evidence is also taken into account when undertaking a review in care areas outside of Section 25B e.g. Critical Care, Coronary Care, Theatres</p> <p>The process and methodology used to inform the triangulated approach in calculating Nurse staffing levels at Betsi Cadwaladr University Health Board has three steps:</p> <p>Step 1: The Site Director of Nursing leads the review to calculate Nurse staffing levels in collaboration with the Heads of Nursing, Directorate Matrons, Ward Sister/Manager, and senior colleagues from Workforce and Finance. The review is informed by both qualitative and quantitative information:</p> <ul style="list-style-type: none"> ➤ Acuity data - acuity is measured by using an evidence-based workforce planning tool Welsh Levels of Care⁵. Although the SafeCare Allocate system captures acuity data on a shift by shift basis, formal Acuity Audits are undertaken every 6 months (January and June) in all wards where section 25B of the Act applies⁶. This audit data is reviewed and validated by the Site Nurse Director, Head of Nursing, Matron and Ward Manager prior to final sign off and subsequent publication (Visualiser) by HEIW. An increased level of acuity on wards may require a greater number of nursing staff to safely manage the clinical area, and sensitively care for the patients. Factors such as escalation beds, increases in demand and activity, and the national focus are also considered. ➤ Professional judgement – the Site Nurse Director in conjunction with relevant Head of Nursing, Matron and Ward Manager use their knowledge of the clinical area plus the evidence from the acuity audit to make an informed decision regarding the calculation of nurse staffing levels. ➤ Quality Indicators – the review also considers quality indicators that are particularly sensitive to care provided only by a Nurse. The quality indicators have been shown to have an association with low staffing levels and must be reported on are <i>Patient falls</i> - any fall that a patient has experienced whilst on the ward; <i>Pressure ulcers</i> - total number of hospital acquired pressure ulcers considered to have developed while a patient on the ward; <i>Medication errors</i> - any error in the preparation, administration or omission of medication by Nursing staff (this includes medication related never events). <p>Step 2: A Health Board wide review is undertaken, taking into account national guidance and best practice evidence, and led by the Secondary Care Nurse Director to ensure a consistent Health Board wide approach.</p>

⁵ The Welsh Levels of Care consists of 5 levels of acuity ranging from; Level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis, down to Level 1 where the patients condition is stable and predictable, requiring routine nursing care.

⁶ Acuity audits in January 2021 were deferred due to pandemic demand and activity

Step 3: A Health Board wide position with regards to Nurse staffing levels is subsequently presented to the Executive Director of Nursing and Midwifery as the confirmed designated person⁷ and on approval, this is formally presented to the Board.

For audit purposes, each ward completes the designated proforma available within the 'Nurse Staffing Levels (Wales) Act 2016' Operational Guidance as evidence and to ensure consistency and transparency.

All Nurse staffing establishments have a 26.9% uplift applied to the registered nurse (RN) establishment, and 22% applied to the Health Care Support Worker (HCSW) establishment to ensure there are sufficient numbers of nursing staff to cover periods of absences such as annual leave, study leave/training, and sickness. Band 7 Ward Managers/Sisters are supernumerary and not included in the care delivery numbers for their respective ward areas. The electronic rostering system used within the Health Board captures times when the Ward Manager/Sister has needed to be included in the nursing numbers in order to support care delivery.

Staffing review outcomes have been presented to the Board on 1st November 2018 and subsequently presented to the designated Health Board committee QSE 19th November 2019 and 3rd November 2020. The presentations have included the Nurse staffing requirements for each of the designated wards, together with the rationale and recommendations.

The process for review is outlined in the Health Boards Nurse staffing policy <http://howis.wales.nhs.uk/sitesplus/861/page/48259>

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

		2017/2018			2018/19	2019/20*	2020/21
Extent to which the required establishment has been maintained within wards under section 25B	Required establishment (WTE) of S25B wards prior to commencement of the Acts second duty (March 2018)	RN				*For noting the annual report presented to the Health Board 2019/2020 reported headcount as opposed to WTE. The figures have been calculated accordingly and reflected below as WTE.	
		YGC	YWM	YG			
		225.5	218.3	222.2			
		Total: 666					
		HCSW					

⁷ The designated person must act within the Health Boards governance framework authorising that person to undertake the nurse staffing calculation on behalf of the Health Boards Chief Executive Officer. In view of the requirement to exercise nursing professional judgement, the designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment, such as the Executive Director of Nursing and Midwifery.

			YGC	YWM	YG							
			183.3	131.3	153.8							
			Total: 468.4									
	Required establishment (WTE) of S25B wards calculated during first cycle (May)	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			238.5	230.3	234.2	268.01	280.69	250.42	269.87	230.12	208.05	
			Total: 703			Total: 799.12			Total: 708.04			
		HCSW:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			183.3	131.3	153.8	186.21	172.27	172.17	210.27	160.99	144.09	
			Total: 468.4			Total: 530.65			Total: 515.35			
	WTE of required establishment of S25B wards funded following first (May) calculation cycle	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			324.34	287.04	224.67	271.95	287.53	236.13	292.32	272.51	233.69	
			Total: 836.05			Total: 795.61			Total: 798.52			
		HCSW:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			234.93	160.02	174.08	195.6	168.78	163.56	204.87	195.45	166.39	
			Total: 569.03			Total: 527.94			Total: 566.71			
	Required establishment (WTE) of S25B wards calculated during second cycle (Nov)	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			229	252.83	251.34	268.01	288.37	250.21	244.31	261.34	231.08	
			Total: 733.17			Total: 806.59			Total: 736.73			
		HCSW:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			166.64	145.68	156.52	180.98	182.11	172.17	191.29	202.21	180.54	
			Total: 468.84			Total: 535.26			Total: 574.04			
	WTE of required establishment of S25B wards funded following second (Nov) calculation cycle	RN:	YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG	
			324.67	285.50	236.13	290.48	266.22	235.74	292.32	272.71	234.51	
Total: 846.30			Total: 792.44			Total: 799.54						
HCSW:		YGC	YWM	YG	YGC	YWM	YG	YGC	YWM	YG		
		226.12	167.74	163.56	204.65	160.41	165.71	204.87	196.45	165.39		
		Total: 557.42			Total: 530.77			Total: 566.71				
Accompanying narrative:												
One of the most significant challenges of the Covid 19 pandemic has been making sure there are enough Nurses to deliver timely and sensitive care. The joint statement issued by the CNO / Professional bodies outlined the expectations of meeting the Nurse Staffing Levels (Wales) Act 2016.												
The Health Board has implemented new ways of working and models of care in order to respond and meet the extreme and unprecedented pressures that were experienced at the end of the reporting period in March/April 2021. This has required an extremely flexible approach to the deployment of the nursing workforce across Health Board sites and some wards have been repurposed more												

than once to accommodate the clinical demands. Where there has been a change to ward purpose or a new service commissioned the process for undertaking Nurse staffing reviews has applied the same triangulated methodology to ensure consistency.

The challenge associated with the Covid 19 pandemic, existing vacancy rates and variable skill mix cannot be under estimated. The competency, skill and experience of the Nurses providing care to patients remains a crucial and influential component in the calculation of Nurse staffing. The appointment of new graduates via the streamlining process has been a success but the skill mix on many wards identified the need for additional registrants to provide supervision and practice development and/or HCSW due to the higher acuity/dependency of patient cohorts. As the skill mix improves, it is anticipated that the bi annual calculation will reflect this.

There have been increases in RN establishments required over the reporting periods. A reduction in staffing requirements during the 3 year period due to a major refurbishment on the YGC site that came to completion in 2018 saw ward capacity reducing from 28 beds to 24 across the majority of its inpatient areas.

Respectively for YWM inclusion of assessment areas in the 2018/19 to the 2019/20 reporting period.

Respectively for YG due to skill mix changes in the 2018-2019 reporting baseline period.

In 2019/2020 the staffing establishments included escalation beds that had been escalated for the last 12 months plus.

In 2020/2021 we have seen a reduction in both RN's and HCSW's which is due to the repurposing of wards due to COVID 19 requirements and therefore exclusion from reporting at the point of time of the establishment reviews being completed.

To support ongoing recruitment and retention initiatives, provide a level of stability and look to further strengthen clinical leadership, particularly in the more difficult to recruit to wards revisions were made to skill mix. To provide further stability within the Nursing workforce and provide a further route of access to registered Nurse positions there was an expansion of Band 4 posts across the sites.

Recruitment and retention remains a key feature within the Health Board with dedicated recruitment campaigns across a range of Nursing specialties as vacancy profiles indicate. A priority is increasing registrants, with initiatives such as international recruitment, Clinical Fellowship Programmes for Nursing and Health Care Assistants graduate schemes. Short term mitigation remains through temporary staffing of bank and agency staff and deployment of staff internally (clinical and non-clinical).

The impact on nursing care on a wards physical position and layout is also considered in the Nurse staffing calculations where the layout and physical features of a clinical area and need for infection prevention segregation impacted on workload burden and the efficient use of the nursing hours available.

Despite the challenges of the Covid 19 pandemic the compliance with the Nurse Staffing Levels (Wales) Act 2016 requirements were maintained by the recruitment / up skilling, temporary staffing and redeployment of staff to mitigate shortfalls.

The acuity audits have supported the professional judgement applied to the calculation of Nurse staffing and have demonstrated a marked increase in the nursing care needs of patients. These care needs have included patients requiring enhanced observations, and 1:1 nursing care. The acuity audit findings have reported an increase in the number of patients who met the Welsh Levels of Care 3 and

4. This increase may be due to late presentation of a chronic illness, breakdown of support at home for cognitively impaired individuals, care withdrawn from nursing/residential homes, or due to clinical instability. It is anticipated that there will be an increase in the presentation of patients requiring Levels 3 and 4 as we will continue through the pandemic and into Winter 2021.

However, in the absence of National Acuity data for the Spring 2021 review as per other reviews, evidence available from professional judgement, peer review and safe care suggests themes of patients requiring higher levels of observation due to complex care requirements e.g. cognitive impairment and physical dependency. There has also been an additional impact due to the increase of segregation requirements to ensure patients are appropriately cared for in line with COVID 19 infection prevention guidance. There is also a further emerging pressure on inpatient registered Nurse staffing with the requirement to further enhance separation of the inpatient elective pathway, this impact was assessed and recommendations made as part of the staffing review. Also acknowledged is the additional requirements to allow safe donning and doffing during care delivery to patients and the requirement to ensure appropriate fit testing of staff and the impact of COVID 19 on staff themselves with particular note to that of sickness, health and wellbeing and maintaining resilience to deal with all challenges the pandemic presented.

All reviews are undertaken in line with the requirements of the Act and supplementary All Wales Guidance.

For 2020/2021 the required establishment should be noted in context of the repurposing of wards and the reduction in bed numbers to support enhanced social distancing and absence of January 2021 formal acuity data collection.

NB. Figures of WTE for Ysbyty Wrexham Maelor reflect part year effect changes within ward purpose related assessment areas from 2019/20 and into 2020/21.

The number of wards under section 25B is likely to have changed during the reporting period. For more details of individual wards and their calculated nurse staffing levels, refer to the annual assurance reports.

[Annual report 2018 2019](#)

[Annual report 2019 2020](#)

[Annual report 2020 2021](#)

Extent to which the nurse staffing levels are maintained within Section 25B wards

When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E, and health boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board.

For the 2018/9 and 2019/20 annual reports, this Health Board - together with all other health boards/trusts in Wales - provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act.

During the reporting period 2020/21 all health boards/trusts in Wales have begun to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, made available to Health Boards/Trusts across Wales on 1st July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act: The limited quantitative data that this approach has provided for 2020/21 for this Health Board is presented and discussed below.

Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements.

The information assists to support a dynamic assessment of staffing at coordinated intervals throughout each day and to inform the management of staffing levels. The dependency data is submitted to the All Wales Nurse Staffing group on a bi annual basis for analysis and national benchmarking.

Process for maintaining the nurse staffing level for Section 25B wards

There are well embedded processes within the nursing structures on each of the acute sites for reviewing staffing levels operationally on a daily basis and for making operational, risk based decisions about the deployment of staff via the site huddle meetings, and staff redeployment meetings. The use of the patient acuity data captured on a shift by shift basis for all Section 25B wards across the Health Board informs the operational decisions relating to staff deployment. Each Directorate continues to monitor the staffing situation and ensure that clinical areas manage the risk where there are any staffing deficits.

The process for maintaining Nurse staffing levels are supported by a number of other elements of which include:

- Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to which were strengthened as a result of learning from Hospital Acquired Infection reviews.
- Roster optimisation – ensuring that all rosters are completed as per policy and that all rosters are constructed correctly to ensure that the correct number of staff are able to be provided which are underpinned by a suite of roster metrics monitored monthly (daily during COVID surge to inform redeployment decisions)
- Roster approval process – all Nurse rosters are subject to a double approval process monitored by the senior nursing team to ensure safe and effective rosters
- Use of temporary workforce – any gaps that cannot be filled by substantive staff are tendered to temporary workforce solutions, in advance to provide the best opportunities of not only securing the shift but attracting suitably skilled and regular staff on a block basis where possible to aid continuity

- Streamlined fast track recruitment
- Centralised recruitment team to support campaigns both targeted and generic for Nurse recruitment locally, nationally and internationally supported by Senior Nursing Leadership
- Partnership working with local universities to maximise opportunities for recruitment and retention including innovative opportunities for post graduate development
- New Role developments
- Utilisation of staff and student feedback
- During COVID daily staff deployment meetings for escalation, forward look and mitigating actions
- Workforce planning informed by the Nurse staffing review process and underpinned by the Health Boards Recruitment and Retention strategy

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Section 25B wards

April 6th 2018 – April 5th 2021

Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally	Total number of closed serious incidents/complaints during last reporting period	Total number of closed serious incidents/complaints during current reporting period.	Total number of serious incidents/complaints not closed and to be reported on/during the <u>next</u> reporting period	Increase (decrease) in number of closed serious incidents/complaints between reporting periods	Number of (closed) serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor
NOTE: (*) complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR))					

<ul style="list-style-type: none">Hospital acquired pressure damage (grade 3, 4 and unstageable).		Year 1	Year 2	Year 3	YGC 4	YWM 1	YG 10		Year 1	Year 2	Year 3
		YGC 16	YGC 25	YGC 22					YGC 0	YGC 0	YGC 0
		YWM 37	YWM 22	YWM 21					YWM 0	YWM 0	YWM 0
		YG 31	YG 7	YG 55					YG 2	YG 0	YG 0
		Total 84	Total 54	Total 98					Total 2	Total 0	Total 0
		Total per site for 3 yrs YGC 63 YWM 80 YG 93 Overall total 236			Total 15 Please note these have now all been confirmed closed and will be reported as such in the May 2022 annual report.			Total per site for 3 yrs YGC 0 YWM 0 YG 2 Overall total 2			
<ul style="list-style-type: none">Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).		Year 1	Year 2	Year 3	YGC 1	YWM 2	YG 4		Year 1	Year 2	Year 3
		YGC 16	YGC 10	YGC 25					YGC 3	YGC 0	YGC 0
		YWM 14	YWM 13	YWM 23					YWM 1	YWM 0	YWM 0
		YG 25	YG 18	YG 25					YG 1	YG 0	YG 0
		Total 55	Total 41	Total 73					Total 5	Total 0	Total 0
		Total per site for 3 yrs YGC 51 YWM 50 YG 68 Overall total 169			Total 7 Please note these have now all been confirmed closed and will be reported as such in the May 2022 annual report.			Total per site for 3 yrs YGC 3 YWM 1 YG 1 Overall total 5			
<ul style="list-style-type: none">Medication related		Year 1	Year 2	Year 3	YGC 1	YWM 0	YG 0		Year 1	Year 2	Year 3
		YGC 1	YGC 0	YGC 2					YGC 0	YGC 0	YGC 0

never events.		YWM 0	YWM 0	YWM 12					YWM 0	YWM 0	YWM 0
		YG 3	YG 0	YG 0					YG 0	YG 0	YG 0
		Total 4	Total 0	Total 14					Total 0	Total 0	Total 0
		Total per site for 3 yrs YGC 3 YWM 12 YG 3 Overall total 18			Total 1 Please note these have now all been confirmed closed and will be reported as such in the May 2022 annual report.			Total per site for 3 yrs YGC 0 YWM 0 YG 0 Overall total 0			
• Complaints about nursing care resulting in patient harm (*) (*)This information is not required for period 2018/19		Year 1	Year 2	Year 3	YGC 0	YWM 0	YG 0		Year 1	Year 2	Year 3
			YGC 2	YGC 2						YGC 0	YGC 0
			YWM 3	YWM 7						YWM 0	YWM 0
			YG 0	YG 1						YG 0	YG 0
			Total 5	Total 10						Total 0	Total 0
		Total per site for 2 yrs YGC 4 YWM 10 YG 1 Total 15			Total 0			Total per site for 2 yrs YGC 0 YWM 0 YG 0 Overall total 0			

There is a harms review process within the Health Board for all of the above reported incidents, these are undertaken with clinical teams, supported by our clinical governance and Senior Nursing leads. Thematic analysis is also undertaken with learning and actions disseminated across the Health Board.

Comparative data between reporting periods shows a decline in incidents between the first and second annual reports for Hospital Associated Pressures Ulcers (HAPUs) and falls with serious harm. The increase of HAPUs for YG between year 2 and year 3 was due to a backlog of completion of 'make it safe' incident reviews. Please note, the HAPUs that occurred during year 2 were fully reported at the time and an initial review was undertaken, all HAPUs that were not closed were captured and reported within the next reporting period. Therefore averaging over the 2year reporting periods of 2019/20 and 202/21.

There is an increase in falls reported, on review none were directly linked to staffing shortages however, we recognise the challenges in increased temporary workforce reliance, an increase in acuity and dependency of patients as well as recognising the challenges associated with isolation and segregation to minimise the risks associated with Covid 19 transmission which constricted line of sight in some areas.

The number of medication incidents and complaints are too small to make a statistical analysis.

Section 25E (2c) Actions taken if nurse staffing level is not maintained

Actions taken when the nurse staffing level was not maintained in Section 25B Wards

As a Health Board there has been underpinning work to secure and assure plans for maintaining nurse staffing levels and compliance with the Act to date, of which is ongoing. There is continual development as greater comprehension and information is gained locally and nationally. There are a range of both short and long term actions being taken by the Health Board to improve the extent to which a sufficient workforce is available to work within the Registered Nurse and Health Care Support Worker establishments across all health settings.

These include:

- Initiatives being led by the Workforce and Organisational Development teams and Corporate Nursing to develop and implement innovative approaches to recruitment of Registered Nurses as well as new Health Care Support Workers
- Continue to progress the overseas Registered Nurse campaign including the uplift of Practice Development Nurses to support this programme and newly qualified nurses.
- Establishing educational partnerships arrangements with the Glyndwr and Bangor Universities, and Llandrillo College in relation to the creation of new courses to support the further/higher education such as Clinical Nursing Fellowship Programme/Part-time BN/Level 4 NVQ
- Creation of career pathways

Reviewing the quality of nursing care is an important factor when calculating nurse staffing levels. The senior nursing team via their respective internal weekly scrutiny meetings review all incidents and complaints. All incidents and complaints that have occurred during this reporting period have been reviewed. All reviews consider whether nurse staffing levels have been maintained at the time of the incident or complaint, and if not, whether failure to maintain the nurse staffing level contributed to any harm suffered by the patient. The meeting also considers whether there are lessons to be learnt, and good practice that can be shared. Quality improvement focus over this three year period has included:

Actions 2018-2019

- Test of change for falls prevention.
- Participation in collaborative work for hospital acquired pressure ulcers.
- Development of medicines management framework.
- Introduction of biannual staffing reviews.
- Embedding the utilisation of live staffing data

	<ul style="list-style-type: none"> • Development of nurse staffing escalation policy. • Safe clean care programme focussing on the reduction of harm related to infection prevention practices • Engaging multi-disciplinary teams in the SAFER patient flow bundle⁸ <p>Action 2019-2020</p> <ul style="list-style-type: none"> • Participation in collaborative work for hospital acquired pressure ulcers • Launch of revised Ward Sister / Matron audits • Test of change for falls prevention • Daily site incident review meetings • Issues of escalation at daily safety huddle • Development of medicines management framework • Embedding SAFER principles <p>Action 2020-2021</p> <ul style="list-style-type: none"> • An SBAR was presented to QSE in July 2020 outlining the staffing plans in light of Pandemic surge impact, this outlined potential impact regards staffing ratio changes to meet anticipated demands • Nurse staffing surge plans were created reviewing all services whereby Nursing care is provided including commissioned services, of which were approved by the Health Board • Escalation required regards staffing plan changes were via the Health Board Executive Incident Management Team with approval sought from the Executive Director of Nursing and Midwifery • Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments
Conclusion & Recommendations	<p>As a Health Board there has been underpinning work to secure and assure plans for safe staffing and compliance with the Act to date, of which continues to develop and evolve. There is continual learning as greater comprehension and information is gained locally and nationally. However, it is also acknowledged that there are further actions that can be undertaken to develop and further assure the process and importantly focus and measure the actual impact of staffing on patient harm. The previous annual reporting period has provided significant challenge in the light of pandemic, of which were further enhanced by the Nurse vacancy position.</p> <p>Recruitment and retention remains a key feature with programmes looking to create stability in the current nursing workforce. A priority is increasing registrants, with a focus on national and international recruitment, and BCUHB Health Care Assistants graduate schemes. Workforce optimisation plans will continue to support ongoing recruitment and retention initiatives, and to provide a level of stability through strengthening clinical leadership, particularly in the more difficult to recruit to wards where there has been a conversion of Band</p>

⁸ SAFER – five elements of best practice: Senior Review; All patients have an Expected Date of Discharge (EDD); Flow of patients commences at the earliest of opportunities; Early discharge; Review by multi-disciplinary team

5 to a Band 6 posts. A recruitment and retention initiative 'grow your own' HCSW development pathways to achieve National Vocational Qualification (NVQ) level 4 qualification and/or pursue further opportunity to become a registrant has been a proven success to date.

Short /intermediate term mitigation will continue to be through temporary staffing and the internal redeployment of staff internally.

Recommendations for next steps:

- Targeted focus of innovative Nurse recruitment campaigns both locally, nationally and internationally informed by workforce data/analysis and feedback
- Succession planning for the future, ensuring we are developing our next generation leaders
- Creatively co-designing our post graduate programmes as key attractors supporting the University status held by the Health Board
- Analysing workforce data to better inform Nurse retention strategies and initiatives and ongoing analytics regards leavers and 'what could we do better?'
- Review and implementation of new roles to enhance and develop nursing recruitment pipelines
- Expansion of quality improvement driven collaborates to assist in reducing variation and harm reduction with a zero tolerance approach
- Development of a Nurse performance dashboard as a further monitoring and assurance tool in real time
- Further analysis of deviations from previous reporting periods
- Sharing the outputs of the Nurse Staffing reviews with the Finance and Performance Committee to support changes to the Nurse staffing establishments

Appendices

2018/2019 Annual Report

[Bundle Health Board - public 2 May 2019 \(nhs.wales\)](#)

2019/2020 Annual Report

[Bundle Health Board 23 July 2020 \(nhs.wales\)](#)

2020/2021 Annual Report

[Bundle Health Board 20 May 2021 \(nhs.wales\)](#)



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 7 th September 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Return - All Wales Standard for Accessible Communication & Information for People with Sensory Loss
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)
Awdur yr Adroddiad Report Author:	Perter Morris (Quality Assurance Business Analyst) Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)
Craffu blaenorol: Prior Scrutiny:	Patient and Carer Experience Group Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)
Atodiadau Appendices:	1. Welsh Government Return (please note the 11 evidence documents submitted as an appendix to the Welsh Government Annual Return have not been included in this QSE Committee paper but are available on request for members)

Argymhelliad / Recommendation:

The Committee is asked to note this report.

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	

Sefyllfa / Situation:

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss (AHCS) (WG, 2013) sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the 'Standards' as an enabler to implementing them.

This reported is mandated within the NHS Delivery Framework for 2021/2022 and reports progress against the organisations action plan(s) and associated work stream(s) in relation to organisational compliance against the requirements of AHCS following scrutiny by the Acting Associate Director of Quality Assurance and Patient and Carer Experience Group (August 2021).

Cefndir / Background:

Improving organisational compliance with the AHCS is an integral component of the Patient Experience Strategy (BCUHB, 2019) and the focus for this work has been three key, project managed work streams; (i) accessible health care and sensory loss, (ii) written information for patients and service users and the (iii) developing real and near time patient feedback in order to listen, learn and act on this in accordance with our mandatory responsibilities (WG, 2015a, 2015b, 2021), and provides a common thread underpinning (i) and (ii).

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Whilst this reporting period has been influenced by BCUHB's organisational response to the Covid-19 public health emergency, and has caused the Patient Safety & Experience Department to fundamentally rethink ways of working, this has resulted in a period of creative adaptivity, which provides for a sustainable pathway to ensure that service users with a sensory loss are able to gain access to and participate in our services on the same basis as other service users. The format of the report clearly articulates the achievements (column 1), the risks (column 2) and the controls/solutions (column 3). Whilst BCUHB is not universally compliant with the requirements of the standards across all settings and the latest audit suggests that this can be enumerated to a compliance rate of approx. 55%, the key risks highlighted by this report relate to; raising/increase staff awareness, provision of written information in variable formats commensurate with the needs of people with sensory loss, recording communication needs within the master patient index of our Patient Administration Systems (PAS) and acting on these, and the challenges associated with dynamically developing appointment templates commensurate with identified communication need

Opsiynau a ystyriwyd / Options considered

The following work is underway to improve compliance:

1. Continued development of compliance with Accessible Health Care Standards as a project managed work stream under the auspices of the Patient Safety & Experience Department.
2. Completion of BCUHB audit of Compliance Levels using baseline assessment and action planning by end of Q4 2021/2022. (Each speciality and/or service point(s) to develop an action plan for improvement).
3. Continued development of the capability to listen, learn and act on service user feedback in relation to service users with sensory loss, via the implementation of the CIVICA patient feedback platform, which provides enhanced reporting of feedback via protected characteristics and human rights field.
4. Throughout Q3&Q4 2021/2022 Patient Advice Liaison and Support Officers (PALS) will undertake care2share discovery interviewing, patient stories and continue the roll out and utilisation of BCUHB's real/near time patient feedback system, which for 2020/2021 enables improves reporting by protected characteristics at ward/service point level.

5. Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. (Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q4-2021/2022).
6. In collaboration with BCUHB managers and staff, service users and the Centre for Sign Sight & Sound (COSS) review the content of the Sensory Loss Toolkit to ensure that it is commensurate with the standards, technological developments and the needs of our service users. (By Q4-2021/2022).
7. Continued development of the 'Readers Panel' and peer and service user review of new requests for written information for patients according to criteria contained within guidelines including those relating to accessibility by throughout Q3&Q4 2020/2021.
8. Redevelopment and migration of BCUHB intranet site to organisational SharePoint platform to ensure that managers and staff have access to relevant support learning and support materials, to include updated guidance on searching for, and adding NHS e-learning modules to ESR, blended learning materials relating to the standards, interactive versions of the Toolkit and on-line version of the baseline evaluation – to be completed by April 2022.
9. To secure continued funding for the accessible health care scheme for 2022/2023 – by Q4-2020/21, review the Service Level Agreement (SLA) and amend if necessary to include specific reference to completing the collaborative work necessary to update the Sensory Loss Toolkit.
10. Development of the PALS and Patient & Carer Champions roles to specifically understand and respond to the needs of patients/service users with sensory loss. Including the development of Care2Share, Patient Stories etc., as the basis for placing the voice of the patient/service user at forefront of service delivery.
11. Continued support for sensory loss training and awareness to be facilitated via (i) Sensory Loss Toolkit, (ii) 2Treat me Fairly Equality Training, (iii) Intranet based materials and (iv) e-sensory loss module.
12. Following on from the above, develop a business case for the inclusion of e-sensory loss module within the WP033 – Mandatory Training Policy, as a mandatory enrolment within Electronic Staff Record (ESR).
13. To continue to work collaboratively with the Information Management to ensure that every opportunity is taken to encourage the recording of language preferences including British Sign Language (BSL), and disability fields within the current WPAS(Welsh Patient Administration System) implementations.
14. Continued support from within the Patient Experience Team in relation to relaunch of the Ward Accreditation programme along with specific support from the patient and services user experience team in relation to (i) undertaking the baseline AHCSTDs audit (ii) support ward accreditation audit and (iii) action planning as a result of (i) & (ii).

15. Continued project management of the implementation of the (OFW) RL-Datix™ and Civica™ platform ensuring that community and primary care settings are utilised for piloting and their service points are fully included in the implementation plan.
16. To continue to review and project manage the following established work streams; (i) accessible health care and sensory loss, (ii) written information for patients and service users and the (iii) developing real and near time patient feedback in order to listen, learn and act on this in accordance with out mandatory responsibilities (WG, 2015a, 2015b, 2021), and provides a common thread to (i) and (ii). (To be reviewed monthly in accordance with agreed project plans).

Goblygiadau Ariannol / Financial Implications

Funding for the current SLA with the Centre for Sign Sight and Sound (COSS) for the provision of the accessible health care scheme is recurrent and will enable the continuation of the Accessible Health Care Scheme throughout 2021/2022. The focus of the scheme is to provide support to patients, carers, relatives and other service users with sensory loss in relation to access accessing and participating in our services on the same basis as all other users. Within the context of the actions above and the risks cited below this provides a key overarching control, and it is within this context that the recommendation for the review of the Sensory Loss Toolkit to be incorporated into the SLA for 2022/2023 is an important recommendation, as the resources and expertise to do this in-house, do not exist. If this additional requirement cannot be incorporated into the existing SLA this may have resource implications moving into 2022/2023.

Dadansoddiad Risk / Risk Analysis

The key risks are cited in Column of the main report 'risks to delivery' however, in summary;

1. The ability to roll out a universal training programme in relation to the developing the behaviours underpinning compliance with the standard, remains one of the biggest risks to the project. This risk is compounded by sensory loss training not being mandatory within the NHS in Wales and this will remain a significant risk throughout Q3&Q4 2021/2022 and on into 2022/2023.
2. Access to and participation in our services for patients/carers/relatives with sensory loss on the same basis as all other service users continues to be a key challenge; key risks include access to health information, ability to navigate the appointment system, provision of BSL interpretation, and the difficulty of making known information relating language needs including BSL and disability for recording within the WAPS.
3. Following on from the above; whilst the Wales Information Service (WIS) has ensure that systems are enabled in line with phase II of the Accessible Information Standard (AIS) to record communication needs and include these in e-referrals received by the Health Board. (Such an approach relies on fields relating to language, disability and communication needs being populated in a systematic and rigorous manner derived from universal reference values). Additionally, even where such reference values are present, these are not currently utilised to trigger letter templates in variable formats, nor to produce reminders to BCUHB Healthcare Professionals to book BSL interpretation, where this is a stated language need.
4. Mitigation of risks (1-4) above cited, requires a very high level of vigilance and staff awareness in relation to their responsibility to book a Wales Interpretation & Translation Service (WITS)

interpreter as required; this risk is sometimes compounded where communication needs are unknown to the HCP/Service Point, such as in an emergency situation.

5. Level of staff and managerial engagement given other priorities especially in relation to implementing BCUHB response to the public health emergency as a result of the Covid 19 pandemic. Thus engagement in the baseline audit, sensory loss training and otherwise developing increased awareness and capacity to respond to the requirements of the standards and the needs of service users with sensory loss becomes organisationally diluted.
6. Delays in the procurement of the Once for Wales (OFW) RL-Datix incident and complaints system have resulted in reliance on the Web Based version of Datix and this does cause some issues in relation to segmentation via speciality and via protected characteristics. However, training, 'organisational knowledge' and the proposal to adopt a common data model to underpin both the implementation of RL Datix and the CIVICA real time feedback system provide a high level of control in relation to this risk. However, a protracted delay in the provision and acceptance of a RL-Datix build which is fit for purpose, may exacerbate this risk, moving into 2022/2023.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Compliance with the Accessible Information and Communication Standards for standards with sensory loss is mandated within the NHS in Wales, (WG, 2013, 2019) and is underpinned in statute via the Equality Act (UK, 2010) and Human Rights Act (UK, 1998).

Asesiad Effaith / Impact Assessment

This report provides operational direction only within the auspices of Patient Safety & Experience Strategy (BCUHB, 2019) for which an Equality Impact Assessment has already been completed, and does not make any recommendations in relation to developing or changing services for which an Equality Impact Assessment would be required.

Accessible Communication and Information

NHS Organisation	Betsi Cadwaladr University Health Board
Date of Report	August 2021
Report Prepared By	Peter Morris Quality Assurance Business Analyst. Reviewed by: Carolyn Owen Acting Assistant Director of Patient Safety and Experience. Approved by: Matthew Joyes, Acting Associate Director of Quality Assurance.

The [All Wales Standard for Accessible Communication and Information for People with Sensory Loss](#) (AHCS) sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children. The Accessible Information Standard requirements sit alongside the 'Standards' as an enabler to implementing them.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 31 April.

Complete form to be returned to: hss.performance@gov.wales

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss?

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved – April 2021 to Sept 2021	Risks to Delivery	Corrective Actions & By When
All public & patient areas should be assessed to identify the needs of people with sensory loss	As in previous reporting periods continued utilisation of the self-evaluation tool, and Sensory Loss Toolkit, including primary care variant, which enables managers to evaluate compliance with the standards in relation to their service points, which	As in previous reporting periods, throughout 2020/2021 BCUHB's COVID-19 pandemic response has resulted in a curtailment of many face-to-face approaches to (i) collecting feedback directly	Organisational Compliance with AHCS achieved via BCUHB's Patient Safety and Patient & Carers Experience Groups, thus providing executive/board level oversight. Additionally, compliance with the AHCSTD is reported as an integral

	<p>include a section related to Environmental Signage and wayfinding and is supported by addition guidance.</p> <p>(See Appendix A & B)</p> <p>The self-evaluation tool is utilised as an integral component of organisational governance and performance management in relation to compliance with AHCS.</p> <p>Completion of BCUHB audit of Compliance Levels using baseline assessment and action planning. (Whilst this type of instrument is not universally utilised within the NHS in Wales, it does provide utility in terms of identifying and quantifying risk across BCUHB as the basis for action planning).</p> <p>(See Appendix C)</p> <p>BCUHB's real/near time patient feedback system has been developed to enable dashboard reporting of experience via protected characteristic again NHS Wales PREMs metrics and the filtering of free text characteristics. This enables managers and health care professionals to better understand the needs of patients, carers and service users with sensory loss, and the dashboard has been made available via our intranet and relevant</p>	<p>from patient, carer and service users, (ii) interacting with front line staff, (iii) developing direct relationships with remote service points. Visiting restrictions within clinical areas have provided an additional challenge in relation to providing an effective Patient Advice and Liaison Service (PALS) and this has necessitated the development of new, remote ways of working.</p> <p>Continued roll out of patient feedback questionnaire to all care sectors, which enable segmentation of feedback via sensory loss, as the basis for service improvement, has been negatively impacted by the COVID-19 Pandemic response.</p> <p>However, this has been identified as a priority and is an integral component of the PALS work stream moving forward into Q3&Q4-2021/2022. However, it needs to be recognised that given the current level of sustained COVID-19 transmission, then engagement with key stakeholders is for the most part likely to rely on remote, computer mediate communication, such as MS-Teams™, and a stronger focus</p>	<p>component of the BCUHB's performance plan.</p> <p>Within this reported period the controls remain similar to those deployed in Q3 &Q4 2020/2021 namely</p> <p>Operationalisation of a specific project managed work stream and action plan within the Patient Safety & Experience Team with the aim of ensuring increased organisational awareness and compliance with the standards.</p> <p>The Patient Experience and Carer Engagement Lead Pan BCUHB is the leading the key deliverables relating to this domain for 2021/2022 include;</p> <ul style="list-style-type: none"> • Utilisation of the Baseline Evaluation Tool to leverage increased compliance with AHCSTD and the development of services which increasing meet the needs of people with sensory loss. • In collaboration with BCUHB managers and staff, service users and the Centre for Sign Sight and Sound (COSS) under the auspices of the HB SLA, COSS review the content of the Toolkit to ensure that it is
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	<p>departmental SharePoint(s). During Q1-2021/2022 BCUHB has begun the implementation of the of the Once For Wales (OFW) Civica Patient Experience System and has revised the design of the real time feedback survey to enable enhanced analysis via protected characteristic. The roll out and development of this system will continue throughout 2021/2022 and into 2022/2023 with the long term vision of providing an all-digital platform. The reporting capabilities have been specifically customised to enable segmentation of feedback via protected characteristics and segmentation based on all Wales agreed equality and human rights reference values.</p> <p>Whilst the health board's (HB's) response to COVID-19 has curtailed face to face training, equality impact training has continued as e-learning and enabled managers and Health Care Professionals (HCPs) to develop the skills and knowledge necessary to evaluate and control for risks relating to service developments for people with sensory loss.</p> <p>As in the last reporting period BCUHB's COVID-19 pandemic response plan has placed a greater focus on the use of web-based materials, collaborative communication technologies and the Patient Advice Liaison & Support</p>	<p>on the development of intra and internet resources.</p> <p>Special Note¹ delays in recruitment, coupled with higher than expected levels of sickness absence within the Patient and Carer Experience Team have undoubtedly negatively impacted on the development and roll out of this work stream within this reporting period. Whilst this has partially been controlled for by continued development and roll out of patient experience champions; the need to refocus, reenergise and adequately resource this work stream in association with a more rigorous approach to project management is a key strategic and operational objective moving into Q3&Q4 2021/2022.</p>	<p>commensurate with the standards, technological developments and the needs of our patients, carers and service users. <i>(Carried Forward from previous reporting period).</i></p> <ul style="list-style-type: none"> Continued development of the capacity to report in near/real time the experience of patients'/carers and service users with sensory loss as the basis for service development. Development of the PALS and Patient & Carers champions roles to specifically understand and respond to the needs of patients, carers and service users with sensory loss. Including the development of Care2Share, Patient Stories etc., as the basis for placing the voice of the patient/service user at forefront of service delivery.
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	<p>Service (PALS) to support the needs of our patients, carers, service users and staff. This is underpinned by a project managed work stream within the Patient Safety & Experience Department which has included the introduction and development of Patient & Carers Experience Champions across the HB, to provide a specific ward/dept based focus on developing the capacity to better respond to the needs of patients and service users with sensory loss. The roll out of the programme has been underpinned with the development of a Champion's Handbook (BCUHB, October2020, p.14), which makes specific reference to improving compliance with AHCSTD.</p> <p>(See Appendix D)</p> <p>BCUHB has continued to utilised Patient Stories, Care2Share discovery interviewing and real time patient/carer and service user feedback system during this period and within the constraints of the HB's COVID-19 pandemic response. In addition to the inclusion of the NHS Wales standard PREMs, the survey instrument underpinning BCUHB's real time patient feedback system has been redesigned to ensure that we explicitly capture and segment the views of patients, carers and service users with a sensory loss.</p>		
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Needs Assessments	Key Actions Achieved – April 2021 to Sept 2021	Risks to Delivery	Corrective Actions & By When
<p>All public information produced by organisation should be assessed for accessibility prior to publication.</p>	<p>Within this reporting period, the continued organisational utilisation of guidelines on the producing written information for patients and carers (ISU02) has ensured that departments/service points are able to provide information in variable formats, to ensure that the communication needs of patients, carers and service users with sensory loss are met. Additionally, these guidelines reinforce the role of corporate communications department in relation to the provision of easy read versions where required, and this is audited via the baseline evaluation instrument, which within Q3-Q4 2021/2022 will be a registered tier 3 audit and a stated project deliverable (see special note¹)</p> <p>The Patient Safety and Experience Department has continued to proactively manage this work stream and throughout Q1&Q2 2021/2022 the 'Readers Panel' has met monthly to ensure that;</p> <ul style="list-style-type: none"> • Accessible and variable format versions are made available as required and that managers are aware of their responsibility in this respect. • utilisation of EIDO (where applicable) patient information leaflets which are available in easy read and variable font format and 	<p>Whilst BCUHB guidelines on the written patient information (Ver 0.4 Sept 2020) provides clear organisational clarity in relation to ensuring that all public information produced by the organisation is assessed for accessibility prior to publication, and will over time improve the accessibility, given the range and diversity of existing patient information it is likely to take a number of reporting cycles for these aims to be totally realised.</p> <p>As in previous reporting periods requests for change to templates for appointment letters are under the auspices of Wales Information Service (WIS) project management and whilst the Accessible Information Standards reinforce the need to ensure that public facing information is available in accessible format, this is very difficult to action at a local level.</p> <p>However, the migration to the all Wales WPAS product, the continued development of the Telephone Preference System (TPS) for making and amending appointments, along with the development of patient</p>	<p>Operationally a specific, project managed work stream and action plan has been developed within the Patient Safety & Experience Team for ensuring increased awareness and compliance with the guidelines inherent in ISU02 (Ver 0.4, Sept 2020). The Senior pt Safety & Experience manager is the project lead for this work stream, and as in previous reporting periods this is a key control in relation to managing the risks for this domain. Key deliverables for 2021/2022 are;</p> <ul style="list-style-type: none"> • Continued development, organisational embedding and support for the Patient and Carers Champion role, especially in relation to ensuring improved accessibility for public information – see Champion's Handbook (BCUHB, Oct 2020, p.14), • Continued utilisation and development of the 'Readers Panel' and review of new requests for written information for patients according to criteria contained within guidelines ISU02 (Ver 0.4, Sept 2020) including those relating to accessibility.

	<p>provide a useful resource in relation to the provision of information in accessible format, for standard procedures and diagnosis and that (i) these are readily available on the intra and internet sites and (ii) considered for use prior to the development of bespoke information – see ISU02.</p> <ul style="list-style-type: none"> • Cataloguing of existing written information for patients ensuring compliance with guidelines on accessibility. • Continued funding and support for the Accessible Health Care Support programme delivered by the Centre for Sign Sight and Sound (COSS) to support access to, and progression within health services, including advice and guidance on access to patient information. • Continued endorsement and utilisation of EIDO patient information leaflets which are available in easy read and variable font format and provide a useful resource in relation to the provision of information in accessible format, for standard procedures and diagnosis and that (i) these are readily available on the intra and internet sites and (ii) considered for use prior to the development of bespoke information – see ISU02. 	<p>portal for accessing communications, will within Q3&Q4 2021/2022 enable improved access to information and participation in health services for people with sensory loss.</p> <p>The Outdated Patient Administration system in the West operating region has within Q2-2021/2022 been migrated to the all Wales WPAS platform which has enabled a standard approach to the use of reference values to encode language preferences including BSL and ‘disability’ – moving forward this will enable within Q3&Q4 2021/2022 and 2022/2023 a standardised approach within BCUHB to the ‘system’ identification of people with sensory loss as the basis for customising communications and/or booking BSL interpretation as required.</p> <p>The Patient and Carer Experience Team have begun the process of migrating existing intranet pages to a new organisational SharePoint site for early adoption within Q3-2021/2022. This will provide added assurance in relation to materials related access to and progression</p>	
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	<ul style="list-style-type: none"> • Ensured that UK Government endorsed British sign language (BSL) interpreted videos are available on the intra and internet relating to public health and other general advice in relation to COVID-19 • Following on from the above, the Patient and Carer Experience Team have developed and maintained intra and internet sites containing pages which contain information in relative to the needs of patients, carers and service users with sensory loss and managers & HCPs delivering services. • Expert advice from third sector, volunteer and other relevant organisations is sought in relation to the production of information for patients, carers and service users complies with the requirements of the accessible information and communication standards for people with sensory loss (WG, 2013) 	<p>within health services, and in relation to the rights of patients, careers and services user to for example, make a complaint, provide feedback, accessing health related information etc., on the same bases as other patient, carer and service users is enhanced.]</p> <p>Following on from the above specific intranet pages relating to (i) compliance with the accessible communication and information standards, (ii) the production of written information for patients including relevant information and training materials have been developed and will be prioritised for migration to the new organisational SharePoint which is scheduled to replace the HB's outdated intranet CMS by April 2022, with the Patient Experience site being an early adopter in Q3-2021/2022</p>	
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Standards of Service Delivery	Key Actions Achieved – April 2021 to Sept 2021	Risks to Delivery	Corrective Actions & By When
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
<p>Raising staff awareness</p>	<p>As in previous reporting periods one of the key frameworks for raising awareness is the Sensory Loss Toolkit. The latest version of the Sensory Loss Toolkit contains (i) factsheets (1-4) relating to best practice for dealing with patients, carers and service users with sensory loss and (ii) endorses the use of the NHS Wales e-sensory loss module. This is reinforced by the baseline evaluation tool (see above). The toolkit includes a community and primary care variants.</p> <p>(See Appendix E)</p> <p>The new treat me fairly (equality training) module includes a more comprehensive reference to the AHCS based on factsheets 1-4 from Sensory loss toolkit. During this reporting period this programme along with Equality Impact Assessment training has been delivered using MS-Teams due to social distancing requirements as result of COVID-19. This delivery format continues to provide (i) instructions on how to access the e-learning sensory loss module included on updated web-page and specific reference to the AHCS (factsheets 1-4 Sensory Loss Toolkit)</p> <p>The PALS work stream includes within this reporting period a specific focus on sensory loss awareness and improving</p>	<p>The ability to roll out a universal training programme in relation to the developing the behaviours underpinning compliance with the standard, remains one of the biggest risks to the project. This risk is compounded by sensory loss training not being mandatory within the NHS in Wales and this will remain a significant risk throughout Q3&Q4 2021/2022 and on into 2022/2023.</p> <p>The risks identified below whilst carried over from previous reporting periods will remain relevant throughout Q3&Q4 2021/2022 and on into 2022/2023 namely;</p> <ul style="list-style-type: none"> Access to (enrolment on) e-learning modules which are not an integral component of the ESR learning suite, is for some staff groups problematic due to lack of access to computers during work hours and the need to search for specific courses and add these enrolments to ESR at an individual learner level. 	<p>This continues to remain a major risk moving forward into Q3&Q4-2021/2022 and ideally requires an all Wales control/solution such as mandating the e-sensory loss module and the controls relevant to this reporting period remain broadly similar.</p> <p>Continued support for sensory loss training and awareness to be facilitated via (i) Sensory Loss Toolkit, (ii) ²Treat me Fairly Equality Training, (iii) Intranet based materials and (iv) e-sensory loss module.</p> <p><i>Special Note1</i> Whilst social distancing requirements remain this will necessitate any training to be delivered via MS-Teams – supplemented by the PALS team.</p> <p>Additionally, section 3.2 of the sensory loss Toolkit contains similar guidance and provides an additional control where access to the e-learning module is not possible request that;</p> <p><i>“3.2 Have frontline staff undertaken sensory loss e-learning module AND/OR have factsheets 1, 2, 2b, 3 & 4 been (i)</i></p>

	<p>organisational compliance with the standard.</p> <p>Improved reporting of patient and service user experience via protected characteristics including sensory loss, via regular reporting and dashboards published on the HB's intranet and relevant SharePoint(s). The funding and adoption of the OFW CIVICA patient and service user feedback system will enhance this capability further.</p> <p>The Patient Safety & Experience Team has begun the process of curating a patient story library which can be accessed via our intranet, relevant SharePoint(s) and via Datix™, and includes stories relating to the lived experiences of a patient with sensory loss.</p> <p>Redevelopment and migration to MURA of the inter and intranet sites in line with the sensory loss project plan to include updated guidance on searching for, and adding NHS e-learning modules to ESR, blended learning materials relating to the standards, interactive versions of the Toolkit and on-line version of the baseline evaluation – to be completed. (See also above)</p>	<ul style="list-style-type: none"> • The policy framework underpinning national compliance with the standards does not include specific reference to performance targets associated with training/staff awareness. • Whilst BCUHB has campaigned for changes to the NHS Wales e-learning infrastructure to enable the local (BCUHB level) mandatory enrolment of the NHS Sensory Loss Module on a 3 year cycle as an alternative to 'Treat me Fairly' refresher. The lack of an all Wales Consensus has led BCUHB to reevaluate this approach. However, staff and managers are encouraged to undertake the NHS Wales e-sensory loss awareness module as an additional enrolment. 	<p><i>discussed during a documented staff meeting, (ii) been copied and distributed to frontline staff and (iii) a signed record exists that staff have 'read understood and are able to act in accordance with these guidelines.'</i> (Baseline Evaluation Tool, p.4)</p> <p>Review BCUHB Mandatory Training Policy (WP033) with a view to ensuring that e-sensory loss module is a mandatory enrolment.</p>
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<p>Ensuring all public information is accessible for people with sensory loss.</p>	<p>See ('Needs Assessment' above, and opening section relating to the provision of public information).</p> <p>Continued funding for the Accessible Health Care Scheme, completed SLA with Centre for Sign Sight & Sound for 2020/2021 and on into 2022/2023. Continued review activity data from the accessible health care scheme as the basis for organisational assurance and improving services.</p>	<p>See 'Needs Assessment' above.</p> <p>Despite the efforts described above in relation to ensuring that our patients, carers and service users with sensory loss have access to information, which enables them to gain access to, and participate in health services on the same basis as other patients, carers and service users. Within this reporting period BCUHB continues to recognise the vulnerable nature of these patients, carers and service users, especially during periods of local restrictions due national and organisational response to the Public Health emergency caused by the COVID-19 pandemic.</p> <p>Thus, throughout this reporting period the Accessible Health Care Scheme continued to provide;</p> <p>"the links Deaf and Hard of Hearing patients with Health Professionals like GPs, opticians, dentists and hospital departments. It supports Deaf and Hard of Hearing people to make, check, change or cancel an appointment, while also ensuring their communication needs are supported in the most appropriate way during the appointment" (COSS, Sept 2020).</p>	<p>See 'Needs Assessment' above.</p> <p>The critical nature of the Accessible Health Care Scheme and the SLA that supports this is recognised by BCUHB as a key control in ameliorating the potential risk that patients, carers and service users with sensory loss may experience in accessing information and participating in health services.</p> <p>Therefore, key deliverables for Q3&Q4 2021/2022 and 2022/2023 are;</p> <ul style="list-style-type: none"> • Report to Patient Safety and Patient & Carer Experience Groups, on the effectiveness and utilisation of the service. • Ensure that feedback from patients, carers and service users is used to develop the service • Secure continued funding for 2023/2024
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Standards of Service Delivery	Key Actions Achieved Sept 2020 – April 2021	Risks to Delivery	Corrective Actions & by When
<p>Accessible appointment systems</p>	<p>Within Q2 2021/2022 the HB has migrated the organisational Patient Administration Systems to the all Wales WPAS platform, for all operating regions. Which for the first time within BCUHB enable the utilisation of a standard set of reference values for recording language preferences including BSL and disability. Which in theory means that where present, such fields can be utilised as flags for the production of easy read appointment letters, reminders for HCPs to book BSL interpretation etc.</p> <p>Within this period continued communication with patients, carers and service user groups, Centre for Sign Sight and Sound, Primary Care Governance Leads, and participation at community engagement events, amongst others; in order to increase awareness amongst patients, carers, service users, managers and staff of the importance of recording and responding to the communication needs of people with sensory loss.</p> <p>The continued utilisation of text reminders, use of Type Talk™, and Accessible Health care support workers has created enhanced support for patients, carers and</p>	<p>The risks remain broadly similar to those cited in previous reporting periods, and their locus lies outside the control of Patient Safety & Experience Team and to some extent that of the HB. These include;</p> <p>Whilst the WIS has ensure that systems are enabled in line with phase II of the Accessible Information Standard (AIS) to record communication needs and include these in e-referrals received by the Health Board. (Such an approach relies on fields relating to language, disability and communication needs being populated in a systematic and rigorous manner derived from universal reference values).</p> <p>The utilisation of an IM&T infrastructure, which relies on communication needs related to sensory loss being recorded within primary care and then transferred via electronic referral to secondary care. At the time of writing BCUHB has still to complete the migration of the West operating area to the merged WPAS platform – this has been delayed further due to BCUHB's COVID-19 Pandemic Response Plan (see above)</p>	<p>Given the operational cited risks, then the controls cited above in relation to the development of specific project management work-streams, the development of accessible patient information, the continued development of the PALS function, the introduction of Patient & Carers Experience Champions, the development of the inter and intranet along with innovative frameworks for harvesting patient, carer and service user feedback and the continued funding and development of the Accessible Health Care Scheme will be a key organisational imperative for Q3&Q4 2021/2022 and intro 2022/2023.</p> <p>The WPAS implementation project within BCUHB will continued to be rolled out throughout Q3&Q4 2021/2022 supported by the appointment of 4 wte dedicated project officers and will provide the technically enabled ability to enable:</p> <ul style="list-style-type: none"> the standardisation of the coding and recording of communication needs, and the production of exception reports e.g. clinic preparation lists which flag in advance the need to book a WITS interpreter,

	<p>service users with sensory loss to engage with appointment systems on the same basis as other patients, carers and service users.</p>	<p>Within 2022/2023 it is likely that the current system will remain characterised by a;</p> <ul style="list-style-type: none"> • Reliance on patients, carers and service users to request that communication needs relating to sensory loss are communicated to health care providers (primary, community & secondary). • An appointment system which does not automatically create an alert reminding HCPs to book BSL interpreter, and this relies on local knowledge of the service user's needs being passed on to the service point. Although this risk is partially ameliorated via the AHCW scheme and the local knowledge <p>These risks will remain relevant throughout 2022/2022, and whilst these have been partially mitigated within Q2-2021/2022 via the implementation of the WPAS platform throughout all operating regions of BCUHB along with the standardisation of primary care system and the generic utilisation of reference values relating to communication and language within the Master Patient Index (MPI) table.</p>	<ul style="list-style-type: none"> • and increased integration with primary care information system, NHS Wales Health Portal(s) and other supporting systems.
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<p>Communication models</p>	<p>(See also section above relating to the provision of public information).</p> <p>As in previous reporting periods within Q1-Q2 2020/2021 the WITS interpreter service continues to provide front line face to face or MS-Teams™ based BSL interpretation and feedback on whole is positive.</p> <p>Digitally accessed interpretation services can now be supported via BCUHB internet based on MS-Teams™ and each ward/department within BCUHBs hospitals and managed practices has been provided with a informatics technology tablet to facilitate this process, along with digital visiting, and provides the a key component of the infrastructure necessary to support Insight™ digitally accessed interpretation services, or any other similar platform. (It is recognised that pending all Wales agreement, this will become an integral feature of BCUHB's WITS contract)</p> <p>During this period, BCUHB staff and managers are constantly reminded via, site Quality & Safety Group Meetings, Governance & Scrutiny Groups, via ward managers and matrons meetings, via e-mail, via posters, via the</p>	<p>(See also section above relating to the provision of public information).</p> <p>Staff Awareness in relation to the responsibility of HCPs to book a WITS interpreter as required; this risk is sometimes compounded where communication needs are unknown to the HCP/Service Point (see note above).</p> <p>Feedback from patients, carers and service users even within a COVID-19 context indicates a preference for a face-to-face interpretation service and such an approach is supported via the Accessible Health Care Scheme. Clearly moving towards a digital translation and interpretation service will remain a considerable cultural challenge, and in the short term being able to offer both options in a COVID-19 secure manner remains a key challenge.</p> <p>Developing the capacity for a digital remote interpretation services as an integral component of the HB's SLA with WITS will provide an important control especially in relation to unscheduled/emergency care. However, the HB does need to be cognisant of the need to provide translation services in a dignified manner recognising that some patients, carers and service users</p>	<p>See also section above relating to the provision of public information).</p> <p>As previously reported the Accessible Health Care Programme along with participation with WITs partially controls for this risk and continued, recurrent funding for this scheme moving forward is imperative.</p> <p>Continue to improve staff awareness via training and though quality assurance initiatives such as ward accreditation, utilisation of self-evaluation tool, patient safety metrics etc. (See also previous sections relating to raising awareness).</p> <p>Additionally, the continued development of PALS function and the role of the Patient and Carers Champion, coupled with the monitoring and implementation of Guidelines on Written Information for Patients (ISU02, Ver 0.4 Sept 2020) will enable the principles of effective communication for people with sensory loss to be repeatedly reinforced and practiced as the basis of cultural change and delivering the associated project managed work stream.</p> <p>Monitor incidents and complaints arising from communication with patients, carers and service users</p>
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	<p>PALS service, and via Treat Me Fairly Equalities Training, of their specific responsibility to book interpretation services including BSL where this required. This message is reinforced via Factsheets 1-4 from the Sensory Loss Toolkit and additional intranet and internet based information and real time messaging.</p> <p>The Accessible Health Care Communication card, is credit card sized and available to all patients, carers and service users who wish to identify and make known their communication needs, these have been distributed throughout BCUB and are available from our PALS team and from the COSS.</p> <p>Monitoring, reporting and learning from any incidents, complaints, or PALS enquiries, which relate to AHCSTD.</p>	where possible may wish to utilise their preferred interpreter.	with identified sensory loss as the basis for improvement
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Primary and Community Care. Priority areas include:			
Standards of Service Delivery	Key Actions Achieved Sept 2020 – April 2021	Risks to Delivery	Corrective Actions & by When
Raising staff awareness	<p>(See also Above).</p> <p>Establishment of a managed work stream to review the community version of the Sensory Loss Toolkit – this work has been scoped but is subject to the departmental level review of the project management arrangements for this work stream – see <i>special note</i>¹ above.</p>	<p>(See also Above).</p> <p>The risks for this reporting period remain broadly similar to those highlighted in 2020/2021 namely;</p> <ul style="list-style-type: none"> Geographic distribution of service points, and difficulty of engaging staff and service users in 'remote' locations. 	<p>(See also Above).</p> <p>These actions are largely carried over from Q1&Q2 2020/2021.</p> <p>Continued support from within the Patient and Carer Experience Team in relation to relaunch of the Ward Accreditation programme along with specific support from the patients, carers and services user</p>

	<p>As with previous reporting periods, given the continued limitations imposed on face to face visiting due to organisational and national response to the COVID-19 public health emergency. The PALS team have continued to engage remotely with area governance and GP practice managers in order to raise awareness of the issues, support evaluation and action planning.</p> <p>Following on from the above, the Patient Safety and Experience team in conjunction with managers and staff to promote the utilisation of the self-evaluation Toolkit to ensure that compliance is regularly monitored and action plans for improvement are developed as appropriate.</p> <p>Within Q2-2021/2022 the HB has successfully implemented the CIVICA™ once for Wales patient experience system in all managed GP practices and Community Hospitals which will enable the systematic collection, analysis and service development based on feedback from patients, carers and service users with sensor loss in real/near time.</p> <p>Following on from the above, the implementation of CIVICA has greatly enhanced the ability to support the integrated reporting patient experience, incident and</p>	<ul style="list-style-type: none"> The majority of GP Practices are autonomous and not directly managed and therefore integrating these practices within BCUHB's governance frameworks relies on good will and the skills of the GP Development teams. This still remains a risk within 021/2022 (see existing controls (left) and additional actions (right)) <p>During Q1-2021/2022 BCUHB's the Ward Accreditation programme was suspended, due to the COVID-19 response. The audit of ward accreditation metrics provides a key control in relation to compliance with the AHCSTDs. Specifically, metrics (PE12-PE14) see below, and the use of these was only re-established within Q2-2020/2021.</p> <p>(See Appendix F)</p>	<p>experience team in relation to (i) undertaking the baseline AHCSTDs audit (ii) support ward accreditation audit and (iii) action planning as a result of (i) & (ii).</p> <p>Continued project management of the implementation of the (OFW) RL-Datix™ and Civica™ platform ensuring that community and primary care settings are utilised for piloting and their service points are fully included in the implementation plan.</p> <p>Following on from the above, development of the of intelligent reporting of patient, carer and service user experience, incidents and complaints along with general compliance with accessible health care standard by GP Practice, ward/department, speciality, hospital and operating region, and additionally indicate DATIX incidents and complaints relating to, or associated with non-compliance with standards and/or meeting needs on the basis of protected characteristics.</p> <p>Ensure that patient safety information relating to patients, carers and service users with protected characteristics is reported via IRIS dashboards.</p> <p>Proactive support sensory loss awareness week in Q3-2021/2022.</p>
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	<p>complaints by protected characteristic as the basis for raising awareness and service improvement.</p> <p>During Q2-2021/2022 the Ward Accreditation programme has been re-established in a none face to face manner, and the ward accreditation matric and associated audit tool re-established, (see op cited), this provides high level assurance in relation to compliance with the standards (via metrics PE12-PE14).</p>		
Accessible appointment systems	(See Above).	(See Above).	(See Above).
Communication models	(See Above).	(See Above).	(See Above).
Implementation of the Accessible Information Standard	<p>As in previous reporting periods within Q1-Q2 2020/2021 key focus of work has continued to be focussed on the following;</p> <ul style="list-style-type: none"> Developing the infrastructure for measuring and reporting compliance; utilisation of the self-evaluation/internal audit instrument, ward accreditation audit tool, and continued development and deployment of the Sensory Loss Toolkit. BCUHB has continued to development partnership working with the third sector to support access to and progression within 	<p>Level of staff and managerial engagement given other priorities. See above note in relation to the non-mandatory nature of sensory loss training.</p> <p>Large geographical distribution of services across three operating areas (East, Central, West), and localised governance arrangements result in a large strategic and operational span of control. Culturally governance and organisational assurance have not always been viewed as an integral</p>	<p>(See Above)</p> <p>AHCS compliance reportable on a quarterly basis to Trust Board, reinforced operationally via Ward Accreditation, Continued development of the PALS service in all operational areas and reporting and review via BCUHB's Quality & Safety and Patient & Carers Groups executive sub-committees. (Quarterly Q3 & Q4 2021/2022)</p> <p>Continued development of the PALS model to support patients, carers and service users with</p>

	<p>health care services for people with sensory loss.</p> <ul style="list-style-type: none"> • Following on from the above, the utilisation of service level agreements with the Centre for Sign Sight and Sound (COSS) and WITS to provides access to interpretation services and advocacy services for patients, carers and service users with sensory loss, in line with the requirements of the standards. • Via implementation of Patient Experience Strategy (BCUHB, 2019) and the Patient Advice Liaison & Support Service (PALS), provide the infrastructure required to support patients, carers and service users with sensory loss in relation to access to health care services and as a focus for engagement. • BCUHB has continued to actively support the All Wales Sensory Loss Group to advise and support development of national approach to developing services, which are more responsive to the needs of patients and other patients, carers and service users with sensory loss. • Continued development and utilisation of formal frameworks listening and acting on feedback by categories of sensory loss including real team patient feedback, NHS Inpatient Satisfaction Survey, Patient 	<p>component of operational management.</p> <p>The above risks again remain relevant moving forward into Q3&Q4 2021/2022 Key controls include;</p> <ul style="list-style-type: none"> • Continued funding of the Accessible Health Care Scheme (AHCS) • Efforts to Improve Staff Awareness • Changes in the reporting of local and Organisational Quality Safety and Effectiveness and Organisational Assurance data to specifically include progress made against agreed organisational plan for improved compliance with AHCS, derived from Patient Safety & Experience Team, project managed work stream. • Development and resourcing of a robust project management arrangements for this work stream – see <i>special note</i>¹ above. 	<p>sensory loss through engagement in direct enquiries and in relation to audit and action planning within service points. (On going Q3-Q4 2021/2022)</p> <p>Continue to develop the in-house reporting of patient experience in relation to sensory loss, so that managers and staff are able to listen, learn and act on feedback. (Monthly reports to all service areas; ward/department managers, Quarterly Q3 & Q4 2021/2022) reporting to Quality & Safety and Patient & Carers executive sub-groups)</p> <p>Continue to review the sensory loss and written patient information work streams in line with agreed project deliverables (see above), (Monthly throughout Q3-Q4 2021/2021)</p> <p>Continue to support the role out and implementation of the Patient Carers Experience General Complaints Policy/procedure (BCUHB, January 2021) via on-line training and intranet based support materials.</p>
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	<p>Stories, PALS Enquiries, Patient Comments and analysis of incidents and complaints.</p> <p>Additionally, the development, ratification and launch of the new Patient Carers Experience General Complaints Policy (BCUHB, January 2021), has resulted in an improved pathway for the response of concerns based on the key principles of First Contact, Early Resolution, Investigation and Learning. This streamlined approach will enable any issues or concerns relating to the experience of patients, carers and service users with sensory loss, will be resolved in a proactive manner, at the earliest possible point.</p>		
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Standards of Service Delivery	Key Actions Achieved during April to September 2020	Risks to Delivery	Corrective Actions & by When
Secondary Care. Priority areas include:			
Accessible appointment systems	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Implementation of the Accessible Information Standard	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Standards of Service Delivery	Key Actions Achieved during April to September 2021	Risks to Delivery	Corrective Actions & by When
Emergency & Unscheduled Care. Priority areas include:			
Raising staff awareness	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)	(See also Primary & Community Care and Health Prevention)
Communication models	(See Primary & Community Care Above)	(See Primary & Community Care Above)	(See Primary & Community Care Above)

Concerns & Feedback (CF). Areas include:			
Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	<p>Within Q2-2021/2022 the HB has successfully implemented the CIVICA™ once for Wales patient experience system and adopted a real time feedback survey which incorporates the NHS Wales equality and human rights reference values, enabling the segmentation of service user experience via protected characteristic.</p> <p>BCUHB's Putting Things Right (PTR) internet pages have can be read via voice recognition software provide spoken access and provide considerably improved visual, access compared with the previous Cascade™ content management system. This along with latest web browser technology will ensure improved compliance with Web Accessibility Guidelines (QCAG) 2.1 AA and include an ability to change font size and support for a</p>	Delays in the procurement of the Once for Wales (OFW) RL-Datix incident and complaints system have resulted in reliance on the Web Based version of Datix and this does cause some issues in relation to segmentation via speciality and via protected characteristics. However, training, 'organisational knowledge' and the proposal to adopt a common data model to underpin both the implementation of RL Datix and the CIVICA real team feedback system provide a high level of control in relation to this risk..	<p>(See previously cited controls)</p> <p>Manage the local implementation of the (OFW) RL-Datix™ and Civica™ platform ensuring that community and primary care settings are utilised for piloting and their service points are fully included in the implementation plan, and as far as possible these systems share a common data model (hierarchy of locations and specialities and reference values defining communication needs and disability).</p> <p>Ensure that patients, carers and service users with sensory loss are able to provide feedback using the on-line platforms cited above e.g. provision of BSL interpreted questions, use of Read Aloud™ technologies, use</p>

	<p>variety accessibility add-ins such as Adobe™ – Read Out Loud. The PTR page is supported by BSL guidance in the form of a pre-recorded video link.</p> <p>As in previous reporting periods within Q1&Q2 2021/2022 whilst restrictions in place during COVID-19 pandemic response continue to be a feature of the operating environment; in practice the support of an Accessible Health Care Worker may be required to ensure that patients, carers and service users with sensory loss are able to access the PTR framework on the same basis as other patients, carers and service users. Thus, continued funding of this scheme within 2021/2022 provides an important tenet of BCUHB's approach to supporting patients, carers and service users with sensory loss.</p> <p>As in previous reporting periods service user feedback is regularly collected and fed back to service managers via (i) Real-Time Patient Feedback System (ii) Complaints and Incident Monitoring, (iii) Patient Stories and (iv) NHS Wales Inpatient Satisfaction Survey. The data from these sources is segmented by protected characteristic and reported in near time to managers</p>		<p>of TPF, capture of voice messages etc.</p> <p>As detailed in the PALS work stream continue to utilise telephone care2shares to identify and share feedback relating to compliance with the accessible information and communication standards.</p> <p>Continued funding of the Accessible Health Care Scheme for 2022/2023 and on into 2023/2024.</p>
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	<p>and staff, monthly to site Quality & safety groups and quarterly to the organisational Quality & safety and Patient & Carers Experience groups. Additionally, the experience of patients, carers and service users with sensory loss is reported bi-annually to equalities operational group and is a standard agenda item.</p> <p>When issues in relation to accessing services and/or the PTR process are identified these are communicated to the relevant managers for action.</p> <p>Within Q2-2020/2021 the development of intelligent reporting derived from common data model underpinning CIVICA and Datix (Web) has ensured the intelligent reporting of service user experience, incidents and complaints along with general compliance with accessible health care standards by GP Practice, ward/department, speciality, hospital and operating region, and additionally indicate DATIX incidents and complaints relating to, or associated with non-compliance with standards and/or meeting needs on the basis of protected characteristics.</p> <p>(See – Appendix G)</p>		
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<p>Highlight any contributory factors received in sensory loss and actions taken</p>	<p>See Equalities Report (above cited)</p>	<p>As in previous reporting periods, Making, changing and emending hospital and other health care appointments remains challenging for many patients, carers and service users with sensory loss, and this finding is reinforced through engagement events. Capturing and acting on this experience in real-time also remains a challenge and whilst the current approach 'to design out' such situations is to be commended, it has to be recognised that these will arise and BCUHB needs to ensure that we are able to respond to these in a proactive manner.</p> <p>Patients, carers and service users with sensory loss are very willing to tell us about their experiences, the challenge for the Health Board remains to incorporate these into the learning and planning processes.</p> <p>Ward audits as an integral component of the ward accreditation framework and PALS care2share activity and other interactions with clinical services, sometimes highlight that the Sensory Loss Toolkit and/or other supporting materials e.g. Hospital Communication Book, are either out of date or not available in hardcopy within some service points, this is immediately</p>	<p>(See Above)</p> <p>And is in previous reporting periods;</p> <p>Continued monitoring of service user experience by protected characteristic including complaints and incidents to ensure that any issues are acted on in as close to real time as possible, and scrutinised by the BCUHB's organisational quality & safety, and listening & learning groups, as well as within local PTR scrutiny groups. (Produce monthly and quarterly Q3 & Q4 2021-2022 exception reports for site Quality & Safety Groups, Governance Teams, and quarterly for organisational Patient Safety & Patient and Carer Experience executive sub-groups).</p> <p>Following on from the above; development of intelligent real time reporting for incidents, complaints and PALS activity data relating to Accessible Health Care Standard, using interactive dashboards.</p> <p>Continued engagement with service user with sensory loss in order to identify and ameliorate issues impacting on access to and progression within health care services. (Meet <i>monthly</i></p>
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		<p>ameliorated as an integral component of the work of the PALS teams.</p>	<p>with Centre for Sign Sight and Sound to review patient experience in relation to the accessible health care scheme).</p> <p>Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards. (Each regional patient experience team to curate a patient story relating to an aspect of sensory loss by Q2-2021/2022) .../Cd Fwd from 2020/2021</p>
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Patient Experience*	Key Actions Achieved during 2020	Risks to Delivery	Corrective Actions
<p>Mechanisms are in place to seek and understand the patient's experience of accessible communication and information</p>	<p>Within this reporting period BCUHB continues to utilise a variety of mechanisms to survey and learn from service user experience – see above. The DATIX complaints monitoring enables the segmentation of feedback via equality/discrimination, which provides an indirect ability to monitor concerns via protected characteristics. The Real Time Patient Feedback Survey and the NHS Inpatient Survey enables the self-reporting of service user feedback by protected characteristics and a report is forwarded to BCUHB's strategic Equality Group on a quarterly basis and included in the Listening and Learning and Quality Safety & Effectiveness reports. Such feedback has been reinforced by the operational deployment of PALS officers in all operating areas within Q1&Q2 2021/2022.</p> <p>Continued development and deployment in Q3&Q4 2021/2022 of in-house provision for real/near time feedback and the utilisation of PowerBi™ and Excel VBA™ to develop interactive dashboards has significantly enhanced BCUB's ability to harvest service</p>	<p>As in previous reporting periods the utilisation of the real/near time feedback tends to be greater in acute than community and primary care settings and it is constant challenge to ensure sufficient returns to provide meaningful feedback and universal coverage, especially in relation to reporting on protective characteristics Q3&Q4 2021/2022. This has been particularly challenging during this period due to continued restrictions on ward/departmental visits due to BCUHB's response to the COVID-19 pandemic.</p> <p>Given that this is likely to be a feature of operating environment throughout 2021/2022 it is recognised that there will need to be shift towards the utilisation of web based collaboration tools to gather feedback remotely e.g. collection of digital patient stories, utilisation of Skype™/Teams™/Telephone for discovery interviewing and administration of patient satisfaction survey(s). (see also above)</p>	<p>(See Above)</p> <p>Continued development of awareness of the importance of patient feedback and the availability of relevant data sets to support learning and service improvement – many of these actions have been cited above, but in summary, the key controls here are;</p> <p>Develop the capacity and capability to utilise digital patient stories in order to raise staff awareness and promote the service development necessary to improve compliance with the standards.</p> <p>The development of intelligent real time reporting for incidents, complaints and PALS activity data relating to Accessible Health Care Standard, using interactive dashboards.</p> <p>Continued development of BCUHBs intra and internet sites, and local SharePoint(s) – in line with the objectives inherent in the Patient Safety and Experience project managed work streams relating to (i) sensory loss, (ii) production of</p>

	<p>user experience and report this in real/near time be protected characteristic including sensory loss. This work has been enhanced with the restructuring with the Patient Safety and Experience team resulting in the appointment in Q1-2020/2021 of a Head of Quality Assurance.</p>		<p>patient information and (iii) learning and reporting.</p> <p>Development of an Patient Safety and Experience Information Strategy with the aim of developing an immersive and interactive approach to the sharing of information relating to patient experience, incidents and complaints which is capable of segmentation by location and protected characteristic in order to aid learning and service transformation.</p>
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	Key Themes	Corrective Actions
<p>The key themes to emerge from patient experience feedback (both positive and negative)</p>	<p>(See above comments in relation to the booking of WITs interpreters and the controls cited). Within Q1 2020/2021 the following feedback has been received from patients, carers and service users who identify as (deaf or hearing impaired) or (blind or visually impaired)</p> <p>(See Appendices H & I for high level summary)</p> <p>Whilst the detail responses for each of the NHS Wales PREMs metrics is included in the above reports for each of the cited protected characteristics, and the size of the samples in each case is relatively small; it is pleasing to note that the general level of patient satisfaction amongst each of the potentially vulnerable groups is high and similar to participants who do not identify themselves as having a sensory loss. (In summary, within Q1 2021/2022; blind or partially sighted patients'/service users average overall satisfaction score was 9.02/10 and deaf or hearing impaired patients'/service users average overall satisfaction score was 9.05/10).</p> <p><i>Special Note</i>³ (Data extracted by pe192547 on 10.08.2021 – therefore Q2-2021/2022 data not available at time of writing – this will be updated prior to forwarded to WG performance unit).</p>	<p>(See Above).</p>

*** Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs.** There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate pro-forma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee 7 th September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Mental Health – Ligature Risk Reduction and Adult Inpatient Service Development Exception Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health (Executive Lead for Mental Health and Learning Disabilities Division)						
Awdur yr Adroddiad Report Author:	Mike Smith, Director of Nursing, Mental Health and Learning Disabilities Division						
Craffu blaenorol: Prior Scrutiny:	Divisional Directors, Mental Health and Learning Disabilities						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Committee is asked to note this update from the Mental Health Division on its progress with ligature risk reduction and adult inpatient service development.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	X	Ar gyfer sicrwydd For Assurance	X	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
This is an exception report from the Mental Health and Learning Disabilities Division (MHLD). This report aims to highlight the ongoing progress of the programme of work to reduce the incidence of and the risk from ligature incidents within the Division, and to improve the safety and quality of experience for the patients in our services.							
Cefndir / Background:							
The Health Board has undertaken a great deal of work to reduce ligature points over several years, investing resources in this area and developing guidance and systems to create a safe environment.							
The work is significant given that ligaturing is a frequently used method of suicide and/or attempted suicide for mental health service users (whether in in-patient or community settings).							
Since September 2020, the Division has been reviewing its overall approach to ligature points. This was informed by the 'Care Quality Commission' guidance to English Health Trusts in early 2020.							

The focus of the guidance is on the threat to patients from low level ligature (ligature points below head height) risks in addition to the high level ligature points. A similar but broader Welsh Patient Safety Notification (PSN 13) was issued in June 2021, and this is now the national guiding document.

The focus within the Division has been on:

- Adapting the control documents (*i.e. the approved documents, that ward areas use to assess the levels of risk, record the conclusions and associated mitigation plans*), and
- Reassessing all environmental risks with the new adapted tools (*this approach has extended to the Child Adolescent Mental Health Services (CAMHS) in-patient services in the North Wales Adolescent Service in Abergelge Hospital*).

The new guidance has been significant in its impact. The established tools such as the “Manchester tool” have been embedded across the United Kingdom in practice as a ligature risk assessment tool for many years now. This tool had informed prior ligature removal and risk reduction works that the BCUHB MHL Division had previously completed. The tool is still valid, however the scoring systems have now changed to cover all ligature risks.

Since the review work commenced in September 2020 there have been two catastrophic in-patient ligature incidents within the Division. These have been previously reported to the QSE Committee, and a number of similar serious incidents, involving low level height ligatures, have sadly occurred across Wales.

As a result of these tragic incidents and the significant risk of ligature incidents, the Division implemented the “Ligature Risk Reduction and Inpatient Service Development” programme of work with a dedicated Senior Clinician leading the activity, supported by a broader team of subject area experts, and this work has been reported to the Divisional Senior Leadership Team (SLT)

Divisional patient feedback (including from the recent Community Health Council [CHC] events) often refers to the “cold clinical environments” within in-patient wards following previous risk reduction work and the Division is aware of the need to preserve a “healing environment”, maintaining a safe and caring environment.

Ligature Risk Reduction

Early in the review process outlined above it became apparent that all the evidence on risk reduction recommended a robust and holistic approach.

The Division is acutely aware of the fact that ligature itself is only one form of self-harm prevalent within in-patient care. For this work to be effective, it is believed that it should not just be about removing the availability of ligature points, as there is also emerging data and guidance on non-suspended ligatures (e.g. garrotes), equally being a consequent unintended consequence of the removal of low level ligature points. Unnecessarily depriving people, of their liberties is a key consideration for the Division, and is given attention in all planning work.

The “therapeutic milieu”, engagement of patients and staff, together with the use of therapeutic observations, positively support the appropriate shared management of risk, and this has an equal part to play in broader harm reduction programmes. The ligature risk reduction programme of work has 18 actions in total that are monitored via the Divisional SLT. These actions relate to:

- The ligature risk and anchor point risk reduction procedure
- The Ligature Risk Reduction Audit (this provides information on current state)
- Monthly local and divisional ligature risk reduction meetings
- Anti/lower-ligature furniture and equipment procurement
- Ligature awareness training (including risk formulation and management of risk)
- Compliance and review of the 7-day acute care inpatient pathway
- Compliance with the therapeutic engagement and observation policy

The following section provides an update on the programmes of work:

- An update was provided to the Divisional SLT on the 29th July 2021. This identified that the ligature and anchor point risk reduction policy had been ratified by the policy and procedure group.
- Annual audits have been completed for all wards. The ‘whole premises’ audits which cover receptions, public toilets and other public areas in the same buildings, are expected to be completed by the 31st August 2021.
- Monthly local and divisional ligature risk reduction meetings are commencing, and the Terms of Reference have been agreed. The monthly review of risk assessments and action plans will be reviewed at local meetings as a standard agenda item.
- The Divisional Lead for Ligature risk reduction is a participant in the “All Wales anti-ligature task and finish group”. The group aims to develop an all-Wales anti-ligature policy.
- Patient safety alerts in relation to ligature risks and ligature point risk assessment tools and policies (shared in 2018 and June 2021), have been reviewed by the Division. The MHLDD response to PSA13 (June 2021) has been signed off.
- The reviews for the two catastrophic incidents are underway. The external review for the incident at the Hergest Unit has commenced with Professor Michael Doyle, and his team attending the Hergest Unit in August 2021. The Divisional review of the fatal ligature incident at the Ablett Unit is nearing its completion, with a task and finish group finalising the action plan.
- The acute care operating framework and the therapeutic engagement and observation policy were circulated to staff for feedback and are now being adapted following the consultation.
- Baseline reviews have been completed in relation to compliance with the 7-day acute care inpatient pathway and the therapeutic engagement and observation policy in the West, Central and East mental health in-patient units. Initial findings indicate variation in practice.. The In-patient Service Development programme of work aims to significantly reduce these variations through the reinforcement and application of the policies supported by the implementation of adult mental health specific mandatory training in ligature risk reduction, engagement and observation.
- A risk has been created and described in the risk register for the Division. This scores as a tier 1 risk. At this moment, the risk is being managed in the Division with mitigating actions

updated by the Divisional Director of Nursing and Head of Governance. This is in the process of escalation within the Board.

Next Step actions

The next step actions include immediate, short and longer terms actions:

- Additional risk training will be implemented across the Division. This will commence in the West as a priority. Informal training has commenced within the West locality by the Divisional Clinical Risk Lead, whilst the formal mental health mandatory training programme is being developed.
- The formal adult mental health mandatory training programme (with a focus on risk reduction, risk formulation and risk management, engagement and observation, pathways of care) will be ready for implementation in December 2021.
- Quarterly Senior Leadership walkabouts of in-patient areas are underway.
- The Division will review its Older Adult admission pathway in the West area through its Older Adult pathway group.
- The Division will deliver a learning event in September, chaired by the Divisional Medical Director and the Director of Nursing, where the findings of the local reviews and agreed programmes of work from this work will be presented.
- The Division will share their learning and experience, and support other Health Board Directorates as they progress their anti-ligature actions.

Asesu a Dadansoddi / Assessment & Analysis

Divisional Reflections

The approach to reducing harm in inpatient environments is necessarily complex and multi-faceted.

The ligature risk reduction work is a national issue across Wales and also in the UK with national approaches emerging. BCUHB is connected to and contributing to national streams of work and will adapt to emerging best practice.

What were perceived as high impact risks, the “suspension from a height” opportunities, had mostly been removed in prior works across the Health Board. This has resulted in a changed threat of ligature harm opportunity, to the “lower level risks” that we now face. We also reflect that ligaturing is only one method of harm amongst in-patients, but is the most frequent threat to safety which we have to prepare for.

The Division reflects that the therapeutic environment of hopefulness and security of the person, and the relationship of support, toward the recovery of wellbeing, with the staff as helpers (not just watchers) is equally as important.

We have ensured a “work stream” to review the application and appropriateness of the therapeutic observation and engagement policy, to mitigate and manage risks in the short term when people are not engaging fully or able to take full responsibility themselves.

The Division is re-launching the Wales Applied Risk Research Network (WARRN) evidence approaches across the inpatient and community areas, and we are refreshing the training elements. This will support our work on formulating and expressing the risks, and related risk mitigation measures.

Recommendation:

The Committee is asked to note this update from the Mental Health Division on its progress with ligature risk reduction and adult inpatient service development.

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

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

Dadansoddiad Risk / Risk Analysis

This stream of work reported relates to the divisions only Tier 1 risk. This currently scores 20 on the Divisional risk register. As the work progresses, the activity reported here is expected to reduce the scoring of the mitigated risk toward the target level.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

This report provides information on harm reduction activity for service recipients

Asesiad Effaith / Impact Assessment

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



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 7 September 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Public Service Ombudsman for Wales Public Interest Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Awdur yr Adroddiad Report Author:	Denise Williams (Senior Complaints Manager – Ombudsman Liaison) Carolyn Owen (Acting Assistant Director, Patient Safety & Experience)						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes (Acting Associate Director, Quality Assurance) Gill Harris (Executive Director of Nursing and Midwifery/Deputy Chief Executive)						
Atodiadau Appendices:	1. Public Service Ombudsman for Wales' Public Interest Report 2. Draft Action Plan						
Argymhelliad / Recommendation:							
The Committee is asked to note the Public Service Ombudsman for Wales' Public Interest Report for information and the Health Board's action plan response for assurance.							
Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	x	Er gwybodaeth For Information	x
Sefyllfa / Situation:							
The Health Board has received the attached Public Service Ombudsman for Wales' Public Interest Report issued under S23 of the Public Service Ombudsman (Wales) Act 2019 on 21 July 2021. This paper provides the report for the Committee to formally receive in public session, along with the Health Board's action plan							
Cefndir / Background:							
The Public Services Ombudsman for Wales has issued the Health Board with his Public Interest Report relating to a complaint (reference COM39422). The complaint related to the care and treatment received by Mrs M at Glan Clwyd Hospital and Llandudno General Hospital, namely:							

- Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset and weight loss which she developed following bowel surgery.
- Clinicians failed to accurately assess Mrs M's frail condition and discharge her without appropriate home care support in place. This was subsequently provided by the Council but was inadequate and, within days, Mrs M was readmitted to hospital.
- The decision to remove Mrs M's nasogastric tube led to further weight loss and deterioration.
- A secondary cause of Mrs M's death – an ischaemic bowel – was not identified from scans or investigations conducted during her admissions.
- The Health Board and the Council failed to coordinate their response to the complaint. The council's response was received 6 months after the response provided by the Health Board.

The Ombudsman upheld complaint 1 – he found that senior clinicians at both hospitals (including the colorectal Multi Disciplinary Team - MDT) failed to identify that Mrs M had developed a post-operative blockage in the small bowel. He found that despite conspicuous radiological and clinical evidence pointing to this, physicians inappropriately excluded a physical cause for Mrs M's symptoms and attributed her weight loss and aversion to eating to a 'food phobia'. The Ombudsman could not definitively conclude that the failure to identify and treat the small bowel obstruction meant that Mrs M's death was preventable. This was because it was unclear whether she could have sustained further surgery, given her frail condition and comorbidities. The Ombudsman nevertheless considered this to be an alarming, systemic misdiagnosis and considered the uncertainty surrounding whether an opportunity to surgically intervene was lost to be, in itself, an injustice to Mrs M and her family.

The Ombudsman upheld complaint 2 – He found that the attempt to discharge Mrs M failed due to multiple shortcomings on the part of both the Health Board and the Council in relation to pre-discharge planning and to the post discharge support Mrs M received.

The Ombudsman did not uphold complaint 3 – He found that the nasogastric tube was appropriately managed and was removed at Mrs M's requests.

The Ombudsman upheld complaint 4 – He found that although difficult to detect, ischaemia might have been preventable had the clinical suspicion of a small bowel obstruction been considered and pursued. However the Ombudsman could not definitively conclude this because direct treatment of ischaemia would have rested on Mrs M being able to sustain surgery. As with complaint point 1, the Ombudsman nevertheless considered that the uncertainty surrounding the question of whether an opportunity to conduct surgery was lost, amounted, in its own right, to a serious injustice to the family.

The Ombudsman upheld complaint 5 – He found that there were complaint handling failings.

The Ombudsman recommended that:

Within 1 month:

- Provide Mr D with a fulsome written apology for the clinical, care and communication failings identified in the report. This apology should make reference to diagnostic, discharge and complaint handling failings and to the protracted distress and suffering that Mrs M endured as a result of them, and which her family will continue to endure on the basis of the report's findings.
- Make a payment to Mr D of £5,000 in recognition of the distress and a further £250 in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about these matters to the Ombudsman.

Within 3 months:

- Confirm to the Ombudsman that the report has been shared with the Clinical Director(s) responsible for the relevant Surgical and Medical physicians involved in Mrs M's care (along with lead physicians in the Colorectal MDT) and that its findings have been reflected upon and directly discussed with those physicians (where possible) including at those physicians' appraisals and revalidation.
- That steps have been taken to ensure that these physicians undergo training/revision in regard to:
 - The diagnosis, care and treatment of SBO's (with reference to the NCEPOD Bowel Obstruction Study 2018 or other appropriate clinical guidance)
 - The theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered.
- That these physicians are able to reflect on the poor (medical) management of Mrs M's nutritional needs and on the need to ensure that somatic explanations for loss of appetite are considered before resorting to psychological explanations.
- That the report has been shared with the relevant Director of Nursing at the Second Hospital and that its findings have been reflected upon and directly discussed with those nurses involved in Mrs M's discharge (where possible)
- That the relevant nursing team undergoes revision / reflection on the planning, assessment (of capabilities) and communication elements of the Health Board's Discharge Policy (i.e. communication with social care professionals and family members); and that the nursing team is reminded of the importance of documenting actions, plans and developments surrounding the discharge process.
- The report is shared with the Health Board's Equalities Officer to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care.

Asesiad / Assessment & Analysis

The Health Board accepted the findings and conclusions of the public interest report and agreed to implement the recommendations listed.

An action plan has been drafted (attached at Appendix 2) and all recommendations will be implemented within the timescales set out by the Ombudsman.

The Health Board's Quality Assurance Department will monitor the action plan to ensure all recommendations are implemented and lessons have been learned. The Health Board's final action plan update will be submitted to the Ombudsman before the deadline in October 2021 in order to ensure compliance is met.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

The investigation of a complaint against
Betsi Cadwaladr University Health Board
and Denbighshire County Council

A report by the
Public Services Ombudsman for Wales
Case: 202000661 & 202001667

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mr D and to his late mother as Mrs M. Relevant staff involved are referred to by their posts/designations.

Summary

Mr D complained about the care and treatment that his late mother, Mrs M, received at Glan Clwyd Hospital and Llandudno General Hospital. He complained that:

1. Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset and weight loss which she developed following bowel surgery.
2. Clinicians failed to accurately assess Mrs M's frail condition and discharged her without appropriate home care support in place. This was subsequently provided by the Council but was inadequate and, within days, Mrs M was readmitted to hospital.
3. The decision to remove Mrs M's nasogastric tube led to further weight-loss and deterioration.
4. A secondary cause of Mrs M's death – an ischaemic bowel - was not identified from scans or investigations conducted during her admissions.
5. The Health Board and the Council failed to coordinate their response to the complaint. The Council's response was received 6 months after the response provided by the Health Board.

The Ombudsman upheld complaint 1. He found that senior physicians at both hospitals (including the Colorectal MDT) failed to identify that Mrs M had developed a post-operative blockage in the small bowel (a small bowel obstruction – SBO). He found that, despite conspicuous radiological and clinical evidence pointing to this, physicians inappropriately excluded a physical cause for Mrs M's symptoms and attributed her weight loss and aversion to eating to a "food phobia". The Ombudsman could not definitively conclude that the failure to identify and treat the SBO meant that Mrs M's death was preventable. This was because it was unclear whether she could have sustained further surgery, given her frail condition and comorbidities. The Ombudsman nevertheless considered this to be an

alarming, systemic misdiagnosis and considered the uncertainty surrounding whether an opportunity to surgically intervene was lost to be, in itself, an injustice to Mrs M and her family.

The Ombudsman upheld complaint 2. He found that the attempt to discharge Mrs M failed due to multiple shortcomings on the part of both the Health Board and the Council in relation to pre-discharge planning and to the post-discharge support Mrs M received.

The Ombudsman did not uphold complaint 3. He found that the nasogastric tube was appropriately managed and was removed at Mrs M's request.

The Ombudsman upheld complaint 4. He found that, although difficult to detect, ischaemia might have been preventable had the clinical suspicion of an SBO been considered and pursued. However, the Ombudsman could not definitively conclude this because direct treatment of ischaemia would have rested on Mrs M being able to sustain surgery. As with complaint 1, the Ombudsman nevertheless considered that the uncertainty surrounding the question of whether an opportunity to conduct surgery was lost, amounted, in its own right, to a serious injustice to the family.

The Ombudsman upheld complaint 5. He found that there were complaint-handling failings on the part of both bodies.

The Ombudsman recommended that:

- Both bodies provide Mr D with fulsome written apologies for the failings identified in this report.
- Both bodies share the report with their respective Equalities Officers to facilitate training on the principles of human rights in the delivery of care.
- Each body makes a redress payment to the family of £250 in recognition of failings in complaint handling.

- The Health Board makes a redress payment of £5,000 to the family in recognition of the distress that the findings of this report will give rise to.

The Ombudsman additionally recommended that the Health Board:

- Demonstrates that the report has been discussed with the physicians involved in Mrs M's care and that the diagnostic failings are reflected upon at their appraisals and revalidation.
- Evidences that these physicians have undergone training/revision in regard to: the diagnosis and treatment of SBOs; the theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered; the medical management of nutritional needs.
- Demonstrates that the relevant nursing teams referred to in the report have undergone revision/training in respect of the Health Board's Discharge Policy and are reminded of the importance of documenting actions, plans and developments surrounding the discharge process.

Both the Health Board and the Council accepted the findings and conclusions of the report and agreed to implement these recommendations.

The Complaint

1. Mr D complained about the care and treatment that his late mother, Mrs M, received at Glan Clwyd Hospital (“the First Hospital”) and Llandudno General Hospital (“the Second Hospital”). He complained that:

- Clinicians failed to adequately investigate and appropriately treat Mrs M’s symptoms of abdominal pain, gastro-intestinal upset, persistent nausea and weight loss which she developed following bowel surgery.
- Clinicians failed to accurately assess Mrs M’s frail condition and discharged her from the Second Hospital without appropriate home care support in place. The home care support subsequently provided by Denbighshire County Council (“the Council”) was inadequate and, within days, Mrs M was readmitted.
- The decision to remove Mrs M’s nasogastric (“NG”) tube (a tube passed into the stomach via the nose to aid the provision of nutritional support) led to further weight-loss and deterioration.
- A secondary cause of Mrs M’s death – an ischaemic bowel (a condition resulting from a reduced blood supply to the intestines) - was not identified from scans or investigations conducted during her admissions to either hospital.
- Betsi Cadwaladr University Health Board (“the Health Board”) assured the family that those aspects of the complaint that involved social services would be shared with the Council who would respond separately. The response was received 6 months later but only after Mr D pursued this matter with the Council.

Investigation

2. My Investigator obtained comments and copies of relevant documents from the Health Board and from the Council and these were considered in conjunction with the evidence provided by Mr D. Clinical

advice was obtained from 3 of my Professional Advisers: Dr Misra Budhoo (a Consultant Colorectal & General Surgeon), Ms Annabel van Griethuysen (an Advanced Dietetic Clinical Specialist), and Mrs Jean Hazelwood (a Specialist Practitioner District Nurse). I refer to them throughout the report as, respectively, the Medical Adviser, the Dietician Adviser and the District Nurse (“DN”) Adviser.

3. My Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. As Ombudsman, I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included in this report every detail considered during the investigation, but I am satisfied that nothing of significance has been overlooked.

4. My decision to issue this report as a public interest report under s23 of the Public Services Ombudsman (Wales) Act 2019 (“the Act”) reflects the gravity of the identified failings in Mrs M’s medical care and treatment. Whilst the findings of the report in relation to the Council’s home care provision are also concerning, I accept that, in isolation, they may not have met my public interest report threshold. For this reason, I do not require the Council to give publicity to the report or to otherwise modify its response to it in accordance with my public interest report procedure.

5. Mr D, the Health Board and the Council were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant clinical guidance, policies and procedures

6. Reference is made within this report to the following legislation, clinical guidance and policies:

- The Health Board’s Discharge Policy & Protocol (Adults): Acute and Community Hospitals 2018 (“the Discharge Policy”).

- The Council's Domiciliary Care Services Standard Operating Procedure ("the SOP").
- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011; "Putting Things Right" ("PTR") - the process for dealing with complaints about the NHS.
- European Society for Parenteral and Enteral Nutrition (ESPEN) guideline on clinical nutrition and hydration in geriatrics ("the ESPEN Guidance").
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Bowel Obstruction Study 2018.
- The Human Rights Act 1998 ("the HRA") and the European Convention on Human Rights ("the ECHR"). Article 8 of the ECHR is enshrined in UK law by the HRA and deals with the right to respect for one's private and family life which encompasses issues of dignity. All public bodies are required to comply with the Act.
- A guide to handling complaints and representations by local authority social services - Welsh Government August 2014 ("the Complaints Guidance").

Relevant background information and events

7. In December **2018** Mrs M (then aged 69) was diagnosed with locally advanced cancer of the colon (where a tumour has infiltrated or adhered to adjacent organs or structures). Her scheduled surgery was expedited, and on 31 January **2019**, surgeons at the First Hospital performed an extended right hemicolectomy (the removal of the right side of the colon) with en-bloc small bowel resection (the removal of part of the small intestine and surrounding tissue). Mrs M suffered an episode of vomiting on 4 February, but otherwise made a satisfactory recovery and was discharged on 8 February.

8. Following discharge, Mrs M began to suffer with low abdominal pain, nausea, vomiting, loss of appetite and episodes of diarrhoea. These symptoms persisted and Mrs M was briefly readmitted to the First Hospital

on 19 and 25 March and on 10 May (she was also seen as an outpatient on 26 April). On each occasion, investigations were inconclusive and Mrs M's condition was treated conservatively. On 19 March a CT scan (a computer enhanced X-ray providing images of the internal organs) identified "loops" in the intestine (a sign associated with an obstruction) and a further scan on 25 March identified thickening of the loops. Clinicians also identified inflammation of the small bowel mesentery (the membrane that attaches the intestines to the abdominal wall) which was treated with antibiotics.

9. On 17 May Mrs M was readmitted to the First Hospital following an intensification of her symptoms. Her loss of appetite and weight were so concerning that an NG tube was introduced. Mrs M's case was discussed at the Colorectal Multi-Disciplinary Team meeting ("the MDT" – a meeting of clinicians from colorectal and related clinical disciplines) and, suspecting that her cancer might have spread, a plan was put in place to conduct exploratory surgery once Mrs M's nutritional status was stabilised (and following her recovery from a chest infection and a lower-limb DVT – a deep vein thrombosis or blood clot).

10. Clinicians at the First Hospital also considered that Mrs M's loss of appetite and aversion to food was not entirely explained by her physical condition and was likely to be partly psychological in nature (a "food phobia"). Mrs M received regular input from dieticians and, in view of her anxious condition, from the Psychiatric Liaison Team (a dedicated psychiatry team involved in the assessment and treatment of patients in general hospitals with mental health problems).

11. Mrs M was subsequently transferred to the Second Hospital (a community hospital) on 10 June for rest and recovery. Although she continued to struggle with appetite and weight-loss, her NG tube was removed at her request and an attempt was made to discharge her on 25 July via referral to the Council's Reablement Team for home care support (reablement teams provide a social care service for the over 65s on a short-term basis to promote greater independence in matters of self-care). Prior to this, Mrs M underwent assessments that appeared to confirm that she was able to self-care (on 11 and 12 June) and to climb stairs (on 14 and 21 June). However, due to her deteriorating condition, together with changes made to her home care provision that left her without

a support package for several days, Mrs M was unable to cope at home and, following the intervention of a psychiatric liaison nurse (“a PLN”) and a district nurse, was readmitted to the First Hospital on 3 August.

12. On readmission, Mrs M was anaemic (iron deficient) and had a concerning low blood-albumin level (an indicator of malnourishment). Her NG tube was reintroduced. A CT scan of her abdomen identified excessive fluid in the tissues, but clinicians found “no evidence of bowel obstruction” or of ischaemia. Mrs M’s case was discussed by the MDT on 19 August and, in view of her poor nutritional status and frailty, it was agreed that she could not sustain major surgery. Sadly, over the next few days, Mrs M deteriorated and she died on 24 August. A post-mortem subsequently determined that the primary cause of her death was acute peritonitis (inflammation of the membranes of the abdominal wall and organs, typically caused by infection) secondary to small bowel ischaemia.

13. Mr D complained to the Health Board about Mrs M’s care by telephone, both during the discharge process (on 16 July) and following her death (on 27 August). He was provided with a formal response on 10 January **2020**. Mr D was unhappy with the response and subsequently approached my office.

Mr D’s evidence

14. In his complaint to my office, Mr D described how, following her initial bowel operation, Mrs M suffered with constant abdominal pain, nausea and vomiting and, as a result, developed an aversion to food. Her numerous readmissions to the First Hospital failed to resolve these problems and the family became increasingly concerned that the cause of her deterioration was not being addressed.

15. Mr D said that, following transfer to the Second Hospital, the NG tube was removed but this led to even greater weight-loss, which was alarming, and so it was subsequently reinstated. Mr D said that Mrs M’s weight-loss became painful to witness and that she felt “abandoned and helpless”. On 10 July Mrs M underwent a mental health review at the family’s request as she had told them that she would rather die than continue to suffer any longer.

16. Mr D said that when clinicians at the Second Hospital discussed discharge with Mrs M (who lived alone) she became very distressed as she knew she would not be able to cope. This was underlined when, during a brief pre-discharge visit to her home, Mrs M struggled to climb the stairs and could only descend in a sitting position. This meant she could not easily access the toilet in her upstairs bathroom, and so would have to use a commode on the ground floor. Mr D said that, as Mrs M was “a very proud woman”, she felt she had no choice than to go along with the plan. A physiotherapist had assessed her as able to climb stairs on 21 June. However, her discharge was 5 weeks after this, by which time she had significantly deteriorated.

17. Mr D said that Mrs M was in “no fit state” to be discharged on 25 July and that the only support she received was from the PLN who had conducted her mental health review. Mr D said that the PLN contacted social services on behalf of the family in an attempt to obtain additional home care support. When it became clear that there would be a delay in its provision, she arranged for Mrs M’s readmission to the First Hospital. Mr D said that the discharge arrangements were completely inadequate but that the family would always be grateful to the PLN for the efforts she made on their behalf.

18. Mr D said that, following Mrs M’s readmission, she was considered too frail to sustain surgery. He said that this period was extremely distressing for her and the family. He described how Mrs M was “...unrecognisable. Her hair was falling out, she was leaking fluid from her body and she was covered in bruises and patches of dark colours all over her arms”.

19. Finally, Mr D said that (at the time of submitting his complaint) he had heard nothing from the Council, despite being assured that it would respond separately to his concerns about the role of social services in Mrs M’s discharge.

The Health Board's evidence

20. In its complaint response letter of 10 January 2020, the Health Board assured Mr D that his concerns about the role of social services in Mrs M's discharge would be shared with the Council who would respond to him directly.

21. The Health Board said that, on the day before her discharge, Mrs M expressed a desire to go home. She reported feeling better psychologically and felt that she would eat better at home. The Health Board said that Mrs M was self-caring with toileting and personal hygiene needs and had been assessed (on 14 and 21 June) as able to mobilise independently and to be able to climb stairs. The Health Board added that a home access visit was conducted by an Occupational Therapist (an OT) on 25 June to assess Mrs M's living conditions (without Mrs M being present). The OT advised that the stair rail be replaced with one that would allow for an easier grip. This was ordered and fitted before Mrs M's discharge. The OT also ordered a perching stool, a commode and a toilet frame (which were delivered on 10 July).

22. The Health Board said that, prior to her discharge, the Ward Manager contacted social services and explained that Mrs M would need additional support due to her psychological condition. It was agreed that a Social Care Practitioner ("the SCP") would meet Mrs M at her home on the afternoon of 25 July to conduct an assessment. The Health Board said that the Ward Manager referred Mrs M to the Reablement Team and, in addition, contacted the PLN who confirmed she would contact Mrs M to arrange a visit.

23. The Health Board said that, on 26 July, the PLN visited Mrs M who was "very upset" as there was, as yet, no package of care in place. The PLN saw that Mrs M could not manage the stairs despite having been assessed as being able to do so. The PLN therefore contacted the SCP who explained that she had discussed the level of support needed with the Reablement Team but, in view of the PLN's concerns, would arrange for twice daily visits to be commenced immediately.

24. The Health Board said that the Reablement Team subsequently withdrew its home care provision and commissioned a care package from a private care agency (which it felt more appropriate to Mrs M's needs). Pending its instigation, the PLN agreed to conduct support visits each Tuesday and Thursday and additionally arranged for a colleague to visit Mrs M on a Monday, Wednesday and Friday. The Health Board said that, however, by Friday 2 August, Mrs M was extremely poorly and the PLN (and a district nurse) arranged for her to be readmitted to the First Hospital the following day.

25. With regard to the family's concern about Mrs M's medical care following her readmission, the Health Board said that Mrs M had abdominal distension (expansion of the abdomen by the build-up of fluid or gas) for which the medical on-call team sought a surgical review. Though an abdominal X-ray showed her bowel to be dilated (due to a build-up of fluid), a subsequent CT scan did not show any bowel obstruction.

26. The Health Board said that NG feeding was recommenced from 8 August and Mrs M was seen multiple times by the PLNs and a consultant psychiatrist (who prescribed medication for anxiety). The Health Board said that the medical team undertook further investigations, including an upper gastro-intestinal endoscopy on 21 August (in which a camera on the end of a flexible tube is passed down the oesophagus) that did not show any abnormalities.

27. The Health Board said that, in response to her deteriorating condition, Mrs M was reviewed by the Medical Emergency Team and by Intensive Care Unit (ICU) clinicians. However, as it was felt that she was unlikely to benefit from escalation to ICU, a decision was made, following discussion with the family, to provide her with end-of-life care. Sadly, Mrs M passed away soon after 18:00 on 24 August.

28. In its communications with my Investigator, the Health Board emphasised that:

- The cause of Mrs M's symptoms, including aversion to food, was not clear and could not be definitively established.

- The MDT decision to conduct further exploratory surgery was based on the suspicion of recurrent malignant disease or perhaps chronic infection.
- Alongside her poor nutritional status, Mrs M developed a chest infection and a DVT during her 17 May admission which precluded major surgery.
- The CT scan of her abdomen conducted on 5 August showed no evidence of bowel obstruction or ischaemia.
- Mrs M's loss of albumin was attributable to Protein Losing Enteropathy (a condition in which albumin leaks into the intestine).
- The NG tube was removed at Mrs M's request. The risks were explained to her, but she was deemed to have mental capacity to make this decision.
- A medical doctor used the term "anorexia" to describe Mrs M's fear of eating. However, this was not a psychiatric diagnosis.
- A copy of Mr D's complaint was sent to the Council on 1 November 2019 with a request that it respond directly to the family.

The Council's Evidence

29. The Council provided Mr D with its outstanding complaint response on 16 July 2020. In its letter the Council apologised for the delay and stated that there had been a miscommunication with the Health Board which failed to provide, as expected, notification that its formal response to the family had been issued.

30. The Council said that Mrs M received support from the Reablement Team for a period following her discharge, though this was discontinued following discussion with her. The SCP attempted to arrange an alternative care package with a care agency, but this service would not have been available until 5 August. The Council said that the service last visited

Mrs M on 30 July - and Mrs M agreed that Reablement was not the type of service she required as she essentially wanted help to empty the commode and for someone to “pop in to keep an eye on her”.

31. In a letter to my Investigator, the Council said that:

- It received a number of assessments completed by hospital staff which indicated that Mrs M was able to mobilise and transfer, as well as climb stairs.
- Mr D was verbally abusive to home care staff which led to an alert being placed on the system advising of the need for double handed calls for staff safety.
- Support was ended on 30 July as there were insufficient staff to deliver the double handed calls and Mrs M “...was not able to engage with the service to a large extent”.
- Mrs M was observed to be preparing meals and drinks. She declined support with personal care.
- It was accepted that there was a gap in service provision between 30 July and 3 August. During this period, Mrs M was not provided with support to empty her commode.
- There appears to have been a considerable difference between what Mrs M felt able to do on the ward, and what she felt able to do at home.
- It accepted that there was a lack of shared responsibility and joint working between the Council and the Health Board.
- The concern Mr D expressed about social services was more in the nature of a comment or query. The Council said that it would have been happy to respond to the matters he raised, but there was a “disconnect” between it and the Health Board. The Council said that the Health Board failed to confirm that its response had been sent to Mr D and that “...the local authority only became aware of [this] when Mr D contacted us in July 2020”.

Professional Advice

Medical Adviser

32. The Medical Adviser began by noting that Mrs M's surgery (on 31 January 2019) was more difficult than normal due to the locally advanced nature of the tumour and the involvement of the small bowel. He said that, following surgery, blood tests identified an abnormally raised CRP level (C-Reactive protein - a marker of inflammation), a raised white blood cell count (WCC - indicating a response to infection) and a low albumin level (indicating a nutritional deficit – although a drop in albumin may also occur in the acute phase of an infection). Mrs M was given antibiotics and her CRP level improved but, 5 days after surgery, she suffered an episode of vomiting. The Medical Adviser said that the last entry in the records before her discharge stated that her CRP had reduced although her WCC had increased.

33. The Medical Adviser said that the development of vomiting (with a rising WCC) 5 days post-surgery, should have led clinicians to consider conducting a further CT scan. He said that, in Mrs M's case, the risk of post-operative complications arising from 2 bowel anastomoses (the sewing or stapling together of the 2 remaining ends of the intestines after a section is removed), some small bowel repair, a rising WCC and a low albumin was significant. As such, these factors should have lowered the threshold to investigate by CT scan, but one was not performed.

34. The Medical Adviser noted that Mrs M re-presented to the First Hospital on 19 March with wave-like abdominal pain, vomiting and inability to tolerate food. Her CRP was again elevated (though no explanation for this was recorded) and a CT scan showed dilated loops of small bowel. The Medical Adviser was clear that these features, together with her other presenting symptoms, were consistent with a small bowel obstruction ("an SBO" - a blockage in the small intestine). However, an entry made in the records on the following day stated that Mrs M had no further pain and that, if fit, she could be discharged home.

35. Mrs M was readmitted on 25 March with increasing abdominal pain (in 30-minute waves). The Medical Adviser said that a CT scan was performed and it was recorded that there was “no significant bowel pathology”. However, the scan report identified “thickening of two small bowel loops” (in addition to the persistent dilatation identified in previous images). The plan was to continue with 5 days of antibiotics. The Medical Adviser noted that an entry in the records on 1 April said that Mrs M had reported feeling much better and, as this was the last recorded entry, was presumably discharged. It appears that Mrs M was then seen as an outpatient on 26 April. A Consultant Colorectal Surgeon recorded that Mrs M’s “apparent pain” was “...due to her not eating sufficient amounts”. A dietician referral was completed, and a plan recorded to see Mrs M in 6 weeks.

36. The Medical Adviser said that the next entry related to Mrs M’s 10 May admission, when she presented with intermittent pain and tenderness on the right side of her abdomen. He noted that her CRP was again raised and her albumin very low. Abdominal X-rays showed a dilated small bowel. The Medical Adviser said that these X-rays (and a further CT scan) showed dilated loops of small bowel and featured “laddering” (where small bowel loops appear to be stacked on top of each other). He said that this finding indicated an SBO that was either incomplete (where there are loose motions) or complete (where there is no bowel motion). However, the following day it was again documented that Mrs M was feeling better and could be discharged.

37. The Medical Adviser said that Mrs M was readmitted on 17 May (her substantive admission) with dull abdominal pain, vomiting and poor intake of food. She was described as weak and frail and was diagnosed with possible recurrent malignancy, severe hypoalbuminaemia (very low albumin) and frailty.

38. The Medical Adviser said that Mrs M had multiple admissions for essentially the same problem. The medical notes consistently recorded colicky abdominal pain, vomiting and diarrhoea and often recorded rapid improvement when tenderness in the lower abdomen subsided. On each occasion, Mrs M presented with an elevated CRP and a slowly dropping albumin level. The Medical Adviser said that, whilst investigation reports

were never definitive, the scans consistently identified dilatation of the small bowel and subsequent scans indicated a progressive thickening of the bowel (while showing no evidence of a recurrence of bowel cancer). The Medical Adviser said that these factors, taken together, were strongly indicative of a chronic, incomplete SBO. As such, consideration could and should have been given to further investigation and/or treatment.

39. The Medical Adviser said that Mrs M's apparent food phobia was not, therefore, of psychological origin but was a response to the pain that she suffered after eating. This, in turn, explained her poor dietary intake. The Medical Adviser said that, despite the multidisciplinary approach to Mrs M's care, it appeared that the plan for treatment was led by the "conclusive exclusion of a surgical cause for her symptoms" and that "...overall, the [medical] management represents a failure to critically review, conclude and pursue this diagnosis [of SBO], despite the clear indications pointing to it".

40. With regard to whether this diagnostic failure implied that an opportunity for surgical intervention was missed, the Medical Adviser said that he could not answer this definitively. He explained that, even if the SBO had been identified, it would not have been unreasonable for clinicians to have initially attempted to manage Mrs M's condition conservatively (in keeping with established practice). Additionally, given that this approach met with some limited success (insofar as Mrs M's symptoms appeared to settle during her March admissions), it was not unreasonable that urgent surgical intervention was not initially considered appropriate. The Medical Adviser said that, subsequently, by the time it became clear that Mrs M's condition was not resolving (by, approximately, her second readmission in late March), her nutritional status was compromised and it was unlikely that she would have been considered a candidate for surgery without significant improvement of her condition. The Medical Adviser said that, by May, Mrs M's deterioration and the additional complications of a chest infection and a DVT precluded surgery. The Medical Adviser stressed that surgical intervention would only have taken place under optimal conditions and it was not possible to definitively state that such conditions existed at any time during Mrs M's admissions. As such, he could not say with certainty that an opportunity to conduct surgery was lost.

41. The Medical Adviser said that this uncertainty did not alter the fact that “...three admissions within a short timeframe should have prompted further investigations and possibly definitive treatment”. He noted that none of the scans conducted employed oral contrast or dye (taken either as a drink or intravenously) to help with diagnosis (as recommended by NCEPOD), and that further investigation via a CT-PET scan (a more discriminating scan used in the detection of cancer) might have been considered. This scan would have shown potential sites of abnormality and might have pointed towards other causes of Mrs M’s symptoms. The Medical Adviser added that Mrs M’s poor absorption was attributable to her SBO and not, as stated by the Health Board, to Protein Losing Enteropathy.

42. With regard to Mrs M developing ischaemia (identified at post-mortem), the Medical Adviser said that this is always a possibility with SBOs but is difficult to detect with non-contrast CT scans. He noted that the post-mortem made mention of a “complex mass of bowel with ischaemia”. This suggested chronic obstruction eventually leading to ischaemia and perforation (and thus to peritonitis). The Medical Adviser said that “...the ischaemia here is likely an acute event leading to perforation and a natural consequence of matted bowel and obstruction...actual ischaemia could not have been detected earlier but might have been potentially preventable had the clinical suspicion of incomplete SBO with recurrent symptoms been considered”. He stressed however, that prevention of ischaemia in Mrs M’s case would have rested on her suitability for SBO surgery which (as outlined above) could not be said definitively (in retrospect) to have been possible.

43. The Medical Adviser said that, in view of Mrs M’s initial complex surgery, he would have expected a formal plan to have been recorded to ensure improvement after her discharge. He said that the day-of-discharge documentation always appeared abruptly, despite Mrs M’s regular returns to hospital, and the records did not contain any discharge summaries. He said that Mrs M’s admissions continually included a history of vomiting (with episodes of vomiting in hospital) but there was no objective review of volumes or of the content of the vomitus. He also considered that reliance on dietician input alone was not reasonable since the Consultant is ultimately responsible for the care of the patient. He said that it is difficult

to see from the records that Mrs M's nutritional difficulties were treated with great concern. Albumin levels below 10 are uncommon and did not seem to trigger any level of anxiety regarding diagnosis.

44. In conclusion, the Medical Adviser emphasised that:

- Most of Mrs M's nutritional deterioration was unsurprising. That an organic cause for it was not conclusively excluded before considering psychiatric reasons was a missed opportunity. Clinicians appeared to act with "tunnel vision".
- Very little consideration seems to have been given to the possibility of providing parenteral nutrition (nutrition via a vein, that would by-pass the stomach). Mrs M's nutritional deterioration required more than NG feeding.
- Discharging Mrs M repeatedly without fully addressing her problems (and hoping her appetite would return) was not acceptable.
- Whilst it was not possible to say with any certainty that Mrs M, at any point, was capable of sustaining a further surgical intervention, the missed SBO diagnosis made this possibility progressively more remote as her condition deteriorated and the underlying cause of her inability to absorb nourishment was not addressed.
- Finally, Mrs M was always unlikely to improve in a community hospital. She required further investigation, parenteral nutrition, and a definitive management plan.

Dietician Adviser

45. The Dietician Adviser noted that, following initial referral, the dietetic team offered Mrs M a "food first" approach (as opposed to alternative forms of nutrition). The Dietician Adviser said this was based on Mrs M's preferences and was an appropriate line of treatment (supported by the ESPEN Guidance) which reflected a patient-centred approach.

46. The Dietician Adviser said that (post-discharge) follow-up appointments were arranged by the dietetic team and Mrs M had ongoing monitoring in the community which was appropriate. The dietetic team also appear to have liaised with the wider MDT in respect of the underlying causes of Mrs M's reluctance to eat, including concerns about her mental health.

47. The Dietician Adviser said that, subsequently, Mrs M was unable to meet her nutritional requirements orally and dieticians recommended NG feeding. Mrs M appeared to tolerate the NG tube, along with small amounts of oral intake, and was regularly reviewed throughout May and early June. However, she subsequently appeared to disengage with artificial / NG tube feeding and requested the tube be removed prior to her discharge. The Dietician Adviser said that, on readmission, the dieticians appropriately reintroduced NG tube feeding when it was clear that Mrs M continued to struggle with eating.

48. With regard to Mr D's complaint that the NG tube should not have been removed before discharge, the Dietician Adviser stressed that its removal was carried out at the request of Mrs M who had the mental capacity to make that decision. The notes also indicated that Mrs M was reporting that she was managing oral intake better (she was receiving home-prepared food). Having said this, the Dietician Adviser felt that Mrs M might have been communicating differently with staff and family.

49. With regard to the suggestion that Mrs M's loss of appetite amounted to anorexia, the Dietician Adviser said that Mrs M had no prior history of this condition or dealings with mental health services. She said that the term "anorexia" in clinical practice is generally used to describe someone with no appetite and should not be confused with the clinical diagnosis of anorexia nervosa, which requires specialist eating disorder input and is very different. The Dietician Adviser noted that Mrs M did, however, have difficulties with her mental health, including fear of food and eating. Due to this, the dieticians did include mental health service referrals at frequent points during their reviews.

50. In conclusion, the Dietician Adviser said that, overall, the dietetic treatment provided to Mrs M was appropriate, evidence based, and patient focussed. Moreover, the advice and plans put in place, in regard to supporting oral intake and NG feeding, were consistent with ESPEN guidance.

District Nurse (DN) Adviser

51. The DN Adviser began by noting the Health Board's statement that the Council was informed of the plan to discharge Mrs M in a telephone call from the Ward Manager to the SCP (a call that was not recorded in the nursing notes). The SCP and a Social Care OT subsequently visited Mrs M at home on the afternoon of 25 July to assess her needs and produce a care plan. A referral to the Reablement Team was made by the SCP and this was expedited following a home visit by the PLN the following day. Two (retrospective) referrals were subsequently received from the Second Hospital, dated 26 and 31 July. It was agreed that Mrs M would receive 2 (30 minute) visits a day for assistance with preparing breakfast and an evening meal. It was also agreed that home-care staff would empty Mrs M's commode and assist her in having a daily wash or shower. The DN Adviser noted the OT's assessment and actions (see paragraph 21).

52. The DN Adviser said that the communication between the Health Board and the Council in advance of Mrs M's discharge was fragmented, confusing, lacking in clarity and at times contradictory. There appeared to be no expectation / advance consideration on the part of Health Board clinicians that Mrs M would require a home care package (other than "additional support" due to her psychological condition). There was also a consistent failure to adequately record any consideration this matter was given. The DN Adviser said that, overall, clinicians showed little awareness of numerous elements of the Health Board's Discharge Policy – primarily those relating to communication and recording (e.g., sections 1.2-1.9, 5.51, 5.6.11 and 6.5.2). The DN Adviser said that Mrs M's discharge was not a complex one and that during the weeks she was in the Second Hospital a package could have been prepared to meet her care needs (though this would not have precluded the possibility of the discharge failing).

53. The DN Adviser said that only a passing reference to Mrs M's discharge was recorded by the MDT (on 22 July). She said that, in view of the number of emergency admissions in Mrs M's case, together with the fact that the surgical team were considering further exploratory surgery, she would have expected an MDT to gather and consider all of the relevant information and to identify and put in place what was required for her package of care. She added that there was no documented record of the family being involved at any point with the discharge plan.

54. The DN Adviser said that the care plan prepared by the SCP did not reflect Mrs M's needs as she expressed them in the pre-discharge "What Matters Conversation" (the WMC). This is the stage at which the patient/client's preferences, desires and goals are recorded¹ and did not appear to comply with the standards set out in the SOP (with its emphasis on tailoring services to the client's needs). The DN Adviser noted that the WMC had clearly recorded Mrs M's concern that she was not able to fully wash herself or to cook due to her inability to stand for any length of time. It also referred to how she found transferring to and from the sofa difficult and to how unsteady she was in climbing and descending the stairs.

55. The DN Adviser said that, despite this, the "action required" parts of the care plan enjoined staff to "prompt" Mrs M to perform self-care and mobilisation activities. This appeared to disregard her need for help with these tasks. The DN Adviser said that Mrs M required home care visits to assist her, not prompt her.

56. The DN Adviser said that the care package provided did not address Mrs M's anxiety relating to food, and Reablement staff failed to document oral intake of diet or fluids. Equally, no record was made of any encouragement given to Mrs M to wash or shower. The DN Adviser said that the 1-page, 5-point care plan was wholly inadequate. Moreover, Mrs M did not appear to know what she could expect from her package or from the staff attending to her.

¹ As stipulated by the Social Services and Well-being (Wales) Act 2014).

57. The DN Adviser said that, with regard to the Reablement Team's decision to withdraw its service, the rationale for this was nowhere made clear. Whilst it was understood from the SOP that Reablement offered a "...personalised approach whereby the individual using the service sets their own goals and is supported to achieve them...", there was no recorded discussion of such goals and/or of what, precisely, made Mrs M's situation inappropriate for Reablement intervention. The DN Adviser noted that, according to the SOP, the service can provide "...assistance with washing, showering, bathing, getting up, retiring to bed, toileting, emptying commodes, preparation of meals, diet and fluid intake" and that this precisely reflected the assistance that Mrs M required. The DN Adviser also noted that reference was made by the Council to Mrs M's son having been abusive to Reablement staff who, for safety reasons, subsequently attended Mrs M's home in pairs. However, the DN Adviser could find no documented account of this incident in the daily records or elsewhere.

58. The DN Adviser said that there was no documented explanation for why the Reablement Team felt unable to continue to support Mrs M for the brief period before the private care agency took over her home care. This decision appeared to have been taken with little regard to Mrs M's frail condition (as emphasised by the PLN) and, moreover, sat uneasily with the statement in the SOP that "...if it is agreed that a change is required, we will work with the individual to try to ensure the transfer is done in the best possible way".

59. With regard to the home assessment conducted by the OT, the DN Adviser could find no reference to the problem of where Mrs M would sleep (given her difficulties with climbing stairs). She added that, whilst Mrs M had undergone a stair-assessment in the Second Hospital, this took place some weeks before the discharge and entailed climbing only 3 or 4 steps in a highly supervised environment. Negotiating a full flight of stairs, however, can be very different. Moreover, Mrs M's difficulty with climbing stairs became clear during a pre-discharge home visit in which she had struggled to climb and descend the stairs. There was no evidence that this was inputted into Mrs M's care plan.

60. In conclusion, the DN Adviser emphasised that:

- There was a concerning failure by clinicians at the Second Hospital to adhere to the Health Board's Discharge Policy.
- Assessments repeatedly described Mrs M as self-caring. However, this was at odds with the contents of her WMC.
- Assessments of Mrs M's physical capacities may have been out of date by the time she was actually discharged.
- The Reablement Team's care plan was inadequate.
- The decision of the Reablement Team to withdraw its support provision was not adequately explained.
- Without the voluntary assistance of the PLN, Mrs M would have had no professional support at all.
- Whilst the Council acknowledged that it had not considered how Mrs M would manage to empty her commode, there was no recognition of the severe difficulty this created or of how it might have compromised her dignity and added to her anxieties. This was a particularly acute problem for her, given that she was suffering with a long-term gastro-intestinal upset. The Council's complaint response letter to the family neither mentioned nor apologised for this failing.

Mr D's comments on a draft version of this report

61. Mr D said that, during each of Mrs M's admissions, clinicians spoke of anorexia as a diagnosis and that this caused his mother "endless confusion and anxiety". Mrs M was continuously told that her only problem was lack of food intake. This led her to make determined efforts to eat "...but each time she ended up in worse pain". Mr D said that, in desperation, Mrs M even discussed with mental health clinicians the possibility of undergoing Electroconvulsive Therapy (ECT - a procedure in which small electric currents are passed through the brain causing changes to brain chemistry that can reverse symptoms of certain mental health

conditions). Mr D added that this procedure might have gone ahead had Mrs M not been deemed too weak to undergo it. He said this reflected her desperation to get well and the extent to which she had come to believe that her problems were “all in her mind”. Mr D said that the family still find this matter distressing some 2 years on.

62. With regard to the Council stating that Mr D was, on one occasion, “verbally abusive” to a member of the Reablement Team, Mr D said that this was an unfair description of an incident which was taken out of context. He said that, on 29 July 2019, he visited his mother and found her extremely distressed after learning that her support visits had been withdrawn by the Council. Mr D said that, feeling angry and upset, he telephoned the Council and demanded to speak to the SCP. As this was not possible, he insisted that the SCP call him back in due course. However, this did not happen. Mr D said “...I was not subsequently told my behaviour was unacceptable or that it prompted double-handed calls”. Mr D said that he was angry on that occasion but not abusive and that the Council has “...used this incident without justification”.

63. Finally, Mr D said that family members are still haunted by the memories of Mrs M’s acute physical and mental suffering. He said that one of the hardest parts of dealing with their loss is the memory of how their mother was made to believe that her mental health was the main contributing factor to her deterioration.

Analysis and conclusions

64. In considering Mr D’s complaint and in reaching my findings, I have had regard to the advice that I have received from my Advisers, although the conclusions reached are my own. The investigation has considered 5 complaint elements and I will address each of them in turn:

1. That clinicians failed to adequately investigate and appropriately treat Mrs M’s symptoms

65. I concur with the Medical Adviser that overall, Mrs M’s medical management represented a failure to “...critically review, conclude and pursue a diagnosis of SBO, despite the clear indications pointing to it”.

This process began (in January 2019) with a failure to recognise the extent of the risk of post-surgical complication that Mrs M was exposed to and with a failure to have recorded a formal plan to ensure improvement after discharge. This was followed by a failure to lower the threshold for CT investigation of her post-surgical symptoms. Subsequently, there appears to have been an abiding, systemic failure during each of Mrs M's 4 readmissions to:

- Identify the signs of an SBO from X-rays and CT scans (including signs such as progressively thickening loops and laddering that can point to obstruction).
- Relate Mrs M's other symptoms to the radiological evidence (her abdominal pain on eating, her nausea, vomiting and diarrhoea), along with the failure to note the easing of these symptoms in response to a reduction of solid food intake and an increase in liquid food supplements.
- Respond to / investigate Mrs M's elevated CRP and WCC levels and her significantly low albumin level (which was incorrectly considered to be attributable to Protein Losing Enteropathy).
- Consider the use of contrast in CT scans (in accordance with clinical guidance) that might have confirmed an SBO or signs of ischaemia and/or consider conducting a CT-PET scan (to exclude the possibility of Mrs M's cancer returning).
- Consider parenteral nutrition and devise a definitive management plan (as opposed to discharging her without addressing her problems in the hope that her appetite would return).

66. I also concur with the Medical Adviser that Mrs M's apparent food phobia was not of psychological origin but was a response to the pain that she suffered after eating – especially attempts at solid food. As such, whilst Mrs M's general anxiety was addressed by the psychiatric team, the idea that this was linked to a food phobia (i.e., to an "irrational" fear of food) was incorrect. As Mr D observed in his comments on the draft report, the impact of this error on Mrs M was profound.

67. It is additionally concerning to note from the Medical Adviser's comments, reproduced in some detail above, that:

- Clinicians acted with “tunnel vision” in the way that they conclusively excluded a surgical cause for Mrs M's symptoms.
- Mrs M's discharges appear to have been organised abruptly without consideration of the repeating admission-discharge pattern and without documenting any formal follow-up plan (either in medical records or in discharge-summaries).
- Mrs M's uncommonly low albumin level did not trigger any particular level of concern regarding diagnosis.

68. I am satisfied that, for the reasons I have outlined above, clinicians failed to adequately investigate Mrs M's symptoms and consequently failed to diagnose her condition of an incomplete SBO. Whilst any such diagnostic failing is a matter of concern, in this case it is additionally concerning to note that the presence of the SBO was supported by conspicuous clinical evidence. I would add that the records provided by the Health Board suggest that the failure to identify the incomplete SBO (from the CT scan evidence) was systemic in nature. That is, the “conspicuous clinical evidence” was apparently missed by a significant number of senior physicians involved in Mrs M's care (including a Consultant Colorectal Surgeon, a Consultant Surgeon, a Consultant Physician, a Consultant in Elderly Care and the Colorectal MDT as a whole). I consider the widespread nature of this failing to be, in its own right, alarming, given my Adviser's view that the signs of an SBO were so evident. I also consider that this systemic failing constitutes a disquieting injustice to Mrs M and her family (and, in view of the implications for patient safety, has led me to forward a copy of this report, at draft stage, to Health Inspectorate Wales).

69. I have also carefully considered whether this diagnostic failing implies that Mrs M's deterioration and death might have been prevented. With regard to this, I have been guided by the Medical Adviser's view that it is not possible to say with any certainty that Mrs M, at any point (after approximately late February), was capable of sustaining surgical

intervention. As such, I cannot conclude with certainty that this failing led, directly or indirectly, to Mrs M's death. It is important to note that every surgery carries an element of risk. Mrs M had already undergone complex surgery in January, so her surgical risk was greater if she were to undergo another significant procedure.

70. Having said this, I nevertheless consider that the uncertainty surrounding this question will remain for the family an enduring source of distress and anguish and, to that extent, I regard it as a significant and disturbing injustice. I am also of the view that the diagnostic failure indirectly caused Mrs M avoidable physical and psychological suffering that was undoubtedly deepened and lengthened by her multiple admissions; by the suggestion/suspicion that her cancer had spread; by the attempt that was made to discharge her in late July (and the burdens of self-care that were inappropriately placed on her by this process); by the suggestion that she was suffering from a mental health disorder (and the ramifications of this as emphasised by Mr D in his comments on the draft report); and by the incomplete understanding of Mrs M's condition that informed the approach to her of all of the clinicians and carers she encountered. Collectively (as well as individually), these failings impacted upon Mrs M's human rights in terms of not only dignity but her quality of life. There was also an impact on the wider family's rights in terms of their witnessing her debilitating decline (as described by Mr D). Whilst it is not for me to make findings of a breach of human rights, even where I might consider there may have been one, the serious events here call into question whether proper regard was given to them in Mrs M's case.

71. On the basis of all these considerations, I **uphold** this element of the complaint.

2. Mrs M's discharge from the Second Hospital

72. I concur with the DN Adviser that communications between the Health Board and the Council in advance of Mrs M's discharge were "fragmented, confusing, lacking in clarity and at times contradictory". Whilst this may largely reflect inadequate record-keeping, such records as

there are suggest there was a concerning failure to observe and comply with (at least) all of the sections of the Discharge Policy listed by the DN Adviser.

73. I also accept the DN Adviser's view that the pre-discharge assessments that were conducted and documented (by OTs and physiotherapists) did not address the problem of where Mrs M would sleep and included a stair-assessment that took place some 5 weeks before the discharge. As such, the assessment did not accurately reflect Mrs M's condition and ability on discharge itself.

74. Additionally, it appears that:

- No specific home care support package had been arranged in advance for Mrs M or discussed in advance by the MDT.
- The referral to the Reablement Team was made by the SCP and OT, not by the Health Board. The Health Board's referrals to the Council were made retrospectively.
- The involvement of the PLN in Mrs M's discharge was not anticipated or planned. Her assessment of Mrs M's abilities and needs (and the extent of the support she would require for them to be met) was conducted on the day following Mrs M's discharge and contradicted assessments that had concluded that she was self-caring, able to mobilise and to climb stairs.

75. I agree that, for the reasons given by the DN Adviser, the care plan prepared by the SCP was inadequate and did not reflect Mrs M's needs as she expressed them in the WMC (and/or as assessed by the PLN). I also agree that the care plan did not address Mrs M's anxiety relating to food and that Reablement staff did not document oral intake of diet or fluids. I am also concerned to note that:

- The rationale for the Reablement Team's decision to withdraw its service was not made clear anywhere. Whilst reference was made by the Council to Mrs M "not engaging" with the Service, this was not clarified or elaborated on.

- The Council's contention that Mr D was "abusive" was not recorded and, as Mr D emphasised in his comments on the draft report, he was not informed that his behaviour had been interpreted as such (or that it had resulted in carers conducting double-handed visits).
- The Reablement Team failed to provide Mrs M with assistance with a range of tasks explicitly specified in its SOP as being within its remit to provide.
- There was no recorded discussion of goals or outcomes that Mrs M wished to / was expected to achieve.
- No explanation was offered as to why the Reablement Team felt unable to continue to support Mrs M for the brief period before the private care agency took over her home care.
- Without the voluntary assistance of the PLN, Mrs M would have had no professional support at all.
- There was no recognition of the difficulty that Mrs M would have encountered in using and emptying her commode following the withdrawal of the Reablement Team. This would have directly impacted on her personal dignity and her human rights.

76. In summary, I am of the view that there were numerous, significant failings and deficiencies (of planning, care-management and recording) before, during and after Mrs M's discharge (on the part of both the Health Board and the Council). The failure of the Health Board to conduct the discharge in accordance with its Discharge Policy was compounded by the failure to coherently document relevant processes, discussions and decisions as these occurred. The significant failings in the home care support that Mrs M received from the Council exposed her to risk (in failing to address her care needs and in leaving her without any appropriate source of support); added to her (and her family's) already heightened anxiety; and created an acute problem around her toileting needs which compromised her dignity and placed an improper and unfair burden on

those in contact with her (friends, family and the PLN) to assist her with this and other matters. I reiterate my comments above in terms of the impact on both Mrs M's and her wider family's human rights.

77. Whilst I accept Mr D's comment (echoed by the Council and the Advisers) that Mrs M was "a proud woman" who found it difficult both to admit that she had incapacities and to accept the assistance of others in personal/intimate tasks, I do not accept that this problem was adequately considered and/or addressed as it might have been had her family been appropriately involved in her discharge. I am of the view that had Mrs M's discharge been properly considered by the MDT in conjunction with her, with the Council and with family members, then a far more accurate picture of her care needs would have emerged and an appropriate means of meeting them might have been arranged.

78. In conclusion, I consider these failings, taken together, undermined any possibility of Mrs M's discharge from the Second Hospital succeeding and, therefore, of being of any benefit to her at a time when she was suffering from a debilitating and unresolved illness. In my view, this amounts to a significant injustice to her and to her family and, consequently, I **uphold** this element of the complaint.

3. That clinicians should not have removed Mrs M's NG tube

79. I concur with the Dietician Adviser that, on the basis of the available records:

- The removal of the tube (in advance of discharge) was done at Mrs M's request. The risks of this were explained to her but Mrs M had the capacity to make this decision.
- At the time, Mrs M reported that her management of oral intake was improving and was likely to improve further with home-prepared food.
- Whilst dieticians (along with other clinicians involved in Mrs M's care) were not fully appraised of the precise cause of Mrs M's aversion to food (i.e., the presence of an SBO), the care and

treatment offered was appropriate to the clinical circumstances and clinical goals as these were understood and formulated at the time.

- The NG tube was appropriately reintroduced following Mrs M's readmission. Its use was accurately documented.

80. For these reasons, I **do not uphold** this element of Mr D's complaint.

4. That clinicians failed to identify ischaemia of the bowel

81. I accept the Medical Adviser's view that, although difficult to detect, ischaemia of the bowel is associated with SBOs. I also accept his view that the problem of detecting ischaemia might have been aided by performing a contrast CT scan which would have highlighted the quality of blood supply to the bowel. However, I have seen nothing to suggest that this option (or the option of conducting a CT-PET scan) was considered.

82. I also accept the Medical Adviser's view that "...actual ischaemia could not have been detected earlier but might have been potentially preventable had the clinical suspicion of incomplete SBO with recurrent symptoms been considered". As this suspicion was not considered, I **uphold** this element of Mr D's complaint. However, with regard to the implication that this failing led to Mrs M's death, I am again unable to definitively conclude this. This is because I accept the Medical Adviser's view that prevention and/or direct treatment of ischaemia in Mrs M's case would have ultimately rested on her ability to sustain surgery. As outlined above, this cannot be said (in retrospect) to have been definitively possible, and I am not able to consider matters with the benefit of hindsight, knowing the eventual outcome. Nevertheless, I am satisfied that, whilst it cannot be said with certainty that Mrs M's death could have been prevented, it is clear that in failing to pursue the clinical suspicion of an SBO, opportunities to intervene were lost. These opportunities may or may not have included the option of surgical intervention, but in keeping with my earlier comments, I regard the uncertainty surrounding this question as an avoidable injustice to Mrs M and her family.

5. Complaint handling

83. The Council's delay in responding to the family's complaint appears to have been due to a communication failure between the Health Board and the Council. The Health Board says it provided the Council with details of Mr D's complaint and expected it to respond directly. It appears that the Council thought that the Health Board would inform it when its complaint response was ready, and that the Council's response would then be issued as a supplement to it. However, the Council said that the Health Board failed to confirm that its response had been sent to Mr D whereas the Health Board expected and thought that the Council would respond independently.

84. Given that there was no clear agreement on issuing a joint response, it was not unreasonable in my view that the bodies sought to produce separate, though interrelated, responses. However, I would note that the Complaints Guidance advocates that local authorities should work collaboratively with health boards and, unless there is good reason not to do so, co-ordinate their investigations and responses with other public bodies. Whilst I am not critical of the decision to issue separate responses if it was considered better to do so, I am critical of the fact that:

- The complaint was received by the Health Board in July (and added to in August) but the Council was not informed that it contained a concern directed against it before 1 November (thus making the co-ordination of a joint response impossible).
- The issuing of the complaint response on 10 January 2020 (with its explicit reference to the Council's pending response) should have prompted the Health Board's Concerns Team to share the letter with the Council or at least to notify the Council's Complaints Officer that the letter had been issued.
- The Health Board's failure to confirm that its response had been sent to Mr D did not, even by July 2020, prompt the Council to query this matter with the Health Board.

85. I consider that these failings (on the part of both bodies) avoidably delayed the provision of the Council's response to Mr D and obliged him to pursue the matter at what was a difficult time for the family. The inconvenience to him entailed by this extended his complaint, added to his distress and frustration and made it more likely that he would escalate his complaint to me. I consider this was an injustice to Mr D and, consequently, I **uphold** this element of the complaint.

86. Finally, I consider that the level of financial redress I am recommending in paragraph 87(b) appropriately reflects the distressing impact that the report's findings will have on the family. In recommending this sum, I have additionally been guided by the limited options for redress that are available to me, given that Mrs M has now passed away.

Recommendations

87. I **recommend** that, within **1 month** of this report being issued the **Health Board**:

- a) Provides Mr D with a fulsome written apology for the clinical, care and communication failings identified in this report. This apology should make reference to diagnostic, discharge and complaint handling failings and to the protracted distress and suffering that Mrs M endured as a result of them and which her family will continue to endure on the basis of this report's findings.
- b) Makes a payment to Mr D of £5,000 in recognition of this distress and a further £250 in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about these matters to me.

88. I further **recommend** that, within **3 months** of this report being issued, the **Health Board** confirms to me:

- c) That this report has been shared with the Clinical Director(s) responsible for the relevant Surgical and Medical physicians involved in Mrs M's care (along with lead physicians in the

Colorectal MDT) and that its findings have been reflected upon and directly discussed with those physicians (where possible) including at those physicians' appraisals and revalidation.

- d) That steps have been taken to ensure that these physicians undergo training/revision in regard to:
- The diagnosis, care and treatment of SBOs (with reference to the NCEPOD Bowel Obstruction Study 2018 or other appropriate clinical guidance).
 - The theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered.
- e) That these physicians are able to reflect on the poor (medical) management of Mrs M's nutritional needs and on the need to ensure that somatic explanations for loss of appetite are considered before resorting to psychological explanations.
- f) That this report has been shared with the relevant Director of Nursing at the Second Hospital and that its findings have been reflected upon and directly discussed with those nurses involved in Mrs M's discharge (where possible).
- g) That the relevant nursing team has revised / reflected on the planning, assessment (of capabilities) and communication elements of the Health Board's Discharge Policy (i.e. communication with social care professionals and family members); and that the nursing team has been reminded of the importance of documenting actions, plans and developments surrounding the discharge process.
- h) That this report has been shared with the Health Board's Equalities Officer to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care.

89. I **recommend** that, within **1 month** of this this report being issued **the Council**:

- i) Provides Mr D with a fulsome written apology for the care, discharge communication and complaint handling failings identified in this report. This apology should make reference to the inadequacy of the care plan that was prepared for Mrs M, for the poor recording of her dietary, self-care and mobilisation problems and for how the withdrawal of the Reablement Service left her without appropriate professional support. It should also refer to how the withdrawal of assistance she required in using a commode compromised her dignity.
- j) Shares this report with its Equalities Officer so that the Reablement Service can receive training on the principles of human rights in the delivery of services.
- k) Makes a payment of £250 to Mr D in recognition of the failure to respond to his complaint until prompted by him to do so, and in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about this to me.

90. I am pleased to note that in commenting on the draft of this report **the Health Board** and **the Council** have accepted its findings and have agreed to implement these recommendations.



Nick Bennett
Ombwdsmon/Ombudsman

21 July 2021

ENDNOTE

This document constitutes a report under s.23 of the Public Services Ombudsman (Wales) Act 2019 and is issued under the delegated authority of the Ombudsman.

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: [@OmbudsmanWales](https://twitter.com/OmbudsmanWales)

Summary: Mr D complained about the care and treatment that his late mother, Mrs M received at Glan Clwyd Hospital (the first hospital) and Llandudno General Hospital (the second hospital). He complained that:

- Clinicians failed to adequately investigate and appropriately treat Mrs M's symptoms of abdominal pain, gastro-intestinal upset, persistent nausea and weight loss which she developed following bowel surgery.
- Clinicians failed to adequately assess Mrs M's frail condition and discharged her from the second hospital without appropriate home care support in place. The home care support subsequently provided by Denbighshire County Council was inadequate and, within days, Mrs M was readmitted.
- The decision to remove Mrs M's naso-gastric tubing (a tube passed into her stomach via the nose to aid the provision of nutritional support) led to further weight-loss and deterioration.
- A second cause of Mrs M's death – an ischaemic bowel (a condition resulting from a reduced blood supply to the intestines), was not identified from scans or investigations conducted during her admission to either hospital.
- The Health Board assured the family that those aspects of the complaint that involved social services would be shared with the Council who would respond separately. The response was received 6 months later but only after Mr D pursued this matter with the Council.

Scrutiny		Hospital Site Medical Director Divisional Director Divisional Head of Nursing			
Action Plan Lead(s)		Hospital Site Medical Director Divisional Director Divisional Head of Nursing Senior Concerns Manager (PSOW Single Point of Contact)			
Updated		Date Created 16.6.2021, updated 16.6.2021, updated 22.7.2021, updated 23.8.2021			
Ombudsman Recommendations		Leads	By	RAG	Comments/update
a.	Provide Mr D with a fulsome written apology for the clinical, care and communication failings identified in the report. This apology should make reference to diagnostic, discharge and complaint handling failings and to the protracted distress and suffering that Mrs M endured as a result of them, and which her family will continue to endure on the basis of the report's findings.	Senior Concerns Manager (Ombudsman Single Point of Contact)	20 August 2021		

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b.	Make a payment to Mr D of £5,000 in recognition of the distress and a further £250 in recognition of the inconvenience and trouble to which he was put in pursuing a complaint about these matters to the Ombudsman.	Senior Concerns Manager (Ombudsman Single Point of Contact)	20 August 2021		
c.	Confirm to the Ombudsman that the report has been shared with the Clinical Director(s) responsible for the relevant Surgical and Medical physicians involved in Mrs M's care (along with lead physicians in the Colorectal MDT) and that its findings have been reflected upon and directly discussed with those physicians (where possible) including at those physicians' appraisals and revalidation.	Mr Ramesh Hospital Site Medical Director	20 October 2021		

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d.	That steps have been taken to ensure that these physicians undergo training/revision in regard to: <ul style="list-style-type: none"> • The diagnosis, care and treatment of SBO's (with reference to the NCEPOD Bowel Obstruction Study 2018 or other appropriate clinical guidance) • The theory and practice of the use of contrast media in CT scans and the clinical contexts in which the threshold for CT investigations should be lowered. 	Mr Andrew Foulkes Clinical Director (Surgery) Dr Mick Kumwenda, Clinical Director (Medicine)	20 October 2021		
e.	That these physicians are able to reflect on the poor (medical) management of Mrs M's nutritional needs and on the need to ensure that somatic explanations for loss of appetite are considered before resorting to psychological explanations.	Mr Andrew Foulkes Clinical Director (Surgery) Dr Mick Kumwenda, Clinical Director (Medicine)	20 October 2021		

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f.	That the report has been shared with the relevant Director of Nursing at the Second Hospital and that its findings have been reflected upon and directly discussed with those nurses involved in Mrs M's discharge (where possible)	Trevor Hubbard, Director of Nursing Nicola McLardie, Head of Nursing (Area)	20 October 2021		
g.	That the relevant nursing team undergoes revision / reflection on the planning, assessment (of capabilities) and communication elements of the Health Board's Discharge Policy (i.e. communication with social care professionals and family members); and that the nursing team is reminded of the importance of documenting actions, plans and developments surrounding the discharge process.	Director of Nursing (Central) Delyth Williams EQ Nicola McLardie, Head of Nursing (Area) Sali Williams Deputy Head of Nursing Nicky Jones	20 October 2021		

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		Matron Liz Bowen Clinical Director for oversight of medical COTE teams in Hospital B and COTE wards in Hospital 1			
h.	The report is shared with the Health Board's Equalities Officer to facilitate training to relevant staff involved in Mrs M's care on the principles of human rights in the delivery of care.	Sally Thomas, Head of Equality and Human Rights	20 October 2021		



Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group (PSQG)
Chair of meeting or lead for report	Gill Harris – Executive Director of Nursing and Midwifery
Date of meeting	13 July 2021 August meeting - stood down (reports taken by circulation)
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality Safety and Experience Committee
Date of meeting	07 September 2021
Presented by	Gill Harris – Executive Director of Nursing and Midwifery

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

- **Complaints and incident performance** was noted as an area where improvement was still needed in respect of divisional performance for timeliness. The Deputy Chief Executive is holding accountability meetings with divisions in regards to this area. The new processes and new training is supporting this work with a significant focus on the Early Resolution of complaints.

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

- **Safe Medications Group:** A detailed update was received including assurance on Patient Group Directions and Drug Safety Alert cascades. Going forward, the work plan of the Group will focus on the draft medicines improvement plan brought to PSQG in May 2021. The local Safer Medicines Practice Groups (SMPGs) will escalate their action plans to the Steering Group to develop an overarching BCU wide plan. A review of historical methotrexate incidents and associated learning was presented to PSQG in June 2021 and an update on action progress was provided. The Ysbyty Glan Clwyd (YGC) insulin administration action plan is progressing towards completion. A draft procedure for prescribing insulin at the front door has been written for discussion by the 3 Multidisciplinary Teams (MDTs) formed at the

three acute sites, with the objective of developing a BCU wide document. The draft guideline will be finalised by the end of July and submitted for approval. Once finalised local training will be prepared and delivered. Improvement will be measured from point prevalence studies in Emergency Department (ED) and DATIX reports.

- **Strategic Falls Group:** Progress against the Health and Safety Executive (HSE) Improvement Notice was reported. The group has established three core sub groups comprising of members to meet weekly to expedite the completion of core actions to meet the HSE Improvement Notice requirements. The sub groups are: 1) Policy and aligned documents, 2) Training and education and 3) Data and reporting. Key members of the Strategic Falls Group are representatives on the All Wales Inpatient Falls Network to support, inform, share learning and influence the development of all Wales standards in respect of addressing the recommendations of the National Audit of In Patient Falls (NAIF.)
- **Concerns Management and Quality Systems Group:** An update on the roll-out of the new RLDatix and Civica systems was provided. The plans remain on track, with the new RLDatix system working to a revised availability date of September 2021.
- **Divisional Reports:** Each division submitted and presented a report. Of note:
 - Secondary Care highlighted increases in occupancy, delays with patient flow and the impact to Planned Care. Assurance was received that each Hospital Management Team (HMT) are taking actions to ease pressures and increase patient flow. Current measures in place are being monitored and reviewed with additional actions being identified and considered to address the issues. YGC have identified the requirement for earlier discharge across the site, inclusive of wards and assessment units. This has been reinforced from the National Collaborative Commissioning Unit (NCCU) visit. Work is being undertaken in relation to the 'perfect ward'. Once this has been established on one ward it will be cascaded throughout the site. Monday 14 June, 2021 saw the launch of the new BCUHB Local Safety Standards for Invasive Procedures (LocSSIPs) Library SharePoint. This site will be live and available for all staff to view and utilise LocSSIPs within clinical areas. The LocSSIPs Library can be found on the intranet home-page.
 - Central Area highlighted challenges to provide sufficient office working space for community dental staff (dental health team members) returning from redeployed roles in Llangefni. They also highlighted staffing issues at Minor Injury Units.
 - West Area highlighted the increasing number of concerns from Holyhead managed primary care practice – mainly around access.
 - Mental Health & Learning Disabilities (MHLDD) Division reported on ligature risk reduction work in response to a serious incident at the Hergest Unit.
- The **Corporate Safeguarding Annual Report** was received and approved.

- A presentation was received from the **Nursing Information Officer** on the new Welsh Nursing Care Record.
- A presentation was received from the Director of Nursing for Wrexham Maelor Hospital on the pilot of a **Matrons Helpline**. The helpline provides access to a senior nurse with the aim of reducing concerns and complaints.
- The **Deprivation of Liberty Safeguards Annual Report** was received and approved.
- A number of **procedural documents** were approved:
 - Primary Care Management of Blood Glucose in Type 2 Diabetes
 - Clinical Guideline for Immunoglobulin Use
 - MHLA Bed Escalation Procedure

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

- **Surgical Safety:** The launch of the new single LocSSIPs portal was noted.



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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 Occupational Health Safety and Security Sue Morgan – Head of Health & Safety
Date of meeting; only if a Sub-group reporting, otherwise 'Not Applicable' (N/A)	3 rd August 2021
Version number	1.0
List Appendices, if applicable	1. Sharps Q1.
Reporting To	
Name of meeting	Quality, Safety & Experience Committee (QSE)
Date of meeting	7 th September 2021
Presented by	Sue Green – Executive Director of Workforce and Organisational Development
1. Alert	

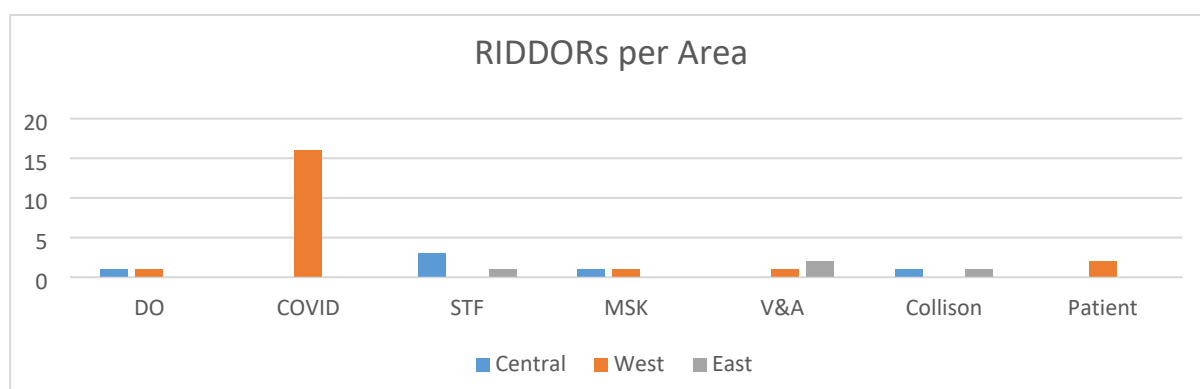
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

With effective COVID-19 management in clinical and non-clinical settings, together with a high uptake of the COVID-19 vaccine by staff, a marked decrease can be seen in Q1 in the number of occupational disease reports that have been made to the Health & Safety Executive (HSE) under RIDDOR. 15 of those reported are associated with the last COVID-19 outbreak in Ysbyty Gwynedd, with 1 further isolated case of transmission to a community staff member in West of the new delta variant. The Area West Team carried out a robust investigation for this case; the Team were supported by Infection Prevention & Control (IP&C), Health and Safety (H&S), Test, Trace & Protect (TTP) and Public Health Wales (PHW) and immediate mitigation was implemented. Although there have been further staff COVID-19 diagnosis, robust investigation has not identified further work-related transmission.

A total of 35 RIDDOR reports were made to the HSE in Q1. These break down into:

1. 2 Dangerous Occurrences (1 fire-related, 1 overturned hoist)
2. 28 incidents involving staff: 16 COVID-19 related; 4 slip, trip and falls incidents, 3 violence and aggressions incidents, 2 musculoskeletal injuries, 3 collisions with equipment
3. 5 Patient related falls with Specified Injury.

Area	COVID-19 RIDDOR's	Non COVID-19 RIDDOR's	Total Q1 2021	Comparison total Q1 2020
Central	0	6	6	13
West	16	5	21	4
East	0	8	8	9
Totals	16	19	35	26



All Root Cause Analysis (RCA)s are currently scrutinised monthly by the Corporate H&S Managers for quality, suitability and effectiveness. Any identified lessons learnt are shared locally and escalated through the H&S Leads and Hospital Management Teams (HMTs) via the Strategic Occupational Health and Safety Group.

Corporate H&S Team Site visits

The H&S team primarily focused on supporting the Hospital Management Teams and department managers to undertake risk assessments for staff returning from shielding. During this quarter, 58 assessments were conducted which has seen a large increase as staff have returned to work or continue with Agile working, with 78% of assessments carried out relating to Display Screen Equipment (DSE).

HSE Update

Following the issuing of an Improvement Notice in August 2020, the Executive Team authorised a number of changes to the fit testing program across BCUHB. These changes included the introduction of a dedicated fit testing program team, fit testing hubs on the District General Hospital (DGH) sites, the move to quantitative testing via the PortaCount machines, the retraining of all fit testers to ensure competence and the recording of fit tests and training on Electronic Staff Record (ESR). The Fit testing Programme Team members were recruited on a secondment basis and a business case has been submitted to the Executive Team for substantive posts. The Fit Testing Program currently has a Programme Lead, 2 Regional Coordinators and an Information Systems Officer. The Regional Coordinator post for East is unfulfilled; this is due to the extension of the secondment not being possible.

Risk Register

The following risks were escalated from the Strategic Occupational Health and Safety Group:

Risk ID3893- Manual Handling Training and lack of dedicated facilities

There is a significant risk that BCUHB is non-compliant with the Manual Handling Operation Regulations 1992 (amended 2002), due to no dedicated training rooms in East or West and only one dedicated training room in Central. Whilst training is unable to take place there is a risk of staff and patient injury, lost work time, HSE enforcement action and reputational damage. The risk was escalated via the group and comments made by the Strategic Occupational Health and Safety Group. Subsequent to the meeting, the Executive Team has agreed a set of mitigating actions and the business case for resources has been agreed. The risk will be reviewed once mitigating actions are in place.

2. Assurance

Estates Triple A report

A report was received from the Director of Estates and Facilities who gave an update on the the Board Assurance framework and risk register along with updates from the Safety meetings established in Estates and Facilities. The report described progress on key areas of risk including, fire safety, water safety, electrical safety and asbestos. Two specific reports were reviewed in relation to Electrical Safety and Asbestos Management. Progress had been made in a number of areas however, infrastructure concerns relating to having staff on site to manage the risks and competence were raised. This is particularly around tracking activity in premises without a specific building managers in place on a number of sites. There is also a requirement to establish robust systems through the Micad database and this forms part of the Estates Business case plan moving forward. It was agreed an in-depth Risk Register review of safety critical issues on the Board Assurance Framework (BAF) and Estates Risk

Register will be undertaken in September to clarify current status and business case developments.

Divisional Triple A Reports

This was a requirement for reports to be submitted from HMTs, Area Directors and the Mental Health & Learning Disabilities (MHLDD) Division. Reports were received from area West, Central Area, Wrexham Hospital and Ysbyty Gwynedd. All other areas will be contacted to ask for reports at next meeting.

Occupational Health Report

A health surveillance programme of investigation to identify hazards and quality of risk assessments through site visits has been undertaken. A clear action plan has been developed and is in progress. Site inspection visits to posture and mobility sites have indicated that Occupational Hygiene assessments are required to determine exposures. Over the next 12 months, a review of the current health surveillance programme will be undertaken. There will be a monthly focus on each hazard to ensure accurate and compliant measurements are in place to produce suitable and sufficient risk assessments and a programme of health measurements. These will then be reported on at the next Strategic Occupational Health and Safety Group as part of the ongoing risk reduction strategy.

3. Achievements

A snapshot of the Health and Safety Teams performance was provided to the Strategic Occupational Health and Safety Group, with a request to provide feedback on the format and content.



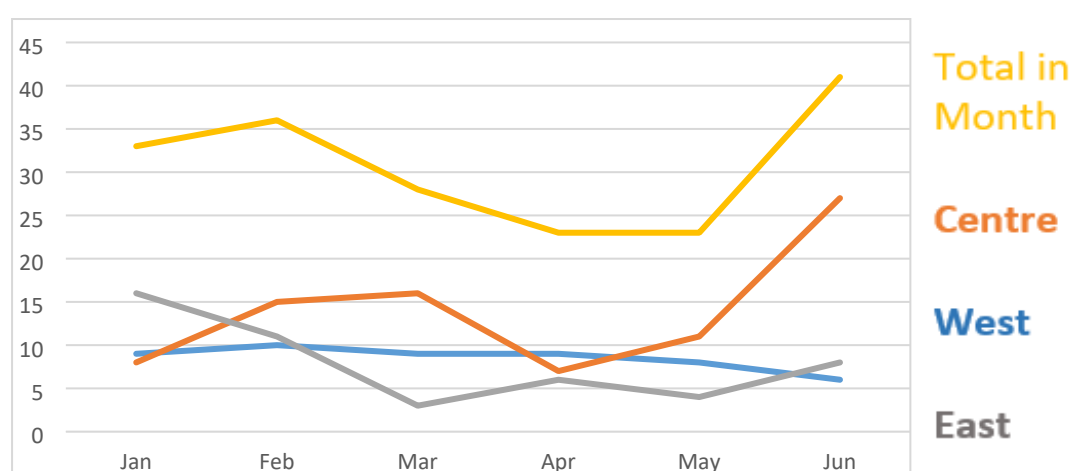
- The Root Cause Analysis Group Terms of Reference were agreed subject to amendments provided by the Patient Safety Team
- The Control of Noise at Work Policy was accepted and ratified.
- The Draft Lone Worker Policy was distributed for information and comments.
- Significant progress is being made to complete the gap analysis following the Corporate Health and Safety Compliance Audit undertaken in 2019/20. Specific H&S reports have now been completed for Water Safety management and Electrical Safety and Asbestos Management. Action plans have been completed and these will be updated via the specific Estates management group with responsibility for these areas.

- A trial of the Full Support FSM18 was completed, feedback gained and results analysed. We achieved a 95% pass rate for people who had already failed on the other single-use variants, in part due to the smaller size of the FSM18.
- Due to clinical fit testers being drawn back as clinical activity has increased, the reduction in number of active Fit Testers caused a deficit in resource for Fit Testing. In recognition of this, the Executives supported the need for an Escalation Protocol which would allow the team to escalate to HMTs and Area Management Teams when there was a need to scale up fit testing program work. This was written, communicated to Directors and went live on the Intranet on 01/07/2021.
- A Fit Testing Hub was established in Wrexham Maelor Hospital (WMH), bringing this site in line with other regions. This provides a specific room where Fit Testers can undertake the Fit Testing activity, as well as acting as a base for Coordinators and providing storage for PortaCount machines, accessories and fit testing supplies.
- Across BCUHB in Q1 1,377 fit tests were undertaken. This appears to be in line with the estimated 6,000 tests, which will be required annually to meet demand.

Appendix 1: Sharps Safety Quarter 1.

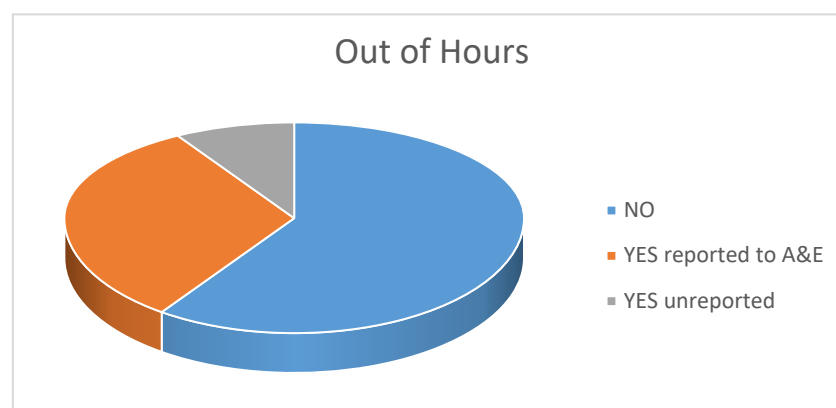
There were 87 needlestick/sharp incidents (NSIs) reported to Occupational Health in Quarter 1. 23 incidents in April, 23 in May and 41 in June. Venepuncture is consistently the highest causative factor, largely based upon frequency of operation being by far the highest activity performed.

	Apr	May	Jun	Total
Bangor	9	8	6	23
Glan Clwyd	7	11	27	45
Wrexham	6	4	8	18
Other	1			1
Grand Total	23	23	41	87



Of 25 incidents where sharp safe devices were reportedly used, 11 stated the injury occurred whilst deploying safety devices or due to device failure. Disposal of waste is an area that needs reviewing particularly where a number of incidents involved facilities staff, which occur away from an identifiable source patient.

5 individuals reported having 2 NSIs over the period. 40% of cases occurred out of hours with 18 of these going unreported at the time.



Behavioural elements include undertaking sharps procedures in the knowledge of the unavailability or improper use of sharps boxes, and unsafe procedures such as re-sheathing

needles. A further investigation into causes listed as “other” reveals more splashing of mucosa and spillage data rather than inoculation, cut or other skin damage.

Recommendations

- Discuss findings at the Health and Safety Leads meeting in September for service areas to review and take local actions.
- Review opportunities to involve NSI into Safe, Clean Care activities.
- A refresh on global awareness of NSI prevention via establish communication methods following Covid pressures potentially taking attention away from basic preventative strategies.



Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Debra Hickman, Secondary Care Nurse Director
Date of meeting	24 June 2021
Version number	V1.1
Appendices	N/A

Reporting To	
Name of meeting	Quality Safety and Experience Committee
Date of meeting	7 September 2021
Presented by	Matthew Joyes, Acting Associate Director of Quality Assurance

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

No significant alerts to escalate.

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

- **Patient Story** – It was agreed to consider the mechanism in place across BCUHB for patients being accompanied to an appointment by a carer or family member. This will be picked up through updated visiting guidelines.
- **Patient Communication and Readers Panels Sub-group:** A robust future work plan is in the development stages for a central library of all Patient Information for staff to access. This will be linked to the Office 365 roll out and new intranet site.
- **Bereavement Quality sub Group:**
 - Confirmed Dr Chris Stockport has agreed to take on the Executive lead role in respect of the Bereavement Quality work.
 - Partnership working is progressing with a number of stakeholders eg Patient Advice and Liaison Service (PALS) service, BCUHB Volunteers Manager etc

- **Triple A reports from Divisions:** The Group will review the reporting template to highlight the 'You said, we did' element. In addition:
 - The new complaints procedure is having a positive effect with Early Resolution, showing evidence of success numbers are reducing.
 - Divisions are working hard to reduce overdue complaints and achieve the compliance target. Positive practice highlighted throughout reporting templates.
- **Engagement Team:** continuing with positive Engagement work to support service improvement, linking with Universities, vaccination centres, supporting Track and Trace.
- **CANIAD:** Ward visits have been re-convened and ICAN community hubs up and running:
 - Identified themes include quality of food and boredom - taking actions forward.
 - Looking at virtual appointments using iPads.
- **Community Health Council:**
 - Highlighted issues around the transition with Child Adolescent Mental Health Services (CAMHS), meetings arranged.
 - Closely monitoring temporary service changes eg GP practices.
 - Vascular services - monitoring the next steps.
 - Urology – concerns around the length of time catheters are in and the quality of life patients are getting.

3. Achievement – include any significant achievements and outcomes

- **iPads:** Wards requesting more iPads to facilitate interaction for patients and relatives. A new order of iPADS has been received and are in the process of configuration.
- **CIVICA Realtime feedback:** The CIVICA All-Wales System soft launch is planned July 2021 ahead of a full roll-out plan during Q2/Q3.
- The group highlighted excellent innovation and proactive work around engagement by all staff and positive feedback from Stakeholders eg CANIAD and the Community Health Council (CHC).